HIV/AIDS Policies and Strategies in the Kingdom of Eswatini

Kate Ann Brace

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BIO: Kate Ann Brace is a Rutgers University student enrolled in the MA Program in Political Science - United Nations and Global Policy Studies, whose academic interests include public health, gender, and the environment. Her research has focused on incorporating women’s empowerment into public health policies as a solution for disease containment. She also has assisted in research related to the communication of environmental concerns in addition to the Youth, Social Entrepreneurship and Sustainable Development project. Ms. Brace will receive her MA degree in January 2020. Currently, she is interning for the City of New Brunswick and is a part-time grant developer for a not-for-profit organization.

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Overview

Most people in the Western world consider the worst of the human immunodeficiency virus (HIV) and its final stage of infection, known as acquired immunodeficiency syndrome (AIDS), to have been most prominent in the 1980s and early 1990s. Therefore, HIV/AIDS is no longer considered a public health or security crisis to all nations. However, the country of Eswatini (formerly known as Swaziland) is currently suffering the worst HIV/AIDS crisis. Eswatini has the highest rate of the disease prevalence in the world, with roughly 28% of people being at various stages of infection (CIA Fact Book, 2017). This is supported by UNAIDS' data and statistics which note that in 2017 there were roughly 210,000 adults and children living with HIV/AIDS. Additionally, an estimated 180,000 people who knew that they were infected (UNAIDS, 2017). HIV/AIDS is most prevalent in women aged 15 to 49, who make up 35.1% of people that knew their HIV/AIDS status (UNAIDS, 2017). Men of the same age demographic, 15-49, have the second highest rate which was 19.3% in 2017 (UNAIDS, 2017). Adolescent girls, young women, and adult women are therefore disproportionately affected, indicating a gendered component to HIV transmission. How can the rate of HIV/AIDS infection be lowered amongst the population which statistically suffers from it the most?

The rate of infection does not give any indication of being rapidly on the decline. In 2017, there were between 6,200 and 7,900 newly HIV infected adults and children (UNAIDS, 2017). Unfortunately, the number of adults and children who died of AIDS in 2017 is estimated at 3,500 (UNAIDS, 2017). As previously indicated, women are one of the most adversely affected groups. This is due to gender inequality and discrimination against women who engage in sex work. There is support for this argument given the previously mentioned statistics. This indicates that, to a certain extent, HIV/AIDS is a gendered problem in the country.

These statistics, however, do not provide a complete picture of the consequences that HIV/AIDS has on Eswatini. The impact of the disease goes beyond the realm of public health and disease control. For example, “agricultural production has declined due to HIV/AIDS, as the illness causes households to lose manpower to sell livestock and other assets to pay for medicine and funerals” (CIA Fact Book, 2017). This is particularly detrimental since agriculture is the largest sector in most African economies and Eswatini is no exception. Experts note that, “the loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest” (Bollinger and Stover, 1999: 4). This can be especially detrimental if there are environmental factors (such as drought) that can put food security in jeopardy (Bollinger and Stover, 1999: 4). One can infer that due to its connection to the agricultural sector, HIV/AIDS is influenced both directly and indirectly by poverty.

HIV/AIDS not only impacts the economy and workforce, it also greatly impacts the lives of children. Children who have lost their parents to the deadly virus are normally taken care of by their extended family members. However, due to the epidemic and the economic constraints it has imposed, there are many “child-headed households”. These households are “at risk of having to cope without parental care or regular income and are located in areas where services are poor…[and] this vulnerable group has to deal with emotional strain and is more likely to be abused and exploited…[with] an increased risk of starvation and malnutrition, increased school absenteeism and withdrawal, inadequate access to medical care, and the sexual exploitation of girls,” (Thwala, 2018: 151).
The female child is more vulnerable to suffer both directly and indirectly from HIV/AIDS than a male child. This is due to the existing gender inequalities in society. Girls become child brides with the permission of their guardians if they are 16 years old. Despite the criminalization of guardians colluding with older men to consent to these marriages, 1% of girls are married by the age of 15 (Avert, 2018). In addition to child marriage, 14% of women aged 15-24 state that they had a male sexual partner that was ten or more years older than them and 7% of women state that the sexual encounter was unprotected (Avert, 2018). This problem is compounded by the fact that 12% of women aged 15-49 are in a polygamous marriages (Avert, 2018). This increases the risk of HIV/AIDS being spread to other women due to a male spouse having unprotected sex with different female partners (Avert, 2018). It supports the argument that HIV/AIDS is a gendered problem due to gender inequality and the societal expectation that women should be subordinate to men (Avert, 2018).

Meanwhile, the Eswatini government is grappling with HIV/AIDS from a health care perspective. While more people are seeking treatment, HIV/AIDS is more expensive to treat than other diseases. The government has had to face three dilemmas: preventing of HIV infection versus treating AIDS; treating HIV/AIDS versus treating other prevalent threatening illnesses; and deciding whether or not to spend money for health care or to spend money in other sectors of society (Bollinger and Stover, 1999: 6). For example, another prevalent disease in Eswatini is tuberculosis (TB). According to Avert, “an estimated one in every 100 people develops [TB] in Eswatini each year” (Avert, 2017). This problem results in the government being faced with a dilemma of which illness to treat due to the high costs associated with these ailments.

In terms of policy, the Eswatini parliament has undeniably made an effort to prevent, treat, and combat HIV/AIDS. In 2000, it endorsed the Millennium Declaration, including the Millennium Development Goals (MDGs). This is significant because one of the eight goals is to combat HIV/AIDS and other diseases. Eswatini is also “guided by the National Development Strategy (NDS) and the Poverty Reduction Strategy and Action Program (PRASAP) both of which complement the ideals of the MDGs (Susuman, 2017, p.1118). The Eswatini government employed “evidence-informed programming and [used] the UNAIDS investment framework...as a critical component of the HIV prevention response...” (Ministry of Health, 2012: 25). Policies were also influenced by an analysis that focuses on preventative measures (Ministry of Health, 2012: 25).

Therefore, Eswatini policy focuses on “priority intervention areas using social behavior change communications and target[ing] key risk behaviors” (Ministry of Health, 2012: 25). This includes “four priority strategies”: to reduce “multiple concurrent partnerships”, “[to increase] comprehensive knowledge about HIV”, “[to increase] comprehensive knowledge about Prevention of Mother-to-Child Transmission (PMTCT)”, and “[to increase] comprehensive knowledge about [voluntary] Medical Male Circumcision (MMC)” (Ministry of Health, 2012: 25-26). Other “strategic interventions” in Eswatini policy are “consistent and correct condom use, HIV testing and counseling, blood safety, post-exposure prophylaxis, and the effective control of sexually transmitted infections” (Ministry of Health, 2012: 26). Eswatini has made an effort to combat HIV/AIDS and wants to lower its rate.

Despite adopting appropriate policies to work toward goal 6 of the MDGs and regularly submitting reports on their progress, did not and most likely will not meet the goal for lowering the rate of HIV/AIDS as set by the MDGs (Susuman, 2017: 1118). The government made progress for better access to treatment for those suffering from HIV/AIDS and the rate of infection is decreasing (60%
of people had lived with HIV before the MDGs compared to the present rates of infection), it was unlikely that goals related to the following would be reached: “increasing awareness of HIV/AIDS among youths 15-24 by 2015”; and “the target rate for condom use…” (Susuman, 2017: 1120).

Even though the target for condom use as a preventative method did not meet the target for the MDGs, Eswatini “had the second highest level of availability of male condoms in the region with 51 condoms available per man per year” (Avert, 2018). This declaration is supported by the successful 2017 condom distribution campaign to encourage young people to use condoms and to improve the accessibility to purchase condoms (Avert, 2018). Since the campaign ended, 70% of women and 93% of men from the ages of 15-24 “used a condom the last time they had sex with a non-regular partner” (Avert, 2018). This shows that there is potential for condom use to be accepted by both men and women.

The strategies toward HIV education have been moderately successful with “56% of young people [having] sufficient knowledge about how to prevent HIV” through the Comprehensive Life Skills Education Programme (CLSEP) and advertisements raising awareness on TV and radio (Avert, 2018). There has been a success in the Prevention of Mother to Child Transmission (PMTCT) strategy with less than 1,000 children being newly infected in 2017 due to 90% of pregnant women with HIV receiving antiretroviral treatment and 75% of children receiving the same treatment (Avert, 2018). Finally, the goals related to MMC remain low despite most men being aware of the procedure and its potential benefits (Avert, 2018).

**Framework**

While Eswatini has had undeniable success with these policies and has decreased the spread and rate of infection of HIV/AIDS, a new policy approach is necessary. However, cultural barriers impede the path of progress. Culturally, “the subordinate status of women can also place them at an increased risk of sexual violence and low access to education and health information” (Avert, 2018). Another cultural component is the continuing presence of and demand for traditional health practitioners (THPs). THPs can obstruct HIV services and treatment by rejecting modern medicine and modern methods of treatment.

There are also legal inequalities that indirectly obstruct the desired decrease of HIV infection. Married women are “assigned…disadvantaged status, granting men more privileges and rights” under Swazi customary law and the Marriage Act of 1964 (Human Rights Watch, 2017). This legal inequality perpetuates the embedded inequality between Eswatinian men and women. Gender inequality affects the proactivity towards the treatment of HIV/AIDS. Even though Article 20 of Eswatini’s constitution “provides equality before the law and non-discrimination”, it doesn’t “prevent discrimination on the grounds of sex, language, sexual orientation, and gender identity” (Human Rights Watch, 2017). This is due to the dual legal system of both Roman-Dutch common law and Swazi customary law operating “side by side” and results in “numerous violations of women’s rights” (Human Rights Watch, 2017).

Finally, according to the President’s Emergency Plan for AIDS Relief (PEPFAR), “the skills and education mix from pre-service and numbers of [health care workers] are not adequate” which results in patients with HIV/AIDS receiving inadequate treatment due to institutional constraints.
(PEPFAR, 2017: 18). With all of these factors and the continuing pervasiveness of HIV/AIDS, there is a need for new approaches to Eswatini HIV/AIDS policy.

The following alternatives are designed with consideration of the barriers facing current policies. However, they do not stray from the primary objective to ensure better implementation and more effective campaigns. The aims of the campaigns are intended to be layered onto existing HIV/AIDS policies and goals that Eswatini currently implements. The alternative approaches will consider current public health circumstances, gender inequality, development, socioeconomic implications, and the current state of the nations’ infrastructure. Finally, there will be a focus on how the United Nations will be involved in the suggested campaigns.

**Alternative I: Major Education Sector Reform**

The first alternative to consider is creating policies which will provide better training of health care workers and to promote education and job opportunities related to the health care sector. The World Health Organization (WHO), UNESCO and UNAIDS can aid in the provision of educational materials and recommend strategies to encourage the expansion of knowledge in this field. The government would work in conjunction with these three organizations to ensure the distribution of materials and resources. On the job training will be created using these educational resources, as well as hands-on instruction to enhance the skills of health workers. A program can be created for some unemployed people to teach them to become health care workers. To reduce gender inequalities, it would be mandatory that a quota for female participants is established for this program.

Major education sector reform would combat unemployment in Eswatini. These training programs can take a direct approach in the instruction of HIV/AIDS treatment by allowing health care workers and health care workers-in-training to work with HIV/AIDS patients under the supervision of medical professionals. If health care workers and those in training to become health care workers are exposed to patients with HIV/AIDS and work directly with them, they will work to reduce the social stigma surrounding those suffering from the virus. Furthermore, the distribution of these educational resources as a result of this policy would increase the circulation of knowledge about testing and other practices.

For the major education sector reform to work, related issues will have to be addressed. To ensure quality instruction for healthcare workers, the educational system as a whole has to be examined. While roughly 83 percent of the population can read, illiteracy would have to be addressed and combatted for the remaining 17 percent of the population (World Bank, 2019). In 2005, the Ministry of Education and Training introduced fees in schools that “effectively end[ed] free primary education” (Human Rights Watch, 2017). Since there is such a high rate of poverty, this implies that a significant number of people who are now of working age, but have not been educated because of their inability to pay the fees mandated by the government. Additionally, there is a “low enrollment [rate] at [the] secondary and tertiary education levels, and a lack of qualified science, mathematics, and ICT teachers…” (Ministry of Education and Training, 2018: 2). While the Ministry of Education and Training have released a three-year plan to “improve the quality of education at all levels…”, the gap that has been left by a lack of qualified science and mathematics instructors will have to be addressed. For major education reform to remain a sustainable solution, the campaign will have to
also train instructors who will continue to instruct the health care workers. This endeavor will take time and be costly.

Due to the existing gender inequality, deeper cultural issues relating to women’s agency and rights need to be addressed. It is possible that other policies would have to be adopted by the government to support the campaign to ensure the protection of women and their rights. However, the government’s ability to fund and support this project is unlikely. Freedom House rates the functioning of the Eswatini government as a 0/12 (Freedom House, 2018). In their rating and explanation, Freedom House adds that, “The King and his government determine policy and legislation; members of Parliament cannot initiate legislation and have little oversight or influence on budgetary matters” (Freedom House, 2018). This indicates a lack of strong governmental institutions and legitimacy precluding a capacity to sustain a campaign such as the one proposed in this alternative policy.

Therefore, King Mswati III would have to support this campaign and the implications that come with it. It is unlikely that he would do so. The Human Rights Committee, the Southern African Development Committee, and the European Union have called on him to “improve respect for human rights” including political participation, the rights of women, and an end to discrimination against HIV positive people (Human Rights Watch, 2017). Ultimately, the King has failed to act on these issues, either because of lack of interest or inability to effectively address and recognize suggestions from international organizations. Therefore, major education sector reform is unfortunately unrealistic.

**Alternative II: Move to the SDGs**

The second potential alternative is to encourage the Eswatini government to replace the goals for HIV/AIDS, outlined in the Millennium Development Goals, with those of the Sustainable Development Goals (SDGs). Since the SDGs are seen as a continuation of the MDGs, it would be easy to adjust policies and targets related to HIV/AIDS. Goals 1-5, as well as Goals 8, 10, 11, and 16 can be incorporated in policy to combat many issues why also combating HIV/AIDS. The goals mentioned are as follows:

- Goal 1: No Poverty
- Goal 2: Zero Hunger
- Goal 3: Good Health and Well-Being
- Goal 4: Quality Education
- Goal 5: Gender Equality
- Goal 8: Decent Work and Economic Growth
- Goal 10: Reduced Inequalities
- Goal 11: Sustainable Cities and Communities

The reason why these specific goals would affect HIV/AIDS is that they have an impact on the context surrounding the spread of the disease. For example, as stated by UNAIDS, the goal to end hunger is significant because “Hunger can lead to risk-taking behavior, undermine HIV treatment adherence and hasten [a person’s] progression to AIDS” (UNAIDS, 2019). Moving towards the SDGs would also increase gender equality in the country in accordance with goal 5 and indirectly
decrease HIV/AIDS. In this case, there is an opportunity for a “cross-sectoral collaboration” in the SDGs for this particular goal because the “nutritional support to households and integrated system to deliver nutritional support and HIV services can enhance health outcomes” (UNAIDS, 2019).

The goal with the most direct impact is the third goal for good health and well-being. Goal 3 would address the “lack of universal health coverage, including sexual and reproductive health services and the [restriction of access] to HIV prevention and treatment” (UNAIDS, 2019). This intersectional approach will address the HIV/AIDS crisis and support the other problems facing Eswatini. Other potential benefits would be an improvement of the international standing of Eswatini. If Eswatini can show and prove that it is making strides towards the SDGs, it could improve its standing in the international community with consequent economic benefits.

The government of Eswatini has stated a wish to “embrace and renew it[s] commitment to the 2030 Agenda for Sustainable Development and is working towards the attainment of the SDGs” (Dlamini, 2017: 1). Despite this declaration, the government has not been as active to embrace the SDGs in comparison to how it accepted the MDGs. As of 2019, Eswatini has not submitted any documents and reports on progress made towards the SDGs. However, when addressing the Economic and Social Council in 2017, HSH Prince Hlangusemphi Dlamini stated that Eswatini has made progress in moving towards the SDGs. As an example, HSH cited that in conjunction with goal 3 by constructing more hospitals and clinics “to ensure that the population has access to health care services within a radius of at least 8 km” (Dlamini, 2017: 3).

The Prince also claims that the government has “scal[ed] up…the Prevention of Mother to Child Transmission of…[HIV]…” in accordance with Goal 3 (Dlamini, 2017: 3). However, the Prince acknowledged the challenge of the government “working towards ensuring that all places are covered by the programs” (Dlamini, 2017: 4). In relation to other goals, a common theme also is a lack of strength in government institutions and “fiscal difficulties facing the country as well as…[the] proper identification and targeting of beneficiaries” (Dlamini, 2017: 2-5). Due to the amount of corruption and the lack of parliamentary oversight, the UN would have to implement strict monitoring measures to ensure its success. The King would also have to be very supportive of the SDGs in order for their implementation to be effective. These constraints suggests that moving to the SDGs is not a viable policy alternative.

**Alternative III: Women’s Empowerment**

The third policy alternative is for UNAIDS, UN Women, and the United Nations Democracy Fund (UNDEF) to encourage the government to support a two to five-year social awareness campaign that is targeted at men from the ages of 15-39 and another campaign targeted at women aged 15-39. The goal of the campaign is to encourage men to support and be respectful of women. A parallel campaign will also promote the empowerment of women in everyday life, such as becoming leaders in their communities or exercising control over their bodies. A message of combating the stigma around those suffering from HIV/AIDS would be incorporated into both campaigns. For example, the messaging of an advertisement could encourage men to use condoms more frequently in their sexual encounters out of respect for their partner. HIV positive women can be incorporated into the campaign as well to prevent the spread of HIV through sharing
their stories and experiences. These women sharing their stories could encourage people to exercise tolerance towards them.

The reason why there is a focus on women’s empowerment in this approach is that, as noted, there is a gender inequality component to HIV/AIDS.

“The disproportionate HIV incidence in young- often poor- women underscores how the social and economic inequalities shape the HIV epidemic. Confluent social forces, including political violence, poverty, racism, and sexism impede equal access to therapies and effective care, but...[also] constrain the agency of women” (Richardson et al, 2014: 1).

Using the Gender Inequality Index (GII), researchers show that “predominantly heterosexually driven epidemics are associated with Gender Inequality Indices (i.e., worse gender equality) in comparison to countries where [men who have sex with men and engage in injecting drugs] are the primary method of transmission” (Richardson, 2014: 3). The transmission process emphasizes that social factors have an impact on the HIV/AIDS epidemic, especially in predominantly heterosexual societies and in societies where it is common to have multiple sex partners, such as Eswatini. Richardson et al conclude that this is “an important reminder that we may not be able to treat ourselves out of the pandemic with medications alone,” and call for public health policies which “consider structural interventions that address gender inequality,” while also reducing HIV prevalence (Richardson, 2014: 4-5). Empowering women outlines a structural intervention to indirectly combat HIV/AIDS and human rights violations through women’s empowerment.

While this alternative of empowering women addresses both HIV/AIDS and gender inequality practices and mechanisms, it would be costly. Unfortunately, this process takes a long time to work through civil society to be a catalyst for change, particularly given the current state of civil society in Eswatini. The Inter-Parliamentary Union’s resolution adopted by the 113th Assembly, regarding “The Importance of Civil Society and Its Interplay with Parliaments and Other Democratically Elected Assemblies for the Maturing and Development of Democracy”, calls on “parliaments to put forward flexible social policies pursuant to prevailing national laws, and to adopt legislation to promote civil society interactions...” (Inter-Parliamentary Union, 2005).

As Human Rights Watch and Freedom House confirm, the state of civil society is extremely poor in Eswatini. In a 2018 report, Human Rights Watch reported that there have been continuing “restriction[s] on freedom of association and assembly” (Human Rights Watch, 2018). The Sedition and Subversive Activities Act remains in effect. The Act “restricts freedom of expression through criminalizing alleged seditious publications and used of alleged seditious words...” (Human Rights Watch, 2018). Furthermore, despite Eswatini signing the African Charter on Democracy, Elections, and Governance, “the government has not taken steps to ratify and implement the charter” (Human Rights Watch, 2018). Therefore, in order for the campaign to empower women successfully, a program to strengthen the standing of civil society supported by the UN and other donors would need to be implemented. Further, the Eswatini government would have been encouraged to eliminate restrictive rules. This would have to be a broad project with considerable financial backing to be sustained over the long term. It would not directly affect the prevention and treatment of HIV/AIDS. However, it could inform a more direct campaign.
Recommendations

While the alternatives listed are viable policy proposals to combat HIV/AIDS in Eswatini, they appear not to directly combat the disease. That is why major education sector reform, moving towards the SDGs, and women’s empowerment would serve as a guiding framework for the policies and campaigns that are recommended. There is an undeniable link between gender inequality and the spread of HIV that needs to be incorporated into how policymakers approach the disease. In the Overview, there is an indication that the rate of infection decreased due to a focus on the masculine role in sexual encounters and their power in them. Since the rate of HIV is higher amongst women, it shows that inequality and a lack of consideration of women’s status in society. Therefore, Alternative III, on women’s empowerment, will buttress the following recommendations that have a direct approach on lowering the rate of HIV/AIDS infection.

The recommended course of action will be policies which are focused on the provision of female condoms and the distribution of the drug Pre-exposure Prophylaxis (or PrEP), specifically targeting women from ages 15-49. If these two tools are placed in the hands of women, it will give them more control over their sexual practices and within a polygamous patriarchal society. It will also decrease the spread of HIV/AIDS and prevent the risk of infection amongst those who are physically intimate with an HIV positive sexual partner. Furthermore, targeting women in the distribution and accessibility of both female condoms and PrEP will indirectly benefit children since the maternal figure will still be present and able to care for them rather than them becoming orphaned or neglected. Therefore, this approach also considers indirect consequences and circumstances that are a result of HIV/AIDS.

The Policies and Distribution Strategies of Female Condoms

Since the Eswatini government already has policies about the accessibility and usage of condoms, the new targets and policies are designed to be layered with existing policy. The newly created policies can specifically mention women as the targets and both PrEP and female condoms being available. An example of HIV prevention and women’s empowerment policy can be that by 2029, 40 percent of sexually active women purchase and use female condoms (or FC) or that 65 percent of women have access to both male and female condoms. This policy would continue to be in effect until the rate of HIV/AIDS in the population falls below 15 percent. This strategy will subsequently give women control over their sexuality and bodies which will improve gender equality while reducing the risk of HIV transmission.

To reinforce and encourage this policy, a social marketing approach is required. One study found that “despite [a] strong body of research in support of FC, the device is often held up as a negative example- a failed method of limited or no value- because of its slow pace to take hold as a marketed product” (Weeks et al, 2013: 26). This endeavor would therefore have to be long-lasting and supported by a social marketing framework. Social marketing can be defined as “the application of proven concepts and techniques drawn from the commercial sector to promote changes in diverse socially important behaviors such as drug use, smoking, [and] sexual behavior” (Evans, 2006: 1207). The change in behavior is due to a combination of persuasion psychology, marketing science, “human reactions to messages and message delivery,” and “the ‘four Ps’ of marketing (place, price, products, and promotion),” (Evans, 2006: 1207). In terms of influencing health behavior, social marketing is commonly used and would be likely to yield desired results.
In the structure of the social marketing campaign, the way that Eswatinian people communicate needs to be considered when developing this campaign. Evans explains that:

“Social marketers use a wide range of health communication strategies based on mass media; they all use mediated (for example a healthcare provider), interpersonal, and other modes of communication; and marketing methods such as message placement (for example, clinics), promotion, dissemination, and community level outreach,” (Evans, 2006: 1207).

When structuring this campaign, vulnerable people not having access to certain types of mass communication must be considered. For example, women at risk of HIV/AIDS might not have access to a television or the Internet. So, a way to promote and persuade could be through billboards, signs, and brochures at the community level. Events could also be held in communities for women to learn more about female condoms, how they are used, and how they are beneficial to them. This is where UNAIDS and UN Women would assist the Eswatini government in developing the social marketing campaign. They would also monitor the public reception and advice on what adjustments need to be made in order for female condom usage targets and HIV reduction in women to be met.

In addition to the social marketing aspect of the campaign, there must be both a distributor of female condoms willing to work alongside the Eswatini government and for an incentive to be put in place for shopkeepers to stock the product. An experienced distributor for the government to partner with would be Veru Inc. which created and distributes FCs, as well as having a branch called FC2 Female Condom International. The branch of Veru Inc. has partnered with governments, donor agencies (including African countries) “to build successful reproductive and sexual health programs and policies that integrate [the] FC2 female condom” (Veru Inc., 2019). By negotiating a partnership between the Eswatini government and Veru Inc., an agreement could be made to lower the price of female condoms to make them more accessible to local distributors and women. This details of this process could be finalized through negotiations regarding the manufactures of PrEP and the Eswatini government. Furthermore, since Veru Inc. has experience in policy creation surrounding sexual health, their team would be knowledgeable in creating incentives for shops and shopkeepers to stock FCs. An example of such an incentive could be to eliminate import taxes on FCs.

The Policies and Distribution Strategies of Pre-exposure Prophylaxis (PrEP)

The other component of this recommendation is the distribution and accessibility of the drug PrEP. This medicine, which is sold under the name Truvada, is used “to help prevent an HIV-negative person from getting HIV from a sexual or injection-drug-using partner who’s [HIV] positive” (Centers for Disease Control and Prevention, 2019). According to the Centers for Disease Control and Prevention, “studies have shown that PrEP is highly effective for preventing HIV if it is used as prescribed” (Centers for Disease Control and Prevention, 2019). Those same studies show that the daily use of this medicine can lower the risk of HIV transmission through sexual encounters by more than 90 percent (Centers for Disease Control and Prevention, 2019). While the drug does have some minor side effects, such as nausea, these subside over time. There are no reported life-threatening side effects from taking Truvada (Centers for Disease Control and Prevention, 2019).
Based on this description and the studies done on PrEP, it would be safe and effective to distribute the drug to Eswatini women. Truvada has specifically been approved for use in Eswatini by the government. However, despite the drug being approved, “as of 2017, only 300 people were using PrEP to reduce their risk of HIV infection” (Avert, 2018). The government has indicated that they plan “to scale up [the use of] PrEP to 3,500 people [who are] at highest risk of HIV, [including] adolescent girls, young women, [and] female sex workers” (Avert, 2018). It seems that the government plans to follow through with this target. In 2018, the Ministry of Health “officially launched a groundbreaking study of a new, long-acting, injectable drug for the prevention of HIV infection” (Columbia University Mailman School of Public Health, 2018). In this investigational drug trial, “a new form of [injected PrEP will be tested]…among HIV negative women” (Columbia University Mailman School of Public Health, 2018). This study, if successful, would eliminate a lot of barriers for women, which include “need[ing] to store the pills at home in a safe location and [the] fear that a family member or sexual partner may notice or find the pills” (Columbia University Mailman School of Public Health, 2018). This study should continue and the goal of having 3,500 people taking PrEP should explicitly emphasize women being recipients of the medication.

While the research is a tremendous step that the Ministry of Health is taking, it will take a while for the trial and for this study to be completed and peer-reviewed. Regardless of whether or not this study is a success, the course of recommended action about PrEP remains the same. Truvada is manufactured by the company Gilead Sciences (Gilead Sciences, 2018). UNAIDS can work in coordination with Gilead Sciences to ensure the distribution of Truvada until the Eswatini government meets its goal of having 3,500 people actively using PrEP by providing the drug. Since the government’s enthusiasm and support combating HIV infection and supporting HIV-negative women, it is likely that this will be well-received by the government.

**Negotiating Prices with Veru Inc. and Gilead Sciences**

Due to Eswatini’s impoverished economy, it would impose a financial constraint on the government to pay for Truvada and female condoms over a long period of time. This aspect of HIV/AIDS policy would take inspiration from the deal struck between the Clinton Foundation and several pharmaceutical companies in 2003. The companies, Ranbaxy Laboratories, Cipla, Matrix Laboratories, and Aspen Pharmcare Holdings, produced antiretrovirals (ARVs) meant to decrease the transmission of HIV from partner to partner. “Pharmaceutical companies had adopted a ‘jewelry-store mode of business’- one based on high margins and low volume” because the drug companies assumed that there would be “few buyers” (Youde, 2011: 168). The Clinton Foundation sought to change this business model to a “grocery-store model,” with lower margins and higher volume in order “to provide a social good” through a health access initiative (known as CHAI) that negotiated “lower prices for a consortium of states which would then place orders with the pharmaceutical manufacturers themselves” (Youde, 2011: 168).

This change in market strategy proved to be beneficial for all parties involved. In this arrangement, the drug companies now had a larger market and were able to gain a larger profit, despite lowering their margins. Market uncertainties were also reduced for companies since there would be a “[relatively] stable and reliable market in order to justify the investment” (Youde, 2011: 168). Another result of this strategic market alteration is that developing countries will still be able to afford ARVs. However, in order to join the Clinton Foundation’s state consortium, the state would
have to sign, “a memorandum of understanding…specifying monitoring and reporting requirements for the state government” (Youde, 2011: 170).

In October of 2003, the Clinton Foundation claimed this approach reduced the price of the popular ARVs by more than 50 percent while still benefiting the manufacturing companies (Youde, 2011: 170-171). The success of this strategy should be incorporated in negotiations between the Eswatinian government, UNAIDS in partnership with UN Women and the World Health Organization acting as mediators on behalf of the government, Gilead Sciences, and Veru Inc. to ensure supply and lower selling prices of both FCs and Truvada. This would ensure that the government will be able to afford the medication and condoms for an extended period of time (roughly 2-5 years). It’s understandable that Gilead Sciences and Veru Inc. would be hesitant to take this course of action and cooperate. UNAIDS, UN Women, and the WHO, in their mediation, should emphasize that both companies would still make a profit, while lowering the cost of Truvada and FCs. This would be due to the sheer amount of people who are at risk of contracting HIV and the prevalence of the virus in the country.

Post Price Negotiations- Securing Demand, Availability, and the Role of UN Branches

One it is established that Eswatini, Gilead Sciences, and Veru Inc. will benefit from this arrangement, the next phase in this recommendation should be implemented. Since a sufficient supply will be assured, demand needs to be secured for women to take the medication. This demand can be achieved through another social marketing campaign that is similar to the one for females to purchase condoms. In the campaign, an emphasis should be placed on encouraging women to obtain Truvada and to use it. This would help break down the barrier of women having to secretly take HIV/AIDS related medicine and change social attitudes towards it. UNAIDS needs to work with civil society to develop a social marketing campaign. Other factors which were considered in the previously mentioned female condom campaign, such as possible restrictions to access information, should also be considered in the Truvada campaign.

With supply and demand being secured, the availability in terms of distribution and accessibility of both FCs and Truvada needs to be addressed. Since Eswatini has made progress in the construction and establishment of hospitals and clinics, a long-term target should be delineated to ensure that hospitals and clinics throughout the country receive a supply of Truvada and are continuously being restocked. In the short-term, significant and densely populated cities, such as Mbabane, Manzini, and Lobamba, should be the primary focus. This is not only due to the number of people in these cities, but also because there will be fewer infrastructure barriers to consider. This way costs will be lowered. The aid community would also support such a project.

To ensure that the previous goals are reinforced, UNAIDS and UN Women would monitor the rate of female condom utilization, the rate at-risk women taking Truvada (whether it be in the injectable form or the oral form), and the public response to both of the social marketing campaigns. The reason for this is to ensure transparency. The key indicators of success would be increased levels of use of FCs and Truvada. The final indicator would be the rate of HIV infection for women between the ages of 15-49.

HIV/AIDS is more than a public health crisis in Eswatini. There is a gender inequality component which contributes to the spread of the disease. In this case, medicine is not the sole solution to this
problem. There needs to be political, social, and cultural components to guide resources to those who suffer most and are the most at risk. Since there is a gender component to HIV/AIDS, it is important to incorporate gender and women’s empowerment into the solution. Giving women agency over their bodies and sexual practices empowers them while reducing the risk of contracting HIV. The recommendations directly target HIV/AIDS, but it lays the groundwork for more inclusive policies.
Works Cited


