

Integrating sexual health services in Swaziland

There are compelling arguments for integrating sexual and reproductive health and HIV/AIDS health services in Swaziland, but also a risk that it will discourage patients from seeking help. Mantoe Phakathi reports.

Almost 10% of the population of Swaziland – more than 100 000 people – were treated for sexually transmitted infections (STIs) in 2008, according to Zandile Mnisi, STI programme coordinator at the Swaziland Ministry of Health. Alarming in itself, the number is also indicative of prevailing high-risk sexual practices in a country that has the highest HIV prevalence in the world. According to a UNAIDS report, preliminary data from a population-based survey show that about one in four (26%) Swazis aged 15–49 years is HIV positive.

Swazi authorities are trying to address these problems by pushing for greater integration of the sexual and reproductive health and HIV/AIDS services offered in hospitals and clinics. This is done by providing STI services at all entry points in the health facilities, Mnisi explains. “For example, pregnant women who come for antenatal care services are screened and treated for STIs, and the same goes for women who come in for family planning services. Children who are brought in for growth monitoring are also examined for the presence of STIs and treated if any are detected.”

There is already a degree of integration in this area. Dudu Simelane, director of the Family Life Association of Swaziland, a nongovernmental organization that provides reproductive health care services, says that all patients who come for STI diagnosis, treatment or any other reproductive health service are offered an HIV test, while patients in Swaziland’s antiretroviral therapy clinics receive treatment for STIs. This is true both for public health facilities and those run by nongovernmental organizations.

The country’s hospitals do less well in offering integrated services than the clinics. “As a country we have a challenge in the integration of services, both in the approach and delivery,” says Rejoice Nkambule, deputy director of Health Services (Public Health) at the Ministry of Health, noting that the STI unit in a Swazi hospital is typically separate from the voluntary counselling and testing centre devoted to HIV/AIDS. Nkambule would like to see this change, but is aware of the challenges – notably the problem of increased waiting times for patients in units offering a broader range of services, and the risk of health worker burnout.



Leticia Bennett, senior nursing sister at the Family Life Association of Swaziland

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nel trained to deliver all the services at one place,” she says, pointing out that the different services combine quite naturally anyway. “The first thing that comes to my mind when I see a patient with a sexually transmitted infection is that this person is not using protection therefore there is a high risk of exposure to HIV,” she says, adding that STIs present an “entry point to start talking about HIV/AIDS”. This viewpoint is shared by Simelane, who says that the main infection prevention mechanisms are also similar – promotion of condom use, reduction in sexual partners or promotion of abstinence.

But is it really that simple? Anecdotal evidence suggests that it might not be, and that the differences between STIs and HIV/AIDS are as important as the similarities. One of the most obvious differences concerns prognosis. HIV/AIDS, while no longer necessarily a death sentence, is still certainly a



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For Dr Velephi Okello, medical practitioner and national coordinator of the HIV/AIDS treatment programme at the Ministry of Health, improving integration need not be a painful process. “We’re saying let the STI corner have HIV services such as testing and counselling with person-

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lifelong disease, whereas STIs tend to be acute and easily treatable. Patients are well aware of this difference and it influences their choices, according to Letticia Bennett, senior nursing sister at the Family Life Association of Swaziland.

Patients presenting with STI symptoms at the Family Life Association of Swaziland clinics are offered HIV/AIDS counselling and testing services at the same time and those who accept are given their results immediately. Despite this fact, roughly 40% of the patients refuse to test for HIV. Why? It is not a matter of price. It costs roughly US\$ 2.50 for the initial HIV test, while charges for STIs range between US\$ 4 and US\$ 9 because of the cost of the medication. “They are just interested in being treated for the presenting symptoms,” says Bennett. Put simply, they would rather not know. Okello too has observed the phenomenon, saying that in her experience as a doctor, she has found that “most people have undergone some kind of counselling and opted out of testing [for HIV]”. The idea that a patient can be treated for their STI without knowing their HIV status, adds Simelane, “is a fallacy and creates false hope...[as] STI treatment with an underlying [unknown] HIV infection would not have a sustainable effect”.

In public health facilities, health workers are expected to offer HIV



Zandile Mnisi, STI programme coordinator at the Swaziland Ministry of Health.

counselling and testing to all patients without the patient having to ask. Nkambule explains that patients still have the right to refuse an HIV test, but there can be little doubt that the approach puts the pressure on, and may run the risk of discouraging people with STIs from coming in for treatment in the first place. According to Mnisi, the Swaziland government is still working on finalizing its Pharmacy Act. The current lack of a policy regulating the circulation of drugs in the country makes it possible for STI patients to buy medication over-the-counter, with all the risks that entails for irrational use. The last thing those patients need is another excuse to stay away from the doctor.

“Treating HIV as a sexually transmitted disease perpetuates stigma and discrimination.”

Velephi Okello

Meanwhile, people who wish to know their HIV status may be discouraged from entering integrated units fearing the stigma associated with STIs. Nkambule recognizes the potential problem here, but believes linking HIV to STIs simply reflects the epidemiological reality of sub-Saharan Africa: “Treating HIV primarily as a sexually transmitted disease might promote stigma and discrimination but, in this part of the world, the fact is that HIV is mainly transmitted through sex,” she says. Okello, on the other hand, points out that mother-to-child transmission alone invalidates any framing of HIV as a sexually transmitted infection.

“Treating HIV as a sexually transmitted disease perpetuates stigma and discrimination,” she says. “Can you imagine how much it would hurt the children, some of them teenagers now, who have been living with HIV



Velephi Okello, medical practitioner and national coordinator of the HIV/AIDS treatment programme at the Swaziland Ministry of Health.

since birth if HIV was considered an STI when some of them are not even sexually active?”

Finally, there is the question of the effect a push for greater integration will have on the male population. Mnisi points out that most people accessing treatment at the moment are women. STI patients are given partner-tracing cards, which are effectively an invitation to the infected person’s partner to come in for treatment. The partners rarely do. For men who have sex with men, the issue is even more difficult because homosexuality is illegal in Swaziland. “We try to talk to our health workers to be tolerant,” said Mnisi. “However, you must understand that, in our culture, homosexuality is not practised openly so people are not used to it.” Nevertheless, she says, “our core mandate as a health sector is to provide equitable non-discriminatory health services to all members of the general population irrespective of their sexual orientation and practices. The same thing applies to people in the commercial sex trade.” It is perhaps only by changing attitudes that Swaziland will start to see a significant decline in its appalling HIV and STI statistics. ■