Rethinking Swaziland’s HIV/AIDS Epidemic
The Need for Urgent Interventions
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ABSTRACT

Swaziland’s HIV/AIDS epidemic has been characterized by the slow onset of a myriad of co-factors culminating in a chronic emergency, burdening every sector of society. Exacerbated by domestic political mismanagement and ill-suited policies of international organizations, impacts will remain endemic for generations.

From near-zero diagnosed HIV infections in 1990, Swaziland now has the highest relative prevalence in the world. The impacts of infection are withering the human capacity to mount effective and systemic interventions. Indicators of social well-being show a population in distress. Aggravated by gender inequality, drought, agricultural decline and insufficient financial resources, livelihood failure in Swazi households has become commonplace – and the situation is deteriorating.

This article argues that the brutal reality facing the Swazi population is perpetuated by the lack of political will of government and conditionalities imposed by international donors. In the absence of comprehensive government-led programming, many communities have initiated interventions. Assisting these vulnerable populations requires sustained international financial commitments. This money would be used to best effect if accompanied by pressure for domestic political accountability in Swaziland. Such changes will facilitate country-wide interventions, particularly those at the community level. While Swaziland is the case study, many of the findings are applicable to generalized epidemics throughout southern Africa.

Key words: HIV/AIDS; Swaziland; humanitarian emergency; international aid; disease burden; gender inequality; Southern Africa

La traduction du résumé se trouve à la fin de l'article.

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There are eight ‘Red Countries’* in southern Africa, so called because they are shaded dark red on UNAIDS prevalence maps. They represent the epicentre of the HIV/AIDS pandemic. Swaziland has the highest prevalence.¹

This epidemic has been characterized by the slow onset of a myriad of co-factors that have culminated to create a complex emergency. Rising morbidity and mortality mean that every sector of Swazi society is struggling to cope. Swaziland is losing large numbers of the most socially and economically active members of its society, leading to mass orphaning and a decline in agricultural production. This is happening in the context of gender inequality and climate change, especially drought. Paradoxically, Swaziland is classified as a lower-middle income country, which means it cannot access certain forms of donor support.

The challenges of responding to the crisis are exacerbated by the lack of accountable domestic governance and ill-suited policies of international organizations. Without greater support from the government and international donors, innovative community-led interventions may be seriously undermined.² Swaziland’s HIV/AIDS epidemic is currently the most advanced in the world; we posit that it may be a harbinger for what awaits the other Red Countries.

The first case of AIDS in Swaziland was diagnosed in 1986. In 1992, when the country’s first antenatal survey was carried out, HIV prevalence among pregnant women attending antenatal clinics was found to be 3.9%. By 2004, just 14 years later, antenatal prevalence had jumped to an astonishing 42.6%. Overall prevalence in the country is currently estimated near 19%,³ a figure which, if applied to American and Canadian populations, would mean that more than 56 million Americans and over 6 million Canadians would be HIV-positive.†

The increase in mortality has already had measurable and dramatic effects. In 1998, the UN estimated life expectancy in Swaziland at 60 years. In 2004, after taking AIDS into account, life expectancy was

* The ‘Red Countries’ are: Swaziland, Lesotho, South Africa, Namibia, Botswana, Zambia, Zimbabwe and Mozambique.
† Based on a prevalence of 18.8% and a population of 301,140,000 in the USA and 32,000,000 in Canada.
estimated to be just 31.3 years – the lowest in the world.4 Government population projections in 1986 estimated the population would grow from about 900,000 in 1986 to 1,203,000 by 2006.5 The 1997 population census recorded 929,718 people in Swaziland. A preliminary result of the 2007 census indicates the population has declined to 912,229.6 Although Swaziland is faced with poverty, malnutrition and drought, AIDS deaths are central to understanding this reversal.

One consequence of premature adult death is the growing number of orphans and vulnerable children (OVC). There are an estimated 120,000 OVC in Swaziland, a number projected to rise to 200,000 by 2010.7 Grandparents have largely assumed the role of primary caregivers. As they die, many of these children are left without support networks. This threatens inter-generational transfers of knowledge surrounding work and family values, and increases vulnerability to external shocks. Regrettably, the harsh circumstances afflicting a third of Swazi children have come to be seen as normal and inevitable8 – an abnormal normality reflecting a desperate society.

Women too suffer disproportionately. Females in Swaziland are economically and politically marginalized. They also shoulder the burden of the epidemic and are more vulnerable to infection. Of females aged 25-29, 49% are HIV-positive, compared to 28% of males in the same cohort.3 The feminization of the epidemic is a reflection of the low status of women. In Swaziland, women were only granted full legal rights in 2006.9 A recent national survey on violence experienced by female children and youths in Swaziland found that, of respondents, nearly 66% of females aged 18-24 had experienced sexual violence and approximately two thirds of 13-24 year old Swazi females reported being coerced or forced into their first sexual experience.10 Despite their marginal status, females are the primary caregivers of both children and the sick. When they die from AIDS, coping strategies become increasingly desperate.

Livelihood failure has become commonplace in Swaziland. Consecutive years of drought, compounded by the incapacitation of infected individuals, have led to falling agricultural production. As 70% of Swazis engage in subsistence agriculture,11 this is having devastating effects on the majority of the people. Malnutrition increases the transmissibility of HIV, hastens the onset of AIDS, and makes individuals more susceptible to opportunistic infections. In 2007, roughly 40% of Swazis required food aid, yet the government recently decided to cultivate cassava for bio-fuel production.12

Many of the government’s actions continue to be out of sync with the reality experienced by the majority of Swazis. The suppression of trade unions from public assembly13 shows that Swazis are more subjects than citizens. The 2006 constitution reaffirms that executive, legislative, and judiciary authority rest with King Mswati III, who has ruled Swaziland since 1986. In terms of political freedom and civil liberties, Swaziland is on par with Sudan and Zimbabwe.14 Engaged, accountable domestic leadership is essential for implementing holistic interventions to contain the spread and impact of HIV/AIDS. It will be increasingly difficult to reverse the deteriorating conditions in Swaziland without basic human rights of political representation and gender equality.

Mortality figures now exceed the thresholds used by humanitarian agencies to determine when a population requires immediate emergency interventions. In every region in Swaziland, the crude mortality rate has exceeded the threshold of 1 death per 10,000 persons per day.15 In the context of development indicators, the Human Development Index rating for Swaziland shows a steady decline since 2000. From a ranking of 112 among 174 countries in 2000,16 Swaziland has fallen to 141 out of 177 countries in 2007.17 Indicators of social well-being clearly assert that Swaziland is experiencing an emergency – a national disaster driven by HIV/AIDS. Shockingly, this has not set off alarm bells in the international community.

The politics of aid have restricted the external funding that is available to Swaziland, and consequently international assistance has been limited. Swaziland’s rating by the World Bank as a “lower-middle income” country means that the Kingdom cannot access the financial resources available to “low income” countries by the International Monetary Fund (IMF), including non-concessional International Development Assistance (IDA) loans. Some bilateral donors, such as the UK’s Department for International Development (DFID), use these categorizations to guide their allocation of foreign aid. These ratings are based on a country’s Gross National Income (GNI) per capita – the total national income divided by the population. As mortality from AIDS increases, Swaziland’s national wealth is divided among fewer Swazis. Consequently, AIDS deaths may be leading to an increase in Swaziland’s GNI per capita. We argue that GNI per capita should not be the measure used to assign international assistance in the Red Countries because it is not reflective of social and structural realities.

Compounding these misleading categorizations, the IMF insists that public sector expenditure be cut and the public service be reduced in size18 – this at a time when additional human capacity is needed to respond to the crisis. As the largest employer in Swaziland, the public sector is both financially responsible for many dependents and essential to implementing alleviation efforts. Cutting the public sector could have long-term negative ramifications for Swaziland’s development.

The absence of sustained financial and institutional support has not resulted in a total absence of action in Swaziland. Despite inadequate resources, some community-led initiatives, facilitated in part by the National Emergency Response Council on HIV/AIDS (NERCHA), are reaching vulnerable populations.2 KaGogo centres, traditionally used as a place for resolving disputes, have been transformed into coordinating centres for wider community interventions such as food distribution and orphan registration and care. Providing sponsorship to orphans and vulnerable individuals for schooling, food and clothing costs, the “Young Heroes” initiative assists children affected by the epidemic. Another innovative response has been the revitalization of the Indlakhu fields, a traditional practice where a Chief allocates land for the community to grow food for vulnerable members in the chiefdom. Community-led initiatives are most effective when supported by domestic and political resources.

The most recent UNAIDS report is a welcome flicker of hope in containing the
global spread of the disease. The fact that world prevalence estimates have been scaled down, however, should not encourage complacency. The situation in southern Africa has not improved.

We do not know the full impacts that HIV/AIDS will have in the Kingdom. We do know that policies must be recast to recognize the state of emergency facing hundreds of thousands of Swazis now. The aftershocks of HIV/AIDS will reverberate throughout every sector of Swazi society threatening human development, economic growth, cultural inheritance and the natural environment for generations. The fact that hundreds of thousands of Swazi children will grow up without parents presents a problem without precedent. Combined with drought, an inefficient public sector and political mismanagement, the situation in Swaziland is devastating.

Swaziland is experiencing an HIV/AIDS-induced complex emergency that is unparalleled. Severe epidemics in other countries did not reach the level of crisis present in Swaziland. Uganda’s prevalence peaked near 14% and has now fallen below 10%, and Botswana has been able to respond by rolling out treatment. This is not to minimize the devastating and continued impacts of HIV/AIDS in those countries, but to highlight that Swaziland is facing the most severe and complex HIV/AIDS epidemic to date.

Urgent interventions are needed. Mitigating long-term effects will require sustained financial commitments from the international community. This money would be used to best effect in supporting the work of civil society and NERCHA, and pressuring the government to increase political accountability. Community-led responses have, of necessity, endeavoured to address the needs of vulnerable populations throughout the country. While the case of Swaziland has been highlighted, many of these findings are applicable to generalized epidemics throughout southern Africa. The positive benefits of community initiatives throughout the Red Countries would be dramatically augmented with greater institutional and financial support from domestic and international sources.

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**RÉSUMÉ**

Au Swaziland, l’épidémie de sida se caractérise par la lente apparition d’une multitude de cofacteurs qui ont mené à un état d’urgence chronique et compliquent l’existence de toutes les couches de la société. Exacerbées par la mauvaise gestion politique interne et par les politiques malavisées des organisations internationales, les répercussions de l’épidémie se feront sentir pendant plusieurs générations.

Alors qu’on ne diagnosticait presque aucune infection à VIH au Swaziland en 1990, le pays affiche maintenant la prévalence relative la plus élevée au monde. L’infection mine la capacité des Swazis de monter des mesures d’intervention efficaces et systémiques. Selon les indicateurs du bien-être social, la population est en détresse. Sous le poids combiné des inégalités entre les sexes, de la sécheresse, du déclin de l’agriculture et de la pénurie de ressources financières, les ménages n’arrivent plus à assurer leur subsistance, et la situation ne cesse de se détériorer.

Dans cet article, nous faisons valoir que la réalité brutale à laquelle la population swazie est confrontée est perpétuée par le manque de volonté politique du gouvernement et les conditions imposées par les donateurs internationaux. En l’absence de programmes gouvernementaux intégrés, de nombreuses communautés amorcent leurs propres interventions. Pour aider ces populations vulnérables, il faut des engagements financiers internationaux soutenus. Et pour qu’on en fasse une utilisation optimale, les fonds doivent être accompagnés d’appels à la responsabilisation politique interne. De tels changements faciliteront les interventions nationales, surtout les projets à l’échelle communautaire. Nous nous sommes concentrés sur le cas du Swaziland, mais bon nombre de nos constatations s’appliquent aux épidémies généralisées en Afrique australe.

**Mots clés :** VIH/sida; Swaziland; urgence humanitaire; aide internationale; charge de morbidité; inégalités entre les sexes; Afrique australe