EDITORIAL
History of the HIV epidemic and response in Swaziland

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Swaziland is a middle income southern African country with a population of about 1.2 million people (CSO, 2007). It has the highest HIV prevalence in the world, 27% for the population group aged above 15 years (Ministry of Health, 2016). The human toll of HIV and AIDS in Swaziland is a tragic reality, adversely affecting social and economic gains. In particular it reversed gains in life expectancy, which fell from 60 years in 1997 to 47 years for females and 43 years for males in 2007. The life expectancy rose to 48.6 and 49.1 years for women and men respectively in 2015 (NERCHA, 2017).

The epidemic had a profound impact on the socio-economic status of the country, resulting in high mortality rates among the productive age groups, forcing the country to focus large amounts of national resources to fighting the epidemic, and increasing healthcare costs. The impact which included the loss of many lives was first observed in the early years, around the 1990s, as the virus took hold in the country. At the time, treatment for HIV was unavailable, and academics predicted a gloomy future for the Kingdom: population growth was projected to become negative by 2004 due to high AIDS-related deaths.

The country rapidly woke up to the peril it faced. The HIV and AIDS response was initially anchored in 1987 at the Ministry of Health under the Swaziland National AIDS Programme (SNAP). More than 7 000 people were dying each year with thousands more being infected, and the situation was classified as an emergency.

In 1999 His Majesty King Mswati III and the Government of Swaziland, realising the severe impact of the epidemic, introduced a multi-sectoral approach to fighting the epidemic. The King declared HIV and AIDS a national emergency and the Government of Swaziland launched a Cabinet Committee on HIV and AIDS and a Crisis Management and Technical Committee (CMTC). This demonstrated political commitment and strengthened collaboration. To further strengthen the country effort to achieve a positive and fruitful national response, in 2003 the CMTC was replaced with the National Emergency Response Council on HIV and AIDS (NERCHA). The Council was established through an Act of Parliament, to fast-track a relevant multi-sectoral HIV and AIDS response, by coordinating the biomedical and non-biomedical sectors of the HIV response.

Swaziland began to tame the HIV and AIDS epidemic by placing it at the centre of its development agenda, and ensuring the highest level of political leadership. The country has a clear vision for Ending AIDS by 2022. It has introduced several interventions to eliminate new infections among young girls in particular, whom, according to both the Swaziland Health Measure Survey (SHIMS) 1 (Ministry of Health, 2011) and SHIMS 2 (Ministry of Health, 2016), show peak incidences.

Since the late 1980s, when Swaziland began to coordinate its response, much has happened. The government and its partners have systematically allocated resources and formulated plans to address the challenges of HIV. Through the collective contribution of multi-sectoral partners in government, civil society organisations, people living with HIV (PLHIV), communities and development partners, the country has stabilised the HIV pandemic.

The collective contribution of the multi-sectoral response has, over the years, been guided by four generations of national strategic frameworks that enabled the country to achieve positive results. The current 2014–2018 extended National Strategic Framework (eNSF; NERCHA, 2014) adopts the "combination prevention approach" which combines biomedical, behavioural, social, and structural interventions for maximum impact on stopping new infections. The strategy prioritises 11 programmes based on the country context and effectiveness.

The country further followed an investment approach to prioritise five specific interventions using the limited resources. These interventions include: accelerated scale-up of antiretroviral therapy (ART) for PLHIV; scaling up voluntary medical male circumcision (VMMC); innovative HIV prevention approaches for girls and young women; elimination of mother-to-child transmission of HIV (EMTCT) and intensifying tuberculosis (TB)/HIV co-infection diagnosis and treatment.

The HIV and AIDS response also aims at adopting evidence and results-based planning and management to continue generating new evidence and knowledge, while improving the management of existing strategic information. The specific objectives include: reducing new HIV infections by 50% and 90% among adults and children respectively; averting 15% deaths amongst PLHIV and in particular those with TB/HIV co-infection; and alleviating socio-economic impacts of HIV and AIDS among vulnerable groups. Reducing the number of new infections is of utmost priority for the country's entire fiscal sustainability.

The country, through its multi-sectoral response to HIV and AIDS, has, obtained positive results in areas such as: reduction of new infections, EMTCT, reduction of HIV prevalence amongst young people, reduction of AIDS-related deaths, scaling up of VMMC among young people, strengthening interventions for key populations, and the promotion and distribution of condoms.

The aim is "ending AIDS by 2022" and Swaziland has adopted the concept of reaching zero new infections, zero stigma and discrimination and zero deaths, which is popularly known as 0:0:0. To fast-track this target the country also adopted a 90:90:90 model: getting 90% of people living with HIV tested; ensuring 90% of the HIV-infected people are receiving treatment; and getting 90% of the people on treatment virally suppressed (UNAIDS, 2014). The country through its combined efforts

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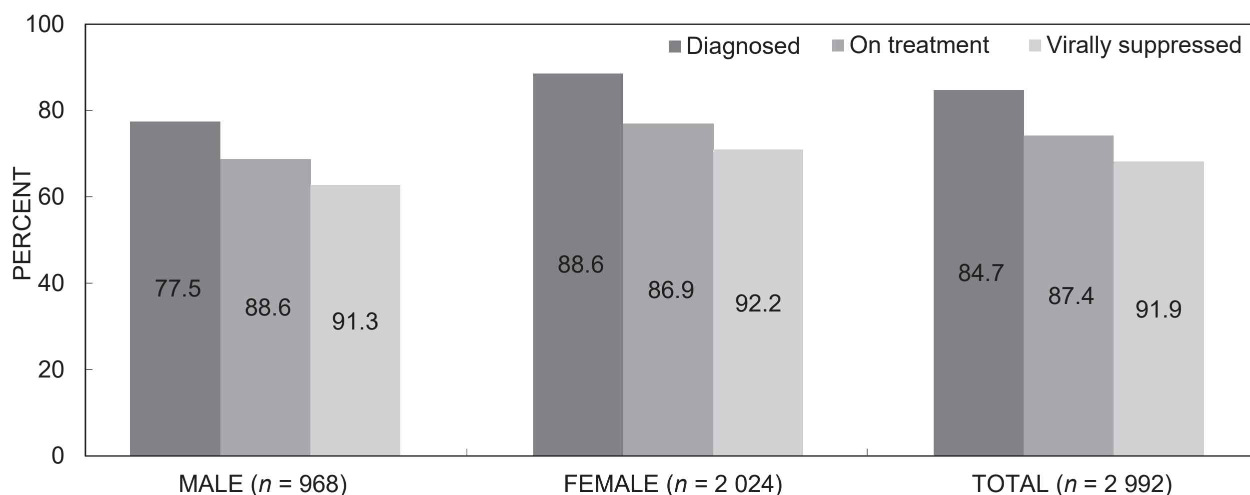

Figure 1: Swaziland 90:90:90 achievements by sex. Source: Ministry of Health (2016)

has been able to scale up its treatment, care and support interventions to achieve the third 90, while getting very close to the first and second. SHIMS 2 (Ministry of Health, 2016) indicates that the 91% of people on treatment are virally suppressed in Swaziland (Figure 1).

Given the complexity of the response, the country continues to intensify advocacy for strengthening HIV synergies within the development sector. This includes interventions which promote a shift from social welfare to social development, through multi-sectoral coordination with joint planning and budgets. The first priority is to prevent new HIV infections, by strengthening interventions for vulnerable groups: orphans and vulnerable children (OVC), and women and girls and other groups. They need continued and enhanced support for critical synergies, including social protection, systems (health, education and community) strengthening, food security and nutrition.

The use of traditional community-based safety nets to care for vulnerable populations in communities has yielded good results. The establishment of Kagogo centres to coordinate the provision of social services for OVC in communities, has helped mitigate the impacts of the epidemic. The country also built community neighbour care points (NCPs) to support OVC with basic human needs.

The provision of national data to support evidence-based HIV programming, and increasing expenditure for HIV and AIDS programmes, has contributed positively to the response. In 1992 Swaziland established a surveillance system to monitor HIV trends. In the years leading to 2006 Swaziland relied on the rates from antenatal care surveillance to estimate HIV prevalence, which rose from 3.9% in 1992 to highs of 42.6% in 2004, and dropped to 39.9% in 2006. Antenatal care was used because it was easier to reach women during their antenatal visits. The limitation of using antenatal care was that the prevalence was derived from probability from selected health facilities and only targeted pregnant women.

To provide prevalence data for the whole population the country conducted a national demographic and health survey in 2006/2007. In 2010 the country through the central statistics office, under the Ministry of Economic Planning conducted a multi-cluster survey which included indicators on behaviours of people in relation to risks to acquiring HIV (CSO, 2011). The survey was repeated in 2014 and it provided data which could be used to redesign HIV programmes (CSO, 2015). In 2011 the country also conducted a health indicator measurement survey and this was repeated in 2016 (Ministry of Health, 2016). All these data sources enable the interventions to be based on evidence.

SHIMS 2 (Ministry of Health, 2016) indicates a decline in HIV infections in the country, declining AIDS-related deaths and increase in viral suppression. This has been achieved through a combination of prevention strategies which the country had initiated to control the number of new infections; provision of treatment for viral suppression; and the virtual elimination of mother-to-child transmission of HIV for young children.

Living with HIV has been transformed to chronic disease management by the successful national ART, treatment and care programme. This contributed to increased viral load suppression in PLHIV in the country. Swaziland was been applauded for these achievements by the participants of the 2017 International AIDS conference held in July 2017 in Paris, France. The country has managed to reduce its incidence of new infections by 44% to 1.36% amongst adults aged 18–49 years and reach a viral suppression rate of 73% among the 15–49-year-old population group (Ministry of Health, 2016). Figure 2 shows the current information on incidence of HIV in Swaziland.

According to SHIMS (2016) the HIV prevalence is stable, and higher among females at 32.5% than in males at 20.4%. The 2015 estimates and projections show Swaziland will experience a further decline in incidence by 2020. The HIV incidence among young people aged 15–24 years has also been reduced for both males and females even though they still remain high at 1.9% for females and 0.9% for males. This indicates that adolescents and young people still need to be at the centre of the response.

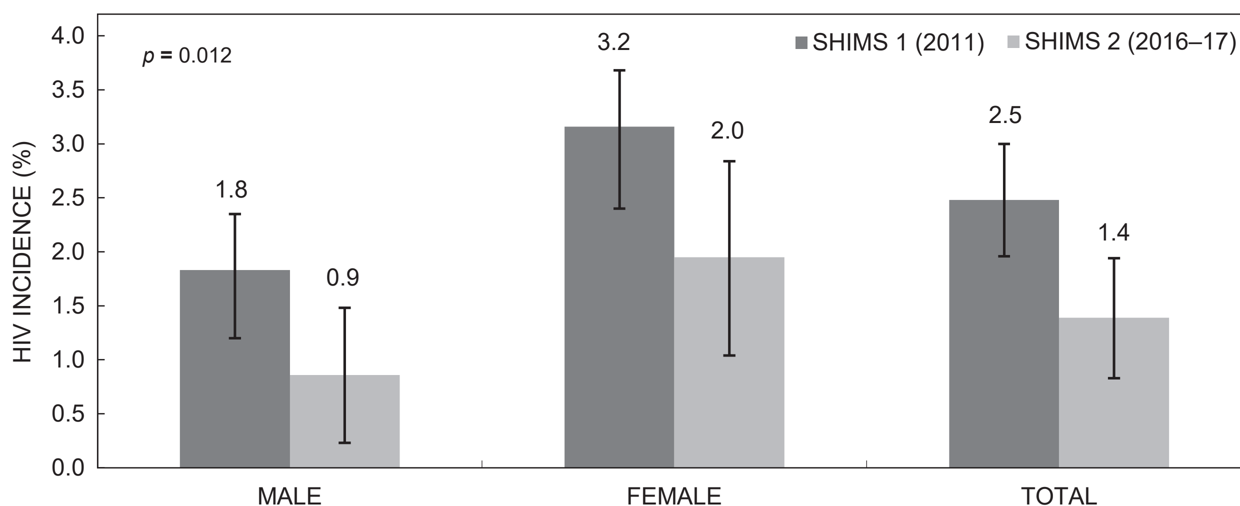

Figure 2: Swaziland HIV incidence decreased by 44%. Source: Ministry of Health (2016)

The HIV and AIDS response does not only depend on the national surveys for information; it also pays close attention to the development of strategic information which informs the design and implementation of the interventions. The current strategic framework clearly outlines the outcomes and indicators which contribute the main goal of the HIV and AIDS response (NERCHA, 2014).

A key role of NERCHA is to ensure that a mechanism is in place to monitor the indicators and provide evidence which will inform programming, and identify and close information gaps. This includes identifying the research gaps, conducting research, and providing capacity building for stakeholders. As a means to achieve the above, the HIV response conducted a National Youth *Indaba* and a National HIV and AIDS Conference in April and July 2016 respectively.

The youth *indaba* aimed to engage young people in a national dialogue and solicit their inputs on how HIV prevention interventions could be tailored to meet their needs. The specific objectives were to: provide a forum for young people to voice their needs towards ending AIDS by 2022; offer an opportunity for policy makers to interact with young people to tailor services to meet their unique needs; and draft a political communiqué informed by young Swazis to contribute to the UN Political Declaration for Ending AIDS by 2030. The meeting gathered information which guided and strengthened the implementation of youth interventions in the country.

The HIV and AIDS conference aimed at: providing government and community entities with an opportunity to share successes and lessons learnt from stabilising the world's worst HIV and AIDS epidemic; creating networking opportunities and encourage future collaborations within and between international and local researchers; and providing an opportunity for global and national HIV researchers who have conducted research about Swaziland, to share their findings and experiences with Swazi stakeholders.

The conference achieved its objectives and provided an opportunity for capacity building. In total, 11 of the abstracts were selected for possible publication in this special issue, subject to peer review. Researchers were empowered through capacity building to develop scientific manuscripts. This further contributed to the objectives and outcomes of the conference.

Overview of the Special Issue

This Special Issue originates from the July 2016 Swaziland National HIV and AIDS conference, which had the strap line "From AIDS crisis to opportunity: What the world can learn from Swaziland". The conference served as a pre-conference for the International AIDS Society conference which took place in Durban, South Africa, in 2016. It was planned to showcase the journey of the Swaziland HIV and AIDS response since its inception, in particular the successes and lessons learnt during the fight against the catastrophic epidemic, as the country strengthened its efforts and stabilised the epidemic.

Swaziland currently has one of the most comprehensive and innovative responses to the epidemic in the world despite the highest prevalence. The conference presented initiatives which ranged from funding and economics to social sciences. Funding and economics included discussions on the funding landscape, the economics of HIV, HIV response efficiency and effectiveness; social sciences comprised discussions on behavioural and cultural influences, law, policy, impact mitigation, human rights and gender issues; treatment, care and support included clinical trials, innovative drugs and complementary and alternative therapies; systems and synergies focused on HIV and AIDS mainstreaming, health systems, community systems strengthening, education system, including the decentralisation of the response, role of civil society, academic institutions and other sectors; and leadership and policy entailed discussions on political leadership, traditional leadership, laws, policies, partnerships and collaboration.

This Special Issue presents the outstanding articles selected from the wide range of papers presented during the conference. All have gone through the standard and rigorous peer review process of the journal. Some highlights are outlined below.

The article, "Love matters: exploring conceptions of love in Rwanda and Swaziland and relationship to HIV and intimate partner violence", shows how Swazi and Rwandan men and women understand and present love in their sexual relationships. Both women and men understand that love should be expressed through evident actions which range from material, physical, and psychosocial to economic support. The researchers pointed out that intimate partner violence compromises love and exposes partners to HIV. Hence education on love is essential for understanding and reducing risks for new HIV infections.

An analysis of Swazi men's perceptions and acceptability of Test and Start is discussed in the article, "'I will take ARVs once my body deteriorates': an analysis of Swazi men's perceptions and acceptability of test and start". The authors argue that Swazi men will still not fully commit to knowing their HIV status, despite the initiation of the test and start programme in Swaziland. Men in the country have challenges in taking an HIV test due to fears that results will be positive, poor services in health facilities and fear to initiate treatment. Fear of starting treatment is linked to lack of assurance for a sustained life time supply of ART by government, side effects and food insecurity. The researchers pointed out the country needs to craft specific interventions for men which will address these factors. These might include HIV education and counselling for men, advocating for early ART initiation, and addressing the health facility issues.

The authors of the article "Mixed results: the protective role of schooling in the HIV epidemic in Swaziland" highlighted that Swaziland has been able to send large numbers of children to school and provided support for OVC outside the school setting. The main challenge the education sector is facing is repetition rather than dropping out. Repetition has been observed throughout the school system and demands more financial resources from government. Most dropouts are as a result of transfers which means the children are not actually dropping out, but remaining in the education system in another school. Dropping out for reasons which could expose children to new infections seems to be minimal. The article also identified OVC as vulnerable to acquiring HIV. However, the country has been able to support OVC psychosocially, economically and otherwise. The authors argue for interventions which will prioritise repetition.

There is a discussion on the "HIV prevention needs for men who have sex with men in Swaziland". The researchers indicate that self-stigma, multiple concurrent partnerships and short-term relationships, decision on condom use and misconception about anal sex are factors which expose men who have sex with men (MSM) to acquiring new infections. Self-stigma is very common among MSM and it emanates from the societal homophobic stigma. As a result MSM tend to live with fear of being stigmatised. Stigma is experienced from healthcare workers and healthcare facilities have hetero-normative settings, meaning that MSM cannot freely discuss their health issues, in particular anal sex. This prevents MSM from seeking health services. To scale up prevention interventions among MSM, the country needs to promote HIV peer education, awareness on the existence of MSM, increase support and the promotion and distribution of condoms and lubricants.

This Special Issue also contains an evaluation of the country's legal response to HIV/AIDS ("Legal responses to HIV and AIDS: lessons from Swaziland"), highlighting the extent to which the country addresses human rights issues linked to HIV and AIDS. The researcher argues that understanding and addressing the human rights related to the epidemic are vital to achieving the desired impact of the HIV and AIDS response in Swaziland. The law protects every human being despite their HIV status and it is crucial for protection against stigma and discrimination, thus contributing to the prevention of new infections and promotion of access to treatment. Swaziland has subscribed to several international agreements to promote human rights, however, most of these do not pay special attention to issues of HIV and AIDS. Considering and aligning the country's laws to international human rights obligations indicates the desire to improve human rights. The Swaziland Constitution which incorporates the principles of the Universal Declaration of Human Rights (UDHR) addresses human rights issues that also protect people infected by HIV. These include issues such as stigma and discrimination and access to health services. To achieve significant results from the different global commitments which the country has subscribed to in terms of human rights, the country has to localise and scale up the implementation of the agreements.

The article on gendered childcare norms, "Gendered childcare norms — evidence from rural Swaziland to inform innovative structural HIV prevention approaches for young women", indicates these are interlinked with gender-based inequality and discrimination. The norms apply mostly to women and have a negative impact on the population group. The authors argue that these expose the women to risks of acquiring HIV since men have diverted from their role of providing material support to children. This role has been added to the roles of women which include providing physical and psychosocial needs. Caring for children further drained the resources of women including their time and finances, resulting in lost opportunities that are both economic and educational. Poor education and lack of finances expose women to activities which promote the risks of acquiring HIV. There is therefore need to craft interventions which will relieve women and reduce their exposure to risky sexual behaviours which promote HIV transmission.

Other authors discuss the predictors of survival among HIV-positive children on ART in Swaziland ("Predictors of survival among HIV-positive children on ART in Swaziland"). The authors argue that ART services and early initiation among children are very effective on health outcomes and survival of children living with HIV. ART paediatric services decrease mortality while early initiation significantly improves children's survival probability. The researchers point out that effective ART and the early management of HIV promote the health and survival of children living with the virus. Factors which affect the health of children living with HIV include malnutrition, delayed ART initiation and TB.

The article "A qualitative analysis of the barriers to antiretroviral therapy initiation among children 2 to 18 months of age in Swaziland" presents socio-economic and structural factors that negatively influence ART initiation amongst the children. The factors include TB/HIV co-infection, longer distances to health facilities, unfriendly facilities and service providers, HIV-related

stigma and discrimination, lack of knowledge, poverty, denial and guilt among parents. To address these factors the researchers recommend scaling up interventions: HIV and AIDS education, promoting access to health services, addressing socio-economic issues such as lack of money for food, male involvement, promoting confidentiality and patient follow-ups.

This Special Issue of *AJAR* focusses on Swaziland, the country with the worst epidemic in the world. The articles in this issue indicate how far the country has come in responding to the epidemic. It is exciting to introduce an *AJAR* issue that focuses exclusively on Swaziland. It is also an opportunity to highlight the extensive work, both academic and practical, done in the country. Finally it highlights Swazi authors who would not have otherwise had a chance to publish their work. While the process has not always been easy we are particularly grateful to all who have contributed to the Special Issue. We should mention: Evidence for HIV Prevention in Southern Africa (EHPSA) for financial support; Rebecca Fielding-Miller for coordination and Tim Quinlan for his mentoring.

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