



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	1.4 million (mid-2010)
Estimated Population Living with HIV/AIDS**	190,000 [180,000–200,000] (end 2007)
Adult HIV Prevalence**	26.3% [25–27.4%] (end 2007)
HIV Prevalence in Most-at-Risk Populations**	STI patients (Hhohho): 48.9% (2000)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy***	85% (2009)

*U.S. Census Bureau **UNAIDS ***WHO/UNAIDS/UNICEF *Towards Universal Access*, 2010

With an estimated adult prevalence of 26.3 percent, Swaziland has the world’s most severe HIV/AIDS epidemic, posing a serious challenge to the country’s economic development. Since Swaziland’s first AIDS case was reported in 1986, the epidemic has spread relentlessly in all parts of the country. According to the Joint United Nations Program on HIV/AIDS’s (UNAIDS’s) *Epidemic Update* 2009, average Swazi life expectancy fell by half between 1990 and 2007, in great part due to the epidemic. Approximately 190,000 people in Swaziland are HIV positive, including 15,000 children under age 15.

From 1992 to 2008, prevalence among pregnant women attending antenatal clinics (ANCs) rose from 3.9 to 42 percent, according to the 2010 United Nations General Assembly Special Session (UNGASS) report. In 2008, prevalence among pregnant women varied markedly by age group, from 12 percent in those 15 to 19 years of age to 49 percent among those 25 to 29 years of age. The primary mode of HIV transmission in Swaziland is heterosexual contact, which accounts for 94 percent of transmissions, according to UNAIDS. Between 50 and 65 percent of new infections occur among steady, long-term partners; countrywide, one in six heterosexual couples is serodiscordant, according to the 2007 Swaziland Demographic and Health Survey (SDHS).

Issues of gender inequity, sociocultural norms and behaviors, and gender-based violence (GBV) all contribute to the disproportionate effects of HIV on Swazi women. For every two HIV-positive adult men, there are three HIV-positive adult women, according to the 2007 SDHS. Women aged 25 to 29 have the highest prevalence of either sex, at 48.9 percent. Among men, prevalence is highest among 35 to 39 year olds, at 44.9 percent, according to the 2007 SDHS. Among people older than 35 years, men are more likely to be HIV positive than women, but among those under 35, more women are infected. The majority of new infections (62 percent) also occur in females, with HIV contributing to an escalating maternal mortality ratio, now at 589 deaths per 100,000 live births, according to the United Nations Children’s Fund (UNICEF). GBV is a severe social and public health problem in Swaziland. A 2007 study by UNICEF and the U.S. Centers for Disease Control and Prevention (CDC) found one-third of females aged 13 to 24 experienced sexual violence before the age of 18.

High HIV prevalence and the differing rates between men and women can be explained to a large extent by intergenerational sex, earlier sexual debut among girls, and the prevailing practice of having multiple concurrent sexual partners. These practices are influenced by gender norms and ideals for both men and women, including a tradition of polygamy and values that endorse men’s power and dominance over women. Economic disparities and women’s economic reliance on men serve to reinforce gender stereotypes and limit women’s ability to make decisions, including those related to safer sex.

High-risk sex (with a nonmarital, noncohabiting partner) is a common practice among adults, with 44 percent of women and 58 percent of men aged 15 to 49 having had high-risk intercourse in the past year. Men are far more likely than women to have multiple partners, however, with 10 times more men having two or more partners in a year compared with women (23 percent and 2.3 percent, respectively). Just over one-half of adults aged 15 to 49 who had two or more partners in the past year reported using a condom at their last sexual encounter.

Most-at-risk populations include youth (particularly girls), sex workers, seasonal and factory workers, long-distance truck drivers, soldiers, and employees of the public transport sector. However, with more than one-fourth of Swaziland’s adult population living with HIV/AIDS, even the general public qualifies as “at risk.”



Children are affected by the epidemic by contracting the disease from their mothers and/or by losing a parent to the disease. In the 2007 SDHS, 5 percent of children between the ages of 2 and 4 were HIV positive, and in 2008, children under 15 were estimated to account for nearly one out of every five new cases of HIV. HIV/AIDS is also responsible for 47 percent of under-5 mortality in Swaziland, reversing hard-won child survival gains.

The National Children's Coordination Unit estimates there are approximately 130,000 orphans and vulnerable children (OVC) in Swaziland. According to the 2007 SDHS, only 22 percent of children under 18 years of age live with both parents, and nearly one-third do not live with either parent. While extended families have absorbed the vast majority of children without parents, traditional safety nets are being stretched to a breaking point as the number of children in need rises. The 2007 SDHS reported nearly 60 percent of households with OVC received no external support during the previous 12 months. The "most basic needs" (defined by the Demographic and Health Survey as one pair of shoes, two sets of clothes,

and one meal per day) are not met for approximately 40 percent of OVC. While the elderly have taken on more caregiver responsibilities, many have lost the financial support of their own children due to AIDS. Their own limited resources make it difficult to support their grandchildren.

Despite the widespread nature of the epidemic in Swaziland, HIV/AIDS is still heavily stigmatized. This stigma hinders the flow of information to communities, hampers prevention efforts, and reduces use of HIV/AIDS services. Other barriers to prevention, treatment, and care include the limited coverage of behavior change communication strategies, limited access to health and social services (particularly for children), inadequate laboratory services and lack of trained laboratory staff, and an insufficient number and limited capacity of health care providers. High rates of unemployment and poverty, drought, and lack of food security limit care-seeking behaviors and contribute directly to high rates of treatment default.

Swaziland has one of the highest tuberculosis (TB) incidence rates in the world, with an estimated 1,200 cases per 100,000 population in 2008, according to the World Health Organization (WHO). An estimated 84 percent of adult-incident TB patients are also HIV positive, which complicates the care and treatment of both diseases.

National Response

In 1999, King Mswati III declared AIDS a national disaster and established the Cabinet Committee on HIV and AIDS and the Crisis Management and Technical Committee. In 2003, the National Emergency Response Committee on HIV/AIDS was established to coordinate and facilitate the national multisectoral response to HIV/AIDS, while the Ministry of Health (MOH) implemented activities. In 2005, the first National HIV/AIDS Strategic Plan was reviewed by a broad group of national stakeholders. Based on this review, a second National HIV/AIDS Strategic Plan for 2006–2008, the National HIV/AIDS Action Plan, and the National Multisectoral HIV and AIDS Policy were developed in 2006 to coordinate the national response. Swaziland is currently implementing its third HIV/AIDS strategic plan: the National Multisectoral Strategic Framework for HIV and AIDS, 2009–2014 (NSF). The NSF has four thematic areas: prevention, treatment, care and support, and impact mitigation/response management.

In 2003, the MOH launched the Emergency Care and Treatment Implementation Plan to provide free antiretroviral therapy (ART) to people living with HIV/AIDS (PLWHA). With ART services now available in all urban and peri-urban settings, the MOH is rapidly rolling out a decentralized care and treatment program to clinics throughout the country. The 2010 WHO/UNAIDS/UNICEF *Towards Universal Access* report estimated 85 percent of PLWHA in need of ART were receiving it in 2009, according to the 2006 WHO guidelines. In 2009, WHO revised its recommendation for the CD4—a specific white blood cell—count at which PLWHA should start ART. The 2006 guidelines recommended initiating ART when a person's CD4 count reached or dropped below 200 cells per cubic millimeter; the revised guidelines recommend initiating therapy at or below a CD4 count of 350.

The Government has also successfully supported the scale-up of prevention of mother-to-child transmission of HIV (PMTCT) programs through its PMTCT Strategic Plan and PMTCT Implementation Plan, expanding services from a base of virtually none in 2004 to 140 out of 172 ANC sites countrywide. According to Government estimates in the 2010 UNGASS report, 69 percent of HIV-positive pregnant women received ARVs in 2009 to reduce mother-to-child transmission.

In 2009, Swaziland drafted a formal male circumcision (MC) policy and implementation plan in response to promising results from recent clinical trials for MC as a method of preventing the transfer of HIV. With only 8 percent of men currently circumcised in the country, according to a 2009 study cited by UNAIDS, scale-up of MC will require considerable funding and investment in capacity building. The scale-up could reduce costs in the long run, although, by potentially altering the trajectory of the national epidemic. In 2010, at the request of the MOH, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) awarded Swaziland \$27 million to implement an Accelerated Saturation Initiative (ASI) to achieve universal circumcision in the 18- to 49-year-old male age group. The ASI will be the first time mass circumcision is being attempted as a HIV prevention initiative in an entire country. A task force, which comprises Government; service providers from the private sector and nongovernmental organizations (NGOs); and traditional authorities, has been established to oversee the rollout of MC, including the ASI.

A National Children's Coordination Unit was established in the Office of the Deputy Prime Minister (DPM). The Department of Social Welfare was moved from within the MOH to the DPM's Office. The NSF prioritizes impact mitigation and children in particular as key focus areas. The policy environment is rapidly evolving with the recent cabinet approval of a National Children's Policy and Social Development Policy. It is also evolving by developing several draft documents, including National Alternative Care Guidelines; Residential Care Guidelines; and Quality Service Standards for OVC Programs. The National Plan of Action (NPA) for Orphans and Vulnerable Children for 2006–2010 was evaluated, and a new NPA covering 2011–2015 has been developed.

Swaziland has made progress in increasing access to education for OVC. In 2002, the Government introduced a budget allocation for grants to support education for OVC. Although the costs of schooling are not fully covered by this grant, the national allocation has steadily increased with almost 112,000 children benefiting from the grant in 2009. In 2010, the Government began phasing in universal free primary education. The 2007 SDHS found only minor differences (a ratio of 0.976) in school attendance between orphans and non-orphans; however, there are still challenges with school retention and high dropout rates.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has disbursed \$76.2 million since 2003 to combat HIV/AIDS in Swaziland, most recently in an eighth-round grant in 2010 for \$7.2 million to support health systems strengthening. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide and is one of Swaziland's largest bilateral donors. Other international donors include the European Union, the World Bank, and several United Nations agencies.

USAID Support

Through the U.S. Agency for International Development (USAID), Swaziland received \$13.6 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Swaziland are implemented as part PEPFAR. Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In June 2009, the Government of Swaziland signed the Swaziland Partnership Framework on HIV and AIDS for 2009–2013. This Partnership Framework was the second of its kind established between the USG and the Swazi Government for PEPFAR programs. The Framework promotes a more sustainable approach to combating HIV/AIDS, characterized by strengthened country capacity, ownership, and leadership, as well as coordinated financial commitments. It focuses on five pillars: developing a comprehensive national HIV prevention program; improving the coverage and quality of HIV-related treatment and care; mitigating the impacts of HIV/AIDS with a focus on children; increasing access to high-quality medical MC; and building the human and institutional capacity needed to achieve and sustain these goals.

The PEPFAR program covers all regions in Swaziland and is organized around the five pillars of the Partnership Framework. The program is working in close collaboration with USAID, CDC, and the U.S. Departments of State, Defense, and Labor to implement a sustainable, evidence-based, results-oriented program, leveraging the particular technical expertise of each agency. USAID provides technical and program management assistance through its Regional HIV/AIDS Program based in South Africa. USAID's support focuses on prevention, impact mitigation with a focus on children, human capacity development, NGO capacity building, and health systems strengthening. USAID also provides significant technical assistance to the development and management of ART and to patient monitoring systems in order to help Swaziland adhere to Global Fund requirements.

With supplementary funding awarded from the PEPFAR Office of the Global AIDS Coordinator's gender challenge fund, USAID will begin implementing gender-focused activities in FY 2011. The program is being designed to address the fundamental causes of young women's vulnerability to HIV infection in southern Africa: poverty and gender inequity. As such, it will have two components: 1) economic strengthening of girls and women (particularly those infected with or affected by HIV, including OVC) and 2) activities to address social norms and behaviors that promote imbalances in gender power and decision making.

USAID and PEPFAR have had a number of successes in 2009 and 2010. Some highlights include:

- PEPFAR and its partners surpassed all FY 2009 targets for abstinence- and faithfulness-based prevention, reaching more than 320,000 people in a variety of community-based settings with abstinence and "be faithful" messages.
- Significant scale-up for providing PMTCT supported 47 health facilities and provided services to 6,714 HIV-positive mothers; 13,000 infants were born to HIV-positive mothers in 2009, estimated UNAIDS.
- A successful back-to-school circumcision campaign in FY 2010 circumcised 7,165 boys.
- Through a partnership with UNICEF, expansion of the "neighborhood care point" initiative in the 200 PEPFAR focus sites reached more than 10,000 preschool-aged children with food and nutrition and psychosocial, education, and health services.
- The Shoulders to Cry On child protection project, which provides community-based education about children's rights and a first line of intervention in child abuse cases, expanded. It is a critical program in a country where one-third of girls experience sexual violence by the age of 18.

Important Links and Contacts

USAID Regional HIV/AIDS Program
P.O. Box 43
Pretoria, South Africa 0027
Tel.: 27-12-452-2000
Fax: 27-12-452-2399

U.S. Embassy/Swaziland
Central Bank Building, 7th Floor
P.O. Box 199
Mbabane, Swaziland
Tel.: 268-404-6441
Fax: 268-404-1695

USAID's HIV/AIDS Web site for Swaziland:

http://www.usaid.gov/our_work/global_health/aids/Countries/africa/swaziland.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

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