

**THE EXTENDED  
NATIONAL  
MULTISECTORAL  
HIV AND AIDS  
FRAMEWORK (eNSF)  
2014 - 2018**



**SWAZILAND**



## Foreword

It has pleased the Government of Swaziland to extend the Swaziland Multisectoral National Strategic Framework for HIV and AIDS (NSF 2009-2014) to 2018. Commissioned in June 2012, the extension updates the current strategy which was developed through a highly participatory and consultative process that provided the context for comprehensive, relevant, targeted, evidence and results-based HIV programming for Swaziland.

The extension of the NSF (eNSF) 2014-2018 takes into account recent realities of Swaziland and the evolving HIV epidemic. The HIV response uses a human development approach that takes cognisance of individual and social factors that are a cause and potential solution of infection. The HIV epidemic reflects the pattern of behaviour in our society, the complexities of our sexuality, our relationships, our beliefs and attitudes that influence the transmission of HIV. It also reflects our reactions to infection, illness and how we support each other, or stigmatise and discriminate one another. The extension of the NSF has created an opportunity to embrace emerging issues by taking into account recent evidence about the status of our response and recognises on- going global and local financial constraints. Our success in responding to the HIV and AIDS challenges will depend on our efforts and commitment to intensify targeted actions and resource investments on what we know works to achieve our desired results.

The extended NSF will guide our interventions over the next five years focusing on high impact interventions, targeting population groups that are vulnerable and at higher risk of HIV acquisition. Swaziland considers HIV as a health, development and human rights issue, and hence our commitment to provide comprehensive, quality HIV and AIDS services to all our people. We hope that the collective action will result in a Kingdom with no new infections, zero discrimination, and zero AIDS related deaths by 2018.

His Majesty's Government requests the support of all stakeholders, partners and civil society to make the vision of sustainable human development a reality by addressing HIV and AIDS as a national priority. Indeed iHIV Yindzaba Yetfu Sonkhe. Let us now, and in the future join our efforts to ensure that the extended NSF is translated into concrete, practical, focused and sustained action.

As we face the challenges of human development, we also have the opportunity in the extended NSF to reverse the impacts of HIV and accelerate socio-economic development of our people. An HIV free generation is possible within our lifetime but only through collective and steadfast commitment, courage, leadership including the active participation and engagement of our communities, people living with HIV and AIDS and other stakeholders. We have as well a moral obligation to future generations to save the current generations from the scourge of AIDS.



**Dr. Barnabas Sibusiso Dlamini**  
Prime Minister  
Kingdom of Swaziland

## Acknowledgements

Once again, the National Emergency Response Council on HIV and AIDS (NERCHA) is proud to provide visionary leadership in the national multisectoral response to HIV and AIDS in Swaziland. NERCHA wishes to thank the Government of Swaziland and NERCHA Council for affording us the opportunity to extend the National Strategic Framework from 2014 to 2018. The eNSF is presented both as a social responsibility and contribution for investing in HIV; an opportunity to move forward while gaining efficiencies in the future.

NERCHA is thankful to the HIV Thematic Technical Working Groups who worked tirelessly to provide invaluable strategic information to shape this strategy focused on providing those priority services that will help the country meet its HIV response objectives. The value of the oversight function of the Independent Multi-disciplinary Technical Review Panel (TRP) cannot be over stated as members provided key technical inputs that moved the process forward.

NERCHA is grateful for the support provided by the Technical Advisory Teams from the World Bank (GAMET) and UNAIDS Regional Support Team (RATESA) in mentoring national teams working on the extension. Special appreciation goes to the World Bank for providing the independent external peer review of the eNSF and its accompanying products. The reviews were crucial to ensure that our strategy responds to the local epidemiological context while at the same time conforming to international best practices. I also pass my sincere gratitude to the NERCHA coordination team, who facilitated the process, for the competency and commitment displayed while executing this important national responsibility.

NERCHA is indebted to all multisectoral stakeholders; Government Ministries, development bilateral and multilateral partners, People Living with HIV and AIDS (PLHIV), implementing partners, Civil Society Organisations (CSO) and local communities; who collectively contribute to the HIV and AIDS response. I must point out that this extension was made possible by the great work done in the initial NSF 2009-2014, whose widely consultative process provided an excellent basis for HIV programming in Swaziland. Through the extended NSF, Swaziland reaffirms its commitment to halt the spread of HIV and reverse its consequences by investing in priority programmes that will reduce new HIV infections, improve life expectancy for PLHIV, and contribute to national human and social development as envisaged by the National Development Strategy (NDS).

I request our bilateral and multilateral stakeholders support the Swaziland eNSF and assist us in identifying resources that are needed to implement the strategy at the required scale. The huge financial gap presented in this strategy also requires that the country commits to more inward-looking resource mobilisation mechanisms to match the need. As a result, Government Ministries and the private sector are requested to mainstream related HIV synergies within what they are already doing.

Finally, I remain hopeful that our collective efforts will enable us to reach new heights and usher in a tide where the possibility of zero new HIV infections, no AIDS-related deaths or HIV stigma and discrimination becomes a reality.



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### Abbreviations and acronyms

ABC	Abstinence, Be faithful and Condoms
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
ARVs	Antiretroviral Drugs
AZT	Zidovudine
BCC	Behavioural Change Communication
CAM	Complementary and Alternative Medicine
CANGO	Coordinating Assembly of non-Governmental Organisations
CBO	Community-Based Organizations
CCM	Country Coordinating Mechanism
COP	Country Operational Plan
CSO	Central Statistical Office
CT	Counselling and Testing
DPM	Deputy Prime Minister
FLAS	Family Life Association of Swaziland
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
HBC	Home-based Care
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
MC	Male Circumcision
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOAC	Ministry of Agriculture and Co-operatives
MOE	Ministry of Education
MOH	Ministry of Health
MTCT	Mother To Child Transmission
MTPI	Medium Term Plan - I
MTPII	Medium Term Plan - II
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



NSF	National Strategic Framework
NSP	National Strategic Plan
NVP	Nevirapine
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan for HIV and AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PSHACC	Public Sector HIV and AIDS Coordinating Committee
RHMS	Rural Health Motivators
SSBCC	Swaziland Social and Behavioural Change Communication Strategy
SDHS	Swaziland Demographic and Health Survey
SMP	Strategic Management Plan
SNAP	Swaziland National AIDS Program
STIs	Sexually Transmitted Infections
SW	Sex Workers
SWAGAA	Swaziland Action Group Against Abuse
SWANNEPHA	Swaziland National Network for People Living With HIV and AIDS
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNV	United Nations Volunteer
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Children's Fund
VCT	Voluntary Testing and Counselling
WFP	World Food Program
WHO	World Health Organisation





## Definition of Selected terms used in the eNSF

<b>Baseline</b>	A quantity, value or fact used as a standard for measuring other quantities and values. Represents the current status.
<b>Culture</b>	Refers to people's inherited way of life. It is manifested through cultural practices and is defined by cultural norms and attitudes.
<b>Discordant couples</b>	A case where one member of a couple is HIV positive and the other is not.
<b>Duty bearer</b>	The person or institution with a legal mandate to provide certain services to another person in need. The duty bearer is obliged by law to provide services in a non-discriminatory, non-prejudiced manner to all persons who required the service.
<b>Effectiveness</b>	The extent to which an intervention objective was achieved or is expected to be achieved
<b>Efficiency</b>	A measure of how economically resources / inputs are converted to results
<b>Empowerment</b>	Action taken to overcome obstacles arising from inequality. Empowerment of women means development of their ability, collectively and individually to take control of their lives, to identify their needs, to determine interests that suit them.
<b>Family</b>	A social unit by blood, marriage, and or adoption, defined by common line relationship of a paternal, maternal or parental nature. This can be biological or adoptive, It can be described as nuclear (parents and children) or extended (the conjugal family as well as other relatives or ascendants of the husband or wife)
<b>Gender</b>	Refers to the social conceptualization of males and female based on social differences and relations between them that are learnt, changeable over time, and have wide variations across cultures. They are context specific and can be modified.
<b>Gender empowerment index</b>	A composite index measuring gender inequality in three basic dimensions of socio-economic and political participation in decision-making and power over economic resources
<b>Gender equality</b>	Entails the concept that all human beings, both men and women are free to develop their personal abilities or make choices without limitations set by stereotypes, rigid gender roles and prejudices; so that their rights, responsibilities, and opportunities do not depend on whether they are born male or female.
<b>Gender equity</b>	It is fairness of treatment (distribution) of females and males according to their respective needs, rights, benefits, obligations and opportunities. Equity is the means to reach equality.
<b>Gender gap</b>	The difference existing in a certain situation whereby inequality is experienced by either males or females leading to availing less levels of participation, access to resources, rights, power and influence, remuneration and benefits.
<b>Gender-based violence</b>	Gender-based violence is a form of discrimination and is deeply rooted in power imbalances and structural relationships of inequality that exist between women and men. It is a form of violence where either a man or a woman exerts his or her power over the other with the intention to harm, intimidate, and control the other person.
<b>Human rights</b>	Human rights are rights inherent to all human beings, irrespective of nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. People are all equally entitled to human rights without discrimination. These rights are all interrelated, interdependent and indivisible. (United Nations Office of High Commissioner for Human Rights)
<b>Multiple and concurrent sexual</b>	Multiple and concurrent partnerships is a situation where a man or woman has more than one sexual partner and overlapping, or a situation where the partners are actively





<b>partners</b>	engaged at the same time. <b>Concurrent sexual partnerships</b> refer to when a person has “overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner” (UNAIDS Reference Group on Estimates, Modelling, and Projections, 2009). The prevalence of the population with concurrent sexual partners is referred to as ‘concurrency prevalence’, and this can be measured in two ways – point prevalence of concurrency, and cumulative prevalence of concurrency
<b>Outcome</b>	A change in behaviour (values, attitudes, practices etc.) of, or the use of new capacities (laws, policies etc.) by target group (people and institutions).
<b>Output</b>	Operational changes or new capacities (knowledge, skills and equipment, products and services), which result from the completion of activities within a specified intervention in a given time.
<b>Poverty</b>	Poverty is a multi-dimensional concept that measures including shortage deprivations of income, food, shelter, credit, employment, and deprivation in and access to basic social services such as (education, health and water.), food security, shelter, credit and employment. It can be defined in absolute and relative terms. Absolute poverty refers to inability to attain a minimum standard of living measured by a range of economic and social indicators such as household incomes, expenditure per capita, health status, life expectancy, access to basic social services, infant mortality rate, nutritional status and literacy.
<b>Result</b>	A measurable or describable change in the lives of people or organizations resulting from a cause and effect relationship or programme intervention.
<b>Results chain</b>	The causal sequence for an intervention to achieve impacts, moving from inputs and activities to outputs outcomes and impacts
<b>Results Framework</b>	A diagrammatic illustration of the logical chain of results that will lead to strategic objectives being achieved.
<b>Rights Holder</b>	A person who has a human and or legal right to claim for services from another person or institution with the mandate to provide such services
<b>Risks</b>	The probability that a person may be affected negatively by a condition or behaviour i.e. acquiring HIV infection
<b>Sector:</b>	A section of society that has common characteristics or interest. The mandates of sectors differ depending on the nature of their core business.
<b>Sex</b>	A biological construct defining the physical differences that males and females are born with
<b>Vulnerability</b>	Results from a range of external factors <sup>1</sup> that are often beyond the ability of a person to control that increases the possibilities of their exposure to HIV infection

<sup>1</sup>This may include personal factors such as lack of knowledge and skills required to protect oneself, and others; factors pertaining to the quality and coverage of services (such as inaccessibility of services due to distance and, cost) etc., and societal factors such as social and socio-cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, particularly such as women and girls.



## Executive Summary

### Executive Summary

The extended National Strategic Framework (eNSF) for HIV and AIDS (2014-2018) is a five-year multisectoral decentralised HIV/AIDS plan for Swaziland. In 2011, the Government of Swaziland commissioned a Joint Mid-Term Review of the National Strategic Framework (NSF) for HIV/AIDS (2009-2014). The review outcomes indicated that NSF strategies remain relevant to the current context of the epidemic. This influenced the Government of Swaziland to opt for an extension of the current NSF for another five-year period from 2014-2018. The extension of the eNSF adopts “investing for results” thinking. It also incorporates commitments to the 2011 UN Political Declaration for HIV and AIDS as well as the 2013 WHO Treatment Guidelines.

With the shifting global paradigm of the HIV/AIDS response and the impact of the global economic crisis, investment thinking has become a pre-requisite to all planning in the country. While demands and need for funding have risen, the availability of funds for HIV and AIDS has declined, globally. As funding priorities shift, increased demand for efficiencies in programming and service delivery is central to a strong response.

### Synopsis of the epidemiology of HIV and AIDS in Swaziland

Swaziland has a generalised HIV epidemic, with a high HIV prevalence rate of 26% among 15-49 year olds (Swaziland Demographic and Health Survey /SDHS 2006/07 and 31% among adults aged 18-49 (Swaziland Incidence Measurement Survey /SHIMS 2011). New HIV infections are declining and the HIV incidence rate among adults aged 18-49 is estimated as 2.38%, comprising of 1.7% and 3.1% amongst men and women, respectively—(SHIMS 2011). According to the preliminary report of the Swaziland HIV Estimates and Projections 2012, the annual incidence rate among 15-49 years is expected to decline from 2.9% in 2011 to 1.9% in 2015, and new infections among children at 18 months of age are estimated to be 11% of all exposed children in 2012, down from 19.6% in 2009. At ages 6-8 weeks, the country has virtually eliminated mother to child infections. According to the SHIMS (2011) the peak incidence of HIV infections is borne by women aged 18-19, 20-24 and 30-34 and men aged 30-34. Both SHIMS and Estimates and Projections models support the evidence of generally declining HIV infections.

The epidemic is characterized by a gender disparity, with prevalence being higher among women (38%) compared to men (23%). Analysis shows that the HIV epidemic is stabilizing and shifting to older populations. Data from the SHIMS (2011) reveal substantial prevalence reductions among the 18-24 year age group, comprised of a 54% and 20% reduction among males and females, respectively. Peak prevalence has shifted to older persons: to women aged 30-34 from those aged 25-29 in 2006/7; similarly for men, to those aged 35-39 from 30-34 year olds in 2006/7. Reported HIV prevalence among female sex workers is very high (70%). Prevalence is slightly lower among men who have sex with other men (17%) than that of the general male population aged 15-49 (19% - SDHS).

The country faces dual epidemics of HIV and tuberculosis (TB), where the risk of acquiring TB is between 20 and 37 times greater among people living with HIV. Over 80% of TB patients are also HIV positive, and TB is responsible for more than a quarter of deaths among people living with HIV. There are 1,380 per 100,000 incident TB cases occurring annually in Swaziland (World Health Organisation Global TB report 2012). Swaziland is making strides in responding to the co-epidemics, with 66% TB/HIV co-infected patients receiving treatment for both in 2012, an improvement from 35% in



2010. There has been remarkable improvement in the TB treatment success rate from 68% in 2009 to 73% in 2012, although this is still below the WHO target of 85%.

Swaziland is seeing a continued increase in drug resistant TB cases. Currently, between 7-10% of all new TB cases are multidrug-resistant (Swaziland Drug Susceptibility Survey, 2010).

### **Swaziland's priority commitments on HIV and AIDS**

Through implementation of the eNSF, Swaziland aims to achieve the following impact level results:–

- i. 50% and 90% reduction of new HIV infections among adults and paediatrics, respectively, by 2015.
- ii. Avert 15% deaths amongst PLHIV and in particular those with TB/HIV co-infection.
- iii. Alleviate socio-economic impacts of HIV and AIDS among vulnerable groups.
- iv. Improve efficiency and effectiveness of the national response.

Achieving eNSF impact level results will assist Swaziland in fulfilling its global commitments to the Millennium Development Goals (MDGs), the 2011 Political Declaration for HIV and AIDS, regionally to Southern Africa Development Community (SADC) and African Union commitments, as well as to the country's National Development Strategy (NDS).

### **eNSF Core Programmes, Critical Enablers and Development Synergies**

Swaziland has prioritised the following programmes as critical for implementation during the eNSF period (2014-2018). The eNSF adopts the “combination prevention approach” which combines biomedical, behavioural, social, and structural interventions for maximum impact on stopping new infections. eNSF core programmes have been selected based on evidence of their effectiveness while care and support programmes for orphans and vulnerable children have been chosen based on the magnitude of gains already made. This prioritisation is also aligned to the global investment approach to HIV programming. The eNSF core programmes are:

- i. HIV Testing and Counselling (HTC)
- ii. Social and Behaviour Change (SBC)
- iii. Condom Promotion and Distribution
- iv. Prevention of Mother to Child Transmission (PMTCT)
- v. Male Circumcision (MC)
- vi. Customised interventions for Key Populations
- vii. Treatment, Care and Support for People Living with HIV (PLHIV)
- viii. Care and Support for orphans and vulnerable children (OVC)
- ix. Addressing Gender Based Violence (GBV)

HIV Testing and Counselling and Social and Behaviour Change are considered cross-cutting themes in all core programmes. HTC also provides a critical entry point to programmes such as treatment, voluntary male circumcision, PMTCT and prevention amongst all and including key populations, whilst social and behaviour change (SBC) is a key strategy for HIV services uptake as well as behaviour change. The involvement of civil society organizations (CSO) and communities, PLHIV, political, religious and community leaders is pre-requisite for SBC. SBC interventions will be targeted, implementation intensified and the coverage expanded. Capacity of service providers will be strengthened in the application of the combination prevention strategy.



Strategies to facilitate the promotion and distribution of condoms will be intensified; new condom outlets will be established in user-friendly locations. Condom-use promotion will target population groups at higher risk of HIV infection, including but not limited to, women and girls, youth, discordant couples, migrant workers and mobile populations, sex workers and men who have sex with men. Promotion of the female condom will also be intensified.

Through the PMTCT programme, Swaziland aims to eliminate mother to child transmission of HIV by 2015. The programme will intensify implementation of all four prongs as emphasis is placed on preventing new infections among children, while keeping their mothers alive. Primary prevention interventions will be integrated at PMTCT sites to ensure that pregnant women who are HIV negative remain so. Services will be scaled up and integrated in all related paediatric care and support services. Special attention will be paid to providing services to avert unintended pregnancies amongst PLHIV and teenage girls. Swaziland will accelerate the roll-out of the option B+, in addition to testing and treating all children under the age of 5. Communities will be mobilised to support PMTCT and in particular intensify men's involvement.

Interventions on voluntary medical male circumcision will target young men, among whom a substantial number are HIV negative. Focus will also be on promoting and providing male circumcision, including neo-natal circumcision.

Although Swaziland acknowledges the need to prevent new infections among key populations and improve their access to prevention, treatment, care and support services, there is insufficient data to inform programming based on their needs. Advocacy will be intensified to strengthen the social, policy and legal enabling environment for targeted interventions.

Available evidence shows that treatment is the most effective strategy for improving the quality of life of PLHIV, and it has benefits for HIV prevention. With the improved provision of testing and counselling, and the adoption of CD4 350 eligibility criterion, treatment uptake has improved significantly. These efforts will be augmented by the adoption of the 2013 WHO treatment guidelines for providing the option for test and treat plus changing the eligibility criterion from CD4 350 to CD4 500. Swaziland will also prioritise the test and treat option for HIV+ mothers, HIV+ children under 14 years, people with TB/HIV co-infection and those with HIV/AIDS/Hepatitis. Mobilizing and engaging communities through SBC interventions, aimed at increasing uptake of HTC amongst couples, is critical for the identification of discordant couples and ensuring early initiation of ART including treatment for TB co-infection.

Because of the heavy disease burden on OVCs, their families and communities, Swaziland has prioritised care and support for orphans and vulnerable children. Almost half (45%) of the Swazi population under 18 years are orphans and vulnerable children. The eNSF recognises the reciprocal relationship between HIV and child vulnerability; and that childhood poverty, abuse, violence and school-dropout increases vulnerability to contracting HIV amongst children, adolescents and their caregivers. HIV in the family is also likely to worsen the quality of life of an OVC. The programme will strengthen social protection for OVC and their families.

Prevention and protection against Gender Based Violence (GBV) is also identified as crucial for providing a supportive environment for HIV programming and has benefits for HIV prevention and treatment. GBV reporting, referral and access to services including post exposure prophylaxis will be promoted.

The eNSF identifies critical social and programme enablers that are necessary for successful implementation of the prioritised programmes. These include political commitment and advocacy, laws and legal policies, community engagement and mobilization, stigma- reduction, use of mass media





and local responses to drive the way forward. Others include community-centred design and delivery approaches, community mobilisation, communication to galvanise support for behaviour change programmes, gender equality, and research and innovation.

Given the complexity of the response, advocacy for strengthening HIV synergies within the development sector will be intensified. Interventions will promote a shift from social welfare to social development through multi-sectorial coordination with joint planning and budgets. Critical synergies include social protection, systems (health, education and community) strengthening, food security and nutrition. Development sectors will also be engaged to undertake both internal and external mainstreaming of HIV, with gender and human rights approaches. Swaziland has developed gender mainstreaming guidelines and has defined a minimum package for HIV/AIDS workplace programmes.

Swaziland is also committed to sustainable financing of the national response. In this regard, resources will be invested in high-impact interventions (the core programmes, enablers and synergies) most likely to produce desired results within available funding. To facilitate this, Swaziland is developing an “investment case” for HIV and AIDS. The investment case will be complemented by efficiency and effectiveness strategies in the national response.

Adopting evidence and results-based planning and management requires that Swaziland continues to generate new evidence and knowledge, while improving the management of existing strategic information. Swaziland will strengthen the national monitoring and evaluation system (M&E), enhance data quality and develop and operationalize a national multisectoral HIV research agenda.

### **The process of eNSF development**

The process of developing the eNSF adopted a participatory approach. Stakeholders’ participation included consultations, interviews, workshops, and group discussions. Some stakeholders also provided documents for review. The four Thematic Technical Working Groups (TWGs) and an eNSF costing team were organised to lead the review of the NSF. Technical support was provided by the UNAIDS country office and Regional Technical Support Team for East and Southern Africa (RATESA), the U.S. President’s Plan for AIDS Relief (PEPFAR) and the World Bank. The World Bank took the eNSF through an international peer review. The process was facilitated by NERCHA.



## Section 1: Strategic Context and Rationale for the Extended NSF

### 1.1 Introduction

HIV and AIDS remains the greatest public health and socio-economic development challenge for Swaziland. The Government of Swaziland has made significant progress in addressing the epidemic through a series of strategic plans and frameworks that articulated key programmes and facilitated their implementation. The development of the National Strategic Framework for HIV and AIDS (NSF) 2009-14 ushered in evidence-informed and results-based management by identifying measurable milestones to be attained at mid and end-of-term. The extended National Multisectoral Strategic Framework for HIV and AIDS (eNSF) 2014-2018 shifts the national response to focus on results and prioritise its investment towards high impact interventions.

The extended NSF provides the strategic orientation to do *“better and more of the right things at the right time and at the right scale”*. Investing for results in the eNSF takes into consideration advancements in medical and social sciences, technological efficiencies that are rapidly changing the course of the epidemic, and the way national governments, global and regional partners are responding to the epidemic. This requires smart investments in highly prioritised programmes that will have greater impact not only on the epidemic, but also on future resource savings. This decision calls for innovative solutions, strong political leadership, effective community involvement and above all strategic partnerships and alliances with all stakeholders.

The paradigm shift in the national HIV and AIDS response planning offers four strategic opportunities:-

1. Integrate HIV and AIDS services with other relevant health care services and mainstream the HIV response within the broader national socio-economic development framework. This requires the recognition of critical enablers and synergies across development and all sectors, and as well transitioning programmes that are best handled in alternative sectors.
2. Re-think and re-organise overall HIV and AIDS expenditure in line with the evidence by placing emphasis on core programmatic areas and investing substantially during the strategy term in order to make savings in the long term, as HIV infections decline and demand for HIV related services, especially ART, stabilises.
3. Strengthen national accountability and ownership by developing a response that recognises the complementarity of community engagement and transformation in scaling up (demand generation), ownership and sustaining the response.
4. Anchor the response within gender and human rights-based planning approaches.

The eNSF has adopted a multisectoral and decentralised implementation approach that provides an opportunity for meaningful participation by all stakeholders. The multisectoral and decentralised implementation arrangement will be guided and supported by the Swaziland HIV Investment Case, the eNSF National Operational Plan (NOP), and the National HIV and AIDS Communication Strategy.

The National HIV and AIDS Multisectoral Monitoring and Evaluation Framework will be updated to align with the eNSF. To ensure synergy, stakeholders will be encouraged to harmonise their responses to the national priorities.



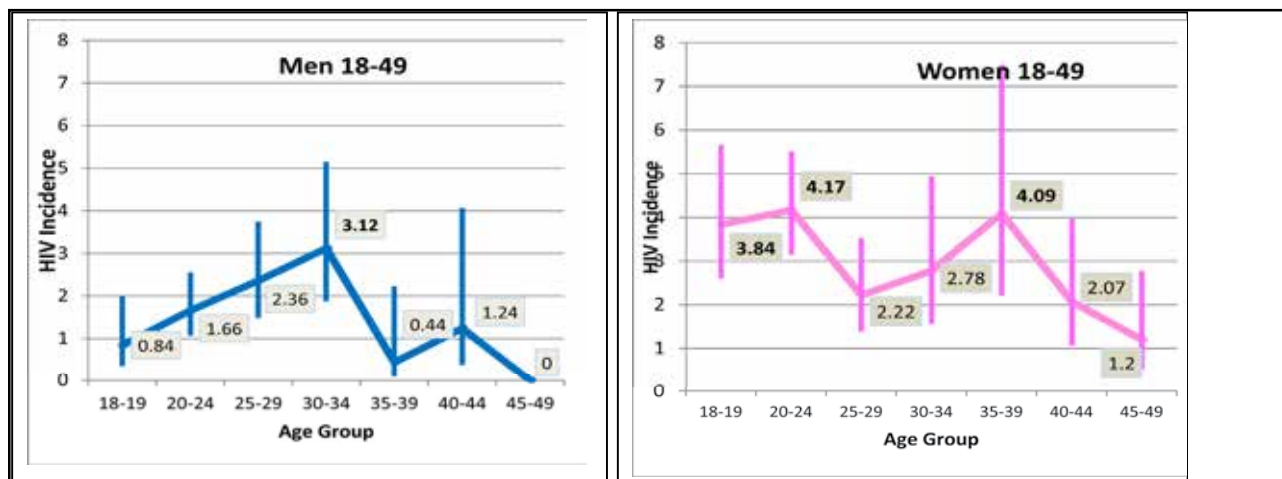
## 1.2 The Epidemiology of HIV and AIDS in Swaziland

Heterosexual contact is the main mode of HIV transmission in Swaziland (Modes of Transmission Study, 2009) and one in three couples (28%) is discordant (SHIMS, 2011). Sixty two percent of new infections occur among women, and almost two thirds (65%) of 100 new infections are among persons aged 25 years and older. Key populations- MSM, SW, and IDU- contribute between 7% and 11% of new infections in Swaziland.

### 1.2.1 HIV Incidence

The HIV incidence rate among adults 18-49 years is estimated at 2.38%, fewer than two percent (1.7%) among men and 3.1% for women (Swaziland Incidence Measurement Survey Study-SHIMS 2011). There is one incidence peak for men, at ages 30-34 and three peaks for women in ages 18-19, 20-24 and 35-39. The Ministry of Health programme data shows that only 2% of children born to HIV positive mother are infected with HIV at ages 6-8 weeks. This is a promising trend towards the elimination of MTCT, even though there are higher (11% in 2012) estimated new infections among children at 18 months of age.

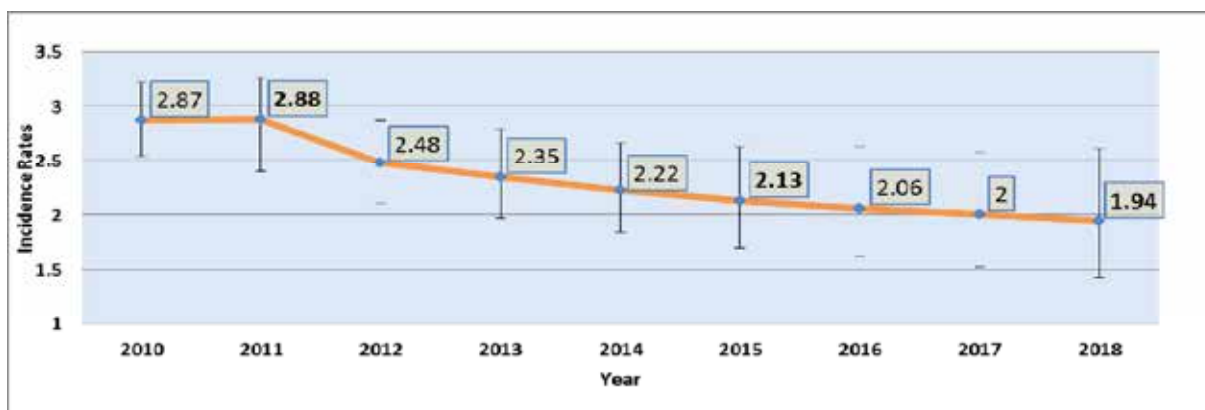
Figure 1: HIV Incidence rates among men and women aged 18-49 years



Source: Swaziland Incidence Measurement Survey Study (2011)

According to Preliminary Swaziland HIV Estimates and Projections (2012), the annual incidence rate among 15-49 year olds is expected to decline from 2.9% in 2011 to 1.9% in 2018.

Figure 2: Actual and projected HIV Incidence rate among 15-49 year olds 2010-2018



Source: Spectrum HIV Estimates & Projections 2012 (preliminary results)

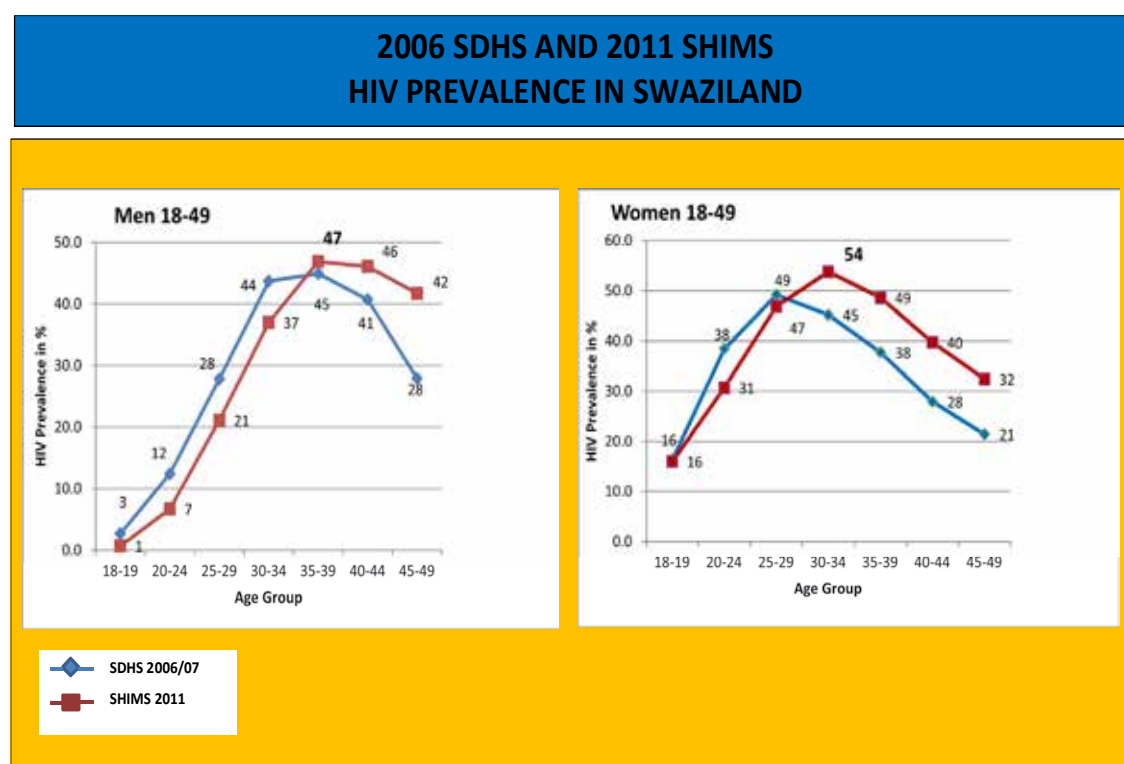


Both SHIMS and the Projections model support the evidence of reductions in the number of annual HIV infections.

### 1.2.2 HIV prevalence

The national HIV prevalence rate among those aged 15-49 is 26% (SDHS2006/07). The SHIMS found HIV prevalence rate among adults aged 18-49 to be 31% (SHIMS 2011); and this figure matches the 2006-/07 Swaziland Demographic Health Survey findings for the same age group. This supports that the HIV epidemic is stabilizing. The epidemic is characterized by a gender bias with prevalence being higher in women (38.8%), compared to their male counterparts (23.1%) as illustrated in figure 3 below.

Figure 3: HIV Prevalence, SDHS and SHIMS



Source: Swaziland DHS 2006/7 and Preliminary SHIMS Report (2011)

The SHIMS shows substantial (54% and 20%) reductions in prevalence rates of HIV among young men and women aged 20-24, respectively. Prevalence peaks have shifted to older populations to women aged 30-34 from those aged 25-29 in 2006-7, and to men aged 35-39 from those aged 30-34 in 2006-7.<sup>2</sup>

The 2010 Ante Natal Care HIV sentinel survey shows similar results as HIV prevalence is highest among the 30-34 age group and drops among those aged 15-24 from a high of 39.4% in 2004 to 34% in 2010. During the same survey none of the survey respondents aged 15 were found to have HIV.

<sup>2</sup>This is probably a cohort effect given the 5 year time lag between the 2 surveillances.



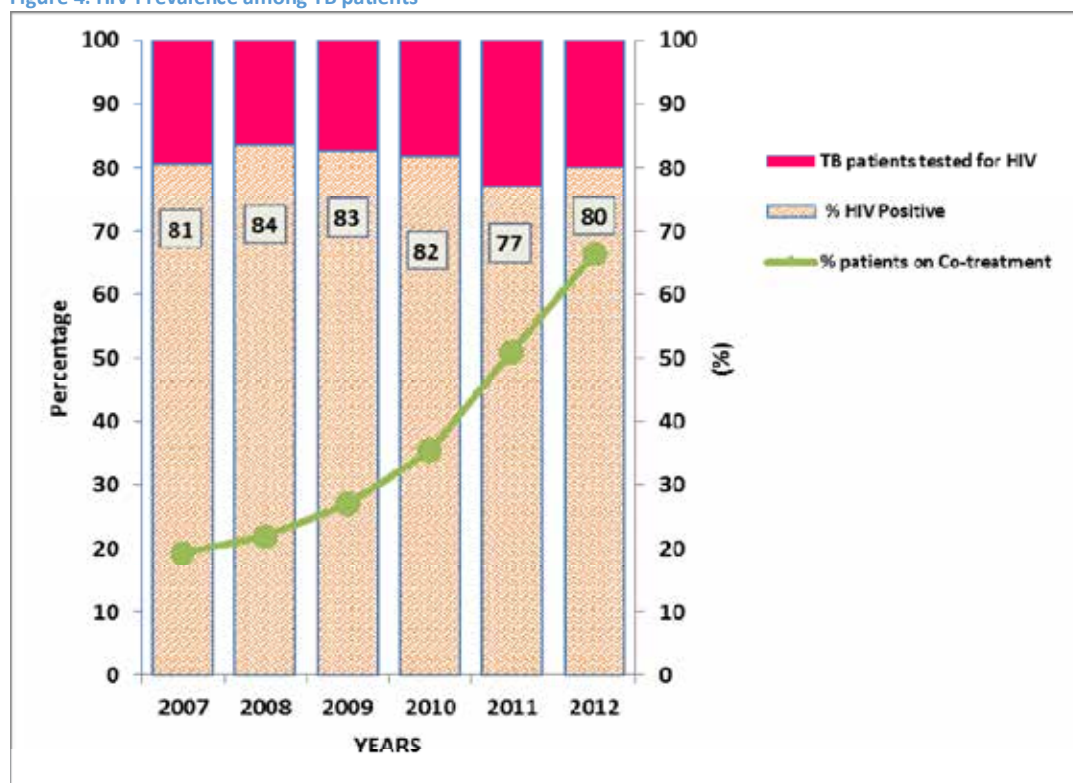


### 1.2.3 TB/HIV Co-infection prevalence

It is estimated that 1,380 per 100,000 incident TB cases occur annually in Swaziland (World Health Organisation Global TB report 2012). In 2012, the number of people newly diagnosed with TB increased from 811 in 2010 to 1,671. The increase is no doubt in part due to a six-fold increase in the TB case detection rates as well as a general increase in the TB burden among the Swazi population. Improvement in TB case finding has contributed to the timely finding of TB cases and subsequent TB treatment enrolment. It is encouraging that the detection rate is increasing. The proportion of males to females who are diagnosed with TB each year remains steady, with men having a slightly heavier burden. Eleven percent of incident TB cases are among children under 14 years.

All TB centres offer HIV testing and counselling. On average, over 90% of TB patients are tested for HIV and the results show high co-infection rates, ranging in the 80% margins, as shown in figure 4 below. A smaller (66%) number of those co-infected with both TB and HIV receive treatment for both. It is encouraging that the rate is increasing. The high TB/HIV co-infection rates emphasize the need for integration of TB and HIV/AIDS services in Swaziland.

Figure 4: HIV Prevalence among TB patients



Source: Annual National TB Programme Reports (2007-2012)



### 1.2.4 Disease progression and infectiousness of People Living with HIV

Sixty-five percent of HIV+ adults aged 18-49, regardless of ART use, are not virally suppressed<sup>3</sup>( viral suppression defined as VL<1,000 c/ml)as 68% of males and 64% of females living with HIV have high

Figure 5: Average viral loads among PLHIV with known and unknown status aged 18-49

	MEAN VL (c/ml)	MEDIAN VL (c/ml)
Total n = 5,828	94,644	14,471
Unaware n = 2,156	129,307	52,081
Aware n = 3,672	74,319	1,134
Current ART n = 1,763	22,979	0
No ART n = 1,909	129,260	39,755

Source: Population HIV Viral Load in Swaziland: Assessing ART Program Effectiveness and Transmission Potential, 2013

viral loads.<sup>4</sup>At 94,644c/ml, aggregate mean viral load among PLHIV in Swaziland is very high (Population HIV Viral Load in Swaziland, 2013). Viral load is higher among those who are unaware of their HIV status and among those who are aware of HIV+ status but are currently not receiving antiretroviral treatment (129,307 c/ml and 129,260 c/ml, respectively). The benefits of HIV treatment are evident as 85% of those who are currently on ART are virally suppressed and have the lowest average viral load at 22,979 c/ml. Men have higher viral loads than women.

## 1.3 Epidemic Drivers and Factors influencing the Spread of HIV

Through a series of studies and surveys, the factors listed below have been identified as key drivers influencing the spread of HIV in Swaziland. eNSF strategies within core programmes are designed to alleviate the threat of their individual and combined effects.

- High average viral load among people living with HIV:** there is generally high HIV transmission potential in Swaziland as a majority of PLHIV (44% men and 30% women) have very high viral loads and only 35% are virally suppressed. Viral load is highest amongst those who are not on ART, who do not know their status, and who know their HIV status but are not enrolled in care, a majority of those being men.
- Low and inconsistent condom use:** Despite increases in reported condom use from 56% to 71% (MICS 2010) among men aged 15-49 who had more than one partner, overall condom use is considered low. Condom use is higher among younger men aged 15-24 (85%) and older women aged 25-39 (76%) and lowest among younger women aged 15-24 (69%) and older men aged 25-49 (66%).
- Gender inequality:** In patriarchal Swazi society cultural values and norms uphold men's privileges and tend to constrain women's decision making in matters of , amongst others, sexuality and reproductive health. Gender inequality is prevalent in all aspects of socio cultural, economic and political areas of Swazi society. Expressions of masculinity in Swazi

<sup>3</sup>Viral load analyses predict disease progression among individuals living with HIV and their potential for transmission within the general population.

<sup>4</sup>Expressed as copies of HIV RNA/ml of plasma



society are characterised by risk taking including engaging in risky sexual behaviour and reluctance to seek health care on time. Programme data reveal only 31% of men aged 15-49 know their HIV status, a sizeable number are not on treatment and only 19% are circumcised. This renders men as not only vulnerable to acquiring HIV, but also increases their risk of infecting their partners. The latter heightened by the high average viral load among males.

- iv. **Multiple and Concurrent Sexual Partners (MCP):** The self-reported rate of women who have more than one sexual partner within a year increased from 2% (SDHS 2007) to 2.7% in 2010. Men who reported multiple partnerships declined from 23% (SDHS, 2007) to 16% among those aged 15-49 (MICS 2010) within the same period. MCP practices remain a great challenge for HIV prevention in Swaziland.

Available evidence also indicates that early sexual debut, low levels of marriage, and a higher rate of divorce or separation contribute to people having a greater number of sexual partners in a lifetime, a factor that is considered a strong predictor of HIV infection.

- v. **Early sexual debut:** Although the median age of sexual debut has increased from 16 (SDHS, 2006/7) to 17 years (MICS 2010) it remains a key factor in HIV transmission. According to the MICS survey 3.8% of young women and 2.6% of young men reported having had sex before the age of 15.
- vi. **Intergenerational sex:** Intergenerational sex, defined traditionally as young women having sex with men who are 10 years or more older than themselves, increases the risk of HIV transmission among children and adolescents. Anecdotal information suggests a rise in the number of boys are also having sex with women who are 10 years or more older. The rate of women aged 15-24 who had higher risk sex with men who are 10 or more years older has doubled from 7% (2006/7) to 14% in 2010. Less than 1% of men aged 15-24 had higher risk sex with women 10 or more years older than them.

Young women report not considering relationships with older or wealthy men as risky (Hearsay Ethnographic Study, 2011). The low general status of women and girls, poverty, income inequality and, to some extent, the desire for material goods can encourage intergenerational 'transactional sex' or sex in exchange for gifts or favours.

- vii. **Gender-based violence (GBV):** Gender Based Violence including sexual abuse remains a daunting challenge for Swaziland and in its response to HIV and AIDS particularly GBV limits the ability of the abused person to negotiate for safer sexual acts, often interferes with adhering to treatment and makes them vulnerable to drastic HIV consequences. According to the 'National Study on Violence against Children and Young Women in Swaziland' (2007), 1 in 4 young females has experienced physical violence as a child, and 5% have been forced to have sex before the age of 18. More than 50% of all incidents of sexual violence are not reported with females seeking help in only 1 in 7 incidents. According to the MICS (2010), 8% of partnered women aged between 15-49 years have been beaten by their husband or partner. Research on attitudes towards domestic violence for both men and women show that 33% of men and 39% of women believe that there are some circumstances when a man is justified in hitting their partner. Gender-based violence among children and adolescents increases the risk of horizontal HIV transmission among them.



- viii. **Low levels of male circumcision:** While the circumcision rate among men aged 15-49 has more than doubled since 2006/7 from 7% to 19% (2010), it remains very low. The level of circumcision is insufficient to have significant population impact on reduction of new infections.
- ix. **Low levels of HTC:** More than half of all HIV positive men are not aware of their positive sero-status (SHIMS 2011). According to the MICS (2010) survey only 40% of people aged 15-49 had tested for HIV during the 12 months preceding the MICS survey (2010) and almost 40% have never tested for HIV and do not know their HIV status. The low testing rate presents a significant challenge in providing targeted prevention and treatment services.
- x. **HIV Stigma & Discrimination:** The Stigma and Discrimination Index Survey (2011) conducted among PLHIV indicated that self-stigma was higher than externally expressed stigma. External stigma is still relatively high with only 47% of people in 2010 reporting accepting attitudes towards PLHIV, a slight increase from 44% in 2007 (MICS, 2010). Internal stigma is higher and includes issues of guilt for being HIV positive (26%), isolation (14%), stopping sex and ending marriage (22% and 18% respectively), not wanting to have children (45%) and fear to access health care (4%) [Stigma Index among PLHIV, 2011].
- xi. **Sex work:** the BSS MARPS (2010) reported that 70% of women aged 15-49 who participate in paid sex and consider themselves as sex workers are HIV positive. This is more than double (31%) that of the general female population the same age. While there is no data on transactional sex, the line between commercial sex and transactional sex remains unclear.
- xii. **Men who have sex with men:** HIV prevalence among men who have sex with men aged 16-44 years is estimated at 17.7%, and increases with age (BSS MARPS 2010). Prevalence is lower than that (20%) of men in the general population aged 15-49. Condom use amongst MSM is low at 66% with non-regular partners and 71% with a regular partner. Self and external stigma, as well as legal prohibition in Swaziland, discourages bi-sexual MSM from disclosing their sexual orientation or HIV status to their female partners. Given the circumstances of the population group it is estimated only 27.1% have been reached with targeted HIV prevention information.

#### 1.4 The Goal of the extended National Multisectoral Strategic Framework for HIV and AIDS (eNSF)

The goal of the eNSF is to ***halt the spread of HIV and reverse its impact on Swazi society***. The national multisectoral response on HIV and AIDS reflects the national context and has set strategic priorities to invest in high impact interventions and sustain the gains that have been made since the response began. Through the Implementation of the eNSF, Swaziland aims to achieve the following impact level results:-

- v. 50% and 90% reduction of new HIV infections among adults and paediatrics, respectively, by 2015.
- vi. Avert 15% deaths amongst PLHIV and in particular those with TB/HIV co-infection.
- vii. Alleviate the socio-economic impacts of HIV and AIDS among vulnerable groups and across the population generally
- viii. Improve efficiency and effectiveness of the national response.

The first priority for Swaziland is to prevent new HIV infections, and reduce mortality amongst PLHIV. The second priority for Swaziland is to preserve and sustain gains achieved in the past. These include continued and enhanced support for orphans and vulnerable children, PLHIV, women and girls, youth





and other vulnerable groups. With the exception of PLHIV, orphans and vulnerable children are the most significant and visible impact of the epidemic on society. The future of Swaziland is its children, hence care and support of OVC is considered a national priority.

The prioritised ninecore programmes for the national response are shown in box 1 insert. Available global evidence<sup>5</sup> indicates these programmes have potential to the potential to yield the desired national results. Core programmes are designed around and implemented using the “combination strategy” model in which different programmes and interventions together contribute towards achieving results. Successful implementation of these rest on the level of investment--the degree of intensity, community involvement to create demand, shift in social norms, and human and technological capacity including the availability of systems to deliver the needed services.

**Box 1: Priority Programmes**

1. HIV testing and counselling
2. Social and behaviour change
3. Condom promotion and distribution
4. Prevention of mother to child transmission
5. Male Circumcision
6. Customised interventions for key populations
7. Treatment, care and support for PLHIV
8. Care and support for OVC
9. Addressing Gender Based Violence

Community, health and education systems strengthening will be a key consideration for the investment approach in Swaziland. The approach will also strengthen synergies with development sectors to promote and facilitate critical enablers such gender inequality, stigma and discrimination, law and policy reform.

## 1.5 Guiding Principles of the eNSF

The following operational principles underpin the extended NSF:

- i. **Investing for Results:** Swaziland is committed to make strategic investments in the prioritised areas to ensure achievement of desired and necessary results.
- ii. **Use of evidence in decision-making and planning:** Stakeholders will be further encouraged to use available evidence to inform prioritisation of programmes and interventions, and resource allocation for HIV and AIDS.
- iii. **Focus on Results:** Swaziland will identify and focus its efforts on specific and measureable results as outlined in the eNSF Results Framework.
- iv. **Gender Equality:** Swaziland is committed to ensuring gender equality and will strengthen strategies to promote gender equality, and reduce gender vulnerability and risks.
- v. **Gender Equity:** Efforts will be made to ensure the equitable distribution and access to essential HIV and AIDS services by all people including those at higher risk of HIV infection.
- vi. **Focus on young women and girls:** Given the gender bias of the epidemic deliberate efforts will be made to target women and young girls.

<sup>5</sup> See UNAIDS (2011), A new Investment Framework for the Global HIV Response.



- vii. **Human Rights based Approach:** Swaziland is committed to ensuring protection, respecting and supporting human rights of all people with particular focus on those of vulnerable groups and populations at higher risk of HIV infection.
- viii. **Greater Involvement and Empowerment of People Living with HIV and AIDS.** Working with PLHIV will continue to inform the response, and strengthen prevention interventions and treatment services.
- ix. **Community participation:** Community engagement and participation is a critical enabler to enhance community input and ownership, create demand for and use of services, reduce vulnerabilities and provide social protection of OVC, PLHIV, women, and youth among others

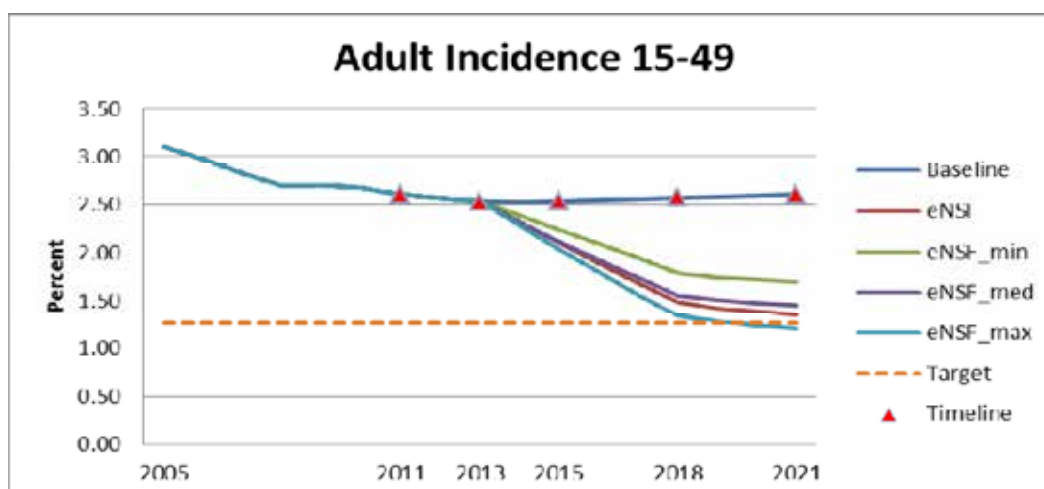
### 1.6 Investing for Results- a scientific approach to decision-making

Mathematical modelling using the SPECTRUM, GOALS, Prevtool and Resource Needs Model was used to ascertain the programme delivery scale required to achieve eNSF objectives of halving new infections, reducing AIDS related deaths and achieving cost-efficient service delivery. Output projections indicate that adequate investments and scale up of MC, condom promotion, ART and PMTCT interventions supported by SBC can substantially avert new infections and AIDS related deaths. Four (4) scenarios were generated for comparison; a baseline scenario which assumed programme service coverage levels would remain constant with no scale-up of interventions; eNSF minimum and eNSF medium scenarios assuming marginal increases in service coverage; and an eNSF maximum scenario assuming major scale up in MC from 19% to 70%, condom promotion from 30% to 80%, ART from 85% to 95% and PMTCT maintained as 95% and a move into Option B+.

The results showed that, depending on the degree to which the implementation of the eNSF manages to create demand for priority programmes, expands MC and establishes effective ART coverage, the HIV incidence rate among 15–49 year olds could be reduced by roughly 28%, 37% in 2015 and 46% in 2018 within the eNSF-min, eNSF-med and eNSF-max scenarios respectively (Figure 6 and table 1). The eNSF therefore adopts the eNSF max scenario, which projected HIV incidence to reduce from 2.9% to 1.8% in 2015 and 1.5% in 2018. Although the goal of halving new infections by 2015 could not be met under any scenario, the downward trend in the eNSF-max scenario will continue beyond 2018 and will reach the target of halving incidence in 2021.



Figure 6: HIV incidence projections using eNSF coverage scenarios



Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland (2013)

The impact on adult mortality will be substantially less than the impact on new infections. This is largely because the country already has high coverage of ART and implementing the eNSF-max scenario, which extends ART coverage to a larger percentage of cases with CD4 between 350 and 500 cells/uL, implies that treatment is provided to a cohort of patients who are at relatively low risk to AIDS-related mortality. Moreover, many high-mortality cases have already been reached. The model showed that there is still relatively high mortality among patients receiving ART, particularly in their first year of treatment. The result of which is that mortality savings due to expanding ART to higher CD4 counts will not manifest as early as 2018.

Table 1: Impact of eNSF variations on infections and HIV-related deaths averted

	eNSF-min	eNSF-med	eNSF-max
<b>% Projected reduction in 2018 absolute numbers of HIV-infections and HIV-related deaths relative to absolute numbers in 2013 relative to baseline</b>			
<b>Incidence reduction among 15-49 years</b>	<b>28.1%</b>	<b>37.4%</b>	<b>46.3%</b>
Total Infections averted	23.1%	32.9%	42.4%
Adult infections averted	20.7%	30.6%	40.1%
Child infections averted	44.3%	53.8%	63.3%
Total AIDS-related deaths averted	0.7%	3.8%	8.5%
Adult deaths averted	8.9%	6.5%	3.8%
Child deaths averted	36.9%	50.7%	64.1%

Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland (2013)

As shown in table 2, the cost of averting new adult infections over the eNSF period is estimated to vary between \$4,412 (eNSF-min) and \$4,173 (eNSF-max) and \$437 (eNSF-min) and \$52 (eNSF-max) for new child infection averted. The eNSF-max is therefore cost-effective at averting new infections than



eNSF-min, especially among children. However, the eNSF-max scenario is slightly less cost-effective at averting deaths than the eNSF-min. The main difference is that under the eNSF-max scenario ART is provided to people that are not facing high risk of HIV-attributable mortality, reflecting that the mortality benefit of extending ART to them does not manifest in the 2013-2018 period.

**Table 2: The Cost increase over 2013-2018 of the eNSF and its variations**

	eNSF-min	eNSF-med	eNSF-max
% Increase in HIV program costs in 2018 relative to 2013	67.0%	75.0%	85.0%
% average annual Increase in HIV program cost 2013-2018	13.4%	18.0%	23.0%
Cost-effectiveness of combined intervention			
Cost per adult Infection averted	\$4,412	\$4,266	\$4,173
Cost per child Infection averted	\$437	\$211	\$52
Cost per adult HIV-related death averted	\$39,017	\$39,107	\$39,697
Cost per child HIV-related death averted	\$2,024	\$2,047	\$2,051

Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland (2013)

Swaziland hopes that by investing heavily today, national level cost savings will be made in the longer term when the cost of the response begins to decline in 2021. However, the short term carries a significant cost burden for Swaziland. During the 2014-2018 eNSF plan period the investment required for HIV prevention to achieve its desired results will be more than triple the current scale.

Without controlling new infections, the cost of the HIV response is expected to increase from 4.4% of Swaziland's gross domestic product to 6.8% by 2020<sup>6</sup> if the scale of the response (coverage, uptake etc.) does not improve and achieve significant impact. In the 2009/10 fiscal year total spending on HIV amounted to E582,670,706. Forty percent of spending was from domestic resources. More locally generated funding is going to be necessary given that nearly all AIDS related external funding is on a downward trend.

Additionally, efficiency measures will be promoted to lessen the high cost burden. This was demonstrated in the 2009 review of the cost of antiretroviral drugs which resulted in improvements in procurement and supply chain management, supplier performance, reliable quantifications, process efficiency and benchmarking. This resulted in a significant (27%) price decrease between January 2010 and March 2011 in comparison to 2009 tender prices. In real terms the reductions amounted to cost savings of US\$4.91 million.<sup>7</sup>

## 1.7 Strategic Gaps and Challenges in the Multi-sectoral HIV and AIDS response identified at mid-term review

<sup>6</sup>UNAIDS (2013), Efficient and Sustainable HIV Responses – Case studies on country progress

<sup>7</sup>UNAIDS (2013) Efficient and Sustainable HIV Response - Case Studies on Country Progress





The following are key gaps and challenges for the national response. Other programmatic gaps and challenges related to specific basic programmes are presented in respective programme discussions. The eNSF's section 2 has developed mitigation strategies as they apply.

- i. **Inadequate funding, weak financial tracking and absence of a resource mobilisation plan:** Most HIV programmes are under-funded with serious implications for coverage and sustainability of interventions and overall effectiveness. HIV prevention spending was 8% of total resources in FY2009/10. The NSF has not at this time undertaken a financial gap analysis to ascertain resources required. A resource mobilisation agenda has not been developed.
- ii. **Inadequate targeting and lack of intensity of HIV prevention programmes:** NSF strategies do not yet adequately address critical risk behaviours, epidemic drivers, underlying factors that increase risk and vulnerability such as cultural and social norms, gender inequality, gender-based violence, poverty, mobility, stigma and discrimination. Prevention programmes are typically provided in a generic manner.
- i. **Inadequate mainstreaming of gender and human rights:** Gender and human rights have been treated as “add on” items in the planning of HIV and AIDS despite centrality of gender and human rights dimensions of the epidemic. There are no systematic strategies to ensure adequate gender and human rights mainstreaming in all aspects of the response planning and implementation.
- ii. **Weak community ownership and participation:** Due to weakness in meaningful community mobilisation and engagement in planning, and implementation of interventions, communities are seen as beneficiaries and not always as strategic partners. This includes low participation of PLHIV.
- iii. **Inadequate enforcement of supportive policies and laws:** Due to lack of capacity and related low monitoring of the legal and policy environment, legal and structural synergies are only marginally addressed.
- iv. **Low uptake and integration of critical services:** Uptake and integration of key programmes including HTC, male circumcision, condom use, remain very low.
- v. **Quality of services:** The quality of programmes, especially non-health programmes, has been compromised by inadequate guidelines and monitoring.
- vi. **Strategic information management:** There is weak management of strategic data and related information. Timely reporting to inform planning requires improvement.



## Section 2: Strategic Programme Interventions

### Overview

The selection and implementation of core programmes is guided by the “combination strategy” model in which key approaches and interventions interact to achieve eNSF objectives of reducing the number of new infections as well as AIDS-related mortality. The ability to meet these objectives depends on the scale and intensity of their individual and combined efforts. It is for this reason that Swaziland has adopted the eNSF Maximum scenario package which includes 65% HTC, 70% male circumcision, 80% condom promotion, 70% ART provision at CD ≤ 500 cells/uL and 95% PMTCT coverage levels, amongst other commitments.

It is evident the epidemic in Swaziland is spreading along socio-economic development fault lines such as poverty, gender inequality, unemployment, and lack of adequate social protection among others. Unless these are addressed adequately, it is unlikely that Swaziland will realise its eNSF objectives. To support this agenda, eNSF strategies will employ community centred approaches in which communities are actively and continuously involved in programme planning, implementation and monitoring and evaluation.

The following section articulates the specific interventions that will be designed and implemented under each of the nine priority programmes.

### *Prevention of new HIV infections*

In line with the combination prevention strategy (CPS), all prevention efforts will rely on the concurrent use of complementary behavioural, social, biomedical and structural prevention strategies at the individual, couple, community and society levels. The strategy also takes cognisance of the complementary action of “treatment as prevention”. In all aspects of the programme, gender and human rights dimensions will be mainstreamed as critical enablers.

For a meaningful impact as well as to provide a generalised response, eNSF interventions will target specific vulnerable groups and key populations at particularly higher risk to HIV acquisition and transmission. The empowerment of communities in general, and women and girls in particular, to take active leadership roles in the response is essential in addressing gender and socio-cultural norms that have implications on the success of the response.

At a macro level implementation of the eNSF prevention interventions will contribute to achievement of the following impact level results:-

Table 3: HIV prevention impact level results

Code	Description
IM 1	HIV incidence rate is reduced from 2.9% in 2011 to 1.4% in 2015 and maintained at 1.4% in 2018
IM 2	% of HIV infected infants aged 12- 18 months born to HIV positive mothers are reduced from 15.4% in 2011 to 5% in 2015 and 2% in 2018



## 2.1 HIV Testing and Counselling (HTC)

### Programme Objective:

The objective of the HTC programme is to ensure that all children, women and men get tested and know their HIV status.

HTC interventions will contribute to the achievement of the following outcome: -

Table 4: HIV testing and counselling outcome result

Code	Description
OC-1	% of people aged 15-49 who report having tested for HIV and received their results in the last 12 months has increased from 47.3% for women in 2010 to 55% in 2015 and 65% in 2018 and from 31.3% for men in 2010 to 45% in 2015 and 55% in 2018

### Programme Overview

HIV testing and counselling (HTC) is a critical entry point for HIV prevention and treatment, care and support services. In Swaziland HTC has also enabled individuals to access other services such as male circumcision (MC), post exposure prophylaxis (PEP), prevention of mother to child transmission (PMTCT), treatment (ART, TB/HIV) and control and management of sexually transmitted infections (STIs). HTC also provides a unique opportunity for service providers to offer health information and education, create awareness of HIV and AIDS, and create demand for other services. It is for these reasons that Swaziland has prioritised the provision of HTC as part of, and as an entry point to all, core programmes.

In an effort to scale up testing and counselling among couples, MOH has introduced the “Love Test” campaign. HTC has been strengthened through skills transfer for service providers for couple testing by hiring and placing lay counsellors in high volume facilities such as Out Patient Departments (OPD), TB settings and clinics. This has resulted in an increase in demand for HTC in these entry points.

The national HIV testing and counselling rate has improved from 16% in 2006/7 to 40% of people aged 15-49 being tested for HIV during the 12 months preceding the MICS (2010) survey. In 2012 alone, 238,791 tests were conducted. Improved knowledge and understanding of HIV and the availability of free ART, including free treatment of opportunistic infections to PLHIV, has encouraged more people to undertake an HIV test. HTC has been incorporated into general healthcare and is being mainstreamed in other health programmes and facilities as a basic care service. As a result 83% (201/242) of health facilities provide HIV testing (SAM 2010), and over 60% of all tests conducted are provider initiated (PIHTC). HTC guidelines have been reviewed to address the needs of special population groups including orphans and vulnerable children (OVC) and people with disability (PWD).

### Gaps and Challenges:

- **Low uptake of HIV testing and counselling.** According to the MICS (2010) survey only 40% of people aged 15-49 had tested in the last 12 months prior the survey. Testing is lower among men.
- **Inadequate capacity to provide quality HTC and limited quality assurance outside health facilities**
- **Stigma and discrimination:** while both self and external stigma exist, self –stigma has been identified as typically the main reason people avoid testing and knowing their HIV status.



- **Low provision of counselling and testing for children under the age of 16 years** - Current guidelines<sup>8</sup> preclude children aged below the age of 16 and OVC from receiving HTC without parental or Guardians' consent which can be a barrier to testing.

**Strategic Priorities;**

- I. Intensify implementation of HTC strategy to address issues of access, quality, gender, age of consent, couple and partner testing and key populations.
- II. Strengthen integration of HTC with other health services and provider initiated testing and counselling (PIHTC)
- III. Intensify community mobilisation to create demand for HTC and reduce stigma and discrimination
- IV. Ensure effective referral to appropriate follow-up services for prevention, treatment and care services

## 2.2 Social and Behaviour Change (SBC)

**Programme Objective:**

The objective for the social and behaviour change programme is to strengthen public awareness and comprehensive knowledge of HIV risks and vulnerabilities in order to increase personal risk reduction and uptake of prevention services.

SBC interventions will contribute to the achievement of the following outcomes -

**Table 5: Social and Behaviour Change outcomes results**

Code	Description
<b>OC-2</b>	% of people aged 15-49 who report having had sex with more than one partner in the last 12 months has reduced from 2.7% for women in 2010 and reduced to 1.5% in 2015 and maintained as 1.5% in 2018 and reduced from 16% for men in 2010 to 12% in 2015 and 10% in 2018
<b>OC-5</b>	% of young women and men aged 15-24 who report having had sexual intercourse before age 15 is reduced from 3.8% for women and 2.6% for men in 2010 to 2% in 2015 and 1% in 2018 for both sexes

**Programme overview**

Swaziland is committed to promoting social and behaviour change programmes that focus not only on bringing about individual behaviour changes, but also lead to behavioural changes at the community and social level. SBC aims to transform structural factors that impact the adoption and maintenance of positive behaviours. In this context, SBC interventions will promote accurate individual knowledge and perception of risk, and increase individual motivation to avoid risky behaviour. Delivering SBC interventions will require a combination of strategies that target risky behaviours and the drivers of the epidemic. SBC will also be used to create demand for increased access, uptake and adherence to behavioural and biomedical interventions.

The SBCC strategy developed in 2010 was intended to guide implementing partners in the design of their individual social and behaviour change programmes and interventions. A variety of tools that

<sup>8</sup>Please note that guidelines were under review to address the issue of testing consent, amongst other areas. However, the eNSF could not preempt their response but recognised the effort.



support implementation of social and behaviour change interventions such as HIV Prevention Toolkit and the Community Conversations Guide have been developed. These have also facilitated the integration of SBC interventions in other programmes such as MC, PMTCT, HTC, condoms and ART.

At household and community levels, SBC interventions will aim to reduce stigma and discrimination associated with HIV and sexuality, promote open discussions on safer sexual behaviours and influence gender roles and norms with aim of addressing gender inequality, intergenerational sex, violence and sexual abuse

#### Gaps and challenges;

- While prevention remains a critical national priority, **investment in prevention remains low**; according to the NASA analysis for the 2009/10 fiscal year, only 8% of total HIV and AIDS expenditure in Swaziland was spent on prevention activities.
- Coordination of prevention interventions remains weak and fragmented with a myriad of approaches, lack of intensity and scale and little standardisation.
- **HIV and AIDS awareness and knowledge has not translated into the desired levels of behaviour change** due to inadequate personal risk perception that focus on translating knowledge into action.
- **Social and behaviour change is difficult to measure**, and hence measurement targets are associated with other programmatic outcomes where behaviour has been positively influenced, such as the impact on the number of people taking HIV tests or getting voluntarily circumcised.
- **Communities have not been adequately mobilised** to support SBC and in particular to generate demand for critical programmes such as HTC, PMTCT, condom use and male circumcision.
- Often **SBC messages are not tailored to specific target groups at higher risk of HIV infection** as per evidence, with lack of necessary intensity and coverage to make an impact at the population level.
- Inadequate capacity to coordinate and evaluate SBCC interventions

#### Priority strategies;

SBC interventions will be integrated in all the other basic prevention and treatment programmes.

- I. Intensify the implementation of the National SBCC strategy and target most at-risk and vulnerable populations.
- II. Integrate social and behaviour change interventions in all prioritised eNSF programme areas, including socio-cultural factors that accentuate HIV vulnerability and risk.
- III. Intensify social and behaviour change interventions tailored to specific target groups as guided by evidence, with intensity and coverage for impact at a population level.
- IV. Intensify community mobilisation and community referral systems for service uptake.





## 2.3 Condom Promotion and Distribution

### Programme Objective

The objective is to ensure correct and consistent use of condoms by all sexually active people.

Condom Promotion and Distribution interventions will contribute to the achievement of the following outcomes—

Table 6: Condom Promotion and Distribution outcome results

Code	Description
OC-7	% of young people aged 15-24 who report using a condom during first sex has increased from 43.2% for women in 2007 to 55% in 2015 and 65% in 2018 and 49% for men in 2007 to 60% in 2015 and 70% in 2018
OC-8	% of men and women aged 15 - 49 with more than one partner in the past 12 months who report the use of a condom during last sex has increased from 74% for women in 2010 and 71% for men in 2010 to 80% for both in 2015 and 85% for both in 2018

### Programme Overview

Increased correct and consistent use of condoms is strategic given that nationally over 90% of all new infections occur through a heterosexual contact (MoT 2009). A National Condom Strategy (2010-2015) provides guidance to condom programming including issues of leadership, coordination and partnerships; supply and commodity security; access, demand and utilisation, and condom programming and support systems. The condom programme also supports interventions that specifically target key populations including youth, sex workers, men who have sex with men and long distance drivers. Such targeted intervention includes special condom distribution deliveries at hot spots frequented by key populations.

Supply of male condoms increased from about 8 million in 2008 to 12 million in 2011. Female condoms have remained below 250,000 during the same period. The overall distribution of condoms declined from 10.6 million in 2010 to 6.5 million in 2011. National condom coverage is estimated at 41.7% with a national penetration of 44.7%. Regional condom penetration rate was estimated at 44.7% for Hhohho, 39.8% for Manzini, 41.6% for Lubombo and 39.7% for Shiselweni. The Government of Swaziland has dedicated a budget line for condom procurement to ensure commodity security and sustainability.

The MICS (2010) showed that condom use at last sex among men with more than one partner has improved to 73% and 71% among women. Provision of condoms for young people in tertiary and vocational institutions, and those out of school has been intensified with increased usage among young people aged 15-24. The BSS MARPs 2011 reported high condom use (82%) among commercial sex workers at last sex with their regular client and 89% at last sex with a new client.

### Gaps and Challenges;

- Condom promotion and distribution strategies have not adequately targeted vulnerable groups and key populations at higher risk of infections, including women and persons 15-24 year olds
- Inadequate procurement and supply chain management of condoms.
- Correct and consistent condom use is low.
- Inadequate data to inform condom programming.



### Strategies for condom promotion and distribution:

- I. Strengthen condom forecasting, procurement and supply management system
- II. Intensify access, demand creation and distribution of condoms using multiple approaches including integration in other health care services.
- III. Intensify and expand condom distribution coverage for specific targeted groups at high risk, including young people, men who have sex with men, sex workers and discordant couples
- IV. Strengthen SBC interventions in condom programming
- V. Strengthen M&E and research for condoms

## 2.4 Prevention of Mother to Child Transmission of HIV (PMTCT)

### Programme Objective

The objective for PMTCT is to eliminate new infections among children and keep mothers alive.

PMTCT interventions will contribute to the achievement of the following outcomes -

Table 7: PMTCT outcome level results

Code	Description
<b>OC-9</b>	% of HIV infected infants aged 6-8 weeks who are born to HIV positive mothers are reduced from 2% in 2011 to 1% in 2015 and maintained at 1% in 2018
<b>OC-10</b>	% of eligible pregnant and lactating women receiving ART increased from 50% in 2011 to 80% in 2015 and 95% in 2018
<b>OC-11</b>	% of eligible children aged 0-5 years receiving ART increased to 70% in 2015 and 90% in 2018

### Programme Overview:

The PMTCT programme offers a package of services that include: counselling and testing; prevention of HIV transmission among pregnant and lactating women who initially test HIV negative; ARV prophylaxis to both infected women and their exposed infants; counselling and support for safe infant feeding practices; family planning, and referral for long-term ART for the child and the mother. PMTCT serves as an entry point for full ART services for the entire family. An average of 33,000 deliveries occurs every year in the country and 41% (13,563) of those mothers are assumed to be HIV positive. In 2010 (SAM) 150 out of 171 Antenatal Care (maternity and infant care) facilities provide PMTCT services, increasing from 132 facilities in 2008.

97% of all pregnant women attend at least one ANC and are attended by skilled personnel (DHS 2007). In December 2012, 86% of HIV positive pregnant women received a course of ARV to reduce MTCT in accordance with nationally approved protocol. According to the Swaziland HIV Estimates and Projections (2012) new infections among children at 18 months of age are estimated to be 11% of all exposed children in 2012 from 19.6% in 2009. Ministry of Health data shows that in December 2011 only 2% of children born to HIV positive mothers were infected at 6-8 weeks old.

Swaziland has a National Strategic Framework for the Elimination of New HIV Infections among children (EMTCT) by 2015 and keeping their mothers alive. This provides a strategic platform for



strengthening and accelerating national efforts to prevent HIV infection among infants and children using the four-pronged approach.

**Gaps and Challenges:**

- High maternal sero-conversion (8%) among pregnant women at labour and delivery
- High unmet need for family planning (13%) among women of reproductive age (MICS 2010) and 63% unmet need among pregnant PLHIV (ANC 2010).
- High infant sero-conversion post-8-weeks.
- High maternal mortality rate estimated at 60% among HIV positive women.
- Inadequate use of early infant diagnosis (EID) post-8-weeks
- Weak health systems for longitudinal follow up of mother and child pairs using the family service approach
- Stigma continues to impact negatively on PMTCT treatment adherence and related services.

**Priority Strategies:**

- I. Intensify the primary prevention of HIV infection among women of childbearing age.
- II. Intensify prevention of unintended pregnancies among women living with HIV.
- III. Intensify the prevention of HIV transmission from women living with HIV to their infants' post-8-weeks.
- IV. Intensify provision of treatment, care and support to mothers living with HIV, their children and families.

## 2.5 Male Circumcision (MC)

**Programme Objective:**

The objective of the MC programme is to increase the uptake of voluntary medical male circumcision (VMMC) among all eligible males in Swaziland.

MC interventions will contribute to the achievement of the following outcomes -

Table 8: MC Outcome level results

Code	Description
OC-12	% of males aged 10-49 who are circumcised is increased to 45% in 2015 and 70% in 2018
OC-13	% of male children under 5 years who are circumcised is increased to 30% in 2015 and 50% in 2018

**Programme overview:**

In 2008 Swaziland started the scaling up of male circumcision (MC) as a HIV prevention strategy. A policy on safe voluntary male circumcision for HIV prevention was developed in 2009 and a Communication Strategy in 2011. This influenced the undertaking of an ambitious Accelerated Saturation Initiative (ASI) that attempted to achieve high national male circumcision coverage in a short period.

The MC services have now been integrated into a majority of public hospitals and health centres; NGO supported fixed sites, outreaches, mobile services and targeted campaigns. Intensified advocacy for



MC has resulted in improved MC uptake as evidenced by the high uptake of the service by young men during school holidays.

The rate of MC among those aged 15-49 has more than doubled from 7% in 2007 to 19% in 2010. As part of MC operationalization, systems have been strengthened including an adverse event management system.

In the extended NSF, the MC program will prioritize adolescents and youth 10 to 24 as well as infants from birth to 8 weeks as primary target audiences. Secondly the programme will target adult males aged 25 to 35 years. This shift in focus, i.e. reducing the age to 10 years is a reflection of the high demand for MMC from the younger adolescents and the move towards an HIV free generation. The development of the Early Infant Neonatal Circumcision (EIMC) program has been fairly successful. Neonatal circumcision has been integrated in 13 facilities, both in the public as well as private sector. Efforts are being made to ensure that neonatal MC practice is accepted as a social norm.

#### Gaps and Challenges;

- Demand for MC services remains low among older men.
- The current level of MC is not sufficient to yield the aspired macro-level reductions in new HIV infections.
- There is low decentralized coverage of service delivery sites and integration of VMMC with other health services.

#### Priority strategies for MC include;

- I. Strengthen and decentralise MC services especially for neo-natals and males aged 10-35 in health and non-health facilities.
- II. Intensify education, awareness and community mobilisation to generate demand and increased benefits of MC for both men and women.
- III. Address socio-cultural, myths and misconceptions of MC that create barriers to service uptake.
- IV. Integrate MC services with other Health services.

## 2.6 Customised Interventions for Key Populations and Vulnerable Groups

### Programme Objective

The objective of the programme is to improve the availability, access and utilisation of HIV prevention and treatment services by key populations at higher risk of HIV infections.

Customised Programmes for Key Populations will contribute to the achievement of the following outcomes: -

Table 9: Customise programmes for key outcome level results

Code	Description
<b>OC-15</b>	% of women aged 15-24 who had sex with a partner 10 years or more older than them is decreased from 14% in 2010 to 8% in 2015 and 5% by 2018
<b>OC-17</b>	% of young people aged 15-24 who are living with HIV is reduced from 23% for women in 2007 to 15% in 2015 and 10% in 2018 and 6% for men in 2007 to 4% in 2015 and 2% in 2018



OC-18	% of female sex workers reporting the use of a condom with their most recent client is increased to 80% in 2015 and 95% in 2018
OC-21	% of MSM reporting the use of a condom the last time they had anal sex is increased to 60% in 2015 and to 80% in 2018

### Programme Overview

Swaziland has a generalised epidemic and identifies women and girls, the youth, sex workers, men who have sex with other men, prisoners and mobile populations as key populations at higher risk of HIV infection. The acquisition of TB is closely associated with the underprivileged and marginalised in society, which include, women, children, PLHIV and prisoners (WHO TB/HIV Policy 2011). Although it is acknowledged that people who Inject drugs (PWID) exist, there is limited data on their size and contribution to new infections.

**Women and girls** women are disproportionately affected by HIV with average incidence rates as high as 4% for the 18-19, 20-24 and 35-39 age groups. Prevalence is also higher amongst women (38%) than men (23%).

**Sex workers** have higher HIV prevalence of 70.3% (BSS MARPS) than the general population. There is no data on the extent of transactional sex generally across the population although anecdotal evidence suggests that it may be widespread. The distinction between “sex workers” and persons engaged in transactional sex is currently not available.

**Men who have sex with men (MSM)** can be at an increased risk of HIV infection. Many MSM surveyed reported also being in heterosexual relationships because of fear of being stigmatised when they disclose their sexual orientation. The BSS MARPs estimates that HIV prevalence amongst MSM is 17.7%

**Injecting Drug Users (IDU)** There is no sufficient data to estimate the population size of this group.

**Inmates:** According to the 2011 UNODC supported study conducted at His Majesty's Correctional Services the prevalence of HIV among prisoners is 35%. There are limited HIV prevention interventions within prisons.

**Mobile populations are at risk of acquiring HIV.** The SDHS (2007) presented that men and women who spend more time away from their home are likely to have multiple partners than those who spent less than 2 nights away in a month. The preliminary results of the BSS 2011 noted that HIV prevalence is 50% and 30.4% in textile workers and cane cutters respectively. Mobile populations have been identified as factory workers, cane cutters (seasonal workers), transport operators, construction workers, long-distance truck drivers and uniformed forces.

### Gaps and Challenges

- Inadequate targeted gender sensitive interventions for women and girls.
- Inadequate evidence to inform programming for sex workers, MSM, IDU, uniformed services.
- Limited targeted HIV prevention services for key populations
- Insufficient policies to guide development and delivery of appropriate services to key populations.
- Limited access and utilization of HIV services.





### Priority strategies

- I. Address policies and legal barriers that prevent provision of comprehensive HIV services to key populations (SW, MSM and PWID) at higher risk of HIV infection.
- II. Develop and implement community and institutional based strategies that address gender, stigma and discrimination.
- III. Develop and implement customised strategic interventions targeting key populations including harm reduction.
- IV. Carry out research and size estimates to improve knowledge, understanding and interventions appropriate for key populations.

### ***Treatment, Care and Support for People Living with HIV (PLHIV)***

HIV treatment, care and support for people living with HIV (PLHIV) remains a priority component of the national HIV and AIDS response. This is in line with the National Health Policy (2007) which states that health programmes must aim to “expand treatment and care interventions to improve the quality of life of PLHIV and mitigate the socioeconomic impact of HIV/AIDS”.

Currently there are 114/242 health facilities offering ART services countrywide, 75 as initiation sites and 21 provide the comprehensive ART package. The Comprehensive package includes HIV diagnosis, prevention and treatment of opportunistic infections including the management of TB and HIV Co-infection, STIs, on-going counselling, palliative care, and provision of antiretroviral medicines, health and nutrition education, and promotion of positive health, dignity and prevention (PHDP).

### **Treatment as Prevention (TasP)**

Evidence shows that effective ART has the potential to reduce HIV viral load and can contribute to prevention of new infections by 96%. This strategy is most effective and sustainable if implemented as part of the broader combination prevention strategy advanced in this eNSF that involves bio-medical, behavioural and structural interventions. The country is in the process of localising the 2013 WHO treatment guidelines which advise high burden countries to consider the ‘test and treat’ option upon discovery of HIV+ status. During strategy term, ‘test and treat’ will be offered to pregnant and lactating women living with HIV, PLHIV in sero-discordant couples, HIV+ children under 14 years, TB/HIV co-infected people and persons co-infected with HIV and Hepatitis B, as it considers the long term financial implications. Social and programme enablers will be strengthened, as well as will the synergies necessary to ensure greater impact.

HIV treatment interventions will contribute to the achievement of the following impact level results:-

**Table 10: HIV Treatment Impact level result**

Code	Description
<b>IC-3</b>	Life expectancy at birth has increased from 47 years for women in 2011 to 50 years in 2015 and 55 years in 2018 and from 43 years for men in 2011 to 45 years in 2015 and 50 years in 2018
<b>IC-4</b>	Maternal Mortality Rate is reduced from 320/100,000 in 2010 to 270/100,000 in 2015 and 200/100,000 in 2018



## 2.7 Pre-Antiretroviral (Pre- ART)

### Programme Objective

To promote a comprehensive package of care that is necessary to delay progression to AIDS stage, prevent and manage common opportunistic infections and ensure early initiation of ART

Code	Description
<b>OC-25</b>	% of PLHIV with known status (on ART & not on ART) who are virally suppressed is increased from 50% in 2011 to 70% in 2015 and 80% in 2018

### Programme Overview

The comprehensive pre-ART package for Swaziland comprises of routine monitoring of CD4 count, screening and management of opportunistic infections, provision of cotrimoxazole and isoniazid prophylaxis, health education, weight and nutrition management and psychological support in preparation for enrolment on ART, and TB Infection Control. It is also aimed at strengthening linkages between primary prevention efforts and sexual and reproductive health (family planning options) that can be integrated and offered as part of a comprehensive pre-ART programme.

Efforts to institutionalise the pre-ART programme include the development of a pre-ART patient monitoring system and intensified community care and support for PLHIV.

### Gaps and Challenges

- **Pre-ART package** is not comprehensively implemented, including development of its M&E system, resulting in high patient loss to follow up.
- **Weak referral linkages from HTC pre-ART especially for newly diagnosed HIV-positive individuals to Pre-ART Care.**
- **Inadequate capacity for procurement and supply of drugs and commodities:** There is also inadequate capacity for procurement planning including quantification and forecasting drugs requirements for opportunistic conditions.
- **Limited task-shifting with only** doctors allowed to prescribe some drugs for opportunistic infections and conditions, even though a majority of patients are attended to by nurses in clinics.
- **Sexual and reproductive health services not integrated in pre-ART:** SRH services are not integrated in pre-ART services. The 2010 HIV Sentinel Surveillance Survey showed that as high as 65% of HIV positive pregnant women had unmet need for family planning. Additionally, it is estimated that over 60% of maternal mortality cases are among women who are HIV positive.

### Priority strategies

- I. Intensify linkages between HTC and Pre-ART.



- II. Strengthen the comprehensive pre-ART package with a strong referral system and linkages to other HIV programmes.
- III. Reinforce the integration of gender sensitive Sexual and Reproductive Health (SRH) services.
- IV. Strengthen the involvement of community structures to increase demand for TB and HIV services and reduce stigma and discrimination.

## 2.8 Antiretroviral therapy for PLHIV (ART)

### Programme Objective

The objective is to improve the quality of life of PLHIV through treatment and strengthen treatment as prevention.

The provision of ART to PLHIV will contribute to the achievement of the following outcome: -

Table 11: ART outcome level results

Code	Description
<b>OC-26</b>	% of adults and children with HIV still alive and known to be on treatment 36 months after initiation of ART has increased from 68% for adults in 2011 to 75% in 2015 and 80% in 2018 and from 66% in 2011 for children to 70% in 2015 and 75% in 2018*

### Programme Overview

Swaziland introduced the ART programme in 2003 to improve morbidity and mortality among people living with HIV. ART is provided for free to patients based on national eligibility criteria of CD4<350. During preparation of the eNSF, the country was preparing to adopt the 2013 WHO treatment guidelines which provide the option for 'test and treat' and for changing the eligibility criterion from CD4 350 to CD4 500. During strategy term, 'test and treat' will be offered to pregnant and lactating women living with HIV, PLHIV in sero-discordant couples, HIV+ children under 14 years, TB/HIV co-infected people and persons co-infected with HIV and Hepatitis B. Targets for ART will be revised after the country has localised the 2013 guidelines and these will be reflected in the National Operational Plan (NOP) and annual plans.

The country has limited options for second and third line therapy and the programme tries to ensure that there is greater adherence to the first line regimen. Current interventions to support adherence include emphasis on treatment support by family members, nutrition support to malnourished people on ART and PMTCT clients, establishment of PLHIV support groups and provision of psychosocial support to parents and children.

The MoH cohort analysis for 2011 showed that 87% of adults and children with HIV who were known to be on treatment were alive 12 months after initiation of ART. However, 68% of the co-hort were alive 36 months after beginning ART. It was identified that there is a high level of stigma among PLHIV which can lead to poor adherence and loss to follow.

Swaziland is in the process of integrating palliative care at all levels of service delivery. National palliative care policies and guidelines have been developed to improve the quality of life of people with chronic illnesses.



By December 2012, a total of 87,534 (91%) PLHIV were actively on ART, comprising of 80,103 adults (93.7%) and 7,431 (70.2%) children in need of ART (MoH Annual Report, 2012). With decentralization of ART services, more people are able to access comprehensive HIV treatment and care services in the primary health care clinics closer to their homes. This has also been possible through the task shifting involving nurse-led ART initiation.

A programme, that involved PLHIV as expert clients placed in health facilities, offering adherence counselling and peer education to clients, has been successful.

Laboratory service coverage has improved with the placement of over 60 Point of Care (POC) CD4 machines in high volume clinics. This has minimized delays on enrolment in care and assisted fast tracking the initiation of patients who are eligible for ART.

The Early Infant Diagnosis (EID) programme has able to test up to 92% of all exposed infants, with an HIV prevalence of 2% at 6-8 weeks. This has facilitated early enrolment of children on treatment.

HIV care services have also been integrated into other health care programmes such as SRH, MMC, TB, and Maternal, Neonatal and Child Health (MNCH) services in an effort to address all the four (4) prongs of PMTCT.

In 2012, Food by Prescription provided nutrition support to 3,653 clients accessing ART or TB treatment, of which 192 were pregnant or lactating women under PMTCT.

### Gaps and Challenges

- **Weak referral and patient tracking system:** The treatment cascade referral system is not able to effectively track PLHIV referrals from HTC to ART programmes, resulting in low and late enrolment to ART and later, poor treatment adherence.
- **Inadequate system for identifying children aged 0-14** who are exposed to or have HIV.
- Occasional stock-outs of CD4 and viral load reagents
- **Stigma and discrimination** remain critical barriers to ART services uptake including treatment adherence.
- **Inadequate focus and targeting of key and vulnerable populations:** Access and utilisation of HIV prevention and treatment services have been compromised by lack of concerted, focused and targeted interventions
- **Palliative care:** Lower level facilities cannot prescribe some medicines for pain management and symptom control of opportunistic conditions

### Priority strategies

- I. Reinforce the referral system and tracking mechanisms for PLHIV on ART.
- II. Strengthen follow-up of HIV-exposed infants, and children with HIV.
- III. Enhance integration of ART services with other health care services such as TB and SRH.
- IV. Strengthen community systems to enhance quality and provision of HIV services for PLHIV including through continuation of nutrition support.
- V. Strengthen procurement and supply management for drugs and related commodities.
- VI. Accelerate task shifting and capacity development of lower level health officers.

## 2.9 TB/HIV Co-infection



### Programme Objective:

The objective of the TB/HIV co-infection programme is to prevent TB deaths amongst PLHIV.

The TB/HIV co-infection programme will contribute to the achievement of the following outcome: -

**Table 12: TB/HIV co-infection outcome level result**

Code	Description
<b>OC-27</b>	% of incident TB cases among PLHIV who have successfully completed their TB treatment has increased from 62% in 2011 to 75% in 2015 and 85% in 2018

### Programme Overview

National efforts to prevent co-infection started in 2007 with the development of the National TB/HIV Co-infection Policy guidelines. The guidelines among other things recommended the use of a simplified screening algorithm that relies on five clinical symptoms to identify those eligible for either Isoniazid preventive therapy (IPT) or further diagnosis for TB and other conditions. According to the 2012 National TB Programme report, 92% of TB clients were tested for HIV and 80% were found to be HIV positive.

Multi-Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) forms of TB are more commonly found amongst HIV positive people. It has been identified that drug resistant TB strains can compromise the effectiveness of ARVs.

TB/HIV services have been decentralized and integrated at different levels providing a 'one stop shop' approach to improve adherence to both treatments and synchronize the drug pick up appointment for patients with co-infection. GeneXpert machines have also been placed in high volume clinics.

The improved uptake of ART (66%) in TB clinics has contributed to a reduction of mortality from 18% to 9% (TB Annual Report, 2012). Provision of CTX among TB/HIV co-infected patients has been sustained between 95% and 98%.

### Gaps and Challenges

- **Low TB/HIV treatment rate:** only 66% of TB patients with HIV received treatment for both HIV and TB (TB programme annual report 2012).
- **Weak HIV/TB co-infection programme:** Coordination between HIV and TB services remains weak TB/HIV co-infection collaborative activities are not being implemented at the optimal rate and there is inadequate integration of community initiatives
- **Lack of isolation facilities:** A number of sputum positive patients are not isolated prior to sputum conversion (i.e. cure, indicated by negative sputum cultures). This has compromised effective infection control and optimal case management of MDR-TB and XDR TB
- **Data capturing of Isoniazid prevention therapy (IPT) activities** – due to inadequate integration of electronic systems, only initiation is captured and not the follow-up for completion of the drug course.

### Priority strategies:

- I. Intensify the mechanisms for delivering integrated TB and HIV services.





- II. Intensify the provision of the Three I's for HIV/TB
- III. Strengthen health sector capacity to identify and manage XDR and MDR TB.

### **Care and Support for Orphaned and Vulnerable Children**

One of the most visible effects of HIV in Swaziland has been the growing number of Orphans and Vulnerable Children (OVC). The proportion of OVC has grown from 31.1% in 2007 (DHS) to 45.1% in 2010 (MICS). With more than half of the country's population being under 20 years (CSO), Swaziland has at least 229,000 OVC, with one in every fourth Swazi child having lost one or both parents. The prevalence of orphanhood and vulnerability increases with children's ages. The Government is cognizant of the reciprocal relationship between HIV and child vulnerability. On one hand, adverse childhood experiences such as poverty, abuse, violence and school dropout increase the likelihood of contracting HIV for children and adolescents as well as their caregivers. On the other hand, HIV in the family is likely to worsen the quality of life of OVC further.

Efforts will be made to strengthen synergies with other development sectors such as education, social welfare, health, and agriculture to address OVC-related issues and in particular, for improving their access to education and retention rates in schools, strengthening life skills, prevention and protection from abuse and neglect, and provision of nutrition and food security for OVC households.

## **2.10 Family Strengthening**

### **Programme Objective:**

The objective is to strengthen the capacity of OVC families to effectively provide comprehensive care and support for OVC.

The family strengthening programme will contribute to the achievement of the following outcomes:-

**Table 13: Family strengthening outcome level results**

Code	Description
<b>OC-28</b>	% of OVC aged 0-17 who received three minimum basic material needs is increased from 62% in 201 to 70% in 2015 and 80% in 2018
<b>OC-29</b>	% of the poorest households who received external economic support in the past 3 months is increased to 50% in 2015 and 70% in 2018

### **Programme Overview:**

HIV and AIDS continue to alter the demographic structure of households, communities, and the nation. It is estimated that 38% of rural households have at least one orphan (VAC 2012), and 41% of households are female headed. Thirty seven percent (37%) households are headed by an elderly person. 73% of rural homes have a chronically ill adult. Only 22% of children are raised in two-parent households (MICS, 2010). Formal fostering and adoption are rare in Swaziland.

The breakdown of traditional family structures and lack of parental care and supervision compromises child socialization, and children lose out on the security of early attachment to an adult which is widely



understood to be central to development of self-esteem. Their source of knowledge on positive cultural norms, reproductive health, relationships and values is diminished or lost as families disintegrate. The absence of male role models<sup>9</sup> in families can negatively affect boys and their perceptions of masculinity.

Most OVCs are cared for by their extended families or grandmothers but these families are often unable to provide for most basic needs (defined as one meal per day, two pairs of clothing and one pair of shoes). Sixty two percent of OVCs have all their three material needs met compared to 80% of non-OVC (DHS, 2007). Only 41% of OVCs receive any external assistance and the most common form of support provided was school assistance. Child malnutrition is a persistent problem, with 38.5% of OVC under age 5 showing signs of long term nutritional deprivation (stunting), compared to 27.5% of non-OVC (MICS, 2010). The lack of positive emotional socialization, combined with household poverty makes OVC highly susceptible to HIV infection as adolescents seek affection and at times material support in sexual relationships.

The following types of families are recognized as most vulnerable and prioritised by the programme:

- i. Families with HIV positive children and adolescents
- ii. Families with children who have dropped out of school
- iii. Child Headed Households
- iv. Elderly headed households
- v. Families with OVC under age 5

Swaziland has defined the Alternative Care for OVC model and developed guidelines for the provision of care. Psychosocial support is provided to OVC in line with the PSS Strategy and the Quality Service Standards as well as the National Plan of Action for Children. Provision of PSS also targets OVC families and communities.

A number of social assistance programs that benefit vulnerable households and OVC are available and include old age grants benefitting elder caregivers, a school bursary scheme, and cash transfers. Also food insecure households receive food support from Government. Food security among children is also addressed through feeding programmes at NCPs and school feeding programmes. NCPs as well provide a package of important services for particularly vulnerable OVC under 5 years. In addition, capacities for families to undertake income generating activities and food security initiatives have been strengthened by civil society organisations.

The country is developing a comprehensive social protection policy and programme to map the poverty and vulnerability situation in Swaziland, with a particular focus on HIV and AIDS. The programmes will identify and implement key strategies that enhance a protective, preventative, promotive and transformative social protection system.

### Gaps and Challenges:

- **Lack of focus on strengthening the family system:** Interventions in socialisation and protection have tended to target individual children rather than strengthening families.

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<sup>9</sup> Higher male mortality due to less health-seeking behaviours by men leads to the fact that amongst single orphans, there are three times as many paternal orphans than maternal orphans. (VAC 2012)



- **Weak linkages with social welfare programme:** OVC initiatives are poorly linked to social welfare services.
- **Lack of programmes** to mitigate the economic drivers of HIV for vulnerable children
- **Psychosocial support** is often difficult to define and PSS programmes have been inconsistently delivered.
- **Income Generating Activities are unsustainable due to the lack of adequate** family capabilities to implement them.
- **Inadequate protection of widows and children's property inheritance rights**, including land.
- **Inadequate monitoring, enforcement and compliance to standards for residential and Alternative Care** facilities for children.

**Priority strategies:**

- Strengthen family/community systems including alternative care to improve socialisation and protection and ECCD for OVC.
- Enhance community systems to improve access to affordable quality HIV services for OVC.
- Financial protection through predictable transfers of cash, food, or other sustainable livelihood mechanisms for those affected by HIV.
- Advocate for policies, legislation and regulation to meet the needs and uphold the rights of the most vulnerable and excluded
- Harmonise existing social protection services and strengthen administration and monitoring of child outcomes.

## 2.11 Gender Based Violence

### Programme Objective

The objective is to strengthen national efforts to prevent and manage Gender Based Violence (GBV).

The GBV programme will contribute to the achievement of the following outcomes:-

**Table 14: GBV outcome level result**

Code	Description
<b>OC-31</b>	% of children aged 20-24 who experienced sexual abuse by the age of 18 is reduced from 33% in 2007 to 15% by 2015 and by 10% by 2018
<b>OC- 32</b>	% of women and men aged 15-49 who say that wife beating is an acceptable way for husbands to discipline their wives is reduced from 39%for women in 2010 to 25% in 2015 and 15% in 2018 and 34% for men in 2010 to 25% in 2015 and 15% in 2018
<b>OC-33</b>	% of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months has reduced from 8% in 2010 to 5% in 2015 and 3% in 2018
<b>OC-34</b>	% of eligible victims of sexual assault who have received PEP services is increased to 50% in 2015 and 80% by 2018



### Programme Overview:

The epidemic in Swaziland has a gender-bias with more women and girls living with or affected by HIV and AIDS. The bias is attributed to vulnerabilities in gender and cultural norms, income inequality and the female biological make-up. Gender-based violence remains prevalent in the Swazi society. According to National Study on Violence against Children and Women in Swaziland (2007), one in three girls experience sexual violence before the age of 18, and one in four women state that they experience some form of physical violence during childhood. GBV has been linked to the spread of HIV by limiting one's ability to negotiate the use of protection, disclosure of HIV status and access to healthcare services. According to the MICS 2010, 39% of women and 33% of men aged 15-49 years believe there are circumstances under which hitting their partner could be justified.

The national violence surveillance system recorded a total of 8,347 cases of violence between January 2011 and October 2012; 34% of these involved children. The types of violence include physical violence (33%), emotional (27%) and sexual violence (22%). However, there is significant underreporting of incidences of violence. More than half of all incidents of child sexual violence go unreported, and less than one in seven incidents result in a female seeking help (VAC 2007). Most violence occurs at home or at the house of a relative or a neighbour, and is perpetrated by an adult known to the child. Sexual abuse is often treated as a family secret (*tibi tendlu*).

The Child Protection and Child Welfare Act (2012) and the Sexual Offences and Domestic Violence Bill (2013) were passed, and these will mitigate GBV and enhance protection of children from abuse.

A large community volunteer cadre '*Lihlombe Lekukhalela*' ('Shoulder to cry on') has been trained to identify and respond to cases of child violence at the community-level. In addition, a multi-sectoral national violence surveillance system has been established with routine data collation on incidences of violence and abuse that collects information from nine organisations, including DSW, RSP, MoE, DPP and civil society organisations. Child-Friendly Corners have been established in 24 police stations that provide a safe and comforting environment for interviewing survivors of abuse and violence. Similarly, child-friendly court with a separate room where the child witness does not need to face the alleged perpetrator has been established in Mbabane, and additional child-friendly courts are planned for all regions. Toll-free telephone hotlines for reporting abuse are available and are operated by the Ministry of Education, the Royal Swazi Police and SWAGAA.

### Gaps and Challenges:

- There is limited understanding of the drivers of physical and sexual violence against women and children.
- Social work services are inadequate with insufficient number of qualified social workers.
- The community response through '*Lihlombe Lekukhalela*' as well as community police relies on volunteerism, and the level of training and mentoring support to these volunteers is not consistent.
- Reporting, case management and referral systems for Government structures as well as for community cadres are unclear.
- There are no facilities specialised in providing temporary shelter for survivors of abuse who need to be removed from their home to protect them from further abuse, until a long-term solution is found.



- Social and economic strategies intended to empower women and girls have not yielded the expected results. Policies have not adequately addressed gender issues, and law reform has been slow in ensuring gender equality, prevention and management of GBV.

**Priority strategies:**

- I. Strengthen the enabling legal and policy environment and mobilise leadership at all levels around GBV in young women.
- II. Strengthen reporting, referral service uptake and prosecution on GBV.
- III. Generate evidence on GBV.
- IV. Intensify primary prevention addressing gender norms, comprehensive sexuality education and rights.
- V. Intensify the provision of comprehensive health services for the management of GBV cases.





## Section 3: Management and Coordination of the HIV and AIDS Response

### Overview

The coordination and management of the national response is premised on the three ones principle: One Coordinating Authority, One National Strategic Framework, One Monitoring and Evaluation system. This included the adoption of multi-sectoral and decentralised approaches that have created more opportunities for diverse stakeholder involvement. However, with the increased number of stakeholders, coordination has increasingly become complex, challenging and dynamic. The process demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages.

The National Emergency Response Council on HIV and AIDS (NERCHA) is mandated to facilitate and coordinate the implementation of the multisectoral response to HIV and AIDS. NERCHA's role includes mobilization of all line sectors to realize and respond to social challenges posed by HIV and AIDS. Other coordinated mechanisms include Government, Civil society, Private Sector, Academia, Bilateral and Multilaterals. Through partnership with the Ministry of Tinkhundla Administration and Development (MTAD), the management of HIV response has been decentralized to lower levels. These mechanisms ensure inter-alia sectoral coordination and monitoring implementation of the response.

The country has developed a number of policies, guidelines and plans that facilitate an effective national response. These include National Development Strategy (NDS), Decentralization policy, National Gender Policy (2010), National HIV Policy, Parliament Strategy on HIV and AIDS (2011), Public Sector Workplace Policy and Wellness Programme (2011). A number of laws have also been reviewed and enacted, some of them being The People Trafficking and People Smuggling (Prohibition) Act (2009), Sexual Offences and Domestic Violence Bill (2010), Children's Bill (2011).

The national response to HIV and AIDS enjoys evident political commitment and support at the highest level, policy of openness enhancing better dialogue and communication, multisectoral interventions and co-ordination at various levels. The management and coordination of the HIV response will build on previous experiences. In this strategy more efficient and effective management and coordination approaches will be adopted to improve accountability and ownership of the national response. The management and coordination of the response will address social and programmatic enablers critical for achieving the results set out in the eNSF.

The effective management of the HIV and AIDS response will contribute to the achievement of the following impact level result:-

**Table 15: Management and Coordination of the HIV and AIDS Response Impact level Result**

Code	Description
IM-5	% of mid-term and end-of-NSF core programmes' service coverage targets that have been met are increased from 30% in 2011 to 50% in 2015 and 80% in 2018



### 3.1. Strengthening institutional arrangements for HIV and AIDS response

#### Programme Objective:

To improve efficiency, effectiveness, gender equality, ownership and accountability of existing coordinating structures at all levels of the response.

The strengthening institutional arrangements for HIV and AIDS response will contribute to the achievement of the following outcome:-

Table 16: Strengthening institutional arrangements outcome result

Code	Description
OC-35	The National Commitment Policy Index (NCPI) is increased from 7 in 2012 to 8 in 2015 and maintained as 8 in 2018

#### Programme Overview

Currently coordination takes place at national, regional, community and at sector level. Civil society and private sector are coordinated through umbrella organisations. The Ministry of Health continue coordinating the health sector response, and the Ministry of Tinkhundla Administration and Development facilitates the decentralised coordination at regional and community levels.

**NERCHA** is the highest policy making body on HIV and AIDS for coordination, policies and programmes. It has facilitated the establishment of coordination structures at decentralized levels.

**Decentralised Geographic Coordination** has been strengthened through the establishment of regional and community structures. These structures are the Regional Multisectoral HIV and AIDS Coordinating Committee (REMCHACC), Tinkhundla Multisectoral HIV and AIDS Coordinating Committee (TIMSHACC) and Multisectoral HIV and AIDS Coordinating Committee (CHIMSHACC).

**Public Sector Coordination** involves all public ministries and departments, directorates and units and has been led by Public Sector HIV and AIDS Coordination Committee (PSHACC). Through PSHACC a public sector coordinating strategy has been developed and is being implemented.

**Non-Government Sectors** have been coordinated by Coordinating Assembly of Non-governmental Organisations (CANGO) through the Swaziland HIV and AIDS Consortium (SHACO) which includes civil society and private sector umbrella bodies that have been created to provide sector leadership in their respective areas.

**Development Partners Coordination** has been facilitated through existing structures including the Donors' Forum and the Swaziland Partnership Forum.

#### Gaps and Challenges:

- Inadequate alignment of coordination structures' mandates
- Weak national and decentralised coordinating structure.



### Priority strategies:

- I. Realignment of coordination structures to improve on efficiency and effectiveness.
- II. Heighten the Three Ones principles at all levels.

## 3.2. Mainstreaming HIV Synergies in the Development Sector

### Program objective

To ensure a multisectoral HIV response with clear accountabilities and for sustainability

The Mainstreaming HIV Synergies in the Development Sector programme will contribute to the achievement of the following outcome:-

**Table 17: Mainstreaming HIV synergies in development sectors outcome level results**

Code	Description
<b>OC-36</b>	% of National Sectoral Development Plans (SDPs) that allocate at least 5% of their total budget to HIV and AIDS activities is increased to 50% in 2015 and to 70% in 2018
<b>OC-37</b>	% of development, public and private sector partners that have mainstreamed HIV, gender and human rights is increased to 40% in 2015 and 60 % in 2018

### Programme Overview

In Swaziland, HIV and AIDS epidemic is considered as a health, development and human rights issue. It is evident that the epidemic is spreading along the socioeconomic development dynamics such as poverty, gender inequality, unemployment, inadequate social protection and food insecurity among others. The impact of the epidemic is felt across all sectors of the economy and society and manifests in different ways such as loss of productivity, reduction in investments and purchasing power for products and services, increased cost of health care and labour and increased vulnerability to HIV infection. Unless these challenges are adequately addressed, it is unlikely that Swaziland will realise its national socioeconomic development including attaining the Millennium Development Goals.

Recognising that the impact of the epidemic transcends social and economic boundaries, Swaziland has adopted a multisectoral approach as a strategy to ensure meaningful engagement of development sectors in the national HIV response, based on their mandates and comparative advantages.

Development synergies (i.e. social protection, education, legal reform, gender equality, poverty reduction, food and nutrition, health systems, community systems and work place policies) have been defined as investments by other sectors (public, private and civil society) that can have a profound impact on HIV outcomes. However, their reasons for being are not typically to tackle HIV.

As part of strengthening synergies, efforts were made to ensure that sectors mainstream HIV, gender and human rights. Sectors that have successfully mainstreamed HIV and AIDS include the Ministries of Health, Education, Public Service and Tinkhundla Administration and Development. Table 18 below summarises strategic synergies with government, civil society and bilateral partners that can support the attainment of eNSF target.



Table 18: HIV Synergies with the Development Sector

Sector	HIV Synergies based on Mandate
1. Prime Minister's Office	Provide national political leadership and commitment, good governance to ensure effective coordination, supervision and proper management of public affairs by all Ministries and Departments to the HIV national response.
2. Deputy Prime Minister's Office	The epidemic has a gender bias, with women more affected than men; the Ministry can provide political leadership and intensify advocacy work, education and awareness of gender related drivers. The ministry can effectively influence changes in policies and legislation to address gender equality, gender based violence and OVC issues and delivery of social service.
3. Ministry of Finance	With prudent management of national financial resources for sustainable socioeconomic development, through effective macroeconomic, fiscal and financial policies, the ministry can resource mobilise for HIV and can steer the course of poverty through initiating pro-poor policies aimed at poverty reduction that can benefit vulnerable populations including PLHIV and OVC. It can also influence other sectors to mainstream HIV and AIDS through sector budgets.
4. Ministry of Economic Planning	Ensure HIV is mainstreamed within the development agenda, facilitation and implementation of a sustainable economic development frameworks and strategies to alleviate poverty. Donor resource mobilisation.
5. Ministry of Education and Training	Through education a large population of young people can be reached with HIV and AIDS and gender based violence prevention information and SBC interventions. Such interventions will contribute to a reduction of new infections, stigma and gender based violence. Similarly through the ministry's cultural outreach, socio-cultural norms, values and practices that are barriers to HIV prevention can be addressed.
6. Ministry of Health	Health sector is the largest supplier of HIV and AIDS services especially in the context of treatment care and support; it is also responsible for managing the TB/HIV co-infection. The sector can strengthen universal access to HIV prevention, treatment, care and support health services.
7. Ministry of Tinkhundla Administration and Development	The Ministry can ensure that HIV services reach out to all people in rural and urban areas by ensuring adequate community systems and infrastructure. It can also mobilise communities to access HIV services and enhance HIV coordination of the response through local structures.
8. Ministry of Labour and Social Security	The Ministry can be instrument in ensuring all public and private sector institutions develop and implement HIV and gender sensitive workplace programmes, while at the same time promoting social protection for vulnerable adults and children. The sector can support structural issues of establishing decent minimum wages.
9. Ministry of Commerce	Commerce promotes human interaction at national, cross-border and international levels. The sector can promote income generation programmes for vulnerable populations in communities. The ministry can promote HIV and AIDS responses within the commercial systems by stimulating the adoption of prevention behaviours.
10. Ministry of Justice	Ministry can ensure protection, respect and fulfilment of basic human rights, and adherence and compliance of both the GBV and HIV national policies and legislation. Ensure that all legislation and policies are HIV sensitive.
11. Ministry of Foreign Affairs	Develop and effectively administer a sound foreign policy on safeguarding National interest. Fostering bilateral and multilateral relations. Support cross border treatment for Swazi nationals abroad
12. Ministry of Agriculture	To ensure sustainable national and household food security and nutrition, the ministry is able to reach many people with HIV and AIDS interventions, especially those related to nutrition and food security.
13. Ministry of	Information, awareness and education constitute the key to behaviour change. The



information, communication and technology	use of mass media has strong effect on advocacy work across the country. The Ministry can play an important role in disseminating HIV and AIDS information, and supporting advocacy work, this also applies to addressing gender based violence.
14. Ministry of Public Service	The ministry leads the development, management and transformation of the public sector to being an efficient system in public service delivery, aligned to good governance and effective reach to workers through workplace programmes.
15. Ministry of Sports Culture and Youth Affairs	Young people are considered the window of hope in the national response. They are also sexually active, and bear higher risks and vulnerabilities for HIV infection. The ministry can develop effective response strategies on sports, arts and culture for HIV interventions for young people.
16. Ministry of Tourism and Environmental Affairs	Tourism promotes people's mobility and informal interactions. Mobility is one of the factors that have been identified as an epidemic driver. The ministry can develop effective HIV strategies that can reduce the probability of exposure among tourists and mobile population. Ensure that all Environmental Impact Assessments (EIA) include HIV externalities.
17. Ministry of Housing	Facilitation of physical planning, and implementation of decent housing programmes in both rural and urban environment.
18. Ministry of Natural Resources	Development and management of natural resources for sustainable national economic development. The ministry will ensure equitable access to natural resources, mainly potable water and sanitation.
19. Ministry of Public Works and Transport	Management and coordination of public works and maintenance of public infrastructure, and national transport system. Provide HIV prevention measures for migrant construction workers and host communities in areas that are being developed. Provide HIV services for mobile transport operators.
20. Ministry of Defence	Uniformed forces are highly mobile and considered among the key populations most at risk. Empowering them to adopt prevention behaviours has a direct prevention impact at community level.
21. Ministry of Home Affairs	Issuance of national identity documents. This presents an opportunity for development of unique patient identifiers. The ministry must ensure that all persons have legal identification documents, especially vulnerable persons.
22. Private sector and civil society organisations	Effective engagement and implementation of the HIV response. The sectors can support community mobilisation, employer practices and mobilise technical and financial resources for HIV response.
23. Bi-lateral and Multisectoral Partners	Strategic partnerships to ensure Swaziland reaches its HIV goal. The sectors can mobilise technical and financial resources for HIV response.

### Gaps and challenges

- Weak leadership and commitment necessary to drive the mainstreaming agenda and in particular to ensure the commitment of resources for HIV synergies.
- Limited understanding and capacity for mainstreaming.
- Lack of clear HIV accountability framework within the development sectors.

### Priority strategies:

- I. Strengthen sector capacity to mainstream HIV within their core mandate
- II. Strengthen leadership and ensure commitment to support the mainstreaming agenda
- III. Define an HIV mainstreaming accountability framework for the sectors (see table 18 for synergy reference).





### 3.3. Strengthening the Social, Policy and Legal enabling Environment

#### Program objective:

To ensure an enabling environment where people including vulnerable groups and key populations at higher risk of HIV infection have their rights protected, respected and fulfilled.

The Strengthening the Social, Policy and Legal enabling Environment will contribute to the achievement of the following outcome:-

Table 19: Strengthening the Social, Policy and Legal enabling Environment outcome level result

Code	Description
OC-38	% of PLHIV who experienced enacted stigma is reduced from 34% in 2011 to 20% in 2015 and 10% in 2018

#### Programme Overview:

Swaziland has made significant progress in strengthening the enabling social, policy and legal environment for the national multisectoral and decentralised HIV and AIDS response.

In creating an enabling environment, the country has implemented strategies that address social and cultural norms, cultural values and practices, and gender relations. Policy gaps that become barriers to service provision have been identified and Public policies that enable and facilitate the development and delivery of essential health care and social protection services have been put in place to enhance the development, availability, access and utilisation of HIV prevention and treatment services. It is also evident that while several policies exist, their implementation has lagged behind. Many of them have not adequately mainstreamed gender and human right in the context of HIV and AIDS response.

Efforts to ensure that existing legislation is sufficient to protect and strengthen the fulfilment of human rights are on-going.

The eNSF has prioritised two interventions that a strong social, policy and legal environment will effectively support. These are reduction of stigma and discrimination associated with HIV and AIDS and gender-based violence. The Stigma Index identified self-stigma as the most prevalent barrier to services uptake.

Gender-based violence has also been identified as a key contributing factor to HIV risk and vulnerability, especially for women and girls. Violence and the threat of violence has been found to increase vulnerability to HIV by making it difficult or impossible to set the terms of sexual relationships, on behalf of women or girls. Gender-based Violence (GBV) discourages women from getting tested for HIV, from publically sharing their HIV status, following preventive measures, and receiving treatment, care, and support services.

These are critical issues that the stakeholders will be required to address to ensure effective uptake of services and protection and fulfilment of human rights for vulnerable groups.

To achieve an enabling environment will require not only having the policies and legal instruments, but also to ensure their effective implementation and enforcement. This will require strong political leadership and commitment, sustained community and civil society participation and broad public awareness of existing policy and legal instruments. Sustained national and community debate on policy issues will be needed to turn policies into programmes and legal instruments as platforms for empowerment.



During the implementation of the eNSF, advocacy will be intensified to review existing laws to ensure that they are aligned to human rights issues in the context of HIV and AIDS. Of particular interest will be policy and legal instruments that address social protection issues, gender based violence, stigma and discrimination, and socio-cultural norms and practices that have a negative impact on society.

### **Gaps and Challenges:**

- People are not adequately empowered at individual-level or collectively at the community-level to address social, policy or legal vulnerability and risk factors associated with HIV and AIDS.
- Weak capacity and strategies for advocacy to sustained political commitment to support an enabling policy and legal environment for HIV and AIDS implementation.
- Inadequate monitoring of the policy environment to ensure that people are not discriminated or stigmatised.
- Inadequate forums to support public debate on the wider social issues brought about by HIV and AIDS and in particular on their effect on vulnerable groups and populations at higher risk of HIV infections. Each of these groups faces unique problems that require specific policy guidelines and legal instruments to address them.
- Inadequate monitoring and evaluation of stakeholders' performance in implementing appropriate policies and legislation.
- Inadequate community and civil society engagement and participation in the implementation of policies and laws.
- The social environment is addressing the conflict between customary practices and public policies and legislation. This is an important aspect, especially in the context of women's and girls' empowerment.

### **Priority Strategies**

- I. Advocate for the review of existing public policies and laws to mainstream HIV and AIDS and gender dimensions using a human rights approach.
- II. Implement the Positive Health Dignity Programme (PHDP) for PLHIV.
- III. Empower women and men to make informed decisions and choices on their behaviour, cultural and social practices that protect them from potential harm to their health.
- IV. Creation of broad public awareness of issues related to stigma and discrimination, policy and legal barriers that prevent vulnerable groups and populations at higher risk of infection from accessing and utilising services adequately.
- V. Address gender inequality, gender-based violence and exploitation of women and the girl child.
- VI. Intensify communication (dissemination) of existing policies, legal instruments and other guidelines intended to protect and fulfil the human rights of vulnerable groups.



### 3.4. Systems Strengthening- Community, Health and Education Sectors

#### Programme objectives:

To strengthen available community systems to lead and sustain the decentralised HIV response and mobile communities for improved uptake of HIV services. To strengthen the integration HIV into health care system and to sustain the gains made in the education sector.

It is anticipated that systems strengthening will contribute to the achievement of the following outcomes:-

Table 20: Community, Health and Education Sectors systems strengthening outcome results

Code	Description
OC-39	% of households who report that the community HIV services they received in the past 12 months were comprehensive has increased from 22% in 2007 to 50 % in 2015 and 80% in 2018
OC-40	% of health facilities that offer quality and comprehensive HIV and AIDS services are increased to 85% in 2015 and 95% in 2018
OC-41	The ratio of primary school completion by OVC vs. non-OVC is improved from 0.97 in 2010 to 1 in 2015 and 2018

#### Programme Overview:

Systems strengthening will be used to develop the capacity to provide HIV and AIDS services in a more efficient and cost effective way. It is also evident that strong systems will ensure increased access, coverage, quality and utilisation of service. The systems strengthening initiatives will focus on health, education and community. Equitable distribution, availability and accessibility of comprehensive health and social services for HIV and AIDS are largely dependent on strong health and community systems. A strong health system is critical in ensuring that the infrastructure, human and financial resources, health commodities including drugs, and the necessary technology are available and are functional. The focus during the eNSF implementation will be to manage the interactions between the key health systems strengthening blocks to ensure effectiveness and efficiency gains.

On the other hand community systems are strategic in supporting community participation in HIV and AIDS response, especially in community mobilisation, delivery of interventions necessary for services demand creation, and retention, and more important supporting delivery of community-based interventions outside of health facilities. Community HIV care services include, HIV related community mobilisations, outreach services such as HTC, MC, ART and TB outreach refills, Home Based Palliative Care. These services are essential in alleviating the burden of care in health facilities. In the case of community based care of PLHIV, communities must gear themselves to new functions given the impact of ART on the quality of life. Community-based structures and systems have been developed to support community interventions. These include Umphakatsi, KaGogo Social Centres (KSCs), Social centres (in urban areas) and Neighbourhood Care Points (NCPs). KaGogo centres serve as coordination centres for HIV services, the KaGogo centre manager sits in the Chief's inner council as the community secretary. The KaGogo centre further serves as an important monitoring and evaluation structure that provides information about community's demographic profile and service provision.



The purpose of education systems strengthening (ESS) is to strengthen the multi-sector partnership role of education as it implements sector driven solutions towards HIV prevention and the care and support to children living with HIV, the Orphans and Vulnerable Children and the Girl Child within a vibrant and relevant education system.

Strengthening synergies within the education sector will promote the protective role of the education; children who stay in school are less likely to engage in early sexual debut, and will make more informed choices about sexual behaviour and practices as adolescents while simultaneously acquiring relevant human resource development skills and training that will reduce their vulnerability beyond school going age. The target population within the education system ranges from ECD to post-secondary education that constitutes the 0 to 18 year olds. (45% of this age group being OVCs). Education sector strategies will also be incorporated to institutions of higher learning –universities, colleges, and vocational institutes to capture young adults.

#### **Programme gap:**

The following are gaps and challenges for systems strengthening

- I. The capacity of systems varies from one system to the other. Capacity building has not followed systematically the six building blocks of systems strengthening approach.
- II. Linkages between the three systems are inadequately developed and operationalized and hence compromising the synergy between them.
- III. Inadequate understanding of the systems by communities and in particular the potential to use strong systems to improve on community-based service delivery.

#### **Priority strategies**

- I. Strengthen the systems using but not limited to the six building blocks of systems strengthening.
- II. Strengthen political and community leadership skills, including advocacy, HIV and AIDS planning and budgeting, communication, especially given their role in facilitating community dialogue and conversations.
- III. Strengthen capacity of vulnerable households and communities to identify and implement sustainable livelihoods as coping strategies.

### **3.5. Resource Mobilisation and Sustainable Financing**

**Programme Objective:** To ensure the national HIV response is well resourced and efficiently managed in a sustainable manner.

Resource Mobilisation and Sustainable Financing will contribute to the achievement of the following outcomes:-

**Table 21: Resource Mobilisation and Sustainable Financing outcome level results**

Code	Description
<b>OC-42</b>	Total funding committed for HIV response is increased to \$102 million in 2015 and \$124 million in 2018
<b>OC-43</b>	% of total expenditure used towards eNSF priority/core programmes is increased to 65% in 2015 and 70% in 2018



## Overview

Swaziland is committed to continue investing in the national response to HIV and AIDS. Currently most of the funding comes from three sources i.e. the Government of Swaziland, Global Fund and PEPFAR, with 56.9% of the funding coming from external sources. Swaziland is concerned about the sustainability of the national response given the dependency on external donors.

As the programmes are intensified and coverage expanded, demand for resources especially for the national response will inevitably increase. Direct costs, such as clinical cost of AIDS treatment and care, as well as the cost of awareness campaigns and other HIV and AIDS prevention measures, were estimated to be 3% of GDP, while indirect costs, a term that is used for all expenditures not included in specific HIV budget line items, for social expenditure approximately 2% of GDP. Projections estimate this figure to rise to near 10% by 2020.

Funding from Government has continued to increase over the years, at approximately SZL103 million in the 2007/8 financial year to over SZL231 million in the 2009/10 financial year.

Table 22 below provides an indicative resource obligation for the implementation of the eNSF between 2014 and 2018 by programme area. Calculated using the UNAIDS Resource Needs Model, it is estimated that the full implementation of the eNSF maximum scenario will require a total resource outlay of US\$550.1 million, consisting of annual requirements of US\$99.6 million in 2014 rising to US\$123.6 million. Annual increases are linked to increased coverage levels.

Table 22: eNSF financial needs 2014 - 2018 (in millions of US Dollars)

Funding Area	eNSF period 2014-2018					TOTAL eNSF	% of total
	Exchange rate 1US\$: E9.84						
	2014	2015	2016	2017	2018		
Social and behaviour change	\$2.28	\$2.56	\$2.85	\$3.14	\$3.45	\$14.28	2.6%
HTC	\$3.84	\$4.36	\$4.89	\$5.44	\$6.01	\$24.55	4.5%
PMTCT	\$1.45	\$1.44	\$1.43	\$1.42	\$1.39	\$7.13	1.3%
Condoms	\$0.81	\$1.04	\$1.07	\$1.10	\$1.13	\$5.14	0.9%
Male circumcision	\$4.00	\$3.72	\$3.47	\$3.22	\$2.98	\$17.39	3.2%
Key populations	\$0.17	\$0.20	\$0.23	\$0.26	\$0.29	\$1.16	0.2%
Treatment, Care and Support (pre-ART, ART, TB/HIV co-infection)	\$44.25	\$48.86	\$53.47	\$58.13	\$63.12	\$267.83	48.7%
Care and support for orphans and vulnerable children	\$20.64	\$15.52	\$15.29	\$15.10	\$14.88	\$81.43	14.8%
Gender Based Violence	\$0.31	\$0.27	\$0.23	\$0.19	\$0.15	\$1.14	0.2%
Social and Programme critical enablers	\$17.58	\$19.43	\$21.22	\$23.04	\$24.98	\$106.25	19.3%
HIV Mainstreaming <sup>10</sup>	\$2.00	\$2.00	\$2.00	\$2.00	\$2.00	\$10.00	1.8%
Strategic information and knowledge	\$2.28	\$2.52	\$2.75	\$2.99	\$3.24	\$13.78	2.5%

<sup>10</sup> Funding is for the coordination, management and monitoring of HIV specific mainstreaming components in development sectors (public, private and development partners).





management							
<b>Total cost of eNSF</b>	<b>\$99.62</b>	<b>\$101.92</b>	<b>\$108.91</b>	<b>\$116.02</b>	<b>\$123.61</b>	<b>\$550.07</b>	<b>100%</b>
HIV synergies in development sectors	\$35.66	\$36.20	\$36.61	\$37.16	\$37.72	\$183.35	N/A
<b>Total eNSF with HIV synergies</b>	<b>\$135.28</b>	<b>\$138.12</b>	<b>\$145.52</b>	<b>\$153.18</b>	<b>\$161.33</b>	<b>\$733.43</b>	<b>N/A</b>

Source: Costing of the eNSF using the UNAIDS Resource Needs Model 2013 and unit costs collection exercises

With the addition of HIV synergies that are invested by the development sector, the cost of the eNSF is increased to \$733.43. HIV synergies are not a direct cost to the HIV and AIDS response but reflect positive externalities<sup>11</sup> that can benefit the response.

The country's recognises that bilateral and multilateral partners supporting the HIV and AIDS response have prior committed to funding some HIV programmes during the eNSF period. However, an eNSF financial gap could not be ascertained because of the re-alignment of the eNSF in relation to the NSF and that most partners do not commit funding projections for the longer time horizon required by the eNSF. As a result, the eNSF financing gap will be updated on an annual basis and articulated in the National Operational Plan (NOP).

### Gaps and Challenges

- **Unpredictable external and internal funding environment for HIV response-** The global financial crisis, Government liquidity crisis and other natural disasters have affected the global and local landscape for funding for HIV. However, the government has maintained its pledge to maintain budgets for social sectors and health including HIV and education, against proposed cuts in other sectors, funding for these sectors in the medium term remains uncertain.
- **Limited diversification of funding sources for the national AIDS response.** There is no strategy to mobilise resources beyond the Global Fund, the United States of America's PEPFAR and Swazi Government. More inward resource mobilisation efforts have not been attempted. In addition, there is no national sustainable financing plan for the response.
- **Resource allocation is not based on priorities.** The NASA (2011) reported that approximately 41% of the total funding in the last fiscal year was spent on coordination and management, followed by treatment, care and support (26%), and impact mitigation (25%). HIV prevention which is the key priority for Swaziland consumed only 8% of total expenditure.
- **There is inadequate resource tracking from both the supply and demand ends.** The biennially conducted NASA is the main source of resource tracking. It is difficult to establish the level of resources that are committed for future years, as the NASA focuses on expenditures. The country's absorptive capacity to utilize all committed funds has not been established.

### Priority strategies

- I. Develop and operationalize a sustainable financing strategy, including the HIV investment case.

<sup>11</sup>Externalities occur in economic activity as spillover effects to other people or sectors not involved in the original activity. Positive externalities result in beneficial outcomes for others and negative externalities impose costs on others.



- II. Develop and implement a costed National Operational Plan (NOP).
- III. Promote the Paris Declaration among donors in order for them to align their support to national planning, budget and financial accountability systems.
- IV. Strengthen capacity for resource mobilisation in areas of HIV forecasting, costing and budgeting and for NGOs capacity to develop fundable proposals.
- V. Institutionalise the optimisation, efficiency and cost-effectiveness of the national HIV response.

### 3.6. Strategic Information and Knowledge Management

**Programme Objective:** To generate, analyse and use strategic information for decision making in HIV response planning, implementation and accountability.

The Strategic Information and Knowledge Management will contribute to the achievement of the following outcome result:-

Table 23: Strategic information and knowledge management outcome result

Code	Description
OC-44	% of eNSF Indicators that are reported on through the aligned multisectoral M&E system is improved from 65% in 2011 to 80% in 2015 and 100% in 2018

#### Programme Overview

Swaziland has a functional national HIV and AIDS M&E system. Routine monitoring is facilitated by NERCHA through the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS). Ministry of Health facilitates the monitoring of health sector interventions through the Health Management Information System (HMIS). Other sectors also have sector specific M&E systems that collect data relevant to the HIV and AIDS response. NERCHA also maintains a geographic information system (GIS) that provides spatial view of service coverage.

Since the launch of the NSF 2009-2014, Swaziland has generated a wealth of empirical data and strategic information. The research and surveys conducted include the Swaziland Income and Household Expenditure Survey (SHIES 2010), Behavioural Sentinel Surveillance among Most at Risk Populations (BSS MARPS, 2010), Quality of Impact Mitigation Survey (QIMS, 2010), Swaziland HIV Incidence Measurement (SHIMS, 2011), Swaziland Population Projections (2011); Multiple Indicator Cluster Survey (MICS 2010); HIV Estimates and Projections (2012), National AIDS Spending Assessment (NASA, 2011), and HIV Stigma and Discrimination Index (2011).

#### Gaps and challenges

- Stakeholders' M&E systems are not adequately aligned or harmonized with national M&E systems, in line with the Three Ones Principles
- Absence of a multisectoral HIV research agenda and inadequate capacity for HIV and AIDS research
- Weak lower level M&E systems especially inadequate stakeholders capacity for data collection, analysis and reporting
- National surveys not done periodically and poorly planned, with limited capacity and resources



- Weak dissemination of strategic information and evidence use in planning

**Priority strategies**

- I. Harmonise and align all stakeholders' M&E systems with the national M&E system.
- II. Strengthen M&E and research capacity at all levels.
- III. Develop and implement a multisectoral HIV research agenda.
- IV. Conduct surveys, research and evaluations as per plan.
- V. Strengthen dissemination of strategic information and its use in planning.



## Section 4: eNSF Implementation Arrangements

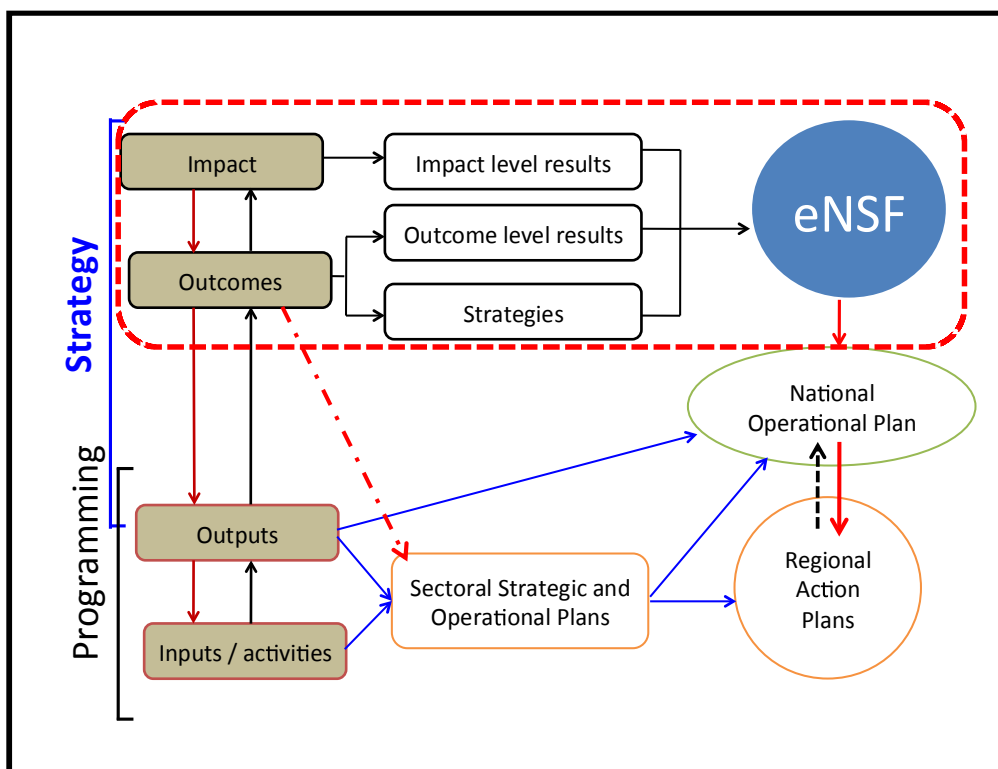
### Overview

The operationalisation and implementation of the eNSF will adopt a multisectoral and decentralised approach. Each implementing partner will identify their strategic niche in the national response based on their individual organisational mandate and comparative advantage.

Implementing partners will be encouraged to align and harmonise their programmes and specific interventions with national priority programmes. In addition partners will be encouraged to plan for the implementation of associated critical social and programmatic enablers that are necessary for the success of individual programmes. Synergies will be developed with development partners, who will be called to support the HIV response and account on their development mandate in the context of HIV.

The implementation of the eNSF will be premised and guided by (a) the National Operational Plan (b) National Communication Strategy and the (c) National M&E Framework / Plan. These plans will be developed concurrently. The diagram below illustrates the linkages between strategic and operational planning for the HIV and AIDS response.

Figure 7: Linkages between strategic and operational planning





#### **4.1 National Operational Plan**

A costed National Operational Plan (NOP) will be developed to guide the operationalisation and implementation of the eNSF. The process of developing the NOP will take into consideration the principles of “joint planning”. While the eNSF focuses on impact and outcome results, the NOP will focus on output results. The linkages between impact, outcome and output results are demonstrated in the results framework (Annex 1).

The NOP will be the platform where policy guidelines and strategies articulated in the eNSF will be translated to actions. Specific activities will be related to specific outputs. It will be necessary to ensure that the activities are relevant and adequate to achieve the output result. However, given the combination strategy for interventions addressed in eNSF, the activities in the NOP may contribute to one or more output results.

The NOP will identify potential lead implementing and collaborating partners. The lead implementing organisations are identified on the basis of their mandate, comparative advantage and existing technical expertise and resources.

The NOP will be a rolling plan that will be reviewed annual and adjusted accordingly. However, a formal review is also suggested after two years.

#### **4.2 The National Advocacy and Communication Strategy**

As noted in the M&E section Swaziland has accumulated a wealth data and knowledge on HIV and AIDS. The greatest challenge is making this strategic information available to people and in particular those involved in decision making, planning including resource allocation, and the implementers.

Swaziland will develop a National Advocacy and Communication Strategy that will facilitate the dissemination of strategic information. The strategy will also guide advocacy work, and awareness creation strategies. It is important that strategic interventions are developed and implemented to ensure that HIV and AIDS issues are placed and retained on the national and community social, economic and political agenda.

As part of eNSF dissemination, the Communication unit will develop effective strategies for taking the eNSF to stakeholders. This will include but not be limited to organised workshops, press conferences, and production of a popular version of eNSF.

#### **4.3 The National Multisectoral HIV and AIDS M&E Framework**

Swaziland will review the current National M&E Framework to align and harmonise it with the eNSF requirements. It is important that the M&E plan provides strategic guidance on monitoring and evaluation of the response, methods (surveys and research) that will be used to generate new knowledge and how people will access that data and information.

The M&E framework will articulate the further the results framework, the targets and the indicators necessary to measure performance.





#### **4.4 Programme Development and Action Planning**

Advocacy will be intensified with relevant sectors to ensure that eNSF prioritised programmes are translated into programme action plans. The action plans will complement the strategies contained in the eNSF and prioritised activities in the NOP. The plans will determine the operational nature of services, coverage and delivery strategies.

The action planning process will take into consideration the eNSF planning guidelines of using evidence, planning for results, ensuring gender and human rights mainstreaming, and infusing processes for community involvement and participation.

#### **4.5 Engaging Communities, Civil Society Organisations, and PLHIV**

Community involvement in the design and implementation of the HIV and AIDS response is a primary requirement for eNSF. Implementing partners will be encouraged to ensure meaningful involvement of communities, including youth and PLHIV in community-based interventions intended to benefit them. Community mobilisation will be intensified through a variety of strategies .

Community-based interventions will be “community and family centred”. All implementing partners will ensure inclusion of strategies that strengthen community and social protection systems.



## Annex1 – eNSF Results Framework

\* Indicator is in the 2011 Political Declaration for HIV

Impact Level Results	Outcome Level Results	Output Level Results
	<b>I – HIV Testing and Counselling</b>	
	<b>People know their status and seek relevant health services</b> % of people aged 15-49 who report having been tested for HIV and receiving their results in the last 12 months has increased from 47% for women in 2010 to 55% in 2015 and 65% in 2018 and from 31% for men in 2010 to 45% in 2015 and 55% in 2018*	<b>More people know their status</b> Number of people who have tested for HIV in the last 12 months and know their status has increased from 178,813 in 2011 to 500,000 in 2015 and to 700,000 in 2018 <sup>12</sup>
	<b>Prevention of New HIV Infections</b>	
	<b>II – Social and Behaviour Change</b>	
<b>Fewer adults become infected with HIV</b> HIV incidence rate is reduced from 2.9% in 2011 to 1.4% in 2015 and maintained at 1.4% in 2018	<b>Fewer people have multiple partners</b> % of people aged 15-49 who report having had sex with more than one partner in the last 12 months has reduced from 2.7% for women in 2010 and reduced to 1.5% in 2015 and maintained as 1.5% in 2018 and reduced from 16% for men in 2010 to 12% in 2015 and 10% in 2018*	<b>SBC programmes target adults 25 and older</b> % of people aged above 25 years who have been reached with social and behaviour change programmes is increased from 26% in 2011 to 50% in 2015 and 75% in 2018  % of formally employed workers reached with a minimum package of HIV prevention programmes in the last 12 months has increased from 11% in 2011 to 45% in 2015 and 75% in 2018
<b>Fewer infants become infected with HIV</b> % of HIV infected infants aged 18-24 months born to HIV positive mothers are reduced from 16.4% in 2011 to 5% in 2015 and 2% in 2018*	<b>Social norms that are protective against HIV are reinforced</b> % of people aged 15-49 who agree that married men should only have sex with their wives is increased from 86% in 2007 to 90% in 2015 and to 95% in 2018  <b>More young people have comprehensive knowledge of HIV</b> % of persons aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission has increased from 58% for women in 2010 to 65% in 2015 and 70% in 2018 and from 54% for men in 2010 to 65% in 2015 and 70% in 2018*	<b>SBC programmes target the youth aged 10-24</b> % of young people aged 10-24 who have been reached with social and behaviour change programmes is increased from 51% in 2011 to 70% in 2015 and 85% in 2018

<sup>12</sup> Indicator is unable to track people tested but reports on the number of tests conducted.



	<p><b>Young people delay sexual debut</b> % of young women and men aged 15-24 who report having had sexual intercourse before age 15 is reduced from 3.8% for women and 2.6% for men in 2010 to 2% in 2015 and 1% in 2018 for both sexes*</p> <p><b>Community leaders lead social and behavioural change</b> % of persons who reported that they heard about HIV transmission risk reduction measures from community leaders in the last 12 months has increased to 80% in 2015 and 85% in 2018</p>	<p>% of in-school youth aged 15- 19 who have attended life skills education at school in the last 12 months is increased to 74% by 2015 and to 95% in 2018.</p> <p><b>SBC programmes target community leaders</b> % of community leaders who have been reached with social and behaviour change programmes increased to 50% by 2015 and to 65% by 2018</p>
	<p><b>III- Condom Promotion and Distribution</b></p> <p><b>More youth use condoms at first sex</b> % of young people aged 15-24 who report using a condom during first sex has increased from 43.2% for women in 2007 to 55% in 2015 and 65% in 2018 and 49% for men in 2007 to 60% in 2015 and 70% in 2018</p> <p><b>People who have multiple partners use condoms</b> % of men and women aged 15 - 49 with more than one partner in the past 12 months who report the use of a condom during last sex has increased from 74% for women in 2010 and 71% for men in 2010 to 80% for both in 2015 and 85% for both in 2018</p>	<p><b>More condoms are distributed</b> Number of condoms distributed per year has increased from 6.5 million for male condoms in 2011 to 10 million in 2015 and 14 million in 2018 and from 202,100 for female condoms in 2011 to 350,000 in 2015 and to 500,000 in 2018</p>
	<p><b>IV-Prevention of Mother To Child Transmission</b></p> <p><b>Fewer infants have HIV at 6-8 weeks</b> % of HIV infected infants aged 6-8 weeks who are born to HIV positive mothers are reduced from 2% in 2011 to 1% in 2015 and maintained as 1% in 2018</p>	<p><b>Fewer unplanned pregnancies occur amongst women living with HIV</b> % of HIV + women aged 15- 49 with unmet need for family planning is reduced from 64% in 2010 to 40% in 2015 and to less than 20% in 2018</p> <p><b>More pregnant women are tested for HIV and those found HIV + receive appropriate regimen</b> % of pregnant women who were tested for HIV and received their results, has increased from 87% in 2011 and maintained at 95% in 2015 and 2018</p> <p>% of HIV positive pregnant women who received a course of ARVs to reduce MTCT in the last 12 months has increased from 86% in 2011 and maintained as 95% in 2015 and 2018*</p> <p>% of infants born to HIV-infected women receiving a virological test for HIV</p>



		within two months of birth has increased from 73% in 2011 and maintained as 90% in 2015 and 2018*
	<p><b>Prong IV-Continuum of care for HIV+ mothers, their children, and families</b></p> <p>% of eligible pregnant and lactating women receiving ART increased from 50% in 2011 to 80% in 2015 and 95% in 2018</p> <p>% of eligible children aged 0-5 years receiving ART increased to 70% in 2015 and 90% in 2018</p>	<p><b>More HIV+ mothers and their HIV+ exposed children are assessed for eligibility for ART</b></p> <p>% of HIV-positive pregnant women assessed for eligibility for antiretroviral therapy by CD4 count or clinical staging has increased from 72% in 2011 to 90% in 2015 and to 95% in 2018*</p> <p>% of children aged 18-24 months who are born to HIV-infected women receiving an HIV test within two months after cessation of breastfeeding is increased to 70% in 2015 and 90% in 2018</p>
	<b>V- Male Circumcision</b>	
	<p><b>On population level, more male adults and children are circumcised</b></p> <p>% of males aged 10-49 who are circumcised is increased to 45% in 2015 and 70% in 2018</p> <p>% of male children under 5 years who are circumcised is increased to 30% in 2015 and 50% in 2018</p>	<p><b>More males are circumcised</b></p> <p>Number of young men aged 10-49 who are circumcised in the last 12 months has increased to 15,000 in 2015 and 21,000 in 2018</p> <p>Number of male who are circumcised before the age of 1 in the last 12 months has increased from 1,149 in 2011 to 5000 in 2015 and to 10,000 in 2018</p>
	<p><b>More parents support their children being circumcised</b></p> <p>% of parents who support their sons to be circumcised has increased to 40% in 2015 and 60% in 2018</p>	<p><b>More people have comprehensive knowledge about medical male circumcision</b></p> <p>% of men and women aged 15-49 who have been reached with male circumcision promotion programmes has increased to 40% in 2015 and 70% in 2018</p>
	<b>VI-Customised Programmes for Key Populations and Vulnerable Groups</b>	
	<p><b>Fewer young women have older sexual partners</b></p> <p>% of women aged 15-24 who had sex with a partner 10 years or more older than them is decreased from 14% in 2010 to 8% in 2015 and 5% by 2018</p> <p><b>Fewer young people have HIV</b></p> <p>HIV incidence rate for young women aged 15-24 is reduced from 3.9% in 2011 to 3% in 2015 and 2% in 2018</p>	<p>See SBC programme for interventions</p>



<p>% of young people aged 15-24 who are living with HIV is reduced from 23% for women in 2007 to 15% in 2015 and 10% in 2018 and 6% for men in 2007 to 4% in 2015 and 2% in 2018*</p>	
<p><b>Sex workers use harm reduction measures</b> % of female sex workers reporting the use of a condom with their most recent client is increased to 80% in 2015 and 95% in 2018*</p> <p>% of eligible HIV+ female sex workers who are currently on ART is increased to 50% in 2015 and 80% in 2018</p> <p><b>Sex workers have comprehensive knowledge about HIV</b> % of population groups at higher risk of HIV infection who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission has increased from 46% in 2008 to 65% in 2015 and 75% in 2018</p>	<p><b>More Sex workers are reached with HIV prevention messages and know their HIV status</b> % of sex-workers reached with HIV prevention programmes is increased from to 60% in 2015 and 80% in 2018*</p> <p>% of female sex workers who have received an HIV test in the past 12 months and know their results is increased to 80% in 2015 and 90% in 2018</p>
<p><b>Men having sex with men use harm reduction measures</b> % of MSM reporting the use of a condom the last time they had anal sex is increased to 60% in 2015 and to 80% in 2018</p> <p>% of eligible MSM who are currently on ART is increased to 40% in 2015 and 60% in 2018</p> <p><b>MSM have comprehensive knowledge about HIV</b> % of population groups at higher risk of HIV infection who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission has increased from 46% in 2008 to 65% in 2015 and 75% in 2018</p>	<p><b>More MSM are reached with prevention messages and know their HIV status</b> % of MSM reached with HIV prevention programmes is increased to 50% in 2015 and 70% in 2018*</p> <p>% of men who have sex with men that have received an HIV test in the past 12 months and know their results is increased to 50% in 2015 and 70% in 2018*</p>
<p><b>Inmates, migrant/mobile and people living with disabilities have comprehensive knowledge about HIV</b> % of population groups at higher risk of HIV infection who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission has increased from 46% in 2008 to 65% in 2015 and 75% in 2018</p>	<p><b>More Inmates, migrant/mobile and people living with disabilities receive comprehensive information about HIV</b> % of inmates reached with combined HIV prevention package in the last 12 months has increased to 50% in 2015 and to 80% in 2018</p>





<p><b>HIV has less of an impact on the life expectancy in Swaziland</b> Life expectancy at birth has increased from 47.2 years for women in 2011 to 50 years in 2015 and 55 years in 2018 and from 43.2 years for men in 2011 to 45 years in 2015 and 50 years in 2018</p> <p><b>Reduced HIV-related maternal mortality</b> Maternal Mortality Rate is reduced from 320/100,000 in 2010 to 270/100,000 in 2015 and 200/100,000 in 2018</p>	<p>% of migrant/mobile population reached with combined HIV prevention package in the last 12 months has increased to 45% in 2015 and to 55% in 2018</p> <p>% of people living with disabilities reached with a combined HIV prevention package in the last 12 months has increased to 50% in 2015 and to 80% in 2018</p>	
	<p><b>Treatment, Care and Support</b></p>	
<p><b>Average viral load among PLHIV is reduced</b> % of PLHIV with known status (on ART &amp; not on ART) who are virally suppressed is increased from 50% in 2011 to 70% in 2015 and 80% in 2018</p> <p><b>More PLHIV survive longer on ART</b> % of adults and children with HIV still alive and known to be on treatment 36 months after initiation of ART has increased from 68% for adults in 2011 to 75% in 2015 and 80% in 2018 and from 66% in 2011 for children to 70% in 2015 and 75% in 2018*</p>	<p><b>VII (a)- Pre- Antiretroviral Therapy</b></p> <p><b>More persons diagnosed with HIV are enrolled in care</b>% of people testing HIV positive enrolled in Pre-ART care is increased to 75% in 2015 and 90% in 2018</p>	
	<p><b>VII (b)- Antiretroviral Therapy</b></p> <p><b>More eligible PLHIV receive ART</b> % of eligible adults aged 15 and older who are currently receiving antiretroviral therapy is increased from 84% in 2011 to 90% in 2015 and to 95% in 2018*. <i>Using CD≥500: Increased to 50% in 2015 and 70% in 2018</i></p> <p>% of eligible children aged 0-14 who are currently receiving antiretroviral therapy is increased from 63% in 2011 to 80% in 2015 and 90% in 2018*</p> <p><b>Allmalnourished PLHIV receive nutritional support</b> % of people living with HIV (adults and children) enrolled in care who are malnourished who receive nutritional support is increased to 60% in 2015 to 85% in 2018</p> <p><b>More PLHIV are emotionally able to cope with their status</b> % of PLHIV (with known HIV status) enrolled in PLHIV support groups has increased from 11% in 2011 to 50% by 2015 and to 80% by 2018</p>	
<p><b>Fewer PLHIV are co-infected with TB</b> % of incident TB cases among PLHIV who have successfully completed their TB</p>	<p><b>VII (c)- TB/HIV Co-infection</b></p> <p><b>Co-infection is diagnosed</b> % of registered patients diagnosed with TB, who test for HIV, is maintained</p>	



	treatment has increased from 62% in 2011 to 75% in 2015 and 85% in 2018	at 95% from 2011 in 2015 and 2018  % of PLHIV enrolled in care who are tested for TB is increased to 70% in 2015 and 90% in 2018  % of HIV-positive patients screened TB-negative who are given INH is increased to 50% in 2015 and 70% in 2018
		<b>Co-infected people receive treatment</b> % of estimated HIV-positive incident TB cases that received treatment for both TB and HIV has increased from 29% in 2012 to 50% in 2015 and 85% in 2018*



IX-Gender Based Violence	
<p><b>Fewer children are sexually assaulted</b> % of children aged 20-24 who experienced sexual abuse by the age of 18 is reduced from 33% in 2007 to 15% by 2015 and by 10% by 2018</p> <p><b>Fewer women experience GBV</b> % of women and men aged 15-49 who say that wife beating is an acceptable way for husbands to discipline their wives is reduced from 39% for women in 2010 to 25% in 2015 and 15% in 2018 and 34% for men in 2010 to 25% in 2015 and 15% in 2018</p> <p>% of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months is reduced for 8% in 2010 to 5% in 2015 and 3% in 2018*</p> <p><b>More victims of sexual assault are protected from HIV sero-conversion</b> % of eligible victims of sexual assault who have received PEP services is increased to 50% in 2015 and 80% by 2018</p>	<p><b>Communities and duty bearers respond to GBV</b> % of reported abuse cases that have been referred to a service provider have increased from 37% in 2011 to 62% in 2015 and to 82% in 2018</p>
Management and Coordination of the response	
X- Strengthening Institutional arrangements for the HIV and AIDS response	
<p><b>Government, Partners, regions, sectors and communities work together</b> The National Commitment Policy Index (NCPI) is increased from 7 in 2012 to 8 in 2015 and maintained as 8 in 2018</p>	<p><b>Development partners align to eNSF objectives</b> % of development partners' coordination systems that are harmonised and aligned to eNSF is increased to 95% in 2015 and 100% in 2018</p>
XI- Mainstreaming HIV synergies in the Development Sector	
<p><b>Government and partners implement a sustainable multi-sectoral HIV response</b> % of National Sectoral Development Plans (SDPs) that allocate at least 5% of their total budget to HIV and AIDS activities is increased to 50% in 2015 and to 70% in 2018</p> <p>% of development, public and private sector partners that have mainstreamed HIV, gender and human rights is increased to 40% in 2015 and 60 % in 2018</p>	<p><b>Development partners, and public and private sector are capacitated in HIV mainstreaming</b> % of development, public and private sector partners that have undergone capacity development on HIV, gender and human rights mainstreaming has increased to 70% by 2015 and 100% in 2018</p>

**Effective Governance of the Multi-sectoral HIV Response**  
% of mid-term and end-of-term eNSF core programmes' service coverage targets that have been met are increased from 30% in 2011 to 50% in 2015 and 80% in 2018



<b>XII- Strengthening the Social, Policy and Legal enabling environment</b>	
<b>Reduced HIV-related stigma and discrimination</b> % of PLHIV who experienced enacted stigma is reduced from 34% in 2011 to 20% in 2015 and 10% in 2018	<b>National policies are reviewed to incorporate HIV</b> % of national laws and policies that have mainstreamed HIV and gender dimensions is increased to 60% in 2015 and to 70% in 2018
<b>XIII- Systems strengthening (Community system, Health &amp; Education sectors)</b>	
<b>Communities lead efforts to coordinate their local HIV responses</b> % of households who report that the community HIV services they received in the past 12 months were comprehensive has increased from 22% in 2007 to 50 % in 2015 and 80% in 2018	<b>HIV core programmes are provided at community level</b> % of communities that provide the minimum package of HIV services is increased to 60% in 2015 and to 95% in 2018
<b>Healthcare system offers quality HIV and AIDS services</b> % of health facilities that offer quality and comprehensive HIV and AIDS services are increased to 85% in 2015 and 95% in 2018	<b>Health facilities cater for increased demand for HIV care</b> % of health facilities dispensing ARV that experienced a stock-out of at least one required ARV in the last 12 months is reduced to 5% in 2015 to 0% in 2018
<b>Improved school completion among orphans and non-orphans aged 10–14</b> The ratio of primary school completion by OVC vs. non-OVC is improved from 0.97 in 2010 to 1 in 2015 and 2018	<b>More children are in school</b> Current school attendance among orphans and non-orphans aged 10–14 is increased from 97% for orphans in 2010 to 99% in 2015 and 2018 and is maintained as 99% for non-orphans in 2015 and 2018*  % of children retained throughout secondary level is increased from 50% in 2015 to 70% in 2018
<b>XIV-Resource Mobilisation</b>	
<b>eNSF financial resources mobilised and efficiently used</b> Total funding committed for HIV response is increased to \$102 million in 2015 and \$124 million in 2018  % of total expenditure used towards eNSF priority/core programmes is increased to 65% in 2015 and 70% in 2018	<b>Financial absorption capacity is improved</b> % of committed funds that have been disbursed has increased to 70% in 2015 and 90% in 2018  % of disbursed funds that have been spent has increased to 75% in 2015 and 90% in 2018  <b>HIV resources are mobilised internally</b> % of total expenditure on HIV and AIDS provided by domestic resources is increased from 43% in 2009 to 45% in 2015 and 60% in 2018



XV- Strategic information and Knowledge Management	
	<p><b>Country's functional M&amp;E system provides timely, quality assured data to inform HIV response planning, implementation and accountability</b> % of eNSF Indicators that are reported on through the aligned multisectoral M&amp;E system is improved from 65% in 2011 to 80% in 2015 and 100% in 2018</p>
	<p><b>All HIV activity is reported and progress reports disseminated</b> % of HIV Implementers (public, civil society and private sector) that submit timely, quality reports to REMSHACs is increased from 65% in 2011 to 75% in 2015 and 90% in 2018</p> <p>Annual National Multisectoral HIV Response M&amp;E report is produced and disseminated at national stakeholder forum</p> <p><b>More HIV research is conducted on time</b> % of planned survey, research and evaluation studies in that have been implemented and disseminated as scheduled is increased to 50% in 2015 and to 70% in 2018</p>





## Annex 2: Target Populations for the eNSF

Population group	Rationale for targeting the groups
Young women and girls	The SHIMS 2011 shows that a high number of new infections occur among young women aged 18-19 and 20-24, whose HIV incidence rates are 3.8% and 4.2%, respectively. This implies that a woman's early sexual experiences are vulnerable to HIV acquisition.
Women	Women have the highest average incidence rate of 3.1%, than men's incidence of 1.7%. Throughout their lives women are at particularly higher risk of HIV infection due to social, cultural, biological, and economic factors that make them more vulnerable.
Youth and adolescents 12-24 years	Young people comprise the majority of the HIV negative population in Swaziland and are therefore a critical target audience for HIV prevention. Changes in family structure have diminished traditional socialization of children leaving adolescents insufficiently prepared for sexual relationships and making them vulnerable to early and/or unprotected sex.
Key populations and vulnerable groups (sex workers, MSM, IDU, and inmates, factory workers, cane cutters, unformed forces transport operators )	These are populations at particularly higher risk of HIV acquisition due to behaviours and practices that put them at risk. Key populations are also most likely to be stigmatised, marginalised and more than often have no access to correct and comprehensive HIV and AIDS related information.
Orphaned and Vulnerable Children (OVC)	OVC account for almost 20% of the total Swaziland population and 45% of children under 18 years. The socio-economical vulnerabilities of OVC put them at particularly higher risk of HIV acquisition than non-OVC. OVC debut faster than non-OVC.
Men	It is estimated that men can significantly contribute to the reduction of new infections by participating in key programmes including voluntary male circumcision, condom use, and reduction of multiple and concurrent partnerships. Men also have the lowest rates of HTC. 31% of men aged 15-49 know their HIV status, only 19% of men are circumcised and men access ART very late at an estimated average CD4 count of 199. Male PLHIV have very high viral loads than female PLHIV, heightening potential for their spread of HIV (SHIMS).
People living with HIV (PLHIV)	PLHIV can play a significant role in HIV prevention treatment as prevention, stigma and discrimination reduction.
People living with disabilities (PWD)	PWD are more vulnerable to HIV infection and some forms of disabilities make it difficult for them to access success equally. Some PWD are also more vulnerable to HIV physical and sexual abuse.



### Annex 3: Priority Synergies with the Development Sector

Synergy	Rationale	Associated core programme	HIV strategies	Responsibility
Advocacy and Communication	Political leadership support for HIV as critical in socio-economic and development agenda	All programmes	Mobilise international and domestic resources for HIV programmes  Support dissemination of HIV information	Cabinet Parliament  Judiciary  Development Partners  Private and CSO sector  HIV implementers
Education	Educates students and youth about HIV and its key drivers and impact  Helps reduce stigma and discrimination of PLHIV  School attendance is a proactive factor for young people	Social and Behaviour change  HTC  Condom	Incorporating HIV IEC into existing text books, curricula an appraisal of teachers  Regular surveys tests of acquired knowledge and attitudes that are linked to performance assessments  Increase school enrolment and completion rates for example by providing tuition to OVC	Ministry of Education  + teacher training institutions  private sector education system  community /mission run schools
Employer practices and legal reform	Increases access of HIV services to vulnerable workers (such as migrant and mobile workers)  Reduces stigma and discrimination through law reform, policies, and avenues to seek redress  Addresses income generation and the empowerment of vulnerable workers		Promote development and implementation of enabling employment related laws and policies at all levels  Create demand for voluntary counselling and testing,  Identify and train peer educators and implement IEC/S&BCC approaches  Provide condoms  Scale up social protection coverage for vulnerable groups	



Community mobilisation	Establish/strengthen & manage community systems for HIV response.  Decentralise HIV response to community level incl. M&E.	All programmes	Mobilise communities to access HIV services.	
Gender Equality and gender-based violence,	Provides protection to women who are susceptible to HIV  Empowers women to mitigate the disproportionate impact of HIV  Advocate for policies and laws that protect vulnerabilities of the youth, in particular young women		Economic empowerment for women  Enforcing laws against GBV  Promoting equal inheritance, housing, property rights  Ensuring linkages between sexual and reproductive health and HIV	Justice  Health  Public sector agencies  Development partners  Private and CSO sector
Social protection and poverty reduction	Provides social protection to households affected by HIV from economic shocks  Reduces risky behaviour, such as by building information, education, communication into existing microfinance programmes and other initiatives for women's economic empowerment		Integrating HIV sensitivity into social protection frameworks and guidelines  Including HIV sensitivity into social protections programmes such as protective, promotion, preventive and transformative	Deputy Prime Ministers Office  Ministries of Finance, Economic Planning
Food security and nutrition		ART  Care for OVC		Deputy Prime Ministers Office  Minister of Agriculture



#### Annex 4: The NERCHA Coordination and the Technical Advisory Teams involved in the development of the extended NSF

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