CHAPTER ONE INTRODUCTION

1.1 Background

The human immunodeficiency virus (HIV/AIDS) pandemic has already caused immeasurable devastation to many individuals, families and communities (Gayle and Hill 2001). HIV/AIDS has already claimed millions of lives. The pandemic continues to inflict pain and grief and to cause fear and uncertainty in many communities. In some countries the HIV/AIDS pandemic is threatening economic devastation (Department of Health 2000, Gayle and Hill 2001). HIV/AIDS is the leading cause of death in Africa and the fourth overall leading cause of death worldwide (Kumaranayake and Watts 2000).

Estimates are that by the end of 2008, there were about 33.4 million people living with HIV globally. Seventy two percent of all HIV-related deaths were in sub-Saharan Africa and about 1.9 million were new infections. More than 95% of these new infections were in developing countries and over 45% were in young people (UNAIDS 2009).

Sub-Saharan Africa, especially Southern Africa appears to be the hardest hit region in the world. Of all people living with HIV, six out of every ten males, eight out of every ten females and nine out of every ten children are in sub-Saharan Africa (Jackson 2002). Although countries such as Botswana and Zimbabwe have shown remarkable declines in the prevalence of HIV, nine Southern African countries - including South Africa – still had a prevalence of over 10% in 2007 (UNAIDS 2009). Estimates are that by 2015 the total cost of HIV/AIDS treatment and care will consume up to two-thirds of health spending by governments in sub-Saharan Africa (Gayle and Hill 2001). The World Bank forecasts that a country like South Africa could face economic collapse within several generations, unless it prevents the rapid spread of HIV/AIDS more urgently (World Bank 2005).

Although data from the Antenatal survey suggest that over the past 3 years (2006-2008) South Africa's epidemic might be stabilizing, latest UNAIDS estimations are that there are about 5.7 million people living with HIV in South Africa (DOH 2009; UNAIDS 2009). This constitutes the largest HIV epidemic in the world (UNAIDS 2009). In 1991 less than 2% of women attending government antenatal services were HIV positive but by 1998 the figure had increased to 22.4% (Johnson, Modiba, Monnakgotla et al. 2001). The South African national HIV prevalence stands at 11.0% (Shisana, Rehle, Simbayi et al. 2009). Currently HIV prevalence among pregnant women attending public sector antenatal clinics stands at 29.3% with Kwazulu-Natal having the highest prevalence in the country at 38.7%. Gauteng province is estimated to be having an antenatal prevalence of 29.3% (DOH 2009).

The 2001-2002 annual report of the Health and Social Development department – in Ekurhuleni – found that of the people tested in public health facilities, during this period, 52% were HIV positive. Presently, Ekurhuleni at 31.5% has the second highest antennal prevalence in Gauteng (DOH 2009).

There has been a significant increase in global funding for HIV/AIDS, from US$ 1.6 billion in 2001 to US$ 8.9 billion in 2006 (World Bank 2008). According to the World Bank (2008) US$18 billion was needed in 2007 for treatment, prevention and care, and the majority of this money would have been needed in sub-Saharan Africa. By expanding initiatives for prevention, treatment and care almost one million deaths will be averted annually by 2011 (World Bank 2008). Unless the incidence of HIV is sharply reduced, HIV treatment will not be able to keep pace with all those who will need therapy (Lamptey and Wilson 2005). Although VCT is a relatively costly activity, there is a belief that it is a cost effective intervention for behavioral change and has been shown in some cases to lead to a decrease in unprotected sex, reduction in multiple sexual partnerships, increase in condom use and an increase in sexual abstinence (IPPF 2004). HIV prevention- of which VCT is an integral part- has to been seen therefore, as a capital investment for the future and not as an item of expenditure. With proper prevention 29

million (63%) of the 45 million new infections expected to occur between 2002 and 2010 would be averted (UNAIDS 2005b).

Many countries have since realized that treatment and prevention strategies are not distinctive and competing responses to HIV/AIDS (Kelly 2002). In line with international trends, South Africa has recognized voluntary counseling and testing (VCT) for HIV as being crucial for both treatment and prevention of HIV/AIDS (DOH 2000; Kelly 2002; Magongo, Magwaza, Makhubele et al. 2002). One of the key strategies of the government's HIV/AIDS/STD strategic plan is to increase acceptability and access to VCT with special focus on youth, women and migrant workers (DOH 2000).

Access to information on ones' HIV status is a human right as well as a public health measure and VCT services are supposed to provide a supportive venue for learning this essential health information (Jackson 2002).

The Department of Health defines VCT as a process by which an individual undergoes counseling to enable them to make an informed decision about being tested for HIV, assess their personal risk for HIV and develop a risk reduction strategy. VCT requires individual choice, confidentiality, informed consent, pretest and post-test counseling, effective referral system and effective counselor support system (DOH undated).

VCT covers a variety of interventions in different settings. These may include VCT services that are mainly client initiated and completely voluntary for asymptomatic people who wish to know their status. Other services can be mainly provider initiated – with the option of opting-out – where a client has the right to refuse. These are mainly in clinical treatment setting for diagnostic purposes and in settings where specific vulnerable groups such as sex workers, drug users, men who have sex with men (MSM) and women attending ante-natal services are targeted for intervention (WHO 2005).

Both UNAIDS and WHO do not support mandatory testing for HIV of individuals on public health grounds but current debates are that HIV/AIDS should be recognized as an

emergency and therefore, be addressed within a public health approach- where individual rights can be restricted- thus leading to the imposition of routine testing (UNAIDS 2003). The normalization of HIV/AIDS in a philosophical context of public health, medical ethics and social justice should therefore, not be seen as a threat to individual human rights (De Cock, Mbori-Ngacha and Marum 2003).

1.2 Justification of the study

Although VCT has been available at some sites across the country even before 2000, there have been very few studies conducted to evaluate its implementation at a local municipality level. This study hopes to give an overview of VCT services in the Ekurhuleni Metropolitan Municipality.

1.3 Aims and objectives

a). Aim: To assess implementation of VCT services in the Ekurhuleni Metropolitan Municipality between January 2004 and March 2007.

b). Objectives:

- To describe the VCT sites included in the study.
- To describe the services offered at VCT sites.
- To determine the uptake patterns in the VCT sites.
- To describe referral systems available to VCT sites.