

Swaziland

The Kingdom of Swaziland (population 1,069, 000) is a small landlocked country in Southern Africa covering an area of 17,364 sq km between South Africa and Mozambique. The capital, Mbabane is situated in north west Swaziland in the Mdzimba Mountains. Lobamba, the royal and legislative capital of Swaziland, lies about 20 km south of Mbabane.

Swaziland is governed by King Mswati III, an hereditary monarch. The prime minister is appointed by the king and thereafter recommends cabinet appointments for the monarch's approval.



A former British protectorate, Swaziland became independent in 1968. Since 1973 Swaziland's system of government has been adapted to bring together both parliamentary and traditional systems. A constitutional review is ongoing.

According to the United Nations human development index (HDI), Swaziland is ranked 137/177 countries worldwide (value 0.519)¹ and 12/45 African countries for which an index is available. This places Swaziland in the group of countries with medium human development.

In 1997, a wide-ranging report² produced under the auspices of the United Nations commented as follows:

Swaziland's achievements since independence are a justifiable source of pride in many areas, but a cause for complacency in none. Huge strides have been made in areas such as education and average life expectancy, but little has been achieved in managing the consequences of population growth, and with:

- one of the highest national antenatal HIV rates on earth
- a high population growth rate of 2.7 percent
- increasing civil disturbances
- serious unemployment
- serious or very serious soil erosion and other environmental degradation
- heavily skewed income distribution with much of the population living in absolute poverty
- indicators such as total fertility rates and under-five mortality being more in keeping with low human development nations than medium human development nations, and
- the recent slowing of growth both in formal employment and GDP

the challenges ahead appear to be even greater than those already overcome.

PALLIATIVE CARE SERVICE PROVISION

Current services

Four non-governmental organisations provide palliative care in Swaziland: Hope House; Swaziland Hospice at Home; Parish Nursing; and the Salvation Army. In addition, several community based church organisations provide supportive care to terminally ill patients.³

An overview of palliative care provision is shown in Table 1.

Table 1 Palliative care provision in Swaziland 2003

<i>Adult Services</i>								
<i>Swaziland</i>	<i>Freestanding hospice unit</i>	<i>Hospital unit</i>	<i>Hospital support team</i>		<i>Home care</i>	<i>Day care</i>	<i>Clinic/ Drop-in centre</i>	<i>Grand Total</i>
Hope House	1							1
Parish Nursing					1			1
Swaziland Hospice at Home					1		1	2
Salvation army					1		1	2
Total services	1				3		2	6

Swaziland Hospice at Home

Hospice at Home was registered as a non-government organisation in July 1990. Stephanie Wyer, founder of Swaziland Hospice at Home outlines the plight of the dying at that time:

They were being taken into the government hospitals, with whatever their symptoms were, they were told in no - it just wasn't told gently, they were told that they were going to die, they were taking up a bed and they would just have to go home and wait to die. And there was nobody, *absolutely nobody*. If they had somebody at their home, that was their good fortune: if they didn't they went back to their huts and they just lay there and waited to die. And that was it, there was just absolutely nothing available.⁴

The stated aim of the hospice is to improve the quality of life for terminally ill people and their families. This is achieved by providing:

- counselling - for the patient and family members
- pain management
- control of distressing symptoms
- day care
- training and advice - for family and community carers
- bereavement support

Patients are referred to Hospice at Home by hospitals, relatives or friends. During the period 2000-03, the number of patients cared for by Hospice at Home more than doubled (Table 2).

Table 2 Patients cared for by Hospice at Home 2002-2002

Year	Number of patients
2000-01	522
2001-02	683
2003 -	1144

Source: Thulie Msane⁵

Salvation Army

The Swaziland Community Care Programme was established in Mbabane by the Salvation Army in 1985. Due to the ever-increasing number of HIV/AIDS patients a palliative care programme was initiated in 2000. Provision includes:

- home care
- HIV clinic - in the Mbuluzi district of Mbabane.
- bereavement care
- orphan care – currently 300 children⁶

Around 180 clients are seen daily.

Hope House

Located in Manzini, Hope House is an inpatient unit modelled on the Swazi homestead which caters for the needs of AIDS patients at the end of life. The facility opened in 2000 and consists of a group of bungalows which provides accommodation for HIV patients and caregivers.

The Hope House concept was developed by World Vision International⁷ in partnership with the Roman Catholic Church during the late 1990s. Funding was provided by the National Office of World Vision International: Austria, Germany, Ireland and Taiwan. Other support has come from The Italian Co-operation,⁸ and Women and Law in Southern Africa (WILSA).⁹

Patients may be referred to Hope House by a number of organisations, including Swaziland Hospice at Home and the Swaziland AIDS Support Organisation (SASO).¹⁰

Parish Nursing

This three year project began in 2000 supported by the 'Secure Future' programme of the Bristol Myers-Squibb Company.¹¹ Located in the Roman Catholic Diocese of Manzini, it is run in partnership with Maternal Life International (MLI).¹² The project is summarised as follows:

Swaziland has under-developed health infrastructure and is predominately a rural area with a shortage of health care professionals specializing in HIV/AIDS care. By working through the Catholic Church, this program will

demonstrate how countries can tap into existing infrastructure and draw the community into HIV/AIDS work. Community-Based Parish Nursing's project plan covers curriculum development, use of telecommunication for ongoing training, direct patient and family care, HIV testing and counselling, education and training of community volunteers.¹³

Thandiwe Dlamini, administrator of Parish Nursing, describes the care provided by parish nurses and outlines its underlying principles. She writes:

Parish Nursing aims to integrate the practice of faith with the science of nursing. It links nurses with churches to focus on health related issues and to provide a holistic approach in the healing and caring process of a patient. The programme offers patients a holistic health approach which combines physical and spiritual dimensions. The Parish Nurses work part time and are assisted by community members who have been trained in home-based care. Each nurse sees around five to eight patients per day and approximately 240 patients per month.¹⁴

Reimbursement and funding for services

All the hospice services are charities and rely heavily on donations for their income. Yet funds come from a variety of sources, as indicated below:

Hope House: each patient pays the equivalent of US \$1 per day. Support has also come from the Catholic Bishop's Forum which agreed to pay administrative costs for a period of 6 months

Swaziland Hospice at Home: is subvented by the government and also receives funds from its international partners including, Friends of Swaziland Hospice at Home (UK)

Parish Nursing: is supported by a grant of US \$273,000 over a three year period from inception by the Bristol Myers-Squibb Company

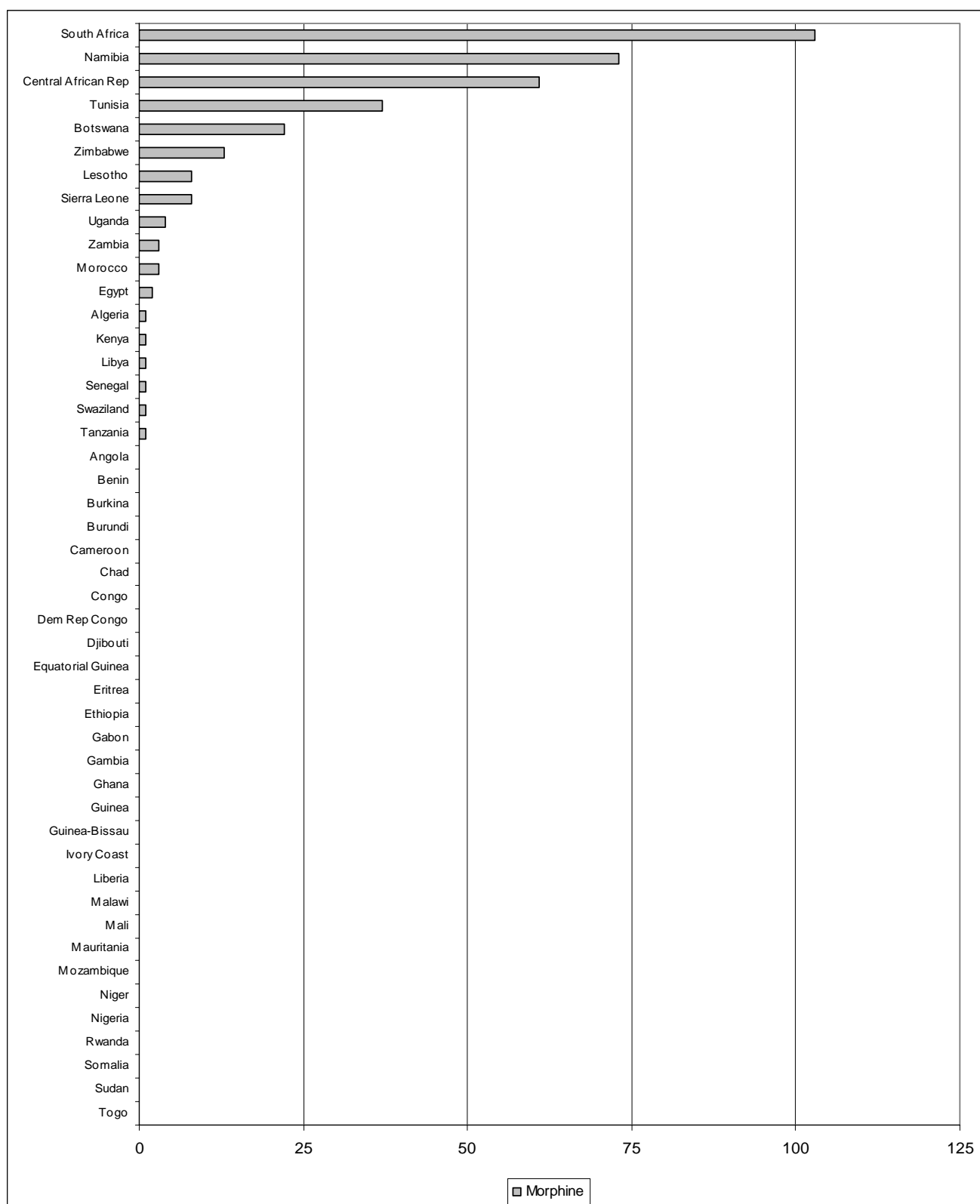
Salvation Army: the Rotary Club of Mbabane has supported the salaries of the medical staff and continues to give periodic assistance. The clinic charges a fee for medicines and is self funding in this respect. Nursing, counselling and home-based care is free of charge, supported by charitable donations. Two international donors provide support for orphans and assistance also comes from the Southern African AIDS Training Programme (Canadian Public Health Association).

Opioid availability and consumption

The International Narcotics Control Board¹⁵ has published the following figures for the consumption of narcotic drugs in Swaziland: dihydrocodeine 1kg; pethidine 1kg.

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)¹⁶ in Swaziland was 1. This compares with other African countries as follows: Egypt 2; Uganda 4; Zimbabwe 13; Namibia 73; South Africa 103. Twenty nine countries reported no morphine consumption during 2000-2002 (Table 3).

Table 3 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: countries of Africa



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

Sibusiso Dlamini writes:

Morphine syrup is not [generally] available in the country, but there are morphine tablets. These are prescribed by doctors only. I have personally been talking to the chief pharmacist asking them to avail morphine syrup as it's cheap and easy to use for clients, but until now this has not been attended to by the government.³

Thulie Msane describes how morphine and other drugs are prescribed and supplied to Swaziland Hospice at Home patients:

Morphine syrup is only made available as needed per patient. It is not stocked in large volumes. This can be accessed by patients as indicated. Hospice is the custodian of morphine as alluded to by the home based care manual for Swaziland.

Morphine is prescribed with the assistance of a visiting doctor, after the patient has gone through the pain management protocol – a new nursing diagnosis to manage pain - and morphine is indicated. Other drugs are prescribed by nurses after they have made a physical assessment and come up with a nursing diagnosis. All prescribed medication are supplied to patients by hospice nurses.¹⁷

Parish nurses use analgesics such as Stilpayne, Painagon and Tylenol; they do not give morphine.

National and professional organisations

Organisations associated with palliative care in Swaziland include the following:

- Friends of Swaziland Hospice (Wales) UK,
- Skill Share Africa¹⁸
- International Association of Hospice and Palliative Care¹⁹
- Friends of Swaziland Hospice (Swaziland)
- The Salvation Army
- The Rotary Club of Bethlehem, USA²⁰
- The World Health Organisation
- World Vision International; Austria, Germany, Ireland and Taiwan
- The Roman Catholic Church
- Women and Law in South Africa

- Swaziland AIDS Support Organisation.
- Co-ordinating Assembly of Non-Government Organisations
- Catholic Bishop's Forum
- The Italian Co-operation
- Maternal Life International
- Bristol Myers-Squibb Company

At a meeting of palliative care providers held in June 2003, a commitment was made to form a national palliative care association.

Palliative care coverage

Hospice at Home: offers support to all Swaziland inhabitants with a terminal illness. Singer and Dlamini report:

Swaziland is divided into four regions; each region is served by one nurse from SHAH. The nurse makes home visits to referred patients from his/her own region. The nurse determines the frequency of home visits. This depends on time available and the patient's condition. It is impossible to schedule more than 4-5 home visits a day because of distances and poor road conditions. The home visit is used to: follow up on the patient's condition, to change and modify treatment plans according to the patient's condition, to give psychological and spiritual counselling to the patient and to the caring family, to teach and support good patient care. Often, appropriate medications are dispensed at this time.²¹

Home visits to remote homesteads can be hazardous, however, as Stephanie Wyer explains in this story about Patrick, a hospice nurse:

Patrick, was a very wonderful young man with fantastic knowledge of hospice and palliative care; a wonderful nurse; wonderful with his patients, very loved. And about two years ago, I went back to see them as I do most years - we went out for three weeks and did lots of lectures. Anyway, Patrick came to the airport when we were coming back and saw us off. And three days later, I had a called from Sibusiso who told me that I must sit down, he had the most *awful* news, Patrick had been out visiting his patient and he had - in between one patient and the other - he'd come to some road works and it said, 'Do not continue beyond this point' and it had an arrow pointing, and he obviously went the way of the arrow, and went straight over a mountain and was killed. So they lost their senior nurse and we lost a very dear friend. So that was a big setback, a very big setback.⁴

Parish Nursing: the programme covers 30 communities in the four regions of the country. In each case, the area covered is within walking distance from the home of the nurse.

Salvation Army: the clinic serves three local communities around Mbuluzi. at present 3/10 nurses provide palliative care alongside 50 (volunteer) community/ family carers.

Palliative care workforce capacity

Hospice at Home has 5 full time nurses; 1 part time nurse; 1 part time doctor; 5 administrative staff and 150 volunteers. These volunteers play an important role within palliative care. Singer and Dlamini state:

Swaziland Hospice At Home volunteers are called "friends". This is based on the love and friendship between our volunteers and the patients. They develop a friendship relationship with the terminally ill patient, thereby committing their time, money, and energy to help improve the quality of life of terminally ill Swaziland patients.²¹

Parish Nursing has 30 (retired) nurses in the programme. These nurses work part-time with the support of community members trained in home-based care.

The Salvation Army has 10 nurses in the community care programme; 3 are palliative care trained; 4 are double qualified in nursing and midwifery; 3 nursing assistants work in the clinic. In addition, there are a total of 50 trained community carers and family carers (volunteers) who give assistance.

Education and training

Driven by the impact of HIV and AIDS, a home care strategy was implemented nationally in 2000. This strategy included palliative care education for health professionals, together with a determined drive to raise public awareness of palliative care. Hospice providers played a key role, as Thulie Msane²² indicates:

As government initiated the strategy, there was a need for hospice to train care givers (Rural Health Motivators), civic society, churches and schools in raising awareness of the home-based concept and palliative care concept.

The schools of nursing invited hospice as facilitators on home-based palliative care and students have been trained in the following topics;

- palliative care concept
- symptom management
- death, grief and bereavement
- pain management
- home-based palliative care
- spiritual care
- HIV/AIDS symptom management.

As of June 2003, a total of 4316 people have been trained across a broad range of groups and services (Tables 4 and 5).

Table 4 Personnel trained under the national home-based care strategy 2000-02

Year	Doctors	Nurses	Student nurses	Civic group	Community carers	Total
2000-01	31	63	35	1217		1311
2001-02	25	466	70	993	807	1941

Source: Thulie Msane

Table 5 Personnel trained under the national home-based care strategy 2002-03

Year	Health professionals	Defence force	Civic group	Correctional services	Total
2002-03	500	40	474	150	1164

Source: Thulie Msane

HISTORY AND DEVELOPMENT OF PALLIATIVE CARE

Narrative history of palliative care

Hope House: this inpatient unit is managed by Sarah Dlamini, a nurse and former director of the Coordinating Assembly of Non-Governmental Organizations (CANGO). The Hope House project involved a team of church and lay volunteers under the leadership of Fr. Larry McDonnell. Journalist James Hall writes (2000):

A team of church and lay volunteers under the leadership of a local Catholic priest and educator, Fr. Larry McDonnell, have erected 15 units, with 10 more awaiting construction in an innovative community that combines traditional Swazi hospitality with the latest applied theories in AIDS treatment and prevention. The complex is noteworthy for another reason. While only able to offer accommodation to a mere fraction of AIDS sufferers in Swaziland, it presents a prototype for imitation elsewhere in the kingdom.

Among the deeply-traditional Swazi people, the subject of AIDS is taboo. Sufferers do not acknowledge the cause of their illness, lest fearful family members refuse to attend their funerals. The health care and leadership vacuum has been filled by volunteers and social workers like Fr. McDonnell, who has been ministering to Swazis for three decades, mostly as an educator.

In March this year, the project called Hope House will receive its first tenants. Fifteen of 25 homes have been completed on the edge of Swaziland's commercial hub, Manzini, on land owned by the Catholic Archdiocese. Hope House is set on the rim of a beautiful green valley, and has the feel of a homestead.

Patients are not warehoused to die, but live what remains of their lives in dignity as part of a community. 'Our residents will be men and women who are no longer allowed to stay in hospital,' says Fr McDonnell. Swazi health facilities are unable to cope with the influx of AIDS patients, who are discharged when death is near. "Swazis live in strong extended family units, but sometimes there is no one at a traditional homestead to tend to an AIDS

sufferer. A father may be dead, a mother sick, and children incapable of the responsibility.²³

Swaziland Hospice at Home: Ingrid Watkins – chairperson of Friends of Swaziland Hospice, outlines the history of the hospice as follows:

Mrs. Stephanie Wyer MBE founded the Swaziland Hospice at Home. She went to live in Swaziland to join her husband who was working there. She arrived in Swaziland in March 1990. Her background was Macmillan nursing and in that spirit and experience the hospice work started almost immediately. She found a doctor who would work with her for prescribing medication etc. She acquired THE 'yellow jeep', which soon became well known. She started to visit cancer-patients at home and soon other patients and their families would ask for her help. Swazi-nurses became interested in her work.

A steering group was formed. The Hospice was registered as an NGO on 4th of July 1990. A part-time nurse Judith Mamba (first member of staff) joined her and they worked together. People who started to work as volunteers, mainly for fund-raising also offered help. In August 1990, the British High Commissioner gave a caravan to the Hospice. (In post was Mr. Brian Watkins, whom is now Patron of FOSH (WALES)). The Fire Station in Manzini offered a site on their land to put the caravan on. This caravan became the centre for courses in palliative care for nurses and other health professionals in Swaziland. During the same period of time Stephanie asked her friends in Wales to support the work she had started. At the end of 1990 we formed FOSH. (Wales) UK, (Friends of Swaziland Hospice). Up to date this is a registered charity raising funds for SHAH (Swaziland Hospice at Home).

In 1991 Stephanie interviewed Mr. Stuart Craig in London. He was appointed to become the first Administrator of SHAH through Skill Share Africa. In 1992 two part-time nurses were appointed to work with Stephanie and Judith. One nurse was from South Africa the other from Zimbabwe both with palliative care experience. At the end of that year (1992), they left and two Swazi nurses joined the team; they were Ms. Sweetness Masonga and Mr. Sibusiso Dlamini. Both needed in service training. In 1993, a lady called Ms. Bunny Boyder with the help of Dr. Samuel Hind donated land to the Hospice. When this lady died she left more land and a house to Hospice. During 1994 the caravan was replaced by a one-storey building. Today this building facilitates the clinic where patients and families can come for treatment, help and advice.

In March 1994, Stephanie and her husband returned to Wales. She went back to Swaziland in August 1994 to assist the educator with a course she was running. She stayed for a month in which time a new director was appointed called Gcebile. Stephanie officially handed her work over to her in September 1994. Stephanie returned again in December 1994 to give the new Director support that was needed. She was then able to hand over the full management of SHAH to the Swazi people.

A director was appointed. Specialist Nurses delivered the hospice service in the community. Administration staff were employed. Through the years FOSH

(Wales) had enabled SHAH to get equipment for patient care (such as syringe drivers, special beds etc.), books, magazines for education, cars (including maintenance) for the nurses to visit patients.

In 1999, FOSH was successful in getting a community grant from the Lottery Board for Education for a period of three years. This project should have ended in September 2002, but will be finalised in January 2003. The project has enabled the hospice to grow into a centre for courses in palliative care in Africa. FOSH has been able to facilitate training in Britain for Swazi-nurses in further education at St. Christopher's Hospice. This is ongoing at present. In the same year, FOSH was able to raise monies for the appointment of a doctor. This proved to be complicated but in April 2002 a doctor started to work for the Hospice. During the same year, a group of supporters in Swaziland formed FOSH (Swaziland).

In 2001 the American Embassy donated an extended two-storey building to the Hospice. This was opened in 2002 and used for administration, conferences and lecturing. The original building is now a centre for patients and families to walk into for advice, food, clothes and medical help. A doctor and a nurse are present to see those who come. Patients can rest before they go home again (often they walk a fair distance; also their illness makes them very tired).

Mr. Sibusiso Dlamini, a trained nurse working with hospice, was prepared to pay a visit to Wales in 1997. FOSH (Wales) sponsored him and gave him a second home during this time. He stayed on and went to St. Christopher's in London, gaining a degree from the Royal Marsden Hospital, London in palliative care in 2000. He returned to hospice in 2000. Small beginnings have developed into much needed and valued palliative care work'.²⁴

Sibusiso Dlamini has since moved from Swaziland Hospice at Home to take up a post with the National Emergency Response Committee on HIV/AIDS (NERCHA).

Parish Nursing: 'A New Robe' parish nurse programme

The parish-nurse model for Africa was developed by Maternal Life International in collaboration with Dr. Cynthia Gustafson, director of the Carroll College Parish Nurse Centre in Helena, Montana. It is based upon a Christian philosophy of care:

The parish nurse role reclaims the historic roots of health and healing found in many religious traditions. Parish nurses live out the early work of monks, nuns, deacons and deaconesses, church nurses, traditional healers and the nursing profession itself.

The spiritual dimension is central to parish nursing practice. Personal spiritual formation is essential for the parish nurse. The practice holds that all persons are sacred and must be treated with respect and dignity. Compelled by these beliefs the parish nurse serves, advocating with compassion, mercy and justice. The parish nurse assists and supports individuals, families, and communities in becoming more active partners in the stewardship of personal and communal health resources.

The parish nurse understands health to be a dynamic process, which embodies the spiritual, psychological, physical, and social dimensions of the person. Spiritual health is central to well being and influences a person's entire being. A sense of well being can exist in the presence of disease, and healing can exist in absence of cure.²⁵

The administrator of the Parish Nurse programme is Thandiwe Dlamini - a former director of the Swaziland Red Cross and the founder of many health care and social service organizations in the country. She was appointed Counsellor for Distinguished Service of His Majesty King Mswati III in 1998. The Parish Nurse programme came about as follows:

In the summer of 2000, Maternal Life International (MLI) was awarded a grant for \$272,900 from the Bristol Myers-Squibb 'Secure the Future' Foundation. The purpose of the award was to allow MLI to design and implement a parish nurse program in twenty-five communities in Swaziland. The resulting program, entitled "A New Robe" is the first parish nurse program to be implemented in Africa. It provides a range of services, including hospice home-based care for AIDS patients, HIV testing and counseling, and HIV/AIDS community education. Similar to programs in the United States, the program reflects a holistic approach to health care, inclusive of the spiritual and social dimensions of AIDS care.

The common thread that binds "A New Robe" together is a profound respect for the life and dignity of the human person. Working with the Catholic Church of Swaziland and utilizing the start-up money provided by Bristol Myers-Squibb, MLI has hired and trained an in-country nursing director and 19 nurses. Ongoing support and education, as well as medicines and supplies are being provided through MLI's fundraising efforts.²⁶

Hospice success stories

The successes of Swaziland Hospice at Home are described as follows:

The organisation has managed to train health workers including nurses and doctors on palliative care and home-based palliative care. The transfer of skills to health caregivers has enabled the organisation to roll out hospice service to eligible clients in the rural areas, the pro poor, and poor clients providing access to quality of care. The organisation has managed to alleviate pain and suffering to all terminal patients and advocate for care and support, reducing stigma and marginalisation of such clients. We have succeeded in enlightening the nation on the concept of palliative care and the need to integrate this especially in the nursing circular. Student nurses are referred to hospice for skill development and practical experience of palliative care, especially pain management.⁵

Parish nursing success stories are recounted thus:

Patients who have been discharged from hospital are visited regularly by the nurses and checked, and palliative treatment given. Professional guidance re:

medications is given to family carers. Some of our clients who had been bed-ridden after treatment have recovered and gone back to work. Successfully counselled people. Some of the terminally ill have never been to hospital and these visits are the only medical interventions they will ever have.¹⁴

Life/oral histories

Stephanie Wyer – *Founder, Swaziland Hospice at Home*, has been interviewed by Michael Wright, 1 July 2003. This interview is in accordance with the broader IOELC protocol that places the interview in the public domain and grants access to bona fide scholars. Length of interview: 1 hour 15 minutes.



Stephanie Wyer speaks of her background in psychiatric nursing and her subsequent move into palliative care as a home care sister working for St David's Foundation in Gwent (Wales). When she accompanied her husband to Swaziland, she found little care for the dying and was encouraged to establish a local hospice. She recalls how her yellow jeep became the first hospice vehicle; how a nun helped her to form a steering committee; and how, despite bureaucratic difficulties, the hospice became a registered NGO in July 1990. She tells how early support came from the King's niece, a registered nurse, and from a South Africa-based physician who visited Swaziland weekly to provide medical expertise. She goes on to reflect upon how staff were recruited, educated and trained; how funds were raised and accommodation acquired; and the key roles played by individuals and groups both within Swaziland and internationally.

PUBLIC HEALTH CONTEXT

Population

In 2004, Swaziland had an estimated population of around 1.07 million of which 97% is African and 3% European. Between 1991 and 2001 the annual population growth rate was 1.8%. Around 55% of the population are Protestant Christians; 10% are Muslim; 5% Roman Catholic Christians; and 30% subscribe to indigenous beliefs.²⁷

Epidemiology

In Swaziland, the WHO World Health report (2004) indicates an adult mortality²⁸ rate per 1000 population of 818 for males and 707 for females. This may be a conservative estimate. During 2002, around 15,000 deaths were recorded in Swaziland²⁹ - but as this figure takes no account of (unregistered) home deaths, the actual number is thought to be higher.

Life expectancy for males is 36.9; for females 40.4. Healthy life expectancy is 33.2 for males; 35.2 for females.³⁰ Predictions suggest that life expectancy will fall to 27 by 2010 – from a life expectancy of 61 in 1995.³¹

The disease profile of Swaziland is that of a developing country and reflects poor socio-economic conditions with some elements of epidemiological transition, typified by a rise in the prevalence of non-communicable diseases. Because it is a lower middle-income country, there is a reasonable level of infrastructure. According to Swaziland's Health Statistics Report, 1999³² the four major causes of outpatient consultations were respiratory diseases (27.8%), skin disorders (11.1%), diarrhoeal diseases (11.1%) and genital disorders (7.6%).

Swaziland is one of the worst HIV/AIDS affected countries in the world. The HIV prevalence in pregnant women grew from 3.9% in 1992 to 34.2% in 2000 and 38.8% in 2003.³³ Estimates suggest that between 210,000 and 230,000 people in Swaziland were living with HIV/AIDS at the end of 2003. In the same year, up to 23,000 adults and children are thought to have died from the disease (Table 6).

Table 6 Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	38.8% (range: 37.2%-40.4%)
Adults (15-49) living with HIV	200 000 (range: 190 000-210 000)
Adults and children (0-49) living with HIV	220 000 (range: 210 000-230 000)
Women (15-49) living with HIV	110 000 (range: 110 000-120 000)
AIDS deaths (adults and children) in 2003	17 000 (range: 13 000-23 000)

Source: 2004 Report in the global AIDS epidemic

UNAIDS reports:

Women of childbearing age make up 47.7% of women in Swaziland, or a quarter of the population (report of the 1997 Swaziland Population and Housing Census Vol. 4). This population is highly vulnerable to HIV infection, particularly the younger women. Periodic surveillance of antenatal clinics in the country has shown a consistent rise in the prevalence of HIV infection among women attending the clinics.

The most recent surveillance report of 2002 gives an overall prevalence of 38.6% The highest prevalence of 41.0% was among the younger age group of 15–29 years. The older women, 30 years and over, had a prevalence of 27.7% (Swaziland Ministry of Health Eighth HIV Sentinel Surveillance, 2002).

It is also estimated that there are over 60 000 orphans, with approximately four children per household with an average age of 11 years. An estimated 15 000 households or more are headed by orphaned children, living on their own or with a sick parent or relative, with no resources or skills to provide for their basic needs.³⁴

Health care system

Although Swaziland is classified as a lower middle-income country, the socio-economic indicators show widespread poverty and reflect huge inequities in access to services and opportunities vital to human life. An estimated 66% of the population live below the poverty line and rural-urban disparities are prominent. While 91% of the urban population have access to safe water, this falls to 37% for the rural population. Per capita expenditure on health for the urban population is three times that of the rural population.³⁵

Sibusiso Dlamini explains how these conditions impact upon the delivery of palliative care:

While we would like to ensure control of our clients physical symptoms, starvation is the first symptom we face in Swaziland, and it is practically and professionally not possible to push a client to take a tablet or medication on an empty stomach. As a result, palliative caregivers are forced to scout for food to give to their clients as a first line of intervention.³⁶

Prior to 1983, health care provision focused on curative measures provided by hospitals in urban areas. Access, therefore, was problematic for the rural dwellers who comprised 85% of the population. This situation gave rise to the Primary Health Care Strategy of 1983, which sought better provision and increased accessibility within the country's rural areas. Health services have now been decentralised throughout the four regions of the country.¹⁸

In 2001, the total per capita expenditure on health care was Intl \$ 167 (3.3% of GDP).³⁷ Among the countries of Africa, this figure falls within a spending range of Intl \$652 in South Africa (8.6% of GDP) and Intl \$12 in the Democratic Republic of Congo (3.5% of GDP). At 2.0% the smallest spending as a percentage of GDP is in Equatorial Guinea (Tables 7 and 8).

The WHO overall health system performance score places Swaziland 177/191 countries. This composite measure of overall health system attainment³⁸ is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

In 2001, there were six hospitals in Swaziland, five health centres, and four public health units; 162 clinics and 187 outreach clinics. In 2003, around 600 nurses and 50 doctors were engaged in health care.

Tables 7 and 8 Total health expenditure (Intl \$) per capita and as a percentage of GDP: countries of Africa, 2001

Table 7 Health expenditure (Intl \$) per capita: Africa		Table 8 Health expenditure (Intl \$) as a percentage of GDP: Africa	
Country	Per capita	Country	%GPD
South Africa	652	South Africa	8.6
Tunisia	463	Kenya	7.8
Botswana	381	Malawi	7.8
Namibia	342	Namibia	7.0
Libya	239	Djibouti	7.0
Morocco	199	Botswana	6.6
Gabon	197	Tunisia	6.4
Algeria	169	Gambia	6.4
Swaziland	167	Zimbabwe	6.2
Egypt	153	Côte d'Ivoire	6.2
Zimbabwe	142	Mozambique	5.9
Côte d'Ivoire	127	Uganda	5.9
Liberia	127	Guinea-Bissau	5.9
Kenya	114	Zambia	5.7
Equatorial Guinea	106	Eritrea	5.7
Lesotho	101	Lesotho	5.5
Djibouti	90	Rwanda	5.5
Gambia	78	Morocco	5.1
Angola	70	Senegal	4.8
Senegal	63	Ghana	4.7
Guinea	61	Sudan	4.5
Ghana	60	Central African Republic	4.5
Central African Republic	58	Utd Rep of Tanzania	4.4
Uganda	57	Angola	4.4
Zambia	52	Benin	4.4
Mozambique	47	Mali	4.3
Mauritania	45	Sierra Leone	4.3
Togo	45	Liberia	4.3
Rwanda	44	Algeria	4.1
Cameroon	42	Egypt	3.9
Sudan	39	Niger	3.7
Malawi	39	Ethiopia	3.6
Benin	39	Mauritania	3.6
Guinea-Bissau	37	Burundi	3.6
Eritrea	36	Gabon	3.6
Nigeria	31	Guinea	3.5
Mali	30	Dem Rep of the Congo	3.5
Burkina Faso	27	Nigeria	3.4
Sierra Leone	26	Cameroon	3.3
Utd Rep of Tanzania	26	Swaziland	3.3
Congo	22	Burkina Faso	3.0
Niger	22	Libya	2.9
Burundi	19	Togo	2.8
Chad	17	Chad	2.6
Ethiopia	14	Somalia	2.6
Dem Rep of the Congo	12	Congo	2.1
Somalia		Equatorial Guinea	2.0

Source WHO World Health Report 2003

Political economy

The Kingdom of Swaziland is the second smallest country in Africa after Gambia. Natural resources include asbestos, coal, clay, hydropower, forests, small gold and diamond deposits, quarry stone, and talc. Environmental issues centre on the limited supplies of potable water; the depletion of wildlife populations due to excessive hunting; overgrazing; soil degradation; and soil erosion.

In this landlocked economy, subsistence agriculture occupies more than 60% of the population. Manufacturing features a number of agroprocessing factories. Mining has declined in importance in recent years: diamond mines have shut down because of dwindling accessible reserves; iron ore deposits (high grade) were depleted by 1978; and health concerns have cut world demand for asbestos. Today, the main earners of hard currency are exports of soft drink concentrate, sugar, and wood pulp.

Swaziland is heavily dependent on South Africa from which it receives four-fifths of its imports and to which it sends two-thirds of its exports. Remittances from the Southern African Customs Union and Swazi workers in South African mines substantially supplement domestically earned income. The government is trying to improve the atmosphere for foreign investment. Prospects for 2001 are strengthened by government millennium projects, increased road building and factory construction plans.³⁹

GDP per capita is Intl \$5,029 (Table 9).

Table 9 GDP per capita (Intl \$): countries of Africa, 2001

Country	GDP per capita (Intl \$)
Libya	8272
South Africa	7538
Tunisia	7183
Botswana	5747
Gabon	5514
Equatorial Guinea	5239
Swaziland	5029
Namibia	4918
Algeria	4104
Egypt	3901
Morocco	3887
Liberia	2965
Zimbabwe	2271
Côte d'Ivoire	2045
Congo	1936
Lesotho	1844
Guinea	1752
Togo	1608
Angola	1578
Kenya	1452
Senegal	1323
Central African Republic	1289
Djibouti	1288
Ghana	1272
Cameroon	1269
Mauritania	1257
Gambia	1214
Sudan	1112
Uganda	964
Nigeria	915
Zambia	906
Benin	888
Burkina Faso	886
Mozambique	805
Rwanda	799
Mali	700
Chad	656
Guinea-Bissau	630
Eritrea	629
Sierra Leone	606
Niger	604
Utd Rep of Tanzania	599
Burundi	529
Malawi	501
Ethiopia	382
Dem Rep of the Congo	346
Somalia	

Source WHO

ETHICS

According to Sibusiso Dlamini, ethical issues relating to palliative care cluster around notions of acceptability and accessibility. He writes:

Swaziland's health care system is basically divided into two. There is the modern western health system and the traditional indigenous system. Though this is not based on any research or survey in Swaziland, a majority of our terminally ill clients attend traditional healers either before or after attending the western or modern hospitals. In general, according to research, more than 70% of Swazis attend to the traditional healers either before or after attending the modern western health system.

The question could be: what role do our traditional healers play in palliative care? How is palliative care interpreted in the Swazi or African context? Does the Swazi traditional system have a palliative care concept?

Most clients with terminal illnesses might believe they were bewitched or possibly believe they are being punished by their ancestors for some wrong doings. That challenges the acceptability of the palliative care concept in the country. Though the government is now fully accepting the concept, clients fight for their lives till the end. Swaziland is one of the leading countries in Africa who are holding on to culture and traditions.

With approximately 200 000 HIV positive people and 20 000 terminally ill due to AIDS in the country, the health system is now overstretched. The country has approximately 2000 hospital beds in total. Approximately 18 000 of these clients are discharged home, while the home-based care programme is very poor. Though a number of nurses have been trained on basic palliative care, most of them have left the country or are in the hospitals. Home-based palliative care is highly compromised. At the same time those nurses who are trained on basic palliative care in the hospital have been allocated to other wards eg maternity hence their effect is questionable. In general only a few clients have access to palliative care.²⁹

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² MacDermott MD(1997) Common Country Assessment, Swaziland, published on the web at <http://www.ecs.co.sz/cca/index.htm>

³ Personal communication: Sibusiso Dlamini - 5 June 2003.

⁴ IOELC interview: Stephanie Wyer - 1 July 2003.

⁵ Personal communication: Thulie Msane - 16 June 2003.

⁶ IOELC interview: Major Brenda Greenidge – 26 July 2003.

⁷ World Vision International is an international Christian aid agency which was established in 1950 and focuses particularly on the needs of children. In 2002 the charity was active in 96 countries, See: <http://www.wvi.org/home.shtml>

⁸The Italian Co-operation is an initiative of the government of Italy. Established in 1987, it is intended to offer assistance to resource poor areas of the world, and has focused particularly upon Africa. See: <http://www.unccd.int/cop/reports/developed/2000/italy-summary-eng.pdf>

⁹ Women and Law in Southern Africa is an educational and research trust which operates in seven countries in Southern Africa.

¹⁰ This is a country wide AIDS support organisation, founded in 1993. See: <http://www.enda.sn/africaso.org/swazilandaidssupp.html>

¹¹ In 1999, Bristol Myers-Squibb Company, together with the Bristol Myers-Squibb Foundation, pledged \$100 million over a five year period to help South Africa, Botswana, Namibia, Lesotho and Swaziland find sustainable solutions for women, children and communities suffering from the HIV/AIDS epidemic in their countries. See: <http://www.securethefuture.com/>

¹² Maternal Life International is a Roman Catholic organisation which moves beyond contraceptive technology as a sole solution to the AIDA pandemic and attempts to address the broader needs of women in terms of obstetrical care, AIDS specific interventions and education . See: <http://www.maternallifeintl.com/locations.htm>

¹³ Swaziland Community-based Parish Nursing: See: <http://www.securethefuture.com>

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- ¹⁴ Personal communication: Thandiwe Dlamini - 22 June 2003.
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- ¹⁷ Personal communication: Thulie Msane - 18 Dec 2003.
- ¹⁸ Skillshare International see: <http://www.skillshare.org/>
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- ²⁴ Personal communication: Ingrid Watkins - 11 Nov 2003 and 6 Feb 2004.
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- ²⁶ ‘A New Robe’ parish nurse programme. See: http://apha.confex.com/apha/129am/techprogram/paper_22536.htm
- ²⁷ See: <http://www.cia.gov/cia/publications/factbook/geos/wz.html>
- ²⁸ This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.
- ²⁹ Personal communication: Sibusiso Dlamini - 18 June 2003.
- ³⁰ See: WHO statistics for Swaziland at: <http://www.who.int/countries/swz/en/>
- ³¹ Fact sheet 2002: The USG response to Swaziland’s HIV and AIDS epidemic Feb 1 2002 (US Embassy in the Kingdom of Swaziland). See: <http://usembassy.state.gov/posts/wz1/wwwhivfsheet.html>

³² Published by Swaziland Ministry of Health and Social Welfare.

³³ 7th HIV Sentinel Surveillance Report, 2000.

³⁴ See: <http://www.unaids.org/en/geographical+area/by+country/swaziland.asp>

³⁵ WHO Country Co-operation Strategy 2002-2005.

³⁶ Dlamini S. Palliative care in Swaziland. *Progress in Palliative Care* 2003;11(4):191-192.

³⁷ Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries. See:
<http://www3.who.int/whosis/country/compare.cfm?country=s&indicator=strPcTotEOHinIntD2000&language=english>

³⁸ Tandon A, Murray CLJ, Lauer JA, Evans DB. Measuring overall health system performance for 191 Countries. GPE Discussion Paper Series: No 30; WHO.

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