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HIV and AIDS in Swaziland and the role of the church

Introduction

Swaziland is a monarchial middle income country situated in the sub-Saharan region, and still have the highest HIV prevalence in the world (27 percent) for the population group aged 15 years and above. The prevalence is higher among females at 32.5 percent than in males at 20.4 percent for the population group aged 15 years and above and highest among females aged 35 – 39 and males aged 45 – 49 years (Swaziland Health Indicator Measure Survey, SHIMS 2016). Despite the highest prevalence, the country has made great HIV achievements which has impact positively into the lives of the people. The country celebrates the stable prevalence since it means less HIV deaths which has been brought about by the strengthened interventions for the treatment, care and support programme. The HIV incidences for the age group 18-49 years was reduced by 44 percent to 1.36 percent with 1.7 percent among females and 1.0 percent among males. The incidences among young people aged 15-24 years were slightly reduced to 1.9 percent for females and 0.9 percent for males and the viral suppression rate for people living with HIV is currently 73 percent (SHIMS 2016).

Recent studies indicate other great improvements which include a reduction in mortality rate and an improvement in life expectancy. These achievements are also as a result of the combined efforts of the different sectors in the HIV and AIDS response. The sectors which include government departments and the civil society implemented intervention under HIV prevention, treatment care and support and impact mitigation. Civil society efforts include contributions by the faith based organizations led by Church Forum (extended National Strategic Framework, eNSF 2014-2018). The focus of this paper is mainly on the contributions of the faith based organizations into improving the HIV and AIDS response in Swaziland. The overall coordination of the Faith based organisations response is vested in Church Forum. The primary responsibilities of church Forum include strategic leadership and advocacy, planning, monitoring & evaluation, resource mobilisation and ensuring proper implementation of programs. Members of the Forum include Swaziland Conference of Churches, League of Swaziland Churches, Council of Swaziland Churches and individual churches not affiliated to any group such as the Swaziland Conference of the Seventh Day Adventist Church and International Tabernacle Ministries.

Church Forum held meetings for its members to share annual plans, and identify synergies and areas for collaboration to ensure that FBOs plans were well aligned to the HIV and AIDS national strategic framework. The Church Forum, with support from various partners, build the capacity of church bodies by focusing on the capacity needs common to all churches. These include provision of new HIV information, raising awareness on HIV among church leaders, training on HIV stigma and discrimination, project management training, and advocacy to enable church leaders to speak with one voice as well as advocacy targeting internal structures of the church to take their role in the HIV response as well as external advocacy to mainstream HIV in the church programmes (Church Forum Strategic Framework, 2013-2018). The organisation has been able to carry out this assignment, however, it is currently

facing funding challenges which limit their efforts. The organisation has also adopted decentralisation approaches to improve communication and information flow on HIV issues from the local churches to branches in the regions and to the national umbrella body.

In addition to coordination which is conducted through Church Forum, the faith based organisations were also involved in the implementation of HIV prevention intervention. The focus was mainly on providing HIV education to sensitise communities and improve their knowledge on HIV and AIDS. Such initiative has contributed to the findings that about 49 percent and 51 percent of young women and man have general knowledge on HIV and AIDS, respectively. The organisations emphasises abstinence among young people who are not married. This has made contribution to the results of the Multi Indicator Cluster Survey (2014) which indicates that about 56 percent of the young girls and women and 55 percent of young men, aged 14-24 years in Swaziland are virgins (never had sex). The study also shows that only 3.0 percent and 2.8 percent of the young women and men respectively, engaged in sexual activities before the age of 15 years.

Faith based organisations are also engaged in treatment care and support programmes which include support for people living with HIV, and family strengthening that involves caring for people affected by HIV and AIDS. The church has been involved in the establishment of support groups where people living with HIV acquires information and support to practice positive living. Interventions for people living with HIV also include income generation projects to improve livelihoods. Treatment and care services are also provided by the organisations in health facilities.

Faith based organisation have 29 health facilities in the country. Contribution through the facilities include HIV test services (HTS), prevention of mother to child transmission and HIV and AIDS treatment thus contributing to the UNAIDS fast track strategy which was adopted by the country. The strategy is popularly known as 90 : 90 : 90 which is about reaching 90 percent of people living with HIV to test, getting 90 percent of the tested people to treatment and getting 90 percent of the people on treatment to be virally suppressed (UNAIDS 2014). The recent Swaziland Health Indicator Measure Survey (SHIMS 2016) indicates that the country is at 87.4 :84.7 : 91.9 which shows that the country is very close to reaching the first two 90s and has exceeded the target for the last 90. For HIV testing 66.5 percent and 54.5 percent women and men aged 15-49 years reported to have tested for HIV in 2014 (MICS 2014). The number of HIV test decreased to 57.1 percent among females and 47.8 percent among men of the same age group (SHIMS 2016). The results , however, indicates a higher percentage of young people aged 15-24 years who tested for HIV, 80.2 percent and 62.3 percent women and men had tested and know their status.

Prevention of mother to child transmission results indicates that 89.9 percent of women age 15-49 years who received antenatal care during the pregnancy of their most recent birth, reported that they received counselling on HIV during antenatal care. About 96.3 percent of women age 15-49 years reported that they were offered and accepted an HIV test during antenatal care and received their results (MICS 2014). This includes contribution of church organisations for services which were conducted in the different health facilities.

Support for orphaned and vulnerable children (OVC) and the chronically ill is also provided through home based programme where churches train and deploy caregivers to provide support to bed ridden patients at their home. Support had also been provided to OVC through Neighbourhood Care Points (NCP), and OVC households, however the organisations currently lack resources. The increasing number of orphans and vulnerable children is one of the

most visible effects of HIV in Swaziland. Children classified as Orphans and Vulnerable Children (OVC) increased from 45 percent in 2010 to 71 percent in 2014 with Lubombo and Shiselweni regions presenting the highest rates – 75 percent and 73 percent respectively. During the same period, orphan-hood decreased from 24 percent to 20 percent with 41 percent of adolescents aged 15-17 having lost at least one parent and 54 percent of children having a chronic ill parent (MICS 2014). Estimates of the number of orphans based on patterns of mortality and fertility show a declining trend from 82,991 in 2013 to 67,820 in 2020. Total orphans represent about 19 percent of the total child population. The number of AIDS orphans is almost double the number of non-AIDS orphans. The faith based oragnisation also played a vital role in strengthening the capacity of families to effectively provide comprehensive care and support for OVC, thus making a contribution to the HIV response and obataining the indicated results.

Faith Based Organizations (FBO) also engaged in advocacy on GBV through a programmes like Transformative Masculinities and Health Gender and Theology. Churches have integrated awareness sessions for men and women focusing on how to win over the community to address cultural power structure by addressing cultural norms that propagate the imbalanced power structure.

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