The Kingdom of Swaziland

MONITORING THE DECLARATION OF THE COMMITMENT ON HIV and AIDS (UNGASS)

SWAZILAND COUNTRY REPORT
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FOREWORD

The 2010 UNGASS report is a follow-up of the 2005/6 and the 2007/8 reports all of which provided useful information on the progress made towards attaining universal access and meeting the MDG's by 2015. The UNGASS process is not merely a data collection process to satisfy international reporting, but has become an institutionalised process that allows the country to take stock of the progress made in the fight against HIV and AIDS.

The country has made significant strides in the fight against HIV and AIDS. Today, through the use of Surveys, Surveillances and routine monitoring, we are better able to know our epidemic. The information provided by the first ever Demographic and Health Survey in 2007, has allowed the country to know the national prevalence rate, by age and region. Prior to the SDHS the country relied on information generated from Ante Natal Care Clients, that is, a group/cohort that was already engaging in sexual relations and thereby biasing the prevalence results. The Modes of Transmission Study 2009 further informs on the sources of new infections and the main modes of transmission. In Swaziland new infections are likely to occur among people aged 25 and older and heterosexual contact is the main mode of transmission.

The findings of this report highlight how the country has progressed in areas such as prevention of mother to child transmission and PLHIV survival through the successful provision of ART, and educational support for OVCs. Also notable is that the rate of civil society participation in the management of the HIV response has improved.

The UNGASS process allows us to interrogate the data and sources that form part of the national response. The process includes vetting of country data, consensus building around programming, and identifies gaps in the national M&E systems, that require further strengthening.

On behalf of His Majesty's Government, I would like to express gratitude to the UNGASS Core Team, the Ministry of Health, Civil Society organisations, Development Partners, the Public sector, and all the stakeholders that participated in the development of this important document. I would like to acknowledge NERCHA and UNAIDS for the provision of technical and financial support.

It is my sincere hope that this document will be used to inform policy makers, program managers to focus on their respective areas of speciality to enable the scale up of HIV interventions and close the gaps in the provision of quality services to the Swazi populace.

Derek von Wissell
Executive Director – National Emergency Response Council on HIV/AIDS (NERCHA)

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ACRONYMS

ABC	Abstinence, Be faithful and Condomise
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
AZT	Zidovudine
BCC	Behaviour Change Communication
CANGO	Coordinating Assembly of non Governmental Organisations
CBO	Community based organizations
CCM	Country Coordinating Mechanism
CMTC	Crisis Management and Technical Committee
COP	Country Operational Plan
CSO	Central Statistical Office
CT	Counselling and Testing
DPM	Deputy Prime Minister
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
FLAS	Family Life Association of Swaziland
GDP	Gross Domestic Product
GFTM	Global Fund to fight TB, HIV and AIDS and Malaria
GLP	Good Laboratory Practice
GMP	Good Manufacturing Practice
HAPAC	HIV and AIDS Prevention and Care Program.
HBC	Home-based Care
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling (Practitioner initiated)
IEC	Information, Education and Communication
MC	Male Circumcision
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEPD	Ministry of Economic Planning and Development
MOAC	Ministry of Agriculture and Co-operatives
MOE	Ministry of Education
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
MTPI	First Medium Term Plan
MTPII	Second Medium Term Plan
NAC	National AIDS Committee
NAP	National Action Plan
NASA	National AIDS Spending Assessment
NBTS	National Blood Transfusion Service
NCP	Neighbourhood Care Points
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Government Organisations
NSP	National Strategic Plan
NVP	Nevirapine
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Program for HIV and AIDS Response
PLWHA	People Living with HIV and AIDS
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSHACC	Public Service HIV and AIDS Coordinating Committee
QMS	Quality Management System
RHMS	Rural Health Motivators
SDHS	Swaziland Demographic and health Survey
SMP	Strategic Management Plan
SNAP	Swaziland National AIDS Program
SNBTS	Swaziland National Blood Transfusion Services
SOP	Standard Operating Procedures
STIs	Sexually Transmitted Infections
SW	Sex Workers
SWANNEPHA	Swaziland National Network for People Living With HIV and AIDS
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Internal Children's Emergency Fund (United Nations Children's Fund)
VCT	Voluntary Testing and Counselling
WFP	World Food Program
WHO	World Health Organisation
WLSA	Women and Law Southern Africa

CHAPTER II: STATUS AT A GLANCE

a) The inclusiveness of the stakeholders in the report writing process

The process of compiling the 2010 UNGASS Country Report was overseen by the UNGASS Core Team. The UNGASS Core Team comprised of representatives from civil society, People Living with HIV (PLHIV), Public Sector Aids Coordinating Committee (PSCHACC), Ministry of Health, Ministry of Education, UNICEF, UNAIDS and NERCHA. NERCHA and UNAIDS were selected as the secretariat of the process.

The functions of the UNGASS Core Team were to;

- Develop of a work plan for the process
- Review of the 2010 reporting guidelines
- Review of 2008 UNGASS report
- Decision on the type of Surveys to be undertaken
- Formulate terms of reference for the consultants
- Identify and engage consultants
- Identify, verify the sources of data and focal persons
- Data vetting
- Uploading of country data into the UNGASS 2010 Online Data Entry (CRIS database)
- Revision of report drafts
- Presentation of UNGASS country report to national stakeholders

In accordance with the UNGASS guidelines for 2010 reporting, the Core Team used the following tools; Review of secondary data; review of routine and surveillance data that is integrated to national monitoring and evaluation frameworks in the Ministry Health and NERCHA; use of modelled data from Spectrum and EPP; Structured one-on-one interviews based on key questionnaires; and Special Surveys (Most-at-risk populations Survey and Life Skills-Based HIV Education Survey).

Key documents perused included Quarterly Service Coverage Reports from NERCHA, Swaziland Demographic and Health Survey (SDHS 2007); draft HIV Estimates and Projections Report 2009; Modes of Transmission report (2009), National Aids Spending Assessment report (NASA 2007), Health Sector Response Plan (2009-2013), HIV Sentinel Surveillance Report (2008), Service Availability Mapping Report (2008), and NERCHA Annual M&E Report (2009).

Key informant interviews for the National Composite Policy Index (NCPI) were conducted with policymakers and various programme heads.
For the Government Policy section, the respondents were MoH, PSHACC; Deputy Prime Minister's Office, Ministry of Justice and NERCHA. For the NGO bilateral and multilateral AIDS agencies, representatives comprised of Women and Law of Southern Africa – Swaziland chapter; CANGO; AMICAALL; SWANNEPHA; FLAS; multilateral and bilateral agencies: UNAIDS; UNICEF; PEPFAR.

The consultative and validation forum for the national stakeholder meeting was held on the 2nd March 2010. Stakeholders included government, civil society organisations and PLHIV, private sector, development partners and non government organisations. Draft indicator findings were presented, discussed and adopted by the stakeholders.

b) The Status of the Epidemic

Swaziland has one of the highest HIV prevalence rate in the world, 26% (31% women and 20% men) SDHS, 2007 and a high estimated HIV incidence rate of 2.9% compared to other countries in the region (MOT, 2009). The National Multisectorial Strategic Framework for HIV and AIDS (NSF 2009-2014) states that the country has a generalised hyper-endemic HIV prevalence, with HIV firmly established in and spreading through the general population.

According to the SDHS, significant variations exist by sex and age. For instance, within the 15-49 year age group, female prevalence is 31% and male prevalence is 20%. Highest prevalence rates are observed among the 25-29 year age group for women and 35-39 years for men at 49% and 45%, respectively. Prevalence in adults aged 50 and older is 14% and 4% in young children aged 2 – 14 years. The HIV Sentinel Surveillance (2008) prevalence rates in pregnant women attending ANC aged 15-49 years is 42%, with variations in age groups, (15 – 19 years 12% , 20 – 24 years, 38% and 25 – 29 years, 49%) .

The HIV population is projected to be 185, 803 in 2009 and is projected to increase to 216,735 by 2015. New infections in adults are projected to slightly decrease from 12,281 in 2009 to 11,381 in 2015. On the other hand, AIDS deaths are projected to increase from 7,114 to 8,389 during the same period. However, early enrolment on ART as well as adherence may improve PLHIV survival.

According to the MOT 2009, the major mode of HIV transmission is through heterosexual contact. The MOT showed that new infections are likely to occur in adults aged 25 years and above, many of whom are assumed to be married or cohabit with a steady partner. Furthermore, the majority of new infections (62%) occur in females.

Due to the illegal nature of sex work, IDU and MSM, prevalence data relating to these groups is lacking. Behavioural information on female sex work has been collected through mini-surveys done by various stakeholders. Evidence of Homosexual transmission (men having sex with men), internationally defined as a most-at-risk group, is insufficient in Swaziland. However, modelling data based on regional defaults estimates this population as 2% of the male population aged 15-49. In addition, research into the extent of injecting drug use (IDU) is limited in the country.

Plans are underway to conduct a Behavioural Surveillance Survey in 2010 that will inform the country about the most-at-risk populations and their behavioural patterns. The Multiple Cluster Indicator Survey, also scheduled for 2010, will further provide internationally comparable and statistically rigorous data about the situation of children and women.

Vertical transmission of HIV from mother to child occurs during pregnancy, child birth and breast feeding. With the introduction of the MTCT prevention programme in 2003, the percentage of HIV positive infants born to HIV infected mothers has been lowered to 16.9%.

A high TB incidence rate is attributable to the severe HIV epidemic having increased six fold over the last 15 years. The 2006 HIV Sentinel Surveillance Survey reported estimated prevalence of HIV among TB patients as high as 79.6%. Moreover, in 2008 routine surveillance data for HIV infection among TB patients reported 84% HIV positive testing (based on 70% of all registered TB cases).[1]

[1] NERCHA National HIV and AIDS Response Annual report (2009)

The impact of HIV has permeated every aspect of Swazi society. The extended family unit, a mainstay of Swazi culture, has been over stretched and this is compounded by rising unemployment, drought and lower national production. HIV has given rise to the number of orphans and vulnerable children, child-headed families, grand-parent headed families and single parent families. The major challenge for Swaziland's HIV and AIDS response remains that of halting the spread of HIV and reversing the impact on the society. The country has conducted the Quality of Impact Mitigation Survey in 2009 and is at the report preparatory stage. The QIMS will inform about the timeliness, reliability and effectiveness of mitigation services in order to influence the design of a more coherent response and of greater relevance to the impact of HIV in Swaziland.

THE POLICY AND PROGRAMMATIC RESPONSE

The following Policies have been put in place during the reporting period 2008-2009;

National Strategic Framework 2009

The NSF was launched in September 2009. It identifies the drivers of the epidemic as; poverty, multiple and concurrent sexual partnerships, low and inconsistent condom use, intergenerational sex, early sexual debut, and low HIV testing and disclosure. The NSF is results based and evidence informed with tangible targets aimed at reducing the incidence rate, promoting safer sexual behaviour, improving the quality of life for PLHIV and enabling households to cope with the effects of HIV and AIDS. The ultimate goal of the NSF is to improve the Swaziland Human Development Index from 0.542 in 2008 to 0.55 in 2014.

National Male Circumcision Policy 2009

Launched in August 2009, the National Male Circumcision Policy provides guidance on how male circumcision should be implemented. Also in place are a national MC implementation plan and protocols, as well as a draft communication strategy. The aim of the Policy is to scale up male circumcision as a proven prevention strategy, alongside other prevention interventions. Targeted age groups include boys and men aged 15 to 24 years and neonates.

National Policy on Children 2009

The policy aims at providing policy guidelines to ensure that appropriate interventions are put in place to adequately care for and protect children in general; and orphaned and vulnerable children in particular.

National Social Development Policy 2009

This policy seeks to promote and protect the rights of all vulnerable groups and their dependents, promote gender equality and mitigate the effects of HIV and AIDS. Strategies of the policy include the strengthening capacities of communities and families to support the needs of the poor and vulnerable, to provide social assistance and relevant psychosocial support, and promote social integration of particular vulnerable groups and family empowerment.

UNGASS indicator data in an overview table

Table 1 below summarises the trends of UNGASS indicators over the past two years, 2007/8, and 2008/9. It includes the overall rating of efforts to enforce existing policies, laws and regulations, the implementation of HIV prevention and HIV Treatment, Care and Support programmes. The country has made significant progress in the area of Treatment, Care and Support. ART enrolment has increased over the years and PMTCT has improved infant survival. There is still a challenge in the implementation of HIV prevention and management programs. Financial and human capacity constraints have been highlighted as major setbacks among implementing organisations.

Table 1: Overview of UNGASS indicator data report

UNGASS Indicator Number	Indicator	2007	2008	2009
1	Domestic and International AIDS spending by categories and financing sources	E346,128,488		
2 Government view	Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2009 and in 2008	7	-	6
	Overall, how would you rate political support to AIDS programmes in 2009 and in 2008	7	-	7
	Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009 and in 2008	6	-	6.5
	Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children	7	-	7
	Overall, how would you rate the M&E efforts of the AIDS programme in 2009 and in 2008	7	-	6
2 Non Govt organisations, bilateral agencies and UN organisations' view	Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2009 and in 2008	5	-	6
	Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009 and in 2008	3	-	3
	Overall, how would you rate the efforts to increase civil society participation in 2009 and in 2008	4	-	6
	Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009 and in 2008	6	-	7
	Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009 and 2008	5	-	6

UNGASS Indicator Number	Indicator	2007	2008	2009
3	Percentage of donated blood units screened for HIV in a quality assured manner	100%	100%	100%
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	35.4%	52.9%	89.2% (59.2%)
5	Percentage of HIV-positive pregnant women who received anti-retroviral drugs to reduce the risk of mother-to-child transmission	64.8%	65%	69%
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Incomplete data	No new data	Incomplete data for the numerator
7	Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results	Overall: 16% Women: 22% Men: 9%	Overall: 16% Women: 22% Men: 9%	Overall: 16% Women: 22% Men: 9%
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	76.4%	No new data	76.9%
9	Percentage of most-at-risk populations reached with HIV prevention programmes	76.9%	No new data	100%
10	Percentage of orphaned and vulnerable children aged 0 -17 whose households received free basic external support in caring for the child	At least one type: 41.2% Received all: 0.2%	At least one type: 41.2% Received all: 0.2%	At least one type: 41.2% Received all: 0.2%
11	Percentage of schools that provided life skills-based HIV education in the last academic year	Overall: 50.5% Primary school: 43.5% Secondary/High school: 70.8%	No new data	Overall: 50.5% Primary school: 43.5% Secondary/High school: 70.8%

UNGASS Indicator Number	Indicator	2007	2008	2009
12	Current school attendance among orphans and among non-orphans aged 10-14 (ration or orphans to non-orphans school attendance percentage)	Orphans: 91.4% Female-85.6%; Male -94.7% Non-orphans: 92.6% Female -93.7%, Male: 91.6%	Orphans: 91.4% Female-85.6%; Male -94.7% Non-orphans: 92.6% Female -93.7%, Male: 91.6%	Orphans: 91.4% Female-85.6%; Male -94.7% Non-orphans: 92.6% Female -93.7%, Male: 91.6%
13	Percentage of young women and men aged 15 – 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major conceptions about HIV transmission	Overall: 52.2% Women: 52.1% Men: 52.3%	Overall: 52.2% Women: 52.1% Men: 52.3%	Overall: 52.2% Women: 52.1% Men: 52.3%
14	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major conceptions about HIV transmission	46.2%	No new data	32.2%
15	Percentage of young women and men aged 15 – 24 who have had sexual intercourse before age of 15	Overall: 5.9% Women: 6.9% Men: 4.8%	Overall: 5.9% Women: 6.9% Men: 4.8%	Overall: 5.9% Women: 6.9% Men: 4.8%
16	Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months	Overall: 7% Female: 1.6% Male: 13.6%	Overall: 7% Female: 1.6% Male: 13.6%	Overall: 7% Female: 1.6% Male: 13.6%
17	Percentage of women and men aged 15 – 49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Women: no data Men: 56.2%	Women: no data Men: 56.2%	Women: no data Men: 56.2%
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	98%	No new data	87.4%
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No new data	No new data	Not reported on as No new data is available

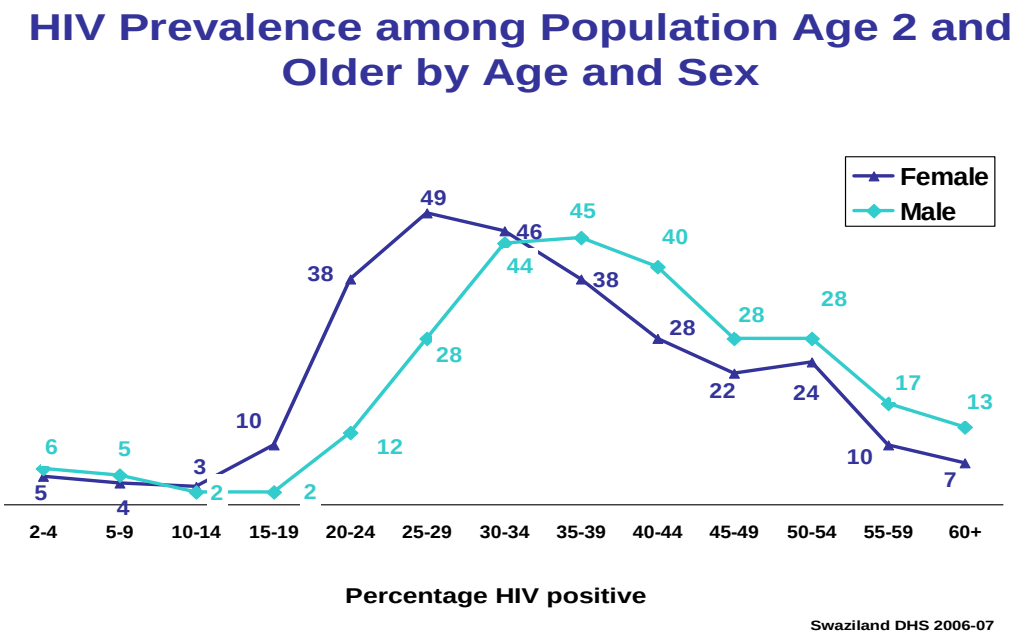
UNGASS Indicator Number	Indicator	2007	2008	2009
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No new data	No new data	Not reported on as No new data is available
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No new data	No new data	Not reported on as No new data is available
22	Percentage of young people aged 15 – 24 who are HIV infected	ANC 34.6% (2006 report)	ANC 38.1% SDHS; Overall: 14.4% Women: 22.9% Men 5.9%	ANC 38.1% SDHS; Overall: 14.4% Women: 22.9% Men 5.9%
23	Percentage of most-at-risk populations who are HIV infected	No new data	No new data	Not reported on as No new data is available
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	64%	No new data	Overall = 77.3% Children = 78.2% Adults = 77.1%
25	Percentage of infants born to HIV-infected mothers who are infected	-	21.5%	16.9%

CHAPTER III: OVERVIEW OF THE AIDS EPIDEMIC

The Kingdom of Swaziland borders Mozambique to the East and the Republic of South Africa to the South, North and West. It occupies a surface area of 17, 364 km^2. The country is divided into four administrative regions: Hhohho, Manzini, Lubombo and Shiselweni. Swaziland's HIV response mirrors the globally approved principles of "The Three Ones", that is One National HIV Strategic Framework, One Coordinating Structure (NERCHA) and One Monitoring and Evaluation System.

According to the 2007 Population Census, the current population of Swaziland is 1,018,449. The intercensal growth rate is 0.38%, indicating decline in fertility coupled with an increase in mortality. Swaziland is among the worlds worst HIV-affected countries with a sero-prevalence of 26% among adults aged 15-49 years (31% for women and 20% for men) and 19% for the population 2 and older (SDHS 2007). As shown in figure 1 below, HIV prevalence level by age peaks earlier among females than males, at 25 -29 years and 35-39 years, respectively.

Figure 1: HIV prevalence among population aged 2 and older by age and sex



HIV prevalence among pregnant women seeking antenatal care in government health facilities is even higher. According to the HIV Sentinel Surveillance conducted in 2008, 42% of ANC clients were HIV positive. This shows a rapid increase from 4% in 1992, to 42.2% in 2005, slight reduction to 39% in 2007 and 42% in 2008.

The Modes of Transmission report estimates that over 90% of all new infections occurred through heterosexual contact, that 68% of new infections occur in persons above 25 years of age and a majority of these infections occur among women.

This pattern is confirmed by the antenatal sentinel surveillance results which shows that, over time, HIV prevalence among younger age groups has declined whereas that of older women increased as the epidemic has matured. HSS data reflects that HIV prevalence within the age group 15-19 was 32.5% in 2002 and is now 26%, while that of women aged 30-34 years was 29.6% in 2002 and has almost doubled to 49.1% by 2008.

IMPACT OF THE EPIDEMIC

The impact of HIV is manifested through an increase in the mortality rate and subsequent decline in life expectance, from 60 years in 1990s to 31 years by 2007. The crude death rate has more than doubled from 13.1 deaths per 1,000 population in 1997 to 31.1 deaths per 1,000 population in 2007. Annual AIDS deaths are projected to increase from 7,114 in 2009 to 8,389 by 2015. Without intervention, that is ART, AIDS death projections were estimated to be 21,730 by 2015. The population projection for 2015 is estimated to be 1, 12 million, about 37% lower that it would have been in the absence of AIDS (United Nations, 2007).

The impact of the epidemic continues to be manifested among children. HIV has contributed to the increase in the number of orphaned and vulnerable children, which are estimated to be 15% of the population. This has overwhelmed the capacity of the extended family to cope, resulting in an increased number of child headed households, poverty and destitution.

HIV continues to have an impact on labour at all levels, either through prolonged illness, absenteeism or death. A study of three central ministries of Finance, Economic Planning and Development, and Public Service and Information, alludes to the fact that reduced productivity, shortages of skilled manpower, increased mortality in the work force, increased absenteeism and rising medical costs would be the major effects resulting from the HIV/AIDS epidemic (Assessment of the Impact of HIV and AIDS On The Central Ministries of The Government of Swaziland, June 2002).

The health sector suffers the burden of HIV in several ways. Not only has the sector been required to provide additional health services, but they have also had to cope with reduced workforce that is not immune to HIV infection. For instance, 50% of available hospital beds are occupied by HIV and AIDS related patients.

The education sector has been equally hard-hit, compromising the quality of education as more teachers succumb to AIDS and increased absenteeism and increased pupil teacher ratio.

Due to the negative effect on labour productivity, HIV has seriously affected the outputs of key sectors and ultimately the Gross National Product (GNP). Evidence from several studies show that the main cost to society is not the direct cost of prevention efforts and medical care, but rather the cost resulting from decline in outputs and the complex less easily estimated social disruptions and instability.

CHAPTER IV: NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The National Policy Environment and Strategic Framework

The Swaziland response to HIV was historically anchored in the Ministry of Health. The government established the Swaziland National AIDS Programme (SNAP) within the Ministry of Health to lead the HIV response. As the impact of the epidemic became evident, it became necessary that a more developmental approach with a multisectoral angle would be more appropriate. Highest political commitment to the fight against HIV was demonstrated in 1999, when His Majesty King Mswati III declared HIV as a national disaster. In 2002, the National Emergency Response Council on HIV and AIDS (NERCHA) was established to facilitate the coordination and implementation of the multisectoral response. Through this structure the country has formulated and launched an HIV and AIDS Policy (2006), two National Strategic Plans and a functional national M&E system that is aligned to other national and international systems.

The objective of the National Strategic Plan 2006-2008 was to guide implementation of the response to prevent the spread of HIV, decrease vulnerability of individuals and communities to HIV and to care for those living with HIV and reduce the adverse socio-economic effects of the epidemic. A joint review of the NSP was undertaken in 2008 and culminated in the development of the National Strategic Framework 2009-2014. The NSF, developed in 2008 through multisectoral consultation, includes reasonable targets that the country aims to achieve by 2014. The goal of the NSF is to improve the Swaziland Human Development Index, from 0.542 in 2008, to 0.55 in 2014. This is in realisation of the negative impact that HIV has made on labour productivity and national output. The NSF outlines the role and responsibilities or all partners who are contributing in the fight against HIV and AIDS in the country. An M&E Framework was developed to guide the monitoring and evaluation of the NSF in line with the Results Framework.

This chapter discusses how the country has made progress in each of UNGASS indicators.

Indicator 1:
Domestic and international AIDS spending by categories and financing sources

A National AIDS spending assessment was conducted in the period 2005 to 2007. In 2008/2009 the NERCHA annual reports financial section based on an accounts policy provides information on total HIV and AIDS spending for 2007/8 and 2008/9 (based on the calendar year April 1st to March 31st). Total spending on HIV and AIDS by NERCHA was: E139, 100,368 in (2007-2008) and E103, 775,408 in (2008-2009). The financial report was based on funding sources: Swaziland Government Grants, Global Fund Round 2, 4 and 7; American Institute for Research grant, Young Heroes grant, and UNDP grant.

The categories highlighted in the national financial report are: HIV & AIDS Programme Expenses, Prevention, Care and Support, Impact mitigation, Sector Support, Monitoring and Evaluation, Administration, Regional Coordination, Information Centre. The categories and sub categories of the national funding matrix for the UNGASS reports are not used in the annual financial report.

Indicator 2:
National Composite Policy Index (areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)

The National Composite Policy Index (NCPI) measures the extent to which countries have developed policies and strategies on HIV and AIDS in the broad areas of: political support, Strategic planning, human rights, HIV prevention, Treatment, Care and Support, and Civil society involvement in the response. A number of specific Policy indicators were identified for these policy areas. The composite index is an average score (on a scale of 0-10) of the components.

Part A of the NCPI was intended for policy makers and focal persons at NERCHA, Ministry of Health, Ministry of Justice, Ministry of Economic planning and Development, and the Public Sector HIV and AIDS Coordinating Committee.

Part B of the NCPI was intended for civil society organisations which including; people living with HIV, the UN organisations, the USG, AMICAALL, FLAS, WLSA, CANGO.

1) The Government perspective

The key informants for the Government perceptive included Ministry of Health, NERCHA, Deputy Prime Ministers Office, Ministry of Justice, and PSHACC. The following is a summary of the views of the key informants in the areas that included: strategic planning; political support; prevention; treatment, care and support; monitoring and evaluation; and policy development and implementation status.

Strategic Plan

The country developed a first national multisectoral strategy 2000-2005. A second strategic plan was developed for 2006-2008 and a new national multisectoral strategic framework for HIV and AIDS (2009-2014) has been developed. All strategies included key sectors such as: Health, Education, Labour, Military/Police, women and young people. Prior to the development of the NSF a needs assessment was conducted in 2008/2009 to identify population groups that need to be targeted. Targeted groups include: women and girls, young women and young men, orphaned and vulnerable children and the elderly and disabled persons. Subpopulations that were classified as Most-at risk include commercial sex workers, migrant/mobile and prisoners. Injecting drug users and MSM are not included in the NSF.
Key informants reflected that the major challenges as; the strategic framework was not adhered to; response was donor driven, as opposed to being guided by the priorities set in the National Strategy, over reliance on donor financial support; and the implementation of programmes that were not in the national strategy. Informants also noted the need to develop an operational plan for the NSF, as the HIV road map would be expiring at the end of March 2010.

Political support

There is good political support at high Government level with political and traditional leaders including His Majesty the King speaking about HIV and AIDS at national functions. HIV is integrated in many national documents, namely the National Development Strategy, Poverty Reduction Strategy and in development partners' strategies. The Swaziland Government is committed to the fight against HIV and provides expenses for 35% of the HIV and AIDS programme. NERCHA is placed within the highest government office, the Prime Minister's office, while the social security and welfare portfolio rests at the Deputy Prime Ministers Office.

Swaziland has an officially recognized national multisectoral AIDS coordination body, NERCHA; members of the NERCHA Council include representatives from civil society organisations, people living with HIV, traditional leaders, and the private sector. Government has demonstrated high political support in the response to HIV and AIDS, through planning, budgeting and implementing HIV and AIDS programmes in the country. There exists a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies and programmes.

In creating an enabling environment, the country has development laws to protect its citizens. These include; Human Trafficking Act 2009, Sexual Offences and Domestic Violence Bill, review of the Marriage Act, review of Deeds registry, review of the administration of Estates and by providing Free Primary Education.

Challenges highlighted included: the absence of role playing through demonstrating corrective behaviour by leaders, slow rate of enactment for important laws, the lack of adequate coordination of response; failure to correctly align HIV programmes to National Development Strategies, duplication of efforts and lack of resource mobilisation strategy for the NSF. Informants noted that financial commitment from Government can and should be improved seeing that the bulk of the HIV budget is provided by donors and partners, as reflected in the NASA 2008.

PREVENTION

There has been some notable increase in the implementation HIV prevention programmes over the years. The NSF has defined priority programmes that need to be implemented so as to achieve the national and regional HIV response results. For the HIV prevention programme: primary programmes focus on social and behaviour change communication; male circumcision; PMTCT programme; and condom distribution programme. Secondary programmes focus on HIV prevention among most-at-risk populations; blood safety; and treatment and prevention of sexually transmitted infections.

The PMTCT programme has set strategies for scaling up its interventions. Centres providing PMTCT services have increased from 110 to 132 in 2008 (SAM, 2008). The number of pregnant women who received a course of ARV prophylaxis to reduce MTCT is 65% (UA report 2008). The condom logistics, promotion and management programme has been widespread to the general population. A total of 7,200,000 condoms were distributed free or sold to end-users by HIV implementers from April 2008 to March 2009 (NERCHA M&E Annual Report 2009).

Behavioural change is still a challenge in spite of the programmes in multimedia campaigns and community interventions. A scaling up of strategies targeting the youth is planned through schools, youth centres and community level activities. According to the Baseline survey of life skills education in schools done in 2009, HIV and AIDS, gender and life skills education related issues have been integrated into a number of mainstream subjects in the curriculum at the primary education level.

These subjects include English, Science and social Studies. However, at secondary and high school levels HIV and AIDS, gender and life skills related issues have not been integrated into the school curriculum. The Ministry of education encourages schools to allocate time (40 minutes per week) into their timetable for counselling and guidance activities. These activities include HIV and AIDS, gender, career guidance and other contemporary issues.

Challenges in prevention include the non-recognition of subpopulations, namely the MSM, IDU and as a result there are no programmes that are tailor made for the groups. Prisoners are classified as MARPS but local regulations do not allow the distribution of condoms to prisoners. The lost opportunity for integrating HIV prevention into the sexual reproduction health was also identified as a challenge for prevention.

TREATMENT, CARE AND SUPPORT

Since the introduction of the ART programme in 2003, there has been an increase in the number of PLHIV enrolled and initiated on ART. Paediatric ART is further supported by early enrolment of positive children. The NSF has defined the primary and secondary programmes to be focused on HIV testing and counselling programme; management of Tuberculosis and HIV co-infection programme.

The MoH has developed a quality assurance programme that looks at standards in service delivery. In an effort to improve drug procurement and management, a procurement unit has been created and country is in t he process of constructing regional warehouses.

What remains a challenge is the inadequate health infrastructure to enable effective service delivery, low levels of HIV testing, lack of human resource and accessibility of treatment and care to rural areas.

MONITORING AND EVALUATION

The country has a national monitoring and evaluation framework that recently underwent revision to align it to the NSF. The development of the M&E Framework was consultative and all-inclusive with the endorsement of key development partners, i.e. the World Bank, UNAIDS and United States Government.
The M&E framework addresses all the essential components of a functional M&E system including a data collection strategy, a standardised set of indicators, HIV surveillance/research/evaluations, data analysis and data use strategy, etc. Approximately 7% of total HIV programme funding is earmarked for M&E (NASA 2007). An M&E TWG has been in existence since 2006 and serves to coordinate all HIV M&E related issues. Since 2007, notable achievements in the area of M&E have been the design of a new strategic plan, revision of the national M&E framework.

Other achievements not mentioned by the key informants include, undertaking of several surveys such as the Modes of Transmission Study, the Service Availability Mapping, the NASA, the design of the QIMS protocol and capacity building in M&E concepts, and in modelling and size estimations methodologies.

Monitoring and Evaluation is coordinated by NERCHA, who compiles quarterly service coverage report containing both clinical and non-clinical information. The NERCHA M&E unit is fully staffed with four permanent but new staff, most of whom were recruited in 2009. The National M&E unit has been capacitated with staff and has received training on M&E concepts. All the country's four regions are capacitated with a regional M&E officer.

The Ministry of Health continues to monitor clinical data. Within the MoH, a Strategic Information Department has been established that comprises of three units, namely, M&E, Health Management Information System (HMIS) and Research.

Challenges highlighted are lack of resources required by partners to provide effective services, poor usage of data and reports, late feedback, need for capacity strengthening in the regions and implementing partners. Other shortcomings in M&E include low levels of reporting, uncoordinated reporting efforts and poor strengthening of the research function of M&E. Moreover, even though all regions have HIV and AIDS Regional Coordinators and M&E officers, training is still outstanding.

vi) Policy development and implementation status

The ranking was: 0 = poor, ..., 10 = good

Table 2: Policy development and implementation status (Government view)

Indicator	Year 2003	Year 2005	Year 2007	Year 2009	Comments
1.1 Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2009, 2007 and in 2005	6	4.5	7	6	• HIV programmes are weak and activity based • Low level of implementation • Budget and programmes are donor driven • NSF has not been costed
1.2 Overall, how would you rate political support to AIDS programmes in 2009, 2007 and in 2005?	5	4.5	6.5	7	• Increase in the domestic budget (government) • High level of political commitment • Reliance of donor resources
1.3 Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009, 2007 and in 2005	5	4.5	6	6.5	• NSF developed chapter on prevention with targets • Increase in the number of campaigns through media • Increase of Community campaigns
1.4 Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children in 2009, 2007 and in 2005	7	5	7	7	• OVC education bursary improved school attendance for OVC • Introduction of Free Primary Education in 2010 • The existence of Neighbourhood Care Points (NCPs) • Resource constraints • Deepening of poverty status of orphans and vulnerable children • No national HTC plan for OVC, child-headed homesteads

1.5 Overall, how would you rate the M&E efforts of the AIDS programme in 2009, 2007 and in 2005	1	4	7	6	• New M&E Framework designed to be in line with the NSF • Resource constraints • Low and late reporting • Late feedback • Data analysis is weak • High attrition
1.6 Average score Government only	4.8	4.5	6.7	6.5	

2) The Civil Society Perspective

Key informants for civil society organisations included, Swaziland networks of people living with HIV (SWANNEPHA); umbrella body for non-governmental organisations (CANGO); human rights group (Women and Law in Southern Africa- Swaziland WLSA); Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL); Family Life Association in Swaziland (FLAS); UN organisations (UNAIDS); Bilateral agencies (PEPFAR).

The following is a summary of the views of the key informants in the areas that included, human rights; civil society participation; prevention; prevention; treatment, care and support; policy development and implementation status.

Human rights

Civil Society presented the view that the country's laws and regulations protect people from discrimination of any nature but are not specific to HIV and AIDS. Companies have workplace HIV policies which are informed by the ILO - HIV and AIDS codes of practice, but the general feeling is that these policies are not implemented. Due to the illegal nature of some of the activities of most-at-risk populations, local laws and regulations that protect these sub-populations are lacking. All civil society informants identified a general lack of laws and regulations particularly for the MARPS sub-populations such as commercial sex workers, men having sex with men and injecting drug users. Moreover, there has not been any size estimation of the MARPS. Using regional default, the Modes of Transmission study estimated MSM as 1% of all men in the country, 0.1% of men and 0.8% of females as commercial sex workers and IDU as 0.2% of adult population.

Civil Society participation

Civil society participation in the response has slightly improved from a rating of 4 in 2007 to 6 in 2009. Civil society is involved a number of HIV and AIDS programmes key amongst them are; global fund activities through their involvement as members of the Country Coordinating Mechanism (CCM) and in the development of the NSF. There has also been an increase in funding from the global fund for civil society particularly in Round 7. Similarly, Government has increased subvention funding for the civil society.

However, civil society participation is impeded by poor coordination, limited financial and technical support and a general lack of harmony between government and civil society.

Prevention

The country has embarked on several studies and consultations with civil society on prevention. There is a move to provide evidence informed prevention initiative, such as: MC; PMTCT, which are coupled with community mobilisation activities that promote HIV prevention. Challenges identified include: poor condom distribution efforts; absence of coordination of community HIV prevention activities, lack of appropriate behaviour change.

Treatment, Care and Support

In general, civil society appreciates the great strides taken by the country in providing treatment, care and support for people living with HIV and AIDS. Some challenges identified include delays in ART enrolment; limited access to treatment in rural areas; poor compliance to treatment; poor opportunistic infections drug supply management and that not all workplaces provide treatment, care and support to their employees.

Civil society appreciates that the country has policies and strategies that support the needs of orphans and other vulnerable children. Pivotal efforts include the National Plan of Action for OVCs, educational bursary for OVC; neighbourhood care points and the move to provide free primary education in 2010. However, care is not comprehensive enough – as evidenced by the absence of care institutions and results in lack of parental guidance for OVCs.

v) Policy development and implementation status

The ranking was: 0 = poor, ., 10 = good

Table 3: Policy development and implementation status (Non-Government organisations view)

Indicator	Year 2003	Year 2005	Year 2007	Year 2009	Comments
1.1 Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2009, 2007 and in 2005 1.2	-	2	5	6	• Long process of adopting bills into laws • Compliance to policy is not mandatory • Absence of legislation to effectively address violence perpetrators • Criminalisation of activities of sub-populations' denies them of legal protection
1.3Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009, 2007 and in 2005	-	2	3	3	• Slow enactment of laws and policies • Inadequate resources for implementation
1.4 Overall, how would you rate the efforts to increase civil society participation in 2009, 2007 and in 2005	-	4	4	6	• Involvement in policy formulation has increased • Representation in key formations has increased • Effective participation remains a challenge
1.5 Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009, 2007 and in 2005	-	5	6	7	• lack of and/or poor coordination of prevention interventions • Absence of condom distribution strategy • Some sub-populations special needs are not addressed

Indicator	Year 2003	Year 2005	Year 2007	Year 2009	Comments
1.6 Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005	-	3	5	6	• Scaling up of ART programme • Poor drug procurement and patient monitoring • Poor accessibility to ART services in rural areas
1.6 Average score (Civil Society, Bilaterals and Multilaterals)	-	3.4	4.6	4.8	

PREVENTION

As reflected in the NSF, the prevention strategy for Swaziland aims to reduce the number of new infections, that is, the incidence rate, from 2.9% in 2008 to 2.4% by 2014. As a result, prevention interventions in the country are designed to reduce exposure to HIV infection, reduce the probability of transmission when exposed, and influence change in societal norms, values and practices. Programmes in place include: Behavioural Change Communication (BCC); PMTCT; STIs; Blood safety; condom usage; male Circumcision (MC); Post Exposure Prophylaxis (PEP); and Workplace HIV program. Prevention programmes such as PMTCT, ART, VCT, STI and HTC services can be accessed without any payments in health facilities.

Existing policy bodies on HIV prevention are multisectoral in representation and their functions are holistic in that they deal with the response from the different perspectives of individual, community, urban and rural settings. The NERCHA council itself is multisectoral by including members from public sector, private sector, civil society (NGO, FBO, PLHIV organisations), Youth Council and traditional leaders. However, the absence of a national prevention technical working group has resulted in national prevention efforts being addressed in singular programmes than as joint and complementary prevention strategies.

Indicator 3:
Percentage of donated blood units screened for HIV in a quality assured manner [100%]

The Swaziland National Blood Transfusion Services (SNBTS) in Manzini is a centralized facility for blood donation and all Health facilities in the country receive blood from the SNBTS. Services provided by SNBTS include screening of blood for HIV and other transfusion-transmissible infection such has HCV, syphilis and malaria (blood from malaria infested areas). According to the SNBTS, all donated blood units are tested for transfusion transmissible infections in a quality assured manner and adherence to procedures in compliance with the Quality Management System (QMS) for Blood Centre.

For external quality assurance, the SNBTS uses the National Reference Laboratory because it is independent of the blood transfusion services. Participation in an External Quality Assessment Scheme, for all the infectious markers was suspended due to lack of funding. It is estimated that Swaziland requires between 18,000 to 20,000 units of blood annually based on the standard of 2% requirement of the total population. In 2009, 12000 units of blood were donated and all was tested for transfusion transmissible infections. From the total units 1% was HIV positive, 4% hepatitis B, 0.01% hepatitis C, and 0.01% syphilis and consequently 9800 units were usable and distributed as safe blood for transfusion in health facilities.

Indicator 5:
Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission [69%]

The objective of the PMTCT program is to ensure that all pregnant women testing positive are given PMTCT and provided a more efficacious regimen. Swaziland has adopted the four-pronged approach to the prevention of HIV infection in women and infants. This includes;

i) Primary prevention of HIV infection among women of child-bearing age,

ii) Prevention of unintended pregnancies in HIV positive women,
iii) Reduction of mother-to-child transmission (MTCT) by provision of prophylaxis, and
iv) Treatment, care and support for HIV positive women their infants and families (NSF, 2009-2014).

According to the PMTCT operational plan 2007 -2011, PMTCT services are to be integrated into all facilities providing ANC .The minimum package for PMTCT include comprehensive ANC for pregnant women, HTC; ART or ARV prophylaxis; infant feeding; young child counselling and support; follow-up services and continuum of care including linkages to treatment and care. Currently PMTCT services are offered in 79% out of the 172 health facilities providing ANC (SAM, 2008). The country uses three regimes for PMTCT, these are; single dose NVP; dual therapy (NVP and AZT) and ART.

As shown in table 4 below, in 2009 out of a total of 36,882 estimated pregnancies, 69.9% were tested for HIV, of those tested 39.8% tested HIV positive. From the HIV positive women, 8182 received ARVs for PMTCT: 1831 single dose NVP, 4507 dual therapy (NVP and AZT), 1844 ART. The programme has seen an upward trend from 2007, where 64% of pregnant mothers received ARVs for PMTCT to 69% in 2009. The challenge for the programme remains to strength prong 2, as routine monitoring trends observe more women presenting at ANC with known positive status.

Table 4: Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT 2007 – 2009

Indicator	2007	2008	2009
Estimated number of pregnant women	40,000	40,000	36,882
Number of women needing PMTCT	13,278	13,115	11,913
Number receiving ARVs for PMTCT	8,542	8,469	8,182
Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT	64%	65%	69%

Source: HMIS 2009

In an effort to maximise opportunities to reduce the risk of mother-to-child HIV transmission, the PMTCT is integrated into all existing sexual, reproductive and maternal and child health programmes. The target of the programme is to implement a comprehensive PMTCT in at least 95% of the health facilities by 2010. HIV Estimates and Projections for PMTCT indicate that 95% of mothers in need will be receiving by 2015.

Indicator 7:
Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know the results [Overall: 16%; Women: 22% ; Men: 9%]

HIV Testing and Counselling (HTC) is the main entry point to HIV treatment, care and support services. The HTC programme was established in 2002 and was only focusing on the client initiated approach, known as Voluntary Testing and Counselling (VCT). In 2006, the country adopted provider initiated HTC approach and the objective was to integrate HIV counselling and testing into the existing general health care system.

There are three HTC models in the country: free standing centres offering client initiated or VCT services; integrated HTC services, and outreach HTC services.

According to the 2008 Service Availability Mapping (SAM) report, there are 178 facilities offering HTC services.

Of these, 7 are free standing facilities offering client initiated HTC/VCT, while 171 are health care facilities offering provider initiated HTC (this includes, but not limited HTC services offered in the context of PMTCT, TB or PEP). This indicates that HTC services are available in 79.8% of the total health facilities in the country.

The SDHS 2007 reports that 16% of the population between 15-49 years had been tested for HIV and know their results (22% women and 9% men). There has not been any national survey including bio-markers since the last SDHS in 2007. Routine data observes a scale up in the number of people testing for HIV to 121,562 by December 2009, from 53,246 at the end of 2007.

Indicator 8:
Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results [76.9%]

According to the NSF, Swaziland most-at-risk populations (MARPS) are defined as commercial sex workers, prisoners and migrant populations. MSM are defined as key populations. There are no laws criminalising MSM and sex work but there laws prohibiting sodomy and brothel work. In Swaziland there is still lack of data on the extent of the MARPS and the level of HIV prevalence among these sub-populations. The BSS will further provide more realistic estimation. Attempts are made by various organisations such as FLAS and PSI to reach MARPS with targeted HIV prevention programs.

In the absence of a catchment strategy for MARPS, a mini-survey for sex workers was conducted in November 2009 using the respondent-driven sampling method. There were 143 respondents and they were all females. These were invited to a 1-day workshop in three (3) regions (Hhohho, Manzini and Shiselweni). Commercial sex workers in the Lubombo region have not yet formed an informal association for ease of contact.

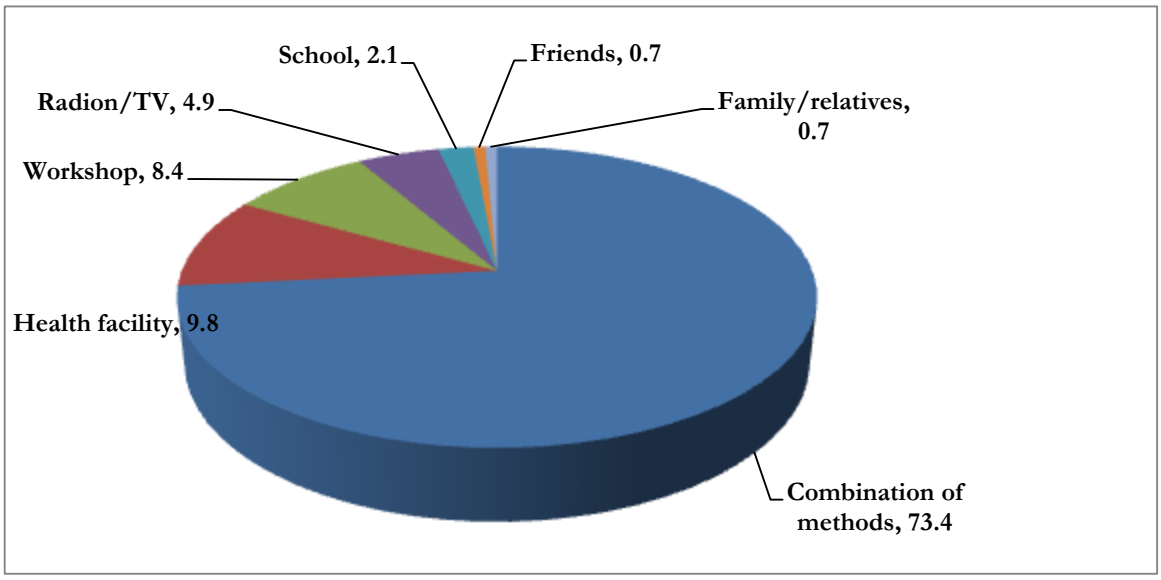
The limitations of the survey included; commercial sex workers are only a sub-section of total MARPS; survey was conducted during working hours; time was limited; the criminalisation of sex work in the country made the process highly sensitive and private; and limited literature on sex work in Swaziland.

From the survey, the following statistics was obtained: In total 76.9% of the respondents reported to have tested in the past 12 months and 98.2% of them reported that they know their status.

Indicator 9:
Percentage of most-at-risk populations reached with HIV prevention programmes [100%]

Information for this indicator was generated from the mini-survey on commercial sex workers that was done in November 2009. All respondents (100%) have been reached with HIV prevention programmes. A majority 73.4% have been reached through a combination of medium (workshops, radio/TV, at school, family members and clinics/hospitals); 8.4% only learnt through a workshop and 9.8% through a health facility. Figure 2 shows the proportion of how respondents were reached with HIV preventive programmes.

Figure 2: Sources of Information on HIV and AIDS



Source: Female Sex Workers Mini-Survey, 2009

Indicator 13
Percentage of young women and men aged 15 – 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [Overall :52.2%; Females: 52.1%; Males: 52.3%]

The NSF has created social and behavioural change communication programmes that seek to influence attitude change and promote safer sexual practices by proving information. The country uses two types of methods to disseminate information, mass media and production of IEC material. At the individual level, much work has been done to change the course of the HIV epidemic by educating individuals about HIV transmission and prevention. However recent studies have highlighted the important role of the external environment in shaping individual behaviour, implying that knowledge on its own is not enough to change behaviour. The programme is also cognisant that misconceptions are time-evolving and embarks on a more proactive course. In that regard, the programme provides a holistic approach, targeting communities and existing structures to change social norms, eliminate stigma and discrimination and dispel misconceptions about HIV transmission and prevention.

There has not been any population survey to provide data on this indicator since the last SDHS in 2007.

The results of the SDHS 2007 indicated that 52.2% of the age group 15 – 24 correctly identified methods of preventing HIV transmission and who reject major conceptions , 52.1% females and 52.3% males.

Indicator 14:
Percentage of most-at-risk populations who both correctly identify ways of preventing the sexually transmission of HIV and who reject major misconceptions about HIV transmission [32.2%]

The NSF has developed social and behavioural change communication programmes that target the MARPS. However due to the absence of a catchment strategy for this sub-population, HIV prevention services have not been customised specifically to the needs of this sub-populations. This situation is believed to increase their vulnerability to HIV infection as they may not to have access to services such as condoms, HIV prevention information and sexual health services that addresses their specific needs.

Data for this indicator was derived from the mini-survey on female CSW that was undertaken in November 2009. Respondents were asked questions to establish their knowledge of in the following areas: sex with one faithful partner; correct use of a condom; HIV identification by merely looking at a person; mosquito bites; meal sharing with infected person.

Of the 143 respondents, only 46 (32.2%) correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission in all of the above mentioned areas. It is worth noting that the same target group, albeit not a cohort, scored a 46% on the same indicator in 2007. Given the current levels of HIV infection in the country, the lack of correct knowledge on prevention and transmission of HIV among this category is of great concern.

Indicator 15:
Percentage of young women and men who have had sexual intercourse before the age 15 [Overall: 5.9%; Women: 6.9%; Men: 4.8%]

Local prevention programmes have largely focused on individual Behaviour Change Communication (BCC). However, there is growing consensus that BCC strategies must be complemented by more community based participatory approaches that will address broader underlying social and economic influences that affect behaviour. The risk of HIV infection among young people has been driven by among other factors; trans-generational sexual relationships, early sex debut and late marriage; and multiple concurrent sexual partners. Mass media (billboards, radio talk-shows, radio-drama series) campaigns targeted at the youth encourage them to 'preserve themselves' for the future and also to reduce the number of sexual partners. Other channels include targeting youth through schools, youth centres and community level activities.

The national universal access targets aim to reduce the number of young women and men who have sexual intercourse before the age of 15 to 3% for both females and males by the year 2010.

No recent population surveys have been conducted during the reporting period, therefore the reported figure remains the SDHS data of 2007. The SDHS 2007 reports that 6.9% and 4.8% of females and males respectively aged 15-24 had sexual intercourse before the age of 15 years. The strategy is to reduce these figures to 3.5% and 2.5% for females and males respectively in 2014.

Indicator 16:
Percentage of adults aged 15 – 49 who had sexual intercourse with more than one partner in the last 12 months [Overall 14.3%; Females: 2.3%, Males: 22.9%]

Multiple sexual partnerships remain one of the key drivers of HIV infection in Swaziland. Although the 'be faithful' aspect of prevention has been integrated into several policies and strategies, a lot still needs to be done to discourage MCPs. The true nature and extent of the problem is not known and there is no empirical evidence on concurrency. A national campaign was developed and public reaction was somewhat negative, reflecting great sensitivity around the issue. Therefore, there is need to create awareness and understanding among stakeholders and populations that MCPs must be addressed in order to prevent new HIV infections.

Although no recent population surveys have been conducted, according to the SDHS 2007, Swazi men are more likely to have multiple partners than women, as the study indicates that 2.3% of females and 22.9% males aged 15 – 49 were reported to having sexual intercourse with more than one partner. The report further provides that a higher percentage of people having two or more sexual partners reside in urban areas than in rural areas for women, while the reverse is true for men; women - 4% are located in urban areas and 1.7% is located in rural areas; men - 21.4% is in urban areas and 23.7% are in rural areas.

Indicator 17:
Percentage of adults aged 15 – 49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse [56.2% for men, no data for women]

Condom usage is highly promoted in the country and is recognized as one of the key HIV prevention interventions. The Ministry of Health initiated the development of the National Condom Strategy; this strategy is informed by a Rapid Needs Assessment which was conducted early 2008. The strategy is in response to condom stock-outs and the need for improved supply chain management. The overall target is to have sufficient condoms circulating in the country and the number of male and female condoms distributed annually to the public and private sector is targeted to be increased to 12 million by the year 2010.

No recent population surveys have been conducted. The SDHS reports that 56.2% of men with two or more partners in the last 12 months used a condom during last sexual intercourse. No data on condom use for females with more than one partner was identified. Condom use is common with higher risk partners, with the SDHS indicating that 55% of women and 68% of men, who had sex with a non-marital or non-cohabiting partner in the 12 months preceding the survey used a condom during last sex. The rate of condom use in higher-risk sex increases with the level of education and household wealth quintile in both men and women.

Indicator 18:
Percentage of female and male sex workers reporting the use of a condom with their most recent client [87.4%]

As highlighted earlier, there is still lack of data on the size and extent of the activities for this population. However, the MOT 2009 estimates the total population size of sex workers as approximately 2,298, both male and female.

Data for this indicator relied on the mini-survey of commercial sex workers that was conducted in November 2009.

The level of HIV prevalence among this population remains a challenge as data collected by the rapid assessments may not be representative of the situation. Respondents in this survey were all females of which 3.5% were bisexual (female to male and female to female) and 96.5% were not bisexual.

When asked if they used a condom with the last client, 87.4% responded that a condom was used and 12.6% did not use a condom. A majority (84.8%) initiated the use of a condom whilst 12% said it was a joint decision with the client.

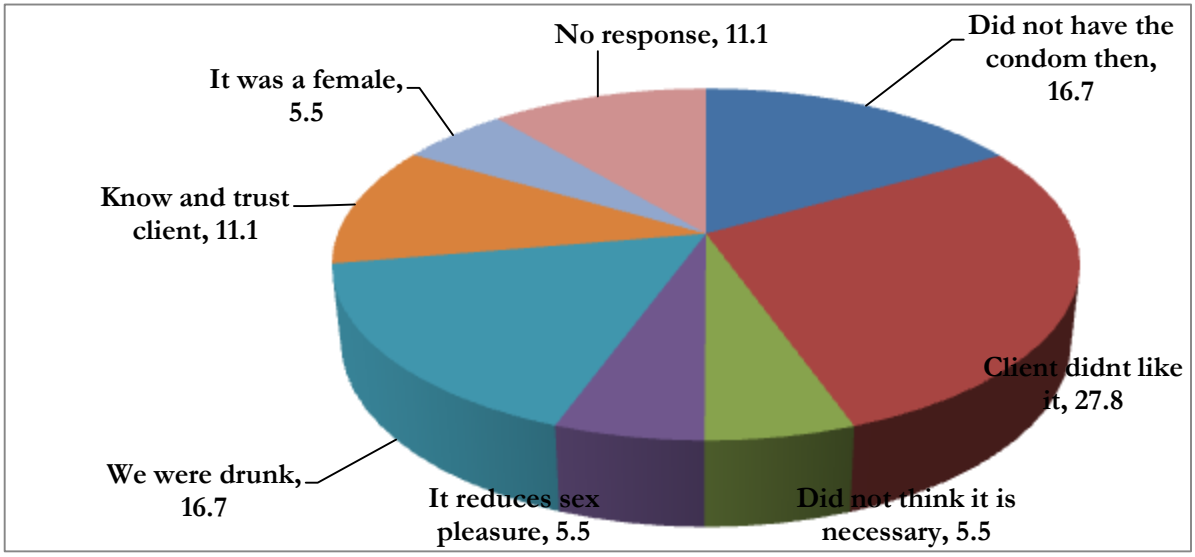
Table 5: Percentage of commercial sex workers reporting the use of a condom with their most recent client

AGE	USED A CONDOM		TOTAL (%)
	YES	NO	
15-24	62	9	87.3%
25+	63	9	87.5%
Total	**125**	**18**	**87.4%**

Source: Mini-survey on female Commercial Sex Workers, 2009

As illustrated in figure 3 below, from the 12.6% who did not use a condom, the majority (27.8%) said the client did not like the use of a condom; 16.7% did not have a condom at the time of the sex act and 16.7% did not use a condom because they were drunk.

Figure 3: Reasons for not using a condom with most recent client



Source: Mini-survey on female commercial sex workers, 2009

Indicator 19:
Percentage of men reporting the use of a condom the last time they had sex with a male partner

Swaziland is not reporting on this indicator as no data or programmes are available for this sub-population.

Indicator 21
Percentage injecting drug users reporting the use of sterile injecting equipment the last time they injected

Swaziland is not reporting on this indicator as no data or programmes are available for this sub-population.

Indicator 22:
Percentage of young people aged 15 – 24 who are HIV infected [ANC results: 38.1%, SDHS overall: 14.4%; women: 22.9%; men: 5.9%]

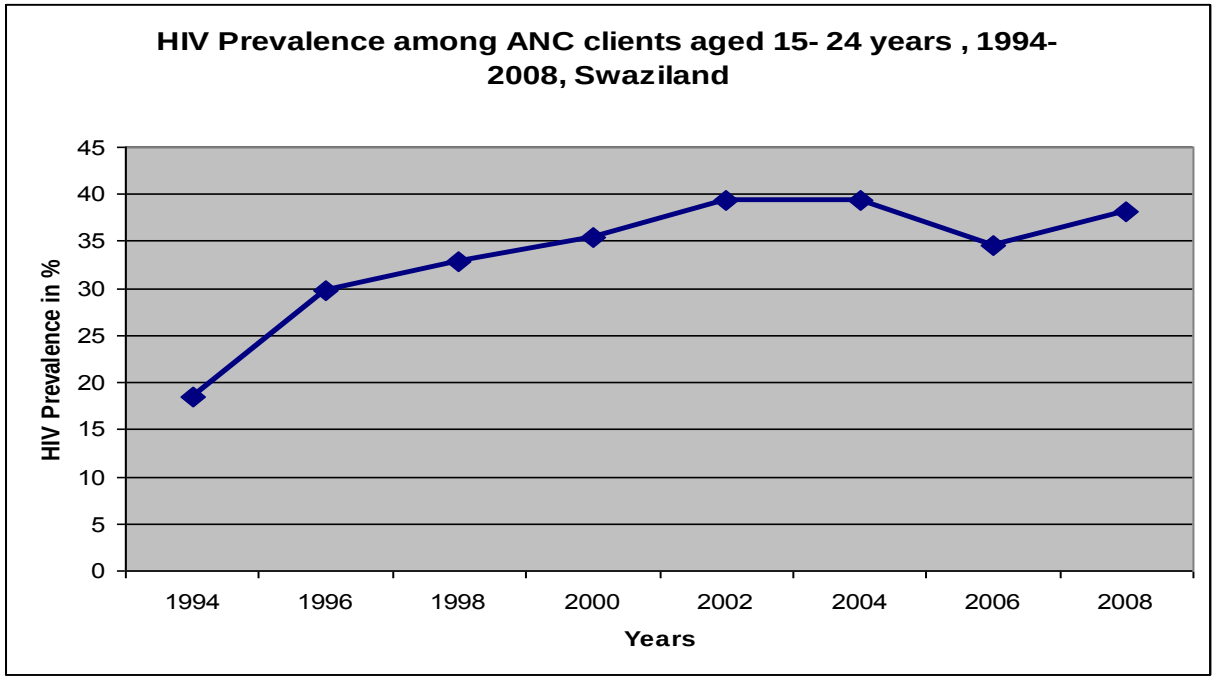
In Swaziland, as in most of sub-Saharan Africa, national HIV prevalence estimates have been derived primarily from sentinel surveillance of pregnant women. The most recent biennial HIV Sentinel Surveillance Survey in 2008 reports HIV prevalence among pregnant women aged 15 – 49 years as 42.0%. HIV prevalence in women aged 15-19 was 26.3% and women aged 20 – 24 was 44.7% as shown in table 6 below. There are limitations in sentinel surveillance data because not all pregnant women attend ANC.

Table 6: Percentage of young people aged 15 – 24 who are HIV infected [ANC results 2008]

AGE GROUP	NO. TESTED	NO. HIV POSITIVE	% HIV POSITIVE	95% CI
15 – 19	392	103	26.3	22 – 31
20 – 24	709	317	44.7	41 – 48.5
TOTAL	1101	420	38.1	

Source: HIV Sentinel Surveillance, 2008

Figure 4: HIV prevalence among ANC clients aged 15-24, 1994- 2008



Source: HSS, 2008

As shown in figure 4 above, the rate of HIV prevalence among ANC clients aged 15-24 has not shown signs of decreasing. This is of concern as HIV prevalence in this age group is used a proxy for incidence.

The SDHS found a HIV prevalence of 14.4% for both men and women in this age group, 22.9% for women and 5.9% for men.

Indicator 23:
Percentage of most-at-risk populations who are HIV infected

Swaziland is not reporting on this indicator as no data was available.

CARE AND SUPPORT

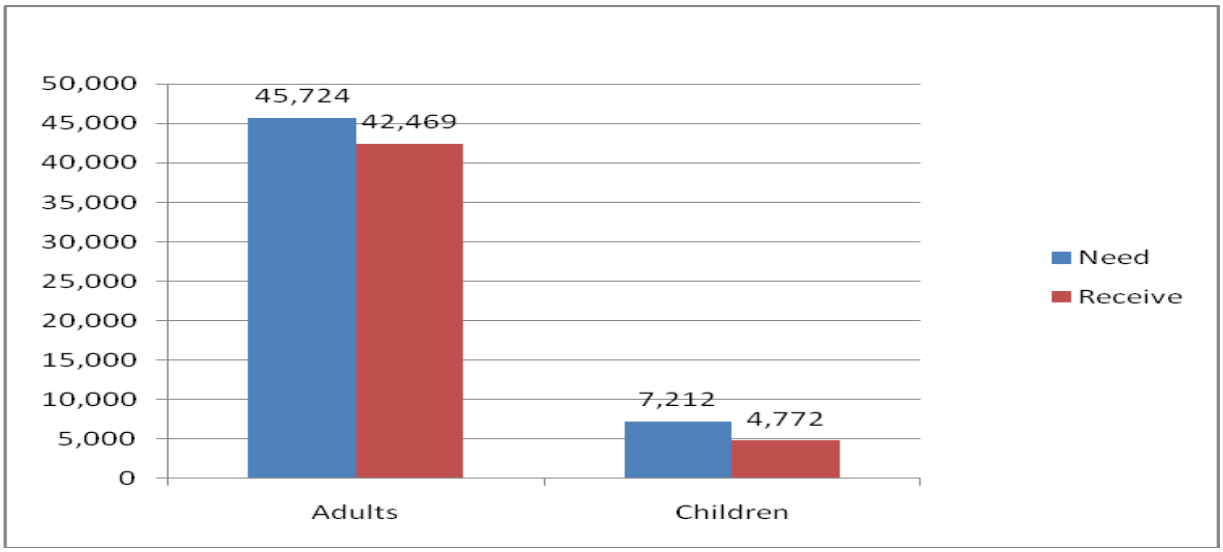
The NSF and Health Sector Response Plan (2006-2010) addresses the areas of treatment care and support by emphasising the need for increased access and effective utilisation of ART; management of opportunistic infections; diagnostic testing and counselling, institutional and home based care; and palliative care.

Indicator 4:
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy [Overall: 89.2% CD4 count 200: Children: 66.1%; Adults: 92.8%]
[Overall: 59.2% CD4 count 350; Children: 66.1%; Adults: 58.5%]

The ART programme began in 2003, and since then a significant number of sites are providing ART services. There are 89 health facilities offering ART services as either initiation sites (24) and/or refill and outreach (65). In an effort to ensure that more people have access to ART services, support services such as laboratory facilities, human resources and availability of drugs, have undergone significant improvement. In addition, strategies have been developed to encourage privately owned clinics to implement ART and for the existing initiation sites to provide ART outreach services within their catchment areas. Guidelines for the provision of ART and management of people receiving ARVs have been in place since 2006 with the aim being to ensure that there is a continuum of care and a holistic focus on ART patients in an integrated health system from the ART centres to communities and from pre-diagnosis to palliative care.

According to the 2009 HIV Estimates and Projections for Swaziland, using a CD4 count below 200, there were 52,967 people in need of ART (45,748 adults and 7,219 children). Routine data reflects that by the end of 2009, there were 47,241 people that were actively on ART of which 42,469 were adults and 4,772 children as shown in table 7 and figure 4 below, resulting in coverage of 89.2%. Also notable is that a majority of patients on ART were on first line regimen (98%) by the end of the year.

Figure 5: Adults and children in need and receving ART in 2009



Source: HIV estimates and Projections 2009 & MoH M&E data

Figure 4 above shows that there are more adults who receive ART than children, at a need-receive coverage of 92.8% and 66.1% respectively.

With the CD4 count of 200, the country is close to attaining Universal Access coverage for adults. Routine data further shows that 63% of total enrolments were female and compared to 37% for males, as shown in table 7 below.

Table 7: Number of people actively on ART in 2007 and 2009

AGE,SEX CATEGORY	2007			2009		
	NEED	RECEIVE	%	NEED	RECEIVE	%
Children (0-14)	6,491	1,776	27.40%	7,217	4,772	66.10%
Female	3,226	881	27.30%	3,589	2,470	70.80%
Male	3,264	895	27.40%	3,628	2,302	65.20%
Adults 15+	33,454	18,834	56.30%	45,748	42,469	92.80%
Female	20,448	12,027	58.80%	27,508	27,471	99.90%
Male	13,006	6,807	52.30%	18,240	14,998	82.20%
TOTAL	**39,945**	**20,610**	**51.60%**	**52,965**	**47,241**	**89.20%**

Source: HIV Estimates and Projection 2009 & HMIS 2009

The country is in the process of integrating the ART guidelines to incorporate some of the World Health Organisation (WHO) recommendations on ART and PMTCT. A key feature of the review entails the early enrolment into ART, from CD4 count criteria of 200 to CD4 count of 350. Beginning June 2009, the country piloted the early ART initiation but has not been rolled out to all ART providing facilities. The high coverage, from 51.6% in 2007 to 89.2% by 2009 is partly attributed to the early enrolment is being piloted in key facilities, namely the Mbabane Government Hospital and Raleigh Fitkin Memorial Hospital that cater for approximately 40% of all ART patients. Moreover, when the demand for ART is revised to the 350 CD4 count eligibility criterion, the percentage of people receiving antiretroviral therapy in 2009 is 59.2%.

Indicators 6
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Tuberculosis is still a public health challenge in Swaziland. TB is labelled as the leading cause of morbidity in adults living with HIV and AIDS and according to the WHO Global TB Surveillance Report, 79.9% of TB patients were co-infected with HIV. Projections indicate that the current burden of TB will continue to increase despite the rising number of people initiated on ART. There are 18 health facilities in the country that have the capacity to diagnose and initiate TB treatment, including a major TB hospital in Manzini that serves as referral for severe TB cases. Only 41.2% of health facilities do HIV testing and counselling among TB patients. To decrease the burden of TB among people living with HIV, it is essential that all TB cases are screened for HIV, likewise all TB cases screened for HIV.

In 2007, 6517 TB patients received an HIV test, of which 5,252 (80.6%) tested positive to HIV. From the total positive 5,252 HIV positive TB patients, 4,987 (95%) were receiving Comtrimoxazole Preventative Therapy (CPT) and 1,014 (19.3%) were initiated on ART.

The country is unable to report on this indicator as data for the numerator is incomplete. However, the WHO estimates that 26% of HIV infected TB patients are enrolled in ART in 2009.

Indicator 24:
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [Overall: 77.3%, Children: 78.2%, Adults: 77.1%]

Adherence to ART is major factor that enhances survival and can prolong the life of a person who is HIV positive. Since 2008 the country has been able to establish a system for patient monitoring and drug management. The country has facilitated active participation of all relevant stakeholders including people living with HIV. In order to scale up retention rates for people on ART, the ART programme has trained PLHIV organizations, clinicians as well as community based carers on treatment literacy.

Table 8: Cohort for patients starting ART, 12-month Cohort group, Jan-Dec 2008

Category	Net Cohort	Cohort Alive	Proportion Alive
Children	1115	872	78.2%
Adults	9919	7652	77.1%
Total	**11034**	**8524**	**77.3%**

Source: ART Patient Management System, 2008

Table 8 above depicts ART retention rates for patients initiated from the 1st January 2008. The data shows that 78.2% of children and 74.8% adults who were on ART were alive 12 months after initiation of treatment. A larger percentage of the cohort group was lost during their first six months on ART. Patient survival rate is better after the critical six months, as reflected by the high 12 months survival rate in the table. Adults are the mostly affected group as more children survived after 12 months.

Indicator 25:
Percentage of infants born to HIV-infected mothers who are infected [16.9%]

HIV Estimates and Projections Report 2009 estimates the number of new infant infections to be 1,651 in 2009 and the number of mothers in need of PMTCT as 9,329, resulting in 16.9% of infants being born HIV positive to HIV-infected mothers.

Through the use of Dry Blood Spot (DBS), the country is able to screen, routinely, children who exposed to HIV and are infected. Routine health data indicates 8970 children were tested through DNA PCR during 2009 and from those 1059 (12%) tested HIV positive. However, not all ANC providing facilities offer PMTCT and not all eligible women receive ARV prophylaxis for PMTCT. Also the number of children testing is affected by the fact that some infants born in 2008 were tested in early 2009. Furthermore, routine data may be affected as some mothers continue breastfeeding even after an HIV positive test thus exposing the infant to infection and similarly the higher sero-conversion rates amongst breastfeeding mothers.

IMPACT MITIGATION

The impact of HIV and AIDS in the country has significantly affected all sectors of society and the economy. The National Strategic Framework has set the broad goal for impact mitigation is to reduce the socio-economic impact of the epidemic on homesteads, communities, families and individuals. Key interventions to mitigate the social and economic impact of HIV epidemic include, provision of psychosocial support programme for vulnerable groups, food and nutritional support to vulnerable households, socialisation and protection of OVCs, educational support and early childhood care and development.

The SDHS 2007 informs that only 22% of children under the age of 18 live in a household with both parents and about 33% are not living with either parent. About one in four children have lost one of their parents, while 4% of those are double orphaned. 31.1% of all children under 18 are classified as orphaned and/or vulnerable children (OVC).

Indicator 10:
Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child [At least one type: 41.2%; Received All: 0.2%]

The country has developed a National Plan of Action for OVC which includes programmes such as the establishment of Neighbourhood Care Points (NCPs) and KaGogo centres. These centres provide basic services such as food, general care, and basic health care services, educational support, psychosocial support and shelter for OVCs.

No recent population surveys have been conducted since the SDHS in 2007. According to the SDHS 2007, 41.2% of OVC received at least one type of basic external support, the basic external support includes: medical, emotional, social/material and school related support. 2009 HIV Estimates and Projections estimate that the number of orphans and vulnerable children will increase from 99,037 in 2007 to 102,349 in 2015. The majority of these children are subjected to social and economic circumstances worsening their state of vulnerability, which increases their risk to exploitation and of adopting risky and dangerous behaviours. Subsequently their susceptibility to contracting HIV is heightened while the SDHS found that female OVC were most likely to engage in sexual relations before the age of 15 at 9% compared to 6.4% of non-OVCs.

Indicator 11:
Percentage of schools that provided life skills-based HIV education within the last academic year [Overall: 50.5%; Primary schools: 43.5%; Secondary and High Schools: 70.8%]

According to Education Statistics 2007 there are 805 registered primary, secondary and high schools in the country. Primary schools provide 7 years of education, secondary schools 3 years of education and high schools 5 years. According to the Baseline Survey of Life Skills Education in Schools 2009, at primary level HIV and AIDS, gender and life skills education related issues have been integrated into a number of mainstream subjects in the curriculum. These subjects include English, Science and Social Studies. However, at secondary and high school levels HIV and AIDS, gender and life skills related issues have not been integrated into the school curriculum. The Ministry of education, though, has encouraged schools to allocate time (40 minutes per week) into their timetable for counselling and guidance activities. These activities include issues like, HIV and AIDS, gender, career guidance and other contemporary issues.

In schools some children participate in peer education activities. Through the peer education programme, children educate their peers in a structured manner. Most of the activities are conducted after formal lessons in the afternoon and or during the sport periods. The most frequently addressed topics are: HIV transmission, child abuse and violence, adolescence, puberty, teenage pregnancy, AIDS stigma and discrimination, drug abuse, ART, life skills, health and hygiene.

During the last assessment conducted in 2007, a total of 93 schools out of 756 (556 primary and 200 secondary and high schools) in the country were sampled. Out of the 93 schools, 35 were government owned and 53 were government assisted and 5 were private. The results showed that 51% of the schools reported having provided at least 30 hours of life skills in each grade during 2006. About 71% of secondary and high schools and 43.5% of primary reported offering up to 30 hours of life skills training. There was no significant statistical difference between rural and urban schools; 47.6% of rural school and 56.7% of urban schools provided life skills training.

Indicator 12:
Current school attendance among orphans and among non-orphans aged 10-14
[Both: 92.3% ; Orphans: 90.0% ; Non-orphans: 92.7%]

Swaziland has performed relatively well in facilitating access to primary education for children. In 2002, the Government of Swaziland initiated the Orphaned and Vulnerable Children Fund. The fund has increased tremendously since its inception, from E16 million to E130, 000 million in FY 2008/09 and has benefitted over 100, 000 OVC who would have otherwise never been to school. 111,878 children benefitted from the fund in that year.

The SDHS found that there was a minor difference in school attendance according to survivorship of parents and reported that 90% of orphans[2] (94.7% male and 85.6% female), compared to 92.7% children whose parents were both alive were in school, as shown in the table 9 below.

In addition, the SDHS found that, in general, OVCs were not disadvantaged in terms of access to and attendance in schools in comparison to other children. In fact the survey found that there were more OVC in class at an OVC to non-OVC ratio of 1.01, as 92.2% of OVC and 91.6% non-OVC were attending school. It is expected that enrolments will be further enhanced by the Free Primary Education programme that began in the beginning of 2010.

Table 9: School attendance among orphans and non-orphans

School attendance	Both parents dead	Both parents alive
Male	94.7	91.6
Female	85.6	93.7
All	90.0	92.7

Source: Swaziland Demographic and Health Survey, 2007

[2] Orphans were termed in the SDHS as having both parents' dead. While non-orphans termed as having both parents alive and living with at least one parent.

CHAPTER V: BEST PRACTICES

- **Use of traditional ceremonies as vehicles for HIV prevention**

Swaziland as a Kingdom has preserved the age-old culture and traditional ceremonies. There are two most important annual traditional ceremonies: the Incwala ("First fruits") in December which symbolises the most important and sacred of all Swazi ceremonies; and Umhlanga ("Reed dance") in late August. As well as being cultural events, these promote chastity among the youth. The Umhlanga is a ceremony for un-betrothed maidens and according to the UNICEF annual report of 2009, this ceremony was attended by about 80,000 maidens from all over the country and from neighbouring countries, South Africa, Lesotho and Botswana. Similarly the Lusekwane pre-Incwala event, is for unmarried boys where they are taught life skills.

The high numbers of attendance at these events present an opportunity for social catchment of the youth. To take advantage of the opportunity, UNICEF and other partners support Khulisa Umntfwana (a non-governmental organisation that focuses on the development of the girl child) with various HIV and AIDS prevention interventions such as drama, peer education, film etc during the duration of the Reed dance. During the Incwala HIV prevention campaigns are provided by Lusweti with particular emphasis on young men.

Such intervention plays a major role in ensuring that correct HIV and AIDS information is shared among maidens and young men, which may influence behaviour change in the future.

- **Life Skills through Traditional structures ('Kagogo' centres)**

Given the loss of the family structure and considering that a majority of Swazi children do not live in a family with both parents, the country has established 'kagogo' (Grandma's) centres. These centres provide support to orphans and vulnerable children by teaching life skills to children. In essence these play the role of parenting to majority of OVCs. The centres have act as an entry point for service delivery and enhance communication between development partners and communities. Furthermore, there is commitment and ownership of programmes from the community leadership.

- **Integration of HIV and Sexual Reproductive Health services under the Family Life Association of Swaziland (FLAS)**

The Family Life Association clinic, has integrated sexual reproductive health and HIV and AIDS services. This integrated clinic brings together family planning, antenatal care, maternal and child health services, prevention of mother-to-child transmission of HIV services and HIV counselling and testing, along with access to antiretroviral therapy. Family Life Association has been conducting male circumcision to offer biological protection against HIV acquisition in the context of HIV prevention.

CHAPTER VI: MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress made and challenges reported in 2007

The 2007 UNGASS report indentified the following as challenges:

- Human resource capacity
- Strategic work planning
- Coordination of the response
- Financial resources
- Monitoring and Evaluation and Research

Progress made on the indicated challenges:

Human resource capacity

During 2008 and 2009 the ART programme conducted workshops to capacitate health workers in improving quality ART services to adult and children patients. The training covered a variety of topics relevant to their work, including pharmacovigilance, use of electronic medical register, development Standard Operating Procedures and HIV and TB integration, paediatric ART management.

Monitoring and Evaluation training is an ongoing programme within NERCHA. The National M&E unit has been capacitated with staff and has received training on M&E concepts. Capacity building for the regions and implementing partners remain a challenge. Although all regions have HIV and AIDS Regional Coordinators and M&E officers, training is still outstanding. Implementers have problems of identifying and retaining M&E focal persons for the organisations. This has a negative bearing on reporting rates.

Strategic planning

The country has reviewed and developed its National strategic document, the National Multisectoral Strategic Framework for HIV and AIDS (NSF), which covers a span of five years. The NSF is evidence based and results focused, has mainstreamed gender and human rights dimensions, and links planning to monitoring through the NSF's Results Framework. It forms the blue print for the development of all HIV and AIDS programmes by the various implementing partners, sectors and organisations in the country. It sets out clear and quantified results that the national HIV response aims to achieve by 2011 and 2014.

In Swaziland, HIV response management principles encompass the "three ones" approach; that is, One coordinating structure, One strategic HIV response framework and One M&E system. For example the Health Sector has developed an action plan that flows from the strategic framework.

COORDINATION OF THE RESPONSE

National level structures: The National Emergency Response Council on HIV and AIDS (NERCHA) was established in 2003 within the Prime Minister's Office. NERCHA is mandated by an Act of Parliament (NERCHA Act, 2003) to coordinate the national HIV response, as defined from time to time in the country's national HIV strategies, to facilitate a relevant multisectoral response, and to mobilise resources.
At a strategic level, NERCHA is governed by a council and at an operational level, a NERCHA secretariat has been created to oversee the day-to-day management of NERCHA's activities.

NERCHA has facilitated the implementation of the national multisectoral response through coordination of the different sectors and by creating an environment for strengthened partnerships. Coordination of the response has been decentralised to the regions and the sectors.

At the regional level: the Ministry of Tinkhundla Administration Development has established four Regional Multisectoral HIV and AIDS Coordinating Committees (REMSHACCs) for each of the country's regions. The REMSHACC are serviced by a secretariat consisting of a coordinator, Monitoring and Evaluation Officer and secretary.

Decentralised structures; within all 55 Tinkhundla, HIV is mainstreamed within the administration and development agenda of the Inkhundla. At the chiefdom and town levels, KaGogo Social Centres have been built to support coordination of HIV and AIDS and clerks have been placed to facilitate the functioning of the communities. NERCHA works very closely with the Ministry of Tinkhundla Administration and Development in the strengthening of regional and lower level coordination structures.

Sectors: 18 Sectors have been supported with coordination as well monitoring and evaluation capacity. Although most sectors are in place and implementing a coordination role, their comparative advantage in the response to HIV and AIDS remains to be strengthened in order to make maximum use of their comparative advantages.

Within the health sector, The Swaziland National HIV and AIDS Program (SNAP) coordinates the Health Sector response. To enhance this coordination this unit of the MOH has been decentralised to the regions.

Financial resources

Swaziland has not been spared from the Global recession, this has affected the flow of financial support to the country. The country largely depends on few funding sources, among which but not limited to are: the Swaziland Government, Global Fund, UN Agencies, PEPFAR, EU, Italian Cooperation, Médecins Sans Frontières, Red Cross and others.

CHALLENGES IN 2009

- **Community system reporting**

  The major challenge for SHAPMoS is low levels of reporting and late submission. Within MoH the inadequate monitoring of activities or interventions taking place at the community level. Timely and reliable feed back to stakeholders on M&E information products remains a challenge

- **Coordination and management of services**

  The coordination role of NERCHA is still in need of strengthening and there is lack of clarity on roles and responsibilities for partners in the HIV response. Prior to the development of the NSF, the NSP was seen as a NERCHA document as opposed to national. However, the NSF has seen major buy-in from important stakeholders who have reflected keen interest to align their strategies.

- **Inadequate capacity**

  - **Human resource**

  There is inadequate skilled and experienced human resource. In addition there are inadequate strategies to mitigate staff turnover.

  - **Structures**

  There are inadequate structures to effectively coordinate and monitor the response.

- **Programme development**

  The challenge in program development is that not all programs are guided and informed by the National Strategy. There is also the absence of Standard operating Procedures that would include service standards and modes of operation.

- **Financial resources**

  - **Lack of administrative costs finances**

  There is inadequate resource available for HIV. Civil society has reflected that even where resources are provided these do not include administrative costs for the programmes they seek to implement. The majority of the civil society organisations also lack the capacity to manage funds allocated to them.

  - **Grant management**

  There is inadequate grant disbursement and tracking systems. There is also poor monitoring and reporting of grant utilisation.

- **Partnership development**

There is inadequate development of partner coordination. There is also inadequate harmonisation of development partners program with national strategies.

- **Sustainability**

Programme sustainability remains a challenge in Swaziland as there is no donor exit strategy; inadequate community ownership and there is project funding rather than program funding .

REMEDIAL ACTIONS

- **Community system reporting**

  NERCHA has revised SHAPMoS to include a community form, in addition to the SHAPMoS implementers form. This will enable closer monitoring of the community level.

The Ministry of Health is engaged in building a system for the collection and collation of data from all Health Sector based community interventions. Tools have been developed that will be piloted in the current year.

- **Coordination and management of services**

  Coordination forums for all sectors and support for community coordination structures called Community HIV and AIDS (CHIMSCHACC)

- **Inadequate capacity**

  - **Human resource**
    - Filling of existing posts
    - Supervision and mentoring
    - Development of staff retention strategy
    - Establishment of volunteer support plan
  - **Structures**
    - NERCHA as the Organisational Development Coordinator whose responsibility includes that of building the capacity of civil society organisations to manage funds.

- **Programme development**

Programme technical documents will be developed as appropriate.

- **Financial resources**

  - **Lack of administrative costs finances**

  Funding for sub-recipients should include administrative costs.

  - **Grant management**

There will be strengthening and improvement of existing systems to ensure efficiency and effectiveness.

- **Partnership development**
  - Forge new partnerships, consolidate and strengthen existing ones
  - Encourage partners' to align their HIV programmes with the country's National Strategic Framework.
- **Sustainability**
  - Develop a sustainability strategy and donor exit strategy
  - Strengthen community engagement in HIV and AIDS interventions
  - Advocate for programme funding rather than project or activity funding.

CHAPTER VII: SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Swaziland has benefitted from several development partners among them, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Government, the United Nations, the European and Italian Cooperation among others. The country has continued to strengthen and consolidate these partnerships and strategic alliances through various fora. The coordination of development partners is facilitated through existing structures including the Donors Forum and the Swaziland Partnership Forum. Funding for the response is from government, Global Fund Grants including bilateral and multilateral donors. Government resources are primarily used to coordinate the response, whereas grants from development partners are utilised for specific programmes. The United Nations coordination is trough the UN Theme Group on HIV and AIDS. The strategic direction for coordination of development partners is to improve and harmonise coordination modalities among partners.

The Partnership Framework on HIV and AIDS 2009-2013 is a five-year joint strategic agenda for cooperation between the Swazi Government and the Government of the United States of America (the USG) to support achievement of the goals of the NSF and in so doing, contribute to the PEPFAR goals for prevention, care and treatment. During this five year period, the priority thrust of the Framework is to rapidly scale up proven interventions throughout Swaziland to reach men, women and children with needed services and support. The main elements of the Framework include expanded and improved service delivery, policy reform and coordinated financial commitments. In addition to achieving enhanced service coverage and quality, the Framework aims to strengthen local capacity to sustain an effective HIV response.

Areas of intervention include;

- Decentralized and improved quality of care and treatment services for adults and children, including HIV testing and TB/HIV
- A coordinated and comprehensive approach to sexual prevention using social and behavioural change communication
- Rapid expansion of medical male circumcision (MC) to reach 15-24 year old males
- Impact mitigation focused on vulnerable children and their families
- Development of human and institutional capacity to manage an effective HIV response, including aspects of strategic information

CHAPTER VIII: MONITORING AND EVALUATION ENVIRONMENT

NERCHA is mandated to facilitate and coordinate the monitoring and evaluation of all HIV and AIDS interventions in the country. NERCHA performs this function in collaboration with other stakeholders. NERCHA as little as possible, collects data itself, but utilises information products from the various stakeholders to inform the multisectoral response. NERCHA has established a national M&E office and is capacitated with staff, comprising of the National M&E Coordinator, SHAPMoS Manager and two M&E Officers. NERCHA works very closely with the Ministry of Tinkhundla, Administration and Development in strengthening regional and lower level coordination structures. This has resulted in the deployment of regional M&E officers at all four regions.

The MoH continues to coordinate all clinical HIV and AIDS programmes and is responsible for monitoring of HIV clinical services. In 2009, the Ministry of Health established the Strategic Information Department, which comprises of three units; M&E, HMIS and Research. In addition, the Ministry has established posts for the department. These units have further been decentralised to the four regions of the country. To further strengthen M&E functions, the Ministry has placed strategic information officers in major hospitals. Research structures in the health sector are at the initiating stage. Non-clinical information is provided by the REMSCHACCs, MoE, MTAD, NCCU and sectors.

Routine programme monitoring data of the country is managed through a system called SHAPMoS, the Swaziland HIV/AIDS Planning and Programme Monitoring System encompassing both clinical and non-clinical data. SHAPMoS focuses on three types of monitoring; demand monitoring, supply monitoring and planning and financial monitoring. Surveys, surveillance, assessments, and modelling are different types of episodic data collected in Swaziland about the HIV response in the country. The M&E system is reliant on different databases from the various sectors that address sector specific information requirements. Sectors that have existing database systems include, MoH, MTAD, National Children's Coordination Unit (NCCU), Central Statistical Office (CSO), MoE, regions SHAPData and development partners. NERCHA is in the process of developing a Geographic Information System (GIS) and it will help to visually display some of the data that NERCHA are capturing and, therefore, make it easier for people to understand how to utilize it.

The availability of episodic data for monitoring and evaluating the national response has improved. The SDHS, MOT, HSS, Vulnerability Assessment Committee (VAC), Service Availability Mapping and routing surveillance all offer information on the response. Other surveys in the pipeline include the BSS, MICS, Aids Coordination Assessment, DHS (or alternatively AIDS Indicator Survey), Quality of Impact Mitigation Services (QIMS), National Aids Spending Assessment, Condom Availability Survey, Workplace Survey and Client Satisfaction Survey.

The HIV research function is currently underutilised and this is partially due to the absence of a National Research Council. Nevertheless, the Ministry of Health and NERCHA are in the process of developing a national health research agenda, and will incorporate HIV. The research agenda will be also used to mobilise resources for research in Swaziland. The MoH has developed an ethical committee which has power to of approval for all research protocols involving human subject.

The national M&E function is overseen by a multisectoral technical working group, the M&E TWG. The TWG plays a leading role in assisting NERCHA with the development of national M&E strategies, systems, and tools, with developing M&E capacity among partners, and in disseminating critical results.

- **Challenges faced in the implementation of a comprehensive M&E system**

  There is evidence of political commitment in the area of M&E.

  The country has made strides in the area of data availability but there still remains a challenge in the quality of the data, information products. In addition, noted is the minimal use of data in decision making and planning.

- **Remedial action planned to overcome the challenges**

  The MOH is engaged in activities that aim at addressing the quality of data. Such activities include data audit, data profiling, etc. Furthermore, there is room for improvement in the development of information products for use by different departments or programs in the Health Sector, thus the need for capacity building in the area of data use.

- **Need of technical assistance and capacity-building**

  Sectors have not adopted and mainstreamed to the national M&E system and there is lack of skills at regional, sector and community level.

  Monitoring and evaluation over the years has been overlooked in program implementation. Through HIV and AIDS interventions M&E has gained its rightful position for policy decision and reporting purposes. Since it is a new area, capacity building to all programs is a necessity. Expertise in M&E training is minimal within Government and the need for technical assistance cannot be overstated.

REFERENCES

11th Round of National HIV Sero-surveillance among Women Attending Antenatal Services at Health Facilities in Swaziland – (2008), Mbabane, Swaziland.

Global Fund Round Seven Proposal

Draft HIV Estimation and Projections for Swaziland 2009

HIV Prevention Response and Modes of Transmission Analysis, 2009

National Emergency Response Council Quarterly Report on HIV and AIDS, Jan – Mar 2009

Situational Analysis on Commercial Sex Work in Swaziland. 2007

Special Cross Sectional Survey on Life Skills Training in Schools, Swaziland. 2009 Swaziland 2009-2014 National Strategic Plan

Swaziland Demographic and Health Survey 2006-07 Report

Swaziland Human Development Report 2008

Swaziland Monitoring and Evaluation Framework 2009-2014, Mbabane, Swaziland.

The Road towards Universal Access to HIV and AIDS Prevention, Treatment, are and Support. Swaziland Report November 2007

UNAIDS Accenture Financial Flow Project: Swaziland 2007

UNAIDS UNGASS Monitoring of the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2010 Reporting.

UNGASS Indicators Country Progress Report by NERCHA M&E OFFICE – (2008), Mbabane, Swaziland.

UNICEF Annual Report 2008/9

ANNEXURE 1

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

	Yes	No
1. Which institutions/entities were responsible for filling out the indicator forms:		
a) NAC or equivalent (NERCHA)	Yes	
b) NAP (NSF 2009 - 2014)	Yes	
c) Other (please specify)		
2. With inputs from		
Ministries of:		
Education	Yes	
Health	Yes	
Labour– PSHACC	Yes	
Foreign Affairs		No
Others (please specify)		
Civil society organisations		
People living with HIV	Yes	
Private sector		No
United Nations organisations	Yes	
Bilateral	Yes	
International NGOs	Yes	
Others (please specify)		
3. Was the report discussed in a large forum?	Yes	
4. Are the survey results stored centrally?	Yes	
5. Are data available for public consultation?	Yes	

6. Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report? NERCHA and UNAIDS	
Name/Title: Nokwazi Mathabela (Mrs)	National M&E Coordinator
Signature: Mathebela	Date: 29 March 2010
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ANNEXURE 2

National Composite Policy Index questionnaire

PART A GOVERNMENT OFFICIALS

STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV? (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under1.2)

Yes	No	Not Applicable (N/A)

Period covered: [write in]

IF NO or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1 How long has the country had a multisectoral strategy?

Number of Years: 9 years

Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
1. Health	Yes	No	Yes	No
2. Education	Yes	No	Yes	No
3. Labour at workplace	Yes	No	Yes	No
4. Transportation	Yes	No	Yes	No
5. Military/Police	Yes	No	Yes	No
6. Women not specific	Yes	No	Yes	No
7. Young people	Yes	No	Yes	No
8. Other*: [write in]	Yes	No	Yes	No

The gender unit within a CBO is funded by government

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations		
a. Women and girls	Yes	No
b. Young women/young men	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex workers	Yes	No
f. Orphans and other vulnerable children	Yes	No
g. Other specific vulnerable subpopulations* elderly and disabled	Yes	No
Settings		
h. Workplace	Yes	No
i. Schools	Yes	No
j. Prisons	Yes	No
Cross-cutting issues		
k. HIV and poverty	Yes	No
l. Human rights protection	Yes	No
m. Involvement of people living with HIV	Yes	No
n. Addressing stigma and discrimination	Yes	No
o. Gender empowerment and/or gender equality	Yes	No

Were target populations identified through a needs assessment?

Yes	No

Studies by PSI, FLAS

IF YES, when was this needs assessment conducted?

Year: 2008/9

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

All population

1.6 Does the multisectoral strategy include an operational plan?

Yes	No

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes	No
b. Clear targets or milestones?	Yes	No
c. Detailed costs for each programmatic area?	Yes	No
d. An indication of funding sources to support programme	Yes	No

implementation?		
e. A monitoring and evaluation framework?	Yes	No

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

a. Active involvement	b. Moderate involvement	c. No involvement

IF active involvement, briefly explain how this was organised:
- Consultative meetings (Stakeholder)
- Partners
- Technical working group

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes UN agencies	No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No UN agencies have other programmes

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and Why
The strategic framework is not followed. Donors take lead and organisation follow them since they (organisations) need money for programmes

2. Has the country integrated HIV into its general development plans such as in:
(a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1 **IF YES**, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	a. Yes	b. No	c. N/A
b. Common Country Assessment / UN Development Assistance Framework	a. Yes	b. No	c. N/A
c. Poverty Reduction Strategy	a. Yes	b. No	c. N/A

d. Sector-wide approach we don't have	a. Yes	b. No	c. N/A
e. Other: PEPFAR	a. Yes	b. No	c. N/A

2. **IF YES**, which policy areas below are included in these development plans?

1. HIV prevention	Yes	No
2. Treatment for opportunistic infections	Yes	No
3. Antiretroviral treatment	Yes	No
4. Care and support (including social security or other schemes)	Yes	No
5. AIDS impact alleviation	Yes	No
6. Reduction of gender inequalities as they relate to HIV prevention/ treatment, care and/or support	Yes	No
7. Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
8. Reduction of stigma and discrimination	Yes	No
9. Women's economic empowerment (e.g. access to credit, access to land, training	Yes	No
10. Other:	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1 **IF YES**, to what extent has it informed resource allocation decisions?

Low High

0 1 2 3 4 5

4

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)? Yes

4.1 **IF YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes	No
Condom provision	Yes	No
HIV testing and counselling	Yes	No
Sexually transmitted infection services	Yes	No
Antiretroviral treatment	Yes	No
Care and support	Yes	No
Others:	Yes	No

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g., indicate if HIV testing is voluntary or mandatory etc):

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	No

Regulations are general; there is no legislation for most-at-risk population

5.1 **IF YES,** for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: [write in]	Yes	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented: Briefly comment on the degree to which these laws are currently implemented

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	No

6.1 **IF YES,** for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other:	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies: Briefly comment on how they pose barriers:

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes	No

(a) **IF YES**, is coverage monitored by sex (male, female)?

Yes	No

(b) **IF YES**, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?
Children and adults (Male and female) in all regions

Briefly explain how this information is used:

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?
At the health centres which can then be deduced to regions

Briefly explain how this information is used:

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	No

Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
6											
Since 2007, what have been key achievements in this area: There has been an improvement – the strategy covers all sectors What are remaining challenges in this area: • The programme is still weak, it is all activity based • Implementation and resources are still a challenge • Budget is highly donor driven • There is no specific budget for the strategy, thus some parts are not implementable											

POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes	No
Other high officials	Yes	No
Other officials in regions and/or districts	Yes	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 **IF YES**, when was it created?
Year: 2001

2.2 **IF YES**, who is the Chair?
Name: Ndabankulu simelane (Chief) Position/Title: Chairperson

2.3 **IF YES**, does the national multisectoral AIDS coordination body:

Have terms of reference?	Yes	No

Have active government leadership and participation?	Yes	No
Have a defined membership? **IF YES**, how many members? 18	Yes	No
Include civil society representatives? **IF YES**, how many? 14	Yes	No
Include people living with HIV? **IF YES**, how many? 1	Yes	No
Include the private sector?	Yes	No
Have an action plan?	Yes	No
Have a functional Secretariat?	Yes	No
Meet at least quarterly?	Yes	
Review actions on policy decisions regularly?	Yes	No
Actively promote policy decisions?	Yes	No
Provide opportunity for civil society to influence decision-making?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A

IF YES, briefly describe the main achievements:
Partnership forums – AIDS quarterly meetings

Briefly describe the main challenges:

- Coordination
- Alignment of programs
- Duplication
- Resource mobilisation

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage:

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes	No
Technical guidance	Yes	No
Procurement and distribution of drugs or other supplies	Yes	No
Coordination with other implementing partners	Yes	No
Capacity-building	Yes	No
Other:	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No

On going

6.1 **IF YES**, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	No

Being amended

IF YES, name and describe how the policies / laws were amended:
▪ Sexual offences – reviewed ▪ Paternity law ▪ Marriage law ▪ Estate law ▪ Pharmaceutical Act

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
Overall, how would you rate the political support for the HIV programme in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10 7
Since 2007, what have been key achievements in this area: ▪ New government ▪ New Prime Minister ▪ Increased allocation on budget What are remaining challenges in this area: ▪ Creating commitment in traditional leadership

PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No	N/A

1.1 **IF YES**, what key messages are explicitly promoted?
☐ Check for key message explicitly promoted

a. Be sexually abstinent	✔
b. Delay sexual debut	✔
c. Be faithful	✔
d. Reduce the number of sexual partners	✔
e. Use condoms consistently	✔
f. Engage in safe(r) sex	✔
g. Avoid commercial sex	✔
h. Abstain from injecting drugs	✔
i. Use clean needles and syringes Not promoted	✖
j. Fight against violence against women	✔
k. Greater acceptance and involvement of people living with HIV	✔
l. Greater involvement of men in reproductive health programmes	✔
m. Males to get circumcised under medical supervision	✔
n. Know your HIV status	✔
o. Prevent mother-to-child transmission of HIV	✔
Other:	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	No	N/A

2.1 Is HIV education part of the curriculum in:

Primary schools? to a lesser degree	Yes	No
Secondary schools? 70%	Yes	No
Teacher training?	Yes	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes	No

IF NO, briefly explain:

3.1 **IF YES**, which populations and what elements of HIV prevention do the policy/strategy address?

 Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations
Targeted information on risk						Migrant workers
reduction and HIV education						✔
Stigma and discrimination Reduction						Don't know
Condom promotion						✔
HIV testing and counselling Reproductive health, including sexually transmitted infections prevention and treatment						✔
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	N/A
Drug substitution therapy		N/A	N/A	N/A	N/A	N/A
Needle & syringe exchange		N/A	N/A	N/A	N/A	N/A

Overall, how would you rate policy efforts in support of HIV prevention in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10 8
Since 2007, what have been key achievements in this area: ▪ Multimedia campaigns ▪ Community interventions ▪ Peer education What are remaining challenges in this area: ▪ Behaviour change ▪ Behaviour dynamics

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?

- Good information
- Reduction of multi-partners
- PMTCT
- Male circumcision

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't Agree	N/A
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out-of-school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: [write in]	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

2009 Very poor
Excellent

0 1 2 3 4 5 6 7 8 9 10

7

Since 2007, what have been key achievements in this area:

- Strategy created
- Campaigns through media
- Community campaigns

What are remaining challenges in this area:

TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	No

1.1 **IF YES**, does it address barriers for women?

Yes	No

1.2 **IF YES**, does it address barriers for most-at-risk populations?

Yes	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No

IF YES, how were these determined?

- Human resources shortage
- Drugs needed in health facilities
- Facilities needed

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common	Agree	Don't Agree	N/A
HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the	Agree	Don't Agree	N/A

workplace			
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other	Agree	Don't agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes	No

IF YES, for which commodities?:

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?
2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10 8
Since 2007, what have been key achievements in this area: ▪ Increase in the people who need treatment What are remaining challenges in this area: ▪ Health infrastructure; Human resource; Access due to distances and poverty

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	NO	N/A

5.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

5.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? %

It is very low

Overall, how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children in 2009?
2009 Very poor Excellent 0 1 2 3 4 5 6 7 8 9 10 7
Since 2007, what have been key achievements in this area: ▪ 100% are in school; Introduction of free education; NCPs What are remaining challenges in this area: ▪ Resource constraints; Poverty of orphans and vulnerable children

MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes	In progress	No

IF NO, briefly describe the challenges:

1.1 **IF YES**, years covered: Since 2005

1.2 **IF YES**, was the M&E plan endorsed by key partners in M&E?

Yes	No

1.3 **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	No

IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes	No
IF YES, does it address:		
routine programme monitoring behavioural surveys	Yes	No
HIV surveillance	Yes	No
Evaluation / research studies	Yes	No
a well-defined standardised set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing data quality (i.e., validity, reliability)	Yes	No
a data analysis strategy	Yes	No
a data dissemination and use strategy	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No

3.1 **IF YES**, what percentage of the total HIV programme funding is budgeted for M&E activities? 7% (NASA report)

3.2 **IF YES**, has full funding been secured?

Yes	No

IF NO, briefly describe the challenges:

3.3 **IF YES**, are M&E expenditures being monitored?

Yes	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves: Joint review of the entire response is done in year 3 of the 5 years

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes	In progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit?

5.1 **IF YES**, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	No
in the Ministry of Health? M & E Health	Yes	No
Elsewhere?	Yes	No

5.2 **IF YES**, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: 4		
Position: M & E coordinator	Full time / Part time?	Since when?: August 2009
Position: SHAPMOS manager	Full time / Part time?	Since when?: March 2009

Position: SHAPMOS officer 1	Full time / Part time?	Since when?: January 2009
Position: SHAPMOS officer 2	Full time / Part time?	Since when?: January 2009
Number of temporary staff: 0		
Position:	Full time / Part time?	Since when?:
Position:	Full time / Part time?	Since when?:

5.3 **IF YES**, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

IF YES, briefly describe the data-sharing mechanisms:
SHAPMOS
What are the major challenges?
Reporting level is low. On average it is 52% (Nercha)

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

- CANGO
- SWANNEPHA
- SASO

Role:

- Advise on the implementation of the National HIV and AIDS M & E system
- Facilitate provision and guidance in data collection
- Review and develop HIV and AIDS roadmap

7. Is there a central national database with HIV- related data?

Yes	No

7.1 **IF YES**, briefly describe the national database and who manages it
Nercha: CRIS database, managed by Nercha IT

7.2 **IF YES**, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above
b. Yes, but only some of the above: [write in]
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes	No
At subnational level **IF YES**, at what level(s)?	Yes	No

(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No

9. To what extent are M&E data used
9.1 in developing / revising the national AIDS strategy?:

Low High
0 1 2 3 4 5
3

Provide a specific example: What are the main challenges, if any?

9.2 for resource allocation?:
Low High
0 1 2 3 4 5
4

Provide a specific example: The national strategic plan and roadmap include costed activities from which funding is sought using those tools who in turn are guided by M & E into products What are the main challenges, if any?

9.3 for programme improvement?:

Low High
0 1 2 3 4 5
4

Provide a specific example: M & E has allowed the country to know the drivers of the epidemic, HIV prevalence, the success of programmes. Now more than before the detailed research needs for the country can be articulated What are the main challenges, if any?

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:
a. Yes, at all levels
b. Yes, but only addressing some levels:
c. No

10.1 In the last year, was training in M&E conducted

At national level?	
IF YES, Number trained: 4	
At subnational level?	
IF YES, Number trained:	
At service delivery level including civil society?	
IF YES, Number trained: 11,451	

10.2 Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities: [write in]
Participation on the review of the NSP 2006-2008

Overall, how would you rate the M&E efforts of the HIV programme in 2009?

2009 Very poor
Excellent

0 1 2 3 4 5 6 7 8 9 10
6

Since 2007, what have been key achievements in this area:
Designing of the new M & E with the new strategic framework

What are remaining challenges in this area:

- Resources required by partners and stakeholders to provide effective services
- Not timeously

PART B: CIVIL SOCIETY, BILATERAL AGENCIES, UN ORGANISATIONS

HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	No

Comments:

- The laws and regulations are general they are not specific to HIV
- Employment Act is not specific. Those companies with HIV policy do not implement those policies
- The laws are still a Bill
- There is a general provision in the national constitution

1.1 **IF YES**, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision: [write in]

Comments;

- The country laws are no specific to HIV
- The country is using ILO code, HIV workplace policies. So at the workplace level, there are policies but the implementation is a challenge

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes	No

Comments:

- No regulations for some of the most-at-risk populations (sex workers, men having sex with men)
- Men having sex with men are not welcome in public health facilities – they are to first report to the police if they present with anal infections
- Most health workers bring their values and beliefs at the workplace – they don't offer health services to all who present with ailments but they judge the clients and if they don't believe in their (client) practices they frown and not provide the service accordingly
- The vulnerable subpopulations that are regulated is the elderly and the orphans and vulnerable children

2.1 **IF YES**, for which populations?

a. Women Yes to an extent. If the Bills for sexual offenses and domestic are passed in parliament may be there will be protection for women	Yes	No
b. Young people Yes to an extent. There is a policy which has just been formulated and yet to be launched.	Yes	No

c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates Health services are provided for inmates though they are not given condoms	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: disabilities – they are not accommodated, some of their needs cannot be included in the general statements	Yes	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:
Briefly describe the content of these laws:

- Consenting age for girls
- Trafficking human especially women and girls
- Protection against rape

Briefly comment on the degree to which they are currently implemented:

- Not fully protecting these populations

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes	No

Comments:

- Yes to some populations like the sex workers and men having sex with men
- The criminalization of sex work in the country deprives the populations adequate HIV and AIDS management services
- The criminalization of men having sex with men
- The criminalization of unsafe abortion is obstructing effective treatment, care and support
- Marriage laws still give the woman a minority status. They limit the woman's autonomy in decision making
- Inheritance laws are not protecting the women and children (family members take advantage of them)
- Maintenance laws are an obstacle – they are not forcing partners
- Accessing and controlling property laws are not protecting women and children
- Child headed families are not protected – family families fight over control because they are only interested in the assets left by parents
- The practice in correctional service facilities of refusing inmates to use condoms

3.1 **IF YES**, for which subpopulations?

a. Women There are no obstructing laws but the society environment is preventing women from some of the services	Yes	No
b. Young people	Yes	No

young people below the age o 18 cannot test for HIV because they are still minors (consenting age)		
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers Sex workers are not provided with adequate condoms	Yes	No
f. Prison inmates Inmates do receive health care services – but they are not given condoms because the practice of men having sex with men is illegal in the country	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: [write in]	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies:

- Criminalisation of sex work, injecting drug users, men having sex with men

Briefly comment on how they pose barriers:

- Criminalisation keep these groups underground

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

Yes to an extent though

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Human rights are mentioned in

- National policies (NSF, NDS)
- There are policies BUT they are not translated into laws which will make them implementable. Thus there is no action plan for the policies since there are no legal implications
- Universal access to services – government has it in its policies
- The country is signatory to a number of declarations and is yet to rectify them
- The recognition of organisations for people living with HIV
- The national policies state how services and interventions will be implemented; they address people living with HIV; they address gender and equality; they address women and children
- Discrimination against HIV infected discouraged. Compulsory testing prio to employment is discouraged

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes	No

- There is need to have a structure to enable the documentation of the reports so that action is taken immediately where necessary before more damage is done.

- There is no 1 mechanism: there are disjointed databases by some civil society organisations (NGOs) they each have their own recording system

IF YES, briefly describe this mechanism:

- Women and law organisation
- Human rights commission (though just elected – but this should be part of its mandate)
- Police stations receive reports and records
- SWAGGA

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes – to an extent	No

Yes but not sure of the extent

IF YES, describe some examples:

People living with HIV are involved in

- Planning – NSF, CCM, NERCHA council
- Budgeting – they are members of the Global fund team
- Financial support– the funds are not adequate, there are no grants for people living with HIV; no transport to bring clients closer to health facilities
- Political support – the commitment is questionable
- Most-at-risk populations (sex workers, men having sex with men) are illegal and therefore not catered for

Vulnerable populations like orphans and elderly are taken care of

Women & Law:

- Financial: UN systems; Global; NERCHA – these systems have been consultative
- The challenge is on implementation:
  - Political level: the recognition of issues submitted by the different forums of civil society organisation is questionable – in most times those issues fall off within the political system in the country
- Not all populations are involved and representated (eg elderly, sex workers, disabled)
- Participation in policy formulation, National strategic framewok review and formulation

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes	No
b. Antiretroviral treatment	Yes	No
c. HIV-related care and support interventions	Yes	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

- HIV prevention services: the country is providing free services in public health facilities. (condoms are free, PMTCT is free, Male circumcision is free)
- Antiretroviral treatment: free across
- HIV-related care and support interventions: In public health facilities there is minimal payment for Opportunistic Infections treatment, drugs – though sometimes patients have to buy the medication because it is not available in the health facilities

- In private health facilities clients only pay for consultation and get free HIV treatment medication.
- The procurement and logistic management in the country is still weak (stock outs, poor distribution)
- Service providers are sharing the burden
- There is still a challenge on disabled persons: the access to health facilities is not addressed adequately (for instance, transport to the facilities for some, communication for those who are mute)
- Some workplaces don't allow many off days (sick leave), thus workers share medication because they cannot get for themselves when at work – challenge to adherence
- Families sometimes share medication
- The criminalization of some activities (sex work) is hindering access to the services
- The distribution of these services must be in accordance of the needs of the different populations
- The distribution of care and support intervention must be in proportion with the need (eg home based care – there is no material, health workers don't visit homes)
- VCT are in place
- Doctors are trained to offer treatment
- Support for NGOs to provide services

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No

- The policies are not discriminating, they apply to all citizens
- The HIV policy talks of gender equality
- If there are limitation in access, it would not be the intention of the government

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No

- The policies are not discriminating, they apply to all citizens
- However, all services are linked to either pregnancy or childbirth. Other women are included in the general statement

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes	No

The policies are not discriminating, they apply to all citizens

IF YES, briefly describe the content of this policy:

- The policies are not discriminating, they apply to all citizens. But the practice in the different health facilities may deny equal access to some populations. For example, MSMs is illegal therefore when a man presents with anal infections, health workers require that the person reports the case to the police. In this way the MSM population is denied health services.
- The approach in all is general yet the needs of the different populations differ

- Not much is regulated in the country
- HIV policy where discrimination is discouraged and comprehensive services to all groups is guaranteed

9.1 **IF YES**, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	No

- The policies are not discriminating, they apply to all citizens
- There is no special handling of certain populations

IF YES, briefly explain the different types of approaches to ensure equal access for different populations

- Treatment and services targeting children

10. Does the country have a policy prohibiting HIV screening for general employment purposes? (Recruitment, assignment/relocation, appointment, promotion, termination)

Yes	No

- Government is against mandatory HIV testing. The Industrial Relations Act does mention the prohibition of HIV screening at the workplace.
- No the policy that has this clause is the ILO codes of practice which is mandatory
- Policies are not yet finalised
- Yes though some companies violet the policy (eg the army)

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	No

- Policy still not finalised
- There is a committee – not sure if there is a policy

11.1 **IF YES**, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	No

IF YES, describe the approach and effectiveness of this review committee:

- The effectiveness of the committee is limited especially because it is chaired by the Ministry of Health (which is government) instead of at least an academic institution
- It does not capture all researches done in the country
- Challenge: the committee lacks academic and private sector involvement
- It is an adhoc process as there is no statutory body

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

- The newly established commission is hoped to will be able to manage this

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	No

It is not related to human rights

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:

- PSHACC is the focal point within government (for civil servants)
- The Human Right commission is in place but not operational
- Benchmarks are in the NSF

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes	No

- UNDP conducted a workshop for the judiciary
- UN has attempted to help the judiciary put in place a strategic plan which specified the need for their capacity building

14. Are the following legal support services available in the country?
– Legal aid systems for HIV casework

Yes	No

- Women and Law do refer for legal support
- No – though there are NGOs that refer people to lawyers but it is not a formal system of referral
- UNISWA is offering some services but not specific to HIV
- NGOS have be offering out-of-court

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

- SWABCHA to an extent
- Women and Law
- SWAGGA

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	No

- No – funds are not adequate
- Civil society is doing a lot on this issue

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

There is NO specific programme as such – there are sporadic activities

IF YES, what types of programmes?

Media Yes to an extent Yes only on adverts	Yes	No The media is perpetuating it
School education Yes but; not much coverage; not strong	Yes	No
Personalities regularly speaking out	Yes	No
Other: [write in]	Yes	No

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009? 4

Since 2007, what have been key achievements in this area:

- There are bills still to be passed at parliament
- Development of NSF
- Establishment of OVC care unit – DPM
- Not much improvement
- There is children policy

What are remaining challenges in this area:

- There is need to support the survivors (not to use the word 'victim')
- There no specific laws for perpetuators of violence
- Need to address the issue of the criminalization of HIV
- There is need to address the social environment – policies on their own cannot change the behaviours
- The policies are not enforceable
- There are no laws to protect human rights
- There is need for a law reform commission that will periodically review laws and regulations of this country (most of the laws are very very old)
- There is no coordinated approach to policy making by the different stakeholders – there is a lot of overlaps
- The adoption period of bills to laws is a long period – to an extent that issues addressed are overtaken by events
- Most of the existing policies are not translated into laws
- Strengthen laws and eract other relevant ones

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009? **3**

Since 2007, what have been key achievements in this area:

- There are bills in parliament waiting to be passed
- The Human Trafficking and OVC legislations have been passed
- Not much improvement has been made
- The dissemination of the HIV policy to stakeholders

What are remaining challenges in this area:

- There are no laws
- The criminalization of sex work and men having sex with men practices
- Some companies violet the human rights to their interest (example: Insurance company still test for HIV in the Life policy cover)
- The recognition of the right of people living with HIV
- Enforcing the legislation is a challenge :
    - Resources are inadequate
    - Capacity building: people have to understand how to implement the law; people have to appreciate their roles to play
- Lack of coordinated approach among stakeholders
- Policies are not translated into laws

CIVIL SOCIETY * PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations? **3**

Comments and examples:

- People living with HIV have worked hard to advocate for their position
- The country has a coordinating mechanism – NERCHA
- Civil society is participating in a number of programmes and committees (example: CCM, Global fund)
- Funding for civil society has been increased (especially round 7 of the Global fund)
- There is participation but there is need to build capacity in order for te civil society to actively participate
- There are no forums to address issues with the highest authorities in government (example: audience with the Prime Minister)
- There is participation by civil society though politics and external influence takes the lead
- The contribution is not very strong – civil society wants to participate
- Lobbying has intensified

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)? **4**

Comments and examples:

- The development and establishment of NSF, CCM, UN joint
- There is intensive consultation

- Challenge is in budgeting: civil society is not involved much – they are only consulted
- NERCHA does not involve civil society in the national budgeting process (the budget is not based on the needs of the civil society)
- Civil society was involved in the NSF
- Budgeting and planning is for government, civil society fall out
- Participated in regional plans

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy? 3

b. the national AIDS budget? 2
c. national AIDS reports? 3

Comments and examples:

- National strategy: there is NSF which is consultative
- National budget: the budget processes are closed, can nott be open. There is limited budget; HIV budgeting is not wholly in government , it is highly funded by stakeholders
- There is not much coordination of AIDS reports
- NERCHA gets reports from implementers
- There is a mechanism for reporting
- There is involvement though not all organisations participate (eg commercial sex workers)
- Civil society is participating in strategy but involvement is questionable
- They are invoved in budget through Global fund
- In reporting there is SHAPMOS

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan? **3**

b. participating in the national M&E committee / working group responsible for coordination of M&E activities? **3**

c. M&E efforts at local level? **3**

Comments and examples:

- There is no community M & E framework in the country; there is no collection of community based input to M & E; Most of the M & E done is data from health facilities
- The existing structures are not fully utilized, the country can do better than what is done
- The present M & E doesn't capture everything done at community level
- The M & E does not major the impact – the given indicators in M & E do not measure the impact (eg reporting that you distributed so much doesn't reflect if the use was effective)
- The M & E system is consultative
- Civil society is involved in reporting

- Civil organisations don't have much capacity
- The majority of organisations are struggling
- SHAPMOS forms ensures participation

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)? **4**

Comments and examples:

- The representation does not include sex workers, men having sex with men, inmates
- The criminalisation of sex worker and anal sex
- There is a high effort on ground by for instance peer educators at the different levels; HIV support groups
- Challenge is the recognition at national level the efforts done by civil society
- Sex workers not included

6. To what extent is civil society able to access?

a. adequate financial support to implement its HIV activities? **2**

b. adequate technical support to implement its HIV activities? **2**

Comments and examples:

- Civil society is not organised: there is no effective leadership though there is a potential
- NERCHA is still interfering with civil society activities
- There is no technical support – though the ministry of health does provide technical assistance for M & E
- Not much is accessed by civil society
- On national level, civil society receives less than the need. Thus organisations get sources from others and in turn this distorts the interventions
- What get support are the programme activities, there is no support on management costs. Thus NGOs fall out because there are limited operational costs
- There is no capacity building in finance management, governance, M & E, planning, mobilisation o resources – writing a business plan
- M & E technical support is more provided for government
- Financial support is improving
- Technical support is not effective, it is not coordinated
- Currently has huge financial gap

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	<25%	25%-50%	51–75%	>75%
Prevention for most-at- risk-populations:				
- Injecting drug users N/A	<25%	25%-50%	51–75%	>75%
- Men who have sex with men	<25%	25%-50%	51–75%	>75%
- Sex workers	<25%	25%-50%	51–75%	>75%
Testing and Counselling	<25%	25%-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25%-50%	51–75%	>75%
Clinical services(ART/OI)*	<25%	25%-50%	51–75%	>75%
Home-based care	<25%	25%-50%	51–75%	>75%
Programmes for OVC**	<25%	25%-50%	51–75%	>75%

Overall, how would you rate the effort to increase civil society participation in 2009? **5**

Since 2007, what have been key achievements in this area:

- There has been an increase of funding from the Global fund for civil society (round 7). There is PEPFAR
- More civil society community is participating
- There is no increase but there is maintenance of existing groups
- The representation at CCM
- There is greater consultation
- There is recognition by the Ministry of Health
- Increase in subventions
- Subcontracting some civil society to implement using Global fund

What are remaining challenges in this area:

- The government is anti-civil society (may be because civil society is getting into politics) therefore, their efforts are being undermined
- Funding is still not adequate to implement HIV programmes
- There is need for capacity building among civil society organisations
- There is need to increase financial, technical support and sustainability support
- The role of civil society organisations is not appreciated due to lack of tolerance from government
- Poor coordination, there is need a strong centre for coordination

PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?

- Needs assessment exercise was conducted, there was intensive consultation
- Behavioural change studies have been done
- HIV prevention awareness is high
- Studies and surveys have been conducted
- There is good evidence based analysis – Modes of Transmission study
- Planning process

IF NO, how are HIV prevention programmes being scaled-up?

- Government does not have a prevention programme structure. Activities are done at adhoc, there is no coordination.
- There is need to have an HIV prevention unit to assist coordinate the programmes

To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't Agree	N/A
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A FLAS,
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people but coverage of schools is limited, and the quality of what is offered needs to be improved	Agree	Don't Agree	N/A
HIV Prevention for out-of-school young people Offering is very limited	Agree	Don't Agree	N/A
HIV prevention in the workplace though the practical aspect	Agree	Don't	N/A

of implementing the policies is a challenge. The business sector is trying BUT the civil society is still weak. Large companies implement and small to medium companies do not.		Agree	
Other: [write in]	Agree	Don't Agree	N/A

Overall, how would you rate the effort in the implementation of HIV prevention programmes in 2009? **6**

Since 2007, what have been key achievements in this area:

- Introduction of male circumcision
- PMTCT
- The prevalence rate has gone done mostly with the youth
- Not much has be done since 2007
- Resources have been increased
- There has been an increase in the intensity of activities
- Increase in community based activities on prevention, though the quality is not that good
- More condom usage, less multi sexual partners, fewer underage early sex
- Circumcision

What are remaining challenges in this area:

- Condom distribution is still a challenge: there is poor supply chain management
- There are no behaviour change programme – they are inadequate and not well planned
- There is still high prevalence, behaviour is not changing with some people
- There are still populations that are left out in the campaign for HIV prevention (sex workers, men having sex with men)
- There is need to address specific population groups and society levels (eg. Matsapha firm workers)
- The country is investing in intervention programmes which may not be effective
- Lack of coordination
- There is no impact assessment
- National leadership
- Behaviour change

TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No

IF YES, how were these specific needs determined?

- There is assessment of health facilities – this informs the Ministry
- Baseline studies and surveys have been made (SDHS)
- Clinical discharge rates are high
- Consultations were made
- There is a national committee that regulates the programmes
- Information from health facilities
- Health facility database
- Planning process

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care The quality of the service needs to be improved. There is shortage if material	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people INCH is not implemented they are only given bactrim, therefore, treatment is partial.	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009? **6**

Since 2007, what have been key achievements in this area:

- There more health facilities providing the services – more people are getting treatment
- There is decentralisation of treatment services
- There has been an increase in funding – more budget allocation
- Government accommodates NGOs
- ART is free
- HIV treatment awareness is high
- People are seeing the difference in those who are on ART
- Access has been increased
- Survival within 12 months has increased by about 74%
- There has been a scaling up
- Home based care allowances
- Rapid scale up of ART programmes
- Improvement in TV programmes
- Expansion of services

What are remaining challenges in this area:

- The supply chain management need to be improved
- There are no OI drugs
- People are still delaying treatment
- There is stigma and discrimination in some health facilities where are still designated treatment rooms
- Insufficient support
- Need to have adequate institutional accountability (all businesses should be providing the services to employees)
- There is insufficient accessibility in rural areas
- The monitoring of drugs and clients is still a challenge
- Compliance to treatment by clients is a challenge
- Decentralisation of services
- Health facilities are crowded
- Stock outs
- Quality services
- Improved attitude of health workers

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N/A

2.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

- With the support of UNICEF, there is a coordinating unit in the Deputy Prime Minister's office which strengthen the provision of the policy

2.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? %

- According to the Global fund the percentage used is 45% - UNAIDS
- Not sure of the figure – FLAS, SWANNEPHA, AMICAALL, Women & Law

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009? **6**

Since 2007, what have been key achievements in this area:

- There is a National plan for OVCs
- There is educational support for OVCs (though the support is not holistic)
- There is promotion of universal primary education
- The establishment of neighbourhood care points
- The establishment of school feeding programmes
- Establishment of the NCCU
- There is awareness on OVCs, politician leaders are talking about it in the different forums
- Care points
- National standards of care
- Grants in schools
- NCPS operational

What are remaining challenges in this area:

- There is need for proper coordination of the impact evaluation
- The support is only educational not in totality of the child's needs (example: psychosocial support is missing)
- The child headed families
- The children are vulnerable, they are abused, they lose family assets
- The absence of care institutions results in lack of parental guidance
- The efforts are not comprehensive – there are no values taught to the OVCs
- The management of the OVC fund
- Lack of shelter, clothes, health and socialisation support for the vulnerable children
- The quality of the services provided to OVCs

- Sustainability of services
- Current status
    - There is no adult guidance
    - This is an angry society