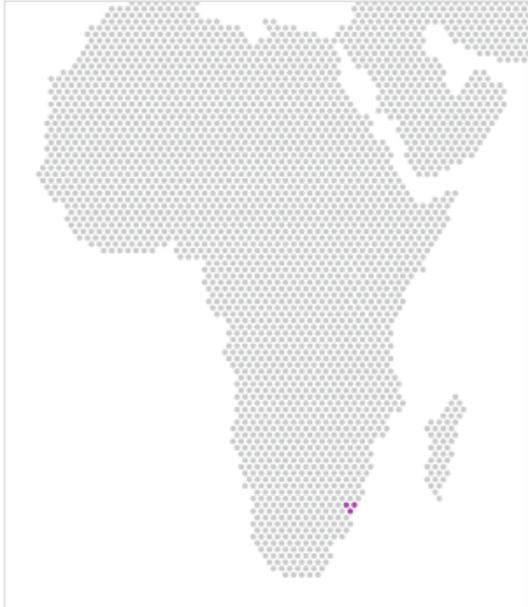


# HIV and AIDS in Eswatini



## Eswatini (2019)

**200,000** people living with HIV

**27%** adult HIV prevalence (ages 15-49)

**4,500** new HIV infections

**2,300** AIDS-related deaths

**>95%** adults on antiretroviral treatment\*

**84%** children on antiretroviral treatment\*

\*All adults/children living with HIV

Source: UNAIDS Data 2020

## KEY POINTS

- Despite its small population size, Eswatini has the highest HIV prevalence in the world and has been greatly affected by the epidemic.
- Although the epidemic is generalised, certain groups are particularly affected, especially those who are socially marginalised and criminalised. For example, the country has the highest HIV prevalence among sex workers in the world (60.5%).
- Over the last decade, Eswatini 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.
- Eswatini has a dual epidemic of TB and HIV and has responded with successful dual test and treatment programmes.
- High levels of HIV stigma and discrimination in Eswatini remain major barriers 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 availability](#), [civil society's role](#), [tuberculosis and HIV](#), [barriers to prevention](#), [funding](#) and [the future of HIV in eSwatini](#).

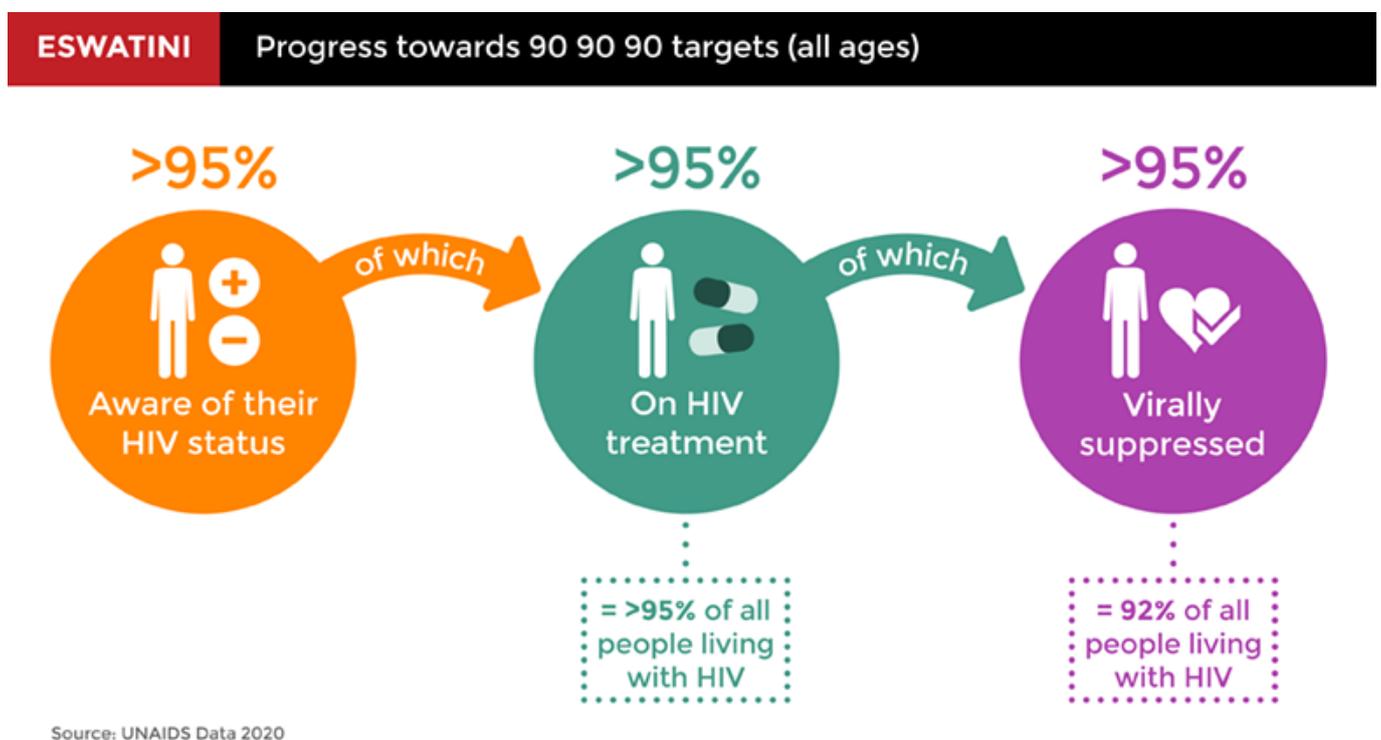
Eswatini, a small, landlocked country in southern Africa, has the highest HIV prevalence in the world, with 27.3% of adults living with HIV. In 2018, 7,800 adults were newly infected with HIV and 2,800 people died of an AIDS-related illness.<sup>1</sup>

HIV and AIDS have had a devastating impact on Eswatini. Heterosexual sex is the main mode of transmission, accounting for 94% of all new HIV infections.<sup>2</sup> The country has a substantial mobile population, and this mobility has also been identified as a key driver.<sup>3</sup> The epidemic is generalised, meaning it affects all populations, although certain groups such as sex workers, adolescent girls,

young women and men who have sex with men are more affected than others.

Over the last decade, Eswatini has made significant progress in controlling its HIV epidemic. HIV prevalence is stabilising and the number of new infections among adults has declined by around a third (31%) since 2010, largely due to rapidly scaling up the number of people accessing antiretroviral treatment (ART). With 86% of all people living with HIV on ART, the country has one of the highest treatment coverage rates in sub-Saharan Africa. Of those people living with HIV and on treatment, 94% are virally suppressed.<sup>4</sup> Nevertheless, HIV is still the country's biggest public health concern. According to 2017 estimates, life expectancy in Eswatini is 58.<sup>5</sup>

Although classified as a lower-middle income country, 59% of people in Eswatini were living below the poverty line in 2017.<sup>6</sup> In addition, the 2015/2016 regional drought severely affected the country, with some areas still experiencing drought conditions and poor harvests. This has long-term ramifications for the rural poor, especially people living with HIV.<sup>7</sup>



**Avert** [www.avert.org](http://www.avert.org)

## Key affected populations in eSwatini

### Women

**Women** are disproportionately affected by Eswatini's HIV epidemic: of the 210,000 people living with HIV in 2018 (190,000 adults), 120,000 were women. Within the entire population, 35.1% of all women are living with HIV, compared to 19.3% of men.<sup>8</sup>

Women's increased vulnerability to HIV stems from gender inequality within Eswatini's society. Women are often subordinate to men, with high levels of gender-based violence and men engaged in multi-concurrent partnerships. For example, around 12% of women aged 15-49 are in a polygamous marriages.<sup>9</sup> Married women also need their husbands' consent to access sexual and reproductive health services.<sup>10</sup>

In 2018, the UN's Human Development Report ranked Eswatini 137 out of 159 countries for gender inequality, indicating just how severe the issue is.<sup>11</sup>

This is demonstrated by the progress of the 2015 Sexual Offences and Domestic Violence Bill, which was passed by parliament but delayed from becoming law for three years. A 2017 report found that King Mswati III withheld royal assent, the final step to pass the Bill into law, due to the perception that the Bill would encroach on traditional Swazi laws and customs. For example, the concept of marital rape is widely disputed among both men and women, as is a woman's right to be in control of her reproductive choices.<sup>12</sup>

In July 2018 the King finally signed the bill into law, seen as a significant milestone for gender equality in the country.<sup>13</sup> Despite this, deeply entrenched attitudes continue to make it a difficult issue to tackle.

## Young people

In 2018, 23,000 **young people** (ages 15-24) were living with HIV in Eswatini.<sup>14</sup> This age group is more likely than others to have low testing, treatment and viral suppression rates.<sup>15</sup>

Young women are particularly affected, with 15.9% living with HIV in 2018 compared to 3.1% of their male counterparts.<sup>16</sup> Early sexual debut and the high level of intergenerational sex between older men and young women helps to drive HIV transmission among this age group. Data from 2017 suggests around 9% of young women had sex with a partner who was 10 or more years older in the last 12 months, although this is a lower level than in 2014 when it was estimated to be around 14%.<sup>17</sup> In addition, one in three young women report experiencing some form of sexual abuse by the time they are 18. <sup>18</sup>

Child marriage exists in Eswatini but is becoming less common. The minimum age for marriage is 18, or 16 with parental consent, although the government also recognises marriages under traditional and customary law, permitted from the age of 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>19</sup>

## Orphans and vulnerable children (OVC)

In Eswatini, 11,000 children (0-14 years) were living with HIV in 2018, of whom 76% were on antiretroviral treatment. New infections among children and AIDS-related deaths have reduced greatly to fewer than 1,000 each year.<sup>20</sup> However, the HIV epidemic continues to have a significant effect on children in other ways. Around 45,000 0 to 17 year-olds have been orphaned due to AIDS-related illnesses.<sup>21</sup>

Around 38% of Eswatini's population are aged under 15 and only 5% are aged 60 or over.<sup>22</sup> With such high HIV prevalence and AIDS-related deaths amongst the most productive working age ranges, care of orphans and vulnerable children often falls upon older generations such as grandparents. This also exacerbates existing poverty for families.

## Female sex workers

Eswatini has the highest HIV prevalence among **sex workers** in the world, estimated at 60.5% in

2015.<sup>23</sup> Sex work in Eswatini is illegal. This makes it difficult for sex workers to access healthcare, including HIV prevention, testing and treatment services. It also means sex workers are subject to routine abuse, discrimination and violence from police, healthcare workers and others in authority as well as from clients and the general public.<sup>24</sup>

The criminalised and highly stigmatised nature of sex work means data on this population group 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. Condom use was 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>25</sup>

Although a third of female sex workers reported having anal sex in the last month, only a tenth were aware this put them at heightened risk of HIV. Nearly 40% reported at least one rape and 17% reported 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>26</sup>

## Men who have sex with men (MSM)

Estimates suggest that HIV prevalence among [men who have sex with men](#) (sometimes referred to as MSM) in Eswatini is 12.6%, although data is extremely limited.<sup>27</sup> Same-sex sexual relations are illegal, which helps to fuel the stigmatisation of this population group.

Despite being highly vulnerable to HIV, men who have sex with men often remain hidden and do not access prevention, treatment or care services. For example, a study involving around 400 men who have sex with men and 100 transgender women in Eswatini found participants who reported that healthcare workers knew their sexual orientation were more likely to receive poor treatment, be gossiped about and avoid seeking healthcare. Similarly, participants whose family members were aware of their sexuality were more likely to be excluded from other family members and be subject to gossip. <sup>28</sup>

Historically, the government has done little to address this group's needs.<sup>29</sup> Few HIV programmes specifically target men who have sex with men.<sup>30</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>31</sup> Around 57% of men who have sex with men are estimated to use condoms.<sup>32</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>33</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. 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>34</sup>

## HIV testing and counselling (HTC) in eSwatini

In recent years, the number of people testing for HIV has rapidly increased. In 2009, just 16% of people living in Eswatini had tested for HIV and knew their results in the past 12 months; by 2016/17 this had risen to 52%.<sup>35 36</sup>

Among people living with HIV, 92% had tested for HIV and were aware of their status in 2018,

compared to 88% in 2015.[37](#)

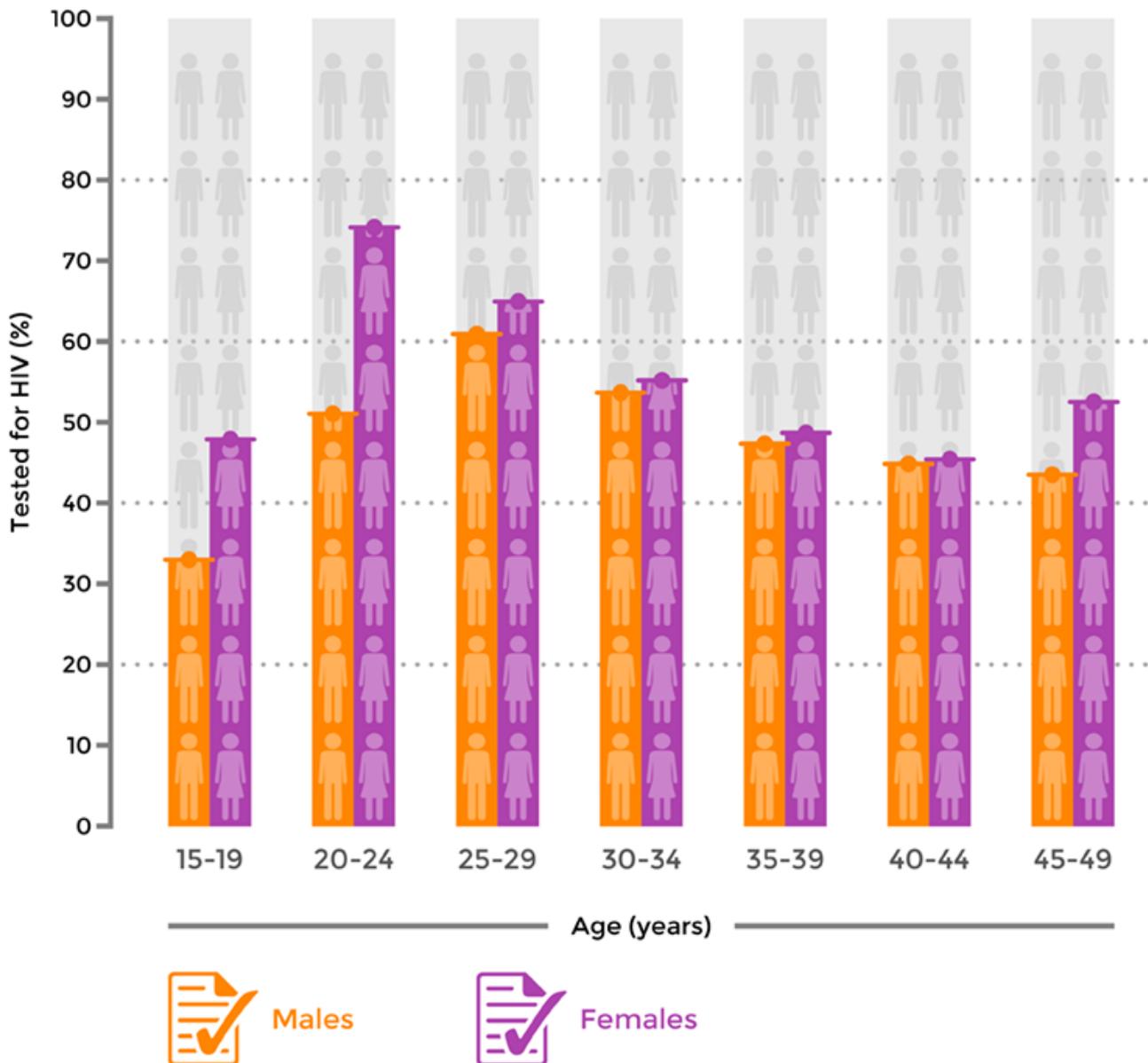
More HIV positive women are aware of their status than HIV positive men (84% compared to 75%). This is due to a general reluctance among men to access healthcare, as well as the widespread availability of HIV testing in antenatal and family planning clinics.[38](#)

Younger people (ages 15-24) also have relatively low testing levels. In 2016/17, around 72% were aware of their status, with young men less likely than young women to have been diagnosed.[39](#)

Eswatini has made big steps to expand access to [HIV testing and counselling \(HTC\)](#). At the end of 2003, just 13 sites were providing voluntary counselling and testing in the country.[40](#) In 2006, Eswatini 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 provider-initiated.[41](#) Community-based testing and index testing are also increasing.[42](#)

However high levels of HIV-related stigma mean many people, particularly men and young people, are reluctant to know their status. Systemic issues, such as long queues and inconvenient clinic hours also deter testing, with men more likely to experience these barriers. Negative provider attitudes and lack of confidentiality also impact young people and people from key populations.[43](#) [44](#)

In 2015, the government launched a self-testing pilot scheme. HIV self-testing enables people to test for HIV at home, which potentially tackles the issue of stigma and other clinic-related barriers.[45](#) In 2017 Eswatini joined Unitaids' multi-country Self Testing Africa (STAR) initiative, which has seen self-testing kits distributed for free in a number of settings, including workplaces and antenatal clinics and during voluntary medical male circumcision outreach camps. By 2020, around 72,200 testing kits will have been distributed by STAR.[46](#)



Source: The Swaziland HIV Incidence Measurement Survey 2016-2017

## HIV prevention programmes in eSwatini

In 2018, 7,800 people were newly infected with HIV. Of these, 4,100 were women (aged 15+) and 2,800 were men, meaning adult women are twice as likely to acquire HIV as their male counterparts. Overall, new infections are declining significantly, falling by 31% since 2010.<sup>47</sup>

Eswatini's current HIV prevention strategy is outlined in its National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023.<sup>48</sup> This focuses on high impact, combined interventions, some of which are outlined below, and targets populations and geographic areas where new infections are highest.

## Condom availability and use

Eswatini's HIV prevention strategy aims to provide [condoms](#) to young people, men and women engaged in high-risk sex, female sex workers and their clients, men who have sex with men, people attending STI and family planning clinics and pregnant and breastfeeding women.[49](#)

In 2015, Eswatini 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).[50](#)

Condoms have been promoted through targeted, mass media campaigns and distributed via other sexual health services, such as STI clinics, and HIV testing services. Condom distribution increased from 18 million male condoms in 2015 to 26 million in 2017. Female condom distribution remains low, with just 172,600 condoms distributed in 2016. About 212,000 lubricants were distributed in 2017.[51](#)

The country's 2017 distribution programme focused on improving access to condoms for young people and key populations via a youth brand-condom ('Got it, get it') and a national campaign ('Free or not').[52](#)

However, the fact that more free condoms are available than ever before has not translated into increased use. In fact, condom use appears to be declining. For example between 2010 and 2014, the proportion of young people using condoms when having sex with a non-marital, non-cohabiting partner fell from 91% to 75% among young men and from 73% to 62% among young women. Similarly, condom use among people aged 15-49 reduced from 69% to 66% for men and from 73% to 63% for women during the same period. Despite extremely high HIV prevalence among female sex workers, it is estimated that around 25% of clients do not use condoms.[53](#)

In 2019, the government reassessed the condom distribution programme in order to make it more targeted and strategic for those in greatest need.[54](#)

## HIV education and approach to sex education

Young people in Eswatini have poor knowledge about how to prevent HIV. Just 49% of young women (ages 15-24) and 51% of young men demonstrated adequate knowledge on this subject in 2014. [55](#)

This underscores the need to offer comprehensive sexuality education for young people, both in and out of school. 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 disseminated during traditional events that bring young people before the King (Umhlanga and Incwala).[56](#)

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.[57](#)

## CASE STUDY: Keeping adolescent girls in school to reduce HIV

Education is a key factor in determining HIV vulnerability as it is linked to how early adolescent girls and young women first start having sex, and how likely they are to use condoms and engage in transactional sex. Only a third of adolescent girls were enrolled in secondary school in Eswatini in 2014. Few girls return to school once they leave, although only 40% of young women have jobs.<sup>58</sup>

A 2017 survey found that 80% of young women aged 15-22 who had left school were sexually active compared to 30% of women of the same age in school. HIV incidence and prevalence was found to be almost four times higher among those out of school compared to those still in education.<sup>59</sup> <sup>60</sup> To address this, a pilot programme offered financial incentives and prizes to remain in school to around 4,300 adolescent girls and young women in Eswatini, 80% of whom lived in rural areas.

The trial found that those receiving the interventions were 37% less likely to acquire HIV. In contrast, study participants not in education or training were 190% more likely to acquire HIV during the study period. Overall, the programme reduced HIV incidence among study participants by 21%.<sup>61</sup>

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

Between 1992 and 2010, HIV prevalence among pregnant woman increased from 4% to 41%.<sup>62</sup> As a result, [prevention of mother-to-child transmission \(PMTCT\)](#) was scaled up and viewed as a vital entry point for the entire family to access HIV services.<sup>63</sup>

In 2018 Eswatini published the National Strategic Plan for Ending AIDS and Syphilis in children 2018-2023, which aims to eliminate the transmission of HIV and congenital syphilis between mother and infant by 2023.<sup>64</sup>

The strategy sets out a number of focus areas to achieve this. These include preventing new infections among pregnant and breastfeeding women, preventing unintended pregnancies, and promoting the diagnosis and effective treatment of HIV and syphilis for pregnant women and their male partners.<sup>65</sup> These efforts are having mixed results. In 2018, fewer than 1,000 children (aged 0-14 years) were newly infected with HIV, compared to 1,300 in 2010. The proportion of pregnant women testing for HIV is increasing, jumping from 64% in 2017 to 91% in 2018. However the percentage of pregnant women living with HIV receiving antiretroviral treatment (ART) is declining. In 2016, 90% of HIV positive pregnant women were on ART, compared to 79% in 2018.<sup>66</sup>

The proportion of HIV-exposed infants being tested for HIV within six weeks of birth is increasing, standing at 78% in 2018 compared to 43% in 2010. Around 75% of children living with HIV were receiving ART in 2018.<sup>67</sup>

## Voluntary medical male circumcision (VMMC)

Given Eswatini'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>68</sup> Efforts were concentrated on young men (ages 15-24), where HIV prevalence was lowest for males.<sup>69</sup>

By 2023, Eswatini aims to ensure 70% of men up to the age of 49, and 80% of 10 to 29-year-olds, are circumcised.<sup>70</sup>

Circumcision rates have risen from 7% in 2007<sup>71</sup> to 35% in 2018. Around 29% of young men (ages 15-24), and 17% of over 25-year-olds, have been circumcised.<sup>72</sup> However, this is far below target.

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>73</sup>

## Pre-exposure prophylaxis (PrEP)

Truvada, an antiretroviral medication used as [pre-exposure prophylaxis \(PrEP\)](#), has been approved for use in Eswatini. The country aims to ensure 70% of people from at-risk populations – defined as sexually active adolescent girls and young women, pregnant and breastfeeding women, sero-discordant couples, adult men, female sex workers and men who have sex with men – have access to PrEP by 2023.<sup>74</sup>

In 2017, Eswatini began a PrEP demonstration project involving around 300 people to inform the wider rollout in the country. PrEP was provided to high-risk groups visiting family planning, outpatient, antenatal and HIV testing clinics. One third (33%) of those offered PrEP agreed to take it, 75% of whom were women. This is mainly due to the entry points utilised for the project, as fewer men than women visit health facilities.<sup>75</sup>

The demonstration project finished in 2019 and has revealed a number of issues that need addressing in order to effectively expand PrEP. These include a lack of awareness, and therefore demand, among target populations, limited access for men, young people and marginalised populations, and low capacity among healthcare workers to initiate people on PrEP.<sup>76</sup> As of 2019, a countrywide operational plan, which will see around 60 health facilities begin to provide PrEP, is under development. This will enable around 4,600 people to access PrEP by the end of the year.<sup>77</sup>

## Antiretroviral treatment (ART) in eSwatini

In 2018, 86% of people living with HIV in Eswatini were receiving [ART](#). Significantly more women living with HIV were on treatment than HIV positive men (91% vs 79%).<sup>78</sup> Coverage is lower among children, with 76% of 0 to 14 year-olds living with HIV on treatment.<sup>79</sup>

ART has been free in Eswatini since 2003.<sup>80</sup> In 2014 the country adopted World Health Organization (WHO) guidelines recommending that anyone diagnosed with HIV be started on ART regardless of their CD4 count (which indicates the level of HIV in the body). This approach, known as ‘treat all’ or ‘test and treat’, means thousands more people are eligible for treatment than before.<sup>81</sup>

Adherence to treatment is generally good, with over 95% of adults and children known to be on ART 12 months after starting it.<sup>82</sup> As a result, 94% of adults diagnosed with HIV and on treatment are virally suppressed. Overall, this equates to 81% of all people living with HIV in the country being virally suppressed.<sup>83</sup>

In 2016, Eswatini conducted an HIV drug resistance survey. This found 10.6% of people who had not previously been on ART were resistant to a common type of antiretrovirals known as non-nucleoside analogue reverse transcriptase inhibitors (NNRTIs). WHO recommends that, if this rate is more than 10%, alternative regimens should be offered. In response, in 2019 the US President’s Emergency Plan

for AIDS Relief (PEPFAR) began supporting Eswatini to move all those with NNRTI resistance to Dolutegravir-based regimens.<sup>84</sup>

Because men are less likely to test for HIV, be on treatment or be virally suppressed than women, early HIV testing, linkage, and retention programmes that target men could significantly improve the impact of Eswatini's ART programme.<sup>85</sup>

#### CASE STUDY: Understanding how stigma affects treatment initiation

Following Eswatini's adoption of 'test and treat', a study conducted in Shiselweni, south Eswatini investigated whether stigma would prevent people not experiencing symptoms from embarking on treatment. The study comprised 106 interviews, conducted between 2016 and 2017, including repeat interviews with 30 people living with HIV and one-off interviews with 20 healthcare workers.

The study found that many asymptomatic people living with HIV were motivated to start ART in order to prevent them from developing symptoms that would visibly show them to be HIV-positive. However, engaging with treatment and care services was also seen as having the potential to expose someone as HIV-positive and thereby open to stigmatisation. When the risk of exposure through clinic attendance was deemed too great, people were found to disengage from care and take treatment intermittently.<sup>86</sup>

## Civil society's role in eSwatini

As one of the world's last remaining absolute monarchies, Eswatini has a challenging environment for civil society. People face many barriers when gathering in public places and are subject to reprisals for 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>87</sup>

Non-governmental organisations (NGOs) in Eswatini 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 (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 upholding ethical information-dissemination, human-rights based programming, equal participation and access to the right information.<sup>88</sup>

Part of CANGO is the Eswatini HIV/AIDS Consortium (ESHACO), a civil society network that advocates for the provision of quality HIV services that are delivered by communities most affected by HIV.<sup>89</sup>

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

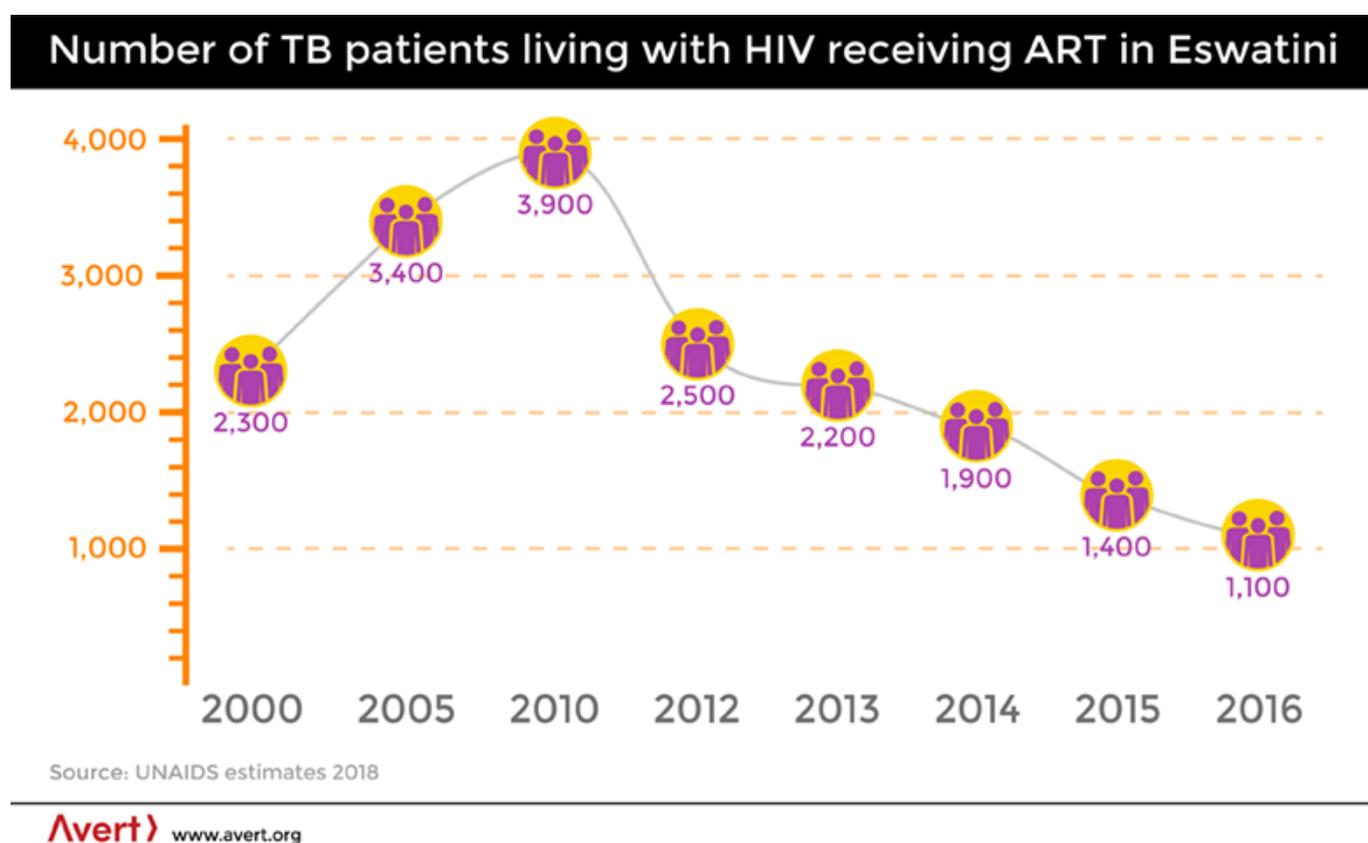
Eswatini has a dual epidemic of [tuberculosis \(TB\) and HIV](#), with 65% of all people who have TB also living with HIV. <sup>90</sup> Men are more likely to be affected due to their lack of access to HIV and TB testing and treatment.<sup>91</sup> In 2016, 79% of people co-infected with HIV and TB were found to have drug

resistant TB strains.<sup>92</sup>

TB preventive therapy should be offered to all people initiating HIV treatment, but not all those eligible in Eswatini receive the service. WHO reports that only 10% of people newly diagnosed with HIV were put on appropriate TB therapy in 2018 (9% on TB treatment and 1% TB prevention), and only 3.7% of those newly enrolled on preventative therapy were expected to complete it.<sup>93</sup>

Eswatini is in the process of strengthening and integrating its 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 2017, around 80% of people with TB were on treatment. This is below the coverage required to control the country's TB epidemic, with people who are HIV-positive particularly in need of better access to TB treatment. However these efforts are significantly reducing TB transmission. In 2010, around 11,050 people developed active TB in Eswatini; in 2018 this figure had fallen to 2,845. Still, more needs to be done to ensure all people with TB are diagnosed and put on treatment in order to reduce transmission further.<sup>94</sup>



## Barriers to the HIV response in eSwatini

### Social barriers

As in many countries, stigma associated with HIV and AIDS in Eswatini 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 people who are HIV-positive to be excluded from family activities.<sup>95</sup>

As a result, people living with HIV tend to seek treatment in health facilities away from where they

live to avoid being identified, which means they are less likely to access treatment on a regular basis. Young people living with HIV will also be reluctant to take their medication in a school setting for fear of disclosing their HIV status.<sup>96</sup>

A 2014 survey by the Central Statistical Office found 37% of women and 36% of men displayed discriminatory attitudes towards people living with HIV.<sup>97</sup> The 2011 Stigma and Discrimination Index found self-stigma among people living with HIV remains high.<sup>98</sup>

Focus group discussions conducted by the Eswatini Ministry of Health with adolescents and young people, men, women and people living with HIV identified self-stigma as one of the main reasons people do not access HIV services. Participants also described experiencing HIV-related discrimination at the hands of community members and healthcare workers. Around one third (38%) of female sex workers and two-thirds of men who have sex with men (62%) said they avoided seeking healthcare due to the perception that they will be badly treated due to their sexual orientation or practices.<sup>99</sup>

## Cultural barriers

Eswatini is a patriarchal society with high levels of gender inequality.<sup>100</sup> The legal requirement that married women must seek permission from a spouse before accessing sexual and reproductive health services exacerbates this situation.<sup>101</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.

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. For example, one study conducted in Eswatini's Hhohho and Manzini regions found that, as the number of material items and goods provided by a man to a young woman increases, the likelihood of condom use decreases.<sup>102</sup>

In addition, married or cohabiting men are more likely than married women to have sex with other people, putting their main partner at risk.<sup>103</sup>

Many people in Eswatini visit traditional health practitioners (THPs), which can hamper access to HIV services and treatment. However many organisations, including the WHO, argue that THPs should be better recognised as primary healthcare providers so they can be more closely involved in the delivery of effective HIV services.<sup>104</sup>

## Legal barriers

Same sex relationships and sex work are illegal in Eswatini, with both groups reporting high levels of [human rights violations](#) against them. More than a third (37%) of female sex workers report being refused police protection, while a third (36%) of men who have sex with men report being tortured due to their sexuality.<sup>105</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, Eswatini'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>106</sup>

A study assessing the link between the criminalisation of sex work and HIV prevalence among female

sex workers in ten African countries, including Eswatini, found that female sex workers in countries where sex work is illegal were almost three times as likely to be living with HIV than sex workers in countries where sex work is not criminalised.[107](#)

In 2017, following Eswatini's first Gay Pride, the King [described](#) same-sex relationships as "satanic", while the-then Prime Minister, Barnabas Sibusiso Dlamini, said being gay was "an abnormality and a sickness." These attitudes, coupled with an extremely hostile legal environment, ensures that lesbian, gay, bisexual, transgender and intersex (LGBTI) people and men who have sex with men face censure and exclusion from the chieftdom-based patronage system.[108](#) 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 Eswatini.[109](#)

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No one blames gays for AIDS here, 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, Eswatini*[110](#)

## Structural and resource barriers

Although Eswatini is politically stable and uncrowded, and has good farming land, high HIV prevalence, unemployment and food insecurity mean many residents experience hardship and poverty.[111](#)

Eswatini is a lower-middle income country, however these factors, coupled with a weak business climate and low foreign investment, mean the country operates more as a low-income country.[112](#)

As a result many residents migrate, particularly to South Africa. This makes the delivery of ongoing healthcare services a challenge and complicates the way in which the country's HIV epidemic is monitored.[113](#)

It also contributes to the lack of skilled healthcare workers in Eswatini, 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.[114](#)

## Data issues

There is a lack of accessible, up-to-date data on Eswatini's HIV response, particularly in relation to key populations. For instance, the country's most recent UNAIDS progress report was filed in 2015, based on 2014 data. Additional support is needed to roll out a client management information system and the use of a unique patient identifier to track people through the prevention and treatment cascades. There is also a lack of reporting for viral load testing at clinics.[115](#)

In 2018, PEPFAR began to conduct integrated bio-behavioural survey and size estimations on populations most affected by HIV, such as sex workers and men who have sex with men. This data will be critical to improve programmes and monitor trends for people most affected by HIV.[116](#)

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## Funding for HIV in eSwatini

The largest contributor of funding for Eswatini's HIV response is PEPFAR, providing 59% of total resources in 2017/18. This is followed by the Eswatini government (26%) and the Global Fund to Fight AIDS, Malaria and Tuberculosis (11%).<sup>117</sup>

Eswatini received approximately US\$146.5 million from international donors in 2017, with the health sector the largest beneficiary of external assistance. The procurement of ARVs alone accounted for nearly US\$19 million in 2017/18. Due to test and treat, the budget for this has increased to more than US\$21 million for 2018/19. Despite economic challenges, domestic expenditure on HIV is set to increase from US\$23 million in 2017/18 to \$25 million in 2018/19.<sup>118</sup>

Eswatini has set ambitious targets to eliminate new HIV infections and AIDS-related deaths by 2023, which means that finding sustainable financing for its HIV response is now a key priority, particularly as international funding is likely to reduce. The country's 2018-2023 HIV strategy states that it is looking to shift focus to internal resource mobilisation while investing in interventions that have the greatest impact.<sup>119</sup>

## The future of HIV in eSwatini

In recent years Eswatini 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.<sup>120</sup>

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

ART coverage shows adolescent boys and girls (ages 15-19) and men (ages 20-39) are lagging behind. Without increased testing and treatment enrolment among these groups, HIV incidence will not decline as quickly as anticipated.<sup>121</sup> In addition, the decline in the proportion of pregnant women who are HIV-positive accessing ART must be reversed, or important gains in this area risk being lost.

The government needs to work harder to collect data and understand the complex needs of population groups most affected by HIV in order to develop adequate HIV programming. The dual epidemic of TB and HIV also remains a cause for concern.

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