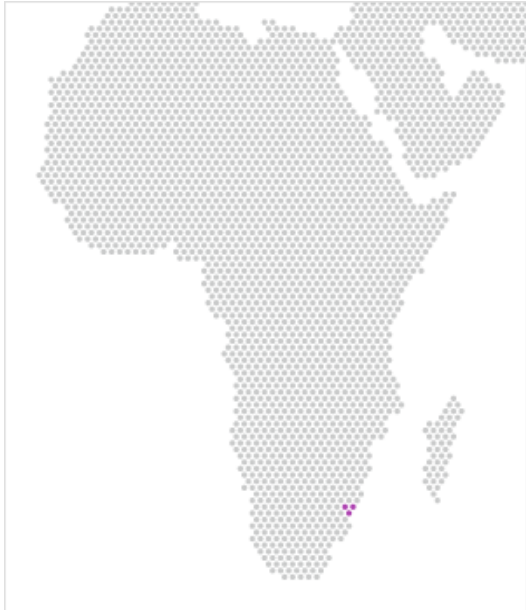


# HIV and AIDS in Swaziland



## Swaziland (2016)

**220,000** people living with HIV

**27.2%** adult HIV prevalence

**8,800** new HIV infections

**3,900** AIDS-related deaths

**80%** adults on antiretroviral treatment

**64%** children on antiretroviral treatment

Source: UNAIDS Data 2017

### KEY POINTS:

- Despite its small population size, Swaziland has the highest HIV prevalence in the world and has been greatly affected by the epidemic.
- Over the last decade, Swaziland has made great efforts to turn around its epidemic with improved access to HIV testing services and the provision of free antiretroviral treatment to those who need it.
- Swaziland has a dual epidemic of TB and HIV and the country has responded with successful dual test and treatment programmes.
- High levels of HIV stigma and discrimination in Swaziland remains a major barrier to people accessing HIV prevention services.

Explore this page to find out more about [populations most affected by HIV](#), [testing and counselling](#), [prevention programmes](#), [antiretroviral treatment access](#), [civil society's response](#), [tuberculosis and HIV](#), [barriers to HIV prevention](#), [data issues](#), [funding for HIV](#), and [the future of HIV and AIDS in Swaziland](#).

Swaziland, a small landlocked country in southern Africa, has the highest HIV prevalence in the world, with 27.2% of adults living with HIV.<sup>1</sup> In 2016, 8,800 adults were newly infected with HIV and 3,900 people died of an AIDS-related illness.<sup>2</sup>

HIV and AIDS has had a devastating impact on Swaziland. Heterosexual sex is the main mode of HIV transmission in Swaziland – accounting for 94% of all new HIV infections.<sup>3</sup> The country has a substantial mobile population, and this mobility has also been identified as a key driver.<sup>4</sup> The epidemic is generalised, which means it affects all populations in society, although certain groups such as sex workers, adolescent girls and young women, and men who have sex with men are more affected than others.

Over the last decade Swaziland has made significant progress on its HIV epidemic. HIV prevalence is stabilising and the number of new infections among adults has nearly halved since 2011, an

achievement largely made possible by rapidly scaling up the number of people accessing antiretroviral treatment. At 79%, it has one of the highest rates of antiretroviral treatment coverage in [sub-Saharan Africa](#), and it has also increased its own domestic investment and funding for the HIV response.<sup>5</sup> Of those people living with HIV on treatment, 68% are virally suppressed.<sup>6</sup>

Nevertheless, the huge amount of people living with HIV in Swaziland means it is still the country's biggest public health concern. According to 2015 estimates, life expectancy in the country is 57 years for men and 61 years for women.<sup>7</sup>

Although classified as a low-middle income country, 63% of people in Swaziland live below the poverty line. In addition, the 2015/2016 regional drought severely affected Swaziland, with parts of the country still experiencing drought conditions with poor harvests. This has long-term ramifications for the rural poor, especially people living with HIV.<sup>8</sup>

## Key affected populations in Swaziland

### Women and HIV in Swaziland

[Women](#) are disproportionately affected by Swaziland's HIV epidemic. Of the 220,000 people living with HIV in 2016, 130,000 are women.<sup>9</sup> In the context of the entire population, 34.7% of all women are living with HIV, compared to 19.6% of men.<sup>10</sup>

Adolescent girls and young women are particularly affected by HIV. In 2016, 15 to 24-year-old women were 4.5 times more likely to be living with HIV than their male counterparts (17.6% vs. 3.8% prevalence).<sup>11</sup>

Women's increased vulnerability to HIV stems from gender inequality within Swaziland's society. Women are often subordinate to men and levels of men engaged in multi-concurrent partnerships are relatively high as is gender-based violence. For instance, in 2010, the most recent data available, 2.7% of women had more than one sexual partner in the last year, while for men this figure stood at 16%.<sup>12</sup> In addition, around 12% of women aged 15-49 years are in a polygamous marriage.<sup>13</sup>

Among young women, early sexual debut and the high level of intergenerational sex between older men and young, sexually inexperienced women is also a factor. Around 14% of women aged 15-24 had sex in the last 12 months with a partner who was 10 or more years older than them.<sup>14</sup> The rate of women aged 15-24 who had unprotected sex with men who are 10 or more years older than them doubled from 7% in 2006/7 to 14% in 2010.<sup>15</sup> One in three women report experiencing some form of sexual abuse by the time they are 18. In 79% of these cases they knew the perpetrator.<sup>16</sup>

Rates of child marriage are reducing. The minimum age of marriage in Swaziland is 18, or 16 with parental consent, although the government also recognises marriages under traditional and customary law, permitted for girls as young as 13. However, in 2012 the government passed a law penalising parents and guardians who collude with adult men to orchestrate a child marriage. Offenders face prison terms of up to 20 years. As a result, in 2017 1% of girls were married by the age of 15 and 5% were married by the age of 18.<sup>17</sup>

Swaziland's Sexual Offences and Domestic Violence Bill has been passed by parliament for several years but has not been signed into law by King Mswati III. This lack of political commitment could be a result of deeply engrained social norms that view the issue of gender equality as taboo.<sup>18</sup>

### Orphans and vulnerable children (OVC) and HIV in Swaziland

In Swaziland, 15,000 children (0-14 years) were living with HIV in 2016 of whom 64% were on

antiretroviral treatment. The annual number of new infections among children and the number of AIDS-related deaths have reduced greatly, and now number fewer than 1,000 each year.<sup>19</sup>

However, the HIV epidemic continues to have a significant affect on children in Swaziland in other ways. Around 71,000 of 0-17 year olds in Swaziland have lost both parents due to AIDS-related illnesses.<sup>20</sup>

Around 38% of the population are aged under 15 and only 5% are aged 60 or over.<sup>21</sup> With such high HIV prevalence amongst the most productive working age ranges, and so many AIDS-related deaths, responsibility for the care of orphans and vulnerable children often falls upon older generations such as grandparents. This also exacerbates existing poverty for families.

## Female sex workers and HIV in Swaziland

Swaziland has the highest HIV prevalence among [sex workers](#) in the world. An estimated 60.5% are living with HIV.<sup>22</sup>

Data on female sex workers is limited. A 2014 study by the Johns Hopkins Centre for Global Health found 40% of female sex workers had an average of six partners per week.<sup>23</sup>

The study found condom use to be high but inconsistent. Around 83% reported using a condom the last time they had sex with a regular client. However, 69% also reported having sex without a condom in the past six months. Lower condom use was reported with non-paying partners than in commercial sex.<sup>24</sup>

Although a third of women reported having anal sex in the last month, only a tenth were aware this put them at heightened risk of HIV. Rape was common with nearly 40% reporting at least one rape and 17% reporting being raped six or more times. More than a quarter (29%) reported having been to jail or prison, and slightly more than 5% reported injecting drug use in the past 12 months.<sup>25</sup>

## Men who have sex with men (MSM) and HIV in Swaziland

Estimates suggest that HIV prevalence among [men who have sex with men \(sometimes referred to as MSM\)](#) in Swaziland is 12.6%.<sup>26</sup>

Data about men who have sex with men in Swaziland is limited, and there are few programmes specifically targeting them.<sup>27</sup> Sex between men is also illegal, and there has historically been little appetite by the government to address this group's needs or acknowledge men who have sex with men exist.<sup>28</sup> As a result, only 27% of men who have sex with men were reached with targeted HIV prevention programmes in 2013, the most recent data available.<sup>29</sup>

A study conducted by USAID found that 25% of men who have sex with men also reported having sex with women in the last year.<sup>30</sup> Although the study found knowledge about condom use and HIV to be high, only 18% knew of the heightened risk of HIV from anal sex, and only 21% had ever been reached with information on sex between men.

[Stigma](#) and self-stigma are also major issues. The study found almost two-thirds of men who have sex with men were scared to reach out to healthcare workers due to their sexual orientation.<sup>31</sup>

## HIV testing and counselling (HTC) in Swaziland

In recent years, the number of people testing for HIV has rapidly increased. In 2009, just 16% had tested for HIV and knew their results in the past 12 months. By 2014 this had risen to 66% of women and 54% of men.<sup>32</sup>

According to 2016/2017 data, 84.7% of adults living with HIV know their status (88.6% of HIV positive women and 77.5% of HIV positive men).<sup>33</sup>

Swaziland has made big steps to expanding access to HIV testing and counselling (HTC) in the country. At the end of 2003, just 13 sites were providing voluntary counselling and testing (VCT) in the country.<sup>34</sup> In 2006, Swaziland introduced a provider-initiated approach to HTC, whereby medical staff offer an HIV test rather than waiting for someone to ask for one. By 2014, 83% of all health facilities were providing HIV testing, and over 60% of all HIV tests given were provided-initiated.<sup>35</sup> Community-based testing is also increasing. In 2015, the government launched a self-testing pilot scheme, enabling people to test for HIV at home.<sup>36</sup>

However, high levels of HIV-related stigma has resulted in a reluctance for people to know their status, particularly among men. Systemic issues, such as long queues and inconvenient clinic hours also deter testing, with men again more likely to experience these barriers to testing. Negative provider attitudes and lack of confidentiality also impact young people and people from key populations.<sup>37</sup>

## HIV prevention programmes in Swaziland

In 2016, 8,800 people were newly infected with HIV. Of the 8,100 adults acquiring HIV, 4,700 were women and 3,400 were men.<sup>38</sup>

Swaziland's current HIV prevention strategy is outlined in its Extended National Strategic Framework (2014–2018). This focuses on high impact interventions, some of which are outlined below, and targets populations and geographic areas where new infections are highest.<sup>39</sup>

## Condom availability and use

In 2015, Swaziland had the second highest level of availability of male condoms in the region, with 51 condoms available per man per year. This is well above the United Nations Population Fund's regional benchmark of 30 male condoms per man per year (2011–2014).<sup>40</sup>

In 2017, Swaziland's condom and lubricant promotion programme was increased further, with an anticipated distribution of 17 million condoms, up from 11 million distributed in 2015. The 2017 distribution programme focused on improving young people and key population's access to condoms via a youth brand-condom ('Got it, get it') and a national campaign ('Free or not').<sup>41</sup>

According to 2014 data, the most recent available, 66% of women and 83% of men aged 15 to 49 who had multiple sexual partners in the last 12 months used a condom the last time they had sex. This shows a significant increase from 2007, when only 56% of women and 48% of males used condoms with every high risk sex.<sup>42</sup>

Safer sex practices were even higher among younger people with 70% of women and 93% of men aged 15-24 using a condom the last time they had sex with a non regular partner.<sup>43</sup>

## HIV education and approach to sex education

According to 2010 data, the most recent available, around 56% of young people have sufficient knowledge about how to prevent HIV.

A Comprehensive Lifeskills Education (CLSE) Programme is offered in all secondary schools in the country. Through the Ministry of Sports Culture and Youth Affairs and its partners, the CLSE concept has been adapted at community level, leading to greater involvement and reach for young people who are out-of-school. For example, part of this intervention has seen HIV prevention messages and information about gender-based violence being disseminated during traditional

events that bring young people before the King (Umhlanga and Incwala).<sup>44</sup>

The Ministry of Health's Health Promotion Programme also runs radio and television shows about HIV. A 2016 survey found radio is a more effective medium for raising awareness, with 90% of respondents aware of HIV radio programmes but only 21% aware of television programmes, mainly due to a lack of access to television.<sup>45</sup>

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

Between 1992 and 2010, HIV prevalence among pregnant woman increased from 4% to 41%.<sup>46</sup> As a result, [prevention of mother-to-child transmission \(PMTCT\)](#) was scaled up and viewed as a vital entry point for accessing HIV services for the entire family.<sup>47</sup>

Some improvement has been seen since, with HIV prevalence among this group standing at 37% in 2013.<sup>48</sup> In 2015, less than 500 children (aged 0-14 years) were newly infected with HIV, compared to 1,600 in 2010. In 2016, UNAIDS reported that 95% of pregnant women living with HIV received antiretroviral treatment.<sup>49</sup> Around 64% of children (aged 0-14) living with HIV were receiving antiretroviral treatment.<sup>50</sup>

The scale-up of PMTCT has involved expanding PMTCT implementation in health facilities and at the community level. By 2013, 162 healthcare facilities out of a total of 252 offered PMTCT services.<sup>51</sup> Other interventions include the better involvement of men in services, strengthening antenatal care follow-up and engaging new-born infants with care.<sup>52</sup>

## Voluntary medical male circumcision (VMMC)

Given Swaziland's generalised HIV epidemic and high HIV prevalence, [voluntary male medical circumcision \(VMMC\)](#) was adopted as an HIV prevention strategy in 2008 at the community level.<sup>53</sup> Swaziland concentrated efforts on young men aged 15-24, where HIV prevalence was lowest for males.<sup>54</sup>

Circumcision rates have risen from 7% in 2007<sup>55</sup> to 26.7% in 2016. However, this is far below the country's target to circumcise 80% of men.<sup>56</sup>

Despite around 90% awareness of circumcision, and some increase in uptake, the need to still use a condom and a fear of pain have been given as reasons not to be circumcised.<sup>57</sup>

## Pre-exposure prophylaxis (PrEP)

*Truvada*, an antiretroviral medication used as pre-exposure prophylaxis, has been approved for use in Swaziland. However, as of 2017 only around 300 people were using PrEP to reduce their risk of HIV infection. There are plans to scale up PrEP to 3,500 people at highest risk of HIV, in particular adolescent girls and young women, men who have sex with men and female sex workers.<sup>58</sup>

## Antiretroviral treatment (ART) in Swaziland

In 2016, 74% of people living with HIV in Swaziland were receiving antiretroviral treatment (ART). More women living with HIV were on treatment than HIV positive men (77% vs 68.7%).<sup>59</sup> Coverage is lower among children, with 64% of 0-14 year olds living with HIV on treatment.<sup>60</sup>

ART has been free in Swaziland since 2003.<sup>61</sup> However, in 2014 Swaziland adopted World Health Organization guidelines that anyone diagnosed with HIV should be started on ART regardless of their CD4 count (which indicates the level of HIV in the body). This means thousands more people are eligible for treatment than before.<sup>62</sup>

Adherence to treatment is generally good, with 93% of adults and children known to be on ART 12 months after starting it.<sup>63</sup> As a result, 91.9% of adults on treatment are virally suppressed. Overall, this equates to 68% of all people living with HIV in Swaziland being virally suppressed.<sup>64</sup>

Men are less likely to test for HIV, be on treatment or be virally suppressed than women. As a result, early HIV testing, linkage, and retention programmes targeting men could significantly improve the impact of Swaziland's ART programme on the number of new infections and the number of AIDS-related deaths.<sup>65</sup>

## Civil society's role in Swaziland

As one of the world's last remaining absolute monarchies, Swaziland has one of the most difficult environments for civil society in southern Africa. People face many barriers when gathering in public places and often face reprisals when expressing their views openly. King Mswati's government has total control over the police, prosecution and judiciary. These arms of government shut down dissent by arresting, detaining and convicting critics of the regime and its policies.<sup>66</sup>

Non-Governmental Organisation (NGOs) in Swaziland work primarily in the health, education, environmental and social services and are coordinated through the Ministry of Home Affairs. The Coordinating Assembly of Non-Governmental Organizations in Swaziland (CANGO) was established in 1983, originally as a network of primary healthcare NGOs. CANGO's HIV and AIDS Consortium was established in 1999. Primarily, the consortium focuses on influencing national HIV policies and avoiding programming conflict.<sup>67</sup>

## Tuberculosis (TB) and HIV co-infection in Swaziland

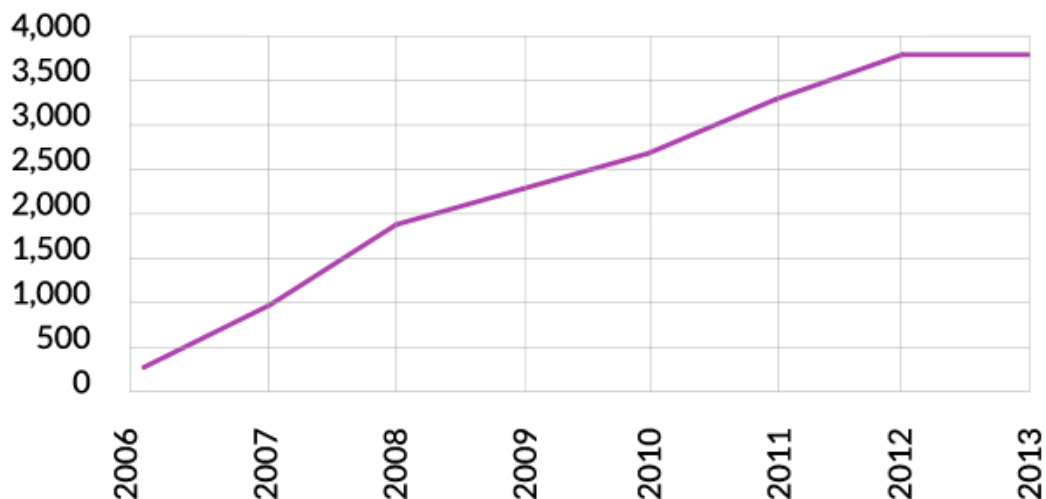
An estimated one in every 100 people develops active tuberculosis (TB) in Swaziland each year.<sup>68</sup>

The country has a dual epidemic of TB and HIV, with 71% of all people who have TB also living with HIV. In addition, 4.2% of people with TB have multidrug resistant TB.

To tackle the problem, Swaziland started a programme of strengthening and integrating TB/HIV services. These services have been decentralised, and are now offered in a 'one-stop-shop', where people can seek screening for TB and HIV testing, as well as being able to pick up their treatment for both at the same time. As of 2016, 97% of notified TB patients had a known HIV status; 79% of people with both TB and HIV had started ART. The TB treatment success rate for people co-infected with TB and HIV is 71%.<sup>69</sup>



Number of TB patients living with HIV receiving ART in Swaziland, 2006-2013



Source: UNAIDS estimates.

## Barriers to the HIV response in Swaziland

### Social barriers

Stigma associated with HIV and AIDS in Swaziland prevents many people from being tested for HIV or declaring their HIV status. HIV is perceived to be linked with sexual promiscuity, and often causes HIV-positive people to be excluded from family activities.<sup>70</sup>



A 2014 survey by Swaziland's Central Statistical Office found 37% of women and 36% of men displaying discriminatory attitudes towards people living with HIV.<sup>71</sup> The 2011 Stigma and Discrimination Index found self-stigma among people living with HIV remains high.<sup>72</sup>

### Cultural barriers

Swaziland is a patriarchal society with high levels of gender inequality. Men often dictate women's reproductive and sexual health, and child marriage and polygamy are practised.<sup>73</sup> The subordinate

status of women can also place them at an increased risk of sexual violence and low access to education and health information.<sup>74</sup>

Inter-generational relationships are common. High unemployment is a factor in this as some young women may have sexual relationships with older men (often called 'sugar daddies'), from whom they may receive money or gifts. This is sometimes referred to as transactional sex. The age and gender imbalance in these situations can make condom negotiation difficult.<sup>75</sup>

Access to HIV services and treatment can be hampered by the existence of traditional health practitioners (THPs), who many people in Swaziland visit. However, many organisations, including the World Health Organization, argue that THPs should be better recognised as primary healthcare providers so that they can become more closely involved in the delivery of effective HIV services.<sup>76</sup>

## Legal barriers

Same sex relationships and sex work are illegal in Swaziland, with both groups reporting high levels of human rights violations against them. Around one-third of men who have sex with men and female sex workers report some form of legal discrimination.<sup>77</sup> More than a third (37%) of female sex workers report being refused police protection. A third (36%) of men who have sex with men report being tortured due to their sexuality.<sup>78</sup>

Although the country's constitution provides for equality before the law and non-discrimination, it does not prevent discrimination on the grounds of sex, language, sexual orientation, and gender identity. In addition, Swaziland's dual legal system, based on both Roman Dutch common law and Swazi customary law, has led to numerous violations of women's rights.<sup>79</sup>

Swaziland's Prime Minister, Barnabas Dlamini, has publicly called homosexuality "an abnormality and a sickness" and lesbian, gay, bisexual, transgender and intersex (LGBTI) people face censure and exclusion from the chieftom-based patronage system.<sup>80</sup>

This legal discrimination against people who are LGBTI, the criminalisation of HIV transmission, and the unequal legal status of married women all act as barriers to reaching people most affected by HIV in Swaziland.<sup>81</sup>

## Structural and resource barriers

There is a lack of skilled health care workers in Swaziland, with staffing levels unable to meet demand in a significant number of health facilities. There is also an urgent need to expand the number of community-based peer and outreach workers who can specifically meet the needs of key populations.<sup>82</sup>

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No one blames gays for AIDS in Swaziland, they just blame gays for being alive and being gay, so it's hard for a gay person to risk exposure.

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- Alicia Dlamini, an HIV testing counsellor in Manzini, Swaziland. <sup>83</sup>



## Data issues

There is a lack of accessible, up-to-date data in regards to Swaziland's HIV response, particularly in relation to key populations. For instance, the country's most recent progress report to UNAIDS was filed in 2015, based on 2014 data. Additional support is required to roll out a client management information system in the country, and the use of a unique identifier to track people through the prevention and treatment cascades. There is also a lack of reporting for viral load testing at clinics.<sup>84</sup>

## Funding for HIV in Swaziland

The US Presidents Emergency Plan For AIDS Relief (PEPFAR) is the largest contributor of funding for Swaziland's HIV response, followed by the Swaziland government and the Global Fund to Fight AIDS, Malaria and Tuberculosis.<sup>85</sup>

In 2016, domestic contributions for the country's HIV response equated to around a third of total spending.<sup>86</sup> Since 2009, domestic funding has covered the supply of antiretrovirals and HIV test kits. However, PEPFAR and the Global Fund have provided stop-gap funding to deal with procurement issues and other critical areas in care and treatment, such as technical assistance and some human resourcing. A lack of funding is preventing viral load testing to be scaled-up.

PEPFAR is the main supporter of prevention programming in Swaziland including condom supply and distribution, VMMC, and prevention programmes for key populations.<sup>87</sup>

## The future of HIV in Swaziland

In recent years, Swaziland has made great progress in tackling HIV - particularly around the areas of treatment, PMTCT and reducing HIV incidence overall.

However, the high HIV prevalence among the general population means the government will need to tackle many of the social and cultural problems that hamper the response. These include poverty, gender inequality and risky cultural practices that contribute to a high risk of HIV infection among the general population.<sup>88</sup>

Effective prevention initiatives and a greater focus on improving access to HIV testing facilities are also urgently needed. The epidemic among key affected populations - particularly female sex workers and men who have sex with men - needs to be addressed.

ART coverage shows adolescent boys and girls (ages 15-19) and men 20-39 are lagging behind. Without increased testing and treatment enrolment among these groups, particularly among men living with HIV, HIV incidence will not decline as quickly as anticipated.<sup>89</sup>

The government also needs to work harder to collect data and understand the complex needs of populations groups most affected by HIV, so that adequate HIV programming can be developed. The dual epidemic of TB and HIV remains a cause for concern.

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