

**SWAZILAND HUMAN DEVELOPMENT REPORT**

**HIV AND AIDS AND CULTURE**

**MARCH 2007**

## FOREWORD

The HIV prevalence rates for Swaziland (at 25.9% of the 15-49 year age group), is estimated to be the highest in the world. The devastating effects of HIV&AIDS at personal, family, community and country levels remains a daunting challenge for our country. If this problem is not halted and ultimately reversed, the nation's very existence is under threat. The current prevalence rates and projections as alluded to in the 2007 report "Reviewing Emergencies for Swaziland: Shifting the Paradigm in a New Era" (Whiteside and Whalley, 2007) points to a bleak future. Analysis of the aforementioned report indicates that coping mechanisms are seriously under stress and life expectancy has fallen to an all time low; from 60 years in 1997 to 31.3 in 2004. All critical social and economic indicators are in a state of serious decline. It is estimated that by 2015 the demographic profile of the country will consist of the older age groups and the very young. *Our nation is indeed under siege.*

The 2007 National Human Development Report's focus on HIV and AIDS and culture is timely as our nation searches for a way out of this crisis. Swaziland is regarded as a country that has combined modernity and tradition in the implementation of its governance framework. As culture and traditions in our country are to a great extent, regarded by many as sacrosanct, the consequences of the HIV and AIDS crisis compels us to think outside the box. The report seeks to provide insights on the interface between culture and contemporary society with the goal of identifying interventions that assist national stakeholders at all levels to effectively address the HIV/AIDS pandemic. It must be noted that behavior change is at the core of preventive approaches to combating the pandemic. Behaviour is to a great extent influenced by culture. It is therefore essential that our culture vis-à-vis HIV and AIDS be interrogated with a view to identify cultural practices that reinforce positive behavior towards combating HIV, and eliminate those negative practices and attitudes that undermine such efforts.

It is only when we acknowledge the strengths and weaknesses of our culture that we can begin to address the challenges posed by the pandemic. The report clearly contextualizes culture and how it relates to HIV and AIDS; it clarifies the declining human development indicators and presents a graphic picture on the current HIV and AIDS trends, patterns and drivers of the pandemic in the country. The country's efforts in addressing this scourge are also well articulated in the report, which helps us to identify key achievements and also gaps in our interventions. Most importantly, the report also recommends various policy options and strategies from which the leadership at all levels should carefully examine with a view towards developing lasting solutions as we attempt to save the nation from this calamity.

I am grateful that the United Nations Development Programme (UNDP) has assisted with the development of this critical document which will go a long way in helping the country to find solutions regarding the devastating effects of HIV and AIDS on human development. It must also be noted that the document is a product of wide consultation with key stakeholders in the country to ensure that what is reflected in the report is factual, balanced and helpful to our course as a nation.

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**Executive Director**  
**Coordinating Assembly of NGOs**

The analysis and policy recommendations of this report do not necessarily reflect the views of the United Nations Development Programme, its Executive Board or its Member States. The report is an independent publication commissioned by UNDP Swaziland. It is the fruit of a collaborative effort by a team of eminent consultants and advisors.

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## ABBREVIATIONS AND ACRONYMS

ABC	Abstain, be faithful and use condoms
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal clinics
ART	Antiretroviral therapy
ARVs	Antiretrovirals
BSS	Behavioural Surveillance Survey
CEDAW	Convention on the Elimination of Discrimination Against Women
CMA	Common monetary area
CSO	Central Statistical Office
CSWs	Commercial sex workers
DOTS	Direct observation treatment strategy
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
EPP	Estimation and projection package (EPP) software
EU	European Union
FGD	Focus group discussions
FDI	Foreign direct investment
GDI	Governance Development Index
GDI	Gender Development Index
GDP	Gross domestic product
GEM	Gender Empowerment Measure
GHDR	Global Human Development Report
GIPA	Greater Involvement of People Living with HIV and AIDS
GNP	Gross national product
GOS	Government of Swaziland
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
IEC	Information, education and communication
IMF	International Monetary Fund
MIC	Middle-income country
MOAC	Ministry of Agriculture and Cooperatives
MOHSW	Ministry of Health and Social Welfare
MDGs	Millennium Development Goals
NCP	Neighbourhood care point
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-governmental organisations
NHDR	National Human Development Report
NVP	Nevirapine
OIs	Opportunistic infections
OVCs	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PPP	Purchasing Power Parity

RPR	Rapid plasma reagin screening test
SACU	Southern African Customs Union
SADC	Southern African Development Community
SDHS	Swaziland Demographic and Health Survey
SHIES	Swaziland Household Income and Expenditure Survey
SNAP	Swaziland National AIDS Programme
SNL	Swaziland National Land
STIs	Sexually transmitted infections
SWAGAA	Swaziland Action Group Against Abuse
TASC	The AIDS Information and Support Centre
TDL	Title deed land
TMPs	Traditional medical practitioners
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VAC	Vulnerable assessment committee
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WTO	World Trade Organisation

## GLOSSARY OF TERMS

### Chapter 1

**Hospice:** A non-governmental organisation with a mandate to alleviate the suffering of people with a terminal illness (e.g. cancer or AIDS) throughout the kingdom, thereby enhancing the quality of life for such people in the final stages of illness. Hospices educate health authorities and medical personnel on the principles of hospice care and the benefits it can accrue to the people of Swaziland.

**Palliative care:** Medical treatment that does not cure the disease, but alleviates suffering and reduces the pain. Hospice at Home in Swaziland provides such care.

### Chapter 2

**Absolute poverty:** This term is often used loosely to denote extreme poverty. It is defined by a fixed standard. An example is the international US\$1 a day poverty line, which is designed to compare the extent of poverty across different countries. National poverty lines are fixed locally and their real value stays the same over time in order to determine changes in poverty in a country.

**Chronic food insecurity:** A state of a continuously inadequate diet, precipitated by the inability to acquire food. In this case, households are persistently failing to produce and/or buy enough food. Chronic food insecurity is different from transitory food insecurity, which is a temporary inability to access adequate food in terms of quantity and quality.

**Extreme hunger:** The inability to meet minimum levels of food consumption. The call in the Millennium Development Goals is to halve the proportion of people who suffer from hunger between 1990 and 2015. Measurement of the progress will be done through two indicators: (i) the prevalence of underweight children younger than five; and (ii) the proportion of the population below the minimum level of dietary energy consumption.

**Extreme poverty:** Indigence or destitution usually specified as the inability to satisfy even minimal food needs. Progress towards the eradication of extreme poverty will be measured through three indicators: (i) the proportion of the population living below the \$1 per day poverty line in PPP values; (ii) the poverty gap ratio (incidence x depth of poverty); (iii) the share of the poorest quintile in national consumption.

**Environmental sustainability:** Maintaining ecological integrity by ensuring that the activities of people, including the pursuit of livelihood, do not irreversibly degrade natural resources within a given ecosystem. Within the context of the Millennium Development Goals the requirement is that country policies and programmes integrate the principles of sustainable development aiming at reversing the loss of environmental resources. Land areas that are protected to maintain biological diversity are considered one of the appropriate indicators for monitoring environmental sustainability.

**Functioning, capabilities and freedom:** The valuable things that a person can do or be, such as being well-nourished, living long and taking part in the life of a community. The capability of a person represents different combinations of functioning a person can achieve. Capabilities reflect the freedom to achieve proper functioning. In that sense, human development is freedom.

**Gender Related Development Index (GDI):** The GDI measures achievements in the same dimensions and using the same variables as the HDI, but takes into account inequality in achievement between women and men. The greater the gender disparity in basic human development, the lower a country's GDI compared with its HDI. The GDI is simply the HDI discounted, in other words adjusted downwards, for gender inequality.

**Gender empowerment:** Enhancing the functioning and capabilities of women so that they are able to participate in the economic, social and decision-making life of the country. In the context of the Millennium Development Goals this refers to granting women equal opportunities for education, wage employment in the non-agricultural sector and participation in decision-making as partly reflected by the share of the number of seats of women members of parliament.

**Gender Empowerment Measure (GEM):** The GEM indicates whether women are able to participate actively in economic and political life. It measures gender inequality in key areas of economic and political participation and decision-making. The GEM, which focuses on women's opportunities in economic and political arenas, differs from the GDI, an indicator of gender inequality in basic capabilities.

**Human development:** The process of expanding the choices and opportunities that people value highly through enhancing their capabilities and functioning. Three choices and opportunities are considered to be essential: having a long and healthy life; acquiring knowledge and becoming part of a world of information; and enjoying a decent standard of living. Other choices are however recognised as also being important for human development, including political, economic and social freedom, guaranteed human rights as well as the attainment of dignity, self-respect and a sense of belonging to the community.

**Human Development Index (HDI):** The HDI measures a country's average achievements in three basic dimensions of human development – a long and healthy life, knowledge and a decent standard of living. As a composite index the HDI contains three variables – life expectancy at birth, educational attainment (adult literacy and the combined gross primary, secondary and tertiary enrolment ratio) and GDP per capita (PPP in US\$). Income enters the HDI as a proxy for a decent standard of living and as a surrogate for all human choices not reflected in the other two dimensions.

**Human poverty:** Deprivations in the multiple elements that constitute human development or simply a denial in opportunities and choices that are most basic to human development. Human poverty is differentiated from income poverty, which is defined as a lack of minimally adequate income or expenditure. Building on the concept of human development, the reason for the differentiation is that inadequate income does not constitute the sum of people's deprivations.

**Infant mortality:** The death of babies before their first birthday. The infant mortality rate (IMR) is the number of babies in this age group who die every year out of every 1 000 live births.

**Maternal mortality:** The death of women from pregnancy related causes. The maternal mortality ratio is the proportion of women who die from such causes annually out of every 100 000 live births.

**Millennium Declaration:** The declaration signed by 147 heads of state and government and 44 representatives attending the United Nations Millennium Summit in September 2000. The declaration outlines the intent of the international community to take steps to combat the deprivations to which a big part of the world population is still exposed.

**Millennium Development Goals:** A set of eight mutually reinforcing development goals contained in the Millennium Declaration and connected to other internationally agreed goals and targets. The MDGs were adopted to help implement the shared values of the international community in the 21<sup>st</sup> century.

The eight Millennium Development Goals are:

- Eradication of extreme poverty and hunger
- Achievement of universal primary education
- Promotion of gender equality and empowerment of women
- Reduction of child mortality
- Improvement of maternal health
- Combating HIV and AIDS, malaria and other diseases
- Ensuring environmental sustainability
- Developing global partnerships for development

The United Nations Development Group, in collaboration with other institutions, has developed quantitative targets and corresponding indicators to measure the achievement of the goals. Monitoring mechanisms at international and country levels have been discussed and put in place.

**Overall poverty:** The inability to satisfy essential non-food as well as food needs. Definitions of essential non-food needs can vary significantly across countries.

**Purchasing Power Parity (PPP):** PPP is a criterion for an appropriate exchange rate between currencies. It is a rate such that a representative basket of goods in country A costs the same as in country B if the currencies are exchanged at that rate.

**Relative poverty:** Poverty by standards that can change across countries or over time. An example is a poverty line set at one half of the mean per capita income. This means the line can rise when income increases. Often this term is used loosely to mean overall poverty.

**Stunting:** Refers to low height for age, indicating poor linear growth in children. Stunting reflects long-term and chronic periods of low food intake.

**Under-five mortality:** The death of children aged between birth and exactly five years. The under-five mortality rate is the number of children in this age range who die every year out of every 1 000 live births.

**Underweight:** This is an indication of malnourishment in a child with low weight for their age. A child can be underweight because of poor linear growth, poor growth in body mass or both. The prevalence of underweight children younger than five has been adopted as one of the two indicators that will be used to assess the Millennium Development Goal of halving the 1990 level of hunger by 2015.

**Universal primary education:** The state attained when children are able to finish a full course of primary education. Movement towards the achievement of universal primary education will be monitored through the ratio of children of primary school-going age actually enrolled in primary school, the proportion of those starting grade 1 who reach grade 5 and the literacy rate of 15-24 year olds.

**Wasting:** The state of children of low weight for their age or thinness due to an acute and short-term severe infection or food deprivation as it takes place during a famine. A child is said to be wasted if their weight is low in relation to their height.

### Chapter 3

**Cervical ectopy:** A condition in which a small ring of cells extend beyond the normal border of the endometrium (the inner wall of the uterus) to the cervix (the neck of the uterus).

**Chancroid:** A sexually transmitted infection caused by the gram negative bacterium *haemophilus ducreyi*, characterised by painful genital ulcers.

**Epithelial barrier:** Highly specialised stratified epithelia tissues, cells closely packed and arranged in more than one layer that form the covering or lining of internal and external body surfaces. It serves to protect the body from physical and chemical damage, infection, dehydration or heat loss.

**Genital herpes:** A sexually transmitted infection caused by the herpes simplex viruses (HSV) type one and type two.

**Genital ulcers:** Sores and blisters on the genital parts that can be caused by sexually transmitted infections, among others.

**Keratinised:** Converted into keratin or filled with keratin. Keratin is a tough, insoluble protein substance that is the chief structural constituent of hair, nails, horns and hooves.

**Prepuce:** A retractable piece of skin in boys which covers the forepart of the penis.

**Syphilis:** A sexually transmitted infection caused by spirochaete bacterium, *treponema pallidum*.

### Chapter 4

**Child:** Universally the definition is a person who is under 15 years of age. In Swaziland it is a person under 18 years of age.

**Orphan:** In Swaziland an orphan is a child (a person younger than 18 years) who has lost one or both parents.

**Orphan and vulnerable child (OVC):** A child under the age of 18 years and belongs to one or more of these categories: parents or guardians are incapable of caring for them; physically challenged; staying alone or with poor elderly grandparents; lives in a poor sibling-headed household; has no fixed place of abode; lacks access to healthcare, education, food, clothing, psychological care; no shelter to protect them from the elements; exposed to sexual or physical abuse, including child labour.

### Chapter 5

**Nosocomial transmission:** Transmission of HIV from patients to health workers that occurs during the duty of the latter.

## Chapter 6

**Phimosis:** A medical condition in which the foreskin of the penis of a male cannot be fully retracted.

**Paraphimosis:** A medical condition where the foreskin becomes trapped behind the head (glans) of the penis, and cannot be pulled back to its normal flaccid position covering the glans of the penis.

**Balanitis:** A term used to include all inflammation of the skin covering the head of the penis.

## SISWATI WORDS AND THEIR MEANING

*banakekeli* – caregivers  
*bandlancane* – chief’s inner council  
*bandlakhulu* – whole community council  
*bunganwa* – having multiple female partners one is not married to  
chief’s *emabandla* – chief’s councils  
*egumeni* – a windbreaker made from grass or reeds  
*emabandla* – advisory structure to his majesty, chiefs  
*emaganu* – marula fruit/drink or brew  
*emajaha* – boys  
*emasiko* – traditions, behavioural norms that people follow with pride and no embarrassment  
*esangweni* – the entrance of a homestead; men camp there in the evening in front of the fire  
*imiphakatsi* – chiefdoms  
*incwala* – cultural ceremony of celebrating the first fruits  
*indlunkhulu* – the chief’s compound  
*indvuna* – headman to the chief  
*indvuna yemajaha / yetintfombi* – commanders of age regiments  
*indvuna yemcuba* – a governor of a chiefdom reporting to the chief  
*inganwa* – a stud, a man with many sexual partners who is proud of it  
*inhlanti* – bearing children for a barren aunt  
*inkhundla* – a place of meeting  
*insila yemaswati* – indigenous, inherited from the ancestors  
*kagogo* or *gogo* centres – grandmother centres, a concept used to extend a helping hand for orphans and vulnerable children, who get meals at the centre  
*Khulisa Umntfwana* – Child Socialisation Parenting  
*kubutseka* – joining a regiment  
*kufaka umntfwana esiswini* – child adoption  
*kuhlanta* – younger sister of a married woman who has a child with her infertile sister’s husband  
*kuhoba* – a hairdo similar to dreads  
*kujuma* – an official visit to a lover’s family  
*kulamuta* – having sex with the younger sister of one’s wife  
*kungena* – custom of widow inheritance  
*kungenwa* – act of a widow being inherited  
*kushenda* – extramarital relationships by a married man or a married woman  
*kutala kute lula ematsambo* – children are an investment in the future  
*kuteka* – customary marriage  
*kuzila* – mourning  
*kuvunula* – adorning traditional regalia  
*kwendzisa* – arranged marriage  
*libandla* – council  
*lilawu* and *intsanga* – separate sleeping quarters for boys and girls  
*lilima* – contribution of voluntary labour by members of the community  
*lusekwane* – a sacred shrub used during the *incwala* ceremony, picked by young boys  
*lusekwane, umhlanga* – customs preserving chastity in boys and girls  
*lutsango* – a national women’s organisation  
*luyabhama emalolini* – sex in a truck  
*ngwenyama* – one of the titles of his majesty the King (the main title of the King as sovereign leader)  
*sitsembu* – polygamy

*tindvuna tetinkhundla* – governors at *inkhundla* level

*tinfombi* – girls

*umcwasho* – a cultural rite of virgin girls tying woollen tassels to signify their purity

*umftwana ngumliba loya embili* – children are the future generation

*umgijimi* – chief's runner

*umhlanga* – reeds or reed dance

*umliba lomunhle nguloya embili* – an idiom meaning children are the future



## BALANCE SHEET OF HUMAN DEVELOPMENT IN SWAZILAND

PROGRESS	CHALLENGES
<b>HIV and AIDS</b>	
<ul style="list-style-type: none"> <li>• The country has declared war against HIV and AIDS, as it is a national disaster.</li> <li>• The HIV prevalence among antenatal clinic attendants rose from 3,9% in 1992 to 42,6% (2004), declining slightly to 39,2% (2006).</li> </ul>	<ul style="list-style-type: none"> <li>• The HIV prevalence rate among adults aged 15-49 of 26% in 2006/2007 is high.</li> <li>• The HIV prevalence rate among women aged 15-49 years of 31% is much higher than that of adult men of the same ages (20%).</li> <li>• The country's life expectancy dropped sharply from 60 years in 1997 to 33,7 years in 2007.</li> <li>• A high proportion of admissions (60%) in hospitals in 2006 are due to HIV and AIDS.</li> <li>• The prevalence of OVCs of 31% in 2006/2007 is high.</li> </ul>
<b>EDUCATION</b>	
<ul style="list-style-type: none"> <li>• The illiteracy rate declined from 28,4% in 1991 to 20,4% in 2004.</li> <li>• There is an enrolment rate of 101% for primary education.</li> <li>• Lower primary education is subsidised.</li> </ul>	<ul style="list-style-type: none"> <li>• The drop-out rate of 21% in primary and 26% in secondary education in 2005 is a major concern.</li> <li>• The teacher-learner ratio of 1:35 in primary schools is high and compromises the quality of education.</li> </ul>
<b>ECONOMY and POVERTY</b>	
<ul style="list-style-type: none"> <li>• Combating poverty is an overarching priority in the poverty reduction strategy and action plan (PRSAP).</li> <li>• The adoption of the national development strategy (NDS) with Vision 2022 in the development frameworks and plans is also seen as a major achievement in improving the economy and the lives of all Swazis.</li> <li>• Compared to other SADC countries, Swaziland's GDP of US\$1 250 is relatively high (UNDP, 2006).</li> <li>• The small and medium enterprise (SME) policy was launched in 2006 to promote employment chances in the country.</li> </ul>	<ul style="list-style-type: none"> <li>• The poverty incidence of 69% recorded in 2001 is too high for an MIC like Swaziland.</li> <li>• The national unemployment rate of 29% is high and demands policy attention.</li> <li>• The GDP growth rate declined by 0,4% between 2003 and 2006.</li> <li>• The economy's high dependence on South Africa for its imports (80%) and exports (60%) is a challenge that needs urgent change.</li> </ul>
<b>AGRICULTURE and FOOD SECURITY</b>	
<ul style="list-style-type: none"> <li>• The cultivation of drought resistant crops, especially in the lowveld,</li> </ul>	<ul style="list-style-type: none"> <li>• Since 2000 the country has faced periods of severe drought.</li> </ul>

<p>increased recently.</p>	<ul style="list-style-type: none"> <li>• There was a reduction from 67 682 hectares in 2003 to approximately 47 000 hectares in 2006 in the area planted for maize, the staple food.</li> <li>• There are high risks of food insecurity: A population of close to 193 000 in 2006 suffered from acute food shortages.</li> </ul>
<p><b>GOVERNANCE and HUMAN RIGHTS</b></p>	
<ul style="list-style-type: none"> <li>• A new constitution was adopted in 2006.</li> <li>• More commissions of enquiry were conducted with the aim of cracking down on corruption in the country.</li> <li>• The decentralisation policy was adopted by government in 2005.</li> <li>• Parliament seats occupied by women have increased from 5 to 18 between 1998 and 2003. This is likely to continue growing and is expected to be slightly above 30% by 2015.</li> <li>• The process of codification of the Swazi laws and customs has started.</li> <li>• A disaster risk reduction policy has been in place since 2006.</li> <li>• All stakeholders made a commitment to fight corruption in the country and a draft national anti-corruption strategy was developed during 2006.</li> </ul>	<ul style="list-style-type: none"> <li>• The harmonization of existing laws with the 2006 constitution is yet to be done.</li> <li>• Gender-based violence is high and rising as reported rape cases grew from 698 in 2003 to 803 in 2006.</li> <li>• The reported cases of crime in housebreaking and theft at 7 324 and of murder and culpable homicide at 152 cases in 2005 is high.</li> </ul>
<p>• <b>WATER and SANITATION</b></p>	
<ul style="list-style-type: none"> <li>• With the kingdom purchasing a rig for digging more boreholes, efforts are being made to ensure that more people have access to safe water.</li> </ul>	<ul style="list-style-type: none"> <li>• The proportion of the population with access to improved sanitation is only 51%.</li> <li>• The percentage of the population with access to safe water at 54% in the rural areas of the country, where the majority of the population reside, is inadequate.</li> <li>• A mapping exercise of all functional water points is yet to be done.</li> </ul>
<p><b>CHILD CARE and CHILD MORTALITY</b></p>	
<ul style="list-style-type: none"> <li>• Exclusive breastfeeding by mothers is promoted.</li> <li>• Approximately 82% of eligible children were fully vaccinated against measles and polio and had completed BCG and DPT immunisations in</li> </ul>	<ul style="list-style-type: none"> <li>• There was a high prevalence of malnutrition of children aged 0-59 months (24%) in 2006/7.</li> <li>• The 2006/2007 infant mortality rate of 85 per 1 000 births is high.</li> <li>• The high prevalence of underweight at 7% is</li> </ul>

2006/2007.	unacceptable.
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## OVERVIEW

### Introduction

In the past Swaziland has met many challenges as a nation, including wars, droughts, famines and epidemics. Fortunately the country has fought off the challenges with firm resolve and determination, assisted largely by a strong adherence in the culture that created national unity, cohesion and bondage among the Swazi people.

The trials are however not over. The challenge currently facing the Swazi nation is HIV and AIDS. This pandemic is not only national, but also regional and global – and hence a more formidable challenge than many of the past ones. About 26% of the adult population aged 15-49 years, 40% of pregnant women attending antenatal care clinics and close to 50% in some sub-groups of the adult population are living with HIV and AIDS. These statistics, along with the rate at which the disease is spreading, indicate that unless urgent action is taken, the Swazi nation may soon be wiped off the world map. As can be seen in Box 1, His Majesty King Mswati III has already warned parliament and the nation to find a solution to the challenge or face the extinction of the nation. This solution could be in the Swazi culture.

#### Box 1 – Swazi nation at risk of extinction

*“There is a real possibility that the Swazi nation will cease to exist, unless we change our attitudes and behaviour.” (King Mswati III, 1999)*

### Culture

Culture is the total way of life of a group of people, including everything they think, say, do, believe and make. UNESCO, the United Nations agency concerned with educational, scientific and cultural activities, defines culture as in Box 2:

#### Box 2 – Definition of culture

*“Ways of life, traditions and beliefs, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communication, as well as arts and creativity.” (UNESCO, 1982)*

Culture is the sum of the learned behaviours of a group of people, generally considered to be their tradition and which is transmitted from generation to generation. Culture is the most easily observed and most distinctive product of a group of people’s way of life. Culture is formed when a group of people live together for a period of time and learn, accept and absorb the same way of life. Culture changes and adapts through a process of cultural evolution. It may be a source of unity or division, while at the same time making a population unique. The most successful cultural adaptations are handed from one generation to the next, while the least successful disappear.

There are seven major characteristics of culture. Firstly, it is learned. When human beings are born, they do not possess any cultural knowledge. Culture is not innate. It is something acquired in the environment and circumstances where one is raised. If one is raised in a culture other than one's own, one acquires that culture because culture is learned through interaction, observation and imitation. Secondly, culture is transmitted. Every old generation passes culture on to the younger generation and constantly reinforces it. If not transmitted, a culture would die.

Thirdly, culture is based on symbols. It is transmitted through verbal and nonverbal language, images and icons. Culture is also changeable: All cultures change over time; no culture is static. Change can occur as a result of invention in a society and/or the diffusion of cultural traits from one society to another. Fifthly, culture is integrated: It is not isolated from the outside world and undergoes constant internal integration in various segments of the society. Sixthly, culture is ethnocentric, referring to the belief that one's culture is superior and more worthy than other cultures. Lastly, culture is adaptive: in order to survive, culture must adapt to new circumstances.

According to Haralambos et al (1982), there are three main functions of culture. Firstly, culture defines accepted ways of behaving, using norms and values of a society that are transmitted through socialisation. Secondly, culture determines how the members of a society think and feel. This is usually taken for granted because it is part of the society. Members are often unconscious of their actions due to their culture. Thirdly, culture provides common solutions to common problems in a society. If a society is confronted with a challenge, it falls back to its culture to find its solution. This encourages a sense of belonging and material prosperity.

The family is important in the transmission of culture through socialisation. Primary socialisation, which is probably the most important aspect of socialisation, takes place in the family, from infancy through childhood to adulthood. The main functions of the family are sexual, reproductive, economic and educational.

### **Culture, HIV and AIDS and human development**

The theme of this report is HIV and AIDS and culture. The pandemic is perhaps the biggest development challenge facing Swaziland today. It is widely accepted that in order to contain the spread of HIV and AIDS and successfully mitigate the impact, culture plays a critical role. This means bringing to the fore many aspects in the Swazi culture that are supportive to this fight and allowing this understanding to form the national response.

It also requires identifying aspects that may promote the spread of HIV and AIDS, with a view to altering them. In this way society can protect itself from the calamity imposed by the pandemic. This will not be easy, because it calls for a review of aspects that have defined Swazi nationhood. Culture needs transformation in response to HIV and AIDS, if the Swazi nation is to survive.

In view of the above, there are many ways of contracting as well as preventing infection of HIV, which differ from one culture to another. Hence, culture influences attitudes and behaviour related to HIV and AIDS, such as seriously taking or not taking the risk of contracting HIV, accessing treatment and care, shaping gender relations and roles that put women and men at risk of infection, being supportive towards people living with HIV and AIDS and their families or discriminating against them. The theme of this report is intended to relate culture to the pandemic by analysing culture as the genesis of the major drivers of, and the hope for, a solution.

Viewed in a negative sense, the interactions between culture, HIV and AIDS and human development can be a vicious circle. In the face of the pandemic negative cultural beliefs, traditions, values and modes of life can lead to family and community crisis and aggravate gender inequalities. This can lead to the collapse of local economic and social organisations and migrations, from rural to urban areas as well as international migrations. This would weaken the cultural resources, such as spiritual and ethical capacity to face change, people's capacity to identify their needs, aspirations and priorities, traditional knowledge, know-how and technology.

The weakness of cultural resources would lead to vulnerability status, such as poverty, abandoned and orphaned children, widowhood, migrations, unemployment, poor health and lack of education. Vulnerability mixed with current sexual attitudes, irresponsible behaviour and sexual debut at an early age would lead to high-risk behaviour, such as violence, drug addiction, unsafe sex, multiple partners, sexual violence and sex work. The vulnerability creates a situation where traditional solidarities between parents and children, boys and girls, in youth groups and among adults and between vulnerable groups and high-risk groups break down. The situation also leads to the collapse of traditional life skills and coping mechanisms, without alternatives to help offset these breakdowns.

On the positive side, a cultural approach can be used to break the vicious circle (Sengendo et al, 2001). HIV and AIDS are regarded as multifaceted issues, requiring multisectoral and multidimensional strategies to reverse the spread. The use of appropriate communication and information channels based on cultural relevance, efficiency and sustainability would create mutual understanding between policymakers, programme managers and the targeted populations. This would restore important cultural values, such as community and family solidarity, ethical and spiritual values and the need to help others in the care and support of people living with HIV and AIDS.

Cultural resources, such as traditional knowledge, know-how and experience, especially of traditional healers, can be positively utilised in the treatment and care of people living with HIV and AIDS. Developing local response in the form of community participation and partnerships is essential in prevention, care and support programmes.

The cultural approach requires long-term, rather than short-term perspectives to have an impact and to lead to in-depth behavioural and motivational changes in the society. Action and information, education and communication (IEC) programmes can only succeed in reaching local populations if based on the cultural values and traditional resource systems.

### **Objectives of the report**

This is the third Human Development Report (HDR) of Swaziland. The first national report was prepared in 1997 and focused on governance and human development. The second one, in 2000, was dedicated to economic growth with equity. This report is on HIV and AIDS and culture, highlighting the HIV and AIDS crisis in the country and the role culture can play in finding a solution.

The report has four objectives. The first is to contribute to, and inform, the country's ongoing development process and plans. Swaziland has a new constitution and several important development frameworks, policies and plans are in place. These frameworks and plans include the national development strategy (NDS) based on Vision 2022 and the poverty reduction strategy and action plan (PRSAP). The policies and sector strategic plans include the population policy, the decentralisation policy, the draft gender policy, the HIV and AIDS policy and the HIV and AIDS strategic plan of 2006-2008. This report will contribute to the elaboration and implementation of these policies and plans by

providing an update on the human development situation and discussing the current state of HIV and AIDS in Swaziland and policy and strategic options for the future.

The second objective of the report is to support and contribute to the achievements of the Millennium Development Goals (MDGs). The report discusses the impact of HIV and AIDS on the MDGs and overall human development. The identified impacts can then be targeted by programmes to reduce the effects and promote the achievement of various MDGs.

Thirdly, the report identifies cultural practices for scaling up and supporting the national response to HIV and AIDS. Swazi culture and the role of the culture in the pandemic as a major driver and a solution is discussed in detail. The identified cultural practices can then be used to upscale and support programmes of prevention, mitigation, care and support.

The fourth objective of the report is for it to be used as an advocacy tool for mobilising resources and changing sexual behaviour in the country. The fight against HIV and AIDS needs a great deal of human, material and financial resources from many stakeholders. The situational analysis of HIV and AIDS in the report will inform the stakeholders about the state of affairs and convince them to join the fight against the pandemic. The policy and strategic options are meant to be used by the stakeholders in formulating programmes and implementing them.

#### **Data sources**

Several data and information sources were used for this report. Firstly, focus group discussions (FDGs) were conducted in the four regions of the kingdom. The aim of the discussions were to get views from the rural and urban communities and people living with HIV and AIDS on issues of culture, poverty, the impact of HIV and AIDS, the past and current national response and how to prevent and control the pandemic. Secondly, key informants were interviewed on the above issues.

Thirdly, secondary sources of data, including various documents produced by national and international organisations, were used to inform this report. Fourthly, a stakeholders' workshop was held in February 2007 to receive and comment on the zero draft. Lastly, the first draft of this report was put on the internet for peer reviews from both the national and international community. The comments from the stakeholders and peer reviewers have been incorporated in the report.

The major constraint of the data sources was the limited recent secondary data sources on HIV and AIDS and related issues on a national level. For instance, the first national sero-survey in the country was conducted in early 2007 and was combined with a demographic and health survey, conducted after 16 years. Only preliminary results of this survey have been available for the report. Secondly, the population and housing census was also conducted this year, the first time since 1997, and at the time of writing the full results were not yet available.

#### **Culture and HIV and AIDS**

This report has seven chapters. Chapter one sets the stage by presenting the Swazi culture and its role in the pandemic. Different cultural practices related to the pandemic are listed and defined. The educational role of culture through the socialisation process, which takes place from childhood to adulthood, is described. Family and regimentation rules and restrictions were used in preventing moral degeneration in the society and violent sexual behaviour.

Traditional medical practitioners have cared and treated many life-threatening diseases in the society, such as diabetes and opportunistic infections of HIV and AIDS. The extended family and other community institutions offered strong safety nets for its members in times of sickness, bereavement, widowhood, orphanhood, poverty, hunger and other disasters. The traditional leadership structure in Swaziland, which is headed by the King and Queen Mother and supported by the chiefs at various levels, is so strong that it can be used effectively in HIV and AIDS intervention programmes.

The country however has a number of potentially high-risk traditions and current practices that make the population vulnerable to HIV infection. These include multiple sexual partners, changing sexual partners, sex at social gatherings like the reed dance (*umhlanga*), intergenerational sex, the early onset of sexual activity, gender inequality and female subordination.

### **Human development in decline**

Chapter two addresses the various dimensions of human development and presents past and present human development indicators. The indicators show that Swaziland was leading most countries in Sub-Saharan Africa (SSA) in the late 1980s and early 1990s in rapid socio-economic development.

Since the late 1990s the picture has however become somewhat gloomy due to, among other aspects, the rapid spread of HIV and AIDS. According to HIV sero-surveillance surveys of women attending antenatal clinics, conducted by the Ministry of Health and Social Welfare, the HIV prevalence rose from 3,9% in 1992 to 42,6% (2004) and down to 39,2% in 2006.

HIV and AIDS constitute a major assault on Swaziland's human development status. The pandemic reversed the gains made in the past and is threatening the wellbeing of the next generation in multiple ways. Swaziland's Human Development Index (HDI), a measure of human development in three core dimensions of longevity, access to knowledge and decent standards of living, which increased from 0,530 to 0,623 between 1975 and 1990, assumed a declining trend to 0,517 in 2006, which is less than it was in 1975. At the same time, the country has one of the highest scores on the Human Poverty Index (53,9%), a measure of deprivation in the same core dimensions of human development measured by the HDI.

These falling indicators of human development status are inconsistent with Swaziland's lower middle-income status, due to three main factors. Firstly, life expectancy in the country has been drastically reduced by more than 30 years in just one decade. This can be mainly attributed to the high HIV prevalence rates, which are currently the highest in the world. Secondly, the Swazi economy is no longer as supportive of progress in human development because of the declining per capita GDP.

Thirdly, the situation has been worsened by the high income inequality in Swaziland. For instance, in 2000/1, 69% of the population lived below the poverty line, while the richest 20% consumed 56,4% of the country's wealth. As a result, the focus has shifted from development, now relegated to secondary importance, to fighting the pandemic.

There are also limited resources to start income-generating projects and people live from hand to mouth as the government invests a lot of money in fighting the HIV and AIDS pandemic instead of job creation. Furthermore, due to the care required by HIV positive people, relatives end up neglecting productive activities to tend to, or take care of, sick people.

## **Trends, patterns and drivers of HIV and AIDS**

The third chapter of the report discusses trends, patterns and drivers of the HIV and AIDS pandemic in the country. Between 1992 and 2006, HIV prevalence among women attending antenatal clinics rose tenfold from 3,9 % to 39,2 %. The meteoric rise in prevalence was experienced in all age groups until 2002, after which a decline was noticed in the adolescent age group of 15-19 years in 2004. In the 2006 sero-surveillance survey it was observed that, in addition to the youngest age group, the prevalence had also fallen in other young age groups of 20-24 and 25-29 and the oldest group of 40-49 years. The age pattern of prevalence has continued to follow an inverted U-shape pattern, with a peak at age group 25-29, but with a shift from the young to the middle ages. The population groups that have been found to be more infected by HIV are women as compared to men, urban residents compared to rural dwellers and people with sexually transmitted infections (STIs) rather than people without them.

The main drivers of the pandemic are biological, behavioural and socio-economic in nature. Women are biologically more exposed to HIV infection than men. The reproductive organs of girls are less developed and prone to tearing during sex. STIs are a major factor in the transmission of HIV in Swaziland. Up to 59% of antenatal clinic clients with STIs were found to be HIV positive, while people without STIs had a lower HIV prevalence. A study in neighbouring South Africa found that uncircumcised men were about 60% less protected than circumcised men.

The behavioural drivers of HIV infection include a lack of correct knowledge about how the virus is transmitted and methods of protection; negative attitudes towards known protection measures of abstinence, faithfulness and condom use; and engaging in high-risk sexual behaviour, including multiple partnerships.

On the socio-economic front, rampant poverty and high income inequality levels in the country expose poor people to sex for financial and material benefits and for survival. Out of school youths are more vulnerable to the risk of HIV infection than their peers in school. A decline in the quality of health sector facilities in the country is denying people living with HIV and AIDS (PLWHAs) and people with STIs access to efficient health services, which exposes newborn babies and sexual partners to HIV infection. Many negative cultural practices have directly or indirectly exposed Swazis to HIV infection. The low social status of women and their subordination to men have made them more vulnerable to the risk of HIV infection than men.

## **Impact of HIV and AIDS on human development**

Chapter four constitutes a discussion of the impact of HIV and AIDS on Swaziland and the inhabitants on various levels. Human development has been undermined by the impact of the pandemic on the four variables of such development, i.e. a long and healthy life, education, wellbeing and participation.

The human development choice of Swazis living a long and healthy life has been limited by a high and increasing level of chronic illnesses in the population, mostly attributed to HIV and AIDS. There is an increased need for more and better health care services in the country, as TB cases dramatically rise and patient loads in hospitals increase because of HIV and AIDS related illnesses. The introduction and expansion of patients on ARVs has also led to an increased demand for health services. Mortality has sharply increased, leading to rising infant, childhood and adult mortality levels as well as a decline in life expectancy at birth to unprecedented low levels. This has adversely affected the population growth rate, which may lead to a decreasing population size after 2015.

The need of the country's population to be formally educated is frustrated by the high death rates of students and parents, reducing the demand for education. At the same time, increased illness and death of teachers have negatively affected the supply of education. The rising teacher:student ratio in the country, psychosocial stress among children and the abject poverty of most of the population greatly compromise the quality of education.

The ability of the population to enjoy a decent standard of living is limited by the decimation of human capital, the death of heads of households who are the breadwinners and the huge cost of health care and funerals that have increased poverty in households. A decline in remittances from family members abroad and people living in urban areas have led to reduced investment in rural subsistence farms. The sale of household properties for health care and survival, combined with long drought periods, have led to reduced production of food and hence greater food insecurity, increased malnutrition and hunger.

The poverty and hunger of family members have incapacitated the effectiveness of extended families as safety nets for members' emergencies. Widowhood and the death of energetic children have deprived the elderly of assistance, increased their stress and overburdened them with the responsibility of looking after orphans they cannot manage. The problem of orphans has increased, with more households being headed by children. The position of women in the household and society at large has also been undermined by the impact of HIV and AIDS. The choice of individuals and households to participate in community activities is hindered by the continued discrimination, stigmatisation and traumatisation of PLWHAs and orphans and widows affected by HIV and AIDS. There is growing concern that the overall effect of the pandemic on the macro-economy may scare away prospective domestic and foreign investors, thereby decreasing the economic growth rate.

### **National response**

Chapter five evaluates the national response to the pandemic. This was initially presented in the form of a short-term plan for 1987-1988 and medium-term plans for 1990-1992, 1993-1996 and 1998-2000. These plans focused on blood safety, public awareness, safer sexual behaviour, the prevention of sexually transmitted infections, voluntary counselling and testing, community home-based care (HBC), the management of opportunistic infections, the promotion of support groups to PLWHAs and the mobilisation of young people against HIV and AIDS. These were followed by two strategic plans: the first for the period spanning 2000-2005 and the second for 2006-2008. The plans were multisectoral and multidimensional, with the aim of being holistic in approach and bringing everyone in the country on board as a stakeholder and participant in the fight against the pandemic. Overall, the national response has made slow progress in addressing the pandemic. This is because human development choices have recently deteriorated, despite the response of the past 20 years.

The participation in the response has not been gender-balanced or community-driven. This is understandable given that overall central and intersectoral coordination and the drive to achieve the MDGs and human development are weak. The country has not used the national pandemic as an engine for driving economic growth and reducing unemployment and poverty, as is the case of countries in the northern hemisphere that turned calamities such as natural disasters and wars into economic fortunes.

While some cultural and traditional practices have the potential to contribute positively to the fight against the pandemic, the national response has not taken full advantage of the rich Swazi culture to mobilise the population to fight HIV and AIDS. Compliance with the principle of "the three ones" is not apparent and reporting of actions by the different responding agencies is fragmented. Overall, the distribution of services is skewed in favour of urban communities as the rural areas continue to suffer.

Shortage of human resource capacity and weak health systems are major impediments to the implementation of many response programmes. General scarcity of data on the performance of programmes makes it difficult to monitor and evaluate the national response.

### **Policy and strategic options**

Policy and strategic options to enable the country to stop new infections and reverse the trend of HIV and AIDS are discussed in chapter six. The leaders of the country need to use the strong traditional Swazi leadership structures to fight the pandemic. Committed, responsible and pro-active leadership is necessary to mobilise the population to implement the current national response effectively. Secondly, there are prevention options that have succeeded in Swaziland as well as other African countries that can be utilised in the national response. These include scaling up programmes on information, education and communication on abstinence, fidelity in marital unions and use of condoms; motivating PLWHAs to utilise voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT), antiretroviral therapy (ART), STIs and opportunistic infections (OIs) services and providing psychosocial support to infected and affected groups.

Highly vulnerable population groups, such as young people, women and children, need to be targeted with specific programmes. PLWHAs have to be involved in the planning, design, preparation, implementation, monitoring and evaluation of programmes that target them and their families. The care and support options include the provision of ART to all that need the service, proper management of STIs and greater involvement of traditional medical practitioners in the care and treatment of OIs. Strengthening the mitigation of the socio-economic impacts of HIV and AIDS calls for innovative policies and programmes to improve the condition of orphans and widows and eradicate the rampant poverty. This requires strengthening the capacities of various population groups and institutions to implement programmes effectively, the frequent collection and analysis of data on programmes and the mobilisation of resources from domestic and international sources.

### **The way forward**

In chapter seven recommendations in the form of key messages to the main players for action against the pandemic are outlined. The messages are directed at the traditional leaders who need to lead and guide the nation correctly by taking advantage of positive cultural practices. Negative cultural practices could be addressed by accelerating the harmonisation of cultural practices with the 2006 constitution, reducing practices which conflict with the stated aim of the constitution of ensuring gender equality. The government should make policies and laws that can lead to a positive change towards cultural beliefs and practices that contribute to the spread of the pandemic. It is also the responsibility of the government to ensure that the recent decline in the prevalence of HIV is maintained, by scaling up the interventions and being more pro-active.

NGOs are asked to involve communities and people who are affected in the planning and implementation of programmes. United Nations agencies are requested to help the government in the mobilisation of resources for the intervention programmes and to provide technical assistance so that international best practices can be applied in Swaziland. Local communities and families should participate in all the programmes in their area to ensure sustainability. They should work to strengthen social safety nets against disasters. It is the responsibility of individuals to protect themselves against HIV infection and help other people do the same.

## **CHAPTER 1: CULTURE, HIV AND AIDS**

### **1.1 INTRODUCTION**

The kingdom of Swaziland has endeavoured to preserve cultural traditions while undergoing modernisation. Unfortunately not much has been written on the role of culture in the development of the Swazi nation. Since the theme of this report is HIV and AIDS and culture, this chapter sets the stage by linking culture to various thematic areas of the national response to the pandemic.

The chapter discusses the structure of the Swazi family, how culture influences development, the socialisation of children, the use of culture in preventing potentially high-risk behaviour, the contribution of culture in impacting mitigation and how cultural institutions have facilitated the response management in the country. The ultimate aim of the chapter is to identify the positive aspects of culture that support human development and that can curb the negative effects on human development in Swaziland.

### **1.2 THE FAMILY**

The Swazi family structure is hierarchical, with the husband as family head; the wife or wives each residing at her marital home or husband's residence; and the children at the bottom of the hierarchy. In the past the extended family was the dominant form of family in Swaziland. It consists of relatives with consanguine ties (blood relatives), which include the grandparents, paternal aunts and uncles and cousins. The traditional homestead was generally large due to the extended family network and the need for manual labour in a predominantly agricultural environment.

Today the family head is the bearer of guardianship over members of the family, meaning there is no one individual that has authority over guardianship. Although the family head has power as the guardian of the family, he exercises most of his power in consultation with the elders of the family, namely the grandparents, paternal aunts and uncles. The family head is expected to be a good role model for his family. Guardianship is central in defining family relationships. It defines the rights and obligations vested in the family and includes parenting, care and support, protection from harm, discipline and other aspects of a person's livelihood. The traditional Swazi family controls, determines and safeguards all actions of its members, which necessitate consultation before any member makes major decisions (Government of Swaziland, 2004).

Urbanisation and modern development processes have contributed to social change, giving rise to non-traditional families in Swaziland. The family structure has evolved to more nuclear family forms, including single parent families, grandparent families and also child-headed families, the latter mainly as a result of HIV and AIDS. This has escalated the challenges of parenting in a society that is modernising and responding to the demands of a globalised world. Family support networks are shrinking, with the quality of relationships affected by urban and modern lifestyles. Families have less contact with each other, reducing the safety nets that existed in traditional society. It is consequently difficult for family members to get assistance in times of need. Child-headed households are the direct result of the fragmented family network(s).

### 1.3 THE ROLE OF CULTURE IN DEVELOPMENT

According to Wilson (1989) culture covers the various forces that contribute to behaviour in society. These contributions usually come from formal institutions, such as churches, the state, and these days the media; standards of behaviour; laws; as well as conventional practices and customs. Swaziland's culture refers to the way of life of the Swazi people. It includes customs, traditions, practices, dress code, living patterns, intimate relationships and everything that occurs in a society that is handed down from generation to generation. Participants in focus group discussions defined various concepts of Swazi culture as indicated in the glossary of Swazi words.

Culture is becoming increasingly prominent in development debates, as policymakers acknowledge that the social and cultural norms people observe influence their attitudes and choices and that people need not, and in many societies do not, act autonomously (Moncrieffe, 2004). UNESCO (2001) approved a cultural approach to inform HIV and AIDS interventions and research. Taking a cultural approach means considering a population's characteristics – including lifestyles and beliefs – as essential references in the preparation of action plans. This is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or stopping the expansion of the pandemic. The way the Swazi people should respond to HIV and AIDS therefore “reveals their cultural, social and moral values” (Brandt, 1998:148).

Culture influences attitudes and behaviour related to the pandemic. It influences the choice of taking or not taking the risk of contracting HIV, of accessing treatment and care. It also shapes gender relations and roles that put women and men at risk of infection, determines the level of support towards, or discrimination against, people living with HIV and AIDS and their families (UNESCO, 2001).

Despite the evolution and misuse of culture, Swazis have maintained a sense of pride in their beliefs, traditional values and norms. Although there is evidence that these cultural aspects are weakening over time, there is still a strong desire to preserve them. Culture cannot be ignored or wished away. It influences the development paths a society takes, and more and more people are insisting on their cultural rights within the context of a globalised world. A comprehensive cultural approach to development requires that policymakers design and implement policies that capitalise on the positive aspects of culture, while curbing the negative aspects (Moncrieffe, 2004).

### 1.4 SOCIALISATION OF CHILDREN

In the Swazi culture there are many aspects that influence the prevention of HIV and AIDS, mostly through education. The extended family performs an important function in the socialisation of children and young adults. Gendered socialisation structures ensure the socialisation of male children by male adults and female children by female adults. Children are taught language, culture, behaviour and work. Informal forums for socialisation are *egumeni*<sup>1</sup> for female children and *esangweni*<sup>2</sup> for male children. These forums provide for the discussion of a wide range of issues, including sexuality and marriage. Children go through various stages of development that are observed and closely monitored by the adults, to give them proper guidance and counselling. Children in Swaziland are brought up in a less routinised and casual way, with a few rites of passage to adulthood. They go through distinct stages during their upbringing, where each stage has its own features in the socialisation process.

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<sup>1</sup> *Egumeni* is a windbreaker made from grass or reeds

<sup>2</sup> *Esangweni* is the entrance of a homestead – men camp there in the evening in front of the fire for conversation

Childhood socialisation prepares a child for adulthood. There is gendered differentiation in socialisation, which presents challenges for gender equality in future development patterns. Girls practise to become acceptable mothers and wives, while boys are taught how to be tough husbands and fathers. Children are expected to assist in minor gender specific tasks. Boys herd goats and calves, and when they enter the puberty stage they join the older boys in herding cows and other livestock. Traditionally, boys are supposed to get a calf as appreciation for services rendered in herding cattle for a neighbour or relative, helping them to own resources at an early age. Boys also perform light duties for relatives, such as herding their cattle and doing agricultural cultivation.

Girls attend to children and perform household chores. They seldom have time to play, as domestic chores take up most of their day, including fetching water and firewood far from home. When girls enter the puberty stage they start doing craftwork, contributing to household property. Unlike boys, girls do not get any tangible or material resources for services rendered, which denies them a similar opportunity to access and control resources. This reduces girls and women to an economically subordinate position, which has made poverty feminised. As will be discussed in subsequent chapters, poverty has been identified as a driver of HIV and AIDS in Swaziland, which heightens the vulnerability of girls and women to infection.

Another method of child socialisation is a strong oral transmission of culture through instruction, stories, social gatherings, praise singing and songs. HIV and AIDS responses have used a combination of these oral messages to develop specific education programmes for the youth, both in and out of school, according to their age groupings as defined by modern society. The out of school youth are particularly targeted because they are a potentially elusive and risk-prone population.

**Chastity values** were promoted by the family and age regiments. Older boys and girls had sleeping quarters that were separated by distance. The female quarters were built on the left-hand side of the homestead in close proximity to the mother's house so that she could easily monitor unwelcome visitors. Similarly, boys' quarters were situated at the right-hand side of the homestead, which is easily monitored by the adult males.

Outside the family, regiments determined the rules and restrictions observed at each development stage to adulthood. The youth would begin courtship, but observe restrictions of early sexual debut. Regiments worked on character building by monitoring conformity and sanctioning non-conformity. Age regiments became the social control mechanism that monitored behavioural change by enforcing a code of conduct for its members. Regimentation provided members with a sense of belonging, which was a strong social achievement, especially for males. Regiments also provided non-formal education, such as life and survival skills, grooming and initiating its members into various roles as they developed to adulthood.

**Sexual debut** was supposed to be sanctioned by marriage. Virginity testing was promoted as a controlling mechanism. Grandmothers and older women used traditional methods of testing virginity in girls. The virginity of boys could also be determined by traditional methods, although the focus was on testing girls. Ridicule was used to sanction negative sexual behaviour. Information on hormonal change and reproductive health was transmitted informally through dialogue with grandparents, parents, aunts and uncles at family level and at community level by peers and regiments. Sex education was drawn away from the mother and father, possibly to remove emotions from the dialogue that would produce negative results. As a result, the older generation parents had difficulties in discussing sexuality with their children. Parents were however not excluded entirely in providing sex education to their children.

Sexual debut was delayed and controlled with customs such as *umcwasho* in girls, which restricted any intimate contact with the opposite sex until the enforcement period was over. The enforcement period varied between two and three years, at times extending to five years, depending on the reasons for enforcement. The last *umcwasho* was extended to five years from 2000 to 2004 to promote abstinence in the face of HIV and AIDS.

In boys, *lusekwane* was meant to control early sexual debut, although young men did experiment with sex before marriage. They however used safer methods, such as thigh sex, with no penetration. Sex with older girls was also discouraged in young boys. The belief was that the young men's *lusekwane* would wilt, signifying deviance in norms associated with sexuality. As punishment he was beaten by his peers if his *lusekwane* wilted.

Today, these social practices have degenerated, as a lot of negative sexual practices are tolerated by society. The effectiveness of the traditional social control mechanisms is challenged by modern social practices, which encourage individual rights to group ethos. The major strength of age regimentation was in promoting respect for group values and authority.

The process of urbanisation and the increasing influences of western cultural precepts on many population groups, especially the young, are seen as responsible for the breakdown of traditional customs. In this sense, the increase in premarital sexual activity and unmarried teenage pregnancy are seen by many authors as a consequence of the introduction of western values and ways of conduct, which expand more easily in the urban context and through the media (Villarreal, 1998). Urban subcultures and youth subcultures are competing with traditional values and a means of interfacing the two have to be sought. The media promotes popular culture that uses contemporary communication messages and technologies. The billboards, television, text messaging and music attract the youth's attention and have been used for HIV and AIDS education.

Sex education has been gradually integrated into the formal school system, but has been met with resistance from some parents. Sex education is about providing information on the physical and emotional changes associated with puberty and sexual reproduction (Sex Education Forum, UK in SHAPE, undated). It is against this backdrop that communication on sexuality and HIV and AIDS should start at family level, as part of basic family socialisation.

This must be complemented by the school system, the church and other community forums, as these are the secondary socialisation units which shape the attitudes and values of children as they mature (SHAPE, undated). Studies have indicated that sex education, if started at childhood, does not only lead to delayed sexual activity, but also to young people adopting safer sex practices. Sex education encourages the youth to delay sexual activity. SHAPE (undated) found that schoolgoing youth delayed sexual debut longer than out of school youth.

It is critical that young people are provided with accurate information that will help them make sound and informed decisions regarding their sexuality before they become sexually active. Adolescents and adults younger than 25 have been found to be the most sexually active. They have been implicated as being the most responsible for the transmission of HIV. These young people want to experiment with many things, including unprotected sex. Chapter three offers a detailed discussion on the nature and pattern of the drivers of the spread of HIV and AIDS in Swaziland.

## 1.5 PREVENTION OF POTENTIALLY HIGH-RISK BEHAVIOUR

Potentially high-risk behaviour includes the cultural practices that have a negative effect on human development with the eminent HIV and AIDS pandemic in Swaziland. Culture is progressive because it is responsive to changing times. Certain behaviours in the Swazi culture are still posing a challenge to human development and are becoming a threat to human choices.

### Multiple sexual partners

Multiple sexual partners in this report refer to sexual relationships that include more than one person as a sexual partner. These relationships can be either normative or legally sanctioned by culture or illicit non-legal sexual relationships. Prominent among these high-risk sexual relationships are multiple sexual partner relationships, whether culturally appropriate or not. These relationships pose an even greater danger, especially when practised with infidelity. Table 1.1 shows relationships that are culturally acceptable as well as those that are not, but that still fall under the category of multiple relationships.

**Table 1.1: Multiple sexual relationships and the cultural dimension in Swaziland**

Marital status	Number of partners	Extra-marital relationships		Status of the multiple relationship
		Nature	Number of partners	
Not married (single)	No partner (single)	<ul style="list-style-type: none"> <li>Sex with a commercial sex worker</li> <li>Early sex/sex before marriage</li> <li>Sex with a sex worker (not for commercial gain)</li> </ul>	Single person with two or more concurrent partners at the same time or over a relatively short period of time (multiple partners)	Not culturally appropriate/accepted
Married 1:1 (monogamy)	Two partners in marriage	<ul style="list-style-type: none"> <li><i>Kulamuta</i> (intimate relations with a sister in-law)</li> <li><i>Singani</i> (lover)</li> <li><i>Kungena</i> (widow inheritance)</li> <li><i>Inganwa</i> (stud)</li> </ul>	Married man with one or more concurrent partners at the same time or over a relatively short period of time (multiple partners)	Culturally appropriate/accepted
		<ul style="list-style-type: none"> <li>Casual sex outside marriage</li> <li>Sex with commercial sex worker</li> </ul>	Married man or woman with one or more concurrent partners at the same time or over a relatively short period of time (multiple partners)	Not culturally appropriate/accepted
Married 1:+1 (polygamy)	Three partners or more in marriage	<ul style="list-style-type: none"> <li><i>Kwendzisa</i> (arranged marriage)</li> <li><i>Inhlanti</i> (wife's sister)</li> <li><i>Kungena</i></li> </ul>	Married man with one or more concurrent partners at the same time or over a relatively short period of time (multiple partners)	Culturally appropriate/accepted

		<ul style="list-style-type: none"> <li>Casual sex outside marriage</li> <li>Sex with commercial sex worker</li> </ul>	Married man or woman with one or more concurrent partners at the same time or over a relatively short period of time (multiple partners)	Not culturally appropriate/accepted
Widowed	No partner (single)	<ul style="list-style-type: none"> <li><i>Kungena</i> (widow inheritance)</li> </ul>		Culturally appropriate/accepted

In Swaziland there is strong adherence to cultural beliefs and practices that have been in place for many generations. That these cultural practices and norms have survived many generations is a clear testimony that they are valuable. Yet, it appears that over the last several decades strict adherence to these norms for their original purpose has slipped and men have tended to conveniently invoke culture in order to get sex from an (unwilling) powerless woman.

The above, together with the socio-economic circumstances in the country, clearly indicate that there has been a general decline in morals regarding sex. In the presence of HIV within a “sexually loose” community, practising culture by either conveniently “cherry picking” or deliberately adhering to the long-cherished cultural beliefs and practices that directly or indirectly enhance the spread of HIV transmission without precautions and/or modifications, is consequently more destructive than beneficial to the individual and community.

Table 1.1 presents some of the Swazi cultures and norms that directly or indirectly promote sex, resulting in changing sexual partners, increasing the prevalence of concurrent sexual partners, reducing age at sexual initiation or duration of secondary abstinence and decreasing chances of consistent condom use with a partner of (unknown/known) sero-status.

Studies on the spread of HIV and AIDS in Swaziland have all identified polygamy as negatively influencing the spread of the virus. However, a defensive attitude has been maintained by the cultural gatekeepers to preserve polygamy against the deafening evidence of its negative consequences in contemporary society.

Without suggesting that the figures here are conclusive in measuring the predominance of polygamy in Swaziland, findings from focus group discussions (FGDs) for this report show that out of 325 participants only 70 (about 22%) were in polygamous family forms, suggesting that there could be a probability that polygamy as a form of marriage is on the decline in Swaziland. This information nevertheless needs further investigation to be conclusive.

Multiple sexual practices have to be reviewed with the HIV and AIDS pandemic in mind as well as the spirit of gender equality that the constitution of the kingdom promotes. *Clause 28(3) grants women the right to choose whether to uphold any custom their conscience is opposed to.*

Enabling legislation and monitoring mechanisms within the traditional structures have to be defined for women to access their rights. CEDAW was ratified by the Swaziland government in 2004, without reservations and the process of domestication and implementation is ongoing. The constitution of Swaziland has been in operation for a year, but at the time of writing no enabling gender empowerment legislation had been promulgated.

## **Social mobility**

Increasing mobility in the population contributes to the spread of HIV from urban to rural areas. Many people now move to, and from, towns and suburban areas faster and more frequently than before. Besides, factors such as the frequent transfer of civil servants, especially in the police and teaching services resulting in the separation of couples; the good road networks in Swaziland and shorter travelling distances make people increasingly mobile. These factors explain the narrowing gap between the rural and urban HIV infections in Swaziland.

Adult's choices to delay marriage characterise the changed lifestyle of men and women in Swaziland. In 1997 the mean age at first marriage for women and men in Swaziland was quite high at 28,3 years and 31,3 years respectively. The proportion of those never married by the age of 50 was also very high at 23% for both genders (CSO 1997). This was in contrast with the almost universal marriage in the past. The 1986 census reported that about 90% of women aged 70 years and over had married (CSO 1997). In the meantime other types of sexual relationships have become common, resulting in the high prevalence of consensual unions, child-bearing outside marriage and female-headed households.

Anecdotal evidence (as observed in the major cities) shows an increase in cohabitation in the urban areas of Swaziland, which again points to a change in values regarding marriage. Some cohabitating partners leave their legal spouses in the rural homesteads and find other partners in the urban areas where they are employed. Cohabitation has the potential of encouraging relationships of poor quality, where couples feel no obligation towards fidelity. Societal pressures to marry have weakened, and the long periods spent in educational institutions have contributed to delayed marriage, among other things.

These indicators are typical of a middle-income country that is highly integrated into a highly urbanised larger neighbouring country, namely South Africa. The cultural and socio-economic impact of Swaziland's proximity to metropolitan areas such as Johannesburg and Durban cannot be avoided, especially with regard to youth and urban subcultures in Swaziland.

## **Social gatherings**

Social gatherings bring a sizeable number of people together, presenting opportunities for good as well as bad behaviour. They happen at community and national level, taking the form of weddings, other celebrations, night vigils, cultural events, funerals, etc. Getting together for social functions has the potential of promoting high-risk behaviour due to many people making social contact. FGDs noted that unbecoming behaviour characterises most social gatherings.

There have been positive attempts to tap on the potential of the major cultural events such as the reed dance and *incwala* to bring large numbers of people to one event. NGOs have made a positive impact on the gatherings by taking the opportunity to educate and promote HIV and AIDS advocacy campaigns. It is important to plan a full schedule of activities for the duration of the cultural ceremonies to minimise the idle time available to the participants.

## **Intergenerational sexual activity**

The Swazi culture condones intergenerational sex and marriage. Unfortunately, the older age of a sexual partner is associated with increased risk of HIV infection. Young women form partnerships with men who are at least 15 years older than themselves and there is a growing trend of similar behaviour with young men having older women as sexual partners. Financial benefits are the major cause for this behaviour.

Findings from FGDs revealed that most young women preferred older men who support them financially and male respondents in youth focus groups argued that the girls end up in multiple sexual relationships to maximise financial gain. A study conducted in Zimbabwe on sexual mixing of younger women with older partners found that sex is more frequent and condom use is rare. Their partners are also more likely to have other concurrent partners, thereby increasing the risk of HIV infection (Gregson et al, 2002).

FGD participants were concerned about the lack of role models to the male youth. They noted that the rich people driving big cars and some of the country's leaders condoned intergenerational sex by practising it. The participants viewed the actions of the leaders as dampening the war against HIV and AIDS. The recent campaign of *umcwasho*, promoting chastity in girls, was not properly evaluated to prove its worth. Instead, the campaign was violated immediately after its enforcement by the men who either married or impregnated the maidens.

### **Gender inequality and female subordination**

Cultural dispositions place women and girls at greater risk of HIV infection, due to social disempowerment and the inability to make decisions about sexual preferences. Multiple concurrent sexual partners and sexual mixing patterns, among other things, were identified as major causal factors for HIV prevalence (Whiteside et al, 2003).

Buseh et al (2002) note that women in Swaziland have multiple sexual partners as a means of economic security, given that having more than one partner adds to a woman's potential for economic support. Zamberia (2004) argues that whereas socio-cultural norms and values militate against sex work, material circumstances dictate that this is the most viable strategy.

Poverty has largely been feminised in Swaziland, which is the major contributing factor to the ineffectiveness of responses to minimise the spread of HIV. The empowerment of women is the catalyst that is required to gain better mileage in the responses to HIV and AIDS. Women in Swaziland are sick and dying of HIV and AIDS related illnesses because they cannot exercise their rights to safer sex with their husbands and partners in sexual relationships.

The major contributing factors to HIV infection are infidelity and early sexual debut. People between 25 and 29 years were more at risk. As the 2002 and 2004 ANC results show that 47,7% and 56,3% respectively of people who attended antenatal health care tested HIV positive, followed by the 20-24 age group, with 45,4% and 46,3% respectively. The new infection rates measured by the 15-19 age group were 32,5%, 29,3% and 26,0% in 2002, 2004 and 2006 respectively, which are alarming. The participants in women FGDs argued that the reality is that most women are often infected by the single partner they have, because it is normative to expect fidelity from women and not from men, thereby increasing the vulnerability of women, especially married women.

On the positive side, AIDS has given new impetus to women's rights in Swaziland. Women activists and advocacy groups believe it is no coincidence that Swaziland has the world's worst HIV infection rate and some of the continent's most traditional views on the status of women (Women's e-News, 24 October 2005). There are cultural inhibitions that restrict women's freedom and make them vulnerable.

There are many challenges in the socio-cultural context that inhibit gender equality initiatives. The gatekeepers of culture are sensitive to making changes that emancipate women. Even though there is a promising build-up of constructive attitudes to women in politics, much more subtle resistance can be observed in other sectors of the economy, suffocating the process of women empowerment.

## **Sexual violence**

Sexual violence is a manifestation of gender inequality. Violent acts of a sexual nature were punished by a fine of two cows in traditional society, which was steep. In modern society, rape is an offence that is punished by the courts, but there is still an outcry from women activists about the laxity of the law in punishing offenders of rape and other sexual assault cases.

It has almost become normal to read or listen to news about rape and sexual assault in the country. In a recent article by the *Times of Swaziland* (26 January 2007) it was reported that a woman was assaulted by a lover for negotiating condom use, after which she succumbed to unprotected sex. These are almost daily occurrences in the lives of many Swazi women, whether educated or not. The practice of sexual violence is further encouraged by a lack of respect for the female gender.

According to the Swaziland Action Group Against Abuse (SWAGAA, 2005-2006) a total of 277 or 14% of their clients attended counselling on sexually related cases from April 2005 to March 2006. Over the same period rape was the highest reported form of sexual abuse, comprising about 65% of the cases. Sexual harassment followed, with 14% of the cases, and incest with 13%. The least reported cases were sodomy at 5% and attempted rape at 3%.

Surprisingly, the sexually related cases do not reflect the majority of cases attended to by the counsellors. FGD participants reported that orphans are now targeted for sexual abuse by culprits in the communities, which is all the more reason to strengthen the laws and upscale psychosocial support at community level. SWAGAA is to be commended for decentralising its activities to the communities. Although they are located in the ordinary and company towns, more outreach into rural communities is required.

## **Stigmatisation, denial, myths and cultural beliefs**

Silence, stigma and denial are common, despite the education and sensitisation campaigns that have reached out to many communities in Swaziland. On an individual level, denial of risk prevents seeking counselling and treatment. At a national level, stigmatisation prevents leaders from adopting a firm stand on the issue, leading to generalisations that do not address the realities of the pandemic.

Stigmatisation compounds problems of denial, encouraging myths and cultural beliefs of witchcraft. A lot of work has been done by NGOs on reducing stigmatisation, but PLWHA still complain about the prevalence thereof in all sectors of society. Stigmatisation inhibits the VCT programme, because people fear the unknown reaction of family members and spouses. In FGDs some women who were caregivers (*banakekeli*) intimated that beliefs of witchcraft still exist in communities where symptoms of AIDS are visible. This intentional recourse to witchcraft is sometimes used as an “escape route” to avoid pointing a finger at the real problem – HIV and AIDS.

## **1.6 TREATMENT AND SUPPORT**

### **Traditional health care**

Traditional medicine is one of the most ancient cultural practices in Swaziland, based on indigenous knowledge. As far back as 1894 the practice was flourishing and caught the attention of the colonial powers that made an effort to outlaw it (Green and Makhubu, 1983). Many people in Swaziland rely on traditional medicine or use it as a first point of reference before making use of modern medicine. Traditional medical practitioners (TMPs) provide an environment that is familiar to the people. TMPs

relate to the people in a humane manner; the people are assured of attention, understanding, sympathy and a solution to their problems (Amusan, 2006). As such, traditional healers play a positive role in the treatment and support of infected and affected people.

The Ministry of Health and Social Welfare (MOHSW) has involved traditional healers in HIV and AIDS education, as a precautionary measure against onward transmission of the virus through blood and other body fluids. Other countries, such as neighbouring South Africa, have moved ahead with policies that address the integration of TMPs in the national health system. There have been numerous attempts to encourage this cooperation in Swaziland, with varying levels of success.

There is a need to strengthen the trust between traditional and modern health caregivers. Providing training to traditional healers on how to recognise HIV and AIDS symptoms and promoting the use of disposable gloves and other hygienic practices have largely been achieved through effectively involving the Association of Traditional Healers in Swaziland. Establishing referral mechanisms from the traditional to the modern health sector is still a challenge. Traditional healers usually have good interpersonal relationships with their patients and this can be tapped on to promote VCT.

Traditional medicines treat a wide range of diseases, from ordinary headaches, diarrhoea and vomiting to life-threatening diseases such as diabetes and HIV and AIDS symptom management. Amusan (2006) argues that the indigenous knowledge system in Swaziland is very rich and much of it centres around the use of plants in health care, although this information is largely untapped and certainly under-utilised.

A lack of collaboration and cooperation between traditional and modern medicine is slowing the progress of antiretroviral treatment, since beliefs are still very much focused on mixing the two treatment methods, which is detrimental to the patient.

### **Caring for the sick in the family**

All the extended family members were obligated to take care of their own family members. In fact, the strength of guardianship was centred on the principle of care and support. The caregiving role was traditionally carried out by women, especially married women and grandmothers. With AIDS related sickness, many children and young girls in particular are engaging in caregiving roles, looking after sick parents and siblings. Children have also adopted parenting and guardianship roles for their younger siblings. This abnormal situation has transformed the roles of family members in Swaziland and other countries ravaged by HIV and AIDS.

The frequent use of girls in caring for the sick is reversing the school enrolment rate that has equalised for boys and girls. Traditionally, children were protected from personal contact with the sick, even more so from terminally ill people. A child's role involved small chores such as bringing in water and food. The child was therefore protected from any psychosocial stress that is prevalent today with orphans and vulnerable children.

Traditional safety nets such as the extended family are unravelling as more young adults die of AIDS related illnesses. A new concept of HBC has been born with HIV and AIDS. HBC is increasingly relied on to compensate for the inadequacies of a public health system buckling under the weight of the country's HIV and AIDS pandemic (IRIN, 2007). The need for HBC is not new, but has been accelerated by HIV and AIDS.

Before the introduction of Hospice at Home, terminally ill people were sent home from hospital to be cared for by their families until they died. The lack of social services and the absence of any home based care increased the physical and emotional pain experienced by patients and their families. HIV and AIDS have increased the number of terminally ill people in Swaziland.

In a country with less than 2 000 hospital beds, home based care is challenged. There are only four major NGOs providing palliative care – Swaziland Hospice at Home, the Salvation Army, Hope House and Parish Nursing, which have limited personnel. Among the concerns of palliative caregivers are a lack of funds; limited medication and other supplies, and the poverty of clients and their families. Subsequently, the majority of terminally ill people do not have access to palliative care. Although there have been many challenges that require urgent attention, some successes have been recorded in training caregivers.

There is no doubt that HBC is becoming critical with the shortage of hospital beds due to AIDS related illnesses. HBC relies on family resources as caregivers and materials needed to assist sick people. HBC has been introduced to communities, but the families have not been well-endowed with resources to complement the service. There is a need to investigate this matter with the aim of boosting the capacity at family level to implement HBC effectively.

### **Death and burial**

Traditionally women sat in the mourning house with the corpse until burial took place, which was usually a day or two after the death. The men prepared the burial stretcher and dug the grave. The bereaved family did not perform any manual labour before the burial and the neighbours and community members provided them with food and water and psychosocial support. Children were not allowed near the dead – they neither viewed a dead body nor attended the burial. A number of rites were performed during and after the burial and in the entire mourning period the rites had to be followed religiously to avoid any bad omen or successive deaths in the family.

Most of these practices have changed with modern society. Nowadays children attend funerals and view dead bodies. Because of HIV and AIDS some children are even forced to care for dying parents and siblings, thereby sustaining the trauma they were protected from in traditional society. Immediately after the burial, the children are left on their own, trying to deal with the trauma of death and supporting themselves in child-headed households, which have become a common feature in Swaziland.

## **1.7 IMPACT MITIGATION**

### **Safety networks at family level**

Social change fuelled by modernisation and urbanisation has weakened and to a large extent destroyed the extended family system. The extended family structure is no longer a viable option for childhood social development. In addition, the orphan population has overwhelmed the already overstretched family resources.

In the past, traditional cultural practices ensured that a social safety net was provided for needy people. The family and the community were active and provided support structures that cushioned individuals and families from the harsh effects of poverty. At the family level, resources were shared and there was no pronounced distinction between family members. The extended family is however becoming weaker because everyone, even those considered better off, is not in a position to spare food or money.

**Poverty** is widespread in Swaziland – 69% of people are living below the poverty line (SHIES, 2001). A number of methods to alleviate poverty are readily available, including the deployment of a community and family safety net, the use of self-help and mutual help schemes and agreements, loans, revolving funds and other time-honoured approaches (Khumalo, 2006). The issue of poverty as a factor and driver of HIV and AIDS is discussed in detail in especially chapters two and three.

Among the factors responsible for the high levels of poverty is the persistent drought that has caused famine in many rural communities, especially in the eastern lowveld and Lubombo plateau. In addition, the loss of income through retrenchments and rising general unemployment contributed to the lack of access to productive resources by the poor.

High levels of income inequality have entailed that a disproportionate share of the limited resources is captured by rich people. Consequently poor people have none or limited resources to fight or cope with the pandemic. Lastly, the pandemic has intensified poverty due to the loss of earnings from breadwinners in families (Ibid). Many studies link poverty and the pandemic, although HIV and AIDS are not confined to poor communities. Vulnerability to sexual exploitation can be added to these factors.

The ills that have been created by poverty are numerous and have weakened the good practices that were created by the traditional social networks. Individuals and families are now entirely dependent on selling their labour or engaging in income generating activities where possible. The FGDs observed that the youth in particular are selling their bodies for income, which exacerbates high-risk sexual behaviour, as most of the sex is unprotected.

### **The community as a safety net**

Communities have a social responsibility towards the welfare of their members. In the past, traditional cultural practices ensured that a social safety net was provided to needy people (Khumalo, 2006), meaning that mechanisms of sharing resources were in place. The community donated surplus food to the chief *indlunkhulu* who then catered to the needy in the community. Due to recent trends with urbanisation, migration and poor crop yields, the viability of this system was in doubt until recent measures enacted by government and civil society.

Through the National Emergency Response Council on HIV and AIDS (NERCHA), donations of seed and other inputs revived the ploughing of *indlunkhulu* fields to cater for orphans and vulnerable children. Other NGOs are also assisting to make this concept viable. FGDs have however reported that there is no proper monitoring of this project. In some communities residents consequently took most of the maize for their own consumption, depriving the vulnerable children who were the intended beneficiaries.

NGOs and other international donors, such as UN agencies, sponsor a lot of interventions at community level (details in chapter five). Their efforts have re-activated the traditional practices of providing a safety net to needy people in the community. Orphans and vulnerable children are also taken care of through programmes that have adopted traditional concepts like *gogo* centres. Traditionally, grandmothers acted like a mother hen, sheltering all those who required assistance in families, hence the term *gogo* centres.

Urbanisation and modernisation have shifted all responsibility for service and care from communities to institutions like schools, hospitals and other service providers who are doing it for commercial gain. Voluntarism and a moral sense of obligation have become secondary. Poor people are overburdened by this practice. Communities however manage to help needy people by means of donor assistance.

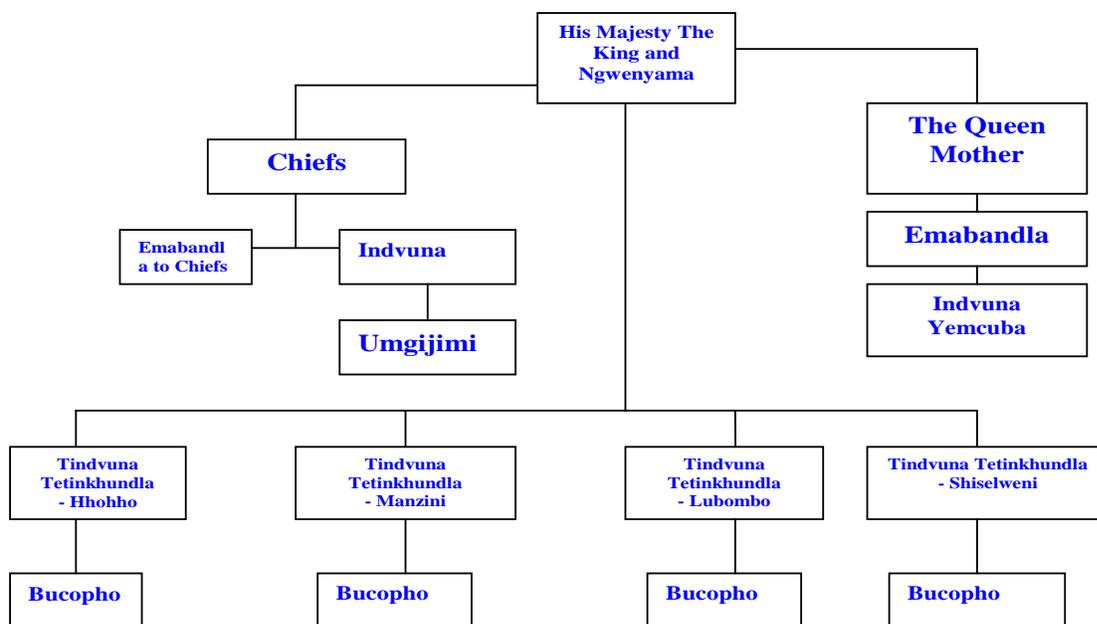
The biggest challenge remains the sustainability of these programmes. The challenge is the decline in the traditional ways of assisting each other, especially helping disadvantaged or weak people. Communities are already struggling to make ends meet and poverty is widespread, with a prolonged drought that shows no signs of immediate relief. Nonetheless, the government is making inroads in the finalisation of policies that will hopefully alleviate poverty and the food security crisis. Although, judging by the progress report on the MDGs as discussed in chapter two, current trends suggest that it is unlikely that the country will have halved poverty levels by 2015.

## 1.8 CULTURAL SYSTEMS AND STRUCTURES

### The Monarchy

The traditional system of governance that is practiced in Swaziland is headed by his Majesty the King and *ngwenyama*, *emabandla* to his majesty, chiefs, *indvuna yemcuba*, chief's *emabandla*, *umgijimi*, and *tindvuna tetinkhundla*, as shown in figure 1.1. The apex of this traditional leadership structure is the King, who rules, with chiefs at the lower traditional level. He is followed by the Queen Mother and *emabandla* or advisory structures.

**Figure 1.1: Traditional leadership structure in Swaziland**



In 1999 King Mswati III became one of the first leaders in Africa to declare HIV and AIDS a national disaster. He has continued to support the fight against the spread of HIV and AIDS. In 2000 he declared a five-year period of girls observing *umcwasho*, a cultural rite promoting abstinence and condemning early sexual debut in adolescent youths. The Queen Mother also joined the fight, using cultural prevention methods through *Khulisa Umntfwana*, a project with the mission to raise children with good morals. In addition, the government intensified and scaled up the national response, as discussed in chapter five.

While appreciating the efforts by the royal family to fight the pandemic, participants in FGDs were conscious that the King and other leaders should be good role models to the nation. The King is viewed as a unifying symbol in Swaziland's socio-cultural politics. Kingship and rank are central to the Swazi socio-political system, with royalty and tradition as the basis upon which authority has been maintained (Forster and Nsiband, 2000). If the nation has reason to doubt the conduct of the royal family regarding the seriousness of HIV and AIDS, the battle will be lost.

The royal family have lived to the premise that tradition is a living thing, which has to be made contemporary to each generation. The King and the royal family have adopted a modern lifestyle that is mixed with traditional practices, which are becoming more seasonal than defining their entire lifestyle.

Contemporary Swaziland is however faced with the challenge of the gatekeepers of tradition, who are trying hard to "lock" culture as a permanently defined social construct. The realities of traditions and behavioural practices are continually evolving, making culture as a living thing inescapable. This calls for the renewal of tradition to make it contemporary to the generation of today. Otherwise, traditions will be shunned, scorned and rejected. Yet there are very good values and principles in the traditions that can still benefit society especially in the fight against HIV and AIDS.

The monarchy should be encouraged to participate in HIV and AIDS education, with specific emphasis on VCT, reaping the benefits of knowing one's status and taking the appropriate measures to make informed choices.

### ***Indlunkhulu (Chiefdom)***

The chief or *umphakatsi* is the traditional leadership of a community with a hierarchy of authority. The chief acts on behalf of the King in the administration of a demarcated area and is highly respected. The chief makes pronouncements that become law in his area and he is usually taken seriously by the people.

Chiefdoms have clearly defined geographical boundaries and populations. They are formal structures recognised by the traditional and modern systems of government. A chief rules with his *bandlancane* (inner council), who deal with everyday issues. Issues that need to be settled by the whole community are taken to the larger council, the *bandlakhulu*. The chief's right-hand man is the *indvuna* (headman), to whom all matters are reported in the first instance. Community programmes and responses to HIV and AIDS have to be discussed with him before they are reported elsewhere. The operations and final pronouncements are in the control of the inner council. It is essential to have a good working relationship with the headman and inner council to gain maximum acceptance of programmes and policies.

Other officials in a chiefdom include commanders of age regiments, such as *indvuna yemajaha* / *yelutsango lwakangwane* / *yetintfombi*. The chief's runner is *umgijimi*, whose duty it is to do errands on behalf of the chief, including making announcements. The work of the commanders of regiments has essentially become seasonal, as they only come to the limelight when there are events that require their specific regiments to attend to.

The role of chiefdoms is important in HIV and AIDS related issues, since they are closer to the people. They have authority to make pronouncements that are supported by the whole community. Chiefdoms are located in rural areas, where most people live. The concerns raised by FGDs were that a lot of the activities and information on HIV and AIDS are concentrated at the *inkhundla* level, which most of them reach with difficulty, instead of being filtered down to the *imiphakatsi*, to which they have easy access. The government policy of decentralisation will have to address this issue, ensuring that information and

services reach the people where they are. In addition, there is a need to guard against problems of coordination and monitoring of activities and programmes initiated at community level by donors and other caregivers. There are also problems of capacity at grassroots level, making good initiatives less effective. Sustainability has become a critical area of concern with many community initiatives.

## **1.9 CONCLUSION**

Culture and tradition are central in defining Swaziland as a nation. Culture denotes the totality of the social environment into which a person interacts. It includes the community's institutional, social, political and economic arrangements, but also the assumptions and values embedded in its practices and organisation. Culture should not inhibit development and change, because culture and tradition are only useful and functional for society if made contemporary to each generation. In the fight against HIV and AIDS the cultural environment is constantly changing, as Swaziland is challenged to renew its age old customs and practices. Cultural diversity, which may not otherwise have been completely embraced by the nation, is manifesting itself in diverse behavioural practices characterising the lives of the Swazi people. The next chapter will discuss the challenge of human development and how culture and HIV and AIDS have impacted on the country's economic and social development.

## **CHAPTER 2: HUMAN DEVELOPMENT IN DECLINE**

### **2.1 INTRODUCTION**

HIV and AIDS have unleashed a major assault on Swaziland's human development status, reversing the gains made before the pandemic became widespread and started threatening the wellbeing of the next generation in multiple ways. The Swazi nation has never before faced a crisis of this magnitude, with such widespread adverse impacts. This chapter is about the relation between HIV and AIDS and human development in Swaziland. It explains the concept of human development and shows how the crisis is undermining the core elements of the nation's wellbeing. The status of Swaziland's human development is explained and compared to the progress made by other countries with a similar baseline status and to the progress of neighbouring countries in Southern Africa.

### **2.2 HUMAN DEVELOPMENT INCREASES PEOPLE'S CHOICES**

The statistics of HIV prevalence presented in chapter three point to a crisis of unprecedented scale. It is easy to forget that these statistics are about real people. The crisis is about the child who has lost parents as a result of AIDS, blighting his or her present wellbeing in diverse ways, such as psychosocial trauma and diminished educational prospects. All these factors cast a shadow of uncertainty on the future of the child. It is about the widow who may have cared for her chronically ill spouse, saw family wealth whittled away by the escalating cost of treatment and care and suffered the misfortune of having the little property left being grabbed by the very people whose support she needs most. The pandemic is about people living with AIDS who watch their means of livelihood slowly fail, because they no longer have the strength to work.

These examples make a point that there are human faces behind the numbers that reveal the crisis and that the statistics should be interpreted with a focus on people. The concept of human development helps us to understand the various dimensions in which HIV and AIDS blight people's wellbeing. It has been promoted by the UNDP since 1990, when the first GHDR was published. The GHDR of 1990 made a rally call that development should not be seen only in terms of economic progress, but should focus on people's wellbeing and be more holistic. It was not enough to achieve economic progress while the majority of the people remained in poverty, ignorant or unable to access health services.

This understanding did not start with the GHDR of 1990. In fact, it acknowledges this fact and cites early Greek philosophers, early leaders of quantification of economics and leading political economists who agreed that the accumulation of wealth was only a means to an end, the end being to guarantee human wellbeing. Unfortunately, over time development increasingly came to be seen and measured in terms of material advancement, rather than only being a means for the expansion of human choices. In the words of the GHDR of 1990, an "*...excessive preoccupation with GNP growth and national income accounts has obscured that powerful perspective, supplanting that focus on ends by an obsession with merely the means*" (UNDP, 1990).

The GHDRs have defined human development as a process of enlarging choices for people, leading to the kind of life they value. These choices are potentially infinite and individuals attach varying importance to different choices. Nevertheless, the GHDR of 1990 identified three choices as core to human wellbeing. Without the fulfilment of these choices, human lives would be fundamentally blighted, while it would be difficult to fulfil other choices – to lead a long and healthy life, be educated and enjoy a decent standard of living. These three factors were considered essential for human lives to thrive.

Other choices have been recognised and there has been debate as to whether more choices should be included. In particular, the 2004 GHDR argued for the addition of a fourth core choice, i.e. to participate in the life of one's community. This is an aspect that informed the philosophy of African development experiences, given more credence by the poverty reduction strategy papers (PRSPs) that emphasised wider discussion of development priorities beyond the narrow confines of central governments to include local authorities, local communities and the civil society.

The essential elements of each of these four choices are outlined below. Also provided is an assessment of how HIV and AIDS may be impeding progress in human development. A detailed account of how HIV and AIDS have undermined the four choices of human development is presented in chapter four.

**To lead a long and healthy life** is a core choice people make, because they generally do not want to die young. For a long life to be desirable, it should however be healthy. It is an important precondition for attaining other choices. As an example, it will be difficult to be productive and attain a decent standard of living without being healthy. The implication is that development, as a basic objective, should aim at securing the health of the society. Governments should invest in health systems and make health services efficient and accessible to the general population. Investments that improve people's access to safe water and adequate sanitation, shelter, adequate food, information to promote behaviour that encourages good health, a clean environment, etc. are all important for raising the health status of the society.

Viewed this way, HIV and AIDS are primary affronts to human development in Swaziland. Evidence presented in chapter four of this report shows that the health status of an average Swazi person has drastically fallen. In general, there has been a rise in morbidity, particularly in cases of chronic illnesses associated with HIV and AIDS. By undermining people's immunities and making them vulnerable to opportunistic infections, HIV and AIDS have increased the disease burden of the country many times over. For example, the incidence of TB, which is strongly associated with HIV and AIDS, rose from 210 people per 100 000 in 1990 to 820 in 2004 (MOHSW, 2005). Swaziland currently has one of the highest TB incidences in the world.

Ultimately, AIDS has shortened the average life span of the Swazi people. Without HIV and AIDS the life expectancy at birth in 2007 would have been 65,2 years, but it has been reduced to 33,7 years (Whiteside, 2006). The pandemic has cut life expectancy by over 30 years in just one decade. It is not surprising that there has been a significant rise in other mortality indicators such as maternal and child mortality. On this score alone, the HIV and AIDS pandemic ought to be viewed as a great disaster, rapidly decimating the social fabric of the Swazi nation.

**To be educated** is another fundamental choice, as humans commonly want to be knowledgeable and do not want to be trapped in ignorance. This is increasingly recognised as a fundamental human right, because life becomes seriously blighted without being educated. The attainment of other choices of life is difficult when people are cut off from the world of knowledge. Formal education is a primary means by which people obtain the capacity to acquire knowledge and apply it in ways that help them to expand other choices. Different aspects of socialisation occurring at home as well as other mediums of human interaction play an equally important part.

Indigenous knowledge as a means to expand people's choices is often overlooked. It is however vital in expanding people's capabilities. The Swazi culture stresses the need to pass knowledge about issues of life from one generation to another. For example, the regimentation for boys and girls discussed in chapter one is the key to acquiring necessary knowledge for life as well as survival skills at an early age. A recovery of some of the values taught through regimentation,

such as the emphasis on chastity, could prove to be a strong weapon in the fight against HIV and AIDS and other sexually transmitted infections.

### **Box 2.1: Instilling responsible sexual behaviour in the Swazi culture**

During the focus group discussions conducted for the Swaziland NHDR 2007, participants discussed at length the role of culture in promoting sexual behaviour, both positive and negative. One cultural practice mentioned to have positive aspects was regimentation. Participants felt that it taught respect and was a social activity for young people to become better Swazis. They were taught and counselled about the stages of life, sexuality, self-respect, good character and personality and chores. It instilled respect and good behaviour before marriage. *Umcwasho* is part of regimentation practices; that was seen as having promoted virginity and discouraging early sexual debut.

Regimentation was used to ridicule inappropriate behaviour. For instance, in the past, when an unmarried girl became pregnant, she was made to wear *sicholo* (a traditional beehive hairdo) which was incomplete to show that she was not a wife but a mother. A boy had to wear *umbhodze* (a head ring worn by married men). These were meant to ridicule them for doing what is not meant for their age group.

HIV and AIDS undermine people's aspirations to be educated, as the pandemic adversely affects the demand for, and supply of, education. On the demand side, children affected by HIV and AIDS can have their learning impaired, because they have to work to supplement household income. Learning can also be influenced by the trauma inflicted by the disease, when young children have to step in to care for their chronically sick parents or simply due to the associated stigma. They may drop out of school completely because they can no longer meet the cost as they have been orphaned or their guardians' livelihoods have been devastated. From 1999 to 2005 actual primary school enrolment has been lower than the projected enrolment (chapter four). Although it is difficult to make a precise causal link, no other factors other than HIV and AIDS and poverty can explain this. As seen below, these two factors are mutually reinforcing.

On the supply side, the loss of teachers as a result of AIDS affects the quality of education that children receive. It is expected that 4 248 teachers will have died between 1999 and 2016. Teacher morbidity and mortality are already raising the learner-teacher ratio, thereby compromising the quality of the education children receive (details in section 4.3 of chapter four).

**To enjoy a decent standard of living** is to obtain the ability to acquire material necessities and lead an acceptable lifestyle. This requires a certain level of income. The higher one's monetary income, the more this freedom is fulfilled. Human progress is unfortunately often viewed only in this way. However, as the 1990 GHDR observed, "*Income is clearly only one option that people would like to have, albeit an important one. But it is not the sum total of their lives. Development must, therefore, be more than just the expansion of income and wealth. It must focus on people.*" (UNDP, 1990).

Nevertheless, it should be recognised that it will be difficult for someone to enjoy other choices without an acceptable level of income. In this context, people's capability to pursue livelihoods of their own choice is crucial to human development. It is for this reason that sustainable livelihoods are linked to human development, as it provides the basis for income generation.

## Box 2.2: Poverty and HIV and AIDS: People's perceptions

A discussion on the relationship between HIV and AIDS in focus group discussions produced a range of insightful responses. These indicated that communities have observed the devastating impacts of AIDS at close range:

- A lot of money is spent on treating HIV related illnesses, resulting in poverty. In addition, the death of parents or breadwinners exacerbates the situation of poverty in families.
- Visible signs of poverty are food shortages, increasing numbers of orphans and vulnerable children, and child-headed households. Sex is exchanged for food and money as a result of poverty.
- Poverty affects the economy in general, in that there are no returns in the investment made in the youth because they die before making any meaningful contributions to the economy. In some cases, the demise of a business person may result in job losses.
- Poverty resulting from HIV and AIDS has a negative impact on education in that children drop out of school due to lack of money to finance their education.
- The death of parents results in lack of interest by children to go to school and this exacerbates poverty. In addition, grandparents are usually left with the burden of taking care of the orphans.
- Subsistence agricultural productivity has declined as a result of the death of able bodied people.
- The focus has shifted from development to fighting the pandemic. Development has been relegated to secondary importance. There is no income to start income generating projects and people live from hand to mouth. Government invests a lot of money on HIV and AIDS campaigns instead of job creation. Furthermore, due to the care required by people living with the virus, relatives end up neglecting productive activities to tend to, or take care of, sick people.
- Unemployment encourages the rich to entice the poor into sexual relations in exchange for money, jobs, etc. Girls seek jobs in industrial areas and lack places to live. They consequently get picked up by men who offer them accommodation in exchange for sex and as a result cohabitation becomes common.
- A lot of land that could be used for residential and other profitable activities is

By implication, the choice to enjoy a decent standard of living requires the creation of a more just society, where resources are not concentrated in the hands of a few while the lives of the majority are blighted. Unfortunately aggregate statistics such as the per capita GDP may not capture this reality and it is necessary to look behind these figures at things such as income distribution.

There is a clear link between HIV and AIDS and the attainment of the aspiration to enjoy a decent standard of living, because AIDS related diseases undermine people's ability to pursue a sustainable livelihood. Financial resources diminish, because the capacity to generate income declines, while the cost of care and treatment escalates. In this environment households are unable to accumulate the needed productive assets for better productivity and are sometimes forced to sell some of these assets. The micro-level effects visible at household and community levels eventually are aggregated to produce meso-effects and finally macro-effects. Surveys conducted between 2001 and 2005 have shown that Swaziland may lose between 1 and 2,8 percentage points of GDP per year because of HIV and AIDS (Whiteside et al, 2006).

**To participate in the life of the community:** The three basic choices discussed above have been recognised as being basic since the 1990 GHDR. There has however been disquiet for a long time that a fourth and equally fundamental dimension is not regularly counted as one of the basic choices of life, i.e. the ability to participate in the life of one's community. In the words of the GHDR of 2004: "*A person can be rich, healthy and well-educated, but without this ability human development is impeded*" (UNDP, 2004). The main problem is that, whereas in the case of the other three dimensions variables have been identified and included in a composite index that measures human development (as seen below), capturing participation in the life of one's community has been notoriously difficult and attempts to do so have floundered.

Many aspects that constitute the choice to participate in the life of one's community have been recognised in past HDRs – political freedom (including freedom of association and expression), cultural liberty, human rights, personal security and being accorded dignity and respect in society. The SADC Regional HDR of 1998 tackled the theme of governance and human development. Seven SADC countries, for which information was available, were ranked according to their attainment on the Governance Development Index (GDI). Unfortunately although Swaziland participated in this effort, it was not among those countries ranked. In 2000, a second SADC HDR tackled the issue of regional integration. Currently, efforts are underway for an Africa-wide HDR that focuses on governance issues, including the development of capable states able to deliver the goods to the people within the framework of the law. The subject of human rights and human development was tackled in the 2000 GHDR, while the 2002 GHDR looked at the necessity of democracy in building human development.

The relationship between cultural liberty and human development was tackled in the 2004 GHDR. It argued that "*leading a full life includes being free to follow different cultural practices and traditions without facing discrimination or disadvantage in participating politically, economically or socially*" (UNDP, 2004). This tenet is well-catered for in the Swazi constitution: "*All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law*" (Government of Swaziland, 2005). The main challenge is whether the institutions, cultural practices and social norms in Swaziland are supportive of the realisation of this objective.

This report argues that culture is important to human development, because it is the basis for a people's identity and therefore important in fostering participation in the community. It sets the norms for human interaction and defines the boundaries and patterns for participation in the life of one's community. In addition, culture facilitates the collective response to challenges a society faces. Nonetheless, culture should always adapt to changing circumstances to facilitate progress in human development. If not adapted, it will not address the critical needs of the time and some of its aspects may in fact become a constraint to addressing the relevant issues.

The HIV and AIDS crisis is modifying the Swazi culture as a facilitator of participation in the life of the community. For example, culturally defined social networks and kinship relations such as the extended family system have been weakened in the wake of the crisis. The extended family in Swaziland is an important safety net for households in distress. This family form has acted heroically in the face of the escalating number of orphans. But it is clear that it has been overstretched by the crisis. The emergence of street children and child-headed households in the Swazi society, which in the past would have been absorbed in the extended family system, is an indicator of the strain the pandemic is imposing on social networks and kinship relations in the Swazi society. The weakening of social safety nets in the face of HIV and AIDS, which deepens the vulnerability context of the Swazi population, is indeed a great concern.

## **2.3 MEASURING HUMAN DEVELOPMENT**

### **2.3.1 Human Development Indices**

Human development is about human choices that make lives flourish. It is complex and cannot be measured exactly. There is however always a need to simplify complex reality to measurable terms, so that we have a more objective basis for tracking progress. Since the publication of the first GHDR in 1990, various indices have been developed to capture important aspects of human development. Below is a summary of these measurements and the basic meaning behind them. A detailed presentation of how the indices are calculated is found in the technical note in annex 1.

#### **The Human Development Index**

Since 1990 human development has been measured by the HDI. This is a composite index that attempts to simplify what is otherwise a complex concept. It captures three core dimensions of human development. Variables capturing these dimensions are used to calculate an index corresponding to each dimension.

The HDI is a simple average of the three indices. The choice of a long and healthy life is captured by life expectancy at birth, from which the life expectancy index is derived. The education attainment index for the choice to be educated is a composite index itself from two variables: the adult literacy rate and a combined primary, secondary and tertiary gross enrolment ratio. The choice to a decent standard of living is represented by the GDP per capita, from which a GDP index is calculated.

As noted above, a major deficiency of the HDI is that it does not capture the choice to participate in community life. Attempts to calculate some aspects, such as the introduction of the Human Freedom Index in 1991 and the Political Freedom Index in 1992, were not convincing and were quickly abandoned. This deficiency applies to the other indices discussed below.<sup>3</sup>

The HDI is just a snapshot of average national performance in human development. Averages can however obscure large disparities in countries. Inequality based on income, wealth, gender, race and other forms of inherited disadvantage, as well as location, can make national averages a misleading indicator for human wellbeing (UNDP, 2006). The solution is to have the HDI disaggregated for such social and geographical groups. This can only be done to the extent to which the necessary data is disaggregated by such groups, which is rare in most developing countries. This must be taken into account when interpreting the HDI figures in this report.

#### **Gender Related Development Index and Gender Empowerment Measure**

The early publications of the GHDR recognised that gender discrimination is a serious affront on human development because it affects a big proportion of the world's population. Attempts were accordingly made to construct a gender disparity adjusted HDI to depict this reality. These attempts were unsatisfactory until the introduction of the Gender Related Development Index (GDI) in 1995. The GDI has been calculated ever since in every GHDR. It takes the same variables used for the calculation of the HDI and makes adjustments for the difference between

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<sup>3</sup> An increasing practice of research that tries to understand the complexity of human wellbeing tries to combine quantitative and qualitative measurements. In this report, participatory methods were utilised to obtain insight into the implications of HIV and AIDS on human development, mainly in FGDs. Fortunately a range of qualitative tools have been developed over the years for this purpose.

men and women in the attainment of each dimension of human development. It *“imposes a penalty for inequality, such that the GDI falls when achievement levels of both men and women go down or when the disparity between their achievement increases... the GDI is simply the HDI discounted, or adjusted, downward for gender inequality”* (UNDP, 1995).

The introduction of the GDI in the GHDR of 1995 was complemented by that of the Gender Empowerment Measure (GEM). This focuses on measuring the extent to which women are participating in the political and economic life and in decision-making. It could be expected that where gender discrimination is low and the process to enlarge choices of life is benefiting women and men equally, this should show itself in the extent to which the participation of women as well as men is increasingly equitable.

The GDI consequently tracks the extent to which the expansion of human capabilities is equitable. The GEM measures the extent to which women seize emerging opportunities to take their place in society along with men. It is important to use the two indicators alongside each other for a more holistic view of gender equality. The introduction of the HPI at this stage and the discussions that took place around it, coincided with the design of the PRSP instrument, thereby helping to sharpen thinking on pro-poor policies and programmes and how to monitor them.

### **The Human Poverty Index**

The negation of human development has been depicted as human poverty, also termed “the poverty of lives and opportunities” or simply “ill-being”. It was introduced in the GHDR of 1997, which equated poverty to a denial of opportunities and choices most basic to human development. This was an attempt to shift dominant thinking that equated poverty to a deprivation in income towards a more holistic consideration. Poverty is multidimensional and manifests itself in varying ways, as there are numerous ways in which people’s lives can be blighted. It is consequently perceived differently by different individuals. As a result poverty cannot be depicted by a single measure, as is often portrayed in poverty measures based on a person’s level of income.

Because human poverty is a negation of the core dimensions of human development, the HPI (introduced in the GHDR of 1997) is also a composite index that tries to capture deprivation in these dimensions. Deprivation in the choice of a long and healthy life is represented by the probability to die at an early age, before 40. Where there are no life tables to calculate this variable, the under-five mortality rate is taken as a good proxy.

Deprivation of the choice of, or exclusion from, the world of knowledge and learning is captured by the adult illiteracy rate. In the case of deprivation of a decent standard of living, the proportion of people below a poverty line could be adopted. This has been found to be too narrow. Instead, it is represented by the deprivation in economic provision, as measured by a simple average in the percentage of people without sustainable access to an improved water source, the percentage of children under five who are underweight and the percentage of children who lack access to health facilities.

In the GHDR of 1998 it was argued that the depiction of human poverty in this way failed to capture the reality in developed economies and would give the impression that human poverty was non-existent in those countries. A different set of variables was selected to approximate conditions in developed economies. Besides the three dimensions captured by the HDI, it was thought that long-term unemployment could represent deprivation in participation. This new index for high-income countries was called HPI-2, while the original index was renamed HPI-1, and is now the standard measure of human poverty in developing countries.

**Table 2.1: HDI, GDI, HPI-1 & HPI-2: Similar dimensions, different measurements**

<b>Index</b>	<b>Longevity</b>	<b>Knowledge</b>	<b>Decent standard of living</b>	<b>Participation or exclusion</b>
HDI	Life expectancy at birth	1. Adult literacy rate 2. Enrolment ratio	Per capita income in PPP\$	-
GDI	Female and male life expectancy at birth	1. Female and male adult literacy rate 2. Female and male enrolment ratio	Adjusted per capita income in PP\$ based on female and male income shares	-
HPI-1	Percentage of population not expected to survive to age 40	Adult illiteracy rate	1. Percentage of people without access to safe water 2. Percentage of people without access to health services 3. Percentage of underweight children under age 5	-
HPI-2	Percentage of population not expected to survive to age 60	Adult functional illiteracy	Percentage of people living below the poverty line (50% of median personal disposable income)	Long-term unemployment rate (12 months or more)

**Source: UNDP: Human Development Report 1999, p127, table 1.**

### **2.3.2 The importance of the human development concept to Swaziland**

The key question is whether it matters if Swaziland embraces human development and its dimensions and various measures to track the development outcomes of the country's development initiatives.

The GHDR of 1990, in arguing for the case for a human development focused approach, stated *"There is no automatic link between income growth and human progress. The main preoccupation of development should be how such a link can be created and reinforced"* (UNDP, 1990). The highly skewed income distribution in Swaziland lends credence to this view. Despite being classified as a lower medium-income country, about 69% percent of the population live below the national poverty line (SHIES 2000-2001).

Swaziland's main challenge for development is not only to increase national income but also to ensure that development is broad-based enough for the majority of the people to benefit from it. This will only be possible when people's capabilities are enhanced, so that they are able to take advantage of the opportunities that an expanding economy can offer.

The concept of human development helps authorities to focus especially on building these capabilities through measures that help each individual enjoy the freedom of choice in the four aspects of human development discussed above, as well as many other choices. By looking at each of the choices, specific policies and strategies can be adopted to enable the Swazi population to realise these choices.

There has been a growing appreciation in Swaziland that human wellbeing must be the overarching objective of development efforts. Swaziland's Vision 2022 has embraced the concept of human development, striving to lead the country to the top 10% medium human development bracket. Human development has been mainstreamed in the poverty reduction strategy and action plan (PRSAP), which considers poverty as multidimensional in terms of factors causing it as well as its manifestations.

Other national documents refer to human development as an objective that the country should strive for. This is, to a large extent, attributable to the influence of the GHDRs and more especially the National Human Development Reports (NHDRs) of which Swaziland has produced three. These reports have helped to make the concept more widely known and accepted.

#### **2.4 LINK BETWEEN HUMAN DEVELOPMENT, MILLENNIUM DEVELOPMENT GOALS AND HIV AND AIDS**

The GHDR of 2003 reported on the MDGs, which evolved from the Millennium Declaration adopted at the Millennium Summit in 2000 by 189 heads of state and governments. The report observed that *“the goals and the promotion of human development share a common motivation and reflect a vital commitment to promoting human wellbeing that entails dignity, freedom and equality for all people”* (UNDP, 2003).

It is possible to group the eight MDGs under the four core dimensions of human development discussed above, as shown in table 2.2. Because MDGs are tightly interconnected and mutually reinforcing, it is possible to argue for a different rearrangement of these goals in terms of how they parallel the different dimensions of human development. But the simple truth is that MDGs are another way of measuring progress in human development.

In light of the theme for the 2007 Swaziland NHDR, the critical question is how HIV and AIDS relate to human development as well as the achievement of the MDGs. This is also illustrated in table 2.2, while the evidence is discussed in chapter four.

HIV and AIDS are linked to human development and MDGs as part of a vicious cycle. The pandemic makes it very difficult for the country to achieve the MDGs and ultimately hampers progress in human development. Yet, deprivation in any of the dimensions of human development is a potent driver of the spread of HIV and AIDS and deepens its negative impacts. It follows that, while HIV and AIDS complicate the thrust towards the achievement of, and progress towards the, MDGs (and by extension human development), the framework of the MDGs is a powerful tool for fighting the spread of the pandemic and mitigating its negative impacts.

**Table 2.2: Link between human development, Millennium Development Goals and HIV and AIDS**

Human development dimension	To achieve a decent standard of living	To have a long and healthy life	To be educated	To participate in the life of the community
Millennium Development Goals	<ul style="list-style-type: none"> <li>• Eradicate extreme poverty and hunger</li> <li>• Ensure environmental sustainability</li> <li>• Develop a global partnership for development</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce child mortality</li> <li>• Improve maternal health</li> <li>• Combat HIV and AIDS, tuberculosis and other diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Achieve universal primary education</li> </ul>	<ul style="list-style-type: none"> <li>• Promote gender equality and empower women</li> </ul>
Impact of HIV and AIDS on human development	<ul style="list-style-type: none"> <li>• Overall decline in economic growth</li> <li>• Deepening poverty and hunger as livelihoods fail</li> <li>• Environmental degradation</li> <li>• Falling capacity in economic provisioning</li> </ul>	<ul style="list-style-type: none"> <li>• Higher morbidity due to increases in opportunistic infections</li> <li>• Higher mortality leading to falling life expectancy</li> </ul>	<ul style="list-style-type: none"> <li>• Fall in the supply and quality of education due to teacher mortality and morbidity</li> <li>• Fall in the demand for education due to learner and parent mortality and morbidity</li> </ul>	<ul style="list-style-type: none"> <li>• Deepening gender inequality due to higher female HIV prevalence</li> <li>• Unequal distribution of the negative impacts</li> </ul>
Deprivation as a driver of HIV and AIDS	<ul style="list-style-type: none"> <li>• Poverty causing high-risk sexual behaviour</li> <li>• Hunger leading to faster progression of AIDS</li> <li>• Hunger reducing the efficacy of ART</li> </ul>	<ul style="list-style-type: none"> <li>• Low health status leading to faster progression of AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Low education reducing access to information and ability to take appropriate decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Inability of women to take decision to protect themselves and others against infection</li> </ul>
Culture as the entry point in the fight against HIV and AIDS	<ul style="list-style-type: none"> <li>• Traditional social safety nets limiting destitution</li> </ul>	<ul style="list-style-type: none"> <li>• Respect for sanctity of life as basis for a social movement to fight AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional institutions as source of information</li> </ul>	<ul style="list-style-type: none"> <li>• Culture defining bounds for participation in society</li> </ul>

## 2.5 SWAZILAND HUMAN DEVELOPMENT STATUS

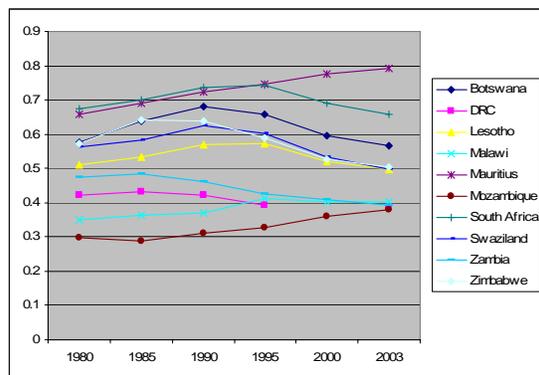
### 2.5.1 Human development status at national level

This section assesses the status of human development in Swaziland through an examination of the various indices discussed above. Information on how the indices were calculated and the data sources is provided in the technical note in annex 1.

The trends in Figures 2.1 and 2.2 show that Swaziland's HDI increased from 0,530 to 0,623 from 1975 to 1990.<sup>4</sup> Thereafter the HDI assumed a declining trend, and by 2003 the HDI for Swaziland was less than it was in 1975. The deceleration in the country's human development status in the 1990s completely reversed the gains of the 1970s and 1980s. The intensity of this deceleration comes to the fore when it is seen that, among countries that had an HDI similar to Swaziland in 1975 (i.e. their value in HDI fell between 0,500 and 0,550), only Zimbabwe (despite doing well on the HIV and AIDS front) experienced a similar reversal in its human development status (figure 2.2).<sup>5</sup>

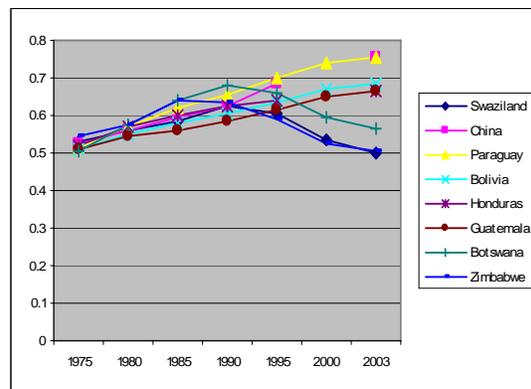
The only other country to have had a decline in the HDI value, although not completely reversing past achievements, is Botswana. Only two Southern African countries among the nine countries compared have experienced reversals in their human development status, while countries in other regions have been making progress, in some cases at a slow pace.

**Figure 2.1: Human Development Indices in SADC countries, 1980-2003**



Source: UNDP, 2005

**Figure 2.2: Long-term movements in HDI in countries with similar HDI, 1975**



Source: UNDP, 2005

The case of Swaziland, and to an extent Botswana, is typical of Southern Africa. Despite a minerals revenue boom, Botswana has some of the highest HIV and AIDS prevalence levels in the world. Of the ten SADC countries with HDI values calculated from 1980, only Mauritius, Malawi and Mozambique had HDI values that were above those of 1980 (figure 2.2). The HDI value of the rest fell below the 1980 value.<sup>6</sup>

4 For a comparison of HDI trends for Swaziland and other countries, HDI values from the global HDRs are used.

5 Oil-producing countries have been excluded from this comparison, as it would be unrealistic to include them.

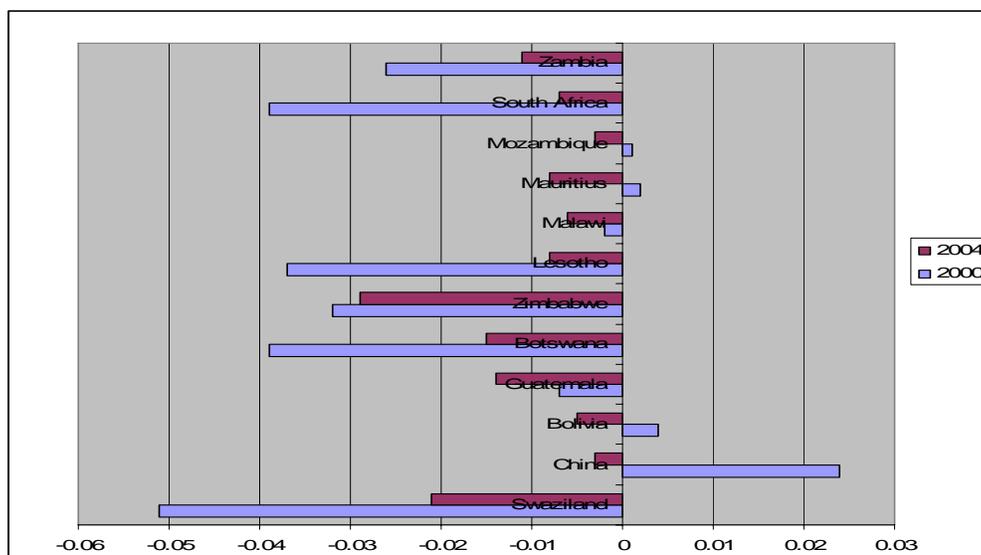
6 Unfortunately, most Southern African countries did not have HDI values going back to 1975, limiting the possibility of making comparisons.

This cannot be explained by poor economic performance, because even those countries which have experienced growth showed a decline in their HDI value. The main explanatory factor is the high prevalence of HIV and AIDS in Southern Africa. It is the highest in the world, cutting life expectancy in countries across the region. The HDI has risen for all countries in West Africa with HDI data since 1980.

Similar trends are seen in East Africa. The two regions have a much lower HIV incidence compared to Southern Africa. These statistics strongly suggest that HIV and AIDS are eroding the human development for Swaziland and other Southern African countries, reversing past achievements in expanding people's choices.

Amidst the deteriorating HDI, there is some indication that the gender gap in human development in Swaziland is declining (figure 2.3). The negative difference between the GDI and HDI, depicting that women fared worse than men, drastically fell between 2000 and 2004. When compared to the countries to which Swaziland's HDI has been compared to, i.e. those with a similar HDI in 1975 and other SADC countries, Swaziland does not fare as well. The gender differential in 2004 was worse than that of only Zimbabwe.

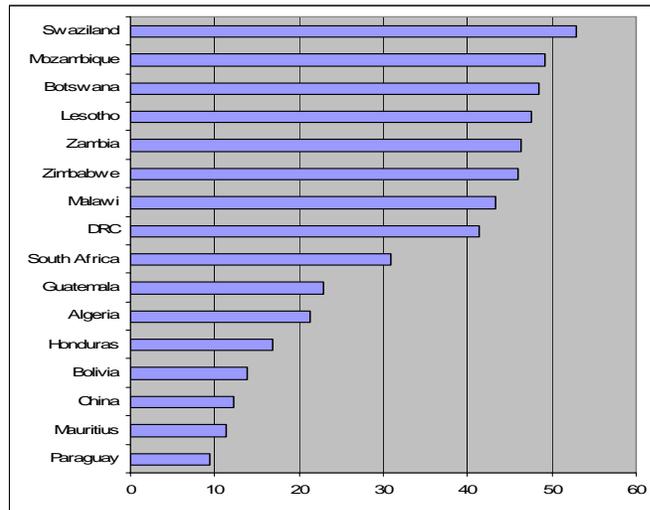
**Figure 2.3: Gender Related Index in selected countries, 2000-2003**



*Source: UNDP, 2006*

Unfortunately, the HPI for Swaziland has only been calculated for 2003 and comparative trends cannot be established. There is however no doubt that the country is still in a dire situation. Figure 2.4 shows that Swaziland had the highest HPI in 2003 among the countries it has been compared with. This was among the highest HPIs in the world, along with Ethiopia, Chad, Mali, Burkina Faso, Sierra Leone and Niger, suggesting that Swaziland has one of the most deprived populations in the world. This is surprising given the relatively high GDP per capita (PPP was pegged at \$4 720 in 2003). The countries mentioned above whose HPI was higher than that of Swaziland had a per capita GDP of only between \$548 and \$1 210. This is a clear indication of the skewed income distribution in the country. It also underlines the point that although it is a middle-income country, Swaziland's human development profile is closer to that of an LDC.

**Figure 2.4: Human Poverty Index in selected countries**



*Source: UNDP, 2005*

### 2.5.2 Human development status of Swaziland's regions

Despite the difficulties of calculating Human Development Indices using Swazi data (box 2.3), table 2.3 presents the HDI for Swaziland and the variables used in the calculations. Using Swazi data allows us to make important regional comparisons within Swaziland. It is admitted that this kind of comparative analysis is highly limited, because the country has only four regions and data to allow calculation of human development indicators is not available at the constituency level.

From the little that is available, a number of observations can however be made:

- ★ The HDI for Swaziland as a whole is estimated at 0,471 in 2006. The value is different from the value obtained from the GHDRs, because the calculations are made using Swazi national data. Table 2.3 shows that Hhohho had the highest HDI and Shiselweni the lowest.
- ★ A look at the variables used in calculating the HDI, shows that Shiselweni had the lowest HDI because it had the lowest life expectancy (that of the other three regions was nearly similar) and the lowest estimated GDP per capita in PPP. Surprisingly, Shiselweni had a better combined gross primary school enrolment ratio than the other three regions, while the adult literacy is comparable to that of Hhohho and Manzini, but higher than Lubombo's. As a result, Shiselweni had a similar education index with the other two and higher than that of Lubombo.
- ★ For Swaziland as a whole, the biggest factor determining a much lower HDI than its middle-income status would seem to dictate, is low life expectancy, as discussed above. This has been chiefly influenced by the high HIV prevalence rate in the population, which is the highest in the world. For the purposes of raising the HDI, urgent measures are required to reduce new infections drastically and enable and/or improve the treatment and care (including access to ARVs) of people already infected with HIV so that they can live a longer and healthier life.

**Table 2.3: The Human Development Index for Swaziland and the regions in 2006**

	Life expectancy at birth (years) 2006	Adult literacy rate (%) in ages 15+, 2004	Combined gross enrolment ratio (%), 2004	GDP per capita, 2004	Life expectancy index	Education index	GDP index	Human development index value, 2006
Swaziland	35,1	79,6	57,9	2 271	0,17	0,72	0,52	0,471
Hhohho	35,1	83,0	54,1	2 955	0,17	0,73	0,57	0,489
Manzini	35,7	80,7	56,8	2 225	0,18	0,73	0,52	0,474
Shiselweni	32,3	79,2	60,8	1 671	0,12	0,73	0,47	0,441
Lubombo	35,7	73,7	60,4	2 027	0,18	0,69	0,50	0,458

**Box 2.3: The challenge of data for the measurement of Human Development Indices**

Swaziland is faced with data difficulties for the calculation of HDI explained in Box 2.1. Most of the data is outdated, as no recent surveys exist to update the findings of the 2000 Swaziland NHDR. The last national census was conducted in 1997 and provided most of the data used in the calculation of the national and regional HDI in 2000. The data of the 2007 census is not available. The SHIES, which provides most of the data for the calculation of the HPI, was last done in 2000/01. A further problem is that published data of the SHIES is not disaggregated by region and rural/urban areas.

Because of the length of time that has elapsed since the census and survey were last conducted, attempts to get raw data for disaggregation were not successful as current staff were not present when the census and the SHIES were done. There were also suggestions that the data itself might have been misplaced.

Given these difficulties in getting the data for the calculation of indicators, the necessary indicators were derived from projections based on the 1997 census and 2000/2001 SHIES, as explained in Annex 1. Most projections assume that the regional differences in the critical indicators that existed also applied to 2006. As a result, the measures of human development provided in this report must be interpreted cautiously. Therefore, the 2007 Swaziland NHDR avoids drawing strong comparisons with the findings of the 2000 report.

A window of opportunity has opened up that will allow the next Swaziland NHDR to utilise updated data. The CSO conducted a national population census and a Demographic and Health Survey in 2007. In addition, the CSO will conduct the SHIES in 2008. These documents will yield the information to calculate national and regional HDI for Swaziland. There is a need to help the CSO undertake the right analysis by providing disaggregated data up to constituency level, as well as by gender (if the GDI is to be calculated for regional and sub-regional levels). For policy dialogue and advocacy purposes it will make greater sense if Human Development Indices are also calculated at constituency level. In the long term, there is a need to

Swaziland's HPI has been estimated at 53,9%, as indicated in Table 2.4. More than half of the population lives in deprived conditions. The HPI is much more varied regionally than the HDI, ranging between 49,6% for Manzini and 60,5% for Lubombo. This means that Lubombo has the most deprived population in Swaziland.

As pointed out above in comparisons with other countries, such a high HPI is inconsistent with Swaziland's status as a low/middle-income country. The main contributor to the inconsistency is the high probability at birth of not living up to the age of 40, estimated at 74,3% in 2004. This is followed by a deprivation in basic human requirements, specifically inadequate access to safe water at 64%.

**Table 2.4: The Human Poverty Index for Swaziland and the regions**

	<b>Probability of not surviving to age 40 (% of cohort), 2004</b>	<b>Adult illiteracy (% aged 15+), 2004</b>	<b>People not using better water sources (%), 2004</b>	<b>Underweight children under age five (%)</b>		<b>Human Poverty Index</b>
	<b>P<sub>1</sub></b>	<b>P<sub>2</sub></b>	<b>P<sub>31</sub></b>	<b>P<sub>32</sub></b>	<b>P<sub>3</sub></b>	<b>HPI-1</b>
Swaziland	74,3	20,4	64	9,6	36,8	53,9
Hhohho	70,1	17,0	47	8,0	27,5	49,8
Manzini	69,5	19,3	49	8,4	28,7	49,6
Shiselweni	78,5	20,8	65	9,1	37,1	56,6
Lubombo	81,9	26,3	81	11,0	46,0	60,5

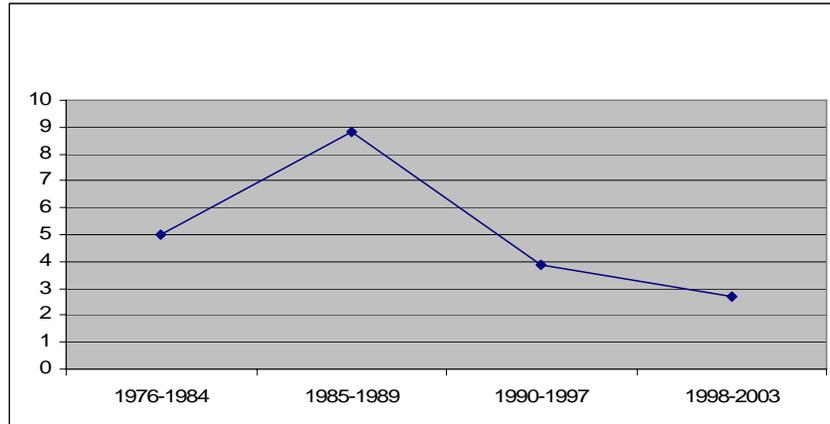
## **2.6 REVERSING THE DECLINE IN SWAZI HUMAN DEVELOPMENT**

The declining human development status of Swaziland is of concern, as it exposes the population to deprivations that are inconsistent with its lower middle-income status. At this rate, the vision to take Swaziland to the top 10% bracket of middle human development status by 2022 will not be achieved. Policy actions are required to reverse the declining trends in human wellbeing in three main areas – making the economy more supportive, reversing the falling life expectancy and protecting the education achievement. These are captured in the human development measures.

### **2.6.1 Towards a more supportive economy for human development**

The Swazi economy is currently less supportive to progress in human development than it was before 1990. Robust economic growth in the 1980s, with GDP growth averaging 8,7 between 1986 and 1990, was followed by a period of much lower growth in the 1990s (figure 2.5). After 2000 this growth occurred at a rate lower than the 2,9% annual growth in the population, leading to a decline in the GDP per capita. If human development is to assume an increasing trend, a reversal in the falling growth rate must be secured. There are however many factors that explain the underperformance of the Swazi economy and that must be understood.

**Figure 2.5: Average annual GDP growth rate (percent)**



**Source: Swaziland Human Development Report 2000 and Ministry of Economic Planning and Development, 2005**

Swaziland's high growth rates before 1990 were driven by high inflows of foreign direct investments (FDI), which averaged 7,1% of the GDP between 1985 and 1993. The country was an attractive destination for FDI because of political and macro-economic stability and favourable investor incentives.

The main factor was however the existence of sanctions against the former apartheid regime in South Africa, which led to the relocation of some firms to Swaziland where they could still get to the South African market. After the sanctions were lifted with the emergence of a democratic South Africa in 1994, Swaziland lost this advantage. In the aftermath of the sanctions having been lifted, some firms shifted to South Africa.

At the same time, Swaziland has to compete with Mozambique across the north-eastern border. Mozambique has become attractive to FDI with the end of the civil war and improvements in the economic and business environment. FDI consequently averaged only 4,7% of the GDP between 1994 and 2002, was negative in 2003 but recovered to 2,5% of the GDP in 2004 (IMF, 2006).

With reduced FDI inflows, the growth in manufacturing activities (which had been the engine of the high growth rates of the years before 1990) also began to slow down. Over the long term, the major bottleneck in economic performance has however been the stagnation in agricultural production, whose contribution to the GDP declined from 36% in 1985 to 9% in 1995. It has maintained more or less the same proportion. This adversely affects human development for two main reasons. Firstly, given that 70% of the population derive their livelihood from agriculture, the underperformance of agricultural sector immediately affects the wellbeing of the majority of Swazis. Secondly, it shows the low factor productivity prevailing in the sector.

Conversely, agriculture is not homogeneous, as it has two distinct sub-sectors with different characteristics. On the one side, there is a dynamic commercial sub-sector, consisting of about 800 farms with an average area of 1 230 hectares for growing export crops, mainly sugar and citrus fruits. These farms are on title deed land (TDL) and occupy some of the best land, use advanced farming methods and account for nearly all the irrigation in the country. The productivity of sugar cane production in Swaziland, for example, is considered efficient by world standards (IMF, 2006). Yields per hectare have increased by about 9% since 1998/1999.

On the other side of Swazi agriculture, small farmers practise semi-subsistence cultivation on Swaziland National Land (SNL), i.e. land held in trust by the King on behalf of the Swazis. They grow mostly maize, but also groundnuts and vegetables. Yields of maize on SNL have nearly halved since the 1998/1999 agricultural season. The fall in yields are due to many factors, which include droughts experienced since the early 1990s, land degradation caused by soil erosion and overgrazing due to the common grazing system on SNL, low on-farm investments due to inadequate security of tenure, inadequate access to credit because this land is mostly untitled, and the negative impact of HIV and AIDS.

Although there are models that attempt to estimate the overall economic impact, these are fraught with difficulties because HIV and AIDS negatively affect so many variables at the same time. As a result it is nearly impossible to map out the transmission channels meaningfully.

It is generally agreed that models underestimate the impact. For Swaziland, three estimates made between 2001 and 2005 identified the reduction in the annual growth rate of the GDP as between 1% and 2,8% (Whiteside et al, 2006). Considering that the average growth rate in recent years has been less than the 2,9%, the significance is clear. Agriculture is especially vulnerable as it tends to be labour intensive and losses in labour due to death and illness adversely affect the sector.

Poor performance in the economy means that its ability to create jobs to absorb the country's burgeoning labour force has also dropped. Despite the labour force expanding at an annual rate of 5,2% since 1991, employment in the formal sector grew at an average of only 1,03% between 1995 and 2002 (Ministry of Economic Planning and Development, 2005).

The situation has been made worse by the fact that the South African economy has not been able to absorb the same number of migrant workers it used to. From 16 500 in 1990, the total number of Swazi migrant workers dropped to only 6 307 in 2002. The implications for the economy have been enormous, given that remittances as a proportion of the GDP have been historically high, as much as 15% of the GDP in the late 1980s.

The Swazi authorities have long realised the need to restore the economy to a higher growth path. Nevertheless, they face serious challenges for policy space to achieve this in the short to medium term. Swaziland is a highly open economy, with the proportion of exports to the GDP as high as 80%, making the economy extremely vulnerable to changes in the external environment.

This factor is made worse by the fact that one country, South Africa, is dominant in Swaziland's external trade, absorbing about 60% of the country's exports and being the source of 80% of imports. South Africa's domestic policies and the performance of its economy consequently have a direct bearing on the Swazi economy. This is reinforced by Swaziland's membership of the common monetary area (CMA) that requires the pegging of the lilangeni at par with the Rand. This means Swazi authorities have little control over monetary policy to steer macro-economic variables. As a result, recent appreciations in the Rand have significantly hurt the competitiveness of Swazi exports outside the CMA.

The lack of insulation from external factors and the fact that a significant proportion of exports emanate from agriculture and forestry, which are vulnerable to variations in weather, means that there are major fluctuations in export earnings and ultimately the country's trade balance. Between 1996 and 2003 imports grew at a faster rate than exports, leading to deficits in the trade account, except for 2002 and 2003.

Because Swaziland is a net importer of services, the balance on goods and services tends to be negative, even in years of a trade surplus. Swaziland enjoys large net inflows on transfers arising from payments from the SACU and remittances by migrant workers, which in the late 1980s and early 1990s often offset these deficits with the current account registering surpluses as a result. Declines in the FDI mean there has been a deficit in the balance of payments in the 1990s and beyond, further indicating the fragile nature of Swaziland's international economic relations.

With these constraints, fiscal policy is the only effective instrument to steer the Swazi economy. Chronic budget deficits have characterised the Swazi economy since the slowdown in economic growth in the early 1990s. To promote macro-economic stability, Swaziland should cut expenditure. At the same time there is rising pressure to finance identified actions to improve the country's human development status, including health, education and actions to attain the MDGs. In the short to medium term, prospects for increases in revenue are not very bright, due to a shrinking economy with the GDP growth projected at only 1,7% in 2006/2007.

According to the 2007 budget speech, 71% of the national budget of 2006/2007 was financed from the SACU receipts, which are expected to decline as trade agreements between the SACU and other countries are implemented, principally with the EU under the Economic Partnership Agreement. This proportion has increased from the 56% of the 2005/2006 budget.

The emerging international trade architecture under the auspices of the World Trade Organisation (WTO), which is pushing for reduced tariffs, will further erode Swaziland's receipts from the SACU. Mention must also be made of the SADC Trade Protocol that is consistent with the global thrust for lower tariff walls. Fiscal policy therefore faces a big challenge to protect expenditures that are important for human development, even as overall expenditure is being cut. It calls for the overhauling of expenditure patterns.

## **2.6.2 Poverty reduction to support human development**

Swaziland's high HPI, which indicates the country has one of the most deprived populations in the world (section 2.5), is inconsistent with its lower middle income status. It shows fundamental problems in the distribution of past gains, as the high growth of earlier years failed to trickle down to the majority of the people.

Even in moneymetric terms, poverty in Swaziland is very high. According to the SHIES conducted in 2000/2001, 69% of the people lived below the poverty line. This means they lacked sufficient income to get food items that would guarantee them the required number of calories for an active life, as well as to afford essential non-food items. In addition, 37% were deemed to be living in extreme poverty, which is indigence or destitution, lacking the ability to satisfy even minimal food intake necessary for an active life.

For a country that had a per capita GDP of E10 732 in 2001 and considering that the annual food poverty line was set at only E722,04 for rural areas and E867,12 for urban areas, these figures are alarming. They point to the fact that income in Swaziland is highly skewed. The SHIES of 2000/2001 established that the richest 20% of the population accounted for 56,4% of consumption, while the poorest 20% accounted for only 4,3%. The Gini coefficient, a summary measure of inequality, was estimated at 0,50, which is very high by world standards.

This level of inequality is associated with the following characteristics:

- **Poverty has a strong rural bias.** Whereas 78% of the population in rural areas lived below the poverty line, this was estimated at 50% in urban areas. In addition, 43% of rural dwellers lived in extreme poverty, in contrast to 20% in urban areas. There was little difference in the incidence of rural poverty between the regions, ranging from 72% in Hhohho to 78% in Lubombo. The regional differences are significant with regards to urban areas, ranging from 39% in Hhohho to 68% in Shiselweni. Shiselweni's population had the highest incidence of poverty among the four administrative regions, as it is a strong rural area, with the lowest incidence found in Hhohho.
- **Rural areas are not homogenous and high inequalities prevail.** A Gini coefficient of 0,51 in urban areas was higher than in rural areas, which had a coefficient of 0,45. The rural inequality depicted was also comparatively high by international standards. This means that, even in rural areas, total consumption expenditure is accounted for by only a small proportion of the population.
- **Poverty is associated with ecological regions.** Overall poverty was highest in the Lubombo plateau, at 81%, and lowest in the highveld region. The harsh ecological conditions in Lubombo explain this observation. Agricultural production is difficult without the required investments in irrigation, but due to water scarcity and current land tenure policies, there is not much investment flowing into the region.
- **Poverty is not gender neutral.** At least 63% of female-headed households were found to be poor, compared to 52% of male-headed households. This difference underestimates the gender bias of poverty, as households classified as male-headed were effectively headed by women, as the men were absent for extended periods of time. These households were said to be poorer on average (World Bank, 2000).

**Poor people suffer serious deprivation in access to social amenities.** This is clear with respect to three amenities critical for wellbeing (table 2.5). Firstly, they have less access to sustainable safe water sources and adequate sanitation facilities. Secondly, poor people are also more likely to depend on wood or charcoal as a source of energy than people who are not poor. Lastly, the quality of their housing is likely to be very poor.

**Table 2.5: Incidence of poverty by selected social variable**

<b>Selected social variable</b>	<b>Incidence of poverty (%)</b>
Has piped water inside home	24,0
Has unsafe water sources	71,0
Use bush for sanitation	78,0
Has flush toilet	23,0
Relies on wood or charcoal as source of energy	71,3
Relies on electricity as source of energy	27,2
Lives in house with grass thatched roof	78,9
Lives in house with tiled roof	18,5

*Source: Central Statistical Office: Swaziland Household Expenditure Survey 2000 - 2001*

Factors driving poverty are numerous. Given that the majority of the rural people live on SNL, the high poverty levels prevailing in these areas is a reflection of the low productivity of their farm enterprises, as established above. Unemployment is a strong driver of poverty. In the SHIES of 2000/2001, 29% of the labour force was unemployed. In Shiselweni, the poorest region in the country, 53% of the labour force is unemployed, compared to 20% in Hhohho, which was the least poor of the four regions at the time of the survey.

The gender differentials in poverty reflect the weak position of women in the Swazi society. They suffer discrimination in access to productive assets, such as land and opportunities for the development of human capital. Poverty is also strongly correlated to inadequate education and is considerably reduced when the head of the household has had secondary education.

Although 77% of households without primary education in Hhohho were poor, the number falls to 29% among households with secondary education. The difference is not as big in Shiselweni, where poverty levels were 80% and 59% respectively, indicating the presence of other strong factors driving poverty. Although education is important in building people's capabilities, it cannot reduce poverty on its own and should be complemented by other interventions.

The shrinking prospects of economic growth mean that poor people are becoming increasingly vulnerable. The situation is worsened by HIV and AIDS. Although there are no studies providing quantitative information on the link between poverty and HIV and AIDS in Swaziland, there is enough qualitative information to suggest that the link is strong (chapter four).

HIV and AIDS are entrenching poverty by devastating livelihoods, as the pandemic undermines the assets at the disposal of households. It is depleting household labour through deaths, increased morbidity and time spent looking after chronically sick household members. Financial resources are depleted because of the increased cost of care and treatment, which in turn means that households are less able to invest in productive activities.

The productivity of natural resources is compromised due to a loss in the intergenerational transfer of knowledge and skills and the intensification in the exploitation of these resources as opportunities are lost to HIV and AIDS affected households.

The social systems that have provided safety nets to poor households are weakening under the weight of HIV and AIDS. They are unable to provide the same level of protection to weak people in the community, as exemplified by the emergence of street children and child-headed households in the 1990s. The prevalence rate is higher among women, and while they disproportionately shoulder the negative consequences of the pandemic as primary caregivers, HIV and AIDS are entrenching existing gender and other social inequalities.

It is beyond doubt that HIV and AIDS are strong drivers of poverty. Poverty is in turn a strong driver of the spread of HIV and AIDS, since poor people are not motivated to protect themselves against infection, may engage in high-risk sexual behaviour as an income generating mechanism and are vulnerable to sexual exploitation. If poverty in Swaziland cannot be fought effectively without dealing with the pandemic, the high HIV and AIDS prevalence rates will not decrease either if the huge inequalities and high incidence of poverty prevail.

## 2.7 HUMAN DEVELOPMENT, MDGs AND HIV AND AIDS IN SWAZILAND

As seen above, MDGs are one way of looking at human development, which is also interrelated to HIV and AIDS through a self-reinforcing loop. The first MDG report for Swaziland was published in December 2003. It showed that out of the seven MDGs that refer to domestic outcomes, only two goals, i.e. universal primary education and gender equality and empowerment, are potentially attainable. The rest were assessed as being unlikely.

The fact that the supportive environment, i.e. appropriate policies and investments, was not assessed as “strong” in any of the cases is reason for concern. Only in the case of combating HIV and AIDS, malaria and other diseases was this deemed “fair”, while for the rest it was said to be either “weak” or “weak but improving”.

The overall conclusion is that a lot more needs to be done to move Swaziland on the path towards attaining the MDGs, as these are critically important for progress in human development. There are some countries less fortunate than Swaziland that appear to have better prospects for achieving the MDGs. The progress made towards attainment of the different MDGs can be inferred from the data provided by the MDG report of 2007.<sup>7</sup> A brief goal-by-goal assessment is made, which enables us to look at whether investments to build people’s capabilities for human development are met and are having adequate results.

**Reduction of poverty and eradication of hunger:** The SHIES of 1994/1995 established that 66% of the population lived below the poverty line. If this is taken as the baseline, the MDG target would be 33%, because the goal calls for halving the proportion of people in absolute poverty by 2015. This was a challenge from the start, given the slowdown in the rate of economic growth at the start of the 1990s. The SHIES of 2000/2001 indeed indicated that 69% of the population are poor.<sup>8</sup>

In the case of hunger, the percentage of children under five years old who are underweight dropped from 10% in 1983 to 7% in 1995. The target would be to reduce this proportion to 3,5%, which does not seem to be an insurmountable target. The concern is that the percentage of underweight children rose again to 10% in 2000. This can be attributed to poor food production due to droughts and general low productivity among SNL farmers, as established above.

HIV and AIDS are complicating efforts aimed at reducing poverty and hunger in several ways. Affected households quickly become labour constrained due to death, chronic sickness and time spent caring for sick people. As seen above, other assets at the disposal of households are undermined due to AIDS, making Swazi communities more vulnerable to periodic shocks such as droughts and the downward spiral in the economy.

HIV and AIDS are definite factors in the skyrocketing poverty of the 1990s and beyond. Poverty in turn undermines efforts to combat the pandemic. In particular, it predisposes some people to high-risk sexual behaviour, such as sex work. Poor people are less likely to have access to safe water and adequate sanitation. People with AIDS are more predisposed to opportunistic infections. Given their poor nutritional status, poor people are more likely to develop full-blown AIDS quickly.

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<sup>7</sup> There is a new effort to establish the country’s MDG database, which will hopefully produce these trends with respect to the value of the indicator in 1990 (or the closest year for which data is available) and the target, as suggested by the MDGs.

<sup>8</sup> This should be interpreted cautiously, as there were methodological differences in the two surveys.

**Achieve universal primary education:** Progress on this goal is mixed. World Bank figures show that the youth literacy rate increased from 85% in 1990 to 88% in 2004. After falling from 77% in 1990 to 74% in 1998, net primary school enrolment regained its earlier status of 77% in 2004 and rose to 81,9% in 2005. The rate of children who reach grade 5 has however dropped to 73% in 2001 from 77% in 1990. Completion of primary school remained stagnant at 61,3% between 1990 and 2004. Of the learners starting grade 1, almost 40% fail to finish their primary education.

Taking a look at Swaziland's recurrent budget, where 24,4% went to fund education between 1999/2000 and 2003/2004, these figures are surprising. It is explained by an expenditure pattern that is tilted towards the funding of tertiary education at the expense of primary education, which is much more accessible to the poor and has enormous implications for poverty reduction. The cost of educating one university student was found to be enough to educate 47 primary and 13 secondary school learners (World Bank, 2000). These expenditure patterns need to be reversed if universal primary education is to be achieved.

There is also a need to raise the primary school completion rate substantially, by dealing with factors in and outside school that prevent children from progressing. Poverty is one factor militating against access and the ability to complete primary education. It is reinforced by HIV and AIDS, as some learners are forced to drop out because one or both parents have died or they have to supplement household earnings that decline due to the adverse effects of the pandemic. The psychosocial impact of the pandemic also militates against the ability of children from AIDS affected households to complete their schooling.

HIV and AIDS affect Swaziland's efforts to attain universal primary education by 2015. It undermines the supply of education through a reduction in the number of teachers due to deaths, chronic illnesses and caring for sick people (especially female teachers). Chapter four provides evidence on the rising teacher-learner ratio attributable to the pandemic. HIV and AIDS also undermine the demand for education among learners affected by HIV and AIDS. Clearly, fighting HIV and AIDS is an important prerequisite for ensuring that Swaziland attains the second MDG.

#### Box 2.4: HIV and AIDS and education: People's perceptions

In the focus group discussions for the Swaziland NHDR 2007, participants were asked to talk about the relationship between HIV and AIDS and education. Below is the range of responses they provided.

- Boys and girls have equal opportunities for educational attainment.
- Education was negatively affected in that parents spend all their resources on treatment thus there was little or no money left to finance education.
- The death of parents negatively affects educational attainment in that there is no money to cater for fees and uniforms. Although the OVC fund provides funding, part of it has to come from the parents or guardians. Orphans are at home due to non-payment of fees by government.
- Infected teachers are likely to miss class when they seek medical attention.
- Hunger has a negative impact in that even if the child's school fees can be paid, they may be unable to concentrate at school due to hunger.
- Girls are more vulnerable because they are impregnated by older men and drop out of school. Pregnancy has a negative impact on girls' educational attainment.
- Although educational attainment is largely affected by HIV and AIDS, some participants felt that the unemployment (of the parents) has a negative effect on educational attainment in general.
- The burden of caring for the sick parents and relatives often falls on the shoulders of the girl child and this negatively impacts on her chances of attaining education.
- People abuse orphans (especially girls who may become pregnant) as they have no one to protect them and this militates against their educational attainment; abuse generally has negative effects and lowers self-esteem.
- Some participants viewed the boy child as advantaged in educational attainment as some parents still believe educating a boy is a good investment. Boys get better opportunities because they are perceived as "permanent" family members, unlike girls who get married and leave the family. Furthermore, because boys do not become pregnant, their chances of dropping out of school

**Promote gender equality and empower women:** Progress on the attainment of this goal has been mixed. Whereas female political participation increased from 4% of seats in parliament occupied by women in 1990 to 20% currently, economic participation declined. The proportion of women employed in the non-agricultural sector dropped from 35% to 31%. There has been a drop in the ratio of girls to boys in primary and secondary education, while the ratio of literate female to male youths increased marginally.<sup>9</sup> However, the figures are impressive for the civil service, where women occupy 58% of professional, technical, administrative and managerial positions.

Therefore, when seen in terms of achieving gender equality in education, this goal is potentially attainable. The feminisation of HIV and AIDS is however still a concern, given that it disproportionately infects female youths compared to their male counterparts. This is likely to complicate progress in achieving gender equity and the political and economic participation of women. As seen above, poverty and HIV and AIDS are not gender neutral and reinforce the gender inequalities that persist in the Swazi society.

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<sup>9</sup> Swaziland has a unique situation where women are more literate than men. The ratio of literate female youths rose from 100,9% in 1990 to 103,2% in 2004.

**Reduce child mortality:** Substantial progress was made to reduce infant mortality between 1976 and 1991. The number of infant deaths fell from 156 per 1 000 live births to 72 respectively. Since then, the infant mortality rate has risen to 78 per 1 000 live births in 1997 and to 85 in 2006. Similar rising trends have been found in the under-five mortality, which increased from 89 per 1 000 live births in 1991 to 106 in 1997 and then worsening to 120 in 2006/2007.

This increase is due to a number of factors, including the fall in immunisation against preventable child diseases as well as HIV and AIDS, because of mother to child transmission. Evidence provided in chapter three shows that as many as 50% of HIV positive pregnant women refuse to take ARVs when counselled to do so.

There are many reasons for this, including a lack of confidence in the health system to supply ARVs consistently, as well as the stigma associated with HIV and AIDS. Someone's HIV positive status is likely to be exposed quickly because of people constantly taking medication, especially to a husband who may have problems accepting his wife's HIV positive status.

**Improve maternal health:** Maternal health has deteriorated over time. In 1991 the number stood at 110 deaths per every 100 000 live births (UNDP, 2003). The fifth MDG target is to reduce maternal mortality by three quarters, or to 52 deaths for every 100 000 live births by 2015. The maternal mortality ratio however more than doubled to 229 deaths in 1997 and rose to 370 in 2006. At this rate the attainment of the fifth MDG is out of reach. The deterioration in reproductive health is mostly attributed to preventable causes, an indicator in the declining quality of maternal health care. Nevertheless, HIV and AIDS keep worsening Swaziland's maternal health status by increasing complications in childbearing because of the low immune system of pregnant women that makes them susceptible to opportunistic infections.

**Combat HIV and AIDS, TB and other diseases:** This report discusses at length the incidence of HIV and AIDS and the drivers and impacts (chapters three and four). It is sufficient to point out that, by undermining people's immunities and making them vulnerable to opportunistic infections, HIV and AIDS have increased the disease burden of the country many times over.

In particular, the incidence of TB rose from 210 people per 100 000 people in 1990 to 856 in 2000. It further rose to 1 182 per 100 000 in 2006. Swaziland therefore has one of the highest TB incidences in the world. But there has been good progress regarding the incidence of clinical malaria, which fell from 4,1 per 1 000 people in 2000 to 2,2 per 1 000 people in 2004. The number of laboratory confirmed cases has dropped from an average of 4 000 per year during the period 1995-2000 to less than 300 per year during the 2004/2005 malaria transmission season. Public campaigns that include indoor residual house spraying coverage and public sensitisation are paying dividends.

**Ensure environmental sustainability:** Several indicators have been listed with regard to the seventh MDG. The Swaziland MDG report of 2007 discusses a number of them. Good progress has been made in the decrease in the use of ozone depleting substances. The importation of such substances fell from 3,07 metric tonnes in 2004 to 0,19 metric tonnes in 2006.

The percentage of protected areas is said to have been increasing since 2002 with a number of sites proposed for gazetting. The number of projects subjected to environmental impact assessments rose from 55 in 2000 to 204 in 2006. Access to safe water stood at 65% in 2005. For the rural population this increased from 42% in 1990 to 54% in 2006.

Despite this, waste management, an increased number of threatened plant and animal species, a decline in indigenous plant cover and soil erosion remain a great source of concern. Given this situation, it is important to take serious measures to improve the status of the environment that would support the population's health and livelihood. Environment sustainability plays an important role in mitigating the negative impact of HIV and AIDS.

## **2.8 CONCLUSION**

The falling status of Swaziland's human development discussed in this chapter is mostly linked to HIV and AIDS, which have cut the country's life expectancy by more than 30 years in just one decade. The other important factor is the poor economic performance in the period after 1990, partly due to the changes in the geopolitical environment that have led Swaziland to become a less preferred destination of FDI, compared to South Africa, Mozambique and other countries in the region.

The impact of the downturn in the economy on human development has been worsened by the unequal distribution of economic gains. With nearly 70% of the population living in poverty, inequality is a big obstacle Swaziland (as a lower middle-income economy) has to face in enhancing human development. The 2006 GHDR ranks Swaziland in the 146th position out of 177 countries with respect to the HDI value. This contrasts sharply with a relatively strong position of 124 out of 174 countries studied in 1995. Countries poorer than Swaziland in terms of their GDP per capita have managed to protect the human development status of their population better than Swaziland has done.

## CHAPTER 3: THE HIV AND AIDS PANDEMIC IN SWAZILAND: TRENDS, PATTERNS AND DRIVERS

### 3.1 INTRODUCTION

A prerequisite for designing an appropriate response to a pandemic such as HIV and AIDS is knowledge about the status of the disease, how it spreads and HIV and AIDS trends within the population. This serves as the basis for planning, resource mobilisation and allocation, priority setting and capacity development in order to manage the pandemic and its associated socio-economic impact. The purpose of this chapter is to provide basic information for understanding the level of the HIV and AIDS in Swaziland and why the pandemic is spreading fast.

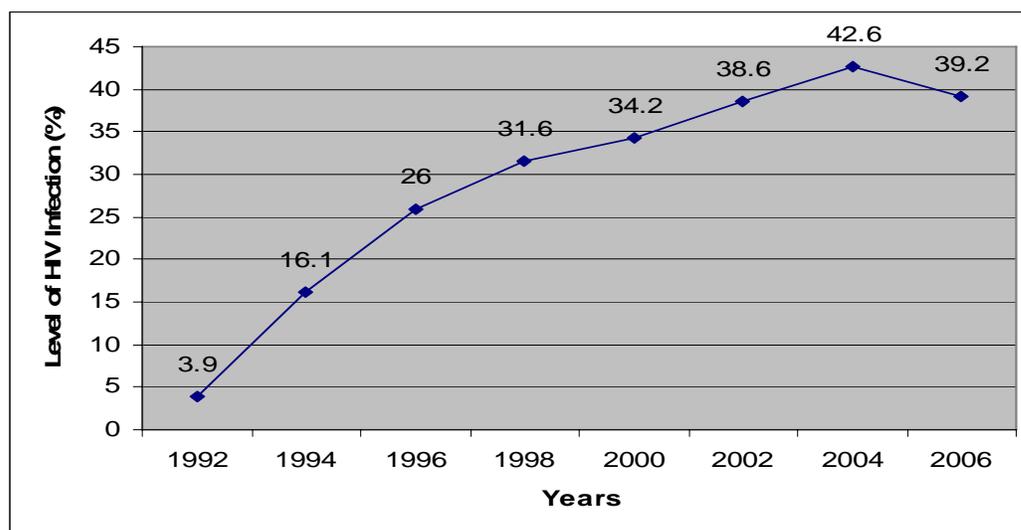
### 3.2 PREVALENCE OF HIV IN SWAZILAND

#### 3.2.1 HIV prevalence among people attending antenatal clinics

The prevalence of HIV in the country has continued to cause concern, both in the government and the general public, since it was learnt that the virus got into the population in the early 1980s. Although it was expected that the level of prevalence of HIV would not exceed 25% in the 1990s, data from the HIV sero-surveillance among people attending antenatal clinics show that the overall level of HIV infection in pregnant women increased more than 10 times, from 3,9% in 1992 to 42,6% in 2004 (figure 3.1). By 2006 it however declined to 39,2%.

Data from other sources corroborated these high rates. For instance, the AIDS Information and Support Centre report for 2004 indicated that of the 782 clients that went for VCT, 40,2% tested HIV positive (TASC, 2004). Using the estimation and projection package (EPP) software of 2005 for modelling the pandemic, Whiteside et al (2006) predicted that the prevalence of HIV in the country would stabilise at around 40% between 2005 and 2015. These prevalence rates are the highest in the world. Other countries with high ANC rates in 2004 are found in Southern Africa, namely Botswana at 37,9% and South Africa at 29,5% (UNAIDS/WHO 2005).

**Figure 3.1: Trends in prevalence of HIV among antenatal clients**



Source: MOHSW (2006)

Against this background the recent SDHS (2007) found that the prevalence of HIV in the general population in the age group 15-49 was 26%, with the rates being 31% and 20% for women and men respectively. Similar rates for South Africa were 30% and 16% respectively. This apparent difference in the rates of HIV prevalence among women involved in ANC surveillance and those in the demographic and health surveys are expected, because population surveys like the SDHS assess the HIV prevalence rates in a nationally representative sample of the general population, some of whom are sexually active while others are not.

On the other hand, ANC surveillances monitor the rate of HIV infection among pregnant women, all of whom are sexually active and engaged in unprotected (and protected) sex before the pregnancy. The frequency of in vitro fertilisation is minimal in Swaziland, compared to in vivo fertilisation resulting from heterosexual sex. The SDHS of 2007 also indicated that the HIV rates in the population for Botswana and Lesotho is 24%, while Zimbabwe's rate is 18%. South Africa and Zambia have the same rate, at 16%, while Malawi is at 12%.

These statistics indicate that the prevalence rate in Swaziland, just like in many other Southern African countries, is still unacceptably high. There is some hope nonetheless, in that for the first time over 2004 to 2006 Swaziland has had empirically verifiable evidence that the prevalence of HIV in the country can be brought down and the trend reversed through concerted prevention efforts.

As has happened in some African countries, there is a possibility that the prevalence of HIV in Swaziland can be brought down further by the national response. For instance, the HIV prevalence in Lesotho declined to 27% from 29% in 2003, in Zimbabwe from 26% in 2002 to 21% in 2004 and in Kenya from 10% in the late 1990s to 7% in 2003 (UNAIDS/WHO, 2005). Uganda, a role model in innovative ways of tackling the epidemic, witnessed a decline from national prevalence levels of 18% to 6,1% during the same period.

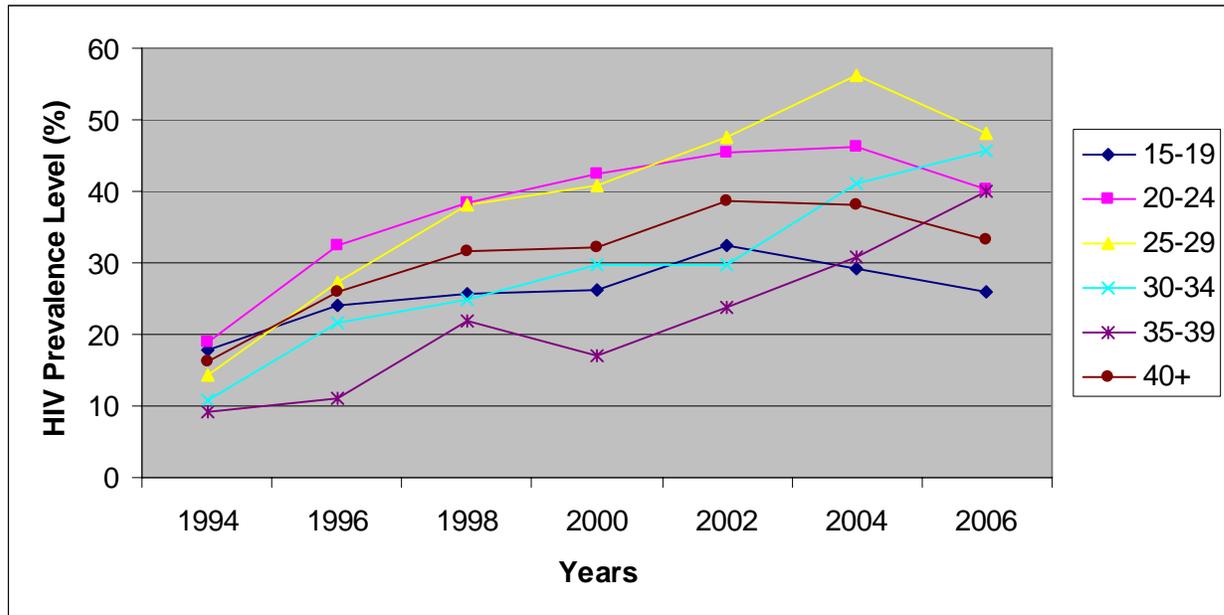
### **3.2.2 HIV prevalence by age**

In general, data from the ANC attendees shows that there has been a positive trend in the level of HIV prevalence across all age groups between 1994 and 2002 (figure 3.2). The highest prevalence occurred in the 25-29 age group, followed by the 20-24 age group. The least infected group across the period was the 35-39 year age span. In 2004 changes in the trend were however noticed. There was a decline in HIV prevalence among the 15-19 age group and stabilisation among women older than 40.

The most recent results for 2006 have shown a noticeable reduction in prevalence in most age groups since 2004. The 30-34 and 35-39 age groups were the exception, showing an increase in prevalence. The net effect of this is that for these two age groups, prevalence rates have continued to increase since 1994. This implies that over time there has been a shift in the burden of the pandemic from the young age groups of 15-19, 20-24 and 25-29 to the middle age groups of 30-34 and 35-39.

These results have been corroborated by the 2006 / 2007 SDHS findings, which indicate that the 15-19, 20-24 and 25-29 age groups have prevalence rates of 6%, 25% and 39% respectively, while the 30-34 and 35-39 age groups have rates of higher than 40% (CSO, 2007).

**Figure 3.2: HIV prevalence among ANC clients by age group and year**



*Source: MOHSW (2006)*

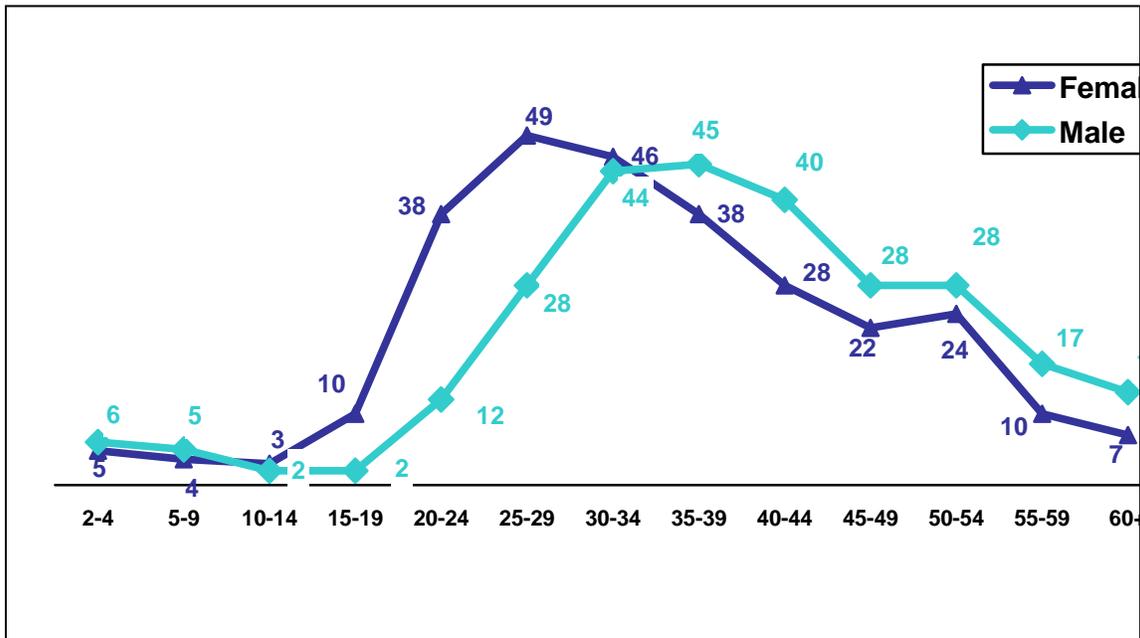
These findings show that the overall age pattern of HIV prevalence in Swaziland is similar to that in other countries, such as South Africa (where the pandemic appears to be levelling off) and Zimbabwe (where the prevalence is declining). Because the 15-19 age group can be used as a proxy for new cases (incidence), it may be perceived that the incidence of HIV infection among antenatal clinic attendees in Swaziland is showing signs of decreasing from 32,5% in 2002 to 29,3% in 2004 and 26% in 2006. The proxy incidence rate, at 6% in 2006/2007, was observed to be lower among the overall population (CSO, 2007), suggesting that the country is probably already past the stabilisation phase in the pandemic.

### 3.2.3 HIV prevalence by gender

The recent SDHS clearly demonstrate similarities and differences in the prevalence of HIV as far as gender is concerned. Considering similarities, the findings from the survey (figure 3.3) indicate that (a) from 2-9 years the prevalence of HIV declines for male and female infants; (b) from 15-29 years the prevalence increases for male and female youths; and (c) from 35-60 years and beyond the prevalence of HIV declines for adults.

Gender differences in the prevalence of HIV are also pronounced. In the 2-9 age group infant boys are more infected than females. In the ages of 10-34 years the youthful females are more infected than the male youths. It is important to note that females aged 15-19 and 20-24 are infected five and three times more than males in the same age range, respectively. The pattern is reversed for ages of 35-60 years and beyond, as males are more infected than women. There are two other important differences. For women, the prevalence rate reaches its highest value in the 25-29 age group (at 49%); while the peak for men is lower at 45%, in the 35-39 age group.

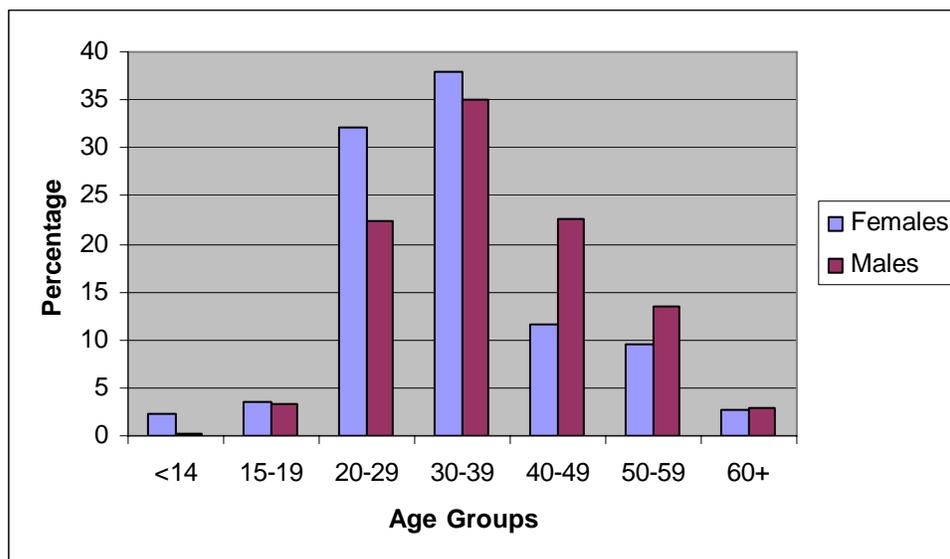
**Figure 3.3 : HIV prevalence (%) among population aged 2 and older by age and gender**



*Source: CSO (2007a)*

These prevalence patterns in the general population had earlier been observed among people who attend VCT. Figure 3.4 shows the TASC report indicated that more females younger than 40 were infected than men of the same age. Among older adults in the age groups 40 and above, more males were infected than females. This situation is similar to other countries. In Zambia, for instance, women aged 15-19 were five times more likely to be infected than males in the same age group, but in the age group above 39 more men than women were infected with HIV.

**Figure 3.4: HIV antibody positives by gender and age, TASC Central Centre**



*Source: TASC (2004)*

From these statistics it clear that overall women bear the greater part of the HIV and AIDS burden. In this regard, UNAIDS (2004) estimated that 54,5% of the 235 000 PLWHA in 2005 were women. This was corroborated by a study from the Ministry of Health and Social Welfare (MOHSW) in 2004 on the impact of HIV and AIDS on the health sector, which reported that 53% of the inpatients with HIV and AIDS were women, compared to 46% male patients. Still to illustrate the disadvantageous situation of women, data from the TASC annual report of 2004 (TASC, 2004) shows that of the 782 HIV positive clients in the year 57,2% were female, in comparison to 42,8% males.

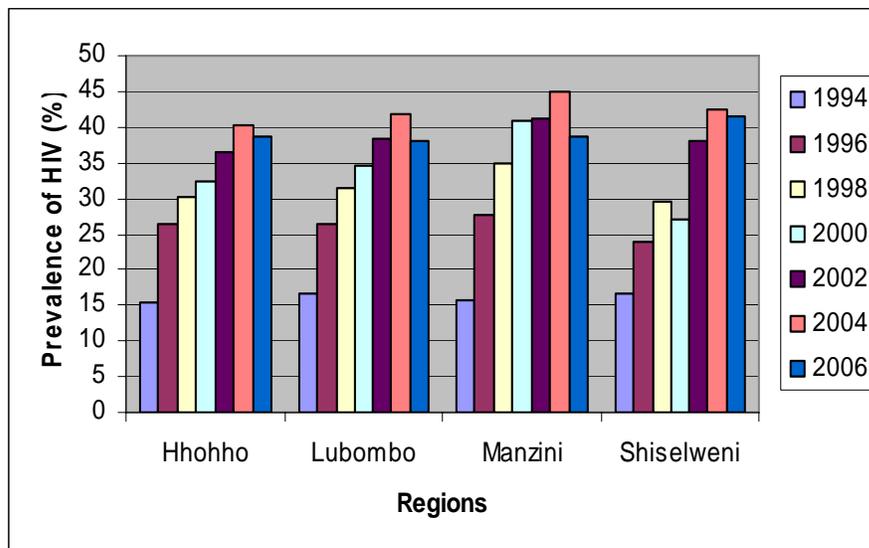
### 3.2.4 HIV prevalence by region

The level of HIV prevalence among ANC attendees increased between 2000 and 2004 in urban as well as rural areas of Swaziland. In 2000 the rates were 35,6% and 32,7% for urban and rural areas respectively, with corresponding levels in 2006 being 41% in urban and 37% in rural areas. These numbers declined from 44,5% and 40,3% respectively in 2004.

Similar patterns have been observed consistently across the regions of Swaziland: There have been increases in prevalence rates between 1994 and 2004, with only small differences in levels of infection among the four regions within each successive year, as shown in figure 3.5. These statistics show that the pandemic was not only uniformly bad, but worsened annually throughout Swaziland between 1994 and 2004. The Manzini region and the urban areas were consistently leading the deteriorating situation.

In 2006 the situation changed. The 10<sup>th</sup> surveillance report showed that a decline in HIV prevalence was recorded in all four regions of Swaziland between 2004 and 2006. In this regard the relative reduction in HIV prevalence between 2004 and 2006 was highest in the Manzini region (14,4%), followed by Lubombo (9,5%) and Hhohho (4%). Shiselweni (2,4%) had the lowest relative reduction in HIV prevalence between 2004 and 2006.

**Figure 3.5: HIV infection among ANC clients by region, 1994-2006**



Source: MOHSW (2006)

These reductions contributed to the status of HIV in the population aged 15-49, as found by the SDHS of 2006/2007. The prevalence rates for the regions and by residence were 29% for Hhohho, 26% for Lubombo, 25% for Manzini, 23% for Shiselweni, 32% for urban centres and 24% for rural areas. Notwithstanding the intraregional variations in other countries in Southern Africa, the prevalence of HIV is usually higher in urban than rural areas. In Malawi, for instance, the urban and rural rates were 23% and 12,4% in 2003, while in Zambia they were 23% and 11% respectively (UNAIDS, 2005). In South Africa a recent sero-survey reported the prevalence of HIV in the 15-49 age group to be 15,2%, but varying in urban centres from 15,6% to 28,4% and among rural dwellers from 11,3% to 12,4% (South Africa HSRC Study on HIV/AIDS, 2005).

### 3.2.5 HIV prevalence among people with STIs

Apart from the sentinel surveillance data, there is limited systematic data on the distribution of HIV infection among different populations in Swaziland. This section presents information on HIV infection among medical patients, people with STIs, people with TB and the military.

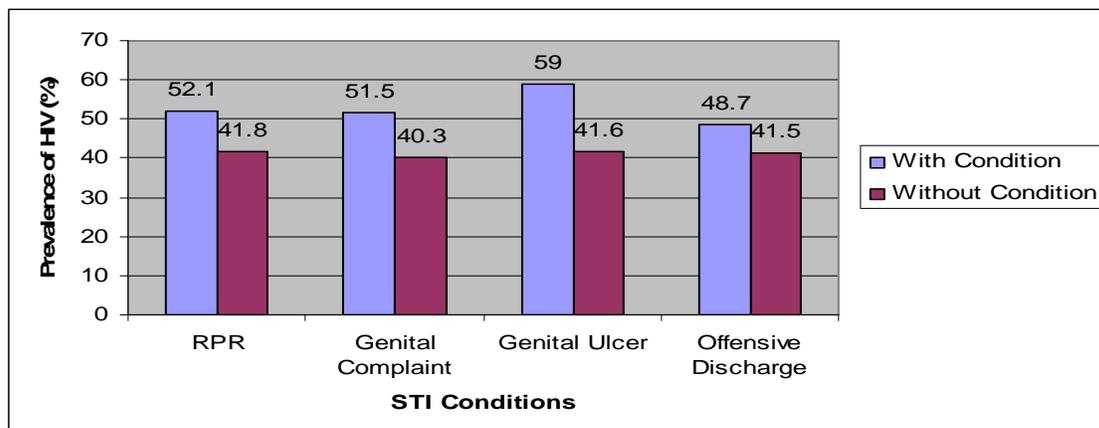
#### Medical patients

Patients who come to the health units are usually not tested for HIV. The nurses and medical personnel however often rely on clinical assessment of the diagnosis as provided for by the WHO. In this regard, a 1998 survey of the four regional hospitals of Swaziland found that 50% of the inpatients were HIV positive (MOHSW, 2005). The percentage of inpatients with HIV was highest in the medical wards (56%), followed by paediatrics (45%) and surgery (38%).

#### People with STIs

Genital ulcers, discharges, genital complaints and syphilis (measured through the RPR test) are monitored among ANC attendees who report STI complaints. The prevalence of HIV among people with such STIs in 2004 was above the national HIV prevalence rate of 42,6%. It ranged from 48,7% among people with discharges to 59% among people with genital ulcers. People without these conditions had a prevalence rate below the national rates, ranging from 40,3% for people without genital complaints to 41,8% among people who tested negative for RPR.

**Figure 3.6: Prevalence of HIV among ANC clients with various STI conditions**



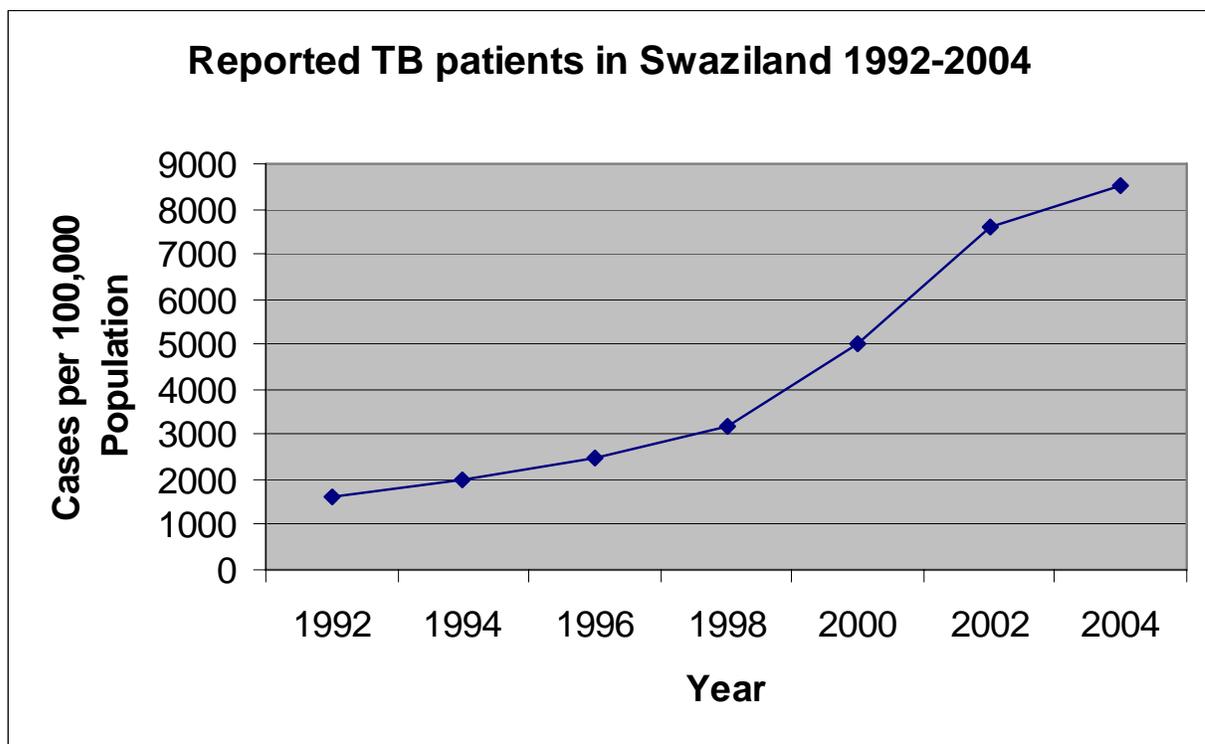
Source: MOHSW (2004)

These statistics are consistent with the findings of Laga et al (1991), which confirmed through epidemiological and interventional trials that STIs facilitate HIV infection: High rates of HIV sero-positivity were found in populations that already have high rates of STIs.

### People with tuberculosis

In 2004 the WHO estimated that about 80% of adults in Swaziland who had tuberculosis (TB) were also HIV positive. As shown in figure 3.7, the number of TB cases has continually increased, from about 200 cases per 100 000 in the early 1990s to more than 800 per 100 000 in 2004. The 2007 MDGs report states that the TB cases have further increased to 1 182 per 100 000 in 2006, the highest rate in the world.

**Figure 3.7: Reported cases of TB in Swaziland, 1992-2004**

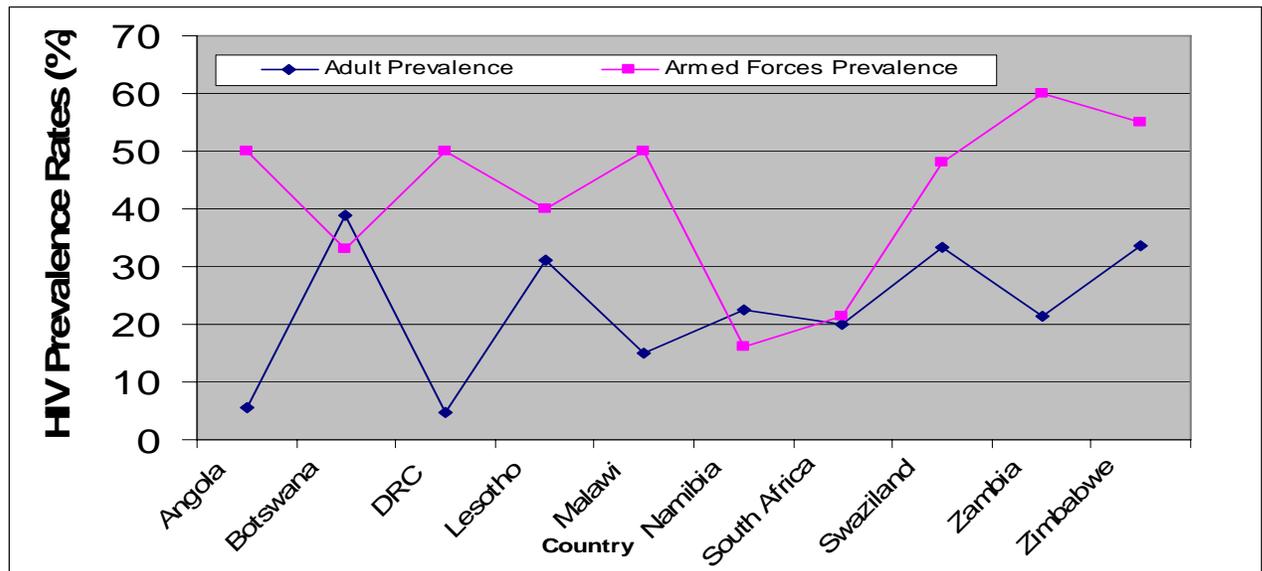


*Source: MOHSW (2005)*

### Military personnel

By 1997 it was estimated that the HIV prevalence in Swaziland was 33,4% of the adult population. At the time, the size of the army was 3 000 (UNDP, 2007). As shown in figure 3.8, the prevalence of HIV among the armed forces in Southern African countries for which there were data between 1996 and 2002, was above that in the civil population. In this regard Swaziland's circumstances were not any different from those prevailing in the region.

**Figure 3.8: Prevalence of HIV infection by country and armed forces**



Source: Zimbabwe HDRT (2003): Chapter 4, Table 4.4

As shown above, the HIV prevalence rates in most of the countries on the graph have gone up, which indicates a likely increase in the military rates as well. By 2002 it was estimated that infection rates among the military in Malawi were as high as 75%, while in Zimbabwe it was 80%. These rates were recorded at times when the rates for the adults in those countries were far below these levels<sup>10</sup>.

Taking this into consideration, along with the fact that by 2002 the reported episodes of STIs among Swazi male soldiers in the previous year (12,1%), was higher than those of seasonal workers (10%) and minibus drivers and assistants (4,3%) (GOS, 2002), the current HIV prevalence can be extrapolated to be about 50%. This is close to the rates of ANC attendees aged 20-24 (40,3%) and 25-29 (48%), whose male counterparts are more likely to dominate the military. The Swaziland Behaviour Surveillance Survey of 2001 reported that 58% of the 387 soldiers interviewed had engaged in sex with non-regular partners in the last 12 months. In Box 3.1 a 28-year-old soldier tells a story of the high-risk lives of members of the military:

**Box 3.1: Soldiers of Matsapha have no difficulty finding sex**

*“The soldiers at Matsapha have no difficulty finding sex. The women who go around the industrial site looking for jobs at factories and can’t find them come to the barracks hungry and they sleep with soldiers in exchange of dinner. There are prostitutes too who come with condoms, but the soldiers consider it cowardly using condoms for fear of AIDS as if they were not real men” (UNICEF 2002).*

<sup>10</sup> HIV/AIDS and displaced persons. [http://www.icad-cisd.com/pdf/publications/e\\_displaced.pdf](http://www.icad-cisd.com/pdf/publications/e_displaced.pdf)

### 3.3 DRIVERS OF HIV TRANSMISSION

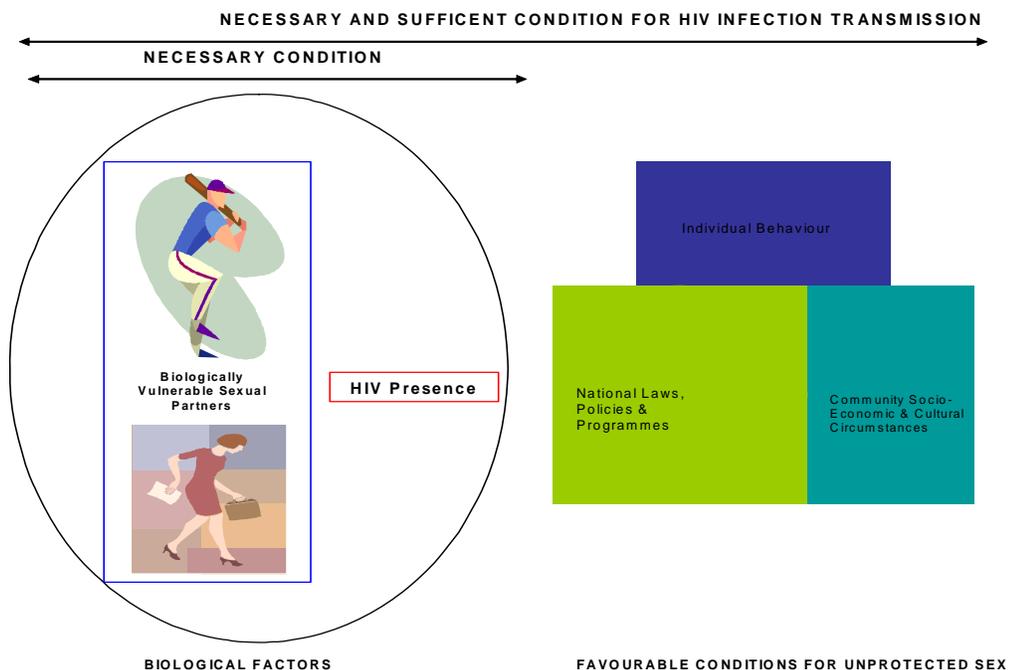
The most common and predominant mechanism of HIV transmission in Southern Africa is heterosexual sex that involves HIV infected body fluid from one partner getting into the blood system of the other partner through openings in the sexual organ. This route accounts for more than 75% of HIV infections. Mother to child transmission and other modes of transmission contribute roughly 7% to 15% and 1% to 10% respectively to HIV transmission.

Based on these statistics it is clear that since the main mode of transmission is through heterosexual sex involving at least one HIV positive person, the differences observed in the previous sections on the varying levels and trends in the pandemic across the countries in the region and in Swaziland in particular must be due to the varying roles and contributions by the factors that drive unprotected heterosexual sex.

These factors can be divided into three categories – biological, behavioural and environmental. Biological factors are physical, physiological and anatomical circumstances of an individual that increase vulnerability to infection. Behavioural factors are outcomes of one’s cognitive processes, experiential learning and decision-making that may increase vulnerability to HIV infection through heterosexual contact. Environmental factors are socio-economic, cultural and political circumstances at community and national level that influence vulnerability to HIV infection.

While the presence of HIV infection and biological vulnerability (i.e. the presence of a heterosexual male and female) are necessary conditions for the transmission of HIV infection in a given population, they are not sufficient, unless unprotected sex occurs. The factors that drive unprotected sex can act separately or in combination among themselves (figure 3.9). The prevalence and likely effect of all these factors on driving the pandemic in Swaziland is discussed in the following sections.

**Figure 3.9: Drivers of HIV transmission in a population**



### 3.3.1 Biological factors

There are different types, groups and subtypes of HIV. HIV is a highly variable virus that mutates rapidly, to the extent that there may be many different strains of HIV in the body of an infected person. In general there are two types of HIV, namely HIV-1 and HIV-2, which are both transmitted sexually.

HIV-2, which appears to be less easily transmitted, is concentrated in West Africa, while HIV-1 is predominant worldwide. HIV-1 can further be classified into three groups: M, N and O. While group O appears to be restricted to West Africa, group N is extremely rare, although it was discovered in Cameroon in 1998.

It is apparent that more than 90% of HIV infections belong to HIV-1 group M. In this group there are at least nine genetically distinct subtypes called A, B, C, D, F, G, H, J, K and CRFs. Subtype C is predominant in Southern and Eastern Africa and is also much more efficiently transmitted through heterosexual sex than subtype B, which is mostly spread by homosexual contact and intravenous drug use. In this report HIV refers to HIV-1.

Against this background all heterosexual people are biologically vulnerable to HIV infection through heterosexual transmission, provided that the virus particles are sexually transferred from an infected person to the bloodstream of the other in quantities that are sufficient for the virus to gain hold, replicate and start to destroy the defense mechanisms of the recipient partner.

The main biological factors that drive this transmission mode include gender, age, presence of an STI and circumcision or lack of it. The discussion below attempts to show how these biological factors are driving the pandemic in Swaziland more than in other countries.

#### Gender

Women are at greater risk of acquiring HIV infection from an infected male partner than are men of acquiring the infection from an infected female partner. The rate of heterosexual transmission from male to female can be 2 to 5 times higher than from female to male. This is due to increased susceptibility of females because they have substantial mucosal exposure to seminal fluids. The risk of becoming infected with HIV increases when a woman has an STI, particularly those that cause ulcerations of the vagina, such as genital herpes, syphilis and chancroid. The risk also increases when the woman is menstruating, is pregnant or has cervical ectopy.

According to the 1997 population census in Swaziland women constituted 52,7% of the population; among the sexually active in the 15-49 age group the proportion of women was 54,5%. Considering the entire female population, only 47,7% of them were in the age group 15-49, while 42,7% were younger than 15. These figures indicate that whether you consider the entire population, young females or only the sexually active females, there is a large pool of women that are already more vulnerable to HIV infection and who will drive the pandemic as long as they engage in unprotected sex.

This situation is exacerbated in Swaziland because many cultural norms in the country do not allow women to be proactive and equal partners in decision-making regarding sex, either in or outside marriage. Cultural norms and practices such as polygamy (*sitsembu*), widow inheritance (*kungenwa*), having multiple female partners (*bunganwa*) and extramarital relationships (*kushenda*) are not uncommon, as discussed in chapter one.

In the past these practices and norms may have been viewed as important in ensuring social cohesion, integrity of families and procreation of the Swazis, but in the era of HIV and AIDS they increase the vulnerability of infection. If one sexual partner in such sexual networks is HIV positive and sex is unprotected, the practice becomes an important driver of the pandemic. The cultural norm in Swaziland that motherhood is regarded as a fulfilment for a woman, further increases the vulnerability of females.

Men are also at great risk because the inner mucosa of the foreskin of the penis is rich in cells that target and take in HIV. The inner foreskin of the sexual organ is not keratinised, hence during sex it is subject to micro-tears. Any indulgence in unprotected sex by a man may expose him or his sexual partner to HIV infection. For instance, rape and cultural practices such as *kuhlanta* (a younger sister having a child with her infertile sister's husband) and *kulamuta* (sex with the younger sister of one's wife) that may involve relatively younger girls, drive the spread of HIV in the communities.

### **Age**

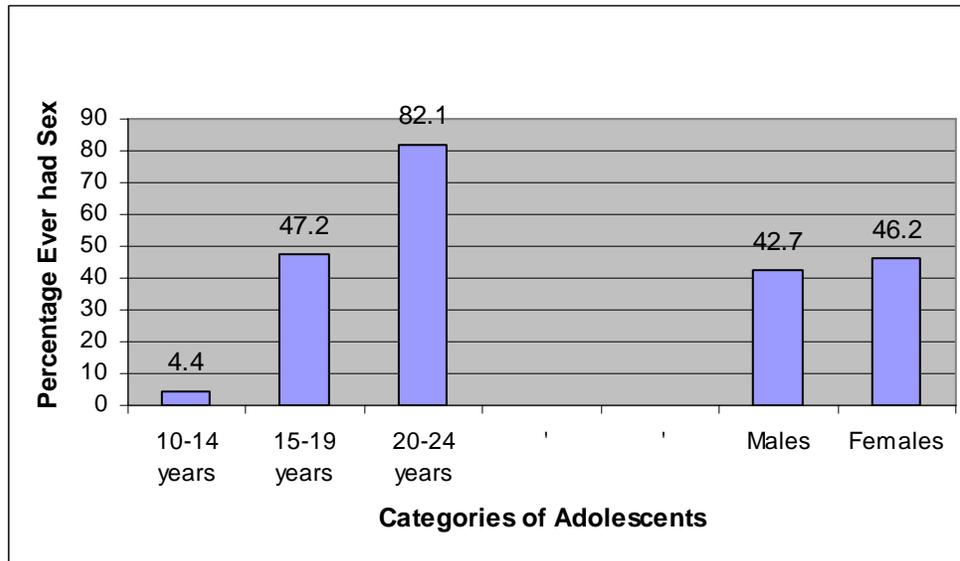
The reproductive organs, in particular vaginal tracts (including the hymen), are less developed and less mature in girls than in adult women. Hence, these structures in girls and the prepuce in boys are prone to tearing during sex, even more so when sexual violence is the mode of access. Likewise, in relatively older women who have reached menopause, the lubrication of the vaginal tract during sex may not be as much as that of women in the 20-49 age group.

Considering the census of 1997, most of the 42,7% of women who were below the age of 15 are expected to have grown into the adolescents and sexually active groups going through the highly vulnerable stages alluded to above. Some of the 47,7% of the women who were already sexually active in 1997 are also expected to have grown into menopause and currently form part of the less sexually active age groups. According to a household survey in Botswana in 2005, infection levels among older men and women were 21% for people in their early 50s and 29% among people aged 45-49 years (UNAIDS/WHO, 2005).

It can be perceived that this transition, accompanied by unprotected sex with sexual partners of unknown sero-status, was one of the key factors that increased vulnerability to HIV infection between 1998 and 2004 among the cohort because by 2004, HIV prevalence had reached 42,6%. Engagement in unprotected sex that includes an infected person, regardless of the age of the partners, is consequently continually driving the HIV pandemic in Swaziland.

According to the Behavioural Surveillance Survey (BSS) study of 2002, only 28,3% of the boys and girls in schools had had sex, while up to 69,3% of the youths out of school had already engaged in sex at one time or another. At the tertiary institutions of learning, up to 70,6% of male students compared to only 62,2% of their female counterparts had ever had sex. These findings are consistent with those of the Baseline Study of 2001 on adolescents in Shiselweni (figure 3.10) where 44% of the adolescents had already experienced sex.

**Figure 3.10: History of sex among adolescents aged 10-24**



*Source: GOS (2002) Shiselweni Baseline Study 2001*

In the more recent Swaziland Urban Youth Sexuality Baseline Study of 2005 it was found that many youths were sexually active: 8,9% of those 10-14 years old, 49,9% of those 15-19 years old and 84,6% of 20-24 year old urban youths had already had sex. In the 10-24 age group more males (54,4%) than females (47,9%) reported having had sex. Sexual activity in the last 12 months among youths aged 10-14 was at a rate of 71,1% among boys and 79,4% among girls.

The results of the SDHS of 2006/2007 also indicated that, although the percentage of the population in the 15-24 years age group that had had sex before the age of 15 was only 7% for females and 5% for males, these percentages rapidly rose to 48% for young female adults and 34% for young male adults that had had sex before the age of 18 in the 18-24 years category (CSO, 2007).

Based on these statistics it is clear that, in general, (a) sexual initiation in Swaziland occurs quite early before the bodies of the boys and girls are fully matured, and that (b) most sexual initiation takes place among youths, especially girls, between the age of 16 and 17. As noted in chapter one, the practices of virginity testing, *umcwasho*, *lusekwane* and age regimentation in the Swazi culture ensured that sex among youths outside marriage was discouraged. Abstinence was therefore a cornerstone in the promotion of chastity values by the family and age regiments.

This is not the case today. The age at which adolescents, for instance, first experience sex ranged from 6 to 23 years. In addition, the mean age of sexual debut for males and females of Shiselweni were low, at 15,9 and 16,4 years respectively. Furthermore, 22,7% and 18,2% of the sexually active urban youths had sex the first time when they were in the age group 10-14 years for females and males respectively. Although the males experienced sex only six months earlier than their female counterparts, the mean age of the male and sexual partners that initiated these adolescents into sex in Shiselweni were 14,8 and 20,1 years respectively. The male adolescents tended to go with female partners that were 1,1 years younger than them, while the female adolescents had sex with men who were on average 3,7 years older than them.

In urban areas, 67,2% females were initiated into sex by older male partners, whereas only 26,1% of boys had older female sexual partners at initiation. The 10,8% of the girls who had their first sexual experience with men more than 10 years older than them, indicates a high level of intergenerational sex in urban areas. While there is evidence of “age mixing” rather than intergenerational sex in rural areas, in the urban areas intergenerational sex is more apparent. In Zimbabwe two out of every three young women aged 17-24 reported that their first sexual experience were with partners who were more than five years older than them. The fact that sex starts at an early age among both boys and girls when they are not yet fully developed biologically, not only renders them vulnerable to HIV infection but also makes low age at first sex to be an important factor in driving the pandemic.

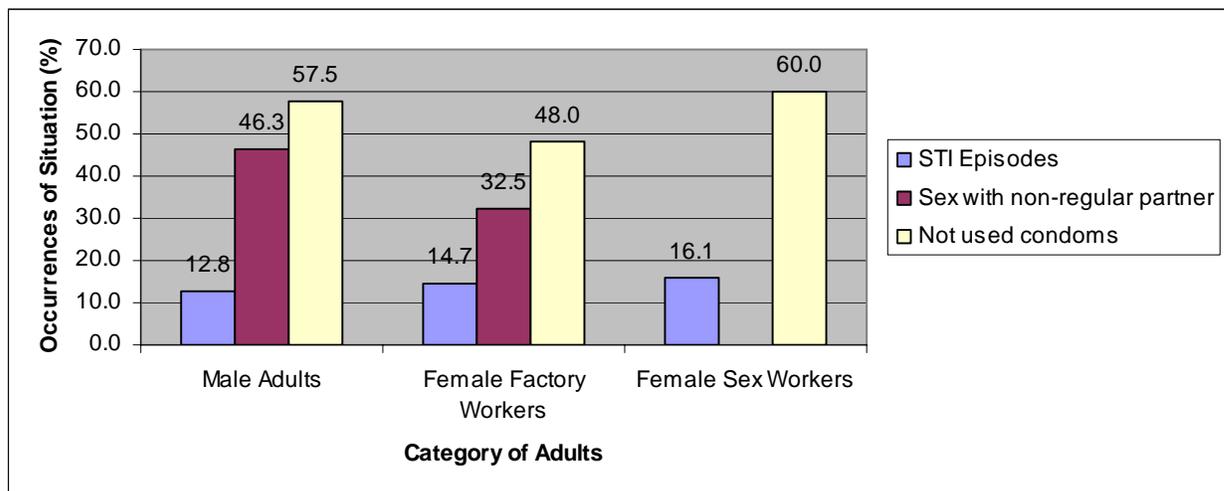
### The presence of an STI with one infected partner

STIs have been universally acknowledged as an important co-factor in the transmission of HIV. The two sexually transmitted conditions are linked by common behavioural and biological mechanisms in various ways. Firstly, a person who has an STI increases their susceptibility to HIV infection if they maintain the behaviour that led to infection with the given STI. Secondly, the various STIs increase HIV infectiousness as well as susceptibility.

Related to this, ulcerative as well as non-ulcerative STIs increase the risk of HIV transmission two to five times. Genital ulcers in particular disrupt the epithelial barrier in the sexual organs. Fourthly, STIs increase the number of cells in the genital tract vulnerable to HIV, increasing susceptibility in uninfected individuals. Lastly, HIV positive people with STIs have increased genital tract HIV viral load, which increases infectiousness. It is against this background that prevention and treatment of STIs are important components of HIV prevention.

It was observed earlier that among the ANC attendees in Swaziland the prevalence of HIV among people with STIs was more than 48% in 2004. In the general population the BSS study indicated that among male adults the prevalence of STIs was 12,8%, 14,7% and 16,1% respectively among females, female factory workers and female sex workers (figure 3.11). That STIs are present in at least one out of 10 sexually active adults and the generally acknowledged high association between STI and HIV infection, implies that this factor is an important driver of the pandemic.

**Figure 3.11 Vulnerability to sexually transmitted infections (STIs) among adults in 2002**



Source: BSS (2002)

The above situation is exacerbated by the fact that, while at least one in three of these adults indulge in sex with non-regular partners, about 50% of them do not use condoms in their sexual encounters. The situation is even worse for female sex workers, for whom sex with non-regular partners can be assumed at 100%. Yet the prevalence of STIs and the non-use of condoms among them is higher than for male adults and female factory workers. When considering that their clients may also have spouses or other sexual partners, the significance of this factor increases.

### **Circumcision of men**

Male circumcision, the surgical removal of the foreskin of the penis, is thought to help reduce the risk of acquiring HIV infection for a number of reasons. Firstly, the inner mucosa of the foreskin, which is removed through circumcision, is rich in HIV target cells. The removal of the foreskin furthermore causes more rapid drying of the penis after sex, bathing or urination, thereby reducing the likelihood of viral, bacterial or other sexual infections. When the foreskin is intact, the likelihood of abrasion and minute tearing during (especially violent) sex is high. This creates an avenue for either the body fluid from an infected female partner to gain entry into the blood stream of the man or the blood (in addition to semen) from the infected man to pass on to the female sexual organ. In Swaziland circumcision is an old customary practice that disappeared many decades ago, after it was stopped by King Mswati II in the eighteenth century (GOS, 2006).

There is empirical evidence to show that male circumcision may offer protection against HIV infection. A study in South Africa found that circumcised men were at least 60% less likely to become infected than uncircumcised men. An interim analysis of two trials on male circumcision in Uganda and Kenya demonstrated a reduction of 51% to 53% in the risk of acquiring HIV among circumcised men.

These results show that although circumcision does not offer 100% protection against HIV infection, it complements other prevention interventions such as abstinence and consistent condom use. Hence, the current low level of male circumcision in Swaziland is possibly denying men substantial protection against HIV infection.

### **3.3.2 Individual and behavioural factors**

The individual and behavioural factors that drive the pandemic by predisposing one to HIV infection are knowledge, attitude and the sexual practices of an individual. The behavioural aspect includes the extent of abstinence before sexual experience, level of fidelity and consistent use of condoms with partners whose sero-status is unknown. These are discussed below.

#### **Knowledge about HIV and AIDS**

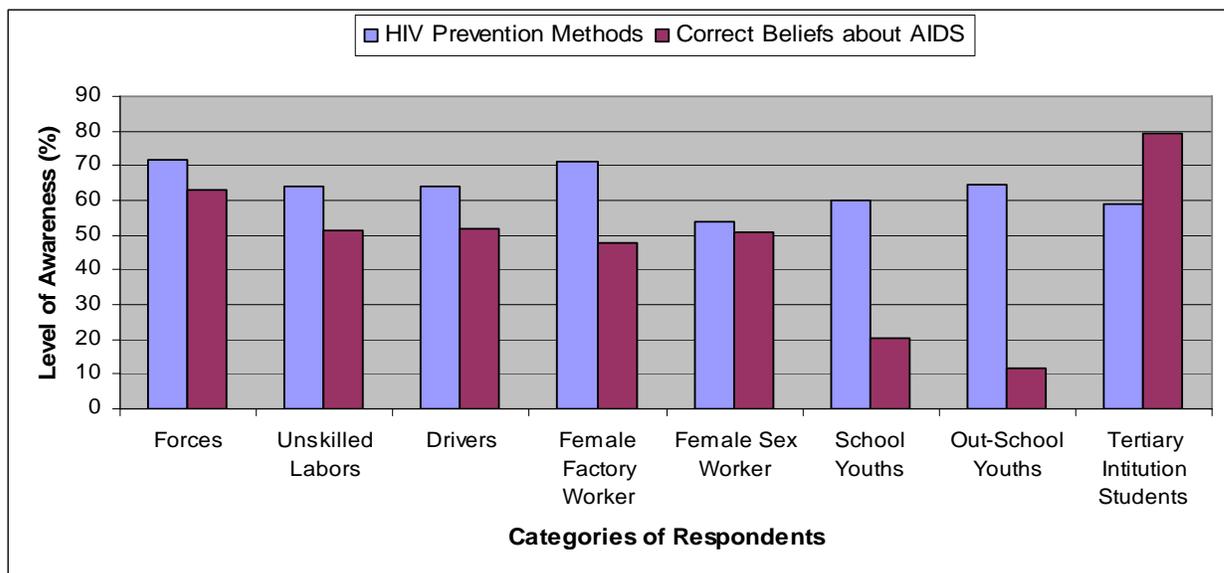
One of the key determinants in responding to the HIV and AIDS pandemic is, at the very least, the level of awareness about HIV infection: what causes it, how it is transmitted and how to protect oneself from infection. It is against this background that one may take appropriate action.

In Swaziland 98,6% of youths in the rural areas of Shiselweni had heard of HIV or AIDS (Government of Swaziland and UN, 2002). In urban areas, both male youths (89,3%) and female youths (89,8%) had heard about HIV and AIDS (AMICAALL, 2005). The SDHS of 2006/2007 has shown that the percentage of people who have heard about HIV and AIDS was 99,8% for women aged 15-49, while for men of the same age group it was 99,3%. For people in the 15-24 age group the number was 99% (CSO, 2007).

As shown in figure 3.12, the level of awareness about HIV prevention methods is also high, i.e. more than 50% across all categories of the sexually active population, in rural and urban areas. Awareness was more than 70% among the forces (i.e. military and police) and female factory workers. In Shiselweni 89,4% noted people can protect themselves from HIV by using a condom, 81,5% reported that having one uninfected faithful sexual partner gives protection against infection and 90,6% acknowledged that abstaining from sex prevents infection. In the urban areas 78,4% of females knew that contracting HIV could be avoided through abstinence and consistent use of condoms (68%), while similar statistics for males were 77,1% and 71,3% respectively.

Despite this reasonably high level of awareness, correct beliefs about HIV and AIDS remain relatively low in all categories of the population, except among students in tertiary institutions. Among the youth more than 79% have incorrect beliefs about HIV and AIDS, even though more than 60% know how HIV transmission can be prevented. Among adults, less than 48% of female factory workers had correct beliefs about HIV and AIDS.

**Figure 3.12: Awareness about HIV and AIDS among various respondents in 2002**



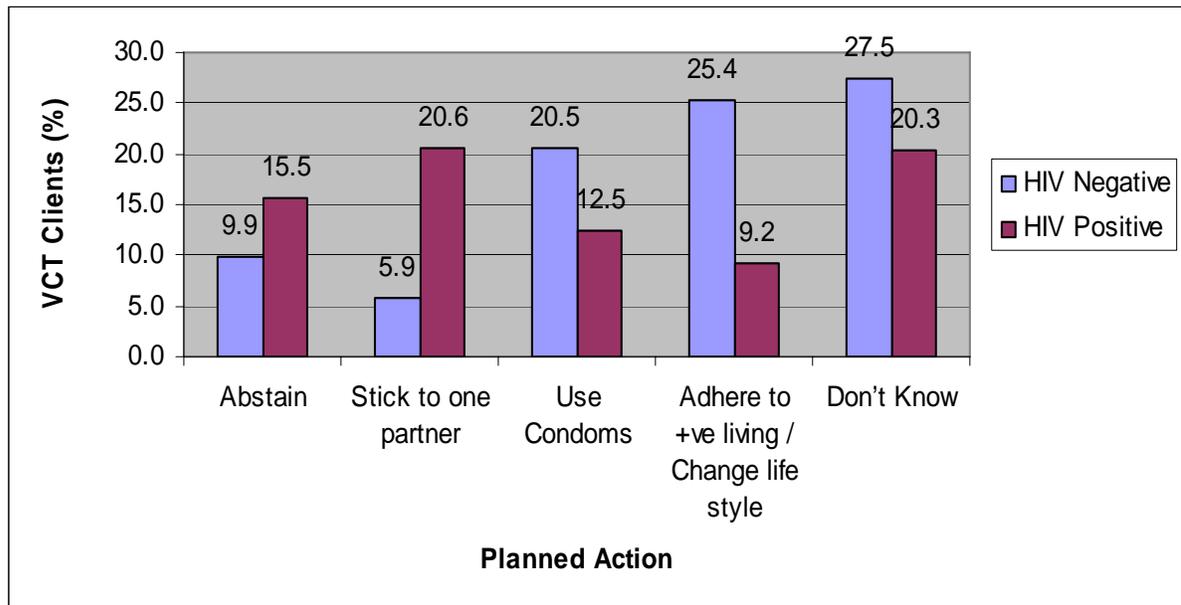
*Source: BSS (2002)*

### Attitudes towards HIV and AIDS

In the absence of relevant data, the attitudes of clients at VCT centres were investigated. This is because VCT is an entry point for targeting a national HIV and AIDS response, including prevention. By establishing the sero-status of a client, VCT promotes opportunities for facilitating behaviour change that prevents infection or re-infection, mother to child transmission and STIs, as well as to promote access to family planning and condoms, screening and treatment.

According to the TASC report about 50% of the 2 726 VCT clients in 2004 went to the VCT centres for curiosity or in relation to getting scholarship or insurance. About 48% went to the centres for reasons linked to their vulnerability to HIV infection (AIDS related symptoms shown by themselves and/or their partner), because they were referred to a VCT centre by medical personnel or when a partner or relative has died as a result of AIDS and they wanted to get married. Only 2% of the clients went for VCT for unspecified reasons.

**Figure 3.13: Intended plan of action upon knowledge of personal HIV status**



*Source: TASC (2004)*

Against the above background, the attitudes of the clients towards behavioural change as captured through a multiple response questionnaire completed after a VCT session, is shown in figure 3.13. Of the VCT clients who tested HIV positive, more than 84% indicated that they would not abstain from sex, about 80% would not stick to one partner and over 87% would not use condoms to protect their partners from infection or themselves from re-infection 21,9%, not indicated on the figure, would ask partners to get tested or get married or did not specify their course of action.

The responses from people on their planned actions if their results turned out to be non-reactive, were that only about 10% with negative HIV results planned to abstain, while only 6% would stick to one partner. Up to 10,9% of the clients did not specify their course of action. On the positive side, one in five would use a condom in subsequent heterosexual sex. It is not clear why there is a high level of indifference and refusal to care for oneself after testing negative for HIV.

The fact that approximately 80% of the people who tested positive would neither abstain from sex nor stick to one partner seems to provide clear evidence of denial on the one hand and selfishness on the other, for no apparent reason.

Although these are choices that an individual makes about their life, they do not lead to a long and healthy life; nor do they enhance a person's prospects to enjoy a decent standard of living as envisaged in the human development concept that the country is advocating, because either choice increases vulnerability to HIV infection.

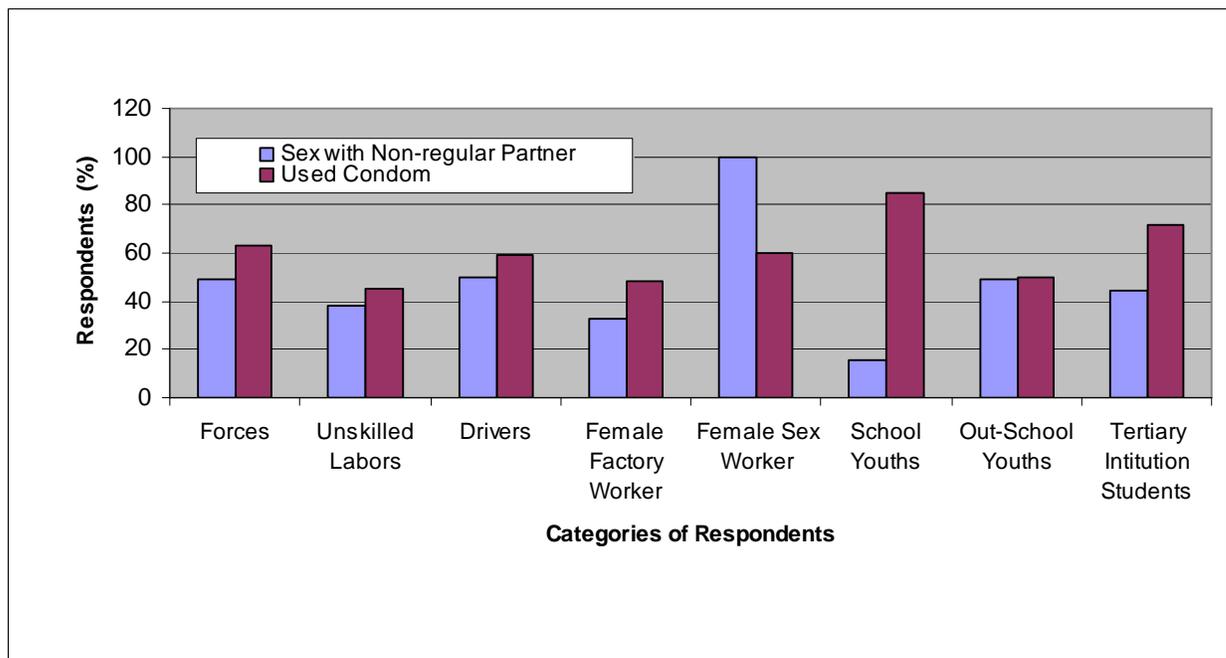
This evidence shows that despite the high level of awareness about HIV and AIDS among Swazis, the high level of negative attitudes towards known prevention measures and towards the need to delay progression to AIDS, is a significant driver of the pandemic.

### Multiple concurrent sexual partners

The practice of multiple concurrent sexual partners was discussed in chapter one. This section attempts to quantify the practice in Swaziland. Among the youth, sex with non-regular partners was as low as 15,7% for schoolgoing youths. Although these practices increased rapidly to more than 49% among out of school youths, students in institutions of higher learning had practised this high-risk behaviour at a rate of about 44,1% within the last 12 months of the survey.

In terms of the actual number of sexual partners among the youth, a study of Shiselweni in 2001 indicated that the mean number of partners for males was 3,9, with 30,8% of the boys having had more than one partner and 14,3% with at least five partners in the previous 12 months to the survey. Among adolescent girls, the mean number of partners was 1,8, with 66,2% having more than one partner and 5,4% with at least five partners. This shows that on average, one boy was having sex with about four females and one girl was involved with two males. These are high numbers of sexual partners for adolescents by any standards.

**Figure 3.14: Sexual practices among adults in last 12 months, 2002**



*Source: BSS (2002)*

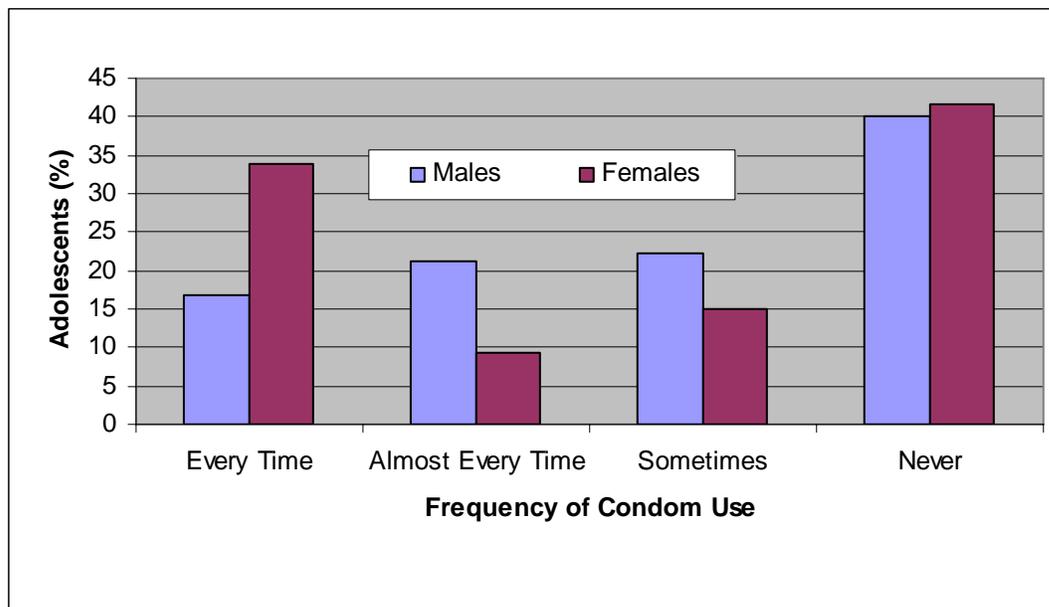
Among adults, sex with non-regular sexual partners was at about 40% for males as well as females (figure 3.14). One of the main reasons for this high rate of infidelity is that extramarital relationships (*kushenda*) and having multiple female partners (*bunganwa*) are culturally acceptable in Swaziland.

Secondly, women tend to indulge in sex with non-regular partners because of material favours such as food and money. Thirdly, one study reported that many Swazis are involved with multiple partners because of sexual gratification: They are promiscuous and enjoy having multiple partners. Some spouses living together even cheat on one another (UNDP, 2002).

## Condom use

Regarding condom use in sexual debuts, more than 40% of the adults used condoms in the last 12 months, although cases where both educated and non-educated women are forced to have sex without condoms are not uncommon in Swaziland. Among the youth, 72% of students in tertiary institutions used condoms and 84,9% of the youth in school used condoms. Only 49,9% of youth out of school used condoms. In a similar study in Shiselweni at least 41% of the adolescents had never used a condom with their non-commercial partners over the last 12 months. The remaining 59% used the condoms inconsistently – 26,7% used them every time, 14,3% almost every time, while 18% only used condoms sometimes. Figure 3.15 shows how these percentages are disaggregated by gender of the adolescents.

**Figure 3.15: Condom use by adolescents with non-commercial partners in Shiselweni region in last 12 months, 2001**



*Source: GOS (2002) Shiselweni Baseline Study 2001*

Among the youth in urban areas more than half of the females (54,2%) and males (51,9%) had used a condom the first time they had sex. Those who did not use condoms explained it in terms of the non-availability of condoms, a sexual partner having objected or them not having thought about it. Other reasons included cost, the use of other prevention methods, the perception that a condom was not necessary and that they did not like using it. In an earlier study by UNDP (2002) participants in a FGD indicated that while there was no shortage of condom supply in urban areas, in rural areas the stock sometimes run out, implying occasional unavailability.

From the above it is apparent that the frequent high-risk sexual behaviour among adults as well as the youth in Swaziland, such as sex with non-regular partners, a high number of sexual partners and non-use or inconsistent use of condoms, is a significant driver of the pandemic. This is particularly important because it is this high-risk behaviour in heterosexual sex without protection with a person whose sero-status is unknown that also makes this an immediate determinant in the spread of HIV to be a major concern.

In Zimbabwe, where there is a decrease in HIV prevalence, reduction in the number of reported sexual partners in recent years and a relatively high rate of condom use (86% among men and 83% among women) have been reported as some of the key factors driving the decline, in addition to a decline in HIV incidence (UNAIDS/WHO, 2005).

There is no data in Swaziland about the level of discordance among couples and the use of condoms among such couples. However, a UNDP report entitled *Facing the future together* indicated that men are more likely to be infected than women within couples. In particular it was reported that in South Africa the men were HIV positive and the women HIV negative in 15% of couples, while 6% of couples consisted of an HIV negative man and an HIV positive woman (UNAIDS, 2004). This means that unless prevention methods targeting discordant couples through “positive prevention” initiatives such as the consistent and correct use of condoms are encouraged, discordance is likely to be a major driver of HIV infection among couples.

### **3.3.3 Socio-economic factors**

#### **Poverty and income distribution**

With a per capita GDP of US\$1 6660 in 2004, Swaziland is categorised as a lower middle-income country. The economy still resembles that of a developing country (Whiteside et al, 2006). This is because 69% of the Swazis live below the poverty line of E128,60 per month (US\$22) and 70% of the population derive their livelihood from agriculture.

As noted in the study by Whiteside et al (2006), Swaziland is currently in an economic slump with stagnant economic conditions, which lead to increasing unemployment and poverty. These conditions make it fertile ground for the rapid spread of HIV and AIDS and for exacerbating the impact of the pandemic.

The SHIES of 2000/2001 reported that while 69% of individuals in the country were living in poverty, those in rural areas were poorer than urban dwellers, with poverty at 76% and 50% respectively. The survey further noted that of the 43% of households that were headed by females, 63% were poor. Unemployment in the country was recorded at 29%, with unequal distribution across the four regions: 53% in Shiselweni, 26% in Manzini, 25% in Lubombo and 20% in Hhohho.

Poverty increases the likelihood of poor women being forced into transactional sex as a survival strategy for accessing among other things food, shelter, favour, protection and promotion. This is supported by the Alliance of Mayors and Municipal Leaders Initiative for Community Action on AIDS at the Local Level (AMICAALL) study, in which it was observed that the most common reason for non-protection among the youths in urban areas from contracting HIV, was poverty (males 36,2% and females 38,3%), followed by ignorance (35,8% males and 34,8% females).

Although participation in commercial sex was less than 1% among adult males, factory workers and youths, its prevalence was higher among minibus drivers and long distance drivers, at 2,3% and 4,8% respectively. Among adolescents in Shiselweni only 0,8% of the 131 female respondents reported having engaged in commercial sex in the past 12 months. Sex with a non-regular partner in the last 12 months was however at 54,8% and 57,7% among military and minibus drivers and their assistants respectively. For the remaining adults, excluding commercial sex workers (CSWs), it ranged from 28,5% (long distance drivers) to 49,1% (guards).

## **Mobility**

Mobility within and across the borders of a country can significantly expose a person to HIV infection, particularly if unprotected heterosexual sex occurs on such trips. This is especially applicable to Swaziland, for various reasons. Swaziland is a small country with good infrastructure, which makes it relatively easy to travel frequently and quickly through the urban and rural areas. Secondly, frequent transfers of civil servants, especially members of the police and teachers, result in the separation of couples for a long time. Thirdly, many Swazis are employed in the mines and other professional and non-professional jobs in South Africa, from where they travel back to Swaziland after having stayed away for periods of up to one year.

It is known that when sexually active adults stay away from their spouses or regular sexual partners for such long periods the likelihood of them acquiring new sexual partners increases. Separation from family and regular sexual partners for long periods creates the temptation to engage in casual sex, which increases the risk of contracting HIV and spreading it to the person's spouse or a steady partner upon returning home (UNDP, 2002).

## **Education**

In chapter one it was observed that boys and girls in Swaziland used to get information on sexual and reproductive health informally through dialogue with their grandparents, parents, aunts and uncles at the family and community levels from peers and regiments, as part of the culture. Sex education has however been gradually integrated into the formal educational system.

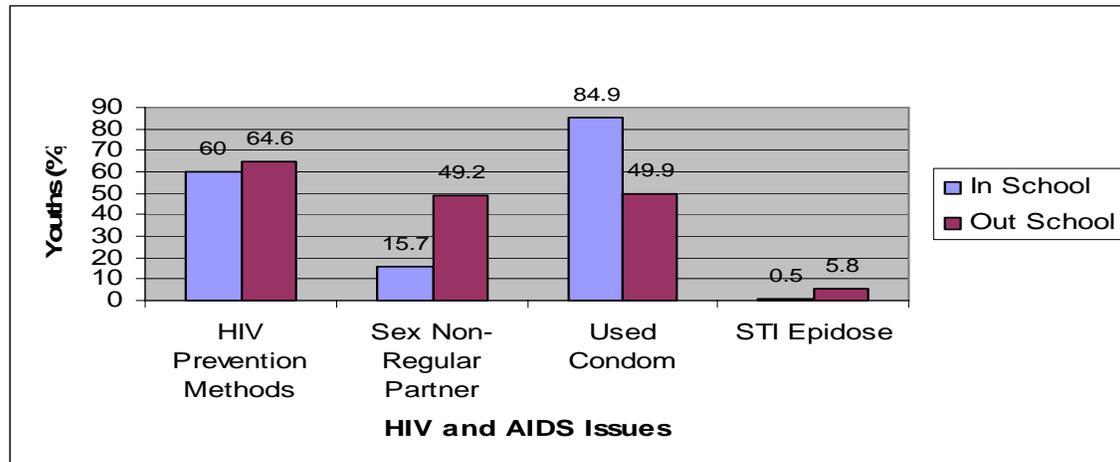
These days schools provide an appropriate and powerful channel for the youth to learn about HIV and AIDS. By being in school, the youth get knowledge, life skills and the ability to analyse and interpret different circumstances, including HIV and AIDS and culture. This is apart from being prepared for gainful employment for national economic development and individual livelihood. Keeping the youth in school means that, most of the time, they are removed from lousing, loitering, redundancy and engagement in self-destructive activities, such as taking alcohol and drugs that may drive them to sex, predisposing them to HIV infection.

The data below supports these assertions. In the urban areas, sexual experience was observed to be much more common among out of school youths (74,7%) than schoolgoing youths (36,1%). The majority of females (90,3%) and males (89,3%) thought that the youth should be taught about sex in schools and 80,7% of females and 81,7% of males wanted the youth to be given information on condom use.

In Shiselweni 61% of youths had heard about HIV and AIDS from schools. Newspapers and magazines (that require reading skills) were a source of information to 44% and 25% of the youth respectively, while radios (that do not require education) provided information to 83% of the youth. Secondly, figure 3.16 below illustrates that when the behaviour of youths aged 15-24 is assessed, those in school show more positive characteristics than their counterparts out of school.

The percentage of out of school youths that have had sex with a non-regular partner (49,2%) is more than triple that of youths that are in school (15,7%). The prevalence of STIs among the out of school youths is more than tenfold that of schoolgoing youths, i.e. 5,8% and 0,5% respectively. On the other hand, about 85% of youths in school used condoms, compared to only about 50% of those that are out of school.

**Figure 3.16: Comparison of responses of youths in and out of school about issues of HIV and AIDS, 2002**



*Source: BSS (2002)*

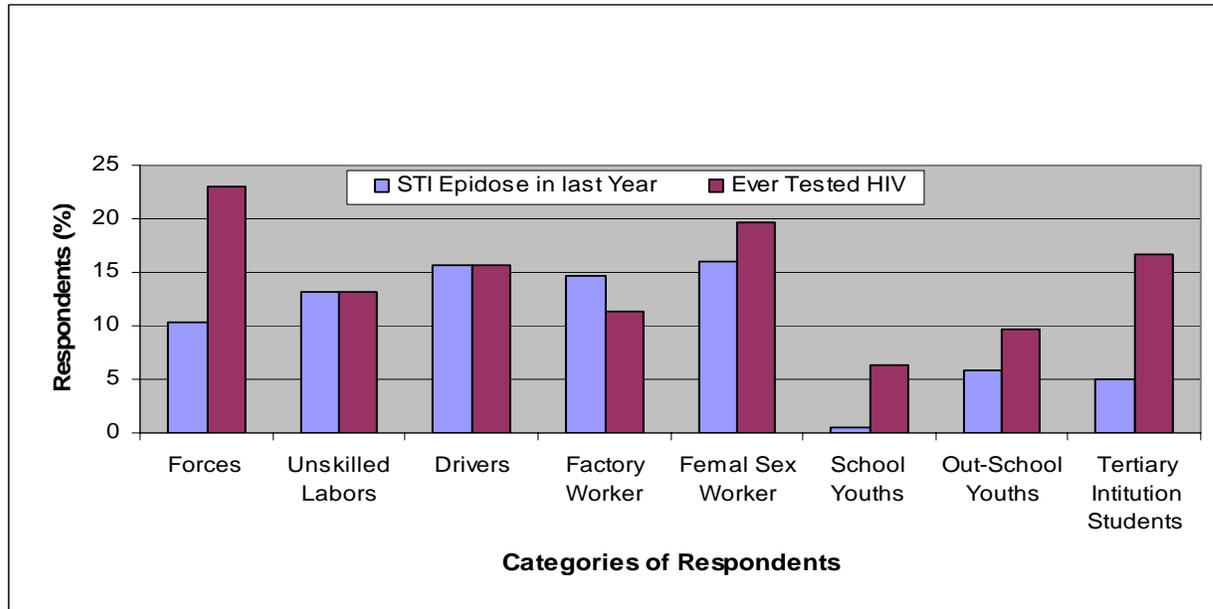
A total of 83% of the clients of VCT centres were people who were highly educated (from Form 1-3 and above) while 22,1% have completed Form 4-5 and 41% have acquired college or university level education. These results tend to show that the search for VCT is associated with educational level. If this is accompanied by proper counselling before and after testing, the provision of ARVs where appropriate as well as positive living and behavioural change, there can be a major impact on the rate at which HIV in Swaziland is spreading.

### Access to health services

Although Swaziland has extensive public and private health facilities and infrastructure, there are challenges that affect the availability of, and access to, health related services. These include the impact of HIV and AIDS on the staff members who provide health services, namely the significant number of deaths, increasing cases of illnesses and absenteeism, low morale and burnout. There are also problems in the health system that have nothing to do with HIV or AIDS, such as a shortage of doctors, nurses and allied medical staff due to migration, death, low and declining staff morale; the declining state of health facilities and the inadequate infrastructure; a shortage of essential equipment and medical supplies; as well as centralised, inefficient and unresponsive management systems and leaderships (MOHSW, 2005). All these factors make it difficult for someone with an HIV or AIDS related problem to access health services easily.

It was noted earlier that STIs are strongly linked with HIV among the ANC attendees in Swaziland. The prevalence of the STI conditions is noticeable throughout the country and among all categories of sexually active people. STIs are least prominent among schoolgoing youths (0,5%), while the STI prevalence rate among adults ranges from 10,3% among uniformed people to 15,6% among drivers. These rates are closely followed by out of school youths and students in tertiary institutions of learning. The 16,1% and 14,7% prevalence rates among CSWs and female workers once again emphasise the vulnerability of women to STIs in general. Figure 3.17 shows that the proportion of adults that have been tested for HIV ranges from about 15% to 25% among males, less than 20% among CSWs and less than 15% among female factory workers.

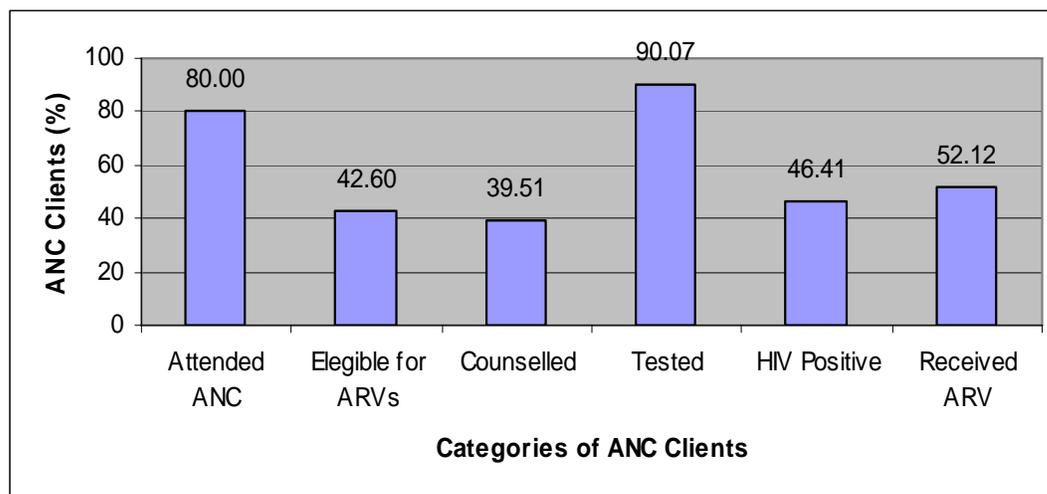
**Figure 3.17: Reported cases of STI and HIV testing**



Source: BSS (2002)

Regarding prevention of mother to child transmission (PMTCT), it was estimated in 2005 that there would be 33 500 births. Assuming that no twins were expected, only 80% of all these expecting mothers attended an ANC (figure 3.18). When a sero-prevalence rate of 42,6% is applied, only 39,5% of the eligible attendees were counselled. However, 10% of the women who were counselled declined to take an HIV test. Of the people who took the test, 46,4% were HIV positive, but only 52% agreed to take ARVs for the sake of their babies. Although the percentage of pregnant women who took ART rose from 28% in 2004 to 52% in 2005, 48% of the unborn babies did not have access to ART as their mothers did not take ART.

**Figure 3.18: Access to PMTCT by ANC clients, 2005**



Source: MOHSW (2005)

A possible reason for the refusal to take ART could be that some men do not allow their women to access PMTCT and other health services without their consent, let alone allowing their spouses to choose the health facility for these services. This compromises the quality of health for women (UNDP, 2002). The predominant lack of knowledge about one's sero-status creates the opportunity for HIV infection on various levels: mother to child transmission, (re)-infection of oneself or infection of one's sexual partner once this is accompanied with unprotected sex.

### **Women's status and inequality**

The Regional Report of the Secretary-General's Task Force on Women, Girls and HIV and AIDS in Southern Africa (UNDP, 2004) identified many instances of gender inequality in Swaziland:

- In 2002, only 18% of Swazi females aged 15-24 demonstrated knowledge of HIV prevention methods (UNAIDS/WHO, 2004).
- The social environment affects the vulnerability of women to HIV and STI infection directly and/or indirectly. The cultural, legal and economic environment of Swaziland disempowered women in exercising their privileges over sexual and reproductive behaviour, while customary laws tend to give more privileges to men in decision-making relating to marriage, sex, family matters, etc.
- Up to 21,4% of women are illiterate. This affects their prospects of employment, age of marriage, childbearing and family planning as well as status in the community.
- There are high rates of sexual violence, which can result in the tearing of the reproductive organs.
- There are frequent incidents of economic violence, including denial of access to productive assets, widow dispossession and damaging/removal of household or matrimonial property when a spouse dies.
- Married women are considered legal minors, while the duality of civil marriage law and common law based on Roman Dutch law aggravates the situation for women.
- In Swaziland, women and girls cannot easily access land or economic resources, due to customary patterns of inheritance. These patterns follow a patrilineal line, but leave the legal status of children to women, who must provide for the orphans against these odds, in the case of the death of a spouse.

In 2002 75% of key informants and respondents in a UNDP funded study agreed that the economic dependence of women on men has an impact on HIV and AIDS, while acknowledging that the Swazi society is characterised by women's low social status and their subordination to men. Box 3.2 shows the views of the discussants and key informants.

### **Box 3.2: Inability of women to negotiate safer sex**

*'Economic dependence makes women submissive because if the men, as the head of families, refuse to use condoms, they have to submit to unprotected sex. In such situations women's ability to insist on condom use becomes impossible because if they refuse sex or insist on condom use, they risk abuse, accusations of infidelity, being abandoned or forced to leave the home.'*

*The study concluded that 'because of the general economic dependence of women on their spouses, their powerlessness, poverty levels and continued passive nature in sexual relationships, women's ability to fend off their risks of HIV and AIDS is seriously compromised. Very few women can negotiate safer sex for fear of risking violence, mistrust and recrimination, abandonment or withdrawal of financial support' (UNDP, 2007)*

These gender inequalities that favour men, which are also discussed in chapter one, directly or indirectly increases the risk of HIV infection among women and girls.

### **3.4 CONCLUSION**

This chapter showed that HIV and AIDS are deeply entrenched in Swaziland. After the HIV prevalence peaked at 42,6% in 2004, it declined to 39,2% in 2006. This significant drop is an indication that, with a concerted effort, Swaziland can further reduce the prevalence of the virus in the country.

The main drivers of the pandemic include multiple concurrent sexual partners, a low age of sexual initiation, high levels of intergenerational sex, inconsistent use of condoms, negative attitudes towards prevention methods as well as denial, selfishness and apathy towards HIV and AIDS. Other drivers are the status of women, gender inequality, sexual violence, the high prevalence of STIs, low levels of male circumcision, low access to critical health services, poverty, high mobility and the prevalence of cultural norms and practices that promote high-risk sexual behaviour.

As a result the attainment of the MDGs and commitments made by Swaziland at the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) may not happen unless the rate of HIV prevalence is brought down urgently. In the next chapter the impact of the pandemic on human development is discussed.

## **CHAPTER 4: IMPACT OF HIV AND AIDS ON HUMAN DEVELOPMENT**

### **4.1 INTRODUCTION**

Whiteside (2006) noted that Swaziland's economy is stagnating. With low growth rates, unfavourable terms of trade and an increasingly impoverished population, the economic gains of the last few decades have been reversed. HIV and AIDS have played a part in this downturn. This chapter explains how the existence of the pandemic has impacted human development in Swaziland over the past two decades. The impact on access to the four choices critical to human development, namely the choice to be educated, the choice to live a long and healthy life, the choice to have a decent standard of living and the choice to participate in community activities, is specifically investigated.

### **4.2 HIV AND AIDS REDUCE THE CHOICE OF SWAZIS LIVING A LONG AND HEALTHY LIFE**

In 2003 the Vulnerable Assessment Committee (VAC) Survey listed the members of rural households having chronic diseases in the preceding year. High rates of chronic illness were reported in all age groups; from the 15-19 age group the rates increased linearly with higher ages up to the 50-54 age group. Nearly 25% of women and almost 20% of men aged 50-54 years were chronically ill. About 10% of the people aged 15-29 years were chronically ill in their prime years, when they are expected to be healthy.

The most common causes of these chronic illnesses were reported to be AIDS related conditions. The high levels of chronic illness among otherwise energetic age groups have serious consequences for child caring activities, food production, domestic management and income generating activities (Swaziland VAC, 2004).

One of the critical service sectors affected by the epidemic is the health sector. This is because this service facilitates individuals towards achieving the core human development choice of living a long and healthy life. The impact on the sector is serious.

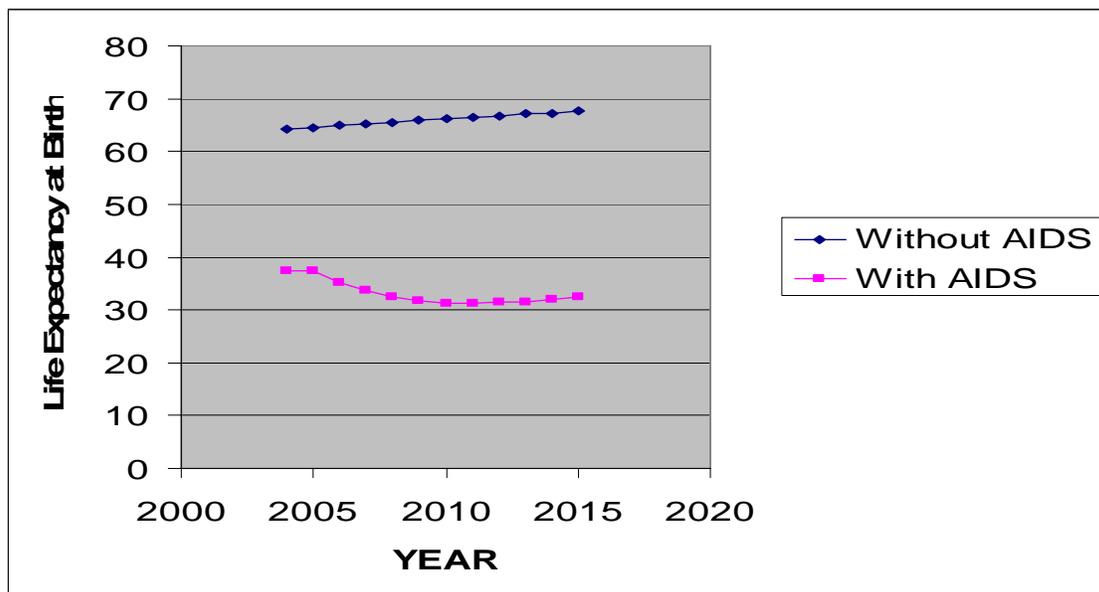
Firstly, HIV and AIDS dramatically increased the need for health care in the country because the prevalence of several HIV and AIDS related opportunistic infections increased considerably. TB, which had declined in prevalence before 1990, is a big problem today. Its prevalence has risen fourfold, from 210 to 820 per 100 000 people between 1990 and 2004 (MOHSW, 2005). More recently the TB cases further increased to 1 182 per 100 000 in 2006 (MPED, 2007). About 80% of adults with TB also have HIV. The resurgence of TB has shot up hospital admissions, making the number of TB inpatients the highest in hospitals (MOHSW, 2005).

The second impact on the health sector is the increased inpatient service load. HIV and AIDS have increased the crowding of wards and the complexity of cases. Health workers report that, due to poor home environments and fear of stigmatisation and discrimination by the home communities, the numbers of lodgers in wards increased, mostly attributed to HIV and AIDS related diseases. Almost all hospital services, including laboratories, allied medical staff, catering and housekeeping, are affected by the burden of the pandemic. An increasing number of outpatients come to health facilities with chronic illnesses and complex conditions that are HIV and AIDS related. To make matters worse, the introduction of ART has increased patient loads, as people on death beds come to health services with the expectation of being able to receive ART (MOHSW, 2005).

The meteoric rise in morbidity has led to a sharp rise in mortality. While the population censuses of 1976 and 1986 and the 1991 Demographic and Health Survey showed a dramatic rise in life expectancy at birth from 46 years in 1976 to 56 years in 1986 and 65 years in 1991, an improvement of 41% in 15 years, the 1997 population census and projections indicated a sharp decline of the same indicator to 60 years in 1997 and 37,5 years in 2004. As can be seen in figure 4.1, it is projected that the persistence of the pandemic would lead to the life expectancy declining even further to 31,2 years by 2011, less than half of what it would have been without HIV and AIDS, namely 66,5 years (Whiteside et al, 2006).

As a result of increased deaths due to HIV and AIDS the death rate, which had improved from 18,5 per 1 000 people in 1976 to 8,4 in 1991, is projected to triple to 23,4 in 2015. In fact, the VAC Survey found a crude death rate of 25,8 per 1 000 people among the rural population in 2003.

**Figure 4.1: Projected life expectancy at birth of Swaziland with and without AIDS, 2004-2015**

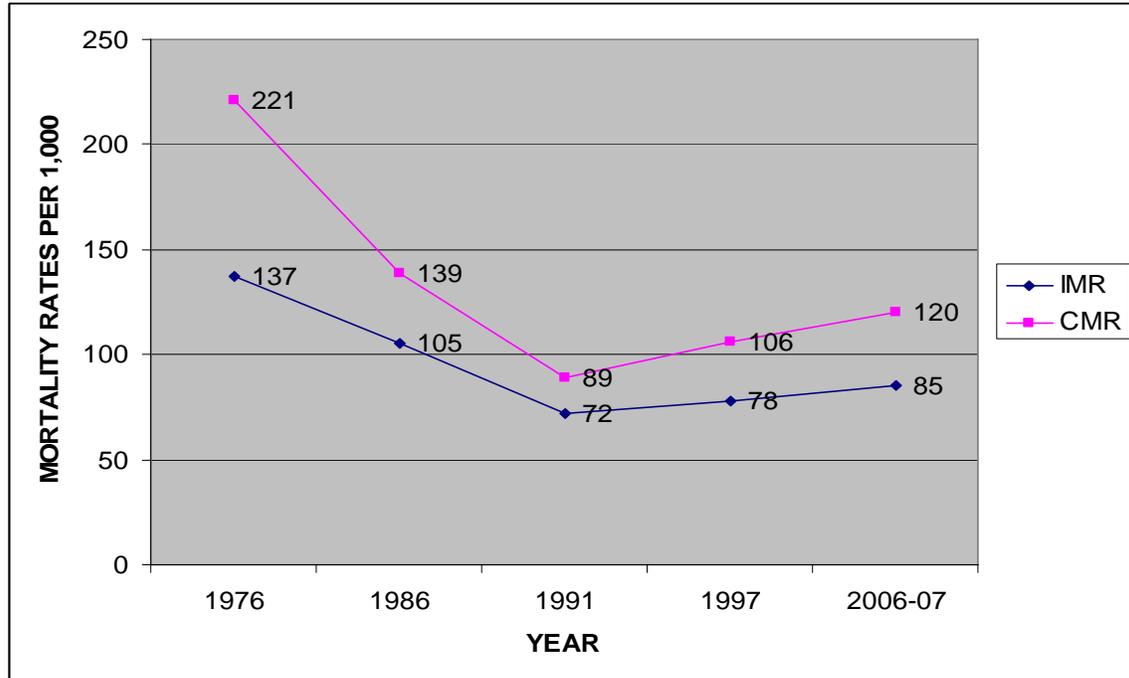


Source: Whiteside (2006)

Mortality levels among children are high and worsening. The mortality of infants and children has increased, due to the negative effects of mother to child transmission of HIV, rising malnutrition, the inability of sick parents to care adequately for sick children, the vulnerability of AIDS orphans and the adverse effects of AIDS on health systems.

As figure 4.2 shows, the SDHS of 2006/2007 found that the gains made in infant mortality in the 1980s and early 1990s (from 137 deaths per 1 000 babies in the mid 1970s to 105 in the mid 1980s to 72 in 1991) had been reversed to 78 in 1997 and 85 in 2006/2007. Similarly, the mortality of children under five, which declined before the early 1990s from 221 per 1 000 children in the 1970s to 139 in the 1980s to 89 in 1991, worsened to 106 in 1997 and 120 in 2006/2007 (CSO, 2007a). This means that if the current trend continues, Swaziland will have little hope of achieving MDG5, which committed the government to reduce child mortality by two thirds of the 1990 level of around 72 by 2015.

**Figure 4.2: Trends in infant and child mortality in Swaziland, 1976-2000**



*Source: CSO (2000) & CSO (2007a)*

The pandemic has adversely affected the population growth of the country. The increasing mortality rates, combined with a decline in the fertility levels, have led to a decline in the population growth rates. The report of the VAC of 2004 projected the rate of natural population growth to fall from 3,2% in 1990 to 1,7% in 2000, 0,7% in 2005 and 0,3% in 2010.

This projected decline of the annual population growth rate agrees with the projections of the World Bank (2001) that the growth would drop to 0,1% by 2015, if the HIV prevalence stays high (compared to 2,5% if there was no HIV or AIDS). These projections have been confirmed by the recently released provisional results from the 2007 population and housing census, indicating a very low annual growth rate of 0,24% between 1997 and 2007 (CSO, 2007b). This implies that if HIV and AIDS continue to worsen, the population growth rate would soon become negative, which is not a good situation for Swaziland.

Given this scenario, the Central Statistical Office (2007b) reported that the population size of Swaziland has slowly been growing from the 1997 figure of about 930 000 people to only 953 000 in 2007. In contrast, assuming there were no HIV and AIDS and the annual growth of population continued at the pre-1986 rate of 3,2%, in 2007 the population size of Swaziland would have been about 1 334 million, implying a loss of 381 000 people or 28,6% due to HIV and AIDS. The negative growth rate that is projected if the rapid spread of HIV infection continues at the current levels will have negative effects on the labour force, dependency ratio, etc. A small country like Swaziland can ill afford this. The King showed his concern about this situation and predicted the extinction of the nation if the trend continues unchecked. Even large, affluent European countries such as France and Germany are uncomfortable with declining populations for different reasons and are trying to stop the decline.

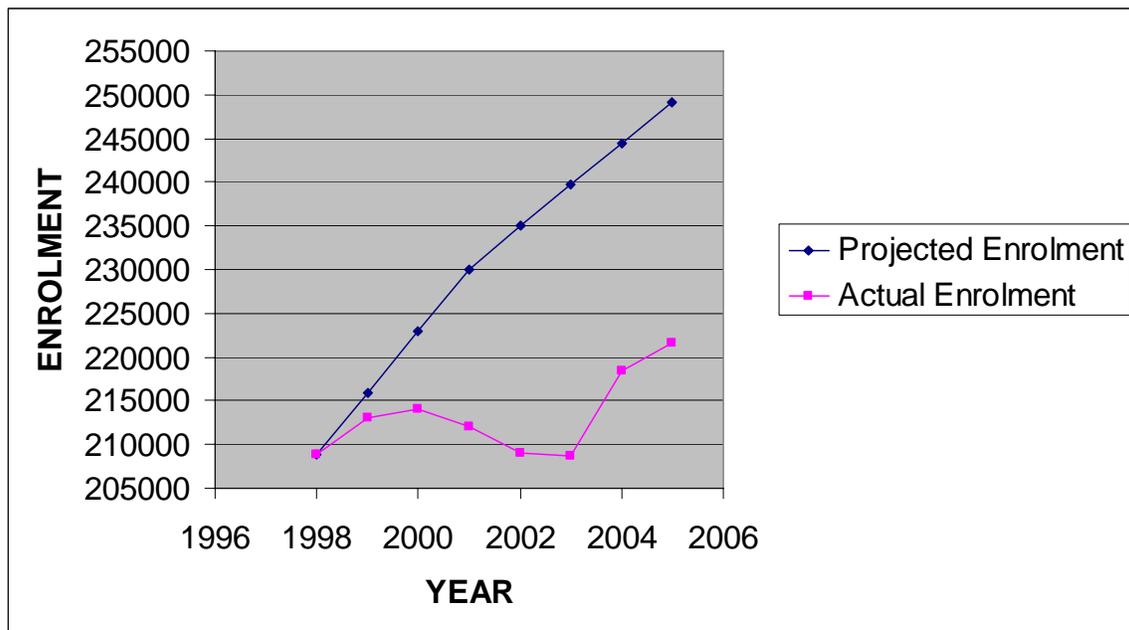
### 4.3 THE CHOICE OF BEING EDUCATED IS LIMITED

Education is critical to the development of Swaziland, as educated youths are the leaders of tomorrow. To be educated and more knowledgeable is one of the core choices of human development. HIV and AIDS have affected the education of many Swazis through the demand for, and supply of, education.

On the demand side, the parents and students who benefit from education are the concern. Given the high prevalence of the pandemic, many young adults have died from AIDS related diseases. This has had two effects. Firstly, the pandemic has greatly reduced the potential parents of children that would be going to school now, which could regrettably reduce the demand for education services.

The reduction can be seen in trends in primary school enrolment. In 2000 the rate of enrolment in primary schools was 81%, but it dropped to 71% in 2003 (UNICEF, 2006). As illustrated by figure 4.3, the actual enrolment in primary schools fell short of the projected enrolment by 2005 (Ministry of Education, 1999 and CSO, 2005). The reason for this is that the projections were made in 1999, when the ANC prevalence was only 32% – much lower than the 40% found in 2004. In 1999 the overall HIV prevalence in the adult population was assumed to be 20%, much lower than what it is believed to be today.

**Figure 4.3: Comparison of 1999 projected and actual enrolment in primary schools**



*Source: Ministry of Education (1999) & CSO (2005)*

Secondly, adults who die when they are already parents, leave behind orphans, many of them double orphans who have no parents to pay for their school fees and other requirements. The construction of a high school at Ludzibini in the Hhoho region has recently been halted, following the death of more than half of the school parents as a result of AIDS (*Times of Swaziland*, 2006). Most of the double orphans are left with their grandparents, who might be too old and weak to earn enough money to meet their school requirements.

A statement by a double orphan from Lubombo (Box 4.1) shows how the abject poverty of children without any of their biological parents has frustrated their educational aspirations:

**Box 4.1: The situation of an orphan**

*“I don’t go to school now because I dropped out at grade three due to lack of money. My cousin and I get food from that car (of the World Food Programme). In the past we were asking for food from neighbours” (UNICEF, 2004).*

Due to a lack of school fees and other school necessities, many children have no access to primary education. Despite the government bursary schemes for the OVCs, many deserving children do not benefit, due to cumbersome administrative procedures. In 2005, 87% of non-orphans aged 10-14 were at school, while only 79% of double orphans in the same age group were accessing education, denying access to 21%. Due to a higher school dropout rate for girls, attributed to providing care for sick parents and to allow the little money available to be used to send brothers to school, girls are worse off than boys.

In addition, the demand side of the education sector has become more complex. New HIV and AIDS related factors of demand for education include psychosocial stress, which makes it difficult for children living with HIV and AIDS to attend school. Stigmatisation, discrimination and traumatisation of children of people living with HIV and AIDS by some teachers and fellow students in schools have also discouraged them from going to school. Many of the children drop out of school to care for sick parents and other relatives and to generate income for the household.

Through impacting the supply of education, the pandemic has adversely affected the ability of children of acquiring more knowledge. Many teachers in the country have died from AIDS related diseases and many others are currently living with the virus. Many of these teachers are stigmatised and discriminated against, as the statement from a 28-year teacher from the Hhohho region in Box 4.2 narrates.

**Box 4.2: Problem associated with declaring HIV positive status by a school teacher**

*“But I had a problem at school. I told them I was HIV positive and they terminated my contract. Legally, they could not do that. However, it was the end of the school year and the end of my contract. It was the head teacher I told about my HIV and two weeks later he told me not to come back. He did not use HIV as the excuse. He did not give me any reason” (UNICEF 2002).*

The Multiple Indicator Cluster Survey of 2000 reported that as many as 70% of respondents, mostly women and people living in urban areas, believed that a teacher living with HIV or AIDS should not be allowed to work. The percentage was the highest in the Manzini region (80%) and the lowest in Lubombo (62%) (CSO, 2000). In the 1999 survey teachers accepted that HIV and AIDS were a reality and a threat to the education system in Swaziland. They were scared and confused about the pandemic and wanted more information.

Qualitative information indicates that many schools have teachers who are living with HIV and AIDS who cannot disclose their status, for fear of being isolated. The Ministry of Education is spending a lot of money to pay for terminal benefits of deceased teachers and those who have retired on medical grounds. Teachers who are absent for a long time due to prolonged illness and recruitment and training exercises also incur high costs.

The Ministry of Education's report of 1999 made conservative projections that additional costs due to teachers' deaths and sickness related to HIV and AIDS would double from E85 601 in 1999 to E167 683 in 2006, rising more than tenfold by 2016, to E902 581. The overall costs for an estimated 4 248 teachers who would die due to AIDS related diseases between 1999 and 2016 were projected at more than E1 billion, excluding training costs and expenses on non-teachers. If these costs are included, the total would be as high as E1,725 billion.

The pandemic compromises the quality of education in several ways. Firstly, teacher-learner ratios have increased, due to prolonged sickness of teachers and teacher deaths caused by the pandemic. The 1999 study projected the ratio to rise from 39:1 in 1997 to 50:1 in 2006 and 52:1 in 2011. It was in fact recently reported that the Nkambeni Primary School in the Hhohho region has closed because of a lack of teachers (*Times of Swaziland*, 2006).

Secondly, given the psychological and emotional stress on children due to a loss of family members, the lack of fees as well as stigma, the learning abilities of the children are likely to deteriorate. Thirdly, the abject poverty of households has led to hunger and malnutrition in children, which disrupts their educational performance.

Children who drop out of school are more vulnerable to HIV infection compared to those who stay in school. This is supported by results of the BSS of 2002, which indicated that 69% of out of school children have had sex, compared to 28% of children who stay in school. This increased the chances of the former group to contract HIV (Family Health International et al, 2002).

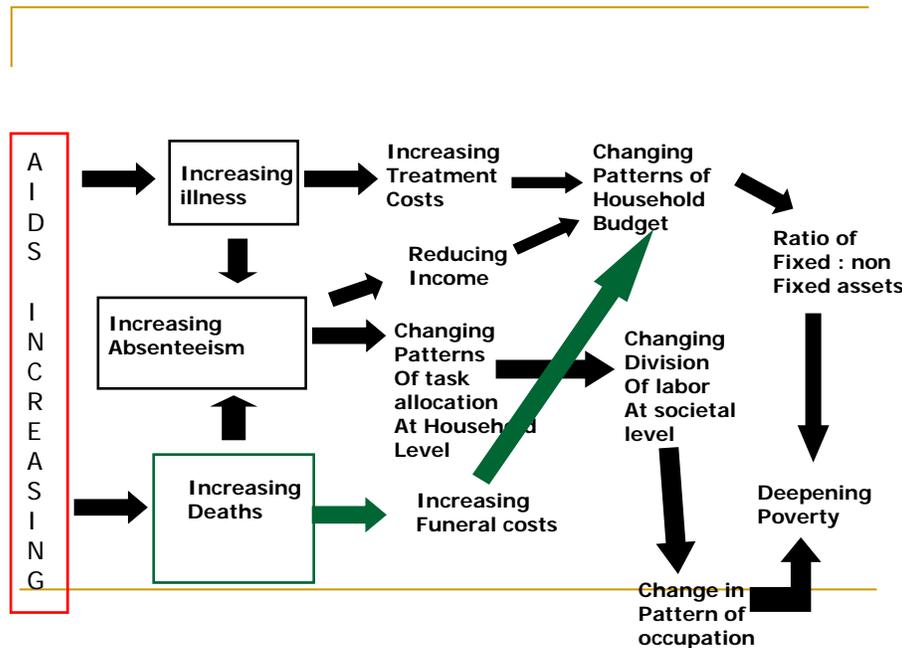
#### **4.4 THE CHOICE FOR ACHIEVING A DECENT STANDARD OF LIVING IS LIMITED**

MDG1 aims at reducing poverty and hunger among Swazis by half between 1990 and 2015. However, between the mid 1990s and 2003 the level of absolute poverty increased from 66% to 69%. It is not difficult to understand why poverty and hunger recently increased.

At the micro-level HIV and AIDS have affected households and families negatively. As shown by figure 4.4, the increasing number of household members getting sick and dying is leading to households being stripped of human capital. A total of 21% of household heads have been reported to be chronically sick by a VAC study in 2004, most of them living with HIV and AIDS. The poorest households are affected the most (VAC 2004).

The death of household heads who are breadwinners of the family often means poverty for the remaining household members, especially women and children. In other households, breadwinners are too sick to be able to work in order to provide for their family. As a result of the disability or death of men with marketable skills, women with inadequate skills are forced to start working in order to support their families. The women enter into the informal sector, as the family loses its social security cover.

**Figure 4.4: Impact of HIV and AIDS on poverty at the household level**



**Source: UNDP, RSC Regional Project, 2007**

Figure 4.4 also indicates that HIV and AIDS have reduced the income in households through a decrease in the labour availability per household. A 2002 study by the Ministry of Agriculture and Cooperatives (MOAC) found that the biggest source of farm labour is household members (contributing to 82% of households), followed by hired labour (44%), hired farm machinery (21%), pooled communal labour (17%) and the use of livestock to plough (10%).

The VAC Survey (2004) noted that prolonged illness diverted chronically sick household members from farming activities. The caretakers, especially women and children, reduce their contribution to farm activities, resulting in a decrease in productivity on the farms of the affected households.

In addition, high costs related to heavy expenditure on health care form a substantial proportion of the overall household expenditure. A national study of 600 households by Finscope and JTK Associates (2003) found that more than 60% of households reported that costs related to sickness and the death of household members were the biggest setbacks to their financial plans. The study further observed that 21% of the households considered funeral expenses to inflict the biggest negative impact on their financial security.

Desmond et al (2004) estimated that on average a household can spend as much as US\$767 on funeral expenses, which cover transportation of the remains to the home, death and burial announcements on the radio, a death notice in the newspaper, a gravesite, animals for slaughter, food purchases, a coffin and other funeral expenses. This list excludes important items such as memorial services and being absent from farm and office work, which can be expensive. This kind of expenditure leaves households with low and modest incomes poorer after the death of their household members. If it is the breadwinner that passed away, the chances of these households recovering and avoiding descending further into poverty are especially slim.

A study by the Ministry of Agriculture and Cooperatives (MOAC et al, 2002) reported that half of household incomes came from remittances of relatives working in South Africa and outside the household. Instead of receiving and investing the remittances, households are increasingly in need of coffins to bury their relatives, which cost money. The study found that 38,5% of households suffered a loss of remittances. As a result, high proportions of households are borrowing (44%) and others are selling their farm assets, such as cattle, goats and farm implements to survive. Reduction of investment in farms from lost remittances means exposure to food shortages. A loss of remittances also increases the vulnerability of households to environmental shocks and stresses such as droughts (which have hit many parts of the country for several years), as well as emergencies such as sickness, death and funeral expenses.

While 87% of households get a significant part of their income from the sale of cash crops and livestock animals, the production of these items has declined. The production of maize, which is the major crop of Swaziland, and the keeping of cattle, for instance, declined by 54% and 30% respectively in one year alone, mostly due to drought and AIDS related illnesses and deaths.

Household food security has also been reduced by HIV and AIDS. The combination of the pandemic with long-lasting droughts and poverty has been disastrous to rural households in many areas of Swaziland. Almost a quarter of the country's population (250 000 people) were classified as vulnerable and food insecure by the MOAC in 2005.

This implies that 132 000 people were malnourished, leading to more exposure to HIV infection. Although natural shocks such as long droughts and famines are not foreign to Swaziland, the pandemic has increased the vulnerability of households in these circumstances and made their recovery difficult, which seriously weakened their livelihood.

More male than female household heads were reported to die as a result of AIDS related diseases (MOAC et al, 2002). Apart from the consequences of increased food insecurity due to a lack of farming skills, widows face difficulties with household property inheritance. According to FGDs some of the properties of deceased husbands have been grabbed by the relatives of the husbands and the widows were thrown out of the family estate, which negatively affects the orphans.

The effectiveness of extended families in Swaziland in responding to crises has been reduced. The traditional role of caring for the weak members, especially orphans, has been greatly compromised. Poverty caused by the pandemic has reduced the financial capacity of the extended families to feed, shelter and pay the school fees for orphans.

The burden of orphan care is increasingly transferred to the older and female-headed households. Grandmothers left to look after the orphans are in many cases too old, weak and poor to support the needy children. As a result the orphans, especially the double orphans, have had to fend for themselves when they were too young. An old woman in her mid-eighties living in Nceka in the lowveld expresses the plight of the bereaved elderly in Swaziland in Box 4.3.

**Box 4.3: A rural old woman receives mortal remains of her children from urban areas**

*"I do not know how my children died. All I received were coffins containing their mortal remains. I was told that they fell sick and died in the urban areas where they worked"*  
(WFP Swaziland, 2005).

This aged woman was sick and unable to walk long distances to collect her monthly ration of food from the Nceka World Food Programme distribution point, which is several kilometres away. She used to depend on the generosity of neighbours for material and food assistance, but the area has been struck by drought for several successive years and is ravaged by HIV and AIDS. She heads a six-member household of grandchildren and great-grandchildren. Due to lack of money, only one of the children is at school, supported by the government bursary for orphans. The woman however has to find money to pay for a uniform, books and other necessities.

The elderly are sick and bereaved of the children that they expected to be an “insurance policy” to would look after them in their old age when they would not be able to work. Given their physical weakness, they are overburdened by the support they have to give their grandchildren and great-grandchildren whose parents have died.

To add to their problems, some of these orphans are living with HIV and AIDS themselves. The elderly are too poor to finance the needs of the orphans. Box 4.4 depicts the sickness and poverty of many orphans in Swaziland staying with their grandparents.

**Box 4.4: Sickness and poverty of orphans living with grandmothers**

*“He was a brilliant boy always jumping around, but his sickness has made him tired and his voice is nothing but a whisper, although his spirit and smile are still strong. We know where he lives with his grandmother near the school, and the head teacher is paying his school fees. Sometimes he comes to school without having eaten anything. The other children then contribute something to buy him something to eat”* (A teacher of an orphan living with HIV and AIDS)

As a result of HIV and AIDS, the situation for the children of Swaziland is becoming increasingly desperate. UNICEF (2006) estimated the number of OVCs in Swaziland in 2005 to be 95 000, representing 17% of all the children younger than 18. The number is expected to increase to 120 000 (22%) by 2010. Of the 95 000 OVCs, 28 000 (29,5%) had lost both parents (double orphans).

Out of the total number of orphans in the country, 63 000 (66%) were orphaned due to the deaths of parents as a result of AIDS related diseases. The SDHS of 2006/2007 reported an increase in the prevalence of orphans to 23% and of OVCs to 31% (CSO, 2007a), which give estimated numbers of 116 171 orphans and 156 578 OVCs (details in technical annex 2).

Children who are orphaned due to AIDS related deaths are discriminated against, stigmatised and traumatised. Many of the orphans are poor and hungry and live in child-headed households with little access to health and education facilities.

Figure 4.5 shows the community coping mechanism of neighbourhood care points (NCPs). These points are found in many rural areas of Swaziland and provide food, education and health facilities to OVCs that extended families have failed to supply.

**Figure 4.5: A neighbourhood care point (NCP) that meets under a tree and supports 62 OVCs, of which 7 have no parents and 55 have one parent**



*Source: UNICEF (2005) RAAAP report, figure 2, final draft report, August 2005.*

The double orphans have often been distributed to stay in the homes of relatives and other guardians, leading to the dissolution of the original households of orphans. However, recent decisions of extended family members to make double orphans stay in their deceased parents' households leads to child-headed households, which are increasing fast in the rural areas. These households are associated with poverty and food insecurity.

A survey of 38 out of 55 *tinkhundla* conducted in 2002 identified 10 616 children living in 2 666 child-headed households (UNICEF, 2005). This implies that there are close to 4 000 child-headed households nationally, with more than 15 400 children. In box 4.5 a child heading such a household complains of the lack of capacity to look after his three-year-old cousin.

**Box 4.5: A child heading a household complains of lack of capacity to look after her cousin**

*“There aren’t any adults around where I live, since my grandmother who was looking after us died. Where I live there are three houses made of stick and mud; one is a kitchen, the other we sleep in and the third has nothing inside. I live in the house with my cousin of three years old, who is a daughter of my mother’s sister who died this month. Her father is dead too. My father and mother died when I was an infant. It is scary living all alone, I worry about criminals attacking us at night; I worry about lions, crocodiles and snakes coming to our house. We don’t have locks on the door to our house; we use a nail that is bent to stop the wind from blowing the door open. I get along well with my cousin, but the problem is when she is sick. She gets flu very often and I do not have money to take her to the clinic. I fear the neighbours may take her away and I would stay alone” (UNICEF, 2004a).*

Women have become poorer due to HIV and AIDS. The VAC Survey (2004) found that more females in rural areas of Swaziland were more chronically ill than males at all age groups except 0-4 years. As high as 15% and 25% of women in the age groups 35-39 and 45-49 respectively were reported chronically sick, mostly due to AIDS related diseases. The main reason for this is the low status of women in society, which makes them vulnerable to sexual exploitation and violence by men. In addition, females are physiologically more exposed to HIV infection than males because of their mucosal surface, which transmits the virus more easily.

As in other parts of Africa, women in the Swazi society are the traditional caretakers of the sick. Girls are withdrawn from school to care for their sick parents or other close relatives and the adult women nurse their spouses until they die. This leaves women with less time to tend their farms and get food for their family. When the spouses die, the widows are frequently stigmatised and their properties are often taken away by the relatives of the deceased husbands. This makes them poorer and destitute, a condition that may force them to migrate to other parts of the country to start a new life, which is not easy. The situation is even worse if they are HIV positive, as they might spread the virus in these new areas where they are not known.

#### **4.5 THE CHOICE OF INDIVIDUALS AND HOUSEHOLDS TO PARTICIPATE IS UNDERMINED**

HIV and AIDS undermine people's ability to participate in the life of the community. Discrimination, stigmatisation and traumatising experienced by PLWHAs make it difficult for them to participate in community activities. In the FGDs with PLWHAs they complained of being isolated by the community because of their HIV status. In Box 4.6 a former nanny's testimony shows the discrimination she experienced from her employer.

##### **Box 4.6: Testimony on discrimination at the hands of an employer**

*"I was looking after children in Manzini as a nanny. Five years after I learned that I was HIV positive, I got sick again. My employer took me to see the family doctor who told him that I was HIV positive. My employer took me off from work (sacked me) because he thought I would die soon. He told me I would not be able to work hard and it was better that I stayed home. This was unreasonable because I had been HIV positive for five years and was working hard without any problems. The TASC counsellors went to speak with him and his wife, but the employers said no. My employers did not want me to stay with them anymore because they feared I would pass HIV to their children" (UNICEF, 2002).*

AIDS affected households feel less accepted by the community, leading to reduced participation. Some widows, widowers and orphans have been forced to migrate to start a new life where they are not known. Children who drop out of school due to lack of fees and other school requirements are robbed of their esteem to continue interacting with their mates and peers at school.

Poverty due to HIV and AIDS preoccupies affected individuals and households with survival activities and does not allow them time for their participation in affairs affecting the community. Social inequalities that are related to gender and education restrain people in the lower social group from participation in activities, where people in the upper social group are dominant.

#### 4.6 IMPACT OF HIV AND AIDS ON THE MACRO-ECONOMY

The lack of a long and healthy life because of HIV and AIDS, as discussed above, has had serious repercussions for the business sector, which is the mainstay of export revenues and contributes almost half of the GDP (48%). Table 4.1 gives findings of a survey of 45 businesses in the country. It shows that most businesses have experience of workers infected with HIV (73,3%) and have felt the impact of the pandemic (64,4%).

High morbidity and mortality of employees due to AIDS related illnesses have significantly reduced productivity, increased production costs and disrupted business operations. The main causes of reduced productivity in these businesses are absenteeism due to illnesses related to HIV and AIDS; workers taking time off to care for the sick and attend funerals; and high turnover of employees due to AIDS related deaths. The main causes of high production costs are increased death benefits, medical costs, caring for employee families and orphans and extended succession plans (recruitment and training of replacement staff). High morbidity that leads to disability and mortality of workers have increased the loss of skills and compromised human resource planning.

**Table 4.1: Number and percentage of businesses reporting different impacts, 2000**

Effects	Fewer than 100 employees N = 25		At least 100 employees N = 20		Total N = 45	
	Numbers	%	Numbers	%	Numbers	%
Have had at least an employee living with the virus	16	64,0	17	85,0	33	73,3
Felt the impact of epidemic	14	56,0	15	75,0	29	64,4
Reduced productivity	13	52,0	13	65,0	26	57,8
Increased production costs	10	40,0	11	55,0	21	46,7
Disrupted operations	9	36,0	11	55,0	20	44,4
Increased funeral attendances	11	44,0	9	45,0	20	44,4
Increased absenteeism	13	52,0	12	60,0	25	55,6
High turnover	5	20,0	10	50,0	15	33,3
Loss of skills	5	20,0	10	50,0	15	33,3
Increased costs of recruitment	3	12,0	11	55,0	14	31,1
Increased training costs	4	12,0	11	55,0	15	33,3
Increased funeral costs	7	28,0	10	50,0	17	37,8
Increased healthcare costs	10	40,0	12	60,0	22	48,9
Increased death benefits	5	20,0	10	50,0	15	33,3

*Source: Muwanga (2001), Tables 6 -14.*

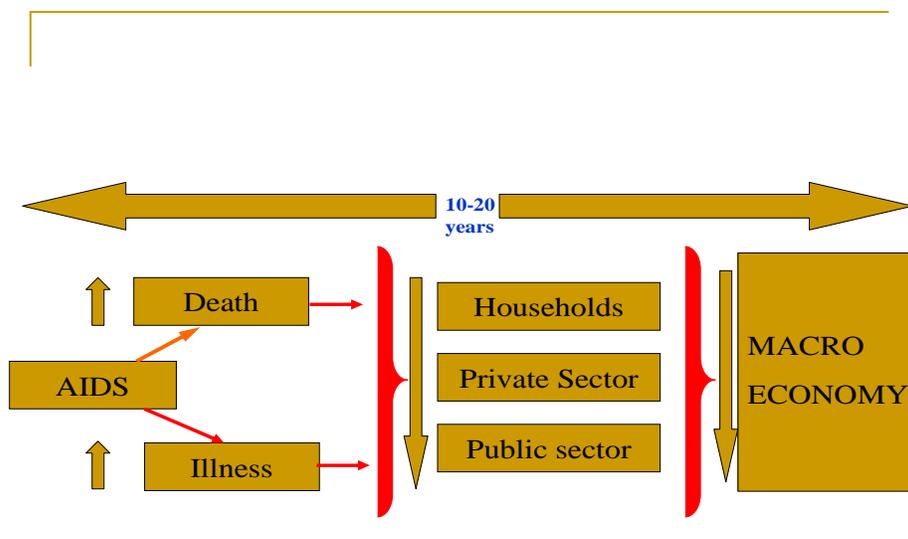
The agricultural sector, which employs more than 70% of the Swazi population, is equally impacted by HIV and AIDS. Subsistence agriculture engaged in the production of maize, beans, vegetables, peanuts, cotton, other cereals and livestock has been adversely affected by the pandemic. A UN study conducted in 2002 found that AIDS related deaths in the subsistence sector contributed 23% of total deaths, with the average age at death from these illnesses being as young as 33,7 years (compared to 41,6 years from other diseases). Most people (78%) diagnosed with HIV and AIDS also had TB.

The commercial agricultural sector has also experienced dramatic costs because of HIV and AIDS. The same UN study of 2002 observed that the majority of farms (13 out of 25) attributed the reduction in production to AIDS related absenteeism and a high turnover of employees. One agro-estate reported a total of 4 709 sick leave days in 1999, averaging at least two days per year per employee. In addition, the increased cost of production was attributed to the increased health care cost and funeral expenses.

Prolonged sickness associated with HIV and AIDS means that workers living with the virus utilise the farm’s health care system for a longer period than people with other diseases. In 1999 one agro-estate spent E132 393 on medicine and transport for referred patients only, which was much higher than the amount spent on other employees. The number increased to E153 753 in 2000 and to E167 374 in the first half of 2001.

Figure 4.6 shows that the serious impact of HIV and AIDS on households and agriculture and the public/private sector has slowed down the economic growth of the country, with dire consequences, especially in the long term. Different studies have recently estimated the annual loss in the GDP due to the pandemic to be between 1% and 2,8% and in the GDP per capita growth to be between 1,1% to 2,3% (Haacker, 2002; World Bank, 2001; ILO, 2005). These losses are a result of HIV and AIDS reducing the size, efficiency and productivity of the labour force, as well as to lower savings and investment.

**Figure 4.6: Long-term impact of HIV and AIDS on the macro-economy**



*Source: UNDP, RSC Regional Project, 2007*

The export sector, on which the Swazi economy relies heavily, has also been hit hard by the pandemic, leading to reduced productivity, efficiency and lower profits. This has had a negative effect on foreign and domestic investments. FDI is estimated to have contributed 37% to the overall GDP and 26% to the GDP for manufacturing between 2001 and 2003, which is quite a high percentage.

FDI however declined by 8,6% in 2003 alone (Minister of Finance, 2005). One of the major factors of this decline in FDI has been the high HIV prevalence in the country. HIV results in a continued increase in the capital-labour ratio and a declining return to capital, thereby discouraging FDI (Haacker, 2002).

The pandemic requires firms to train new employees continually to replace people who are sick or dead. Firms also have to spend large amounts on treating sick employees and giving them their terminal benefits when their contribution to production has been minimal (Whiteside et al, 2006). A Taiwanese textile factory employing 5 000 workers intended for Swaziland was recently reported to have relocated to Lesotho, for fear of a rapid spread of HIV and AIDS. Lesotho's rate of HIV prevalence is much lower, at 23% in 2005 (Isaksen et al, 2002).

A high likelihood of a decline in profit due to lower productivity and higher expenditure on the health care of sick employees is thought to have scared away prospective domestic investors as well. A 2004 study by Muwanga indicated that between 1,83% and 3,46% of the wage bill of the private sector in Swaziland is due to the cost of HIV and AIDS. This is in addition to the high mortality among workers in various businesses in the country (ranging from 4,8 to more than 15,4 per 1 000 employees), high absenteeism of three days per employee per year and low productivity (Muwanga, 2004).

#### **4.7 CONCLUSION**

From the above discussion it is clear that the HIV and AIDS pandemic of the past 20 years has undermined the human development condition in Swaziland. The choice to enjoy a long and healthy life is reduced, possibilities to be educated are limited, to achieve a decent standard of living is limited and it is difficult to participate in community activities. As a result, the overall rate of economic growth has been slowed. To respond to this deteriorating situation, various policies and programmes to counter the impact of the pandemic have been formulated. The implementation, successes and challenges of these efforts are discussed in the next chapter.

## **CHAPTER 5: NATIONAL RESPONSE TO THE HIV AND AIDS PANDEMIC**

### **5.1 INTRODUCTION**

The second national multisectoral HIV and AIDS strategic plan of 2006-2008 includes the following statement: *“There is no doubt that the country is under siege from an epidemic that has been spreading silently over the years. So far national efforts to address this challenge have only yielded heightened awareness of the problem, but have failed to stimulate levels of sexual behaviour change that are necessary for turning the epidemic around. As a result, the epidemic has continued to grow to a point that it has become generalised, mature and very deeply entrenched.”*

This chapter discusses the nature and extent of the national response to HIV and AIDS in the context of human development. A brief account of the historical events that have shaped the national response is presented first. Secondly, the current national response with respect to prevention, care, treatment and support as well as mitigation of impact is discussed.

Lastly, the report describes how the national response is contributing towards ensuring that the people of Swaziland can participate in national development, are knowledgeable, enjoy a decent standard of living and eventually experience a long and healthy life without encumbrances from HIV and AIDS.

### **5.2 HISTORY OF THE NATIONAL RESPONSE**

The Swaziland national response to HIV and AIDS has evolved over twenty years. The first response plan was put in place in 1987, as shown in table 5.1. The nature and scope of the response have changed tremendously since then, having grown from being primarily prevention-based and health sector driven in the early years of the pandemic to being comprehensive and multisector-based in later years.

These changes are characterised by a progressive increase in funding for HIV and AIDS, the number and type of interventions being implemented, geographical coverage of the response, the number and type of participating stakeholders and targeted populations, as well as response beneficiaries.

The poor responsiveness of the population to HIV and AIDS that was experienced in the early years of the pandemic can, among other factors, be attributed to the fact that HIV infection was a new phenomenon in the country and that members of the general public perceived it to be a foreign concern. During this time, HIV and AIDS were thought to only affect men who have sex with other men, a practice which was believed to be uncommon or rare in the country (Government of Swaziland, 2006). The slow start was also believed to have been influenced by limited appreciation of the germ theory and the natural history of HIV and AIDS, which at the time had no observable attributes.

These factors led to the Swazi people failing to realise the silent spread of HIV infection from core groups to the general population. The response only gained momentum following a declaration by King Mswati III during the opening of parliament in 1999 which declared the pandemic a national disaster. This sense of urgency coincided with international advocacy for political action and increasing visibility of the impact of HIV and AIDS, in respect of increased morbidity and mortality in the country.

**Table 5.1: Phases of the national response**

<b>Time horizon</b>	<b>Plan</b>	<b>Intervention areas</b>	<b>Coordinating sector</b>
1987-1988	Short-term plan	Blood safety, public HIV and AIDS awareness and safer sexual behaviour	Health
1990-1992	First medium-term plan	Blood safety, public HIV and AIDS awareness, safer sexual behaviour and <b>preventing STIs</b>	Health
1993-1996	Second medium-term plan	Blood safety, public HIV and AIDS awareness, safer sexual behaviour, preventing STIs, <b>voluntary counselling and impact mitigation, i.e. community HBC, managing opportunistic infections and support groups</b>	Health
1998-2000	Pre-multisectoral plan	Blood safety, public HIV and AIDS awareness, safer sexual behaviour, preventing STIs, voluntary counselling and impact mitigation (i.e. community HBC, managing opportunistic infections and support groups), <b>strengthening the expanded response to the epidemic, providing support to people living with HIV and AIDS and mobilising young people against HIV and AIDS</b>	Health
200-2005	First national multisectoral HIV and AIDS strategic plan	Blood safety, public HIV and AIDS awareness, safer sexual behaviour, preventing STIs, voluntary counselling and impact mitigation (i.e. community HBC, managing opportunistic infections and support groups), strengthening the expanded response to the epidemic, providing support to people living with HIV and AIDS, mobilising young people against HIV and AIDS, <b>preventing mother to child transmission of HIV, ARVs, food security, micro-credit schemes, psychosocial support to OVCs and establishing the monitoring and evaluation framework</b>	Office of the deputy prime minister
2006-2008	Second national multisectoral HIV and AIDS strategic plan	Behaviour change, communication, preventing HIV transmission through blood and blood products, preventing mother to child transmission, preventing accidental exposure and providing post-exposure prophylaxis, preventing and managing STIs, VCT services, pre-antiretroviral therapy, managing opportunistic infections, ARV, preventing and managing TB, providing HBC services, providing palliative care, providing provider-initiated counselling and testing services, traditional and alternative practice, protecting and providing legal, ethical and social rights, social protection and livelihood support, counselling and emotional care, food security support, educational support, mainstreaming HIV and AIDS, gender, disability and positive socio-cultural norms into impact mitigation, planning and programme development, advocacy and communication, resource mobilisation and management, community mobilisation, research, monitoring and evaluation	Office of the prime minister

### **5.3. STATUS OF THE NATIONAL RESPONSE**

From the onset, the national response to the pandemic was founded on three programming components: (a) response management, (b) prevention and mitigation and (c) social and economic impact. All the phases of the response generally maintained these components, except in the case of the current second HIV and AIDS national multisectoral strategic plan (2006 - 2008), which disaggregates impact mitigation into treatment, care and support and impact mitigation. Over the years the number of interventions initiated and the number of people reached increased significantly, leading to the conclusion that the response has indeed grown and become comprehensive. The components of the national response are discussed below.

#### **5.3.1 The national response to prevention**

##### **Information, education and communication**

Research studies that have been carried out in the country indicate that the national response has succeeded in generating levels of public awareness regarding HIV and AIDS. This observation is supported by findings of the SDHS of 2006/2007, which indicated high levels of awareness of HIV and AIDS among most members of the general public (99,8% of women and 99,3% of men, all aged 15-49) (CSO, 2007). Information on HIV and AIDS is therefore perceived to be fairly accessible in the country.

A major challenge of the national response is its inability to stimulate widespread positive sexual behaviour. This can be attributed to various factors, including the general scarcity of information and communication material, the failure to premise information and communication activities on evidence, the failure to address factors that render people vulnerable to HIV infection additional to addressing risk factors, the failure to balance investment that is made in mass media communication as opposed to interpersonal and community-based communication approaches, poor population segmentation and targeting, as well as communication of conflicting messages.

Swaziland does not produce adequate information and communication material. The material that is available tends to be of foreign origin and is mostly presented in English. As a result, the public depends more on information that is communicated orally through workshops, meetings, radio and television than on printed material. This situation encourages communication of non-standardised information that promotes misconceptions and conflicting messages. It also robs members of the public of opportunities for knowledge reinforcement by the national response, as well as to weaken the multiplier effect that accrues from shared printed material among members of the public outside of oral events.

A review of HIV and AIDS related information and communication interventions in Swaziland indicates that, across all phases of the response, few respondents recognised that the determinants of the pandemic are adequately addressed. To date the national response has tended to address inadequate awareness, multiple and concurrent sexual partnerships, secrecy and denial, the high incidence of STIs, low condom use and early sexual debut. Information and communication interventions mostly pay attention to issues of awareness as they relate to the dangers of high-risk sexual practices, such as unprotected sex, infidelity and sex at an early age. Very little effort has been invested in understanding and addressing the factors that in the first instance make members of the Swazi society knowingly engage in high-risk sexual practices. Information and communication interventions that fail to address these factors are not empowering the people, as they do not equip them with the tools required for overcoming specific vulnerabilities.

Observations furthermore indicate that the national response has invested more in mass media than in interpersonal and interactive communication approaches. Recent increases in investment in mass communication include the use of radios and billboards. Another challenge in the area of information and communication is that population segmentation and targeting for purposes of information dissemination have been limited to general parameters such as age and intervention type, instead of characteristics such as sex and social and economic indicators. The evidence suggests that children and young people have been targeted for abstinence while adults have been targeted for mutual fidelity and condom use.

Population targeting appears to have improved in the last two phases of the response. Many organisations now target specific populations such as *lutsango* (women), *tinftombi* (girls) and *emajaha* (boys), who subscribe to traditional and cultural practices, as well as workers, gay and lesbian people, commercial sex workers, religious people, etc. These different target populations are still subject to the same general information, irrespective of their circumstances and vulnerabilities. Failure to segment and target the Swazi population properly renders information and communication interventions ineffective.

Conflicting messages have been communicated from different interest groups from time to time. Some of this information has been communicated to challenge established facts, such as the efficacy of condoms, the role of nutrition in the management of HIV infection and AIDS and the safety of ART. Misinformation has included false treatment claims. Observations indicate that available information and communication interventions are not responsive to these occurrences. This situation leads to confusion that may give rise to high-risk behaviour and non-compliance with prescribed practices among members of the public.

### **Safer sexual behaviour**

From inception, the national response has addressed itself to the ABC strategy, namely abstinence for youths and children and faithfulness/fidelity and condom use for sexually active adults. The number of condoms that are distributed annually has increased over the years. The programme is currently distributing about 10 million free condoms annually, in addition to those that are available through commercial and social marketing outlets. With only 54,2% of young females and 51,9% of young males in urban centres reporting condom use with their first sexual encounter, the method does not appear to be as successful as it should be (AMICAALL, 2005). The SDHS of 2006/2007 indicated that only 56% to 57% of adults aged 15-49 reported using condoms during sex in the preceding 12 months (CSO, 2007).

Similarly, abstinence from sex among young people is clearly not common, since the same SDHS reported that a sizeable proportion of young women and men (48% and 34% respectively) had engaged in sex before they were 18 years old. In addition, chapter three observed that intergenerational sex is common among the youth, especially girls: 29,2% of girls' first sexual partner was five years older than them, while 10,8% of the female youth reported having sex for the first time with a partner who was more than 10 years older than them.

Available information suggests that there are generally few research activities and no in-depth sociological studies that provide information on the sexual behaviour of the people of Swaziland and the factors that drive such behaviour. The few studies that are available tend to explore knowledge, attitudes, beliefs and practices, rather than the determinants of those aspects. As a result of the lack of researched data, information and communication interventions in the country tend to be informed by perception rather than empirical evidence.

At the time of writing, there were also no intervention studies to inform information and communication interventions. Consequently, there is little or no information on the effectiveness of most information and communication interventions that are applied.

The culture of pre-testing information and communication materials is also uncommon. Except for information on preferred sources of HIV and AIDS related information, there do not appear to be any studies that explore the sensitivity index of Swazi society to the manner in which sexual information is communicated by the response. Through work done by Allan Whiteside and the national strategic plan development process, NERCHA has characterised perceived drivers of the pandemic in Swaziland (detailed information in chapter three). This indicates that the national response recognises the value of such information.

### **Prevention of mother to child transmission (PMTCT)**

Although the pandemic was first reported in Swaziland in 1987, PMTCT was only introduced in March 2003. This formed part of the national response, with the objective of reducing mother to child transmission of HIV by 50% by 2010.

Through this intervention the response intended to achieve the set objective through the accelerated expansion of services, the integration of PMTCT into maternal and child health (MCH) services, the strengthening of community capacity to respond to PMTCT and HIV and AIDS, as well as the reduction of stigma and discrimination (Ministry of Health and Social Welfare, 2003).

Available data indicates that limited progress has been made in achieving the objective. The UNGASS report of 2003/2005 observed that a reduction of 1,74% in mother to child transmitted infections was achieved in 2005 (Government of Swaziland, 2005).

While very little success has been recorded in achievement of the PMTCT intervention objective, a lot of progress has been made in ensuring the availability and accessibility of the service. The Monitoring and Evaluation Unit of the MOHSW reported that by the end of June 2007 PMTCT services were available in 110 out of 184 health facilities (59,8%), as is evident in the number of reporting facilities.

Table 5.2 presents PMTCT activities carried out by EGPAF, one of the partners in PMTCT, from July 2003 to June 2007. According to this report more counselling and testing take place in antenatal clinics than in labour wards and postnatal clinics. The proportion of people who test and also receive their HIV results is generally high, given that testing is based on rapid tests that immediately generate results before people leave the facility. This observation indicates that the service is acceptable, as 87,2% of the women who were counselled took the test.

The report also indicates that more people received NVP for children in antenatal clinics than those who are tested through postnatal services. This observation may reflect that exposed infants who are born at home and taken to health facilities within 72 hours also receive the NVP suspension prophylaxis, as with people who use postnatal services (EGPAF, 2006).

**Table 5.2: Reported PMTCT activities by EGPAF**

<b>Service point</b>	<b>Number of pregnant women and mothers counselled</b>	<b>Number of pregnant women and mothers tested</b>	<b>Number of pregnant women and mothers tested HIV positive as a percentage of number tested</b>	<b>Number of pregnant women and mothers receiving HIV results as a percentage of number tested</b>	<b>Number of pregnant women and mothers receiving nevirapine as a percentage of number tested positive</b>
Antenatal care service	39 359	34 334	13 906 (40,5%)	31 036 (90,4%)	9 201 (66,2%)
Labour ward	7 739	7 245	2 517 (34,7%)	7 229 (99,8%)	1 770 (70,3%)
Postnatal care clinic	453	314	97 (30,9%)	272 (86,6%)	

The MOHSW results reported in chapter three showed that in 2005 only 52% of PMTCT attendees who tested HIV positive received ART. There has been a modest increase to 66,4% in 2007, as shown in table 5.2. Nonetheless, the proportion of women who receive nevirapine (NVP) is lower than expected in both cases. This may mean that pregnant women who know their HIV status still missed the opportunity of reducing the risk of passing the infection to their children. The issue of men not allowing their spouses to participate actively in this intervention, discussed in chapter three, may be related to this missed opportunity.

There is no doubt that the PMTCT intervention has positive attributes that have the potential of providing a conducive environment for eventual success in reducing mother to child transmission of HIV infection. These attributes include the intervention being introduced as PMTCT Plus, which not only targets the woman, but also her sexual partner and family members. PMTCT also provides ARV to the parents of the child through the national ARV programme, when indicated.

Even though PMTCT is fairly new in the country compared to most interventions in the response, it has a dedicated focal point that coordinates the application of action on PMTCT. The PMTCT intervention has embraced the concept of working with and through partners. This enables the intervention to extend itself and cover a lot of ground.

The intervention area has baseline data on PMTCT related literacy, practice and service provision, a national policy on nutrition and HIV and AIDS, a national strategic plan and implementation guidelines, as well as a training curriculum that was adapted from a plan developed by the WHO and Centres for Disease Control (CDC). The PMTCT programme has trained more than a third of all nurses who are critical in the application of the intervention, as they are the primary service providers of PMTCT.

Culture can play a significant role in the success of PMTCT. The following cultural practices have some bearing on access to PMTCT services, and the utilisation thereof. The practices include the secrecy around early pregnancy, the prohibition of men from interacting with birth and related activities, and the societal expectation for women to breastfeed.

Culturally, early pregnancy is a guarded secret until it becomes physically visible. This behaviour is believed to be responsible for the late presentation of pregnant women to antenatal care services. Evidence indicates that most Swazi women come for their first antenatal attendance during the second trimester. Consequently, opportunities for early antenatal care intervention, including PMTCT, are missed.

The prohibition of men to interact with birth and related activities renders issues of pregnancy and birth a concern for women only. As indicated in chapter one, men are culturally discouraged from being around when women are giving birth, or indeed to be with them when they have just given birth. This prohibition prevents a father from interacting with, and even seeing, his newborn child. At an even more serious level, the burial of an infant is left to female members of the family. This observation seems to suggest that culture is more likely to compromise male involvement and participation in PMTCT.

The Swazi culture also discourages sexual contact between a woman who has given birth and her sexual partner for a period of six months (elsewhere medical practitioners advise a period of three months). If strictly adhered to, this cultural practice is likely to promote unfaithfulness during the period of sexual moratorium, thereby increasing the risk of acquiring HIV infection and passing it on to the breastfeeding mother and infant. The consequences of this practice are important, because infected people have a high viral load during the early stages of the infection, rendering them highly infectious.

Another area of concern is that women are culturally expected to breastfeed. Family and community expectations leave HIV positive women with a limited choice of not breastfeeding should they opt for alternative feeding. This expectation is likely to force HIV positive women to breastfeed against their best judgment, thereby exposing their babies to the risk of infection.

### **Blood safety**

Available data suggests that while safety of the country's blood supply has not reached acceptable levels, it has improved tremendously over the years. This is evident in that HIV prevalence and syphilis among blood donors have respectively declined from 6,12% and 5,29% in 1993 to 2,19% and 0% in 2006 respectively.

This accomplishment can be attributed to the early introduction of mandatory (100%) and comprehensive screening of donated blood, the decision to target students instead of adults as the main source of donated blood and the introduction of stringent donor deferment protocols. While the mandatory screening of donated blood was influenced by the identification of the first HIV positive person in 1986, the decision not to collect blood from the adult population was informed by unacceptably high rates of HIV prevalence among adults, in comparison to the student population.

Another factor that contributed to blood safety was the introduction of the combined antibody and antigen-based HIV test kit. This has significantly reduced the risk of HIV transmission through the transfusion of infected blood during the window period, a time during which HIV infected people test negative for HIV antibodies. Overall, the national response appears to have made significant progress toward improving blood safety in Swaziland.

While blood safety in the country can be said to have improved over the years, there is still a lot of room for improvement in intervention. The prevalence of hepatitis B remains relatively high. The demand for donated blood (estimated at 10 000 units) has not been met, given that the

country only collects about 6 000 units annually. Blood use, which was expected to decline due to the enhanced rational use of blood transfusion, has increased over the years. Several factors are the cause of this, including the lack of a dedicated budget, limited capacity of the national blood transfusion service to collect all potential blood units in a year, the lack of an organised donor recruitment programme, frequent reagent stock-outs and limited human resource capacity.

Even though there has been a general call for the national blood transfusion service to be delinked from general clinical laboratory services, the status quo remains. Reagent stock-outs are a cause for concern, given that clinicians may be forced to transfuse untested blood in the context of emergencies. According to the blood bank stock-outs arise because of weak and bureaucratic government procurement and logistical processes. The issue of limited human resource capacity is not unique to the blood bank, but a recurring theme in most operational areas of the MOHSW.

### **Voluntary counselling and testing (VCT)**

VCT was introduced as part of the national response in Swaziland during the second medium-term plan of the national response. Since then more than 20 VCT sites have been established, including mobile services. Efforts are now being made to introduce provider initiated counselling and testing services in all health facilities. This intervention is also associated with the establishment of support groups in the country.

While approximately 5% of the world's population know their HIV status (UNAIDS, 2004), the SDHS of 2006/2007 states that 40,7% of women and 18,6% of men in Swaziland reported to have ever tested for HIV. A total of 21,9% of women and 8,9% of men who reported testing in the preceding 12 months also received their results. These findings indicate that fewer men than women test for HIV and consequently are aware of their HIV status. It also implies that HIV testing and knowing one's HIV status is still generally unpopular in Swaziland. While there is progress in this area, a lot still has to be accomplished.

As far as VCT services are concerned, most VCT centres in Swaziland are in the larger urban areas, whereas the majority of people in the country live in rural areas. Service availability and access to these services for rural people is therefore limited. According to PLWHA in Swaziland, VCT services have increased over time, although the quality of the service with respect to customer care has declined. This is partly due to overcrowding and a shortage of staff. Another observation is that the national response has placed more focus on counselling that is related to testing and not so much on support or ongoing counselling. Counsellor training is also perceived to be costly, which makes it inaccessible to many who may aspire to be trained in counselling.

### **5.3.2 National response to treatment, care and support**

**Antiretroviral treatment (ART):** While ART has been going on for quite some time in the private sector, it is a new intervention in the public sector and the national response as a whole. As part of the World Health Organisation's 3 by 5 initiative, ART was introduced as a mainstream national response intervention in 2003.

It is pertinent to note that Swaziland is among few countries in the region that achieved their 3 by 5 initiative targets by 2005. It is estimated that out of 36 500 clients who are candidates for ART, 20 610 (56,5%) were actively on ART by the end of June 2007 (MOHSW, 2006). A significant number of clients are however not complying with treatment.

The programme has a national focal point, national clinical guidelines and dedicated clinicians who are deployed to each of the four regions. The intervention also benefits from a government budget focused on ARV medication, in addition to support from the Global Fund. Many health workers have also been trained in ART. The programme has undoubtedly contributed to an improvement in quality of life of many people. Data on survival to confirm this observation is however not available.

Despite the observed achievements, the ART intervention still faces challenges. These include human resource shortages, noncompliance of people with treatment requirements, high demand for the service, skewed service availability and accessibility of the service in favour of urban areas, limited availability of support services and the absence of a technical working group. The challenge in terms of human resource capacity is prevalent among clinicians and support services, such as the clinical laboratory and pharmacy. The demand for the service currently exceeds the ability of the national response because of infrastructural and human resource constraints.

The relation between the demand and supply dimensions of the intervention results in congestion and long queues in the limited number of centres that are currently available. This situation causes frustration to health workers and users alike and has the potential of compromising the quality of services that are provided. Non-compliance is not acceptable in that it may result in treatment failure and resistance to the medication.

Historically, health services are mostly based in urban centres and ART services are no exception. Rural residents consequently have to travel to urban areas to access ART services, which means they have to invest more in time and money. To ensure that they are attended to, rural residents have to travel very early in the morning, returning late in the afternoon.

The inadequacy of support services in the health system is a problem that affects all components of health and social welfare services in the country. The absence of a national technical working group in the area of ART means that there are not enough consultations with practitioners, users and partners to improve ART programmes. In addition, monitoring ART users and medication remains a challenge.

### **Treatment of AIDS among children**

According to data generated by the monitoring and evaluation unit of the MOHSW, 1 776 children were on ARVs by the end of June 2007, accounting for 8,6% of all people who were on ARVs at the time. Data on the levels of demand for paediatric ART is not available. This makes it difficult to determine whether coverage of the intervention is sufficient. On face value, the observation would be that a very small proportion of children who need the service are currently being reached. National guidelines for managing paediatric AIDS, of which the diagnosis has been described as problematic, have been developed.

Culturally, Swazis attach a lot of value to child survival. Having children is viewed as an extension of oneself. This is captured in idioms such as *umftwana ngumliba loya embili, kutala kute lula ematsambo* (giving birth is extending one's bones). Based on this observation, culture is expected to have made a positive contribution to the intervention. These positive effects of culture could however have been constrained by time spent seeking help from traditional healers as well as HIV and AIDS related stigma and discrimination, especially as it relates to the fear of testing. Testing infants is also an issue, because the status of the infant reflects on the HIV status of parents, who may not be ready for the test.

### **Pre-antiretroviral therapy**

This intervention is one of the latest activities of the national response. It was introduced by the second multisectoral HIV and AIDS national strategic plan of 2006-2008 and is handled along with the management of opportunistic infections. The intention of combining these interventions is to increase the survival of people who are infected with HIV to at least seven years before they develop AIDS. While pre-antiretroviral therapy is a new addition to the national response, some of its elements were introduced as early as 1993, when the first support group was established.

### **Post-exposure prophylaxis (PEP)**

This intervention originated with the advent of antiretroviral medication. As part of early actions the national response introduced and popularised universal precautions, especially among health workers, as a way of dealing with occupational accidental exposure to HIV. The target populations for accidental exposure and provision of PEP have lately expanded to include disciplined forces, the fire department and survivors of rape incidents. Guidelines for addressing PEP have also been put in place.

The PEP intervention does not have a focal person who is responsible for promoting its application. This is because protection from accidental exposure, especially in the health sector, is perceived to be routine practice that should be integrated into general infection control measures. This intervention area also faces the challenge of inadequate availability of protective materials and supplies, owing to persistent interruption of supplies as part of an overall problem of procurement and logistics in the MOHSW. Health workers who have experienced accidental exposure are discouraged from engaging in PEP because of the prerequisite to test for HIV. Access to PEP by beneficiaries outside the health sector, such as the police and the fire department, is not clearly articulated. Training health workers on PEP is ongoing.

### **Management of opportunistic infections**

The management of opportunistic infections (OIs) was introduced early in the national response and is integrated into general clinical services. Clinical management guidelines have been put in place and health workers have been trained in applying them.

The intervention faces several challenges, such as an inconsistency in the supply of medication for managing OIs. As pointed out earlier, stock-outs are part of a general health systems problem. This intervention also suffers from a high turnover of trained health workers and irregular opportunities for training additional personnel. Clinical laboratory services lack adequate capacity support regarding the diagnosis and management of OIs. There is no information on the extent to which this intervention has achieved its objective.

### **Prevention and management of STIs**

The prevention and management of STIs have been part of the national response phases from early in the pandemic. The most common STIs in the country have been reported to be trichomonas (21,9%), chlamydia (18,2%), syphilis (7,8%) and gonorrhoea (7,8%). Chancroid has declined over the years, from 40% in 1990 to less than 1% in 2004. On the contrary herpes, as a percentage of all genital ulcers, has increased from only 12% in 1980 to 60% in 2004 (HAPAC, 2005). The increase in the prevalence of herpes can be explained by the increased prevalence of immune suppression in the Swazi population, due to HIV infection.

The response to STIs has always included public awareness, early intervention and service development, including the training of health workers. A major achievement of the response in this intervention area is the decline of syphilis over the years, even though the prevalence rate of 7,8% is still very high (HAPAC, 2005).

The prevention and management of STIs tend to suffer from the general failure of fully integrated health systems. Under this intervention, the national response is compromised by scarcity of information and communication materials on STIs and inadequate application of syndromic management protocols by clinicians, due to a high turnover of trained health workers. Other challenges include insufficient training and participation of private practitioners in STI continuing education activities and compliance with national protocols.

### **Prevention and management of tuberculosis (TB)**

TB is a very serious concern in Swaziland. Internationally the country is classified as having the highest burden of TB in the world. The major challenge is the re-emergence of the TB epidemic, as evidenced by the increase in the number of new TB cases, from 2 000 in 1993 to 8 330 in 2004/2005. The TB prevalence has grown from an estimated 856 per 100 000 in 2000 to 1 182 in 2006 (MPED, 2007). This intervention area is also faced with the challenge of dealing with high HIV co-infection levels.

The prevention and management of TB are older than the national response, with the national tuberculosis programme having been established in the 1960s. While being part of the national response, operations of the National Tuberculosis Programme have generally been independent of the coordination structure of the HIV and AIDS response. The relationship between these two entities has been primarily collaborative.

The programme has 15 satellite facilities across the country. For many years, the public health programming side of the National Tuberculosis Programme received minimal attention, due to the fusion of the clinical and programming functions. This situation has since been corrected and today programming is headed by a dedicated programme manager, regarded as a positive development by the MOHSW and partners.

In an effort to decentralise TB services and generalise direct observation treatment strategy (DOTS), the intervention has deployed regional coordinators of TB activities. The intervention employs the services of an international TB specialist, who provides assistance in improving the performance of the programme. The intervention has a national strategic plan, national technical guidelines and an emergency plan for combating multidrug resistance. The programme has also developed the capacity to conduct culture and sensitive tests for first line TB medication. This development is considered to be a great strength of the intervention.

The prevention and management of TB in Swaziland are perceived to be generally weak. This perception is based on the observation that DOTS coverage, case detection and the cure rates are low compared to the international targets set in 1993. More than 10 years after these international targets were set by the WHO, DOTS is still applied on a pilot basis. Case detection is estimated to be 54%, compared to the international target of 70%, while the cure rate is estimated to be 52% compared to an international target of 85% (National Tuberculosis Programme, 2006). This intervention also suffers from the general weakness of clinical laboratory services that fail to provide decentralised sputum examination services.

### **Provision of palliative care**

The second national strategic plan treated palliative care as a stand-alone intervention. This intervention was initiated in response to the need to care for terminally ill people with all diseases, especially cancer. As the pandemic generated terminally ill people in the absence of ART, this intervention became an integral part of the national response. Apart from the health facilities, this intervention is facilitated by only one NGO. Data to indicate the level to which intervention objectives have been achieved are currently not available.

Palliative care is one of the smallest activities of the national response. It faces the challenges of having limited access to resources in comparison with other interventions. While the number of people who require the service has increased over the years, its capacity to satisfy the demand is limited. Being a highly regulated work area that can only be applied by registered medical doctors and nurses, palliative care is restricted. Unlike other areas such as community home-based care and VCT, this function cannot be delegated to community volunteers. This constraint limits its coverage and contribution to the national response.

### **Provision of home-based care**

The home-based care (HBC) intervention has developed with the pandemic. A national strategy for this work area was first developed during the second medium-term plan (1993-1996) in anticipation of an overwhelming health impact. The plan was developed in collaboration with the Rural Health Motivator Programme. HBC services are generally provided by community volunteers who work under many different organisations, including the Rural Health Motivator Programme. Data to indicate the level to which the intervention objectives have been achieved is currently not available.

This intervention area has national technical guidelines, a national training curriculum and regional teams of trainers at its disposal. It also has a dedicated national focal point and a national technical working committee. Training in HBC has been standardised and many caregivers have been trained over the years.

The main challenges of this intervention include the coordination of the different interests and approaches of the implementing organisations, the assurance of total service coverage, the referral of people to and from health facilities, the inconsistent flow of materials and supplies, the demotivation among volunteers and the competition for turf among volunteers sponsored by different organisations.

Attributes of the service, such as the contents of HBC kits and remuneration of caregivers, vary. This depends on the capacity and conviction of implementing agencies. Some organisations provide the people with food packages, while others do not.

Organisational relationships of the intervention with the Swaziland National AIDS Programme (SNAP) and national public services remain unresolved. Similarly, the monitoring and evaluation of HBC services remain weak. Consequently, there is no reliable information on the total number of users and active caregivers available, as well as data on the availability and accessibility of these services. This intervention area has to deal with the perception that it is a low priority in the context of antiretroviral treatment.

## **Traditional medicine practice**

This intervention became part of the national response early in the pandemic. Initial activities focused on familiarising traditional medicine practitioners (TMPs) with the basic facts on HIV and AIDS, with the intention to reduce the risk of transmission of HIV among people who consult TMPs. During the same period TMPs were trained on STIs, with the objective of improving their ability to recognise and refer cases of STIs to modern medical practices.

As the national response progressed, the development of this intervention became a low priority. The component of integrating traditional health practices into the national response is very new and as such underdeveloped. This intervention faces major challenges, including weak organisational and management capacity, a lack of credibility among partners, a lack of professionalism among TMPs, the invisibility of TMPs and limited access to funding. The fundamental driver of these challenges is that Swaziland does not have a framework that regulates and professionalises traditional medicine practice. As a result the intervention is primarily driven by associations whose membership is doubted by partners, as there is no legal requirement for practitioners to register.

TMPs are not perceived to be credible and professional, because some members make unfounded claims of treatment and cure. Failure to professionalise the intervention also leads partners to question the value of the intervention to the national response and subsequently the wisdom of investing in the sector. Weak organisational and management capacity of the intervention makes partners doubt the ability of the intervention to deliver on agreements.

### **5.3.3 The national response to impact mitigation**

Impact mitigation was a concern of the national response as far back as the first medium-term plan was implemented, even though the impact of the pandemic was not visible at the time. The prominence of impact mitigation has grown in line with the growth and development of the pandemic. Most activities in the work areas have taken place during the period of the first multisectoral HIV and AIDS national strategic plan.

Interventions in this work area have tended to focus on care and support for OVCs. In 2005 UNICEF estimated the number of OVCs in Swaziland to be 95 000 (UNICEF, 2005). According to the SDHS of 2006/2007, OVCs however constitute 31% of all children (156 578), which is a much larger figure than the one that was estimated by UNICEF. When the SDHS OVC proportion is broken down, orphans and other vulnerable children represent 23% (116 171) and 12% (60 611) of all children respectively.

#### **Support for OVCs**

The national response to HIV and AIDS contributes to addressing the situation of OVCs by attending to the food security needs of these children. This intervention was introduced during the implementation of the last national strategic plan. The intervention seeks to provide at least one meal a day to needy OVCs, PLWHA as well as bereaved and vulnerable adults. The feeding of OVCs is one of the most promising interventions of the national response.

Besides providing food, this intervention supports food production by communities to sustain access to food by OVCs. Food is provided through school and community-based feeding schemes. These are called different names by different organisations, namely *kagogo* centres (NERCHA), neighbourhood care points (UNICEF) and social centres (AMICAALL).

As part of the school feeding programme, the national response is providing at least one meal a day to OVCs through 89,6% (509) of all primary schools. Of the 509 schools benefiting, 65,8% (335) are supported by the Global Fund and 34,2% (174) by the World Food Programme. Through the 335 schools which are supported by the Global Fund, 145 070 children benefit (Ministry of Education, 2006).

Additionally, the World Food Programme supports approximately 73 000 children (World Food Programme, 2007). In total the school feeding programme benefits 219 989 children. This figure is much higher than the estimated number of OVCs in Swaziland and closer to the total enrolment in primary schools (221 596 in 2005). These statistics clearly indicate that the intervention is extended to all children in targeted schools.

As indicated earlier, the intervention provides at least one meal a day to OVCs through a network of community feeding centres, additional to the school feeding programme. Unfortunately, data on the number of active feeding centres and beneficiaries is not available. Community-based feeding is supplemented by periodic distribution of food commodities such as maize and beans.

This intervention also supports food production by chiefdoms, towns and in some instances schools. Chiefdoms and towns are assisted by the MOAC in the implementation of this intervention. This arrangement is considered to be a strong point, in that food production is a portfolio responsibility of the ministry in which it has a comparative advantage and the necessary expertise, consequently making sustainability of the input more likely. Most communities at the level of chiefdoms and towns also have physical structures that serve as eating service points, which are managed locally.

A major limitation of the intervention is that it is currently not incorporated in the annual budget of the MOAC. While the provision of food by the intervention is welcome, the perception is that it is too basic and that it lacks variety. The implementation of this intervention relies heavily on the voluntary participation of community members. Sustaining community interest in supporting the intervention may not be easy in the long term.

This intervention is rooted in the Swazi culture and traditional practices. As noted in chapter one, the responsibilities of chieftainships included looking after the welfare of disadvantaged members of the community, such as orphans and widows. Food for addressing such needs was produced through *lilima*, the contribution of voluntary labour by members of the community.

Under this arrangement the chieftainship acted as custodian of food products that were generated in this way. Although this practice had died out in the past, it is being revived by the national response because of the overwhelming need to reduce hunger among OVCs. This is one example in which the Swazi culture has made a positive contribution in support of the national response to HIV and AIDS. The intervention has great potential for reducing hunger if it is fully embraced and championed by traditional leadership and owned by communities.

### **Providing and protecting legal, ethical and social Rights**

This intervention has always been a concern to the national response. In the early years of the response the focus was on the promotion of confidentiality, informed consent, pre- and post-test counselling as well as the prevention of discrimination based on HIV status. Over time this intervention has grown to cover interests in the provision and protection of the basic rights of women and children.

The concepts and principles of proving and protecting legal, ethical and social rights is reflected in both the 1998 and 2006 national HIV and AIDS policies of Swaziland. The 2006 policy has broader coverage of issues than the 1998 policy, reflecting growing concerns as the impact of the pandemic deepens. This intervention can be credited with preventing indiscriminate testing of people, especially during the early days of the pandemic when misconceptions and public panic were prominent. The availability of the revised 2006 national HIV and AIDS policy is a major strength of the national response. The availability of a dedicated national focal point for this intervention indicates a degree of commitment related to the provision and protection of rights.

The major challenge of the intervention is that it seeks to address a subject that has a lot of sensitivities among members of the public and leadership. Even though the constitution of Swaziland ascribes basic rights, the subject remains contentious. Addressing issues of human rights is also a challenge, because adopting policies and amendments (as well as enactment of laws) is often bureaucratic and takes a long time. This is evident in the number of draft policies, old laws, failure to domesticate international conventions and declarations to which the country is signatory and delays in aligning existing laws to the new national constitution, which should usher in a new legal dispensation.

### **Social protection and livelihood**

This intervention seeks to ensure access to the basic services of clean water, shelter and proper sanitation, as well as social grants to child-headed households, PLWHA, people with disabilities and bereaved and vulnerable elderly people. While the interest in water, sanitation and social grants is a function of the second multisectoral HIV and AIDS national strategic plan (2006 - 2008), the issue of shelter was introduced during the implementation of the first multisectoral HIV and AIDS national strategic plan (2000 - 2005).

This intervention currently shows no visible achievements. As a strong point, it has a focal point that is charged with the responsibility of facilitating its development. Major challenges involve the serious economic downturn and general poverty Swaziland is experiencing. These factors undoubtedly make it difficult for the national response to address access to basic services by the targeted populations. This intervention also suffers from a disadvantage in that provision of basic services is generally seen to be the responsibility of national governments and as such experiences difficulties in attracting donor and private sector interest.

### **Counselling and emotional care**

This intervention is new and was introduced during the implementation of the first multisectoral HIV and AIDS national strategic plan (2000 - 2005). Its objective is to provide people, especially orphaned children and users of HBC, with emotional and socialisation related support. The intervention also includes issues of child adoption and fostering as well as the provision of peer support through participation in support groups for PLWHA.

The element of support groups is older than other interests of the intervention and was introduced early in the response. This intervention currently has no visible achievements. Its strong points include having a focal point that is responsible for its facilitation and having published a training manual that promotes the standardisation of practice. Similarly, trained community volunteers have been mobilised to provide care and support (including socialisation) to orphans. The establishment of an increasing number of support groups of PLWHA and the establishment of a national network for this group can be considered strengths of the intervention.

A major challenge is the lack of information on the demand for counselling, emotional care and mental health. As a result it is difficult to plan and determine the adequacy of the input that is applied. The intervention currently assumes that all members of the target population require the intervention. The reliance of the intervention on community volunteers poses another challenge, in that the input of volunteers is often inconsistent, given that the beneficiaries are not well-compensated and need close supervision.

### **Community-driven interventions**

This intervention is new and a function of the current national HIV and AIDS strategic plan. It seeks to promote local ownership of impact mitigation responses through ensuring that communities have the capacity to plan and manage their responses. Some activities, such as enhancing the capacity of chiefdoms and municipalities, have been going on even before the intervention was prescribed by the current strategic plan.

The objectives of this intervention have not been achieved. Most chiefdoms and towns have HIV and AIDS community committees that are responsible for facilitating activities at the local level. These communities implement impact mitigation activities that include HBC, the provision of psychosocial support, the rehabilitation of and shelter for OVCs, feeding and food production. The intervention also has a national focal point. Although impact mitigation services are being implemented in most communities, they are not driven locally.

Planning and budgeting are mostly external functions. Most communities have no capacity to plan and manage local response, nor do they have community response plans of their own. Another challenge this intervention faces is inadequate commitment from local leadership to provide leadership with regards to the local response.

### **5.3.4 Management of the national response**

#### **Institutional arrangements**

This intervention is new and was proposed by the current strategic plan, even though the restructuring of the coordination function of the national response has been an ongoing process. The organisation of this intervention was necessitated by a need to improve the effectiveness of the response and to recognise the increase in the number of partners. Furthermore there was the challenge created by the effective coordination of the different interests. While there are currently no visible achievements under this intervention, there are strengths. This intervention area has a national focal point, coordination sectors, regional and urban coordination focal points as well as regional, chiefdom and municipal coordination committees.

Under the current institutional arrangement, the national response is pursuing horizontal (sector-based) and vertical (community-based) decentralisation. This arrangement has the potential of perpetuating the disempowerment of communities and creating confusion with respect to response agenda setting, the capacity to respond, access to funding and reporting.

The response is therefore likely to be driven by sectors rather than communities. It also makes it difficult for communities to coordinate the response activities of sectors at the local level. Under this arrangement it is difficult to ensure adequate coverage, because targeting is determined by sectors and not by the demand from communities.

### **Planning and programme development:**

This intervention is new to the response. It was introduced by the current national strategic plan even though related activities have been going on from early in the national response. Following the development of the national strategic plan through an extensive consultative process, an all inclusive national plan of action was developed for 2006/2007. Otherwise there are no visible achievements under this intervention.

Strong points of this intervention include the introduction of a process for developing an inclusive national plan of action and managerial commitment within the national response to implement it. This intervention also has a national focal point. Planning and programme development are still very much functions of the national coordination entity and response sectors.

Communities are still not an integral part of the process. While development partners participated in the process of developing the national strategic plan, they were not part of the process of developing the national plan of action. Despite a call for joint planning, some development partners continue to implement their own plans. The health sector, for example, reluctantly participated in the development of the current national strategic plan and is consequently not a part of joint national planning. The sector was also not part of the process for developing the national plan of action, but conducted its own process. Another challenge is that planning is almost always carried out under short notice, which compromises the quality of the plans.

### **Mobilisation and management of resources**

The funding available to the national response from different sources has increased significantly over time, from less than E1 000 000 in the early years of the response to E45 000 000 in the 2007/2008 financial year (Appropriations Bill, 2007). Despite the increased funding, there is a perception that funding for HIV and AIDS is inadequate. This viewpoint is confirmed by a significant financial gap in the first national plan of action, because the development partners who support activities in the country did not contribute directly to the budget of this plan.

The profile of funding sources has not changed much and at present the country has very few such sources. Despite this situation, the national response has not had an official donor conference to mobilise funds. Hence, there is no mechanism through which partners to the national response are required to declare available funding. Information on the extent to which the response in the country is funded is consequently not readily available.

While there are no visible achievements to record in the area of resource mobilisation, the national response can be credited with good management of available resources. Accumulated experience in managing huge amounts of resources by the national coordinating entity is considered a strong point. Another strong point is the availability of a national plan of action.

The mobilisation of additional resources continues to be a major challenge for the national response. Government investment in the response is still not commensurate to the magnitude of the problem. The national response is mostly funded from external resources, with government directly contributing only 24% of the funds that are channelled through NERCHA (National Emergency Response Council, 2006). In addition, government allocation to the health sector falls below the proposed 15% of the national budget target. While the national response has the capacity to manage funding at national level, other levels of the response (especially some civil society organisations and most communities) lack such capacity.

Funding from development partners who are supporting the response is not integrated into the national response budget, as reflected by funding of the 2006/2007 national plan of action. The national response appears to lack the capacity to mobilise resources. This is evident in that while most partners (including the national coordinating entity) have finance and accounting departments or units, they do not have a resource mobilisation component or units. Resource mobilisation is consequently generally a part-time responsibility.

### **Advocacy and communication**

The current national strategic plan prescribed a dedicated advocacy and communication intervention, with the view that the intervention would promote a culture and capacity to engage in advocacy and lobbying work for the response, promoting interest at all levels. While advocacy and lobbying have been going on since the national response to HIV and AIDS came into being, current efforts were not sufficient. There are no visible successes under this intervention. The only strength is that the intervention has a national focal point, otherwise it is undeveloped.

### **Crosscutting issues**

This is a new intervention, even though crosscutting issues are not new to the national response. These include gender, human rights, poverty and other socio-cultural issues that have implications for HIV and AIDS prevention and impact mitigation. It was hoped that addressing such issues would improve the effectiveness of the response. There are currently no visible successes under this intervention. The only strength is that the national response has organisations that have expertise in these areas that can assist in the development of the intervention.

### **Monitoring and evaluation**

This unit is new to the national response. Some of the work of this intervention was done by an epidemiologist under the health-based response. The intervention was developed in response to requirements of “the three ones” principle, the Global Fund and the need to document performance of the national response. There are currently no visible achievements in meeting the objectives, but a lot has been done to develop the intervention.

At national level a fully staffed dedicated unit has been developed. A monitoring framework and plan of action have also been published. These developments have been taking place through a consultative process. As a result ownership of products that are generated by this intervention is expected to be high among stakeholder organisations. Skills development activities have been carried out to capacitate partners. While the capacity of the health sector to monitor and evaluate health activities has been strengthened, human resource capacity remains a challenge. The ability of the sector to create an accurate picture of what is going in the response and generate the required information products, given the information gaps that still exist, is consequently compromised. The problem of human resources extends to most partners in the national response.

### **HIV and AIDS research**

This intervention is new to the national response. It arose from the realisation that the intervention is generally weak and that research structures were limited or nonexistent. There are currently no visible achievements under this intervention, but it has a national focal point. The process to develop a strategic plan and a research agenda has been initiated. These instruments are to be developed through a strong consultative process. It is important to note that the national response has a limited research capacity, especially in terms of research skills.

## 5.4 THE NATIONAL RESPONSE IN THE CONTEXT OF THE HUMAN DEVELOPMENT FRAMEWORK

### 5.4.1 Choices made available by the national response

The national response has made it possible for the Swazi population and the implementing partners to have a number of choices available to them in the context of the prevention of HIV transmission, treatment, care and support as well as impact mitigation.

#### Prevention of HIV transmission

Table 5.3 presents the current options that have been made available to individuals regarding protection against HIV infection through heterosexual sex.

**Table 5.3: Options available for the prevention of HIV transmission**

Record of sexual behaviour		Option now to . . .			
		Abstain (without sex)	Be faithful (with unprotected sex)	Use condoms at all sexual encounters	
<b>Have been</b>	Abstain (without sex)	<ul style="list-style-type: none"> <li>Continue delaying sexual initiation (primary abstinence)</li> <li>Continue without sex after sexual initiation (secondary abstinence)</li> </ul>	<ul style="list-style-type: none"> <li>When your partner is negative</li> </ul>	<ul style="list-style-type: none"> <li>With any sexual partner of unknown sero-status</li> </ul>	
	Faithful to partner (with unprotected sex)	Both partners are negative	<ul style="list-style-type: none"> <li>In the absence of one's partner (secondary abstinence)</li> </ul>	<ul style="list-style-type: none"> <li>Continue with fidelity if your partner is still negative</li> </ul>	<ul style="list-style-type: none"> <li>If in doubt of regular partner's sero-status</li> <li>With any other new partner of unknown or positive sero-status</li> </ul>
		Partners are discordant	<ul style="list-style-type: none"> <li>In the absence of one's partner (secondary abstinence)</li> </ul>	<ul style="list-style-type: none"> <li>Continue with fidelity, but no sex without condom</li> </ul>	<ul style="list-style-type: none"> <li>With partner as usual</li> <li>With any other new partner</li> </ul>
	Use condoms at all sexual encounters		<ul style="list-style-type: none"> <li>When a condom is not available</li> <li>When your partner refuses to use a condom</li> </ul>	<ul style="list-style-type: none"> <li>If both partners are negative</li> </ul>	<ul style="list-style-type: none"> <li>With a CSW, non-regular sexual partner or discordant regular partner</li> <li>For discordant couple</li> </ul>

In addition to the prevention options above, the following options have also been made available:

- Male circumcision used concurrently with abstinence, being faithful or using a condom
- PMTCT services, particularly for young women and those of childbearing age
- IEC materials – a range of information, education and communication materials accessible through personal contacts, groups and mass media approaches
- VCT services that allow one to make an informed decision about prevention, including a wide range of other HIV and AIDS related services

## **Treatment, care and support**

The national response has made it possible for the Swazi people infected and affected by HIV and AIDS to be able to choose from a continuum of health and social services:

- ART
- Treatment of STIs and opportunistic infections
- Treatment of TB and malaria
- Psychosocial support
- HBC
- Palliative care

In all these cases the services have been made available by the national response. It remains the decision of the individual to access and utilise the services or for an implementing agency to provide the services in a given community or location.

## **Mitigation of impact**

In this area the national response has identified a number of services specifically targeting OVCs. Services have also been made available for the provision of micro-finance and income generating activities, to women in particular.

## **5.4.2 THE NATIONAL RESPONSE AND HUMAN DEVELOPMENT GOALS**

### **Achievement of a long and healthy life**

Life expectancy as an indicator of the quality of life is estimated to have declined from 60 years in 1997 (CSO, 1997) to 33,5 years in 2006 (VAC, 2003), mainly due to an increase in HIV and AIDS related mortality. This means life expectancy in Swaziland has fallen below the 1966 level of 44 years. Many years of investment and progress in improving the quality of life of the Swazi people have been lost in the process. In order to recapture the experience of a long and healthy life, a number of interventions that sought to reduce child and maternal mortality as well as the impact of HIV and AIDS on human development (including the control and management of TB and other AIDS related illnesses) have been implemented.

### **Achievement of a decent standard of living**

According to chapter two, human development can be achieved through eradicating hunger and poverty, assuring environmental sustainability and establishing a global partnership. Out of these three MDGs, the national response is addressing the eradication of poverty and hunger, which is a multisectoral concern. The national response to HIV and AIDS is contributing to this goal from the perspective of addressing food security needs, and providing HBC and ART.

### **Achievement of a knowledgeable life**

Achieving this human development choice falls within the primary mandate of the Ministry of Education. The contribution of the national response to HIV and AIDS arises from the need to ensure that OVCs do not drop out of school. This intervention can be described as one of the most promising efforts of the national response. Without this intervention it would be impossible to reach the goal of universal primary education, as there are currently more than 150 000 OVCs in Swaziland, together with the extent of poverty in the country as described in earlier chapters.

In addition to supporting the participation of OVCs in formal education, the response is developing an informal education programme for children who for some reason cannot attend formal schooling. These two approaches not only provide education to OVCs, but ensure that the education system is utilised as an avenue for empowering the youth by providing them with the relevant information for protecting themselves against HIV and AIDS. In this way, the beneficiaries are not only empowered regarding HIV and AIDS, but are also better empowered to live a prosperous and meaningful life in the greater community and economy of the country.

### **Achievement of full participation in the national response**

The national response addresses gender equity and the empowerment of women under crosscutting issues that require gender and human rights to be mainstreamed. There is indeed a need to address gender as part of the national response to HIV and AIDS because of the disadvantaged situation of women and gender inequality in Swaziland, as was observed in the current national strategic plan (2006 - 2008). This is due to the unquestionable power of men to make decisions regarding sexual matters, one of the main drivers of the pandemic in the country. Intergenerational sex was also identified as a driver of the pandemic. Both these situations have been addressed by ensuring that women are increasingly becoming key partners in the planning and implementation of the national response to HIV and AIDS.

With respect to the participation of men and women in the provision of response services such as HBC, psychosocial support and care for OVCs, women and girls carry most of the burden. This notion is confirmed by an unpublished HBC needs assessment study that was carried out by the urban response. This indicated that HBC in towns was provided mostly by women and girls, with insufficient participation from men (AMICAALL, 2004).

### **5.3 CONCLUSION**

Several conclusions can be drawn from the discussion in this chapter. Firstly, the national response has generally made reasonable progress in addressing the pandemic. This has resulted in what appears to be the beginning of the levelling of HIV prevalence in the country over the past two years, especially among young people. The response is undoubtedly comprehensive, in that it attempts to address all aspects of the pandemic.

Significant progress has been made in some intervention areas, including public HIV and AIDS awareness, blood safety, antiretroviral treatment, PMTCT and support for OVCs. Interventions that still require significant input include behaviour change communication, TB, prevention and the management of opportunistic infections and STIs, pre-antiretroviral therapy, home-based care, response management in general, VCT and the protection of legal, ethical and social rights among others. Effort is also needed in quantifying the positive or negative contribution of the Swazi culture and traditions to the pandemic.

## **CHAPTER 6: POLICY AND STRATEGIC OPTIONS**

### **6.1 SETTING THE AGENDA FOR ACTION**

#### **6.1.1 Introduction**

One of the tenets of an HDR is that it should generate discussions among the population, so that the various options can be assessed critically. Such an assessment should be followed by the development of new policies and, where appropriate, a review of existing policies that provide an enabling environment for national response and realistic interventions that can be readily implemented. The aforementioned policies and interventions consequently result in a sound basis for development partners to provide technical and financial assistance to the government and people of a country. This chapter presents some of the possible policy and strategic options that need to be widely discussed in Swaziland if the pandemic is to be tackled successfully.

#### **6.1.2 The pandemic**

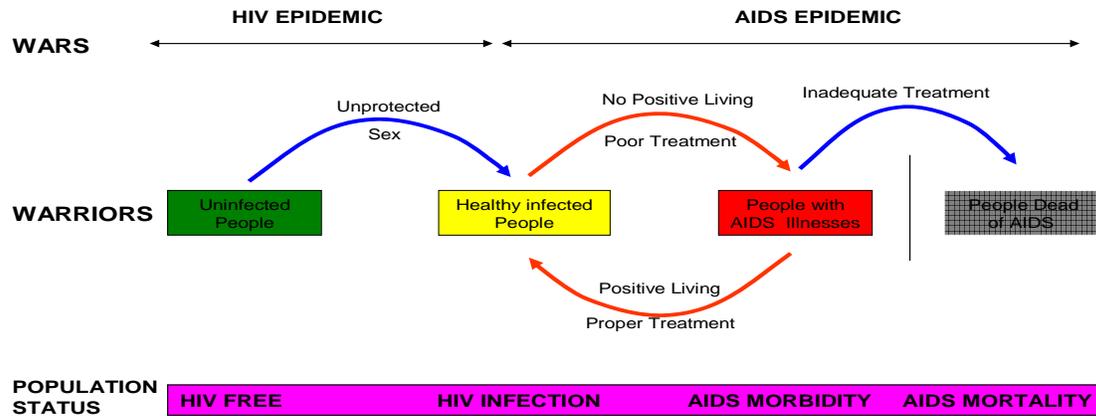
The poor performance of Swaziland's economy is affecting the development of the country. Swaziland's HDI, GDI and the annual GDP growth rate have all declined since the 1990s, while the HPI of the country is one of the highest in the world. This implies that the choices of most Swazis to human wellbeing are limited. Although many factors account for this declining socio-economic situation, it was noted that HIV and AIDS are major factors in (a) negating the country's prospects of achieving its MDG targets and (b) making it difficult for the citizens to achieve a decent standard of living, have a long and healthy life, be educated and participate effectively in the national development endeavours.

The deteriorating situation also exposes the population to greater vulnerability to HIV infection and to a deeper inability to mitigate the health and socio-economic impact of the pandemic. With the highest prevalence of HIV infection among pregnant women in the world, Swaziland is indeed faced with a very serious epidemic that, if left unchecked, threatens the viability of the Swazi nation as a functioning geopolitical entity.

HIV and AIDS in Swaziland can be considered as a situation of two invading enemies confronting the country that have to be fought aggressively (figure 6.1). The invisible HIV invasion, which is noticeable by the high prevalence of HIV among ANC attendees in Swaziland and in the general population, reflects how the virus seems to be apparently winning the fight by continuously attacking and recruiting more children, youths and adults from the constantly diminishing proportion of the uninfected population. On the other hand there is the AIDS fight, detectable by (a) the number of people who have opportunistic infections, are bed-ridden or have died of AIDS related illnesses and (b) the impact at individual, community, sectoral and national level of the direct and indirect consequences of AIDS related morbidity and mortality. This scenario reflects how the nation is losing its people and resources to the deadly pandemic.

Unfortunately a person recruited into the HIV infected pool remains permanently able to infect other people by being a potentially effective sero-converter of a partner through unprotected sex. They are also potential candidates for contributing to the AIDS related morbidity and/or mortality status and statistics in 5 to 10 years after becoming HIV positive. A decline in HIV prevalence among ANC attendees from 42,6% to 39,2% was noted between 2004 and 2006, but this is still unacceptably high. The prevalence indicates that the national fight against HIV and AIDS will most likely intensify within the next several years, while the biologically vulnerable population of Swaziland will continue to offer a potential target for more HIV infection in the future.

**Figure 6.1: The HIV and AIDS pandemic**



Against this background it was noted in chapters one and three that in Swaziland culture is intertwined with governance and the social life of the population. The consequence is that its dynamics are not in tandem with the dictates of the twin HIV and AIDS wars the country is unsuccessfully grappling with. This is because some of the cherished traditional practices, norms and beliefs that helped shape and model Swaziland are unfortunately applied only selectively and conveniently by many individuals. As a result more and more Swazi people are engaging in activities that increase their vulnerability to HIV infection and other STIs.

In the past the consequences of such actions would not have had such a far reaching impact as today because, unlike HIV and AIDS related illnesses, the other STIs that existed were curable. The cultural practices that could curb the spread of HIV and/or mitigate the impact of AIDS on health and socio-economic development are also not adequately utilised because of legal, economic and social concerns linked to culture. The consequences of such cultural actions are not only escalating the HIV and AIDS pandemic, but also threaten the economic development of the country and the very existence of Swaziland.

Numerous responses to the pandemic were presented in chapter five. The indication that HIV prevalence rates are either stabilising or declining in some Southern African countries such as Zimbabwe and Zambia is testimony that it is possible to combat HIV successfully and therefore reverse the trend in the pandemic in Swaziland.

Fortunately a slight downward trend in the pandemic was recorded for the first time in Swaziland between 2004 and 2006, which is very encouraging. It also shows that it is possible that the severe impact of the pandemic, as discussed in chapter four, can be reduced and that the war against HIV and AIDS can be won, resulting in the improved socio-economic situation of the country. Swaziland is faced with the enormous challenge of confronting the enemy, the HIV and AIDS pandemic, with all available means and resources. This chapter presents some of the actions that could be implemented to contain the pandemic.

## 6.2 LEADERSHIP OPTIONS

In the fight against the HIV and AIDS pandemic it is critical to have committed leadership, empowered to mobilise and inspire the citizens to participate in the fight effectively and to support the development and implementation of the necessary legal instruments and policies for guiding the national response to the pandemic.

### Box 6.1: Exemplary leadership in the fight against HIV and AIDS in Uganda

The unprecedented political commitment and advocacy by the country's leadership was a fundamental and critical factor. The president personally carried out education campaigns countrywide, encouraged open debate, called for the provision of timely, accurate information by technical people and urged political leaders to put HIV and AIDS high on their agenda.

The active involvement of religious, traditional and other leaders with their well-established structures, audiences and influence was an important strategy for combating the epidemic. Early and sustained sensitisation and participation in HIV and AIDS education, advocacy, care and support; inclusion of the leaders in the Uganda AIDS Commission and other decision-making organs at different levels; allowing interested groups and institutions to map out their own response within their mandates, beliefs and traditions enhanced the national capacity. (UNDP, 2002)

In Swaziland the King, who is both the head of state and the traditional leader, has legislative, judicial and executive powers. This is in the context of the dual system of government, in which the modern government (led by a prime minister) and the traditional system of governance (run by chiefs who report to the King directly) operate concurrently.

Using his authority and powers, King Mswati III declared HIV and AIDS a national disaster in February 1999. In February 2004 the prime minister gazetted a declaration of the national disaster. These high-level proclamations need to be echoed by all political, administrative, traditional and religious leaders, as well as various professional and civic leaders in the communities, continuously in order to inculcate in the minds of the entire population that Swaziland is at war with HIV and AIDS and that all leaders must guide the fight at their respective levels.

Leadership also implies that those who occupy leadership positions should at all times be role models, as expected in the Swazi culture, without exploiting their position over those of their subordinates and thereby increasing the potential for the spread of HIV infection in the country.

The only available option in this regard is to create a culture of responsibility in which leaders are responsible, respectful, committed, individually motivated and continuously guiding the national response. This culture must permeate the entire Swazi population, in workplaces and institutions, including educational, government, religious and civil society entities and organisations. The leaders must enable the population to learn from past mistakes, best practices and current local and international evidence available to update their knowledge and understanding of the dynamics and drivers of the pandemic so that communities, families and individuals can quickly adapt their response in order to break the cycles and pathways of HIV transmission.

In view of the above, a firm commitment is required from the King and the royal family on HIV and AIDS, providing a good role model for a society who love and idolise their King and obey his authority. Participants in FGDs suggested that mandatory testing has to be made a requirement of every Swazi. If sanctioned by the King, it can be a success. They also suggested that such services as VCT should be available at all traditional events such as the reed dance, *incwala* and *emaganu* where people come in big numbers to pay allegiance to the King. The men in FGDs were particularly optimistic that during such occasions no one would avoid taking the HIV test when an order has come from above. Lobbying the King and other influential members of the royal family can therefore produce desirable results as Swazis still respect the power of the monarchy.

The involvement of the chiefs in HIV and AIDS programmes is also critical. For instance, the chiefs need to be targeted for specific HIV and AIDS interventions that are currently meeting with resistance, such as promoting safer sex practices, HIV testing or knowing one's status, and other behavioural change issues. In this case the chiefs (*libandla*) are an important lobbying group, as they advise and decide on all matters pertaining to the community's welfare.

## **6.3 PREVENTION OPTIONS**

### **6.3.1 Information, education and communication (IEC)**

The prevention of new HIV infection among all the people in Swaziland is an "insurance" against future needs for ARVs and drugs for the treatment of opportunistic infections (OIs). Prevention also reduces the future burden of care and support that is required due to HIV and AIDS related morbidity and mortality, as well as new cases of AIDS orphans and their associated basic and development needs. As a first step to this effort people must be informed about the pandemic. One of the most important areas in the national response to the HIV and AIDS pandemic is consequently the provision of accurate, targeted information that can help different categories of people to make informed decisions.

In the past, IEC materials tended to be generic. Today it is important for the country to focus on the information needs of the different segments of the population. With the emergence of many FM radio stations, it is also important to combine IEC with, for example, radio talk shows and jingles that listeners can participate in through phone calls and the like.

Theatre and drama should be used as another mechanism for reaching many people. TV broadcasting in Swaziland is currently dominated by programmes from South Africa. It is important for national TV to be proactive in documenting HIV and AIDS activities in Swaziland and screening them, so that many viewers can benefit from information conveyed through various experiences. Similar programmes and best practices from other parts of Southern Africa and elsewhere that the Swazi viewers can gain from can also be sourced.

An important communication medium that is usually taken for granted is newspapers. The gainful use of newspapers requires that the journalists and scribes be fully informed about HIV and AIDS, so that they can be advocates in the fight against the pandemic. Another important avenue of disseminating information to the population is a question and answer website, establishing serialisation in the newspapers and creating radio/TV programmes that can be documented and printed in booklet form for dissemination to the population. The key element in all this is to provide relevant information packaged in different formats continuously, while engaging the communities in the development of the packages.

IEC materials and campaigns should be accompanied with options that enable the targeted beneficiaries to take some form of action, such as soliciting additional information, changing behaviour or accessing HIV and AIDS and reproductive health related services. They should also enable the beneficiaries to understand the HIV and AIDS situation better.

It is through this effort towards making IEC materials universally accessible to the different population segments and to the various vulnerable groups that various HIV and AIDS related goals can be achieved: (a) prevention through abstinence, fidelity and the consistent, correct use of condoms; (b) care and support through motivation to access services such as VCT, PMTCT, ART, STIs and treatment for OIs; and (c) psychosocial support to all the segments of the population, including orphans, out of school youths, PLWHA, CSWs, widows, widowers, men and women.

It was mentioned earlier that in order to have a meaningful and effective prevention campaign, there is a need to focus on the various categories of the population separately. In this regard the Swazi culture institutionalised segmentation and regimentation in order to ease the administration and transfer of certain norms and values to the membership of a given category of the population. This traditional wisdom and practice need to be adapted to the national response to the HIV and AIDS pandemic. Prevention campaigns need to target the different categories of the population, as discussed below.

### **6.3.2 Targeting population**

#### **Young people**

From the analysis of the drivers of the pandemic, certain observations of the Swazi youths' sexual behaviour became clear: (a) adolescents are engaging in sex at an early age; (b) out of school youths are more involved in sex than those in school; (c) girls are more likely to engage in sex earlier than boys of the same age; and (d) young people have 2 to 4 sexual partners on average, though the number is higher for boys than girls. The HIV prevalence among young women was consequently far higher than among young men of similar age groups.

Against this background it was also noted that almost 40% of learners enrolled in primary schools do not complete their primary education. When they drop out of school, they are not only in the unskilled adolescent age group, but they also join a burgeoning labour force seeking jobs in a poorly performing economy. This situation is a recipe for the spread of HIV, unless an aggressive targeted prevention campaign is embarked upon.

In the past most prevention messages did not address the youth specifically. Yet, the sexual inexperience of the youth, a lack of knowledge about sexuality and reproductive health and a lack of life skills leave these groups at a serious disadvantage. Even among the young people the circumstances and predisposing factors to HIV infection differ among girls and boys, schoolgoing and out of school youths, orphans and non-orphans and female and male-headed households in the communities.

It is therefore necessary to create policies that enable young people, especially girls, to remain in school as long as possible. With the necessary support, policies must also integrate HIV and AIDS into the school curriculum, as well as enhance vocational training and the provision of seed resources for facilitating self-employment of the out of school youths that graduate from the vocational training centres.

Besides targeted prevention education, a deliberate effort has to be made in formulating policies and laws that punish adults who indulge in sex with youths and under-aged children. In this regard, the cultural practice that promotes abstinence and fidelity not only needs to be advocated by all leaders, but punishment for defaulters needs to be more severe if the public are to adhere to it. In the absence of this cultural practice, a law that inflicts a heavy penalty on culprits who have sex with minors that may result in HIV transmission is urgently required. In Uganda, for example, defilement is punishable by life imprisonment.

## **Women**

Women have productive, reproductive and community management roles in society. In Swaziland, as in most African countries, more women than men are HIV positive. This disproportionately large assault on women by HIV and AIDS significantly affects their contribution to human and national development in Swaziland. Additionally, the women were found to be in a more disadvantaged situation than men in terms of vulnerability to HIV infection due to their biological and socio-economic circumstances, as well as their heavy workload in caring for and supporting babies, orphans and sick people.

Swazi women are seriously disempowered and incapacitated by cultural norms and practices that do not allow women to be proactive and equal partners in decision-making regarding sex. They are also not allowed to access, inherit and/or own resources and instruments for economic production from their parental or marital family.

This situation illustrates the urgent need for women to be empowered with adequate and accurate information about the pandemic and reproductive health in a form that addresses their various predicaments, while enabling them to make informed decisions on sexual matters. Women should not be constrained in freely making personal decisions on when to have sex, with whom, how frequently and with or without protective devices (e.g. female condoms). This requires boldness in terms of policies and/or laws that boldly address the subordinate roles of women in sexual matters. Similarly, policies that reinforce the ability of women to own property and resources that enable them to generate income, earn a living and be self-reliant are long overdue in Swaziland.

## **Adults**

The Swazi culture and traditions encourage women to respect men. This leadership role of men extends to sexual relationships. In the Swazi culture, married women are treated as minors who are subject to the leadership of their husbands. Men are expected to initiate relationships between males and females, including sex. Men determine where, when and how sex happens. Sexually assertive women are branded as harlots.

It is culturally expected and more acceptable for men to engage in a relationship of a sexual nature with a much younger female companion than is the case for women. This practice encourages the domination of sexual relations by men. The ability of women to make decisions to protect themselves against HIV and other STIs are consequently limited by the Swazi culture.

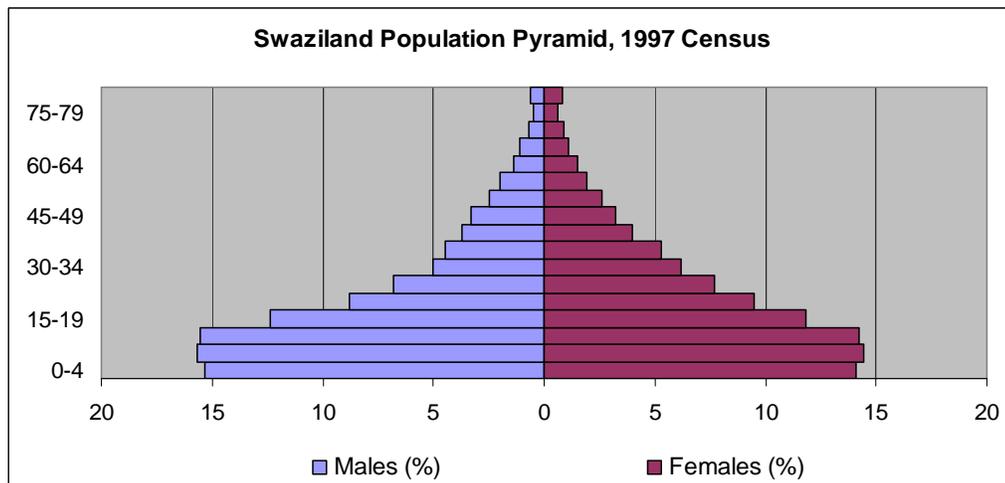
The role of providing social services in families and the community at large within the Swazi culture falls under the responsibility and domain of women. Men tend to be responsible for generating family assets, providing shelter and security and giving political leadership in family and community settings. Women appear to have naturally extended their cultural responsibilities into the national response, whereas men have not.

As a result, women have to supplement the responsibilities of men in the response. Because of this default arrangement, women carry the bigger burden of the response. The overwhelming needs of the response and the fact that women are also suffering from the effects of the pandemic, makes the situation quite challenging. Men are not making a full contribution to the national response, as is culturally expected of them. To address this shortcoming it is necessary for the country to think seriously of a domestic relations bill that redefines the roles and relationships between adults in marriages and other sexual unions.

## Children

The population pyramid of Swaziland in 1997 in figure 6.2 shows that more than 40% of Swazi people are youths, i.e. younger than 15. This could be a blessing in disguise, because the HIV prevalence in this group is less than in the adult population and presents a window of opportunity for preventing the further spread of the pandemic. This is because most of the children in this age group are not yet sexually active. Being pre-adolescents, they are at a stage where it is relatively easy to inculcate values, appropriate practices and skills that encourage abstinence before marriage and fidelity once they are married. Furthermore, these children are either in schools being empowered for self-actualisation and reliance for personal development or they are at home, receiving parental guidance. It is therefore important for the government to establish appropriate policies and regulations in child protection to curb the effects and impacts of sexual and other abuses by adults.

**Figure 6.2: Swaziland population, 1997 census**



Source: Population Census 1997

Because of the large size of the population in this age group, there is potential for the pandemic to be sustained and indeed worsen if current sexual behaviour does not change. To illustrate this point, the youths who were teenagers in the 15-19 age group in 1994, when the prevalence of HIV among ANC attendees was relatively low at about 5%, did not change their behaviour. Ten years later in 2004, when they had reached the age group of 25-29, the prevalence rates among the members of this cohort had soared to 56,3%. Once again, this calls for action from government and cultural leaders to enable adolescents and young people to get back to school, practise abstinence and use condoms.

### **6.3.3 Condoms**

In all the countries where there has been a stabilisation or a decrease in the trend of HIV infection, the use of condoms has been one of the major contributing factors. Condom use can offer protection from HIV as well as other STIs. However, a more aggressive campaign and policy on condom use is required, particularly to adults who engage in sex with non-regular partners, spouses who are separated for long periods of time, spouses in a situation of discordance in HIV infection, as well as CSWs.

Once condoms have been made easily available, Swaziland should explore the possibility of having a law regarding deliberate infection of a sexual partner with HIV. In the meantime, the implementation of the policy of making condoms easily available to people who need them should be closely monitored.

### **6.3.4 Prevention of mother to child transmission**

For the Swazi nation to continue to exist there must be more births. If newborns are already infected with HIV, it will not only be difficult to care for them, but many of them may not survive to adulthood. If they did survive, they will most likely infect their sexual partners in the future.

Deliberate efforts are consequently required to prevent unwanted pregnancies among women living with HIV and to prevent transmission among prospective parents. All women in the childbearing age group and their partners need to be encouraged to access HIV prevention and reproductive health and family planning services.

At the same time, all pregnant women should be encouraged to attend antenatal clinic and PMTCT services. It was noted that only 80% of pregnant women attended ANC services. Out of the 90% who tested, only 39,5% received counselling and 52,1% of the women who tested positive received antiretroviral treatment.

One of the reasons for the low level of response is that men do not always support their spouses in this intervention. A policy is required to make it mandatory for a man and his pregnant spouse to attend a PMTCT session together at least once. In addition, a deliberate policy of integrating PMTCT as an important component of all cultural practices and norms related to procreation would be necessary to sensitise the community on the needs of men participating in the antenatal clinic visits.

### **6.3.5 Male circumcision**

Swaziland is considering introducing circumcision as an intervention for safer sex. This consideration is based on studies conducted in South Africa, Kenya and Uganda, providing evidence that circumcision reduces the risk of acquiring HIV infection (chapter three). In Swaziland circumcision used to be a cultural practice (Government of Swaziland, 2006). On a scientific level, male circumcision is also known to eliminate other health conditions, such as phimosis, paraphimosis and balanitis. At the same time it reduces the likelihood of urinary tract infections and cancer of the penis or cervix.

The benefits of circumcision to women will be indirect. The HIV prevalence among men will fall, resulting in lower transmission rates from men to women. There are a number of challenges and issues that need to be addressed before an appropriate policy on circumcision can be formulated.

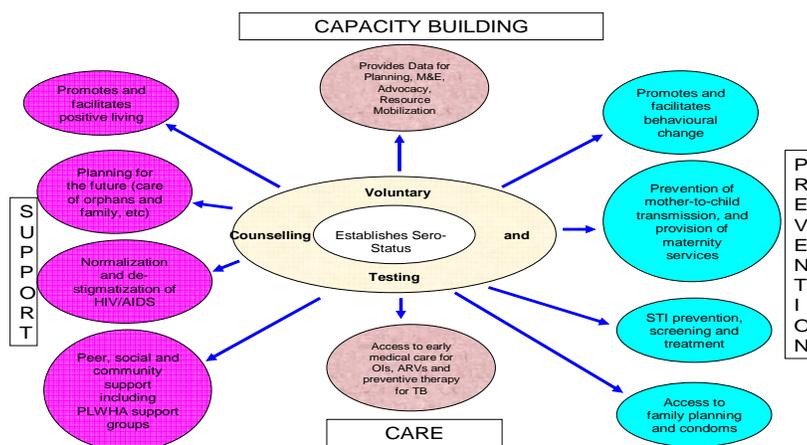
A recent study on male circumcision and HIV and AIDS by Sawires et al (2007), identified 14 issues pertaining to male circumcision as a prevention strategy: (a) determining acceptability, (b) communicating the benefits of male circumcision, (c) defining risk, benefit and harm reduction, (d) providing a framework for a combined prevention strategy, (e) funding social and behavioural research and fighting gender inequality, (f) defining the effects of male circumcision on women, (g) taking care of religious and cultural beliefs and practices, (h) when to circumcise, (i) male circumcision versus female genital mutilation, (j) safety and complications, (k) health systems, (l) the broader context of sexual and reproductive health, (m) addressing perceptions of inequitable power relations, and (n) avoiding branding men as perpetrators of infection.

A national male circumcision task force has been formed, with a broad representation from the government, NERCHA, the medical profession, UN agencies, civil society, the media, traditional authorities and PLWHA. While awaiting the results from international studies and approval by the government, the task force is already developing tools for guiding safe circumcision practices, formulating guidelines for standard surgical procedures, determining needs capacity and the acceptability of male circumcision, developing a male circumcision monitoring and evaluation plan, IEC as well as formulating a behaviour change and resource mobilisation strategy.

### 6.3.6 Voluntary counselling and testing

There is an increasing demand for VCT in Swaziland. This is probably because of the availability of ARVs, which is a major motivating factor for people to test. They believe that if they test positive for HIV, treatment will be provided. Figure 6.3 shows the different type of services that are available to a VCT client, depending on the outcome of the test. Because of the high value associated with proper counselling and testing for HIV, it is imperative to open more sites with appropriate staffing and facilities in easily accessible places in Swaziland. NGOs could play a key role in this regard, in addition to the importance of the integration of VCT in the normal health delivery facilities. The latter may prove more difficult: As counselling is usually a relatively long and time-consuming undertaking, it requires more time from the conventional health staff.

**Figure 6.3: VCT as an entry point for targeting the national HIV and AIDS response**



Source: UNAIDS (2002)

VCT needs to be accompanied with extensive programmes that address the attitude of people before and after the HIV test. If they do not change their attitude, behaviour and practices after VCT, it ceases to be an opportunity for entering other services. It is necessary that government and cultural leaders advocate for the integration of VCT in other health care services (such as PMTCT, the treatment of STIs and reproductive and primary health care) and for youths and adults, particularly those who are already sexually active, to go for VCT periodically.

Another action point that has to be explored is the case of making HIV infected sero-status a noticeable condition, so that people who are infected are legally required to inform their sexual partners. This measure would help protect the non-infected from the infected who deliberately want to spread the virus.

### **6.3.7 Involvement of people living with HIV and AIDS**

The fight against the spread of HIV infection persists as many people living with the virus continue to engage in unprotected sex, resulting in the transmission of the virus to unsuspecting sexual partners. It is only logical that if each person living with the virus is responsible and lives positively, new infections can be averted.

To date, this potentially large reservoir of resources remains largely untapped. This group could however be the most dynamic, relevant and powerful agents in the prevention of HIV infection. For this to happen, a person should know their sero-status. PLWHA also need to be empowered with information and skills to make appropriate decisions regarding their sexual life and their engagement in the fight against HIV and AIDS.

#### **Box 6.2: Potential areas of involvement of PLWHA**

UNAIDS has adopted Greater Involvement of PLWHA (GIPA) as a principle in the national response to HIV and AIDS pandemic.

Accordingly, it has identified seven potential areas of involvement of PLWHA:

1. *Personal involvement*: Active involvement in own health and welfare (e.g. self-education on matters relating to HIV and AIDS prevention, treatment, care and support) and engagement in prevention activities (e.g. positive prevention such as involvement in prevention activities).
2. *Treatment roll-out and preparedness*: Support of treatment roll-out through educating other people living with HIV on treatment options.
3. *Policymaking process*: Participation in the development of HIV related policies at all levels.
4. *Programme development and implementation*: Provision of knowledge and skills and participation in the choice, design, implementation, monitoring and evaluation of projects.
5. *Leadership, support, group networking and sharing*: Leadership of HIV support groups, resource seeking, encouragement of participation of new members.
6. *Advocacy*: Work towards law reform and promotion of access to services.
7. *Campaigns and public speaking*: Involvement as spokespersons in campaigns or at public events (UNAIDS, 2006).

Stigmatisation can negatively affect the involvement of PLWHA in the national response. Once someone living with HIV or AIDS is stigmatised, they may go underground and continue to infect other people. In this regard, the government and all leaders should aggressively campaign against stigmatisation, while encouraging PLWHA to share their sero-status with their sexual partners.

The possibility of making HIV infection notifiable should be considered. A policy to provide incentives and recognition for PLWHA that willingly join in advocacy and general campaigns on HIV and AIDS to the population is required. This emphasises the culture of responsible behaviour that was advocated earlier.

## **6.4 CARE AND SUPPORT OPTIONS**

### **6.4.1 Provision of ARVs**

A deliberate effort to reverse the decline in life expectancy in Swaziland is needed. Since it is strongly linked to AIDS, the fall in life expectancy will be ameliorated with a decline in new HIV infections. For people who are already infected, Swaziland should aim at putting a substantial number of ARVs at their disposal, so that more PLWHA can live a longer and healthier life. To date there are many types of medication that can help PLWHA live a healthy life.

In the Swazi culture a household member who becomes sick is encouraged and supported to seek medical treatment. In this regard, the country has done well by increasing the number of people on ART from 660 in 2003 to 16 960 by December 2005, surpassing the target of 13 000 beneficiaries.

While these statistics are impressive, ARVs come with a number of critical concerns that must be addressed. Firstly, a person on ART must adhere to the treatment regime daily. Secondly, the person remains on ART for life. Thirdly, while the person remains infective, the virus may develop resistance to the medication and undermine its efficacy if they do not stick to the treatment regime. The infected person will consequently transmit a strain of the virus that is resistant to medication to their sexual partner, which complicates the situation.

These scenarios have a number of implications. The first question relates to how the population should encourage people on ART to stick to the treatment regime. Most of the medication is provided through programmes that are externally funded. Swaziland must find a way to maintain everyone on ART if donor support should dwindle.

Another problem is that the country must ensure that there is no complacency in the population, since the availability of ART can reduce the fear of becoming infected with HIV. These questions and others require bold policies by the government and serious advocacy by all the leaders that constantly engage their subjects in issues relating to ART. The government must make sure that the necessary resources are provided to make ART available at all times. People must also be encouraged to live positively and responsibly.

Although ART is expensive and difficult to manage, the value derived from it more than compensates the costs involved: ART defers morbidity and mortality (thereby prolonging and extending productive life), prevents children of PLWHA from becoming orphans and keeps the family and community together.

#### **6.4.2 Management of STIs**

It is generally known that HIV sero-conversion is highly associated with the presence of STIs, particularly genital ulcers and syphilis. The situation in Swaziland not only confirms the strong link between STIs and HIV infection, but also suggests that the control and prevention of STIs is a critical and worthwhile investment in the country. This is because a person with HIV as well as an STI will increase the vulnerability of their sexual partner to contract HIV and STI through sex.

STIs were found to be prevalent among young people and adults. STIs can fortunately be treated and cured, unlike HIV infection, that is irreversible, and AIDS, that has no cure. In order to reduce STIs as a factor in the transmission of HIV, well-equipped laboratories, adequate reagents and medication, qualified medical personnel and effective mobilisation for sexually active people (men and women and their sexual partners) to test themselves for STIs is needed. For people who test negative for HIV antibodies, the presence of an STI should serve as an early warning towards getting HIV infection if their sexual behaviour does not change. This suggests that counselling should be a key component of STI diagnosis and treatment.

#### **6.4.3 Involvement of traditional medicine practitioners (TMPs)**

Considering the interaction between treatment, care and support, it is important to look at the concepts of morbidity and mortality, health seeking behaviour and treatment compliance. In the Swazi culture, illness and death are functions of spiritual activities rather than outcomes of the germ theory and pathogenesis. Because of this understanding of morbidity and mortality, Swazis tend to appreciate traditional medicine more than western style medicine, which they consider as foreign. They would seek the help of traditional healers prior to using western style medication.

Consulting with TMPs, especially in cases where traditional medicine cannot help, leads to lost time. As a result the condition deteriorates and by the time a decision is made to refer the person to western style medication, opportunities for early intervention have been lost. Referrals between the two health systems are furthermore frustrated by a lack of collaboration. The effectiveness of Swazi traditional medicine has not been scientifically tested. The sensitivity of western medicine requires a high level of compliance compared to treatment prescriptions under traditional medicine. This difference in expectations results in non-compliance and treatment failure of western style medicine. The situation requires appropriate policies that facilitate capacity building of traditional medicine practitioners to be knowledgeable about HIV and AIDS and to know their boundaries, so that they can work amicably with modern medicine professionals.

### **6.5 THE MITIGATION OF THE SOCIO-ECONOMIC IMPACT**

#### **6.5.1 Orphans and vulnerable children**

It was reported earlier that out of the total orphans in Swaziland, up to 66% were due to parents dying as a result of AIDS. Some of these orphans are double orphans who have lost both parents. These orphans probably live in child-headed households and may already be infected with HIV due to mother to child transmission or unprotected sex. This scenario urgently calls for action from the government and the communities to provide for the necessary basic, educational and other needs of these children. In the Swazi culture children are cherished as the most important gifts from God to the parents. It is therefore necessary to have policies that provide protection to these children in terms of issues such as education, housing, health, food and nutrition, in addition to the general policies developed to cover the children and young people of Swaziland.

### **6.5.2 Addressing the poverty situation in the population**

One of the key drivers of the HIV and AIDS pandemic is poverty. A situation where a mother is unable to provide the basic needs to her child is a major factor in the woman engaging in high-risk sexual behaviour when looking for resources. In addition, many young girls engage in sex at an early age while in search for simple growth, educational and other needs.

The declining economic situation of the country, serious inequality in wealth distribution, unemployment of 29% (with significant regional disparities), unsafe water sources and a lack of proper sanitation and toilet facilities for 70% of households clearly demonstrate that urgent action is required on the part of the government in providing an enabling environment that can build people's capabilities for human development.

At the macro-level, Swaziland's economic growth rate should increase enough to have a significant positive impact on poverty. This means restoring the economic growth rates of before 1990. It is however critically important that economic gains are more widely distributed than in the past. This will only happen if sectors important to poor people, such as agriculture on SNL, play a significant part in this growth. Measures to increase agricultural productivity on SNL should therefore be devised and quickly implemented. Raising the country's competitiveness in international trade, particularly of manufactured goods, is another way of raising economic growth. This will not only enhance achievement of broad economic growth, but also address poverty, a key factor in the spread of HIV infection.

### **6.5.3 Capacity building for enhancing the national response**

All the interventions that will support the national response, as discussed earlier, require human resources. It was however observed that HIV and AIDS impact negatively on professionals and other types of labour. In the MOAC alone there were around 500 vacancies, mostly due to death and chronic illnesses of field and headquarters workers that could most probably be attributed to HIV and AIDS. In the health sector HIV and AIDS also had a serious impact with staff deaths, illnesses, absenteeism, burnout and low morale, significantly affecting the quality and scope of service delivery.

In the private sector the situation was equally gloomy: High morbidity and mortality of employees due to AIDS related illnesses had significantly reduced productivity and increased production cost, while disrupting business. This had a serious impact on the export orientated agro-estate and manufacturing industry, which contribute to nearly 48% of the GDP. This situation suggests that efforts and policies must be put in place to ensure that training, retooling and other capacity building and retention strategies are adopted by the government and the private sector, if HIV and AIDS are to be contained and the economic decline reversed.

### **6.5.4 Data**

There were various difficulties in gathering secondary data on the pandemic in Swaziland. The following examples of data sources in other countries which do not exist in Swaziland will serve to illustrate this point. In Uganda (a) an HIV and AIDS sero-behaviour survey followed by a home-based counselling and testing survey was carried out in 2004/2005; (b) different cohorts have been studied to provide longitudinal data on HIV and AIDS since the early 1990s; (c) demographic and health surveys are conducted every five years; and (d) evaluation and impact assessment of interventions (e.g. IEC campaigns) and programmes are conducted periodically.

In addition to numerous biological and social studies in neighbouring South Africa, national HIV prevalence, behavioural risks and mass media surveys have been conducted in 2002 and 2005 (Shisana, 2002; Nelson Mandela Foundation, 2005). In Zimbabwe VCT centres provide invaluable data on trends in HIV prevalence among men and women that can be disaggregated by gender, age and type of centre.

When there is data from these sources, triangulation in order to validate and confirm it is possible, apart from looking at the HIV and AIDS situation from many perspectives. Because data from some of these sources is not available, it is difficult to analyse the status of the pandemic from different perspectives, such as desegregation of prevalence by gender and assessment of prevalence of HIV discordance among couples.

Hence, Swaziland needs to invest more in data collection on HIV and AIDS as well as on other socio-economic issues. In this regard it is important to strengthen the capacity of the Central Statistical Office and the statistics departments and units at the universities and tertiary institutions to enable them to collect the needed data and analyse it.

### **6.5.5 Resources**

In order to address the shortcomings discussed in this chapter, financial resources will be required. Firstly, priorities must be determined and the entire course of action budgeted accordingly. This requires a multisectoral approach and mainstreaming HIV and AIDS in the planning and budgeting processes of the government. In this regard, the resources for supporting the national budget have to be mobilised by the government, both internally and externally.

With a declining economy, innovative ways of engaging national stakeholders in (a) business and industrial production ventures in partnership with investors and (b) agricultural production with modern technologies and high-yielding inputs and farm management practices will help increase the GDP and revenue for government.

Prudent macro-economic management is just as important in revamping economic growth. Swaziland will have to adopt sound fiscal management, including cutting excessive expenditure. It is worth noting that some investments critical to building the people's capabilities will have to be analysed and targeted appropriately. The call is consequently not only to cut expenditure, but also to alter and smooth expenditure patterns in areas that are important to poor people.

It is also clear that additional resources will have to be solicited externally from development partners. To date, the Global Fund for AIDS, TB and Malaria, the USA President's Emergency Plan for AIDS Relief (PEPFAR) and others are providing invaluable financial resources to the national response. For this to continue and other development partners to come on board, good governance, transparency and accountability are some of the standard conditions required.

In addition to these, there is a need for the government and the royal family to have a good working relationship with the key partners. In areas where Swaziland is perceived to be weak, slow or divergent in such issues as governance, legislation, justice and human rights, the government, cultural leaders and civil society have to consult and generate appropriate adjustments and/or removals of outdated policies and laws, and work toward the formulation of new policies and laws. In these consultations, tough and bold decisions will have to be made for the purpose of accessing resources from development partners to fast-track the fight against the HIV and AIDS pandemic.

## 6.6 CONCLUSION

Achieving an effective and sustainable national response in the fight against the twin HIV and AIDS wars will largely depend on long-term changes in the behaviour of individuals, communities and the public and private sector in Swaziland.

The government as well as cultural and other leaders must play a pivotal role in campaigning and facilitating this change in behaviour by engaging the entire population in the national response, supporting the development of new social norms and fostering facilitating conditions (e.g. policies) that enhance, encourage, exemplify and catalyse sustainable changes in the attitude, behaviour and practice of people in Swaziland.

In return, the population, communities, families and individuals must not be adamant and resistant to change. They must accept that in an HIV infected globalised and modernising world, their interactions in and outside the country with (a) different nationalities, (b) diverse foreign and indigenous cultures, (c) science and tradition and (d) international and local development imperatives, continuously demand that they change and transform their attitudes with regards to HIV and AIDS, if they are to survive the pandemic.

It is against this belief that this human development report (HDR) has provided options that aim at reinvigorating the campaigns for the recognition and use of cultural norms and practices as entry points to fight HIV and AIDS, and as a result foster sustainable development. It is expected that the suggested options will not be rhetorical, but will be implemented, monitored and adjusted accordingly from time to time.

In this way, Swaziland will not only attain the MDGs and UNGASS targets, but will also ensure that the Swazi people will enjoy a longer life of higher quality while participating in the governance and socio-economic development of their country, with adequate attention given to education and knowledge.

## CHAPTER 7: RECOMMENDATIONS AND THE WAY FORWARD

The above discussion clearly indicates that many players need to be involved in the fight against the HIV and AIDS pandemic in Swaziland. The following messages are for their action:

### Traditional leaders

- ✚ Provide leadership in promoting positive cultural practices and values and appeal to the population to follow them
- ✚ Encourage the population to abandon high-risk cultural practices and values that make them vulnerable to HIV infection
- ✚ Be good role models to the population, especially to the youth who respect the examples of traditional leaders, by practising positive cultural values and refusing to practise high-risk customs
- ✚ Use traditional structures and institutions to mobilise the population to participate in the design, implementation, monitoring and evaluation of HIV and AIDS programmes
- ✚ Support the existing HIV and AIDS programmes under the second multisectoral strategic and action plan
- ✚ Help to strengthen the role of extended families and the community as safety nets against disasters
- ✚ Provide leadership in advocating male circumcision, which will help in the prevention of HIV infection
- ✚ Play a leading role in addressing stigma and discrimination, care and support

### Government

- ✚ Scale up interventions to sustain the recent decline in the prevalence of HIV and AIDS
- ✚ Review and strengthen laws that can be used to protect those groups in society that are most vulnerable to HIV infection
- ✚ Review and revise existing policies related to prevention, care, treatment and the mitigation of the impact of HIV and AIDS with the aim of strengthening them to fight the pandemic
- ✚ Develop guidelines for the implementation of HIV and AIDS programmes
- ✚ Get the MOHSW to be fully involved in the implementation of the current HIV and AIDS multisectoral strategic and action plan
- ✚ Enhance the capacities of data collection and research units in the country to enable them to produce evidence-based information for the planning, monitoring and evaluation of programmes
- ✚ Mobilise domestic and international partners for more financial resources to ensure success of the HIV and AIDS programmes
- ✚ Promote gender equality in all public and private institutions
- ✚ Mainstream HIV and AIDS activities in the public and private sector
- ✚ Provide ART to all who need it
- ✚ Enhance the management of STIs and include prevention and treatment of STIs as an important component of HIV prevention
- ✚ Strengthen the public health system to enable it to handle the HIV and AIDS pandemic adequately
- ✚ Redesign the IEC strategy to ensure the current high awareness of HIV and AIDS is translated into positive attitudes that would prevent more HIV infections and delay the progression from HIV to AIDS
- ✚ Encourage collaboration and cooperation between traditional healers and western medicine practitioners

- ✚ Review the available evidence on the use of male circumcision as a prevention measure and carry out pilot studies to assess its effectiveness and acceptability in Swaziland
- ✚ Invest more in VCT to ensure that proper counselling is done before and after testing to enable positive living and behavioural change as a way to prevent the spread of HIV
- ✚ Make and implement laws and policies preventing discrimination against PLWHA and other marginalised groups
- ✚ Build human capacity through the continuous training of workers in programmes at every level
- ✚ Put more effort into reducing poverty by restoring past high economic growth and promoting investments in the social and productive economic sectors that benefit the poor
- ✚ Improve the implementation of the bursary system for the OVCs to ensure all those who deserve it are assisted
- ✚ Target the drivers of HIV infection in the country
- ✚ Put strategies in place to alleviate the impact of HIV and AIDS on affected individuals and groups
- ✚ Disaggregate data collected in the future to sub-national and lower levels to allow for regional and lower level estimates of development indicators
- ✚ Let the CSOs start calculating human development indices from censuses and surveys on a regular basis, as is done elsewhere

#### **NGOs and community-based organisations (CBOs)**

- ✚ Target vulnerable groups with specific programmes
- ✚ Promote the ABC strategy to the relevant population groups
- ✚ Involve PLWHA and other affected groups in all the programmes that concern them
- ✚ Encourage and educate PLWHA to use condoms consistently and correctly with their sexual partners to avoid infecting or re-infecting them
- ✚ Increase the number of VCT centres and extend them to the rural areas so that the service is more easily acceptable by the rural inhabitants
- ✚ Intensify interpersonal and community-based IEC strategies
- ✚ Extend programmes to the rural areas where most of the infected and affected people live
- ✚ Take prevention programmes to the traditional functions to ensure that people who participate in the functions are protected from high-risk behaviour
- ✚ Train families and communities on how to sustain themselves
- ✚ Train families and communities on how to increase food production and consequently ensure food security
- ✚ Play a stronger role in care and support, as well as impact mitigation

#### **UN agencies and other development partners**

- ✚ Give more support to population groups impacted by the pandemic
- ✚ Involve extended families, communities and affected groups in the planning, design, preparation, implementation and reporting processes of intervention programmes to ensure sustainability
- ✚ Play a stronger role in policy advocacy, capacity building, good governance and the generation of evidence on HIV and AIDS
- ✚ Assist the government with resource mobilisation for HIV and AIDS programmes
- ✚ Use this report to lobby government, private sector, international partners and NGOs for more action in the war against HIV and AIDS

### **Local communities and extended families**

- ✚ Break the silence and denial on HIV and AIDS in the community and families
- ✚ Participate in the HIV and AIDS programmes of your local community
- ✚ Contribute human, financial and material resources towards the programmes in your area to ensure that you are a stakeholder and have influence
- ✚ Collaborate with NGOs and international partners to ensure the success of programmes
- ✚ Encourage your community to abandon high-risk traditional practices, beliefs, customs and values
- ✚ Revive the positive traditional practices and implement them for the benefit of affected families
- ✚ Discourage stigmatisation, discrimination and traumatising of members of your community affected by HIV and AIDS
- ✚ Enhance gender equality in your community by adhering to laws and policies that promote such equality
- ✚ Discourage early marriages of girls by sending them to schools and retaining them until they are adults, as well as passing and implementing local bylaws banning the marriage of girls before they are adults
- ✚ Incorporate the dangers of HIV and AIDS into the socialisation process of children
- ✚ Learn from NGOs and CBOs how to increase food production, ensure food security and sustain the programmes put in place
- ✚ Participate in IEC programmes to understand safe and unsafe traditional practices and to encourage safe practices while discouraging the unsafe ones

### **Individuals**

- ✚ Adopt practices that do not endanger your health
- ✚ Practise safe sex at all times
- ✚ Practise faithfulness in monogamous and polygamous relationships
- ✚ Refrain from engaging in intergenerational sex involving partners of ages varying by at least 15 years
- ✚ Join the prevention programmes in your community to help other people protect themselves from HIV infection
- ✚ Care for and support people infected and affected by HIV and AIDS

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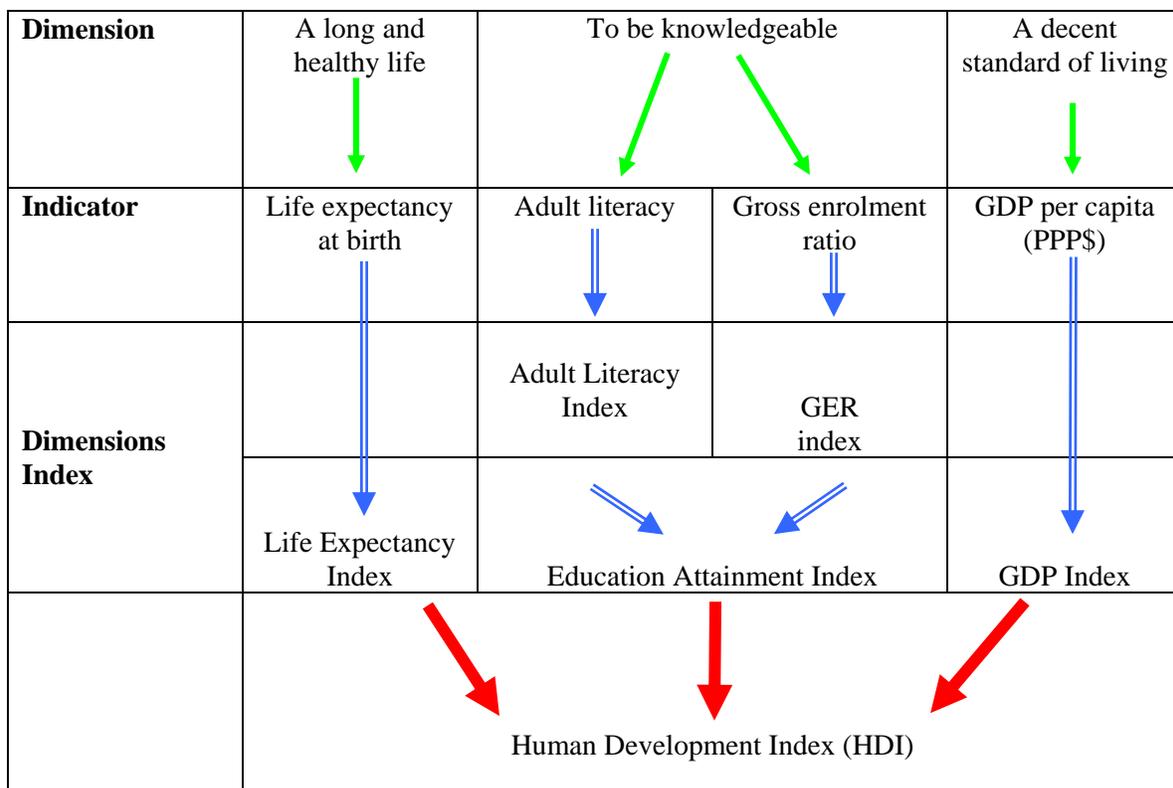
## Technical Annex 1

### Measuring the Human Development Index for Swaziland

The Human Development Index (HDI) seeks to provide a quantitative representation of the three choices of life that are considered core to human development – a long and healthy life, knowledge and a decent standard of living. Each choice has been assigned corresponding quantitative indicators.

	HD dimension	Quantitative indicator	Corresponding index
1	A long and healthy life	Life expectancy at birth	Life Expectancy Index
2	To be knowledgeable	Weighted average of the adult literacy rate and combined primary, secondary and tertiary enrolment ratios	Educational Attainment Index
3	A decent standard of living	Real GDP per capita (PPP\$)	Real GDP Per Capita (PPP) Index

The HDI is a simple average of the three indices derived by dividing their sum by three. The steps followed to calculate the HDI are illustrated below.



By requiring that the indices are first derived, the HDI puts all three basic indicators on a common measuring rod, with the minimum and maximum value of each variable ranging between 0 and 1. This range corresponds to established actual values that depict the defined goal that needs to be attained in each variable.

For each indicator, the maximum and minimum goal posts have been established as shown below:

Indicator	Minimum value	Maximum value
Life expectancy	25 years	85 years
Adult literacy	0%	100%
Gross enrolment	0%	100%
GDP per capita	US\$100	US\$40 000

Except for the GDP Index, each index above is calculated using the following formula:

$$Index = \frac{ActualValue - MinimumValue}{MaximumValue - MinimumValue}$$

In the case of Swaziland and its four regions, values for the indicators needed to calculate the HDI are given below:

Region	Life expectancy at birth (years)	Adult literacy rate (% aged 15 and above)	Combined gross enrolment ratio (%)	GDP per capita (PPP US\$)
Swaziland	35,1	79,6	57,9	5 158
Hhohho	35,1	83,0	54,1	6 711
Manzini	35,7	80,7	56,8	5 054
Shiselweni	32,3	79,2	60,8	3 795
Lubombo	35,7	73,7	60,4	4 603

The HDI in turn has been calculated from the following indices:

- Life Expectancy Index =  $35,1 - \frac{25}{85 - 25} = 0,17$

- The Education Index is a composite of the adult literacy and the gross enrolment indices with a two-third weight given to literacy.

$$\frac{2}{3} \left[ \frac{79,6 - 0}{100 - 0} \right] + \frac{1}{3} \left[ \frac{57,9 - 0}{100 - 0} \right] = 0,72$$

- Increases in income are assumed to have a greater impact at lower values because achieving a respectable level of human development does not require unlimited income. Therefore to derive the needed adjustment, the logarithm of income is used.

$$\frac{\log(5\,158) - \log(100)}{\log(40\,000) - \log(100)} = 0,66$$

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After calculating the dimension indices (above), the HDI is taken as a simple average of the three indices:

$$\frac{0,17 + 0,72 + 0,66}{3} = 0,517$$

### **Notes on data for the calculation of Swaziland's HDI**

Problems related to data availability for the calculation of the HDI for Swaziland and its regions have been highlighted in chapter two. The 2000 Swaziland NHDR utilised the 1997 population census to get the life expectancy and education indices. The update of the HDI has been based on projections and estimations as shown below.

**Life expectancy at birth:** This is based on demographic projections by the CSO, using the 1997 census. Unfortunately projections are only available at the national level and not for the different regions. These projections take HIV and AIDS into account. Published data did not give life expectancy for the regions, even for 1997, and raw data to calculate this was not available to the team. To estimate projected regional life expectancy for 2006, it was assumed that the differences in life expectancy between regions would follow the pattern of differences in infant mortality, observed in the 1997 population census.

**Adult literacy:** No update in adult literacy was available from national data sources. The national level of adult literacy was therefore obtained from the 2006 GHDR, which relied on UNESCO data. This was estimated at 79,6% for 2004. Each region's adult literacy was assumed to have the same ratio to the national adult literacy estimated in the 1997 population census.

**Gross primary enrolment ratio:** This was calculated by first getting the total enrolment in primary schools from the CSO's education statistics of 2005. It was then divided by the total projected population in the age group 6-13.

**Gross secondary enrolment ratio:** The same approach as with primary enrolment ratio was used for the 14-18 age group.

**Combined gross enrolment ratio:** Combined primary and secondary school enrolment figures were divided by the projected population in the age group 6-18 for Swaziland as a whole and for each region. Enrolment figures for tertiary institutions were not available and are considered unrealistic when it comes to making regional comparisons. Therefore the combined gross enrolment ratio refers to primary and secondary school enrolment only.

**Per capita GDP:** This is derived using the following steps:

1. The GDP for Swaziland at factor cost is converted into US\$, using the end of year exchange rate.
2. The total is distributed across regions according to the income distribution pattern established in the SHIES of 2000/2001. This assumes that the distribution pattern remained the same, a heroic assumption given the length of time that elapsed.
3. The GDP for Swaziland and for the regions is then divided by the projected total population for 2003 for the national and regional GDP per capita.

## The Human Poverty Index

The Human Poverty Index (HPI) for developing countries (HPI-1) concentrates on deprivations in three essential dimensions of human life, already reflected in the HDI: longevity, knowledge and a decent standard of living. The first deprivation relates to survival – vulnerability to death at a relatively early age. The second relates to knowledge – being excluded from the world of reading and communication. The third relates to a decent living standard in terms of overall economic provisioning.

In constructing the HPI the deprivation of longevity is represented by the percentage of people not expected to survive to the age of 40 ( $P_1$ ) and the deprivation of knowledge is represented by the percentage of adults who are illiterate ( $P_2$ ). The deprivation in living standards is represented by a composite ( $P_3$ ) of two variables – the percentage of people without access to safe water ( $P_{31}$ ) and the percentage of moderately and severely underweight children under the age of five ( $P_{32}$ ).<sup>11</sup>

The composite variable  $P_3$ , is constructed by taking a simple average of the three variables  $P_{31}$ ,  $P_{32}$ , and  $P_{33}$ :

$$P_3 = \frac{P_{31} + P_{32} + P_{33}}{3}$$

Computing the HPI for Swaziland follows these steps:

**Step one:** Obtain data for each variable whose values are shown in the table below:

	<b>Probability at birth of not surviving to age 40 (% of cohort) 2004</b>	<b>Adult illiteracy rate (% aged 15 and above) 2004</b>	<b>Population not using improved water sources (%) 2004</b>	<b>Under-weight children under the age of five (%)</b>		<b>Human Poverty Index</b>
	<b><math>P_1</math></b>	<b><math>P_2</math></b>	<b><math>P_{31}</math></b>	<b><math>P_{32}</math></b>	<b><math>P_3</math></b>	<b>HPI-1</b>
Swaziland	74,3	20,4	64	9,6	36,8	53,9
Hhohho	70,1	17,0	47	8	27,5	49,8
Manzini	69,5	19,3	49	8,4	28,7	49,6
Shiselweni	78,5	20,8	65	9,1	37,1	56,6
Lubombo	81,9	26,3	81	11	46,0	60,5

<sup>11</sup> A third variable, the percentage of people without access to health services, was previously included in this composite index. It was dropped due to difficulties of getting data in most developing countries.

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**Step Two:** Constructing the HPI for Swaziland only:

$$\begin{aligned} \text{HPI} &= [1/3 (74,3^3 + 20,4^3 + 36,8^3)]^{1/3} \\ &= [1/3 (410\,172,407 + 8\,489,664 + 49\,836,032)]^{1/3} \\ &= [1/3 (468\,498,103)]^{1/3} \\ &= [156\,166,0343]^{1/3} \\ &= 53,85 \end{aligned}$$

Below is a description of the data sources used in the calculation of the HPI for Swaziland and the different regions.

**The deprivation of longevity (P<sub>1</sub>):** The probability to survive to the age of 40 for Swaziland as a whole was taken from the 2006 GHDR and was estimated at 74,3. To get regional estimates, the ratio of the Under Five Mortality Rate (U5MR) for each region to the national U5MR from the 1997 population census was used.

**The deprivation of knowledge (P<sub>2</sub>):** This was derived from the adult literacy rate already estimated in the calculation of the HDI.

**The deprivation of a decent living standard (P<sub>2</sub>)** was obtained from the following statistics:

1. The percentage of people without access to safe water (P<sub>31</sub>) was sourced from the VAC report for 2003.
2. The percentage of moderately and severely underweight children (P<sub>32</sub>) for Swaziland as a whole was obtained from the 2006 GHDR. Regional estimates were based on the ratio of each region to national levels of malnutrition reported in the 1997 population census.

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## Technical Annex 2

### Measuring the number of orphans

The estimates on orphans and OVCs may be confusing to the reader and need clarification here.

There are two sets of estimates of orphans and OVCs:

1. One set was by UNICEF, based on their Rapid Assessment Survey in 2005. This set, not based on a random sample, gives 95 000 OVCs representing 17% of all children younger than 18 years and projects it to be 120 000 or 22% by 2010.
2. In 2006/2007 the Central Statistical Office conducted a Swaziland Demographic and Health Survey (SDHS). This was based on a random sample and was therefore more representative than the UNICEF study. The SDHS of 2006/2007 reported that 23% and 31% of the children in the country were orphans and OVCs, respectively.

To convert these percentages in numbers the following procedure was used:

a) The total population of Swaziland in 2007 was reported by the population and housing census to be 953 000.

b) Due to the lack of the current percentage of children (under 18) in the population we can use 53%, which was the 1997 census proportion (proportions of population by age are not expected to have changed much in the 10 years since 1997). When it is applied to the total population in 2007 this proportion gives:

$$953\ 000 \times 0,53 = 505\ 090 \text{ children in 2006/2007}$$

c) If the number of children is subjected to the percentages of orphans and OVCs in 2006/2007, we get:

$$505\ 090 \times 0,23 = 116\ 171 \text{ orphans in 2006/2007}$$

and

$$505\ 090 \times 0,31 = 156\ 578 \text{ OVCs in 2006/2007}$$