VII. SWAZILAND PHR STUDY FINDINGS

This chapter presents the most significant results from the Swaziland community survey and PLWA and key informant interviews. Key findings include:

1) *Participant Characteristics:* More women than men surveyed reported food insufficiency, lower incomes, lower education levels and having at least one dependent. Of the PLWA interviewed, the majority female, 48 out of 58 reported having experienced the lack of food or water at some point. Fifty-two were caring for 2 or more dependents and 40 had not completed high school. The poverty of female PLWA in Swaziland was also highlighted by key informants.

2) *Knowledge of HIV:* The majority of community survey participants correctly answered questions about HIV prevention and transmission, with no statistically significant sex differences. Gaps in knowledge, such as attributing HIV infection to mosquito bites (34 percent of participants), were also evident, however. PLWA cited condom use as particularly subject to myths and stigmatization. Key informants reported that blaming women for HIV/AIDS was prevalent in rural communities.

3) *HIV Testing:* 59 percent of those surveyed reported access to HIV testing in their community, but 78 percent had not yet tested. Being afraid or not ready to know their HIV status was the most common reason for not testing (43 percent), and wanting to know one's status the most prevalent reason for having tested (58 percent) for those who had done so. Forty-one percent did not feel they could refuse the test, though the majority had made the decision to test, had a confidential test and received pre- and post-test counseling. While more women had tested than men, the most common barriers and facilitators and testing experiences did not differ based on sex. PLWA reported both gender-related barriers to testing and financial and geographical barriers to access.

4) *HIV-Related Stigma and Discrimination:* 61 percent of women and men surveyed held at least one stigmatizing or discriminatory attitude toward PLWA. Many expressed the fear of being stigmatized should they test positive for HIV and have that status disclosed to their partners, families, work or communities. Women reported higher levels of fear of stigma than did men. While most PLWA had disclosed their status to others and reported positive consequences of that disclosure, the majority also recounted experiences of stigma and discrimination. Twenty out of 58 PLWA confirmed that experiences of poor treatment were worse for women than for men living with HIV/AIDS in Swaziland and most key informants interviewed agreed.

5) *Sexual Risk:* Women surveyed lacked control over the decision of when to have sex (40 percent) or use a condom (18 percent) proportionally more than men (3 percent in each category). Thirty-four percent of women and 4 percent of men reported not using a condom at least once in the past year because their partner refused to do so. Eight percent of women and 39 percent of men reported having more than one sexual partner in that time period. A majority of PLWA reported a reduction in the number of partners and more routine use of condoms after discovering their status. However, 16 out of 45 women reported that they lacked control over the decision of when to have sex, as compared with none of the 13 men interviewed. Key informants discussed the underlying socialization to female subservience and the disempowerment of women that underlie risky sexual practices.

6) *Gender Discriminatory Beliefs:* 97 percent of those surveyed held at least one gender discriminatory belief and the majority reported 3 or more such beliefs. The majority also held beliefs in women's rights and equality. Holding either type of belief predicted sexual risk taking. For example, women and men who felt that men should control decisions in relationships with women had nearly twice the odds of unprotected sex with a non-primary partner than those who did not. Conversely, participants who agreed that women should be able to end relationships with men had 50 percent decreased odds of unprotected sex as compared with those who disagreed.

7) *Leadership on HIV/AIDS:* Participants in the community survey found all leaders wanting on every domain of inquiry, including spending on HIV prevention, setting a good example in personal behavior, meeting the basic needs of those infected and affected by HIV/AIDS, opposing poor treatment of PLWA and protecting women and children from abuse. Chiefs and national political leaders in particular were faulted. PLWA cited some accom-

plishments by leaders, but criticized their failure to go beyond rhetoric to action, as did key informants who noted the detrimental failure to move from draft policies to commitment and implementation.

Throughout this chapter, where sex differences are statistically significant ($p \leftarrow 0.05$), the sex stratified data are presented.

Characteristics of Study Participants

Community survey participants were 788 adult men and women from all four regions of Swaziland.[736] Their characteristics are reported in Table 1. Fifty percent were women and the mean age for the total sample was 29 years. Women were more likely to affirm than men that they had problems getting enough food to eat in the past year: 38 percent of women versus 29 percent of men surveyed. Of these, 65 percent of women and men reported that food or water shortages had affected their health care decisions; 82 percent of women and men said that these shortages had affected their ability to support dependents; and 85 percent of women and men reported that these shortages had made them economically dependent on someone else.

Thirty-nine percent of women and 28 percent of men were married and 25 percent of marriages were polygamous.[737] Forty-six percent of women and 42 percent of men lived with a sexual partner or spouse. Eighteen percent of women and 19 percent of men were unmarried and living with a sexual partner. Seventy-two percent of women and 62 percent of men had one or more dependents. Thirty-six percent of women, compared with 48 percent of men, had completed Form 5 (high school) or a higher level of education. Fifty-eight percent of female participants lived in an urban area and

TABLE 1: Characteristics of Swaziland Community Survey Participants (N=788)**

Participant Characteristics	Women (N=397) n(%)	Men (N=390) n(%)	p value**
Mean age	30	29	0.2578
Marital/Partner Status Married Unmarried, living w/ sexual partner Ever Widowed	 157(39) 73(18) 26(7)	 112(28) 75(19) 18(5)	0.003
Having > or = 1 Dependent	286 (72)	240(62)	0.048
Urban Residence Rural Residence	228(58) 168(42)	196(50) 194(50)	0.040
Monthly Household Income < 5,000 Emalangeni (approx. US$821)[735] > or = 5,000 Emalangeni	 357(90) 40(10)	 327(84) 62(16)	0.014
Monthly Household Income < or = 1,000 Botswana pula (approximately US$220 > 1,000 Botswana pula	 326(50) 321(50)	 242(39) 371(61)	0.000
Receiving assistance from government (money, food, supplies, etc.) to care for PLWA or orphans	50(13)	31(8)	0.032
< High School (Form 5) Education` > or = High School (Form 5)	254 (64) 143 (36)	204 (52) 186 (48)	0.005
Problems getting enough to eat, past 12 months	150(38)	111(29)	0.004
Seen by a medical doctor in the past 12 months	273(69)	191(49)	0.000

*The sex of one individual is missing; for sex-stratified data, N=787.
**P values refer to the statistical significance of the difference between women's and men's responses.

42 percent in rural areas; male participants lived almost equally in urban and rural areas.

In addition to being less educated than men, women had lower incomes and were more likely to be receiving assistance from the Government, such as money food or supplies, to care for PLWA or orphans. Women reported more frequent contact with medical care providers: 69 percent of women in contrast with 49 percent of men had been to a medical doctor in the past year.[738] This likely reflects women's greater access to free or basic health services, particularly through the antenatal care program.

PLWA Interviews

Fifty-eight women and men living with HIV/AIDS were interviewed. Their characteristics are reported in Table 2. These individuals were VCT patients, support group members or clients of HIV-related services. The majority were women and urban residents.[739] Their mean age was 34 years. Sixteen of those interviewed were married and 3 were in polygamous marriages. Twelve of the PLWA interviewed had ever been widowed and AIDS was most commonly the cause of a partner's death. Fifty-three participants believed themselves to have been infected by unprotected sex.

Indicating the difficulty many PLWA had in meeting their basic needs and supporting family members, 48 out of 58 had been affected by the lack of food or water at some point. Thirty-six reported hunger as a consequence, 6 reported economic dependence, 5 individuals said that they couldn't farm and 1 reported that access to health care was affected. Food insufficiency is a particularly salient issue for PLWA who are receiving ARV treatment, as adequate calories and nutrition affect both the ability to comply with the medication regimen and the effectiveness of the drugs. One man, age 45, described the typical situation:

> *Without food, the treatment alone is too difficult. It demands that you eat. You get hungry quickly. You need to have a decent diet. They give you the ARVs without supplements, and there are people who cannot even afford half a loaf of bread.*

Forty-three out of the 58 individuals interviewed were getting some type of care or treatment for HIV/AIDS; 14 were receiving no care or treatment. The most common form was ARVs (33 people),[741] followed by nutritional foods or food supplements (17 interviewees) and medication for HIV/AIDS-related conditions (6 individuals). Two people said that they were receiving treatment from a traditional healer, but both were also on ARVs.

TABLE 2: Characteristics of Swaziland PLWA Interview Participants (N=58)

Participant Characteristics	n
Age, mean 34 years	
Women	45
Men	13
Marital/Partner Status	
Married	16
Unmarried	42
Living w/ Sexual Partner (married or unmarried)	16
Widowed	12
Dependents, mean 4.5	12
Urban Residence	40
Rural Residence	17
< High School (Form 5) Education	40
> or = High School (Form 5)	18
Reported Hunger	36
Positive Screen for Depression[740]	21

Women, with fewer economic opportunities than men and, in most cases, primarily responsible for the support of children, reported finding the associated costs of the free ARVs prohibitive. As one 43 year-old woman put it:

> *If you don't have sugar at home for the children, and you need 20 rands [approximately US$3][742] for transport to get ARVs, you will choose not to get ARVs.*

Fourteen individuals were receiving some type of aid related to food and 15 were receiving support or assistance related to HIV including social support groups, adherence support, hospice and other home visits. Additional barriers to self-sufficiency include that nearly all had dependents to care for in addition to themselves[743] and 40 had not completed high school. Of the 52 interviewees who completed a depression symptom checklist, 21 screened positive for depression.[744]

Key Informant Interviews

Several key informants who work with PLWA commented specifically on the poverty of female PLWA in Swaziland. One women's support group leader said:

> *Most women living with HIV/AIDS are not working and most are single mothers without support from the father of the children. They are not working because there are not enough jobs, they*

are brought up to be dependent on men and, if they are sick, they can't work.[745]

HIV Knowledge

The majority of community survey participants correctly identified modes of prevention and transmission of HIV. Responses did identify gaps in knowledge, however. For the most part, women's and men's responses did not differ. PLWA and key informants interviewed identified the persistence of denial, particularly by men, and of HIV-related stigma as perpetuating myths and other incorrect beliefs.

Community Survey

Despite low levels of formal education, and the lack of comprehensive HIV/AIDS prevention and information campaigns to-date in Swaziland, 81 percent of participants scored as having correct knowledge based on their responses to survey questions, with no statistically significant differences overall between women's and men's responses.[746]

In terms of specific knowledge of HIV transmission, 98 percent of women and men surveyed knew that you can get HIV by having sex without a condom and sharing used needles or instruments; 83 percent agreed that a blood transfusion could transmit HIV; and 3 percent believed witchcraft was a means of transmission. Mosquito bites and sharing meals with an HIV-positive person were thought to transmit HIV by 34 and 17 percent of participants, respectively.

With regard to prevention, using a condom correctly every time you have sex (96 percent of women and 90 percent of men), being faithful to one uninfected partner (91 percent of women and men) and abstinence (93 percent of women and men) were identified by the majority in the community survey as successful methods of protection from HIV. A significant minority also agreed that praying (18 percent) or traditional medicine (7 percent) could prevent HIV transmission.

PLWA Interviews

While they were not directly asked about HIV knowledge, the PLWA interviewed were aware of the need for correct information to be widely disseminated at the community level as a key component of a comprehensive approach to the HIV/AIDS epidemic in Swaziland. They also pointed out that individuals may have adequate knowledge of HIV but rely on myths about transmission or prevention of the virus to avoid taking responsibility for having exposed themselves or others to risk.

Condoms — and men's refusal to use them — were described as subject to misinformation about their role in causing AIDS, stigmatized as something non-Swazi or not masculine, and derided as decreasing enjoyment of sex.

They [men] believe that it's not natural, that God didn't create condoms. The example they use is that you can't eat candy in the candy wrapper. And they say condoms cause HIV.

Some men say condoms are from white people, that they spread HIV and that white men want to spread HIV in Africa. When Mbeki [the President of South Africa] said that, it influenced people here.

Perpetuation of some of these myths was mentioned by those interviewed as likely to stem as much from men's denial of their own suspected HIV-positive status or wish to rationalize not testing in order to delay taking responsibility for their own risk-taking behavior as from active belief. The role of persistent high levels of HIV-related stigma played a role as well. As was noted by one 30 year-old woman:

They need to mobilize communities and tell them about HIV/AIDS. They need to teach them what does it mean to be HIV-positive and have AIDS — teach them the difference between the two. Teach that HIV-positive is like flu or a headache — it doesn't mean you are dead. Proper dissemination of information to the communities can help.

Key Informant Interviews

One government official has suggested that the urban/rural divide is a key gap in terms of HIV-related knowledge.

Particularly in the rural areas, [the existence of] HIV/AIDS is not accepted; it's taken as a mystery. People are infected in towns and they go back to the rural areas where they will be cared for, where they will be terminally ill. We need campaigns in the rural areas; in the towns we have media and so much being said.[747]

HIV-related stigma in the rural areas was described as particularly strong, fueled by traditional, conservative views on women's roles.

In rural communities, men think women bring it, because they are doing prostitution within the community. [Men] forget that they are working in the mines, at industrial sites and are careless. Men don't disclose to wives.[748]

Gaps in education, such as those seen in the community survey, and the persistence of stigmatizing beliefs about the transmission of HIV have direct implications for testing.

HIV Testing

While the level of HIV-related knowledge among Swazis surveyed was high, testing levels were low for a country whose leader declared HIV/AIDS to be a national emergency eight years ago and where the impacts of the disease can be seen in every community. Physical access to testing was cited as a barrier for only a small proportion of those not tested in the community survey, whereas personal issues, such as readiness to test, illness and self-perceived risk were most frequently reported.[749] Likewise, wanting to know one's HIV status was the most common facilitator to testing. While the majority who tested found out their results, received counseling and did not experience poor treatment as a result of testing, 41 percent felt that they could not refuse the HIV test. VCT was the favored method of personal testing among survey participants, both tested and not.

PLWA interviewed discussed a number of barriers to testing. They cited gender-related barriers, including the lack of women's empowerment and men's fear of stigma and not wanting to change their sexual behavior; financial and geographical barriers to access; and lack of food support. Key informants agreed that men were more reluctant than women to test, and that lack of resources and fear of stigma were barriers to testing. Routine testing was not seen by those interviewed as an appropriate intervention to increase testing, given the poor status of the health infrastructure and lack of a scaled-up treatment program in Swaziland.

Community Survey

Twenty-five percent of women surveyed and 18 percent of men had tested for HIV. Fifty-nine percent of participants reported that they had access to HIV testing in their community. Sixty-six percent of respondents reported that it is possible for someone to get a confidential HIV test in their community.

Community Survey Participants Not Tested: Barriers to Testing

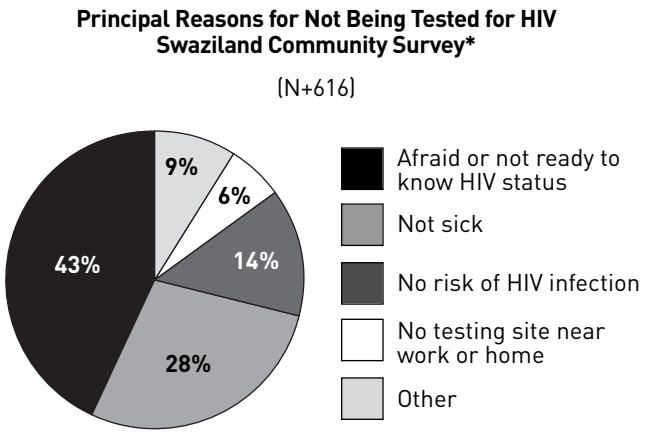
The principal reasons for not yet testing are shown in Chart 1.

For those not tested (616 individuals), the most common reason for not testing, given in response to an open-ended question by 43 percent of participants, was being afraid or not ready to know their status. Two percent or fewer volunteered any of the following reasons as being their most important in terms of not testing: shame to be seen at the testing site; fear of being hit or otherwise hurt by a spouse or partner; worry about disclosure of their test results without their permission; not having access to ARV treatment if they were to test positive; not wanting to change their sexual practices if HIV-positive; or being advised by others not to test. Only women reported fear of partner violence in retaliation for testing, not being allowed to test by a spouse or partner or being advised by others not to test as barriers. Only men reported not wanting to change their sexual behavior as a primary reason for not testing.

When asked a series of structured questions about specific barriers, 14 percent of participants agreed that they had not tested because they thought others would treat them badly if they were to test positive and disclose their status; 12 percent of respondents said that not having testing facilities close to home or work kept them from testing; 7 percent confirmed that knowing they would have to change their sexual practices if they tested positive had stopped them; 5 percent of women and 2 percent of men reported that a spouse or partner not allowing them had prevented their testing; 5 percent said not having ARVs available prevented them; and 2 percent agreed that a lack of food was the cause.[750]

Thus, even when asked directly whether their experience with testing had been influenced by any of these other factors, a far smaller proportion acknowledged

CHART 1: Principal reasons community survey participants who had not been tested gave for not being tested (n=616)



*Respondents could agree with more than one reason. Sex differences were not statistically significant.

their importance than did those who cited not being ready or not being sick. This indicates the challenge presented to health care workers and policymakers to overcome psychological barriers and perhaps the persistently held belief that HIV is equated with physical illness ("being sick") as a first step to encouraging Swazis to test for HIV. Both are likely rooted in the stigmatization of HIV/AIDS in Swaziland, in addition to the very real challenges, for a significant portion of those surveyed, of living with a life-threatening disease with few financial resources.

Community Survey Participants Tested: Facilitators to Testing

The most common facilitator for those who had been tested for HIV (170 individuals) was the personal motivation of wanting to know their status (58 percent of those tested). The other principal reasons are listed in Graph 1. Only women reported recommendation by the PMTCT program.[751]

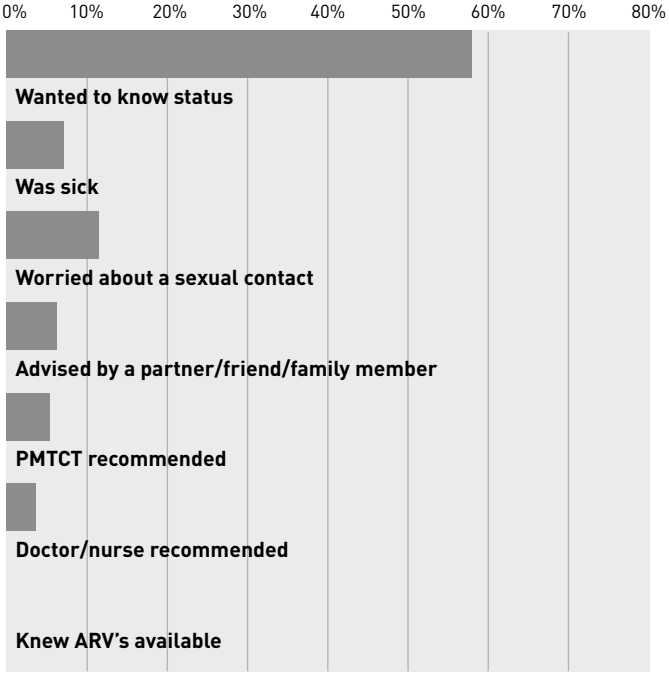
As with the barriers, while there were a number of reported facilitators, none of the others were as common as wanting to know one's HIV status. Three percent of those surveyed had been influenced by messages on television, radio or billboards to test and 2 percent were advised by their church or required by a job to test. No one reported that the knowledge that treatment was available had encouraged them to test. This may reflect the situation that in Swaziland there have not been media campaigns around testing, nor is there yet a scaled-up program of universal access to antiretroviral (ARV) treatment.

With regard to testing sites, nearly half of the women and men in the community survey tested at a public hospital. Reported testing sites are shown in Table 3.

Ninety-four percent of those surveyed found out their test results; 6 percent reported, however, that someone learned their results from the testing center or doctor without their permission. Thirteen percent said that they did not make the decision to get tested and 41 percent felt that they could not refuse the test. The latter report is particularly troubling from a human rights perspective, indicating that there may be some element of coercion involved in the testing process.[752]

Eighty-four percent received pre-test counseling and 75 percent received post-testing counseling. Nearly 100 percent reported that they received useful information, were treated with respect by counselors and had their questions (if any) answered. Some participants reported negative consequences to testing: 5 percent felt that they were treated badly by others in their community and 4 percent reported that they regretted getting testing. Seventy-three percent reported that their partner knew that they had tested; of these, 2 percent (one woman and one man) reported being hurt in any way or threatened on account of this disclosure. Eighty percent of those tested agreed that their experience with HIV testing had led them to encourage others to get tested. Women's and men's experiences did not differ in statistically significant ways.

GRAPH 1: Principal Reasons* for Being Tested for HIV, Swaziland Community Survey (n=170)



*Respondents could agree with more than one reason.

TABLE 3: Reported HIV Testing Sites, Swaziland Community Survey (n=170)

Type of Site	Community Survey n (%)
Public hospital	83(49)
VCT center	32(19)
Private hospital	31(18)
Other location	10(6)
NGO	8(5)
Antenatal clinic	6(4)
TB clinic	----

TABLE 4: Appropriate Forms of Testing for the Participant, Swaziland Community Survey

Testing Method	N	n(%)
VCT ("confidential testing at HIV testing and counseling centers")	781	737(94)
Couples Testing ("testing men and women partners together for HIV and giving them their results together")	780	593(76)
Mobile Testing ("testing from a vehicle that moves around to different places, close to where people live or work, such as markets or community centers, and gives the test results on the same day")	771	435(56)
Routine Testing ("testing everyone for HIV as part of a routine clinic or hospital visit, unless they say no [opt-out testing]")[753]	777	369(47)

Opinions on HIV Testing Programs

Several types of testing programs were described to all community survey participants — both those who had tested and those who had not — and they were asked whether each of these would be appropriate for them and which one would be best. Table 4 shows the number/percentage of those who agreed that the method in question was appropriate for them. Fifty-nine percent of those surveyed reported that VCT would be best for them, 27 percent favored couples testing and 8 and 6 percent, respectively, chose mobile or routine testing. There were no statistically significant differences between the responses of women and men.

PLWA Interviews

Women and men interviewed who were living with HIV or AIDS expressed similar motivations to test as those in the community survey and were likewise generally positive about their testing experiences.

PLWA interviewed perceived themselves as self-motivated to test rather than influenced by information or advice that they received. For example, the two most common reasons for testing were being sick (29 individuals) and wanting to know their status (24 interviewees).[754] VCT centers (22 individuals) and public hospitals (19 individuals) were the most common testing sites.

Gender-Related Barriers

Forty-three interviewees felt that barriers to testing were different for women and men. In particular, the interview participants emphasized that men are less likely than women to want to know their HIV status. Women and men interviewed attributed this to factors including men's misunderstanding of transmission of HIV and their refusal, often willful, to believe that it causes AIDS; men's lower emotional capacity to face the diagnosis; their greater reluctance to undertake changes in sexual behavior if they were to test positive; and their higher levels of fear of stigma, all of which are interrelated to some degree. The statements of two young women were typical:

> *For some men, they just don't know that they can get HIV at all. That's common among men; they believe they're healthy.*

> *Many men deny that there is HIV — and then they don't see any reason why they should test. The men think they know everything.*

Several of respondents felt that men were more fearful and less responsible than women.

> *Men fear the truth because the truth is painful. Women want to know their status. They have more courage.*

> *Men are scared to get the HIV test; women think of the children and get tested.*

> *Men prefer not to know. Once they know, their world is shattered.*

A 36 year-old man explained men not testing in terms of sexual norms for men's behavior and not wanting to change that behavior.

Women get tested when pregnant. Men want to engage with other ladies, we are encouraged to have many girlfriends. Men don't get tested because they don't want to change their practices like their number of partners or using condoms.

One 20 year-old woman cited fear of stigma as a primary barrier to testing for men.

For men, stigma stops them having a test. For women, it is fear of reprisal from [their] husband or partner.

Women's empowerment — and control over sexual decision making — was also identified as an essential component to getting men to test. As one woman, age 20, put it:

Wives and girlfriends need to encourage men to go for an HIV test. They need to say, 'No condoms, no sex.' They need to say, 'This is my body.' The one who controls your body is you. Women lack that control.

A 29 year-old man agreed that lack of women's empowerment was a key barrier to testing for both sexes.

Women are afraid of their men; that is the main barrier for women. If they test, they can be hurt by their men who will blame them for the HIV. For men, it is pride that prevents them from testing. Men know that they can do whatever they want without consulting their wives. So they don't need to test if they don't want to.

Physical and Financial Access

Twenty-eight of 58 PLWA felt that physical access to testing was a problem in Swaziland. Twenty-five mentioned the long distance that rural residents had to travel to get to a VCT as a barrier to HIV testing. Distance was seen as a barrier both because rural people did not know where to go for testing as well as for the prohibitive costs of transport needed to get to the test sites from rural areas. The following two responses were typical:

There are not enough testing centers. Many people are waiting in line for the testing facilities. No one likes to wait in line. Even if you wanted to test, when you are in line, many things could come into your mind no matter how prepared you were to test. Then you would have time to think about your fears, and will not keep waiting in line.

In some areas there is only one VCT for many people, and the times of operation are not convenient. People travel long distances only to be turned back, and then they lose interest.

Lack of food and income were also cited as barriers. One woman interviewed was often sought out by others for advice because she was formerly a teacher. Her husband, who drank excessively and had other sexual partners, died of AIDS and left her with 11 dependents; many family members had also died. She emphasized the importance of nutritional and monetary support to convince people to test, in an environment of persistent stigma fueling their fears of the consequences of having HIV:

If financial and food support can be available, testing may increase. After testing, who will take care of my family? Why should someone be tested if they risk losing their job or facing discrimination?

Key Informant Interviews

Gender-Related Barriers to Testing

Several key informants identified similar differences between women's and men's testing behaviors in Swaziland as the PLWA interviewees. They also suggested that men should be the focus of testing interventions.

A health services provider summed up some of the differences, also highlighting that women face barriers to disclosure after testing, stemming from their dependence on men, whereas testing at all is the challenge for male partners:

We have to create some aggressive strategies to bring in males. Males don't like waiting and they don't like queues, but they should know their status. ...[I]t's difficult for women to report to their partners that they're positive, because then they are blamed and may be rejected, as if he himself is negative.[755]

Concerns Regarding Routine Testing

Several key informants suggested that Swaziland is not ready or in need of routine testing, primarily because they fear that proper counseling would be neglected due to lack of human resources, and/or that the health care delivery system, already overburdened by the existing ARV caseload, lacked the ability to expand in order to meet increased demand for treatment, at least in the short term.

For example, one PLWA educator stated:

The problem with routine testing is that the health system is not ready for it. Three weeks ago I went

to one community to mobilize them. The following day, lots of people came in for testing, but there were no testing kits. So the infrastructure isn't there. It requires pre-test and post-test counseling, and I don't think these structures are ready.[756]

One AIDS official described the current treatment situation in Swaziland as running at capacity.

If you had routine testing, and a massive enrollment of ARVs, you would create a situation where 'can you really cope?' Now the enrollment rate is so consistently high, I would think that we should let it continue. If uptake is not what it should be, than promoting VCT more or introducing routine testing would make sense. … I don't want to raise expectations and dash them. If you are going to tell people to test, but we [can't] treat them, what's the point?[757]

Lack of Resources to Meet Basic Needs

At least one Government official suggested that lack of support and assistance, in the form of economic resources and food assistance for example, was one factor discouraging people from testing, beyond the question of personal readiness and regardless of testing innovations.

Some people prefer to remain not knowing their status because they will need tangible measures in place to address [being HIV-positive] — they'll need ARVs but there is the issue of nutrition, poverty. If there was a cure [this wouldn't be the case], but there isn't.[758]

Stigma

Others at international agencies explicitly suggested that fear of stigma, in part created and maintained by the segregation of testing and treatment services for HIV and AIDS, was the chief barrier to testing. When stigma was prevalent, or perceived as such, privacy concerns became even more fundamental and paramount. As one PLWA community activist stated:

My point of view is that the main obstacle [to testing] is the lack of confidentiality. You go to the hospital, you get treated for an HIV-related ailment, and a lot of people know about it. I think it's that Swaziland is too small—if you tell one person, you've already told the whole world. People are still blaming HIV-positive people for everything.[759]

HIV-Related Stigma and Discrimination

The study results demonstrate that HIV-related stigma, fear of being stigmatized for suspected HIV-positive status and discriminatory attitudes toward PLWA are widespread in Swaziland and frequently resulted in poor treatment for those living with HIV or AIDS, notably for women. For a minority in the community survey, stigmatizing beliefs concerning PLWA translated into attitudes stripping those with the virus of their rights to marry, work or go to school, seek political office or own property on the same basis as uninfected individuals.

At the same time, in response to a generalized inquiry, women and men surveyed nearly universally believed that they had a duty to treat every person with dignity and respect. Nearly all the PLWA interviewed had disclosed their HIV status, and most reported positive consequences from doing so. Still, hurtful and inequitable treatment at home, in the community, at work and other public places was also prevalent and coexistent with experiences of acceptance and support.

Community Survey

Sixty-one percent of the women and men surveyed in the community held at least one stigmatizing or discriminatory attitude towards people living with HIV/AIDS.[760]

Certain discriminatory attitudes may reflect incomplete knowledge about the transmission of HIV and the mistaken belief that HIV is transmitted through food or casual contact. For example, 30 percent of participants in the community survey would not share a meal with someone they suspected of having HIV or AIDS. Other discriminatory attitudes exhibited by participants revealed the underlying belief that fewer fundamental rights should be held by those with the virus or disease. For example, 19 percent of women and men did not believe that PLWA should be able to marry or have an equal opportunity to participate in Parliament. Other discriminatory attitudes are shown in Table 5.[761]

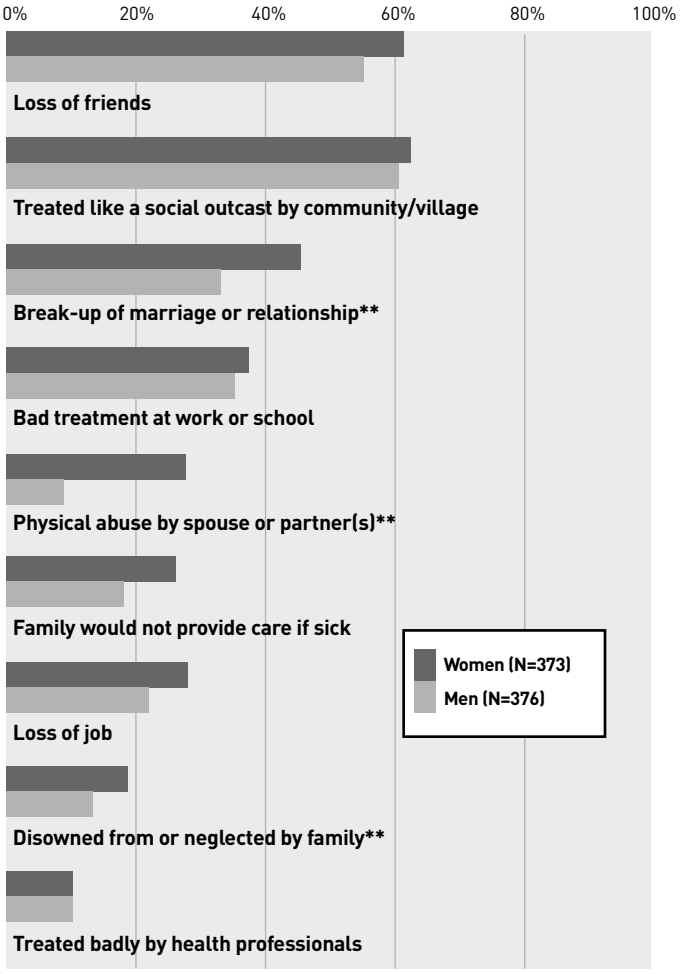
Fears of Stigma and Discrimination

Women in the community survey exhibited a higher level of projected fears of being stigmatized and experiencing discrimination than men should they test positive for HIV.[762] Participants were asked to project their expectations of negative consequences of testing positive and disclosing their status to others. These are shown in Graph 2. The proportion of those surveyed

TABLE 5: Stigmatizing or Discriminatory Attitudes Toward PLWA, Swaziland Community Survey

Statement of Attitude	N	n(%)
Would not share a meal with person believed to have HIV or AIDS	770	230(30)
Would not buy food from shopkeeper or food seller believed to have HIV	756	205(27)
People with HIV/AIDS should not be able to marry	750	146(19)
People with HIV/AIDS should not have the same chance as others to be in Parliament	761	143(19)
People with HIV/AIDS should not have the same chance as others to have a job	771	78(10)
A teacher with HIV but not sick should not be allowed to continue teaching	777	62(8)
Not willing to care in household for a relative sick with HIV/AIDS	764	61(8)
People with HIV/AIDS should not be able to own property	772	60(8)
A student with HIV but not sick should not be allowed to continue attending school	776	48(6)

GRAPH 2: Projection of Stigma and Discrimination, Swaziland Community* Survey (n=749)



*Respondents could agree with more than one reason.
**These sex differences are statistically significant.

predicting that they would be stigmatized by their friends, communities and sexual partners ranged from more than a third to nearly two-thirds of participants. Discrimination at work or school was expected by over one-third of those surveyed. Women had higher projections of stigma and discrimination by partners and other family members, for example, 27 percent of women versus 8 percent of men predicted intimate partner abuse from disclosure.

At the same time, the majority of those participating in the community survey (86 percent) projected that they would disclose their status to their sexual partner should they test positive for HIV. The difference between women's and men's responses was not statistically significant. One interpretation is that the need, whether physical, emotional or ethical, to discuss status may trump the fear of stigma or negative consequences in intimate relationships. Alternatively, the participants may have been responding by articulating ideally how they would act, or would like to be able to act, given that only less than a quarter of them had actually been tested and a significant percentage reported sexual risk-taking, feeling themselves at risk due to the behavior of their partners or lacking control over sexual decision making.

Nevertheless, the persistence of HIV-related stigma in Swaziland, or at least the ongoing fear of stigma and its consequences, is demonstrated by the finding that 48 percent of those participating in the community survey would want the status of an HIV-positive family member to remain a secret. Yet, perhaps reflecting the very visible crisis in Swaziland that has left few families

untouched by the devastating economic effects of the AIDS epidemic, 98 percent affirmed that the Government should provide PLWA with food or other basic assistance. Thus, though stigmatizing and discriminatory attitudes continued to be factors driving behavior, these appeared to be coexisting with knowledge and compassion for those infected and affected by HIV/AIDS, and perhaps with self-interest as well.

PLWA Interviews

Stigmatizing and discriminatory attitudes continued to be significant factors in the everyday realities for PLWA. Despite increased public discourse in Swazi society on HIV/AIDS, and frequent disclosure of their HIV-positive status among those interviewed, both women and men reported that they faced significant stigma and discrimination in private and public spheres. Twenty of 58 Swazi PLWA interviewed expressed their opinions, based on their own lives, that experiences of poor or unequal treatment were worse for women than for men in Swaziland.

Voluntary and Involuntary Disclosure of HIV-Positive Status and Reported Consequences

Fifty-five of those interviewed said that they had told someone of their status, whether a sexual partner, parent or some other relative or close friend. The identity of the recipient of the disclosure varied, as did whether or not spouses or sexual partners were told immediately, after a delay or not at all. Failure to disclose was most often due to fears of violence or abandonment. Nearly half of those interviewed reported that someone had revealed their HIV-positive status to others without their permission. One 30 year-old woman told how a nurse had disclosed her status to a village teacher:

> *My daughter is friends with the daughter of the teacher. My daughter came to me one day and asked me about my status, she said her friend told her. She was very upset. I tried to calm my daughter down, she was crying. I told her I am living, like others with the disease, and that things would be okay.*

Others felt that their status was exposed even without their active disclosure. One 29 year-old man who had told his girlfriend that he was going to test but had heeded her request not to tell her the results, felt that she and others knew anyway. He had been sick with pneumonia and skin infections and attended a health clinic, as well as a support group near Manzini.

> *By looking at me, people are able to tell I'm HIV-positive. They're running away from me. I haven't told my friends, but they know.*

This man reported that he and his partner had not had sex in over a year.

Most reported positive consequences from telling others their HIV status. Fifty of the 58 said that disclosure had provided them with a sense of emotional relief. One 29 year-old man said:

> *I love sharing my status with others. I feel relieved when I tell people. Some ignorant people asked me why did I tell others, they thought I should keep it a secret. I tell them I have nothing to hide.*

A 52 year-old woman said:

> *When I first told three members of my church about my status, they accepted and embraced me in a way that made me feel honored and blessed.*

The majority of those interviewed received support from their family as a positive consequence of disclosure, though this may have been achieved piecemeal or taken some time. One 27 year-old woman whose family members joined a PLWA support group for rural women and families described the difficulties she initially faced:

> *It took some time to feel relaxed, but it was killing me to keep my status to myself. My mother was very hurt when I told her — she couldn't believe it. After a while, she supported me. My brothers didn't want to accept it. They didn't say anything, but I could read their expression.*

Others routinely disclosed their status as part of participation in community education programs and advocacy for their own needs and those of other PLWA. Forty-five out of 58 interviewees reported that by disclosing their status they had convinced others to get tested for HIV. These efforts were framed as actively countering stigma. One 30 year-old woman explained:

> *I told my family and community. We used to visit homesteads with terminally ill people and tell them our own status: 'You can see that I am alive and okay. You can take medications.' People may gossip, but it doesn't matter.*

Nevertheless, there were negative consequences of disclosure for a significant minority of those interviewed. Sixteen individuals lost friends upon disclosure. Fifteen PLWA reported that they had experienced poor

or unequal treatment due to telling others their HIV status. Five individuals reported job loss. Violence or forced sex was experienced by two people. Discrimination took the form of being harassed on the job or even fired.

My boss has been checking my work more vigorously, he said maybe I'm not really working enough. I told him because I just wanted to be clear with him and there might be days I was very sick and couldn't work. Sometimes I have to go to the hospital, and he says I don't have enough time to do my job.

I told my boss my status. He fired me. His excuse was that I am too sick, but really he did not want to work with someone who is HIV-positive.

Experiences of HIV-Related Stigma and Discrimination

While many said they had told people without incident, 32 individuals reported that once their status became known, they had been stigmatized by family members, friends, neighbors, acquaintances, colleagues, or health care workers by being rejected, shunned, gossiped about or pointed out to others. One woman said this was particularly the situation in areas like the one she lived in, a rural part of the region of Hhohho. Another woman, 49 years old, described the general reception for PLWA, especially those experiencing physical illness:

There is stigma both for men and women. When you are sick, people don't want to approach you or comfort you. They just look at you and don't give you any help.

More than half felt there had been changes in their relationships with family, friends or colleagues because of their HIV status. One woman, age 41 at the time of the interview, initially experienced rejection from her in-laws who had tried to send her back to her parental home when she became a widow, assuming that she would die and should do so with her natal family. This woman had tested because she had tuberculosis; she was not surprised to be HIV-positive, as her husband had a child with another woman and drank alcohol and stayed away from home at night. She described the solace and support she received from other PLWA.

After I tested, I just wanted HIV-positive friends. I get support from them. And from support groups. Information gives me strength. Knowledge is power. HIV-negative friends moved away from me.

Others also told stories of family rejection, at least initially. Several women told of experiences similar to this 43 year-old's:

A cousin of mine told me to stop cooking. He said don't touch the pots or anything in the kitchen. He said I could not even wash my dishes in the sink — this hurt me so much. That same cousin is now HIV-positive. I have forgiven him. He did not know better.

In terms of experiences with providers for HIV-related care and the quality of medical care since they tested positive for HIV, individuals interviewed reported positive experiences overall. About the same number felt there was no change in their care before and after diagnosis (23 interviewees) or that they were now receiving better medical care (21 individuals); only 3 people reported that the care they were given was worse now than before.

Discriminatory treatment at work, school, hospitals or other public places was reported, nonetheless, by 14 of the 58 of PLWA interviewed. For example, some said they were treated unequally at medical clinics or other health care facilities because of the HIV status.

I experienced bad treatment from a clerk at the hospital. She was rude and was discussing my status loudly in front of others.

Once the nurses discover you are HIV-positive you are treated badly and neglected. You also get verbal mistreatment.

Doctors [are] fine. Nurses have attitudes. [They] undermine people who are HIV-positive. Quarrel with them. They talk sometimes. [Nurses] build stress, but [PLWA] have to put up with it in order to get drugs.

Stigmatization of Women and Sex Discrimination

Twenty of the PLWA interviewed believed that there were differences in the experience of stigma and poor treatment for HIV-positive women and men in Swaziland. Stigmatization of women, and discrimination against them based on their HIV-status, was linked by those interviewed to normative assumptions around sexual practices and gender roles that ascribed HIV-positive status to "bad women" and blamed and condemned them for "spreading" the virus.

For example, women and men reported that many people assumed that women with HIV had had multiple sexual partners and treated them badly on that account, rather than ascribing their status to the far

more common unfaithful behavior of boyfriends and husbands. One 26 year-old man described this:

Women tend to be discriminated against because it is assumed they became infected because they are promiscuous. But in men promiscuity is condoned in most circles.

As previously described, many women were blamed, for these or other reasons, by in-laws for introducing HIV into the family and subsequently rejected or otherwise mistreated by them. This is particularly consequential because many Swazi families, especially in rural areas, follow the traditional custom of a woman moving to her spouse's home and community upon marriage, thus giving power over her and her children's well being and control over her access to resources to her in-laws.[763]

When a woman is HIV-positive she is called 'prostitute' by her in-laws. They say, 'You are the one who brought the disease into the home.' The woman comes from outside, and is not part of the family.

Key Informant Interviews

Stigma, Disclosure and Gender

Key informants reported that, though the scope and dimensions of stigma may have changed over time, and acceptance of PLWA increased, stigmatizing attitudes and fears of stigma figure strongly for many in Swaziland. HIV-related discrimination persists as an unjust and demoralizing fact of life for PLWA, particularly for women.

Several experts from both government and the PLWA community believed that stigma was lessening in Swaziland, though they disagreed regarding the extent of this decrease:

The more you focus on the issue of stigma, the more of a problem there will be. While I think stigma was an issue in the past, I think it is lessening. Now, when you go to communities, I see an outpouring of support for the sick, I have not seen stigma. I think we are beyond the point of people avoiding contact with others who are believed to be HIV-positive.[764]

Stigma is still a great problem. It takes a lot of shapes, but it's still there. Sometimes you know, because you live with people, but you have no proof. There's self-stigma, social stigma, family stigma, business stigma. The environment has changed since I first tested positive [in 1992] — there is more support rather than rejection. But we need to look at family stigma. And in the workplace: it's very difficult to take treatment publicly, so you don't take it if you don't have the opportunity [for privacy at work].[765]

A representative of the national network of PLWA suggested that cases of discrimination in the workplace were prevalent and as yet scarcely documented, especially for women, who are the majority of workers in several of the most abusive workplaces and industries, such as textile factories.[766]

A lot of women have approached us with the fact that they are discriminated against. They test through a workplace program and are encouraged to disclose—but once the company retrenches, they're the first to go. I think we really have to have a place where you can report such cases.[767]

The majority of key informants interviewed agreed that stigma and discrimination are worse for women than for men in Swaziland. As the PLWA network coordinator described it, echoing the PLWA interviews:

Stigma is worse against women, especially because women are usually blamed for it, for giving HIV both to her partner and her child. She's blamed for the whole thing.[768]

The injustice of the persistence of HIV-related stigma and discrimination, and particularly its gender bias, is underlined when taking into account the sexual risk-taking observed among Swazi men and the lack of control over decision making, in sexual and other matters, among Swazi women.

Sexual Practices: Risk-Taking and Risky Circumstances

Differences in the experiences of women and men were pronounced in the community survey and PLWA interviews. The results paint a clear picture for women of lack of control over sexual decision making in the context of known HIV risk, inability to control male sexual partners and lack of economic, social and psychological empowerment. Men's situation is described by social values encouraging multiple sexual partners and the influence of myths and taboos, personal denial of the threat of HIV and a lack of strong prevention messages discouraging condom use.

Twice as many women (23 percent) as men (11 percent) surveyed perceived themselves to be at high or 100 per-

cent risk of becoming infected with HIV. Forty percent of women and 3 percent of men lacked control over the decision of when to have sex. Similar dynamics can be seen in decision making over condom use. While the majority of community survey participants expressed willingness to use abstinence at some point in the future to prevent the transmission of HIV, 20 percent of women and 17 percent of men reported having no sexual partners in the past month, and smaller proportions reported abstinence in the past year. Interviews with PLWA amplified the finding that women's lack of autonomy and control persists for many HIV-positive women, despite increased knowledge and motivation to change their sexual behavior. A third of those interviewed reported lacking control over when or whether to have sex; economic dependence and fear of violence were cited as the primary reasons.

Community Survey

Women's Lack of Control Over Decision Making in Sexual Relationships

Women's lack of control over whether and when to have sexual intercourse, and whether or not to have unprotected sex, comes through clearly in the survey results. Forty percent of sexually active[769] women, as compared with 3 percent of men, affirmed the statement that "my partner only decides when I have sex." Conversely, 47 percent of men, and 5 percent of women, agreed that "I alone decide when I have sex." In regression analyses, married people had more than twice the odds of lacking control when compared with their unmarried counterparts[770] and those with a high school or greater education had less than half the odds of lacking control.[771] This speaks to the increasingly acknowledged risk of married women and the benefits of education as a route of escape from discriminatory gender norms or economic dependence.

Eighteen percent of women, compared with 3 percent of men, reported that their partners had sole decision-making authority with respect to condom use. In contrast, while 19 percent of women reported that they alone made the decision to use a condom, 37 percent of men reported this level of control.

Exposure to HIV through Multiple Sexual Partnerships

Eighty-eight percent of the participants in the community survey had ever had sexual intercourse. Eight percent of women compared with 39 percent of men in the community survey reported having more than one sexual partner (serial or concurrent) in the past 12 months. Of those sexually active in the past year, 1 percent of women and 21 percent of men reported having more than one partner (serial or concurrent) in the past month.[772] In regression analyses, those who were unmarried and living with a sexual partner had twice the odds of having multiple partners in the past year as those married or unmarried and not living with a partner.[773]

Condom Non-Use

For sexually active participants, 78 percent of women and 67 percent of men reported not using a condom at some time over the past year for a variety of reasons, listed in Table 6. Two percent of women and 13 percent of men surveyed said that they had engaged in unprotected sex with a non-primary partner in the past year.[774]

While it may be expected that some portion of those married or living with partners did not use a condom because they were seeking to become pregnant, 3 percent gave that as a reason in the community survey. The reasons most commonly reported by women were trusting a partner and not being permitted to use condoms by a partner. This indicates that women's decisions, though in the majority reported as their own choices, still implicitly relied and were dependent on the behavior of partners. Men's reasons for not using condoms were most commonly their trust of their partner, followed by inconvenience and the belief that condoms decrease sexual pleasure. While men's trust may be more rightly placed than women's in their sexual partners, given the comparatively low percentages of women in the community survey reporting multiple partners, these answers also speak to the agency that men have over condom use.

Abstinence

Abstinence was defined in the community survey as "not having sex at all, as a way to prevent yourself or others from becoming infected with HIV/AIDS." Forty-five percent of women surveyed and 40 percent of men reported that they were currently practicing abstinence in order to prevent HIV transmission. However, of those who had ever had sex (88 percent of participants), 19 percent of women and 7 percent of men reported having no sexual partners in the past year and 20 percent of women and 17 percent of men reported no partners in the past month. Knowledge of the efficacy of abstinence, in contrast to the actual experience of not being able to practice it, due to lack of control or other factors, may underlie this response. Assimilation of abstinence messages from churches or other sources, embarrassment to admit stigmatized sexual practices,

TABLE 6: Reasons for Not Using Condoms in the Past Year, Swaziland Community Survey (n=424)

Statement of Reason*	Women N=215 n(%)	Men N=209 n(%)	p value
I trust my partner	75(35)	88(42)	0.126
My spouse or partner(s) does (do) not want to use condoms			
Condoms are inconvenient	19(9)	38(18)	0.005
Condoms decrease sexual pleasure	17(8)	38(18)	0.002
I believe that I am in a monogamous relationship with an HIV-negative partner	13(6)	17(8)	0.402
I use other birth control methods	9(5)	10(5)	0.766
I/partner trying to get pregnant	10(5)	4(2)	0.115
Condoms are not available to me	7(3)	15(7)	0.069
Condoms do not prevent HIV/AIDS	3(1)	7(3)	0.185
I do not know how to use condoms	3(1)	6(3)	0.292
Condoms carry HIV	3(1)	6(3)	0.292
I cannot afford condoms	0(0)	2(1)	0.151

*Participants were asked an open-ended question and could give more than one response.

or desire to please researchers with a "correct" response may also explain this discrepancy.

In this same context, 83 percent of women and 75 percent of men reported that they would consider using abstinence some time in the future to decrease their risk of HIV infection. Ninety-seven percent agreed that they have a duty to avoid putting others at risk for HIV/AIDS.

PLWA Interviews

PLWA interviewed echoed the lack of control women have over sexual decision making in Swaziland, both anecdotally and in reporting their own experiences. They highlighted the role of economic dependence and food insufficiency in compelling women to have sex or multiple sexual partners. They discussed the social norms that encouraged multiple partnerships among men. At the same time, their testimony of experiences and sexual behavior change after discovering their HIV-status suggests that some HIV-positive individuals in Swaziland were able to make changes in their personal behavior that could reduce the transmission of HIV.

Women's Lack of Control and Vulnerability to HIV

PLWA interviewed reported that women often have little power to refuse sex to their partners, even in the context of long-term relationships, or to demand the use of condoms from a husband or boyfriend, even when they knew or suspected that he had multiple partners. Women who refused sex were accused of being unfaithful or prostituting themselves. As one 27 year-old explained:

> *Sometimes you don't feel like having sex. Sometimes you have to compromise; otherwise, the man will say, 'If you are saying no to me now, you must be having sex with someone else.'*

Twenty-two out of 45 women reported that a sexual partner had hurt them or forced them to have sex when they did not want to in their lifetime, emblematic of their lack of control. One 30 year-old woman's husband died in 2002 from AIDS, having hidden his HIV-positive status from her; she tested for HIV after his doctor told her the cause of his death.

> *My husband forced me to have sex. He would also beat me for nothing. When he came from his other girlfriends he would beat me.*

Compulsion or coercion to have sex could be more indirect than pressure from a partner. As one 49 year-old woman explained:

Women are having sex because they are hungry. If you give them food, they would not need to have sex to eat.

The link between women's lack of economic resources and sexual partnership choices came through clearly in the interviews. For example, one woman, age 38, explained:

Lack of income is the major factor. You need money — the kids are expecting something from you. You are vulnerable. You decide you can have sex once or twice. You know there is risk, but you say to yourself, 'I won't die from HIV today.'

Three men reported giving women money or resources in return for sex. One, a 36-year-old man, said:

The lady that I stay with. She was in Mbabane to sell some brew. She lacked a place to sleep. She fell in love with me to get a place to sleep. During the day, I proposed love and offered her a place to stay. She had nowhere to sleep. That is how our relationship started.

Multiple Partnerships

As noted earlier, 53 of the 58 PLWA interviewed suspected they had become infected with HIV through sexual intercourse with an HIV-positive partner. Five women and 10 men reported having more than one sexual partner at the time that they believe they became infected. Thirty-seven out of 45 women reported ever knowing that a primary sexual partner had had more than one partner concurrently, as did 10 out of 13 men.

Interviews made it clear that the reasons for multiple sexual partnerships for women and men, given the socio-economic environments in which Swazis live. Thirty-eight reported that there was social pressure for men to have multiple sexual partners. As one 45 year-old man put it succinctly:

Women have multiple partners because they need money. With men, it's Swazi pride, that you can get any woman you want.

Both women and men ascribed men's sexual behavior towards women — multiple partnerships, in particular — to the pressure to adhere to gender norms that value women for fertility and childbearing and men for virility and sexual prowess. One man interviewed, 29 years old and a former bus conductor who found many sexual partners through that line of work and rarely used condoms, explained:

You look like a failure if you only have one girlfriend. They say it is like only having one tooth. If you bite with one tooth and it breaks, it is dangerous.

Four of those interviewed blamed the polygamous marriage of the current King, Mswati III, for setting a poor example, or being an excuse for men's behavior. One young woman interviewed articulated this: "Swazi men have a feeling that if the King can have so many wives, so can they."

Persistent Vulnerability of Female PLWA Despite Sexual Behavior Changes

Two themes stand out in the interviews with PLWA, in terms of respondents' sexual practices. One-third of women interviewed living with HIV/AIDS reported lacking of control over decision making in sexual relationships. At the same time the majority of those interviewed reported having made changes to reduce risk-taking in their sexual practices.

First, the persistent lack of autonomy experienced by women was clear from the discussion of current sexual practices among the PLWA interviewed. This was true for a sizeable proportion of the women interviewed despite their acute awareness of the relationship of women's disempowerment to their vulnerability to coer-

TABLE 7: Lack of Control in Sexual Decision Making by PLWA

	Women N=45		Men N=13	
Statement Response	Yes	No	Yes	No
Lack control over the decision of when to have sex	16	26	0	11
Partner(s) only or mostly partner(s) decide whether or not to have sex	15	24	0	11
Lack control over the decision of whether or not to use a condom	12	29	1	10
Lack control over childbearing decisions	10	30	1	9

cion, and despite their own empowerment as revealed in the interview testimony on other topics, such as testing. Sixteen out of 45 female PLWA, and none of the males, reported that they did not have control over the decision of when to have sex. Other responses indicating lack of control are shown in Table 7.

Second, many women and men interviewed had been able to make changes in the number of their sexual partners and the nature of their intimate relationships. Fifty of those interviewed reported that learning of their HIV-positive status was a catalyst for a number of changes they deemed positive, including reducing the number of sexual partners and more routine use of condoms. Three women and 3 men reported having more than one partner at the time of the interview, compared with 12 women and 13 men interviewed who had ever had more than one sexual partner at the same time. However, women also reported losing interest in sexual relationships or not being able to find a partner — or a partner with whom they felt comfortable disclosing their HIV-status or could successfully insist on condom use.

One 39 year-old man described how his relationship with his girlfriend changed after she tested positive when seven months pregnant. At the time of the interview his child was a few weeks old (and HIV-negative) and the interviewee had just received his own positive test results.

We trust each other more in our love. I've grown up. I'm living a healthy life now — no cheating. As a man, I used to cheat. She didn't know before this.

Both men and women reported choosing abstinence based on a sense of moral responsibility to themselves and/or others.

I feel like being celibate is best. You could re-infect yourself, or the condom can break and you can infect someone else. I haven't had sex since I got tested.

When I tested positive, I made it my duty not to infect others, so I chose abstinence.

While abstinence might be an ideal choice for some, however, it was not always an actual, practical one.

When I'm about to have sex, it reminds me of my HIV status. I wouldn't want to have sex at all, but I can't refuse my husband. But I told my husband, if we don't use a condom, then no sex.

We are not allowed in our culture to say today I don't want to have sex…If I refused to have sex, my husband would beat me.

The compulsion for sex exchange derived from economic dependence affected the women interviewed, even more so perhaps than before the HIV-positive diagnosis, given the restrictions their health and HIV-related illness could place on their ability to earn an income or receive support from their families. Whether or not she wants to remain abstinent, a 29 year-old man explained,

A woman will be forced to sleep with men for food and a place to live.

Key Informant Interviews

According to most key informants, women's lack of control over sexual decision making is prevalent in Swaziland. This resulted in sexual practices that place women and men at risk for HIV infection. This lack of control, and men's refusal to use condoms, were socially sanctioned and rooted in the power imbalance between women and men.

Women are vulnerable to contracting HIV because they don't have the power to control their own bodies. Men… think about themselves, and society applauds them. … They say condoms have worms, or they have HIV. It's just an excuse so they don't have to use condoms.[775]

Others agreed that failing to use condoms was less about misinformation than about gender and sexual relations, which were driving the HIV epidemic in ways very resistant to change.

There's awareness and information of HIV/AIDS that doesn't translate to an improvement in the infection rate because attitudes are difficult to change. …People hear the campaigns but do something different. Collecting condoms is one thing, but using them is a private affair, a grey area, a challenge.[776]

Coupled with masculine ideologies precluding behavior change was the economic dependence of women unable to insist on safe, respectful and responsible behavior from men. Several key informants described the need for both women and men to migrate to find jobs in urban areas or "company towns" (industrial estates in peri-urban or rural areas) and the lack of affordable and available housing for workers who do so as a key factor

in creating an environment of temptation and exploitation. As a result, women and men who were strangers to each other share housing, and women (often with husbands at home) "paid in kind" for a place to live. [777]

> *Many people in Mbabane moved here from rural areas. It's a group that doesn't have the means to survive city life. The women want accommodations, but it's not easy to get accommodation if you're not employed. They stay with the men and permit them to do what they want. ...She's like a beggar.*[778]

The risks that people took through their sexual practices were derived from their socialization and economic circumstances and enforced by expectations and norms. The latter can only change when the social structures underlying attitudes and practices change.

Gender Norms and Beliefs and Perceived Vulnerability to HIV/AIDS

Ninety-seven percent of community survey participants held at least one gender discriminatory belief. Proportionally more men than women held such beliefs. For example, 22 percent of women and 33 percent of men agreed that it is more important for a woman to respect her spouse or partner than it is for a man to do so. Regression analyses demonstrated the associations between attitudes accepting and reflecting women's inferior legal, cultural and socio-economic status in Swaziland and the unsafe practices and circumstances that render both women and men vulnerable to HIV/AIDS. For example, participants who held the belief that it is a woman's duty to have sex with her spouse or partner even if she does not want to had over 2 times the odds of unprotected sex in the past year with a non-primary partner as those who did not hold that belief. On the other hand, the majority of community survey participants, particularly women, endorsed statements of full and equal human rights for women. Decreased odds of sexual risk were associated with holding these beliefs. For example, women and men who agreed that women should be able to hold the same jobs at the same pay as men had half the odds of multiple sexual partnerships in the past year as those who disagreed with that statement. PLWA interviewed confirmed the prevalence of gender inequality and discrimination against women in families, communities and workplaces and its association with women's, and men's, vulnerability to HIV. Key informants similarly explained HIV/AIDS in Swaziland as an epidemic rooted in unequal relationships, social norms and legal structures disempowering women.

Community Survey

Belief in Gender Discriminatory Norms

Swaziland community survey participants were asked to agree or disagree with statements expressing beliefs about men's and women's roles in society in order to assess the prevalence of gender discriminatory norms and support for women's equal rights with men.[779] Persistent discriminatory beliefs[780] were held by a majority of those surveyed and more commonly by male participants.

Ninety-seven percent of community survey participants held at least one gender discriminatory belief. Sixty-one percent of women and 80 percent of men held three or more discriminatory beliefs. Charts 2 and 3 show the proportions of women and men in the community survey holding gender discriminatory beliefs. Twenty-four percent of women and 44 percent of men held 6 or more, indicating widespread entrenchment of such views.

CHART 2: Gender Discriminatory Beliefs Held by Women, Swaziland Community Survey (n=397)

Prevalence of Women's Gender Discriminatory Beliefs

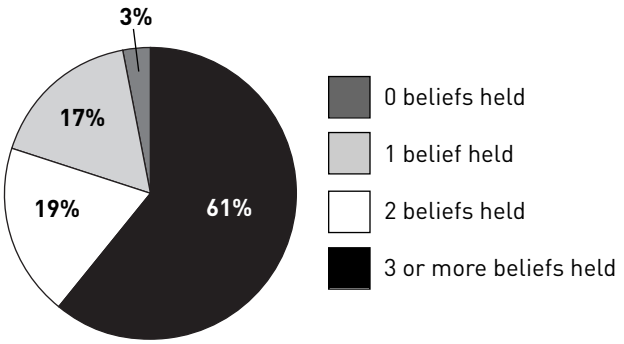


CHART 3: Gender Discriminatory Beliefs Held by Men, Swaziland Community Survey (n=390)

Prevalence of Men's Gender Discriminatory Beliefs

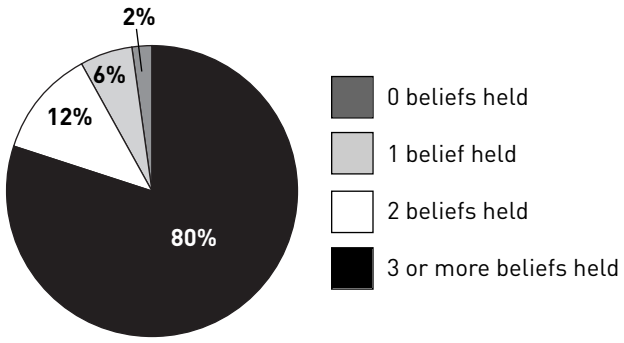


TABLE 8: Selected Individual Gender-Discriminatory Beliefs, Swaziland Community Survey*

Statement of Belief	Women		Men	
	N	n (% agree)	N	n (% agree)
A woman is expected to have children if a man pays *lobola* [bride price] to marry her	384	183(48)	385	228(59)
It is a woman's duty to care for the sick	394	138(35)	385	151(39)
Women should not insist on condoms if their partner refuses	381	104(27)	379	132(35)
It is more important for a woman to respect her spouse/partner than it is for a man to respect his spouse/partner	396	87(22)	388	130(33)
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	389	73(19)	386	129(33)
It is OK for a man to take another wife if his current wife does not bear children	380	63(17)	379	137(36)
It is a woman's duty to have sex with her spouse/partner even if she does not want to	391	49(13)	380	76(20)
A man may beat his spouse/partner if he believes she is having sex with other men	389	40(10)	385	67(17)
A man may beat his spouse/partner if she disobeys him	393	21(5)	388	47(12)
It is OK for men to have more than one sexual partner at one time	396	11(3)	388	45(12)

*All responses in the table show statistically significant differences ($p \leftarrow 0.05$) between men and women.

In terms of specific beliefs, a picture emerges of men and women endorsing social expectations of women's role as subservient to male sexual partners, ceding power in relationships to men and being primarily valued by childbearing as a measure of their worth in families. Selected individual beliefs are listed in Table 8. Approximately one-third of the men in the community survey held the following beliefs: 1) that men should control significant decisions in relationships; 2) that it was more important for a women to respect her spouse or partner than for a man to do so; 3) that women should not insist on condom use if their partner refused; and 4) that a man could marry a second wife if his current spouse does not bear children. Seventeen to 27 percent of women held these beliefs.

The influence of traditional cultural beliefs concerning women and women's social devaluation is evident in these attitudes, and demonstrated most clearly by the fact that more than half of surveyed men and almost half of women agreeing that a woman is expected to have children if the traditional practice of bride price (*lobola*) was part of the marriage.[781] The potential consequences of these practices, in the context of women's poverty and lack of autonomy, were demonstrated by the strongly held belief among male participants that a man should marry another wife if he has paid *lobola* and there are no children. Likewise, about equal proportions of women (35 percent) and men (39 percent) affirmed that it is a woman's duty to care for the sick, a traditional division of labor that has become even more burdensome on women and girls in the era of HIV/AIDS.

At the same time, however, social change was clearly at hand, perhaps more rapidly and profoundly influencing the minds of women than those of men. Compared with the other discriminatory statements, for example, fewer women and men agreed that it is a woman's duty to have sex with her partner even if she does not want to, though more men (20 percent) than women (13 percent) held this view. Changes in attitudes, however, do not appear as yet to be widely reflected in the private and public sphere experiences of women, as discussed elsewhere in this chapter.

Support for Women's Rights

Support for women's rights was articulated by the majority of those surveyed. Responses are listed in Table 9. In light of the prevalence of gender discriminatory beliefs among those surveyed, attitudes that demonstrate support for women's rights are possible indicators of the potential for acceptance of the sociocultural change and legal reforms necessary to enable women to achieve equality with men in intimate relationships as well as the public sphere.

More women than men surveyed endorsed women's equality and empowerment. The majority of participants showed support for increasing women's control over their own lives through property ownership, inheritance rights and other measures to promote autonomy, eradicate inequality and address the inferior legal status of women in Swaziland. For example, women and men supported women's non-discriminatory access to employment and ownership. Seventy-five percent of women and 61 percent of men agreed that a woman should be able to end a relationship with a man, suggesting an endorsement of women's autonomy and decision making on equal footing with male partners. The minority who disagreed represents the persistence of discriminatory views, however.

Holding men responsible for children and recognizing the need to protect women and acknowledge their rights were also supported by community participants. Both women and men felt nearly universally that men should financially support the children they have from all relationships. Similarly, 91 percent of women and men felt that a woman's in-laws should protect her if her husband hurt or mistreat her. These beliefs stand in contrast to the status quo, where many women have experienced social and legal barriers to obtaining financial support from spouses, and disempowered outsider status and abuse from in-laws, particularly if they are HIV-positive or have AIDS.

Associations of Gender Discriminatory Beliefs and Support for Women's Rights with Sexual Risk-Taking

There is a predictive relationship between holding gender discriminatory beliefs and sexually risky practices or circumstances. Those surveyed who held six or more discriminatory beliefs (34 percent of participants) had twice the odds of having multiple sexual partners as those who held fewer discriminatory beliefs.[782]

Holding certain specific discriminatory beliefs predicted having multiple partners or unprotected sex with a non-primary partner, increasing the odds of doing so anywhere from nearly 1.6 to 4 times. These associations are shown in Tables 10a and 10b. Those who endorsed men having multiple sexual partners had 4 times the odds of reporting this practice and 3.5 times the odds of unprotected sex with a non-primary partner as those who did not. Participants who felt that men should control decisions in relationships with women had more than 1.5 times the odds of having multiple sexual partnerships and nearly twice the odds of having unprotected sex with a non-primary partner. Conversely, beliefs in women's rights decreased the odds of sexual risk; these associations are shown in the shaded boxes in Tables 10a and 10b. Participants who thought that women should hold the same jobs at equal pay as men had 51 percent lower odds of having multiple sexual partners and 42 percent lower odds of sex without a condom with a non-primary partner as those who did not. Women and men who agreed that women should be able to end relationships with men had 50 percent decreased odds of having unprotected sex with a non-primary partner than did those who disagreed.

PLWA Interviews

In the interviews, women and men living with HIV/AIDS described the association of prevalent gender norms

TABLE 9: Support for Individual Rights, Swaziland Community Survey*

Statement of Belief	Women		Men	
	N	n (% agree)	N	n (% agree)
Women should be able to hold the same jobs at the same pay as men	390	331(85)	381	286(75)
Women should be able to own property in their own name	385	307(80)	381	240(63)
A woman should be able to end a relationship with a man	381	284(75)	384	236(61)
Women should have their own houses and land when they marry	387	282(73)	382	202(53)

* All responses in the table show statistically significant differences ($p \leftarrow 0.05$) between men and women.

with women's and men's risk of HIV in Swaziland and their own experiences as PLWA with gender-based inequality and discrimination.

Discriminatory Institutions and Behaviors

PLWA interviewed confirmed the strong influence in women's and men's lives of customary law and traditional practices. Swazi women's contemporary situation as dependent on others for resources and status is rooted in many of the traditional elements of southern African tribal culture, such as bride price and wife inheritance, according to those interviewed. For example, as discussed earlier, the payment of *lobola* to the bride's family was viewed as granting the husband and his family absolute rights over a woman's sexual activity and childbearing.[783] Thus there is very little legal or social support for women to refuse to follow the wishes of her in-laws, as custom dictates. One HIV-positive woman interviewed described her own experience with wife inheritance:

> *When you have lost your husband, you have to take another husband in the family. For example, my husband died of HIV. I am supposed to marry his brother. I got a good counselor, and she advised me not to marry his brother.*

TABLE 10A-B: Selected Specific Gender-Related Beliefs as Predictors of Sexual Risk-Taking in the Swaziland Community Survey, Total Sample by Outcome Variable

A) Associations of Beliefs and Multiple Sexual Partners in Past Year

Statement of Belief*	N	AOR**	95% Confidence Interval
It is OK for a man to take another wife if his current wife does not bear children	741	2.57	1.71-3.87
A woman is expected to have children if a man paid *lobola* to marry her	751	1.84	1.25-2.73
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to	756	1.56	1.04-2.32have)
Women should be able to hold the same jobs at the same pay as men	752	0.51	0.33-0.78

B) Associations of Beliefs and Unprotected Sex with a Non-Primary Partner in Past Year

Statement of Belief*	N	AOR**	95% Confidence Interval
It is OK for men to have more than one (sexual) partner at one time	751	3.50	1.61-7.61
It is a woman's duty to have sex with her spouse/ partner even if she does not want to	738	2.25	1.16-4.35
A woman is expected to have children if a man paid *lobola* to marry her	736	1.98	1.03-3.78
Men should control decisions in relationships with women (whether to marry, whether to have sex, how many children to have)	741	1.87	1.02-3.43
Women should not insist on condom use if their partner refuses	726	1.89	1.02-3.50
Women should be able to hold the same jobs at the same pay as men	737	0.42	0.24-0.83
A woman should be able to end a relationship with a man	731	0.50	0.28-0.90

* A separate model was created for each belief.
** The odds ratio is a relative measure of risk, predicting the likelihood of the outcome at issue if a certain characteristic (described by the independent variable) is present. The adjusted odds ratio is the odds ratio adjusted for the possible confounding effects of the other variables included in the models. For all models, the odds ratio was adjusted for sex, age, education level, monthly household income, food insufficiency, marital status, residency location, HIV knowledge, HIV-related stigma and fears of HIV-related stigma.

Fortunately, her in-laws accepted her refusal and, because she owned the home in which she lives, could not legally evict her and her five children.

Others described how in-laws and other members of the husband's family would seek to take advantage of the dependent status of women who were widowed. They also reported women's difficulties in establishing rights to inherit their marital property under Swazi civil law, a time-consuming process of accessing the over-burdened legal system. Most women had left their own family homesteads and had no property in their own names. Estate determinations pending, in-laws evicted women and children from their homes or insisted on their return to the wives' natal families.

While such situations might be overcome if women were able to earn incomes to support themselves financially, gender discrimination in the workforce was described as commonplace by the PLWA interviewed. Not only was it more difficult for women than men to find employment, salaries were low and women usually had families to support. Moreover, women living with HIV or AIDS would often be battling ill health and needing to satisfy increased nutritional and medical needs, in addition to the resource inequalities that all women endured. Employment discrimination often took the form of sexual harassment, including demands for sex in exchange for work, closing the circle of vulnerability.

Before being employed, if you don't agree to have sex with managers, you will not get the job. When an advertisement is placed for a job, sleeping with the manager is a pre-requisite. It happened to me one time ... They told me I would have to have sex with the manager.

One woman was blamed by her in-laws for bringing HIV into the family even though her husband had had an extra-marital relationship and child with another woman and both she and the child died of HIV. Later the husband reconciled with the interviewee and subsequently tested HIV-positive himself. In the interview, this woman pointed to the powerlessness of women in a patriarchal society. She commented on the difficulty of changing this entrenched dynamic, so embedded in social and political structures.

Only the law can help. The law must be revised and amended. Even Parliament, it is run by Swazi men. They don't want to change the laws because the laws serve them, they benefit from the laws.

The new Swaziland constitution contains a passage allowing women to refuse to follow customs to which they are opposed. It remains to be seen whether women will feel empowered to defy their families and tribal leaders and, moreover, how this provision — or any of the Constitution — will be implemented through law and public education and subsequently enforced.

Women's Vulnerability

PLWA were nearly unanimous in their view that women's unequal position in the family and community resulted in women's vulnerability to harm, including the high risk of HIV transmission. One woman explained how men's control of women's lives translated into HIV infection:

Here in Swaziland, the husband is the one that bosses you around so there is nothing you can do without him. My rights lie with my husband. He decides whether we use condoms. I don't have a choice about prevention.

She was 30 years old at the time of the interview and had tested when she was pregnant with her second child, because her husband had had children with another woman.

For those interviewed, men's multiple sexual partnerships were clearly linked to women's vulnerability.

Women are vulnerable because men can have as many wives as they want. And he dictates what to do. He can say no to condoms, and she can't refuse.

Nearly all of those interviewed agreed that lack of income and inability to hold title to property placed women at risk by forcing them to depend on casual and long-term male partners as financial providers. One 28 year-old woman was a widow whose husband, like his previous wife, had died of AIDS, leaving her with five dependents. She summed up the intersection of women's responsibility and disempowerment in this way:

Lack of income is the primary problem that puts women at risk for HIV. Men force their wives to sleep with them without protection. Unemployment, being poor, having to feed and take care of kids.

Fifty-one of the 58 individuals interviewed identified violence against women as a problem in their community, reflecting women's low status and men's power and control which often led to coerced unprotected sex.

There was a time when I had a boyfriend dragging me to his house when I did not want to have sex.

He would lock me up and force me to have sex…I would end up sleeping with him for fear that he would beat me up.

Men's Vulnerability

Those interviewed described men's risk of getting HIV as rooted in men's own behavior of sexual risk-taking, including having many sexual partners, excessive alcohol consumption and refusal to use condoms. It was recognized that this behavior was itself influenced, or even dictated, by social and cultural pressures, and the erosion of traditional limitations. As one 52 year-old woman put it, "A real man is expected to have many girlfriends and wives." Men's vulnerability was understood as the flipside of women's: men's control, coercion and exploitation of women's dependence, allowing men to insist on unprotected sex, likewise left men vulnerable to HIV transmission.

Social expectations put pressure on men to be patriarchs. One unmarried 30 year-old man living with a sexual partner and responsible for supporting five dependents, including his four children, said:

Your family expects you will produce children. Your children will expect an income from you since women are not expected to work. If she works she doesn't belong to you, she belongs to someone else.

Key Informant Interviews

Key informants viewed HIV/AIDS as "a gender issue."[784] They understood women's vulnerability as rooted in inequalities of power between men and women: fostered by civil and customary legal institutions of marriage, property and inheritance and maintained at the individual level in domineering or coercive relationships. A gender expert with a local NGO summed up the situation:

Men always dominate in our society… . Males and females don't share the same amount of power. Females are not respected by society. Our policies, our laws, are betraying women and favoring men. That is the problem. HIV will be there as long as women are subordinate to men.[785]

The challenge presented by this structural and normative gender inequality was also recognized in the expert interviews, including obstacles presented by women themselves. Women, like men, were members of Swazi society socialized into its norms and constricted by its customs and laws in their beliefs and actions. As an AIDS services agency representative explained:

Women don't want to be empowered, they want to subordinate. Always when something is launched, on the radio there will be a woman discussing empowerment strategies negatively, smearing them. For example, CEDAW [UN Convention on the Elimination of All Forms of Discrimination Against Women, acceded to by Swaziland in 2004] caused a lot of discord, there were men and women both for and against. It is very difficult to break the barriers and harness the situation.[786]

Several key informants commented on the entrenchment of gender discrimination in the rural areas in particular:

Seventy percent of the country is rural, and they are very traditional. Young boys are turning out like their fathers. There is not enough change.[787]

At the same time that traditional practices which keep women subordinate persisted, the formerly protective elements of unwritten, customary law — such as the registry of marriages with chiefs who granted each wife and her children their own land[788] and the safe haven that could be found for the vulnerable in the house of the senior grandmother in the homestead[789] — disappeared.[790] As people migrated to urban areas in search of work and families were fractured, the extent to which the benefits of the old ways had been lost has became evident to progressives and conservatives alike. Yet these were not replaced by protective and empowering structures and politics to ameliorate the hardships of the modern society and economy. As explained by a researcher at WLSA, PHR's field partner for the Swaziland study:

In the money economy…the elders are dependent on the young rather than the other way around … and they don't have the power to enforce [beneficial and protective] norms and traditions. Culture is dynamic and it changes — but the problem for women is that culture is frozen, whereas men have changed. They can't accept that women can do the same, that things have changed and women also need to lead the modern life.[791]

Interview testimony was clear that achieving meaningful equality at the individual and household levels required reform of the gender discriminatory norms and institutions, both locally and nationally in Swaziland.

Leadership on HIV/AIDS in Swaziland

The need for mobilization of political will by the leadership in Swaziland to reform discriminatory legal and social structures, address the effects of poverty on vulnerable populations, educate the general public (and men in particular) and, by their personal actions, set a good example to address the HIV/AIDS crisis in Swaziland came through clearly in the surveys and interviews. Forty to 89 percent of survey participants faulted national leaders, chiefs, church leaders and the King in every domain on which they were questioned, including not setting a good example in their personal behavior or sexual practices. For example, 73 percent agreed that national leaders had not spent enough money on HIV prevention and 72 percent felt that chiefs had not done enough to oppose bad treatment of PLWA. Aside from educational campaigns generally, no one strategy for closing the gaps in policy was endorsed by community survey participants when asked an open-ended question, suggesting the need for a range of strategies coupled with enhanced dissemination of information concerning them. PLWA and key informant interviews were also mainly critical of leaders, particularly for failing to take the initiative of concrete actions to speak out about HIV/AIDS, change their own behavior, educate their constituencies and implement policies to address the socio-economic conditions of Swazis that create barriers to access for testing and treatment.

Community Survey

Inadequacy of Leadership Addressing HIV/AIDS in Swaziland

Study findings reflected the large gaps in national and local policy and programs addressing the HIV/AIDS epidemic in Swaziland. Participants in the community survey were asked their opinions of the response of Swaziland's leaders to the HIV/AIDS crisis in five domains: spending on prevention; personal behavior and sexual practices; assistance to PLWA and those affected by HIV/AIDS; opposing HIV/AIDS-related stigma and discrimination; and domestic violence protection for women and children. Their responses are shown in Table 11.

Nearly half of participants voicing an opinion found fault with each category of leader in every domain, and national political leaders and chiefs were found lacking across the board by the majority of those surveyed. Criticism was levied in particular on national leaders and chiefs for not spending enough on HIV prevention[793] and on all leaders for not setting a good example by their personal behavior.

In contrast to the poor marks given to leaders in terms of providing assistance to PLWA and others affected by HIV/AIDS, as mentioned previously, nearly all of those surveyed agreed that PLWA should receive food or other assistance from the Government (98 percent). They also universally supported income generation projects for HIV-positive women to decrease the impact of HIV/AIDS in Swaziland (98 percent).

Whereas 90 percent of participants in the community survey agreed that violence[794] was an important contributor to the spread of HIV in Swaziland, more than half believed that chiefs, national leaders and the King had not done enough to protect women and children from abuse and two-fifths agreed that church leaders had not done so.

In addition, 31 percent of women and men participating in the community survey reported that the way gov-

TABLE 11: Opinions on Leadership in Swaziland on HIV/AIDS, Swaziland Community Survey [792]

	Chiefs		National Political Leaders		King		Church Leaders	
Statement of Opinion	N	n(%)	N	n(%)	N	n(%)	N	n(%)
Not spent enough money on HIV prevention	689	614(89)	688	504(73)	679	325(48)	704	444(63)
Not set a good example in their personal behavior/sexual practices	704	554(79)	677	542(80)	701	538(77)	720	342(48)
Not given survival basics (food, water, shelter, land) to people infected or affected by HIV/AIDS	698	447(64)	691	387(56)	700	294(42)	716	297(41)
Not done enough to oppose bad treatment of PLWA	686	496(72)	685	455(66)	670	359(54)	698	327(47)
Not protected women and children from abuse	708	473(67)	706	418(59)	691	397(57)	725	290(40)

ernment works in Swaziland prevented them from having a say in the way HIV/AIDS is addressed in the nation. The centralized decision making of the Swazi monarchy and the lack of opportunities for civic participation may underlie these views.

The heavy criticism of chiefs may reflect their perceived high level of influence on the daily lives and attitudes of their constituents and, therefore, their actual ability to affect the transmission of HIV and its impacts. National political leaders were also criticized by half or more of respondents in every domain. This assessment was likely for the same reasons as those reported for chiefs, given their responsibility for national policies and their visibility in Parliament and the ministries. In contrast, church leaders were assessed comparatively less harshly; their actions were judged wanting, though, by 40 percent or more of the sample in each category.[795]

Given the cultural significance of and high regard for the royal family in Swaziland, and the potential negative consequences of critiquing the King, during most of Swaziland's history rebuke of the King's actions or policies was rare, private or indirect. Whether a measure of increased openness, the confidential nature of the survey, the current level of dissatisfaction with his lack of leadership on HIV/AIDS, the magnitude of the AIDS crisis itself or some combination of these, community survey participants were critical of the King. Only with regard to spending for prevention measures was the King judged less negatively than the other leaders, yet 48 percent of participants still felt that he had not done enough in that arena. Funding is an area of Swazi policy where the King has great power, both as a political leader and in his role as a direct donor to social causes and to the needs of individuals such as AIDS orphans.

Strategies for Going Forward and Closing the Gaps

When community survey participants were asked in an open-ended question for their opinion about what could be done in Swaziland to prevent further spread of HIV, the only answer given by more than 50 percent of participants, as shown in Table 12, was educational campaigns. This category was inclusive of campaigns on a wide range of HIV/AIDS-related subjects.

The value of information and public education on topics ranging from prevention to testing, treatment and stigma was recognized by 60 percent of women and men. When asked directly, 94 percent of participants said that they would support HIV education directed at men as a prevention strategy. Seventy-three percent of women and 63 percent of men agreed that promoting abstinence could contribute "extremely" or "quite a lot" to changing sexual behavior in Swaziland.[796] As discussed in the section on sexual practices, this opinion may reflect recognition of the efficacy of abstinence to prevent HIV without taking into account the barriers to its successful practice, such as women's lack of control over sexual decision making.

TABLE 12: Preventing the spread of HIV in Swaziland, Swaziland Community Survey (N=787)*

Statement of Intervention	n(%)
Educational campaigns	471(60)
Increasing the availability of condoms	173(22)
Supporting people to get tested	86(11)
Providing resources	59(8)
If the King would set an example or speak out	54(7)
Making treatment, including ARVs, more available**	52(7)
Addressing domestic and sexual violence	44(6)
Increasing availability of testing	43(5)
If people had access to good or better quality medical care	39(5)
If there were more HIV/AIDS support groups	34(4)
Increasing confidentiality at testing sites	32(4)

*Participants could give more than one answer.
**The difference between women's (5 percent) and men's responses (8 percent) was statistically significant (p=0.000).

The second most common response, given by 22 percent of those surveyed, was to increase the availability of condoms. As mentioned previously, only 4 percent of those surveyed affirmed that unavailability or lack of affordability of condoms was the reason they did not consistently use them over the past year. This response may speak, therefore, to the need for increased distribution of condoms or better coverage in certain areas, given that they are already widely available.[797] It also highlights the importance of education around the preventive value of condoms. Finally, it suggests a perceived need for the imprimatur of endorsement by peers and community, church and national leaders in order to demythologize condoms and normalize their use.

Despite the small proportion of community survey participants who reported having tested for HIV, in open-

ended questions only 11 percent suggested that supporting people to get tested would assist in HIV prevention and 5 percent mentioned increasing availability of testing as a prevention strategy. In addition, 7 percent claimed that increasing the availability of ARVs was a key prevention measure. This may reflect the fact that, at this point in the HIV/AIDS epidemic, Swazis were more aware of the impact of education and condom availability on HIV prevention, and had not yet been made cognizant (through campaigns, for example) of the effects of expanded access to testing and treatment as prevention measures.

PLWA Interviews

Women and men living with HIV/AIDS interviewed for the study were asked an open-ended question about whether and how leaders have addressed the HIV/AIDS problem in their communities. They were also asked what the King has done to address the epidemic in Swaziland and their recommendations for what he should do.

Praise and Criticism for Leadership

Feelings about the actions of leaders among PLWA were mixed. Some reported that they had made an effort to disseminate information and establish and expand testing and treatment access.

> *They've increased educational campaigns, established VCT centers and have concentrated on HIV in the workplace.*

Some recognized the important role PLWA needed to play to educate leaders in the first instance.

> *We need to train community leaders, chiefs, key people: HIV doesn't mean that life is over. We need teaching by people in the community. We need to empower leaders first, and fix misconceptions in key people.*

Leaders were criticized for being merely rhetorical and not delivering concrete action in their approach to the epidemic, including changing their own behaviors. Twelve out of 58 individuals interviewed charged that the King in particular was a poor role model for other Swazi men because he was polygamous and has so many wives. They said that other men justified their own behavior by referring to the King, and that the King's behavior therefore undermined HIV education efforts aimed at reducing multiple sexual partnerships.

> *They have not done anything. What they did is just lip service. They don't walk the talk. They use HIV programs for their campaigning only so that they can win our support. But then they do nothing. And the King is a bad role model. If I am a young man, I want to imitate the King. I would also love to have many wives.*

On the other hand, 16 interviewees praised the King, in particular for declaring the epidemic a national disaster in 1999, speaking publicly about HIV, funding orphan care programs and appealing to foreign leaders for financial assistance, particularly for the distribution of ARVs in Swaziland.

> *He has asked every Swazi to help in any way. He has said it's a disaster.*
>
> *The King has asked donors from overseas to support Swaziland.*

Strategies to Increase Testing and Treatment

One of the most direct recommendations for leadership stemmed from the identification of leaders as influential role models for other Swazis: the King and chiefs should get tested for HIV and announce their test results publicly. Those interviewed suggested that the King's actions in particular would have a significant effect on the willingness to test of the general Swazi population.[798]

> *He [the King] should get tested. And all his wives. It would have a big impact. Maybe if he was positive, more people would test. He has to take a step in order for everybody to take it.*

Likewise, leadership was deemed wanting around treatment. In particular, interviewees urged leaders to provide accurate information about the nature and efficacy of the ARV regimen.

> *There needs to be more teaching about ARVs. There are rumors that the medicines which have been donated are poor quality — that they want us to die. We need more information to empower people.*

Other barriers to treatment discussed by the PLWA interviewed suggested the need for a coordinated leadership effort at the national level. Barriers included costs of transport and non-ARV drugs, the lack of dispensaries outside of the 6 located in major towns, inconsistent supply of medications and an unmet demand for trained health workers.

> *The problem is you have to wait in long lines. You can wait five hours. The whole work day is gone. Once I was too sick to come in. But you have to try to get here. Your life depends upon it.*

The problem is the distance from clinics. People who are suffering cannot travel. There is a shortage of doctors, so people must wait for one doctor to prescribe to many people.

The urgency of the situation was discussed by more than half of PLWA interviewed, speaking as they were from the center of a pandemic in a very small country in a region subject to the "triple threat" of AIDS, food insecurity and poverty,[799] for which dire predictions loomed.[800] As one 31 year-old man, whose girlfriend died in 1998 and who himself started exhibiting symptoms in 2002, lamented:

I think the whole African nation will be cut in half by this. Of course I'm worried about the Swazi nation—the nation will die.

Key Informant Interviews

Several key informants criticized the political nature of the response to the HIV/AIDS crisis in Swaziland and felt that the disease itself had been politicized to the detriment of the national approach. Both Government officials and PLWA activists pointed out that national policies related to the crisis — the AIDS and gender policies — remained in draft form for long stretches of time, yet to be formally approved, let alone implemented.

There is a slogan: 'it's everyone's problem.' But the King said that, too. What is the real meaning? It's just a political statement that everyone has to mention. When I see action, I will appreciate the Government talking about AIDS. We should be talking about amending policy, but in our case we [still] have to develop one, fast.[801]

Inaction of Leadership

Like the PLWA interviewed, many experts in Swaziland criticized leaders for failing to follow words with deeds in the area of HIV/AIDS, including as role models for behavior change. A few questioned the influence leaders could have on the general public, given the effects of poverty, food insufficiency and other socioeconomic factors constraining individuals' choices.

There isn't much commitment, but there's a lot of lip services. ...Just talking and not doing. I don't think public figures will make people change. Their lives are different — they have everything you may not have, money to buy food and so forth.[802]

One coordinator for an association working on AIDS and workplace issues suggested a prescription that summarized many key informants' critiques and recommendations for the national leadership:

If the country leadership could change and be seen to do something: first, to talk openly about HIV; second, act what they talk; third, support policies and legal instruments ... especially those trying to amend laws to include HIV/AIDS and fourth, [to comply] with the [human rights] conventions Swaziland has signed, to include budget implementation provisions. This impacts how people behave, because they look at the budget priorities of the Government and then say, okay this is a problem.[803]

In terms of individual leaders, many key informants from the spectrum of Swazi service organizations, government, international agencies and PLWA groups were highly critical of the King — though for the most part "off the record" — indicating, perhaps, the precarious status of the lessening of that particular taboo. They criticized his polygamy, his declaration and subsequent violation of the revival of *umcwasho* (signifying a ban on sex with girls under the age of 18), his enormous material wealth and spending, and his failure to raise the issue of gender in his speeches on HIV/AIDS. One NGO representative explained the reaction of communities when she goes to educate them:

They will say, we don't understand why you say there is HIV/AIDS when 'someone' [the King] behaves as if there is no HIV/AIDS.[804]

Chiefs, as a category of leadership, were faulted for shirking their traditional role:

If the chiefs were living a true chiefly life, they are supposed to protect you [as a woman], there would be more protection in the Swazi way than in the civil law.[805]

Church leaders were criticized for missing opportunities to influence their many parishioners through their Sunday sermons, and particularly for having come so late — or not at all — to accept and encourage condom use or acknowledge the HIV risks of married individuals.

In the church, our priests and bishops are not taking HIV seriously enough ... they just talk about it in a passive way. They should be allocating more time to it because every Friday they're having mourning services and every Sunday they're burying people. They're all saying, abstain and be

faithful. But they also need to talk about condoms in churches. Even in churches, people are failing to abstain, and failing to be faithful.[806]

Public health and medicine were additional areas of leadership singled out for criticism by key informants. Those responsible for failing to address the inadequate health infrastructure were cited as lagging in their response to HIV. Moreover, key informants interviewed repeatedly cited the burden on the public health system that treatment provision and the increasing numbers of people identified as living with AIDS was exacting in Swaziland. The perspective of the national director of Swaziland's AIDS coordinating agency was typical:

Our system could not cope with a more aggressive program to get more people on treatment right now. Until the Ministry of Health increases the number of sites, and gets more doctors, we don't have the capacity to increase enrollment.[807]

Health professionals were criticized by one key informant for not "taking the initiative" to learn about HIV/AIDS and for the fact that training and other programs failed to keep pace with increasing caseloads of HIV-infected and AIDS patients.

Capacity is the challenge. The whole country is not ready. The slow pace of putting in a system. There's brain drain…. Another issue is …HIV is like any other disease — you have the capacity as a nurse to learn. … Doctors also — they don't read — there are guidelines …"[808]

Need for Diverse, Grassroots Strategies

As one donor agency AIDS coordinator noted, in terms of leadership, "[Swaziland] needs to use whatever resources they have: rural health motivators, traditional healers, chiefs."[809] Key informants recognized that participation from the ground up was essential to holding everyone, leaders and individuals alike, accountable to successful strategies for change.

We need to ask people in their constituencies, regionally — how would you prevent HIV as an individual, as a group? Stop pointing fingers at someone else. …How would you like to see women respected in life? If we can individualize the problem, I think we can bring about behavior change. It should come from the people themselves. If it comes from the top, they won't pay attention.[810]

Education, both formal and popular, was identified as crucial to changing the beliefs and practices that maintained HIV-related stigma and discrimination at high levels, continued to entrench gender inequality and discrimination, and preserved the harmful mythology and silence around HIV/AIDS.

At the end of the day it is attitudes. Take a multi-pronged approach. Get young ones at a tender age through the education system curriculum. Traditional authorities — whenever they have meetings with constituents they should talk about [HIV/AIDS], at every funeral occasion. We need more testimonies from PLWA — I'm not undermining the current situation, but in the rural areas, it's still a taboo.[811]

PLWA advocates pointed out that interventions need to comport with the realities of people's lives in Swaziland. Food aid needs to recognize that PLWA had families who were likewise food insufficient and thus they would share their ration with their relatives and run out of food before the end of the month's allotment. Income generation programs needed to supplement credit given with food aid so the resources doled out would not be used for immediate needs. Moreover,

…income generation should be meaningful, not worsen the situation of the women. An example is a project where there were 100 women to watch over 20 chickens. Women need access to resources, skills to do what women think would be meaningful livelihoods for them …start up funds and advice on what to market.. and support at home.[812]

Conclusion

Findings from the Swaziland study highlighted several important themes concerning the HIV/AIDS epidemic in Swaziland: 1) the cross-cutting negative impacts of food insufficiency and economic dependence, particularly for women; 2) fear of knowing one's HIV status, high levels of HIV-related stigma and fear of being stigmatized should one test positive for HIV; 3) women's lack of control over sexual decision making; and 4) prevalent gender discriminatory beliefs associated with sexual risk-taking.

Female community survey participants were more food insufficient, less educated and had lower incomes than male participants. For women and men experiencing food or water shortages, the majority reported that they became economically dependent and that their

health care decisions were affected. The majority of PLWA had also been affected by the lack of food or water.

The majority of those surveyed correctly answered questions about HIV prevention and transmission despite the lack of a national educational campaign. Certain incorrect beliefs persisted, however. For example, that mosquito bites and sharing meals could transmit HIV, and praying and traditional medicine could prevent it. PLWA testimony suggested that men in particular might have correct knowledge, but relied on myths to avoid responsibility in preventing the transmission of the virus to themselves or others.

The lack of scaled-up HIV/AIDS-related infrastructure in Swaziland was reflected in the finding that 25 percent of women and 18 percent of men surveyed had tested for HIV. The chief barrier to finding out one's status was fear or lack of readiness to test. PLWA and key informants also discussed the existence of gender-related barriers to testing. More than half of Swazi community participants who had tested cited personal motivation to know their status; for PLWA that reason was second only to testing because they were sick. While overall experiences with testing were positive, the question of voluntariness was raised by the community survey results: 13 percent reportedly had not made the decision to test and 40 percent felt that they could not refuse the test.

Stigmatizing and discriminatory attitudes toward PLWA were reported by over 60 percent of Swazi community survey participants. The persistence of these attitudes, and the greater burden borne by HIV-positive women, was consistent with the reported experiences of the PLWA interviewed. Moreover, Swazi women reported more fears of being stigmatized should they test positive than did Swazi men. This appears to be in line with actual experiences, as reported by PLWA of poor treatment in the family, work and community as being more common among women. At the same time, PLWA interviewed report near universal levels of disclosure and its positive consequences.

Nearly 90 percent of those surveyed had ever had sex. Differences between women and men surveyed were stark. Forty percent of women and 3 percent of men lacked control over the decision to have sex. Eight percent of women and 39 percent of men reported having more than one sexual partner in the past year. The majority of sexually active participants reported not using a condom at some point in the past year; 18 percent of women and 3 percent of men agreed that they had no control over the decision of whether or not to use a condom. Interviews with PLWA discussed women's lack of autonomy in relationships with partners in the context of their economic dependence on men, as rooted in social, cultural and legal inequalities. Many PLWA reported reducing their number of partners and increasing condom use after testing positive for HIV. However, one-third of female PLWA lacked control over sexual decision making despite knowledge of the risks of HIV transmission and re-infection.

Nearly all Swazis surveyed held at least one gender discriminatory belief and the majority held 3 or more. Twenty-four percent of women and 44 percent of men held 6 or more such beliefs. The content of specific beliefs held illustrated the strong influence of traditional culture and the norm that women should be subservient to men.[813] The majority of those surveyed, and more women than men, also supported women's rights. Gender discriminatory beliefs predicted sexual risk-taking (have multiple sexual partnerships or unprotected sex with a non-primary partner) for both women and men. Conversely, holding beliefs in women's rights had a protective effect, decreasing the odds of risky sexual practices or circumstances. Interviews with PLWA and key informants elaborated on the findings regarding the prevalence of gender inequality and discrimination in all facets of women's lives and its association with women's vulnerability to HIV/AIDS.

When asked extensive questions in terms of assessing the country's leadership around HIV/AIDS, community survey participants affirmed failures and gaps in the national response. Nearly half faulted both local and national leaders on every domain in the survey: spending on HIV/AIDS, role modeling, assisting those infected and affected by HIV, opposing HIV-related stigma and discrimination and taking action to protect women and children from domestic abuse. PLWA had a mixed assessment, noting the need to move beyond rhetoric and their own role in educating the leadership. Key informants condemned the passivity of leaders and cited the need to reform laws, prioritize spending, build capacity within the public health system and address widespread food insufficiency and poverty that affect individual sexual behavior.

Notes

[735] Currency conversion at the Interbank Rate for May 4, 2005 (1 US dollar = 6.14 Swaziland *lilangeni*). FXConverter. Available at: http://www.oanda.com/convert/classic. Accessed on February 13, 2007.

[736] This represents a 92 percent response rate, taking into account subsequent exclusions from the sample of surveys with missing data on key predictors or outcomes.

[737] Participants who were currently married were asked whether there was more than one wife in their marriage.

[738] Thirteen percent of women and 19 percent of men reported having visited a traditional healer in the past year. The fact that participants in both the community survey and the PLWA interviews infrequently admitted to visiting traditional healers is likely a result of the prohibitions and shaming around such consultation from public health and medical sources early in the crisis.

[739] This is likely due to the urban locales of the recruitment for the investigation sample, in addition to the overrepresentation of women among the population of individuals being tested and treated for HIV in Swaziland and the higher prevalence of HIV in women.

[740] N=52. Symptoms of depression were measured using the 15-item Hopkins Symptom Checklist for Depression (HSCL-D). People were considered to screen positive for depression if their score was →=1.75 on this scale. Derogatis LR, Lipman RS, Rickels K, Uhlenhuth EH, Covi L. "The Hopkins Symptom Checklist (HSCL). A measure of primary symptom dimensions." *Mod Probl Pharmacopsychiatry.* 1974;7(0):79-110; This screen has been validated previously in a number of international settings in Africa and elsewhere. Bolton P, Wilk CM, Ndogoni L. "Assessment of depression prevalence in rural Uganda using symptom and function criteria." *Soc Psychiatry Psychiatr Epidemiol.* Jun 2004;39(6):442-447.

[741] Of the 23 PLWA not receiving ARVs, 16 reported that they had CD4 counts too high to qualify for treatment and one said that s/he was "not sick". Of the 6 others not receiving ARVS, 4 expressed concerns about the side effects or the efficacy of the treatment, and 2 of the 4 had made the decision to focus on a healthy diet or other behavior changes to maintain or improve their health. Two also expressed concerns about the difficulty in taking the medications as prescribed and feared getting worse if they forgot to take them on time.

[742] Currency conversion at the Interbank Rate for May 4, 2005 (1 South African rand = 0.164 US dollar). FXConverter. Available at: http://www.oanda.com/convert/classic. Accessed on February 13, 2007; The Swazi *lilangeni* is pegged to the value of the rand.

[743] Fifty-two interviewees had two or more dependents; 5 had over 10 people they were supporting.

[744] This is equivalent to 40 percent, similar to depression prevalence estimates in HIV-positive populations in the US, which is 36-37 percent. Bing EG, Burnam MA, Longshore D, et al. "Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States." *Arch Gen Psychiatry.* Aug 2001;58(8):721-728; Asch SM, Kilbourne AM, Gifford AL, et al. "Underdiagnosis of depression in HIV: who are we missing?" J Gen Intern Med. Jun 2003;18(6):450-460.

[745] Interview with Albertinah Nyathi, Women Together, March 14, 2005, Mbabane, Swaziland.

[746] Participants were asked 11 questions about their knowledge of HIV transmission and prevention, based on questions modified from the UNAIDS General Population Survey and the DHS (demographic health survey) AIDS module. See http://www.emro.who.int/gfatm/guide/tools/dhsaids/dhsaids.html. Using the UNAIDS knowledge indicator scoring system, individuals were scored as having HIV knowledge if they correctly identified the two most common modes of HIV prevention in Swaziland (consistent condom use and abstinence).

[747] Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

[748] Interview with Siphiwe Hlophe, Swaziland for Positive Living (SWAPOL), September 23, 2004, Manzini, Swaziland.

[749] Though it should be noted that those who have not tested, may, by definition, not have attempted to test and therefore may be less aware of potential barriers to access, such as lack of infrastructure in rural areas.

[750] Participants could agree with more than one reason.

[751] PMTCT Plus is provided in Swaziland; HIV testing is available at the sites for male partners. See The Elizabeth Glaser Pediatric AIDS Foundation Annual Report. 2004. Available at: http://www.rhap.org.za/resources/208.pdf. Accessed May 24, 2006.

[752] While those that tested because they were sick may have felt, in the broad sense, that they "had no choice" because their physician needed to determine the cause of their illness, that proportion of respondents does not account for the larger group that reported not being able to refuse the test. In this group, some may have felt a personal imperative to find out the cause of their illness and thus that they could not, in that sense, refuse the HIV test.

[753] This definition was based on the routine testing policy in Botswana, and used in the companion study.

[754] Participants could give more than one answer.

[755] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[756] Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

[757] Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

[758] Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

[759] Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

[760] Respondents were asked 7 questions adapted from the UNAIDS general population survey and the DHS (demographic health survey) AIDS module. Following the UNAIDS scoring system, any participant who reported a stigmatizing/discriminatory attitude on any of 4 principal questions was categorized as having such attitudes.

[761] The sex differences, though statistically significant are not shown here, given that they were small, in most cases less than 1 percent, and overall in the range of less than 1 to 4 percent.

[762] Based on survey responses, PHR created a 9-item index on "projected HIV stigma" with higher scores on a continuous scale of 0-9 associated with a greater number of reported adverse social consequences associated with testing positive. The mean score for women was 2.80 (plus/minus a standard deviation of 2.07) and for men it was 2.46 (+/-1.86), a statistically significant difference.

[763] Even where families no longer live together or are separated, for example by urban migration, by law women married in community of property have minority legal status and cannot register property in their own names; in practice any property in a marriage is often retained by the husband's family.

[764] Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

[765] Interview with Vusi Matsebula, March 12, 2005, Mbabane, Swaziland.

[766] Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

[767] Interview with Thembi Nkambule, Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), May 24, 2005, Mbabane, Swaziland.

[768] Id., Interview with Thembi Nkambule, May 24, 2005.

[769] Defined as having had at least one sexual partner in the past 12 months.

[770] Adjusted odds ratio (AOR): 2.07, 95% confidence interval (CI) (1.19-3.63). In regression models "lack of control" was defined as your partner usually or always deciding when you have sex. All logistic regression models reported included the variables of sex, age, education level, monthly household income, food insufficiency, marital status, residency location, gender discriminatory attitudes (aggregate or individual), HIV knowledge, HIV-related stigma and fears of HIV-related stigma. The associations described in the text have been adjusted for the possible confounding effects of these other variables.

[771] AOR: 0.45, 95% CI (0.25-0.81).

[772] The percentages for women may in part reflect underreporting by women due to the cultural taboo for women in having more than one sexual partner.

[773] AOR: 1.91, 95% CI (1.17-3.11).

[774] The latter is traditional indicator or predictor of high-risk sexual practice (a practice likely to lead to HIV transmission), given that a non-regular sexual partner is also likely to be non-monogamous and HIV status is less likely to be disclosed between such partners.

[775] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[776] Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

[777] Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

[778] Interview with Thulisile Dladla, SEBENTA National Institute, May 20, 2005, Mbabane, Swaziland.

[779] Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

[780] This variable was constructed from responses to 22 statements, including affirmative responses to 12 items expressing discriminatory beliefs, negative responses to 6 items endorsing women's rights and 2 pairs of variables expressing contradictory views concerning the roles of women and men.

[781] Additionally, more than three times as many men (22 percent) as women (6 percent) believed that women should prove their fertility before marriage (p=0.000).

[782] AOR: 1.99, 95% CI (1.17-3.39) for the whole sample (N=768) and AOR: 2.40, 95% CI (1.29-4.47) for men only (N=386). In multivariate models odds ratios are adjusted for sex, age, education level, monthly household income, food insufficiency, marital status, residency location, HIV knowledge, HIV-related stigma and fears of HIV-related stigma.

[783] Additionally, more than three times as many men (22 percent) as women (6 percent) believed that women should prove their fertility before marriage (p=0.000).

[784] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[785] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[786] Interview with Thandi Nhlengethwa, The AIDS Information and Support Centre, March 17, 2005, Manzini, Swaziland.

[787] Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

[788] Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

[789] Interview with Alan Brody, UNICEF, April 28, 2005, Mbabane, Swaziland.

[790] Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

[791] Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

[792] The only statistically significant difference between the opinions of women and men was regarding whether chiefs have set a good example; 82 percent of women answered no versus 75 percent of men.

[793] It has been pointed out, however, that chiefs do not have their own budgets for expenditures. Personal communication at meeting to review preliminary study data, November 2, 2005, Mbabane, Swaziland.

[794] This was defined for participants as threatening or hurting someone or forcing them to have sex when they do not want to.

[795] For some participants this may reflect the partial success of local social programs, the strong faith and confidence in the church felt by many Swazis or a judgment that the church is unwilling or unable to affect the AIDS crisis, having failed in many quarters to acknowledge it as something other than punitive until recently. *See* Rev. Vitillo RJ. "HIV and AIDS: The Challenge and the Context. Why Should Churches Respond to Issues of Stigma and Discrimination in Reaction to HIV and AIDS?" UNAIDS. A Report of A Theological Workshop Focusing on HIV and AIDS Related Stigma. December 8-11, 2003: 22-29. Available at: www.e-alliance.ch/postercd/resource/UNAIDSConsultantReport_english.doc. Accessed June 27, 2006.

[796] As mentioned above, the endorsement of abstinence appears to stand in contrast to the actual practice of it. For example, of those surveyed who were sexually active, only 19 percent of women and 7 percent of men reported having no sexual partners in the past year.

[797] Avert.org. "Condoms: History, Testing, Effectiveness and Availability." May 10, 2006. Available at: http://www.avert.org/condoms.htm. Accessed May 25, 2006.

[798] According to the AIDS coordinator of one donor government's program in Swaziland, the King has been quoted in the press as saying that he tests every 6 months for HIV, but the results have not been made public. Interview with Julie Cory, US Embassy, March 9, 2005, Mbabane Swaziland.

[799] "Triple Threat in Southern Africa." [UNICEF website.] Available at: http://www.unicef.org.uk/campaigns/campaign_pages.asp?page=25. Accessed May 8, 2006.

[800] For example, see de Waal A and Whiteside A. "New Variant Famine: AIDS and Food Crisis in Southern Africa." *Lancet*. 2003; 362:1234-1237; *See also* UNAIDS (2005). *AIDS in Africa: Three Scenarios to 2025*. Available at: http://www.unaids.org/unaids_resources/images/AIDSScenarios/AIDS-scenarios-2025_report_en.pdf. Accessed May 8, 2006.

[801] Interview with Vusi Matsebula, March 12, 2005, Mbabane, Swaziland.

[802] Interview with Thembisile Dlamini, UNAIDS, May 19, 2005, Mbabane, Swaziland.

[803] Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

[804] Interview with Makhosazana Hlatshwayo, Business Coalition on HIV/AIDS, Federation of Swaziland Employers (BCHA), April 29, 2005, Mbabane, Swaziland.

[805] Interview with Zakhe Hlanze, Women and Law in Southern Africa Research Trust — Swaziland (WLSA), March 14, 2005, Mbabane, Swaziland.

[806] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[807] Interview with Derek von Wissell, National Emergency Response Council on HIV/AIDS (NERCHA), May 23, 2005, Mbabane, Swaziland.

[808] Interview with Thembisile Dlamini, UNAIDS, May 19, 2005, Mbabane, Swaziland.

[809] Interview with Julie Cory, US Embassy, March 9, 2005, Mbabane, Swaziland.

[810] Interview with Janet Khumalo, The Family Life Association of Swaziland (FLAS), May 24, 2005, Manzini, Swaziland.

[811] Interview with Gideon Gwebu, Ministry of Home Affairs, Gender Unit, May 16, 2005, Mbabane, Swaziland.

[812] Interview with Gcebile Ndlovu, International Community of Women Living with HIV/AIDS, March 15, 2005, Mbabane, Swaziland.

[813] As the key informant interviews and the country background chapter point out, it is important to understand the complexity of culture which includes the erosion of traditionally protective norms that put women at risk. For example, traditional Swazi culture did not accept rape and intimate partner violence per se, as illustrated by the saying "indvuku ayiwakhi umuti" (violence does not insure family unity). Personal communication with WLSA, September 26, 2007.