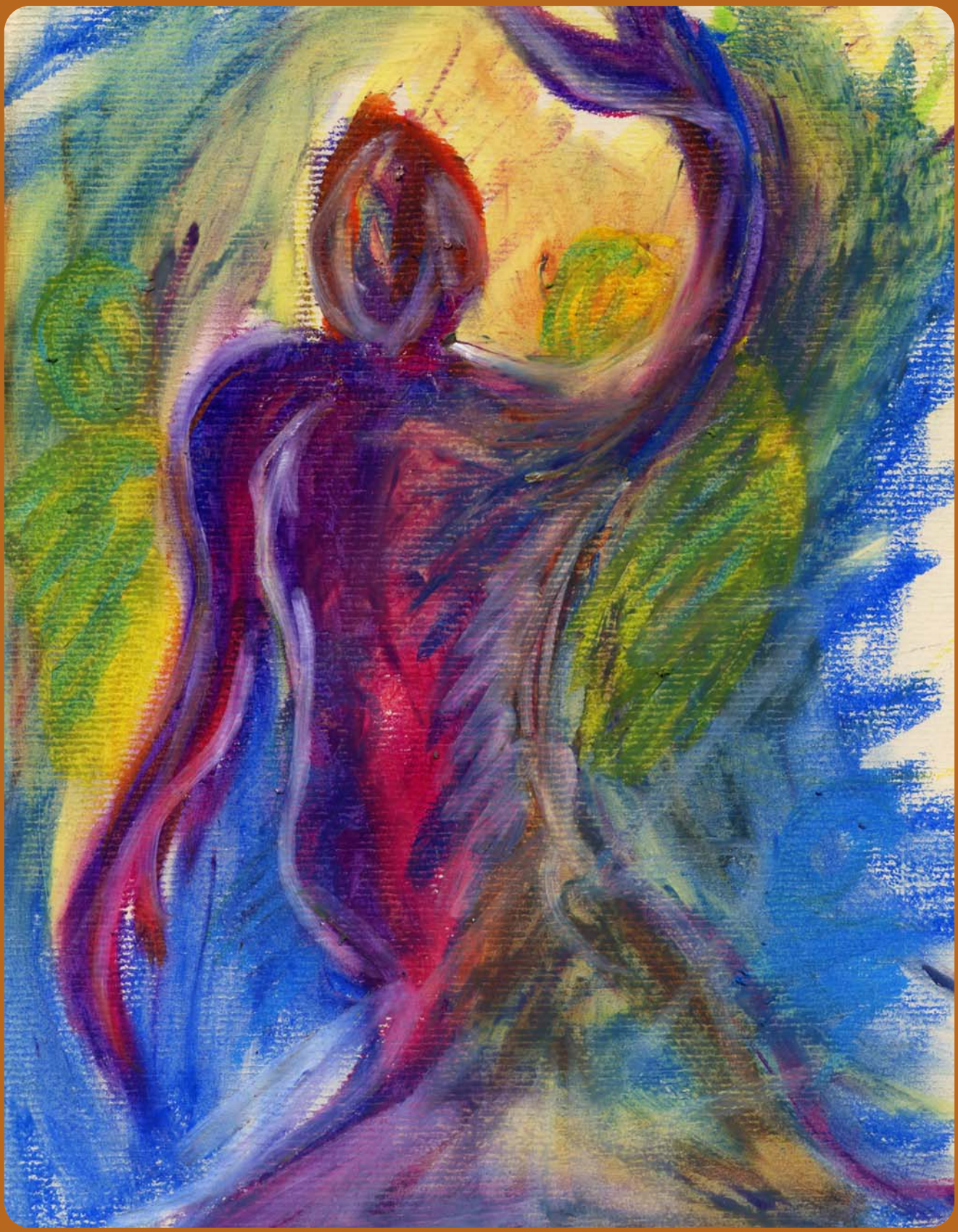


"Anita"

Anushka Virahsawmy

CHAPTER 7
HIV and AIDS

Article 27

Xolile Hlatshwako HIV positive activist says more needs to be done to prevent HIV and AIDS - Manzini, May 2012. *Photo: Trevor Davies*

KEY POINTS

- With an SGDI score of 67%, Swaziland has made notable progress in addressing HIV and AIDS. The citizen score based on perceptions is close at 61%.
- Swaziland has the highest HIV and AIDS prevalence rate in the SADC region at 26 per cent.
- The HIV prevalence rate amongst women is 31% and 20% for men
- Some 69% of HIV-positive pregnant women are on the PMTCT programme. Swaziland ranks seventh in the region regarding access to PMTCT.
- Some 58% of the estimated number of women and 33% of the estimated number of men needing treatment, received it. The low percentage of men receiving treatment is attributable to their poor health seeking behaviours.
- The 2007 Demographic Health Survey found that 31% of Swazi children under the age of 18 years are classified as either orphaned or vulnerable.

Table 7.1: SGDI and CSC scores for HIV and AIDS		
	SGDI	*CSC*
Score	67%	61%
Rank	6	12

Table 7.1 shows that Swaziland is 67% of where it needs to be by 2015 based on empirical information. The citizen's score is close at 61% based on their perceptions of the country's progress.

The current situation

Table 7.2: Key Gender, HIV and AIDS indicators		
	% women	% men
Extent of comprehensive knowledge on HIV and AIDS	89%	87%
HIV infection	26%	
Voluntary Counselling and Testing	22%	9%
On ARV treatment	58.2%	33.1%
HIV positive pregnant women receiving PMTCT	69%	N/A

Source: UNGASS 2010 Country progress reports; IAS 2009 Fact sheet on HIV and AIDS in sub-Saharan Africa.

Table 7.2 shows that there is an increase on extent of comprehensive knowledge of HIV and AIDS showing that the investments on prevention campaigns are paying off.

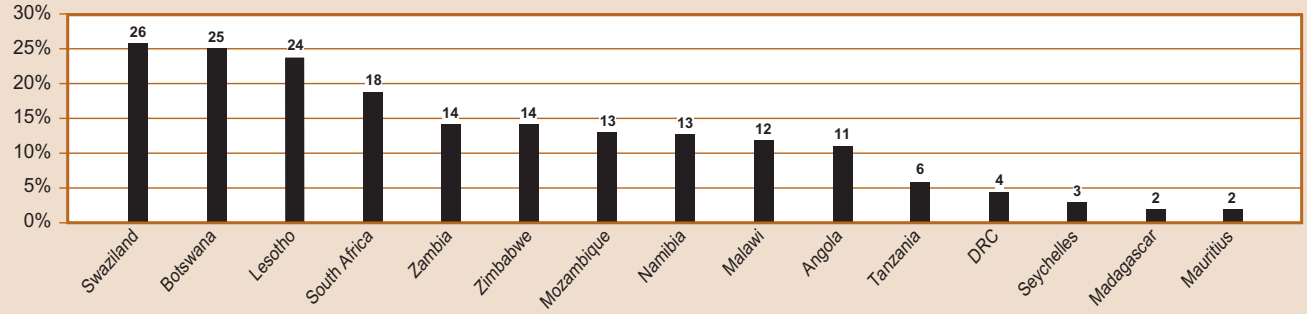
The government declared HIV a disaster in 1999, which resulted in the adoption of the first multi-sectoral HIV and AIDS strategy. The strategy outlined the areas of intervention in the national response. Currently, the country is on the third generation strategy. The National Emergency Response Council on HIV and AIDS was given the role to facilitate the implementation of this strategy.

HIV positive Bongiwe Gwebu during the Mothers to Mothers wellness event. *Courtesy of Swaziland Observer*

The Coordinator of Care, Treatment and Support at the National AIDS Commission confirmed that men have poor health seeking tendencies and will only present themselves for VCT when they are extremely sick. The Swaziland and HIV Estimates and Projections Report (July 2010) states that the number of people living with HIV continues to increase and the number of HIV positive women continues to be higher than men.

Swaziland adopted the multi-sectoral HIV policy in July 2006. Section 2.3 on the impact of the epidemic recognises that vulnerable people - women, children, orphans, widows, widowers, youth, the poor, sex workers, inmates and people with disabilities - are most likely to suffer disproportionately from the impact of HIV and AIDS.

Figure 7.1: Percentage population infected with HIV



Source: 2012 SADC Gender Protocol Barometer.

Figure 7.1 shows Swaziland has the highest prevalence rate of HIV and AIDS in the SADC region at 26%. The infection levels amongst women are 31% and 20% for men. In 2008, the HIV prevalence amongst pregnant women remained at of 42%.

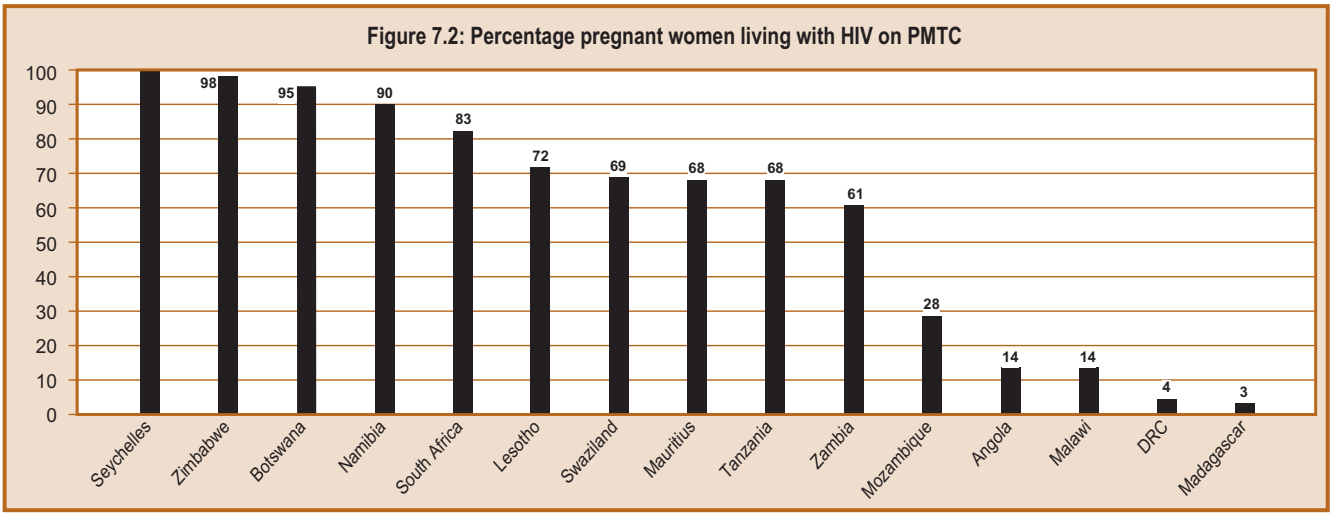
Policies

The policy applies to all governmental, other stakeholders and partners who are involved and support the country in response to HIV and AIDS. It obligates all government ministries and organs, stakeholders and partners to mainstream HIV and AIDS into their plans and programmes. Preventing transmission of HIV is one of its specific targets. The guiding principles of this policy define approaches for implementing the response to HIV and include the following principles:

- Gender equality and equity.
- Promoting positive cultural practices.
- Full meaningful involvement and participation of People living with HIV (PLHIV) and other vulnerable groups in all issues affecting them.
- Protection, non-discrimination, non-stigmatisation of PLHIV and other vulnerable groups.
- Respect for human rights.
- Compliance with international treaties, conventions and declarations signed and ratified by government and national laws. (Swaziland HIV Prevention Response and Modes of Transmission Analysis March 2009).

Prevention

The Protocol requires that by 2015, state parties shall develop gender-sensitive strategies to prevent new infections, taking account of the unequal status of women, and in particular the vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.



Source: 2012 SADC Gender Protocol Barometer.

Figure 7.2 shows that 69% of HIV-positive pregnant women are on the PMTCT programme.

Swaziland initiated its PMTCT programme in 2003. The National PMTCT Guidelines and an operational manual covering the period 2007-2011 have been developed.

The PMTCT coverage currently stands at 67.9% of the 162 health facilities that reported to be providing PMTCT services. The country uses the single dose-NVP as the primary method of ARV prophylaxis. The 2010 Universal target for the country was to ensure that 80% of pregnant HIV-positive mothers access PMTCT.

Swaziland needs to accelerate HIV and AIDS prevention campaigns because of the high prevalence of HIV and AIDS. *Photo: www.avert.org*

The number of HIV-positive pregnant women is expected to decline from 11,031 in 2008 to 9,999 by 2015. It is also projected that the gap will narrow between HIV-positive pregnant women and HIV positive pregnant women needing PMTCT moving towards 2015.

The policy also recognises the protection and empowerment of orphans and vulnerable children. There is a huge demand for the services, particularly for educational, psychosocial, nutritional, health care, protection and socialisation programmes. The 2007 Demographic Health Survey found that 31% of Swazi children under the age of 18 years are classified as either orphaned or vulnerable. Furthermore, it revealed that 41.2% of the OVC received at least one type of support. Disaggregated, the level of support was 41.8% for boys and 40.6% for girls.

Treatment

The Protocol requires state parties to ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls.

Swaziland started providing ARV drugs in December 2003 and approved guidelines to standardise their distribution in 2006. By March 2008, 43% of those in need of treatment were on it, that was a total of 26,812 people. Some 58% of the estimated number of women and 33% of the estimated number of men needing treatment, received it. The low percentage of men receiving treatment is attributable to their poor health seeking behaviours.

In 2008, the nation set a target of reaching 51,000 people to go on treatment. But the actual number of people that received treatment was 26,812 (only 53% of the target). This is partly due to the slow roll out of drugs to only 15.5% of the public and private facilities with the capacity to provide ART, as well as 27 outreach sites. Another contributing factor for not meeting the target is that of many people not knowing their HIV status.

Care work

The Protocol requires Member States to develop and implement policies and programmes to ensure the appropriate recognition of the work carried out by care givers; the majority of whom are women, to allocate resources and psychological support for care givers as well as promote the involvement of men in the care and support of people living with AIDS.

In 2010, inspired by Article 27(c) of the SADC Protocol on Gender and Development, Gender and Media Southern Africa (GEMSA) and VSO-RAISA developed the *Making Care Work Count Policy Handbook*. The objectives of the handbook include to influence the development, adoption, implementation and enforcement of policy frameworks that promote the recognition and support of care providers in the context

of HIV and AIDS, and to promote public engagement on care work related issues.

The handbook proposes six principles that need to inform care work policies:

- **Remuneration:** People doing the work of government have a right to be financially rewarded.
- **Logistic and material Support:** It is imperative that care providers are provided with care kits as well as other support, such as uniforms for identification, bicycles, food packs, monthly monetary allowances, soap, free medical treatment, financial support for income generating projects, raincoats, umbrellas, agricultural inputs, stationery and transport allowances, among others, to provide quality care.
- **Training and professional recognition:** Protocols of training and accreditation should be developed through a governing body within the country to regulate and standardise the training.
- **Psychosocial support:** Care for care providers should be prioritised with psychosocial support programmes developed and provided to care providers.
- **Gender equality:** The gender dimensions of HIV should be recognised and catered for.
- **Public private partnerships:** There is a need to advocate for stronger public private partnerships in the delivery of PHC services through C&HBC programmes.

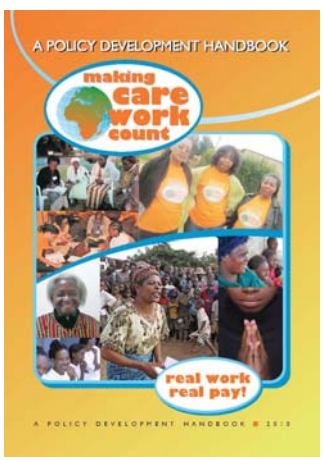
Table 7.3 outlines progress on policy and legislative initiatives to regulate care work in Swaziland based on information available to researchers at the time of writing.

Table 7.3: Progress in addressing care work in Swaziland

ISSUE	PROGRESS
Remuneration	The current CHBC policy calls for a monthly incentive of E200 (roughly USD$25) for Registered Health Monitors (RHMs). Attempts to integrate Swazi care givers into RHM system are ongoing. More effort required to secure government subsidies and other support for care givers.
Logistical and material support	All RHMs and care givers receive CHBC kits and uniforms as a requirement for easy identification within the community, an identity card, t-shirt, shoes, umbrella, a home-based care kit, and a monthly, monetary incentive as above. Community care givers are not entitled to this support.
Training and professional recognition	The Ministry of Health and Social Welfare (MOH&SW) last trained care givers in 2005 and training continues to be the same despite changes in the area of care work. Care work is not recognised as a profession in Swaziland. Only one training manual and reporting tool exists that is applicable to both government and independent care givers.
Psychological support	There is no policy document that exists on psychosocial support for care workers. The evaluation report on CHBC has looked into support for care-givers. MOH&SW requests that all CHBC organisations promote stress management techniques, help care givers adjust to the pace and approach to work, provide peer counselling, and establish a support network.
Gender equality	No policy.

Capacity-building sessions have been held in Swaziland with CSOs on care work. The main components of these processes included:

- Country mapping and stakeholder analysis;
- Building a coalition;
- Influencing policy uptake and implementation;
- Developing an advocacy and lobbying plan; and
- Monitoring and evaluation.



Next steps

- To accelerate and intensify prevention in order to reduce the annual reate of new HIV infections.
- Men should be encouraged to test for HIV and access treatment if needed.
- A campaign is needed to encourage more men to be involved in home-based care.
- TO mitigate the socio-economic impact of HIV and AIDS, especially among the most vulnerable groups, orphans and vulnerable children (OVC), PLHA and their caregivers and families.
- To lobby for the State to increase budgetary allocation on HIV and AIDS as a cross cutting issue.