The Kingdom of Swaziland

The National Multi-sectoral Strategic Framework
For HIV and AIDS 2009 – 2014

The following partners supported the development of the NSF:

National Strategic Framework for HIV and AIDS 2009-2014

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Foreword

The Government of Swaziland presents the National Strategic Framework (NSF) on HIV and AIDS for 2009 -2014. This is a product of a highly consultative process involving all stakeholders in the response to HIV and AIDS. Consultations were held at the national level and decentralized regional meetings, with sector representatives, programme implementers and the involvement of national development partners. The process also benefited from international support from various organizations including UNAIDS, UNDP, UNIFEM, World Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO, UNICEF, PEPFAR, Technical Support Facility, Italian Cooperation and many others.

This highly interactive process ensured that the NSF addresses current needs and epidemic trends in Swaziland, drawing on new global and national knowledge and information on HIV and AIDS. The team of consultants that assisted the country to develop this framework included a specialist on gender and human rights issues. Swaziland's approach is to mainstream these concerns at all levels, and indeed, to mainstream our HIV and AIDS response into our national development agenda. There were also specialists in Health Sector response planning, Monitoring and Evaluation, Resource Mobilization and Costing, and HIV prevention. The National Strategic Framework (NSF) uses a Results Based Approach and evidence based planning. This has not only brought new thinking and a sharpened focus, but also facilitated mainstreaming of the Three Ones principles.

The HIV and AIDS multisectoral response has developed in the light of much better knowledge about the epidemic in Swaziland. The ante-natal clinic prevalence surveys conducted every two years indicate that the epidemic has stabilized (albeit at a very high level). The First Swaziland Demographic and Health Survey (SDHS) was released in 2007 and provided in-depth knowledge of the epidemic from a representative national sample of the whole adult population (men and women). We are more aware of where new infections are likely to come from, based on the Modes of Transmission study conducted in 2008 which also identified strategies to respond.

The NSF presents an opportunity for the national response to be more effective in preventing infections, enhancing care, treatment and support, and mitigating the impact of HIV and AIDS, and if we succeed, in making an impact in the development agenda of the country. Swaziland aims to sustain the success rate in

treatment of people living with HIV, ensuring that Orphans and Vulnerable Children enjoy equal rights and care, and scaling up effective evidence-based prevention strategies. The NSF further supports systems strengthening across all levels to sustain the collaboration and achievements gained by the country, including strengthening monitoring and evaluation efforts. Swaziland will strengthen its monitoring and evaluation efforts to enable implementers to recognize and reinforce good performance, and improve or reprogram activities that are not on track, to ensure that the response delivers on the intended results. This is an exciting time when there are opportunities to increase the resource base to fund an effective response to the development challenges posed by the epidemic in collaboration with our development partners.

Dr. Sibusiso B. Dlamini
Prime Minister

Acronyms

ADB	African Development Bank
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
ASAP	AIDS Strategy and Action Planning service
BCC	Behaviour Change Communication
BE	Bereaved and Vulnerable Elderly
CANGO	Coordinating Assembly of Non Government Organisations
CBCS	Community Based Care Services
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CHBC	Community Home Based Care
CHIMSHACC	Chiefdom Multisectoral HIV and AIDS Coordinating Committee
CRC	Convention on the Rights of the Child
CSO	Central Statistics Office
CSO	Civil Society Organisation

CSP	Concurrent Sexual Partner
DFID	Department For International Development
DHS	Demographic and Health Survey
FLAS	Family Life Association of Swaziland
FODSWA	Federation of Organisations of the Disabled in Swaziland
GBV	Gender Based Violence
GFATM	Global Fund To Fight AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IMS	Impact Mitigation Services
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCP	Multiple Concurrent Partner/s
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant Tuberculosis
MISA	Media Institute for Southern Africa
MLG&H	Ministry of Local Government and Housing
MOE	Ministry of Education
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOT	Modes of Transmission
MRDYA	Ministry of Rural Development and Youth Affairs
	MTAD Ministry of Tinkhundla Administration and Development
MTCT	Mother To Child Transmission
MTP	Medium Term Plan
NAC	National AIDS Council
NAP	National Action Plan
NASA	National AIDS Spending Assessment
NCP	Neighbourhood Care Point
NDS	National Development Strategy
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-Governmental Organisation
NMP	National Minimum Package

NSF	National Strategic Framework
NSP	National Strategic Plan
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Programme for AIDS Relief
PHU	Public Health Unit
PMTCT	Prevention of Mother to Child Transmission
PRSAP	Poverty Reduction Strategy and Action Programme
PSHACC	Public Sector HIV and AIDS Coordinating Committee
PWD	People living with Disability
QSCR	Quarterly Service Coverage Report
RBM	Results Based Management
REMSHACC	Regional Multisectoral HIV and AIDS Coordinating Committee
RHM	Rural Health Motivators
RHMT	Regional Health Management Teams
SADC	Southern African Development Community
SAFAIDS	Southern African AIDS Information Dissemination Services
SAM	Service Availability Mapping
SCC	Social Change Communication
SWABCHA	Swaziland Business Coalition for HIV and AIDS
SLS	Sustainable Livelihood Programme
SNAP	Swaziland National AIDS Programme
SNYC	Swaziland National Youth Council
STI	Sexually Transmitted Infection(s)
SWANNEPHA	Swaziland Network of People Living with HIV and AIDS
TB	Tuberculosis
THO	Traditional Health Organisation
THP	Traditional Health Practitioner(s)
TIMSHACC	Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee
TOT	Training of Trainers
TWG	Technical Working Group
UA	Universal Access
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS

UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
USG	United States Government
VAC	Vulnerability Assessment Committee
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant Tuberculosis

Glossary

The following are definitions of terms used in the National Strategic Framework (NSF)

Term	Description
Broad systems approach	A system that incorporates several approaches that address issues in a holistic but strategic manner.
Chiefdom	A primary level of local government which is lower in level than the Inkhundla
Coordination	The process of bringing together and supporting stakeholders to efficiently and effectively achieve the common goals articulated in the national multi-sectoral HIV and AIDS policy and strategic framework.
Describable	Can be correctly described to avoid mis-interpretations or assignment of other meanings.
Duty bearer	A person who has a legal obligation to provide services to another person.
Epidemic threshold	The level at which HIV epidemic cannot sustain itself. Below the threshold the epidemic is likely to plateau (or decline).
Evidence Based Planning	A process in which planners use available evidence to inform their choices and decisions on interventions and strategies to achieve specific desired results.
Gender	A social construction of sexual characteristics
Health facility	An institution where health care is provided
Health sector	Includes public, private and traditional institutions that provide health care services.
Homestead	A unit of residence comprised of more than one household
Household	A unit of residence comprised of one family
Impact mitigation	A strategy used for alleviating negative social and economic effects on the lives of people, society and economy contributed to by the burden of the HIV and AIDS epidemic, poverty, or income inequalities etc.
Impact result	Long term positive changes in the lives of people, condition(s) or organisation(s).
Inkhundla	A constituency composed of a number of chiefdoms
Inputs	Resources (human, information, finance) required to support activity implementation to produce outputs.

Outcome	A change in behaviour (values, attitudes, practices etc) of, or the use of new capacities (laws, policies etc) by target group (people and institutions).
Output	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.
Programme	A set of organised activities or interventions that are intended to contribute to a common outcome.
Region	An administrative geographic area with clearly identifiable boundaries. Swaziland has 4 administrative regions (Hhohho, Lubombo, Manzini, and Shiselweni).
Regional Coordination	A decentralised multi-sectoral coordination mechanism institutionalised at regional level involving diverse stakeholders.
Result	A measurable or describable change in the lives of people or organisations resulting from a cause and effect relationship or programme intervention.
Results Based Management	A management strategy that ensures that actions and interventions achieve their stated impact and outcome level results.
Results based planning	An evidence-based strategic planning framework that focuses on impact and outcome results.
Results Framework	A framework showing part of all of the chain linking inputs and activities to outputs, outcomes, and impacts.
Rights Holder	A person who is legally entitled to some benefit(s) or service(s) provided by a duty bearer
Sector	A segment of society that has common characteristics or interests, or a segment of the economy with a distinct mandate (i.e. health, agriculture etc). The NSF defines two "blocs" of sectors i.e. the public and the non-governmental (including private) (see annex 2).
Thematic area	An operational area or broad topic with a common central theme or focus. NSF has four thematic areas i.e. (i) prevention, (ii) treatment, care and support, (iii) impact mitigation and (iv) response management.
Vulnerability	Vulnerability is defined as the extent to which a unit of interest i.e. group of people, homestead, household, or individual is able to protect itself from unwanted exposure to negative impacts, whether these impacts come from outside or inside.

The National Strategic Framework Structure

The Swaziland National Strategic Framework (NSF) is organized in the following seven sections.

Section 1:	Contains introductory sections and the executive summary that provides the reader with an overview of the content of the entire NSF and includes NSF Results Framework.
Section 2:	Provides background information to the NSF. It gives an overview of the country's economy, social, political, historical, administrative context and response to HIV and AIDS. The process of developing the NSF, outlining the purpose of the NSF and the guiding principles that has informed its development.
Section 3:	Articulates the epidemiological situation and provides with information on the trends, the stage and the macro-level impacts of the epidemic. It has also identified and described the drivers of the epidemic in Swaziland.
Section 4:	Highlights the achievements of the national response to date and the challenges and gaps that were experienced during the NSP II implementation. The section articulates the opportunities for the national response in the context of the NSF. It further provides information on the policy and legal environment necessary for the operationalisation of the NSF.
Section 5:	Constitutes the core of NSF. It describes Swaziland's strategies in the four thematic areas of Prevention, Treatment Care and Support, Impact Mitigation and Response management. Under each thematic area specific priority programmes and operational strategies are described. Details on the impact and outcome level results are given, baselines and targets are stated for each of the thematic and programme areas. A situation analysis for each programme is presented, achievements are highlighted and a gap analysis conducted. Finally, a strategic direction and strategies for each of the programmes necessary for effective implementation are included.
Section 7:	Annexes to the NSF.

Section 1: Executive Summary and Results Framework

Introduction

This document describes a five year (2009-2014) National Multisectoral Strategic Framework (NSF) for HIV and AIDS for the Kingdom of Swaziland. The planning of the NSF is evidence based and results focused, and has embraced, and mainstreamed, gender and human rights dimensions. The development of the framework is also informed by the National Multi-sectoral HIV and AIDS Policy (2006). The new planning paradigm will enable implementation of the framework to focus on measureable and important impacts and outcomes. The NSF has built on the achievements and lessons --positive and negative-- learnt through developing and implementing the second National Multisectoral HIV and AIDS Strategic Plan (NSP II 2006-2008).

The Purpose of the NSF

The purpose of the NSF is to bring together stakeholders to scale up and mainstream decentralised and effective response strategies to contribute to the NSF results, based on the comparative advantage of each stakeholder or sector.

The Process of Developing the NSF

The NSF was developed in four stages: (i) joint review of the National Multisectoral Strategic Plan on HIV and AIDS 2006-2008, (ii) development of the NSF, (iii) development of Regional Action Plans and the National Action Plan, and finally (iv) costing of the framework. One of the recommendations of the joint review was to shift the planning paradigm to an evidence-based results management approach. The process was broadly participatory and involved stakeholders from communities, civil society, People living with HIV (PLHIV), Traditional Health Practitioners (THP), private sector, development partners (including United Nation agencies and donors) and Government institutions. Stakeholders were involved through technical working groups, regional consultations and programme consultations.

The NSF Guiding Principles

- Focus on prioritized and measurable impacts and outcomes
- Use available evidence to inform the choice of interventions
- Address gender equality and equity
- Mainstream HIV and AIDS in sector policies and programmes to ensure an effective internal and external response, and expand the scope of the multi-sectoral response.
- Promote meaningful involvement of PLHIV
- Adopt and mainstream the three ones principles at all levels of the response
- Support knowledge management related to HIV and AIDS
- Support and strengthen Swaziland's efforts to address its regional and international HIV and AIDS related obligations.

NSF Results Framework

A key feature of the NSF is a results framework that starts with evidence and baselines, articulates specific measurable results (impacts, outcomes and outputs) and links resources to results. The national overarching development result, to which the NSF aims to contribute, is:

> *"Swaziland Human Development Index (HDI) improved from 0.542 in 2008 to 0.55 in 2014"[1]*

The HDI combines life expectancy, literacy and educational attainment, and per capita income. Including it in the NSF emphasizes the integration and mainstreaming of HIV in Swaziland's national development effort.

Impact level results have been articulated for the four thematic areas of the NSF. Thematic areas are made up of a number of programmes, for which outcome level results are articulated. In the National Action Plan and Regional Action Plans, output level results are identified to contribute to the achievement of the outcome results.

Data sources have been identified for all results indicators. Impact and outcome results will be monitored using independent data sources wherever possible, collected through well-developed and rigorous methodologies, such as the DHS. Processes for participatory annual implementation reviews and planning have been defined, and are described in Annex 2.

The NSF Thematic and Programme Areas

The NSF programmes are grouped under the four thematic areas of a) Prevention, b) Treatment, Care and Support, c) Impact Mitigation and d) Response management. Specific interventions under each of the programmes have been selected based on evidence of their efficacy, their feasibility, the availability of resources (financial, technical and human) to support implementation, and their potential to address one or more of the key epidemic drivers.

(a) Prevention

Prevention remains critical for the national response to HIV. Effective prevention will also have long term collateral benefits for treatment, care and support and impact mitigation. The prevention interventions are designed to reduce exposure to HIV, reduce the probability of transmission when exposed, and influence change in societal norms, values and practices that tend to impact on peoples' ability to adopt key prevention behaviours.

The strategic direction for prevention is to ensure that interventions reduce incidence rates to levels at which the epidemic starts declining. Hence the following are the five thematic impact level results.

1.The Annual adult HIV incidence rate is reduced from 2.9% in 2008 to 2.3%[2] by 2014.
2.% of HIV infected infants born to HIV positive mothers is reduced from 21.5%[3] in 2008 to 10% in

2011 and 5% by 2014
3.% of young people aged 15-19 years who are HIV infected is reduced from 10.1% for women in 2007 to 8% in 2014 and from 1.9% in 2007 for men to 1.5% in 2014
4.% of pregnant women aged 15-24 years who are HIV infected reduced from 38.1% in 2008 to 37% in 2011 and 35% by 2014
5. % of female sex workers[4] who are HIV positive is reduced from 23% in 2007 to 20% by 2014

To achieve these results, the following strategies and programme have been prioritised.

- Social and behaviour change communication programmes
- Reduction of multiple concurrent partners among sexually active population
- Increased and comprehensive knowledge of HIV and AIDS
- Scaling up of prevention of mother to child transmission of HIV (PMTCT)
- Male circumcision of HIV negative men, with 15-24 being a priority age group. However the programmes will also ensure infant circumcision.

In addressing change in societal norms, values and practices, the specific interventions will include improving comprehensive knowledge on HIV, addressing sexuality and reproductive health (including relationship strengthening), multiple concurrent partners and empowerment of women and girls. Exposure to HIV infection will be reduced through interventions to discourage early sexual debut, multiple concurrent partners, and inter-generational sex. Abstinence and being faithful will also be promoted. To reduce the probability of infection the NSF aims to scale up prevention of infection to unborn babies through PMTCT, male circumcision and promote condom use. Strategies will be promoted to support condom use at first sex as studies have shown that people who have used condoms at first sex are more likely to continue using condoms thereafter. With regard to focusing on young people, prevention will target programmes that keep children in school, and address out of school youth where no formal opportunities exist to provide life skills.

Prevention programmes will address key epidemic drivers including multiple and concurrent partners (MCP), sexual debut, intergenerational sex, income inequality, mobility and migration, commercial sex, gender inequalities and sexual violence, and low and inconsistent use of condoms.

While prevention will focus on priority interventions, there are other interventions that need continue because of their importance in sustaining the gains already achieved in prevention. These programmes include HIV Testing and Counselling (HTC); Blood Safety and Universal Precautions; Post Exposure Prophylaxis (PEP), integration of prevention programmes for key populations at risk, treatment of sexually transmitted infections (STI) and HIV and AIDS workplace programmes.

Voluntary Counselling and Testing (VCT) in the community will be provided for people who want to know their HIV status. VTC is an entry point for community-based programmes to support people who test negative to maintain their status, and support those who test positive to live positively and access treatment and

care early. All blood will continue to be screened for HIV in a quality assured manner to ensure 100% blood safety. Although there is no empirical evidence of STI control as an effective population-level prevention strategy, STI management is important as a health intervention in its own right; to reduce individual susceptibility to HIV; and as an entry point for BCC for people with high risk sexual behaviours. Swaziland has initiated treatment for viral STIs such as herpes. Genital ulcers caused by herpes have been identified as increasing the chances for infection and so treating genital herpes and ulcers would reduce susceptibility to infection.

Support for mainstreaming of HIV and AIDS in sector programmes and policies covers (i) internal response programmes that will cater for prevention at the workplace and provide care for carers; and (ii) external responses through which sectors address the challenges of HIV and AIDS associated with their external services and/or development programmes.

The coordination of prevention interventions will be facilitated by a national multi-sectoral Prevention Technical Working Group (TWG). The TWG will constitute technical sub committees responsible for specific programme development (i.e. PMTCT, condoms, MC, etc).

(b)Treatment, Care and Support

Treatment, care and support of PLHIV remain an important part of the national response to HIV and AIDS. The thematic area consists of six programme areas: HTC, pre-ART and opportunistic infections, ART (including paediatric ART), Management of TB/HIV co-infection, provision of community-based care services (including palliative care), care and support by Traditional Health Practitioners (THP). The treatment, care and support priority interventions are the provision of ART and treatment of TB/HIV co-infection.

The programmes are designed to complement each other and create an effective synergy. They are expected to contribute to improving the quality of life of PLHIV including children living with HIV, and to increase life expectancy. Quality of life is relatively difficult to measure (and would require special surveys), so the impact level result for this thematic area is:

> Life expectancy increased from 40.2[5] years in 2008 to 44 years, by 2014

Treatment, care and support interventions will improve quality of life through the provision of comprehensive treatment, care and support programme for people with HIV and TB/HIV co-infection. The programme will support testing for HIV and screening for TB to be conducted in either service's provision sites. While clinical services will be provided at health facilities, additional care and support will be provided at community level. It is anticipated that traditional health practitioners will support the programmes by providing quality counselling, referral and by promoting adherence.

In the context of treatment, care and support, HTC is an important entry point. Testing identifies people with HIV and enables health providers to determine the nature of care to be provided. The first option is to ensure that people who test positive could be enrolled on Pre-ART. Efforts will be made to ensure that clients are retained on Pre-ART as long as possible. The second option will be if the person tests positive and meets the criteria for ART, to be enrolled on ART directly. Once enrolled on ART the aim is to ensure that PLHIV adhere to treatment.

Given that TB is a major cause of death for PLHIV, collaboration between the two programmes will be strengthened. The Ministry of Health has initiated such efforts. Key areas of programme collaboration identified in the NSF include effective referral systems and provision of testing for both HIV and TB in designated HIV and TB sites. A key concern is the potential implications of emergence of multi drug resistant (MDR) Tuberculosis and extensively drug resistant (XDR) Tuberculosis.

Community-based Care Services (CBCS) will be strengthened and expanded to cater for the increasing number of people in need. The capacity of CBCS service providers will be strengthened to improve on the provision of medical, psychosocial and material support, and also to scale up palliative care.

Strategies have been articulated for strengthening collaboration with Traditional Health Practitioners in the provision of counselling, treatment literacy, and referral services.

Services will be scaled up in a number of programme areas to ensure comprehensive coverage and equity. To enable this, given the shortage of skilled human resource, "task shifting", will be promoted to allow certain services currently being provided by medical doctors to be provided by qualified nurses. This will require a policy review to institutionalise "task shifting".

(c) Impact Mitigation

The core focus of impact mitigation is to reduce the negative impact associated with HIV and AIDS on society, in particular on homesteads, households and individuals by addressing strategic issues of vulnerability. The relationship between impact of HIV and vulnerability is seen as reciprocal. On one hand, social and economic circumstances such as poverty, abuse, violence, prejudice and ignorance (i.e. pre-existing vulnerability before HIV infection) increase an individual's susceptibility to HIV infection and therefore fuel HIV transmission. In other cases, HIV positive status can generate and reinforce vulnerabilities that further worsen the quality of life of the person affected. Vulnerable groups that the programme will focus on include OVC, PLHIV and the elderly. Interventions will focus on homesteads, households and individuals. Swaziland has established criteria for vulnerability, notably: death of an adult in the household in the past 12 months, presence of an ill adult who requires care, presence of an orphaned child.

It is intended that the implementation of identified impact mitigation interventions will achieve the following thematic impact level results:

1. % of households with vulnerable individual/s[6], that are able to cope with the impact of HIV[7] is increased from 72% in 2008 to 80% by 2014[8].
2. % of households that report that all the services they received were relevant, timely, comprehensive and of good quality has increased to 70% by 2014.

The following interventions have been identified to contribute to the achievement of the above impact level result.

- Food and nutrition for vulnerable households and individuals
- Education support for OVC
- OVC socialisation and protection
- Provision of psychosocial support
- Strengthening of community systems, including identification and support of alternative sustainable livelihoods, as well as the strengthening of community-based institutions to support interventions that are community initiated and driven. Attention will be paid to care for carers at community level to ensure sustainability of services. Stakeholders will complement existing government support to community-based interventions.
- Strengthening social protection systems through improved capacities of Department of Social Welfare and the National Children's Coordination Unit (NCCU). This will involve linking the informal social protection systems to the formal social protection systems. The capacity of NCCU and the Department of Social Welfare to coordinate and monitor implementation of impact mitigation for individuals, households and families affected by HIV and AIDS will be strengthened.

In the case of OVC, support will range from access to Early Childhood Care and Development (ECCD), primary education, food and nutrition requirements, health care, and adequate shelter. The programmes will also ensure that OVC have a caregiver and receive psychosocial support. Existing strategies for effective and positive OVC socialisation and protection will be strengthened. In this regard the new NCP strategy provides an avenue to reach OVC with a holistic, integrated and comprehensive service package.

Nutritional and psychosocial support will be provided to those people in need. Strategies will be developed and implemented to reduce or eliminate stigma and discrimination against PLHIV. They will also be supported in efforts to identify and engage in alternative and sustainable livelihoods that are likely to raise their household income and improve household food security.

The impact of HIV and AIDS has been significant among the elderly. In the first instance the elderly often loose their main source of support when their adult children fall sick. Second, they assume the role of caregivers and breadwinners at an age when they are not economically productive. The programme will mitigate impact on the elderly by strengthening community systems to support them.

(d) Response Management

This component, response management, will focus on six key areas: (i) coordination and partnerships; (ii) strategic and action planning, programme development and project management; (iii) capacity development; (iv) mainstreaming, policy development and advocacy; (v) resource mobilisation; and (vi) monitoring and evaluation. The strategic direction is to ensure effective overall coordination, equitable distribution of quality and comprehensive services and the decentralisation of the planning processes. It also aims towards mainstreaming the HIV response at all levels and creation of an enabling policy environment.

The impact level result for this thematic area is:

> 1.% of mid-term and end-of-NSF service coverage targets (output level result targets)
>   that have been met in the areas of HIV prevention, treatment, care and support,
>   and impact mitigation has increased to 50% of midterm targets by 2011 and 75% of
>   end-of-NSF targets by 2014.

Swaziland has established multi-sectoral coordination structures at regional and sector levels. These include the Regional Multi-Sectoral HIV and AIDS Coordinating Committee (REMSHACC), Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee (TMSHACC) and the Chiefdom Multi-sectoral HIV and AIDS Coordinating Committee (CHIMSHACC). Other structures include the Regional Health Management Teams (RHMT) under the Ministry of Health, and the Municipality HIV and AIDS Teams that are coordinating the urban response. The NSF has re-defined the two categories of sectors: the government sectors include all the government ministries, while the non-governmental sectors include civil society, private sector, and traditional Health Practitioners, among others. NSF will facilitate capacity building and strengthening for these institutions to provide effective and comprehensive coordination aligned to the three ones principles.

NSF has put in place strategies to re-position NERCHA to provide strategic policy guidance and overall national coordination, leaving the regional and sector coordinating structures to facilitate coordination at the operational level. The NSF will attempt to harmonise coordination modalities among different stakeholders, in particular development partners. In addition, it aims to align their programmes with national action plans. The strategic framework will consolidate existing partnerships, especially with Government agencies, civil society and development partners, and facilitate the establishment of new ones. Private Public Partnerships (PPP) will be strengthened. The NSF recognises that the challenges of HIV and AIDS transcend institutional boundaries and hence require collaboration based on comparative advantage.

The strategic framework has further decentralised the planning process and resulted in a National Action Plan and Regional Action Plans. Individual sectors will be supported to develop their own operational plans aligned to NSF. Support will also be given to action planning at sector and community levels, which will eventually contribute to some communities developing their own action plans.

The NSF thematic areas identify programmes that aim to achieve the impact and outcome level results. In some cases, specific programme documents need to be developed to articulate programme level policies, quality standards and, where applicable, articulate operational guidelines and provide strategic direction. Programme development will mainstream participatory and multi-sectoral strategies.

The NSF provided guidelines for mainstreaming HIV and AIDS in sector policies and developing programmes to ensure that sectors respond to both internal and external needs related to addressing HIV and AIDS. A key activity will be reviewing relevant policies that mainstream HIV and AIDS. To ensure effective implementation of the NSF, a strong advocacy component is planned.

The NSF will be used as the main document for national resource mobilisation. However, individual organisations have been encouraged to undertake independent resource mobilisation to support their respective activities aligned to NSF. Strategies for management and tracking resources for HIV and AIDS resources will be mainstreamed in all sector operations.

The NSF includes a planned comprehensive assessment of the national capacity required to implement the planned activities. It is on the basis of the findings of the assessment that capacity will be built or strengthened. A key area of focus for the NSF is ensuring adequacy of qualified and skilled staff at all levels.

During the period of the NSF the national M&E framework will be mainstreamed in all the sectors and regions, in line with the three ones principles. The M&E framework will be reviewed and aligned to the requirements for the NSF. Capacity will be strengthened for effective implementation of the M&E. As regards HIV and AIDS research, the NSF proposes the establishment of a Research unit, development of a focused research agenda, and strengthening of the use of research and evaluation information to inform policy and programme development.

Section 2: Background Information

2.1 Country Context

The Kingdom of Swaziland is landlocked with a surface area of 17,364 square kilometres. The estimated population of Swaziland is 1,018,449 people[9] (Male: 481,428, Female: 537,021). 52% of the population is under the age of 20 years and 79% of the people live in rural areas[10].

Swaziland is divided into four administrative regions i.e. Hhohho, Lubombo, Manzini and Shiselweni. Manzini has the largest industrial site in the country while Lubombo has most of the commercial agriculture plantations. The country is further divided into 55 constituencies known as _Tinkhundla_ and 360 chiefdoms and towns.

Swaziland became an independent kingdom in 1968, with His Majesty the King as the Head of State and the Prime Minister as the Head of Government.

Although manufacturing contributes a growing share of the Swaziland gross domestic product (GDP), the economy is largely agriculture-driven. Most industries process agriculture produce including sugar, wood pulp and food canning. Other agricultural products include corn, citrus fruits, livestock and pineapples.

Swaziland is classified as a Lower middle income country[11] with per capital income of US$2,580 (2007). Swaziland has a high dependence on South Africa for its imports (80%) and exports (60%). Economic growth has slowed down in the last twenty years from 9% in 1986 to 2.8% in 2006[12]. The economic slowdown has been largely due to fluctuations in the performance of the agriculture sector caused by erratic climatic conditions -- in particular a persistent drought, and changes in prices of agriculture products in the world market. The majority of the people are dependent on subsistence agriculture which has also been affected by erratic climatic conditions.

The Swaziland Household Income and Expenditure Survey (SHIES, 2001) estimated that 69% of the population lived in poverty. The Poverty Reduction Strategy and Action Plan (PRSAP 2006) noted that urban poverty is on the rise. Through the implementation of the PRSAP, the Government of Swaziland is committed to reducing poverty level to 30% by 2015, with the longer term goal of eradicating poverty by 2022.

The PRSAP also aims to curb the spread of HIV by promoting strategic prevention interventions and expanding opportunities for comprehensive care, support and impact mitigation for those already infected with HIV or affected by AIDS. By so doing the strategy will promote the development of sustainable human capital. Other areas of focus for the PRSAP include improving access to basic education, primary health care, and improving food security and agricultural productivity (PRSAP 2006).

2.2 National response to HIV and AIDS – Contextual Analysis

The national response to HIV in Swaziland has been driven through the implementation of five consecutive plans: an initial Short Term Plan (STP) 1987-1988; Medium Term Plans I (1990-1992) and II (1993-1996), and two National Multi-sectoral HIV and AIDS Strategic Plans (NSP I 2003-2005 and NSP II 2006-2008). Each plan has ushered in changes on how the national response was to be managed and governed. In 2003 the National Emergency Response Council on HIV and AIDS (NERCHA) was established to coordinate the multi-sectoral response. In 2006 the National Multi-sectoral HIV and AIDS Policy was adopted. In 2006, HIV and AIDS decentralised coordinating structures were established in line with the National Decentralisation Policy of 2005.

While Swaziland has made significant efforts to control the epidemic, HIV prevalence remains among the highest in the world. Sentinel surveillance data show that prevalence among women attending antenatal clinics increased from 3.9% in 1992 to 38.6% in 2002.There is evidence of prevalence stabilising as it shifted from 42.6% in 2004 to 39.2% in 2006[13] and is at 42% in 2008.

The persistent extremely high HIV prevalence and the devastating impact of HIV on Swazi society necessitate a new approach in the national response. This thinking has informed the development of the new National Strategic Framework (NSF).

The joint review of the NSP II conducted in June/July 2008, suggested a more strategic approach in the national response based on available evidence and focusing on achieving specific results, in addition to meaningfully mainstreaming gender and human rights approaches in the HIV and AIDS planning and programmes. This approach has necessitated a shift from the traditional strategic planning process to the National Strategic Framework planning modality that creates the opportunity for a results based management approach, while at the same time creating opportunities for decentralised regional and sector planning within the context of the three one principles. The NSF approach is premised on the need to harmonise and synchronise the various interventions with national response priorities thereby creating synergy, rationalising the use of available resources and focusing on prioritised and specific results. It is on this premise that the National Strategic Framework for HIV and AIDS 2009 – 2014 has been developed. The approach is guided and informed by a set of principles described in section 2.4 below.

2.3 The Purpose of the NSF

The purpose of the NSF is to:

i. Guide the implementation of a multi-sectoral, relevant, comprehensive and effective HIV and AIDS response in Swaziland using Results Based Management (RBM) and the three one principles.

ii. Enable the scaling up of evidence-based and decentralised HIV and AIDS response strategies that have mainstreamed gender and human rights, address national priorities and have significant potential to reverse or start halting the epidemic by 2014.

iii. Facilitate mainstreaming of international commitments to which Swaziland is a party in the national targets and contribute towards the country achieving these targets

The implementation of NSF will contribute to specific measureable and important impact, outcome and output levels results as outlined in the results framework. To achieve these results, priority interventions and strategies have been identified and articulated. It is anticipated that the interventions will result in fewer new HIV infections, and reduced HIV related morbidity, mortality and socio-economic impacts.

2.4 The Guiding principles

The review of the NSP II in June/July 2008 concluded that the high prevalence level, the devastating impacts of HIV on Swazi society and the challenges experienced during implementation of the plan necessitated a new approach. The development of the new NSF was informed by the following principles.

i. **Result-Based Management of the HIV Response**: Planning, implementation and monitoring/oversight of HIV and AIDS interventions at all levels will focus on achieving stated measurable results or change.

ii. **Evidence-Based Planning**: The development of the NSF is informed by available evidence of strategies that have worked and have the potential to contribute to the desired impact and outcome level results while addressing the key drivers of the epidemic.

iii. **Gender Equality and Equity:** Stakeholders will address gender inequalities that contribute towards fuelling the HIV epidemic, by incorporating gender dimensions in all aspects of HIV programming to reduce gender vulnerability and risks of HIV transmission, while at the same time improving equal access to HIV and AIDS services

iv. **Mainstreaming Human Rights Approaches:** Stakeholders will mainstream the use of human rights approaches in HIV programming to ensure respect and protection of basic human rights for people living with HIV and AIDS, vulnerable groups and those affected. In addition the human rights approach will work towards universal access to services for all people in need, and ensure good governance, transparency, and accountability by duty bearers and rights holders.

v. **Systems approach and Mainstreaming:** The NSF will consolidate and link programmes and create synergy between the programmes through a systems approach and mainstreaming. In the context of mainstreaming, consideration is given to how HIV and AIDS services link with, complement and support the wider development mandate of government, and vice versa. For example consideration in this NSF will be given to how HIV services in the health sector can and should support health systems strengthening and how poverty reduction and strengthening sector interventions can have a positive impact on people's lives and on their ability to protect themselves against HIV infection and the socio-economic impacts.

vi. **Promote Greater Involvement and Empowerment of People living with HIV and AIDS (GIEPA):** Stakeholders will embrace and operationalise the principle of meaningful involvement and participation of PLHIV in the national HIV response at all levels.

vii. **'Three Ones' Principle:** Stakeholders will harmonise their operations with the three one principles i.e. having one national (a) coordination authority, (b) strategic framework, and (c) monitoring and evaluation framework.

viii. **Community engagement and participation in, and ownership of HIV and AIDS interventions.** Communities will be supported, empowered and their systems strengthened to ensure that interventions at community level are driven and owned by the communities themselves. Stakeholders will ensure adequate support and strengthening of community solutions, the use of existing infrastructure, equity and sustainability of interventions.

ix. **Knowledge Management:** Stakeholders will make efforts to share and learn from each other based on their "hands-on" experiences, existing and emerging best practices on HIV and AIDS.

x. **A commitment for Swaziland to address its regional and international HIV and AIDS obligations and adherence to international HIV related protocols**: Stakeholders will take due cognisance, will adapt and customise regional and international protocols to ensure compliance and contribute to meeting Swaziland's regional and international commitments on HIV and AIDS.

2.5 The Process of preparing the NSF and Stakeholders' Participation

The process of developing the NSF involved four stages: (i) a joint review of the National Multi-sectoral HIV and AIDS Strategic Plan (NSP) 2006-2008, (ii) development of the NSF, (iii) the development of Regional Action Plans and the National Action Plan, and (iv) costing of the framework. One of the recommendations of the joint review was a shift in the planning paradigm from traditional strategic planning to an evidence-based and results focused management approach. The conceptualisation and development of the NSF embraced this approach.

The process was participatory and involved different stakeholders from communities, civil society, People living with HIV (PLHIV), Traditional Health Practitioners (THP), private sector, development partners (including United Nation's agencies and donors) and government institutions. Stakeholders were involved through technical working groups, regional consultations and programme consultations. These stakeholder groups and consultations identified the priorities for the NSF based on available evidence of interventions that had the potential to a) reduce new infections and hence HIV incidence rates, b) provide quality and comprehensive treatment, care and support and c) mitigate the impacts of HIV and AIDS especially among vulnerable groups. The evidence came from national, regional and international studies and from the NSP evaluation report. The stakeholders further developed and agreed on criteria for the selection of NSF priority interventions.

Representatives of all stakeholders working through the technical working groups were further involved in determining the impact, outcome and output level results the NSF aims to achieve, using a Results Based Management (RBM) approach. Stakeholders set and agreed on the NSF mid-term and final targets. Once developed, the NSF Results Framework (Table 1) was presented to and further discussed with a wider group of stakeholders for consensus, validation and agreement. During the validation process, stakeholders also ensured that gender, human rights and strategies for community participation were adequately addressed in the NSF.

The NSF development process was facilitated by a team of consultants both international and national which was served by a Secretariat. The process started in June 2008 and concluded in February 2009. Throughout the process the team of consultants were located in a central place in the capital city of Mbabane to facilitate accessibility to all interested parties, stakeholders to engage with the consultants, inform and influence the direction of the NSF. The consultants held meetings in the four regions of the country both during the joint review and action planning processes to ensure wide participation of all stakeholders in the process. The general public was informed of the NSF process and consultations through the media.

NERCHA (Council) appointed a Steering Committee whose composition was drawn from all stakeholders to manage the process from the joint review to the NSF and Action Plan development process. The NSF was presented to NERCHA at the end of the process for validation.

Section 3: The Epidemiology and Impact of HIV in Swaziland

Swaziland has the World's highest HIV prevalence rate of 26% (31% women and 20% men)[14] among people aged 15-49 years, and has a high estimated HIV incidence rate of 3% compared to other countries in the region. This means that, of every 100 HIV-negative persons in Swaziland, 3 will become infected with HIV every year. In 2008, an estimated 44 HIV-negative adults were infected every day[15].

It is essential to focus on HIV incidence when determining the effectiveness of HIV prevention programmes. A "mission critical" objective is to lower the annual incidence rate, so as to reduce the number of newly-infected persons every year.

Table 2 summarises key data on the HIV epidemic in Swaziland. The rest of this section summarises what is known about HIV prevalence and incidence trends, sources of new infections and key risk factors. This information is necessary in understanding the epidemic and especially where and how new infections are occurring, helping to articulate the best possible strategies and programmes to prevent new infections.

Table 2: Summary of the HIV epidemic in Swaziland

Adult HIV prevalence, 2007	26%
Estimated number of adults & children living with HIV, 2007	Range between 171 000 to 187,937
Women as percent of adults living with HIV/AIDS	59%
Annual rate of new HIV infections in adults aged 15 to 49	3%
Projected number of new infections in *adults* in 2008	13,060
Projected number of new infections in *children* in 2008	3,147
Projected AIDS deaths amongst *adults* in 2008	9,247
Projected AIDS deaths amongst *children* in 2008	2,711
Estimated (total) number of orphans in 2008	Range between 110 460 to 117 373

Sources: NERCHA and UNAIDS (2007a); SDHS (2007); Swaziland Housing and Population Census preliminary results, 2008

3.1 HIV prevalence levels and trends

Swaziland has an endemic hyper HIV epidemic, with HIV firmly established in, and spreading through, the general population. Swaziland's HIV epidemic has reached unprecedented levels with 26% of the reproductive-age population aged 15-49 years infected[16]. HIV infection is also present in a considerable proportion of adults aged 50+ years (14%) and young children aged 5-14 years (3%)[17]. Figure 1 summarises HIV prevalence by sex and age group in Swaziland and shows how the female-to-male ratio of infection is dramatically different in different age groups, and how rapidly HIV prevalence increases in women between the age groups 15-19 (12% HIV positive), 20-24 (38% positive) and 25-29 (49% HIV positive).

Figure 1: HIV prevalence by sex and age group, and female to male prevalence ratios in Swaziland, 2007
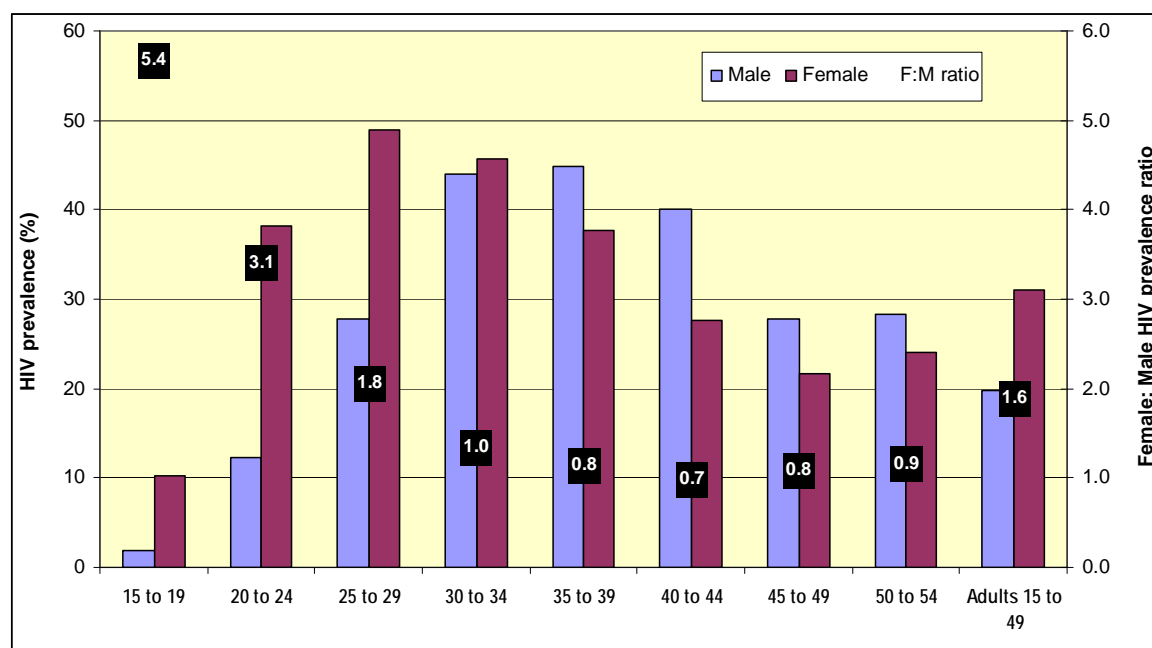
Source: Drawn from data in the SDHS, 2007

National adult HIV prevalence is showing evidence of stabilising at this high level after having peaked between 2004 and 2006. In the latest HIV sentinel Surveillance (2006) data from ANC clients[18], a downturn in HIV prevalence has been observed, particularly amongst young women. As ART coverage improves and more people live longer, AIDS related deaths are expected to fall and stabilise at around 12,000 adults and children per year for at least the next 4 years[19].

3.2 New Infections: How new infections are transmitted

It has been estimated that there would be around 16,200 *new infections* (adults and children) in 2008, rising to just under 18,000 *new infections* by 2012[20]. Most (90%) new infections occur, through heterosexual contact. Other minor sources of new adult infections are through anal sexual intercourse and needle-sharing amongst injecting drug users. Only 1% of tertiary students in Swaziland reported having tried heroin in 2002[21]. This is not expected to be a major factor influencing transmission.

The sources of infection among children aged 14 years and younger include mother to child transmission, sexual abuse, or children engaging in sexual activities at an early age[22]. Of infants born to HIV positive mothers, 21.5% are HIV positive[23].

3.3 Risk Factors and Drivers of the Epidemic[24]

Given that the main mode of HIV transmission in Swaziland is heterosexual, specific sexual behaviours, described below, put people at risk of HIV infection.

Multiple Concurrent Partners (MCP) is generally defined as a sexual behaviour characterised by having more than one sexual partner in the same time period. Swazi men are more likely to have multiple partners than women. According to the SDHS (2007), 2% of women and 23% of men aged 15-49 years who had sex in the 12 months preceding the survey had sex with two or more partners.

Early sexual debut: The median age of sexual debut in Swaziland is low, estimated at around 16. With the average age of marriage at 26, there is a ten year period of premarital sex, often with more than one partner. The SDHS showed that 51% of young women and 29% of men had sex before age 18. These are also the age groups at which HIV prevalence amongst young women increases sharply: from 12% (for women aged

15-19) to 49% (for women aged 25-29). The increase is more dramatic between age bands 15-19 and 20-24 from 12% to 38% (16 points) compared to between 20-24 and 25-29 (11 points).

Low and inconsistent levels of condom use: There is generally a low level of condom use in Swaziland, although the more casual the sexual encounter, the more likely that a condom is used due to increased risk perception[25]. According to SDHS, condom use is lowest among married couples and long-term partners with only 12% of married women reporting using condoms[26]. Between 50% and 40% of young men and women said they use condoms. Condom use amongst out of school young people is very low (37%), making this a key specific group that NSF should target. Consistent use of condoms with partners other than the married partner is important. Condom use is highest among people with multiple partners, but also has much room to increase: 55% of women and 68% men who had more than one sexual partner in the past 12 months reported having used condoms the last time they had sex. The probability of using a condom during higher risk sex increases with educational attainment in men and women, and is higher in younger age groups than older adults. Condom use appears not to have changed greatly in recent years, but more people now report that they will not have sex with their partner if they believe that the partner is unfaithful and refuses to use a condom.

Inter-generational sex: According to the SDHS, 7% of young women who had engaged in high risk sex in the last twelve months reported having sex with a man ten years or more older than them. This proportion is higher among older girls living in rural areas, but decreases with higher levels of education. SDHS further found that, on average, there was a 4-year difference between the age of young women in school and their first sexual partner, and an age difference of 8 years between young women out of school (age 15 to 24) and their first sexual partner. 10% of women said that their first sexual partner was ten years or older than them.

Income inequality (poverty): Various studies[27] show that it is not poverty per se that drives the epidemic, but rather income inequality (which is high in Swaziland). Income inequality is associated with more young people engaging in what has been referred to as 'consumption sex' and taking more risks in the process.

Mobility and Migration: A significant percentage of Swazis are mobile: 42% were away from home or assigned duty station more for than five days at a time, at least 5 times in the past 12 months[28], mostly for work-related reasons. HIV prevalence amongst these short-term mobile people is more than double that in the general population. Oscillatory migration is a significant factor in sexual behaviour and therefore new HIV infections. The Family Health International (FHI) Behavioural survey (2002) showed that only 30% of seasonal workers used a condom at last non regular sex, and 71% of them were married. A regional study confirmed that patterns of risky sexual behaviour differed for men and women who are away from each other, and that one also needed to focus on the non-travelling partner[29].

Commercial sex: Overall, there is lack of local data on the estimated number of sex workers and the level of HIV prevalence among this group in Swaziland. A survey done in 2002 by Family Health International found that the majority of female sex workers (64%) were young women under age 25. The survey also found some male sex workers. With an average of one client per day and a part-time approach to sex work, some of the sex workers in Swaziland are not full time. The FHI study (2002) confirmed this 28% of sex workers were employed in other jobs. Reported condom use with paying clients was 90% (of which 74% consistent), reported condom use with non-paying partners was 60%.

The lines between formal sex work and transactional sex are blurred. The extent of transactional sex (sex in return for gifts or favours) is unclear, but qualitative research has shown that the transfer of money, gifts or services have long been and remain an important and expected part of courtship and sexual relationships in the region[30]. The lack of data indicates a need for more research to better understand sex work in Swaziland.

Gender inequalities and sexual violence: Many cultural norms and values on gender relations that help drive the epidemic persist. From a cultural perspective men have a large degree of control over women.

Values and norms uphold men's privileges and have tended to constrain women's autonomy. These values and norms are deep-rooted, and gender discriminatory beliefs are held by many men and women,[31] also facilitating tacit acceptance of sexual violence. Sexual violence[32] and gender based violence (GBV)[33] are serious human rights and public health issues, which affect women and girls of all ages, from all cultures, countries and socio-economic backgrounds. The 2007 'National Study on Violence against Children and Young Women in Swaziland' found that violence against female children is highly prevalent in Swaziland, with approximately 1 in 4 females having experienced physical violence as a child. Overall, the prevalence of forced intercourse prior to age 18 was 5%, and the prevalence of coerced intercourse prior to age 18 was 9%. The study importantly noted that the risk of violence continues into young adulthood. Among 18-24 year old females in Swaziland, nearly 2 in 3 had experienced sexual violence. Overall, 48% of females reported that they had experienced some form of sexual violence in their lifetime, and 21% reported that they had experienced some form of sexual violence in the preceding 12 months. Boyfriends and husbands were the most frequent perpetrators of sexual violence, and incidents of sexual violence most frequently occurred in the home of either the respondent or a friend, relative or neighbour. Over half of all incidents of sexual violence were not reported to anyone, and less than 1 in 7 incidents resulted in a female seeking help from available services.

Low Levels of Male Circumcision: Randomised controlled trials on male circumcision (MC) in South Africa[34], Kenya[35] and Uganda[36] showed the potential for MC to reduce HIV infection by almost 60%. However male circumcision in Swaziland remains low. It is reported that male circumcision was banned by His Majesty King Mswati II who ruled the country in the 19th century, based on the understanding that men recovering from the procedure would be less able to defend the country[37]. No country has yet rolled out MC as a prevention strategy, although several countries are planning to do so, and it is increasingly becoming accepted as important in countries with very high prevalence, and the World Health Organisation and UNAIDS are supporting scaling up of male circumcision.

Alcohol and drug abuse: The SDHS (2007) noted that engaging in sexual intercourse while under the influence of alcohol can impair judgement, compromise power relations, and increase risky sexual behaviour. This perception is also shared in a recent systematic review of alcohol use and sexual risks in Sub-Saharan Africa that showed a consistent association between alcohol and sexual risk taking[38]. The review further showed that men are more likely to drink and engage in higher risk behaviours, whereas women's risks were often associated with their male partners' drinking. The study also links alcohol and sexual risks with sexual coercion and poverty.

One of the obvious challenges with excessive alcohol usage is diminished capacity to make rational decisions including the use of condoms. Reduced use of alcohol would contribute to less risk taking and possibly adoption of key prevention behaviours.

Section 4: The National HIV and AIDS response to date

The following section presents a summary of the achievements, challenges and gaps of the national response, and the opportunities for a more effective response in the NSF. The section articulates the policy and legal environment in which the response needs to be implemented and managed.

4.1 Achievements

Swaziland has made significant progress in addressing HIV and AIDS. A wide range of interventions have been rolled out throughout the country, contributing to the following achievements.

i. *HIV and AIDS awareness and knowledge levels are relatively high in Swaziland, with some effect seen on behaviours.* Swaziland has achieved universal awareness of HIV and AIDS among all people aged 15 to 49 years (99.8% women and 99.3% men). Of the age group 50 years and older 96% women and 97% men have also heard about HIV and AIDS. Comprehensive knowledge of HIV and AIDS currently stands at 52% for both women and men[39]. According to the SDHS (2007), 85% of women and 93% men know that correct and consistent use of condom can reduce the risk of getting HIV infection, and a relatively high percentage of people with risky sexual behaviour are acting on that knowledge: condom use in the last sexual act by men and women 15-49 years who have more than one sexual partner was estimated at 68% and 55% respectively. The study by CIET Trust[40] indicates that the rate of multiple concurrent partners′ in Swaziland has declined slightly.

ii. *Coverage of health facility-based HIV prevention services has increased.* The coverage for HIV positive women receiving ART prophylaxis for PMTC increased from 36% in 2005 to 65% by June 2008. Women accessing antenatal care who received counselling and testing for HIV increased from 65% in 2005 to 90% during the first quarter of 2008. Facilities providing PMTC also increased from 16 (2004) to 110 2006.

iii. *Blood safety:* Swaziland has achieved 100% HIV blood safety. By 2008, Swaziland was able to meet 75% of demand for HIV-safe blood by health facilities.

iv. *Growing numbers of people are on ART:* By 2007, the number of PLHIV in need of ART was estimated at 58,250[41] and 62,769 in 2008. By September 2008, 30,337 people (48.3%) were receiving ART. Of these 2,124 were children. The number of facilities providing ART increased from 16 in 2005 to 26 sites with 40 outreach sites in 2008. The outreach sites are satellite stations of the core 26 sites.

v. *Joint Management of TB-HIV co-infection has started:* Sixty percent (60%) of all TB cases (5,804) registered in 2007 were tested for HIV. The TB treatment rate was estimated at 42% in 2007

vi. *HIV testing:* By 2007, 36% of women and 17% of men aged 15 to 49 years had tested for HIV and knew their results (SDHS 2007). HTC was provided in 119 sites (SDHS 2007).

vii. *Impact Mitigation:* The following impact mitigation achievements were made
- By 2008, 92% of OVC were attending school.
- Access to food by OVC increased through Neighbourhood Care Points (NCPs), the school feeding programme, the establishment of food gardens and revival of traditional food production by chiefs for vulnerable members of the society.
- OVC were also being provided with medical, emotional and social material support: 41% of OVC were receiving at least one form of external support.
- At least 22% of very sick persons were receiving at least one form of external support.

i. *Decentralised coordination structures have been established*: Within Swaziland's multi-sectoral approach and the "three ones" principles, decentralised coordination structures (REMSHACC, TIMSHACC and CHIMSHACC) have been established. 311 of 360 planned KaGogo centres (OVC community care centers) have been established. To expand and strengthen coordination outside of government systems, non-governmental structures (including in the private sector) have been established. Public sector institutions are increasingly being engaged in the national response based on their respective institutional mandate.

ii. *Data for monitoring and evaluating the national HIV response is much improved*: Between 2006 and 2008, the Swaziland Demographic and Health Survey (SDHS), the 11th Sentinel Surveillance round, the Swaziland Vulnerability Assessment Committee (VAC) Reports, a Mode of Transmission Report (MOT) and Services Availability Mapping (SAM) among others were conducted. Swaziland developed Universal Access targets for prevention, care and support, and impact mitigation services. A road map for M&E was developed, and the national M&E framework is in place. Both health and non-health routine programme monitoring is on-going and being carried out by different stakeholders, with the Ministry of Health facilitating health sector monitoring.

iii. *Partnerships*: Swaziland has continued to strengthen and consolidate existing partnerships and strategic alliances, and establish new partnerships with development partners, United Nations agencies, donors, civil society and private sector institutions. Swaziland has established the Swaziland Partnership Forum on HIV and AIDS and a Donors Forum.

iv. *Resource Mobilisation*: Swaziland has made significant efforts to mobilise the resources required to implement the national response. In the last two fiscal years 2005/06 and 2006/07, government and development partner funding for HIV and AIDS increased significantly.

4.2 Challenges and Gaps

The following challenges were identified and documented during the joint review of the NSP II, in June/July 2008.

i. HIV population prevalence of 19%[42] and incidence (3%) rates in Swaziland remain the highest in the region. One of the findings of the MOT study is that people continue to engage in risky behaviours and that the coverage and intensity of HIV prevention programmes has been inadequate and they are often ad hoc, generic and fragmented. Prevention interventions continue to be "business as usual" and not adequately informed by evidence of what works, best practices and consumer acceptability surveys[43]. Risk behaviours have not changed enough – especially concurrent multiple partnerships, and condom use outside of mutually monogamous relationships.

ii. In treatment, care and support, adequate access and utilisation of services has been constrained by inadequate human resources and a relatively weak health system coupled with the barriers of stigma and discrimination.

iii. The joint review suggested "task shifting" to allow qualified and competent nurses to deliver selected services to augment existing physician capacity. This would require policy changes in the role and responsibilities of nurses and a review of the essential drug list to allow nurses to prescribe selected drugs. The joint review also noted that poverty was increasingly becoming a barrier to accessing and adhering to treatment as lack of transport money, food, proper shelter, water and sanitation affected people's ability to access and adhere to treatment and care services.

iv. Regarding impact mitigation, adequate coordination of services remains a challenge. Community systems are under-developed and under-resourced[44]. Lack of adequate capacity compromise their potential to support an effective and efficient HIV and AIDS social service delivery system.

v. A results-based management approach has not been applied in Swaziland for HIV and AIDS planning previously. The review suggested that this approach, and stronger incorporation of gender and human rights frameworks in HIV programming would lead to more effective HIV and AIDS planning and programme development.

vi. Mainstreaming and application of the three-one principles had only taken place at national level. At regional level, attempts had been made to mainstream M&E and use one coordinating regional authority (the REMSHACC). Multi-sectoral joint planning had not been introduced; however, several sectors and communities had developed sectoral strategic plans.

vii. The sectors have not yet synchronised their M&E systems to the national M&E Framework. Reporting by implementing partners is generally poor, and often late. This is attributed to lack of capacity, particularly in data compilation and analysis prior to reporting. Poor reporting compromises the comprehensiveness of the M&E information. There are also delays in feedback to the implementing partners as reports are produced late.

viii. The impacts of HIV and AIDS are being felt across all sectors of society and economy. The epidemic has negatively impacted demographic trends, including increasing mortality and morbidity and dependency ratios. The number of orphans due to AIDS is projected to increase from 60,000 in 2006 to around 110,000 by 2015. In the 2005/06 Budget speech, the Minister of Finance in Swaziland stated that rising unemployment and food insecurity, and HIV and AIDS had together resulted in a 3% increase in poverty in the last fiscal year. Life expectancy has fallen from 56 years in 1997 to 40 in 2006[45]. AIDS is robbing communities of their bread winners and leaders and the knowledge, skills and capacity necessary to sustain livelihoods and raise children. HIV threatens traditional community coping mechanisms (safety nets) and food security[46].

AIDS is reversing the socio-economic gains since independence[47], by compromising investments in health care, education, agriculture and human capital. As more people succumb to the epidemic, a vicious cycle is created - the capacity to absorb and utilize existing resources for socio-economic development is reduced contributing to deepening poverty. It is anticipated that the annual population growth rate will decline from 2.9% in 1997, to about 2.1% by 2015. Increased expenditures on health care and funerals, and lower incomes (due to morbidity) will cause a decline in personal savings and a reduction in investments, in addition to an overall increase in the cost of health care and labour[48]. Although it is difficult to measure the specific impact of HIV and AIDS on agriculture, it is generally accepted that the epidemic is reducing productive capacity through people falling sick and being unable to work and through absenteeism to attend funerals or provide care. The cost of replacing highly skilled persons is high, especially in skills-scarce economies.

In addition to these broad challenges and gaps, programme (intervention) specific gaps and challenges are identified and articulated in Section 5 of the NSF under each of the programme interventions.

4.3 NSF Gaps Analysis

Table 3 is a summary of identified NSF capacity and programme gaps that will be prioritised to ensure that the NSF achieves its impact and outcome level results within the specified time frame.

Table 3: Capacity Gaps

Area of Assessment	Description of Capacity Gap	Suggested Strategies for mitigation
Human Resources	• Inadequate skilled and experienced human resources • Inadequate strategies to mitigate staff attrition	•Recruit additional skilled and experienced staff. •Develop a staff retention strategy based on a competitive package, career development, and enabling work environment •Establish a volunteer support plan
Coordination and management	•Incomplete adoption/mainstreaming of three ones principles at all levels •Lack of clarity on roles and responsibilities	•Strengthen the coordination forums for all sectors and support community coordination structures
Resource mobilisation	•Lack of skills in resource mobilisation, proposal writing, grant negotiations •Poor knowledge of donors and sources of funding •Inadequate funding, funding continue to be project rather than programme based •Inadequate donor coordination	•Undertake training in proposal writing and resource mobilisation •Conduct resource mobilisation and diversify donor base, including to private sector institutions •Support mini sector wide approaches
Programme Development	•Not all programme areas are guided and informed by a technical national programme document that articulates programme policy, service standards and modes of operation etc.	•Programme technical documents will be developed as appropriate. •Support Technical Working Groups to provide oversight functions
Grant Management	•Inadequate grant disbursement and tracking systems •Poor monitoring and reporting of grant utilisation	•Strengthen and improve existing systems to ensure efficiency and effectiveness
Monitoring and Evaluation	•Not all sectors have adopted and mainstreamed the National M&E system •Lack of adequate M&E skills at regional, sector and community level •Lack of standardised M&E training	•Strengthen manpower, re-design and harmonise tools, and train data collectors at community level
Partnerships development	•Inadequate development of partners coordination •Inadequate harmonisation of development partner programmes with national strategies	•Forge new partnerships, consolidate and strengthen existing ones •Encourage partners' to align their HIV programmes with NSF
Sustainability	•Undefined donor exit strategies •Inadequate community ownership •Short term (project) funding rather than long term programme funding modalities	•Develop a sustainability strategy and donor exit strategy •Strengthen community engagement in HIV and AIDS interventions •Advocate for programme / NSF funding rather than project or activity funding

4.4 Opportunities for the national response

The adoption of the NSF planning framework has created a number of opportunities for the national response.

i. The NSF will shift the implementation of the national response to evidence-based and results-focused management.
ii. NSF has integrated gender and human rights in HIV and AIDS programming. The roles of duty bearers (service providers) and rights holders (service beneficiaries) have been articulated. The NSF will enhance the capacity of service providers to adequately integrate gender and human rights in sector programme planning, financing and service delivery.
iii. The NSF provides the opportunity to expand coverage and improve the equity of services by rolling out essential services, while at the same time emphasising service quality. The expansion of services coverage will ensure that all communities have access to a minimum package of strategic services.
iv. NSF has institutionalised a joint planning process and in particular has created the opportunity for the development of Regional Action Plans that are synchronised with the NSF. The decentralised planning process will be cascaded to community level. Over the course of the NSF period, communities will be empowered to develop their own action plans.
v. In monitoring and evaluation, the NSF takes advantage of the willingness of stakeholders to adopt and mainstream the national M&E framework, improve on reporting mechanisms and expand the scope of stakeholders' use of M&E data to improve the quality of services. The NSF provides a systematic capacity building and strengthening strategy to ensure effective adoption and operationalisation of the M&E system.
vi. The NSF has further articulated the need for HIV and AIDS resource tracking for funds channelled through government and those provided directly to implementing partners, and the participatory planning process has increased awareness of the importance of this, and willingness to help achieve it.

4.5 Policy and Legal Environment

Since 1999, the epidemic in Swaziland has been recognized as a national disaster. The country has developed and implemented multi-sectoral HIV and AIDS strategic plans. Several policies, legal instruments and programme specific technical guidelines have been developed, including the National Multi-sectoral HIV and AIDS Policy (2006). HIV and AIDS are an important consideration in the National Development Strategy (NDS, 1999) and the Poverty Reduction Strategy and Action Programme (PRSAP, 2006).

The National Multi-sectoral HIV and AIDS Policy aims to "create an enabling environment for the national response to HIV and AIDS". The policy has institutionalised the adoption and application of the three ones principles in Swaziland. It guides and informs the development of National Strategic Plans, the National Strategic Framework for HIV and AIDS 2009-2014 as well as specific programmes and service delivery. During the joint review of the NSP II in June/July 2008, the policy was found to have remained relevant and valid.

The NSF is aligned with and complements other national development strategies such as the National Development Strategy (NDS) and the Poverty Reduction Strategy and Action Plan (PRSAP). The NDS

has called for "strengthening the fight against HIV/AIDS pandemic" while the PRSAP's goal is to "completely stop any new infections, reverse the spread of HIV and AIDS and reduce the vulnerability of affected individuals and families by 2011". The PRSAP identified poverty as an underlying factor that drives the HIV epidemic and has embedded in it, strategies to curb the spread of HIV. These strategies are designed to alleviate poverty among the vulnerable groups, reduce the income gap between the rich and the poor and ensure equity in prevention, treatment, care and support and impact mitigation services.

Swaziland is also committed to fulfilling its international obligations as party to the UNGASS Declaration of Commitment on HIV and AIDS (UNGASS 2001), (MDG 2000), The Abuja Declaration and Plan of Action (2001), the Maseru Declaration on HIV and AIDS, The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the UN Convention of the Rights of the Child and the Universal Human Rights Declaration, and aiming to attain the Millennium Development Goals.

4.6 The NSF Risk Assessment and Risk Management Strategies

The NSF has identified the following risks that may compromise its implementation and has articulated strategies to mitigate them

Table 5: Risk Assessment and Risk Management Strategies

	Risk	Risk Management Strategy
1	Inadequate or weak capacity and systems for implementation	A national capacity assessment will be conducted and a framework to address capacity gaps will be developed. Implementation of the framework will be at all levels
2	Inadequate Resources	●Capacity for resource mobilisation will be strengthened through skills development ●Advocacy with government and development partners to increase funding for HIV and AIDS.
3	Impacts of stigma on services uptake	Stigma reduction advocacy work will be conducted at community level and in the workplace. PLHIV will be recruited as expert clients to support advocacy work
4	Inadequate targeting of resources to priority interventions.	Technical assistance will be provided to all sectors, implementers and communities in developing action plans that are aligned to NSF and hence address national priorities
5	Inadequate community participation and ownership	All stakeholders will be involved in community mobilisation and empowerment through community dialogues and meetings
6	Poor performance reporting by implementing partners	The capacity of sectors and community-based organisations will be strengthened to collect data and report on their performance, and use the data to improve their performance
7	Mismanagement and poor accountability of resource	Organisations will be trained in financial management and accountability procedures and strategies
8	Weak enabling environment	●Advocacy work will be conducted to establish policy and legal instruments that support and promote an enabling environment ●Policy makers will be sensitised and trained on key policy and legal matters
9	Programme implementers stop their operations due to unforeseen circumstances	An effective monitoring system at regional and national level will be applied to monitor performance of organisations including early detection of potential organisational threats that may contribute to organisations closing operations

10	Poor governance and leadership	Leadership and governance training and capacity building will be provided
12	Limited alignment of stakeholders plans to NSF	Advocacy work will be carried out with sectors and partners to have their plans aligned to NSF and encourage them use the RBM approach
13	M and E remains inadequate	Capacity will be developed to strengthen strategies to improve and sustain monitoring and evaluation systems and activities
14	Weak programming in some areas of response	Capacity will be developed for programme development using RBM, Gender and human rights approaches. The focus will be on programme areas identified in the NSF
15	Limited understanding of mainstreaming of response to HIV and AIDS	Provision of technical assistance to sectors in conceptualising, understanding and developing strategies for mainstreaming of HIV and AIDS will continue to be provided. Training on mainstreaming will be provided to all sectors

Section 5: Strategic Programme Intervention

5.1 Criteria for prioritising programme Interventions

The Swaziland National Strategic Framework for HIV and AIDS 2009-2014 consists of four thematic areas: (i) HIV prevention, (ii) HIV treatment, care and support (iii) HIV impact mitigation and (iv) Response Management.

Each of the programme areas consists of specific sub-programmes that are referred to as intervention areas. The following criteria were used to select the priority intervention areas for the NSF.

i. **Evidence-based Planning:** Interventions were selected on the basis of available evidence of what has worked in the past or has significant potential to achieve desired results - to reverse the epidemic or improve the quality of life of people infected and affected.

ii. **Focus on Results**: The planning of the NSF moved from "business as usual" to a results-focused approach. For each programme area a specific impact level result has been identified with corresponding outcome level result/s. NSF performance will be measured by 2011 (mid-term) and 2014 (end of NSF period).

iii. **Feasibility of interventions:** Consideration was given to the feasibility of the intervention.

iv. **Resource availability:** Consideration was given to the potential availability of financial, human, physical and information resources required for implementing the NSF and associated National and Regional Action Plans. In identifying the specific activities, further consideration was given to the activity cost effectiveness and long term sustainability.

v. **Addressing the drivers of the Epidemic**: The results-based approach necessarily demanded that the interventions prioritised by NSF address key epidemic drivers and HIV risk factors.

vi. **Sustainability of NSF Interventions**: Consideration of the sustainability of NSF interventions revolves around five pillars i.e. financial, community ownership, organizational development, services availability and coverage, and accountability. To a large extent sustainability is dependent on current and potential capacity to be strengthened during the period of the NSF. Strategies to achieve sustainability are further articulated in Annex 1.

The specific NSF prioritised interventions under each programme area are described in the pages that follow.

5.2 Prevention Programmes

Prevention remains absolutely critical in the national response to HIV and AIDS. Investing in prevention also has collateral benefits in treatment care and support and in impact mitigation. So far, prevention efforts have not been effective enough to halt and start reversing the epidemic, and new infections continue to outpace the number of people placed on treatment.

Effective prevention interventions are those that are selected on the basis of empirical evidence of their efficacy in preventing new infections. They also collectively or individually target the key behavioural and biological drivers of the epidemic. The main mode of transmission in Swaziland is heterosexual;

specific behaviours that put people at risk of HIV infection include multiple concurrent partners, low age of sexual debut, low and inconsistent use of condoms during sex in which there might be exposure to HIV, intergeneration sex, and commercial sex; and contextual factors that contribute are income inequality, mobility and migration, and gender inequalities. These epidemic drivers are discussed in detail in section 3 of the NSF.

The joint review of the NSP II noted that a key challenge with prevention interventions was the failure to reach targeted individuals or key populations with the level of coverage and intensity required to make a significant impact. It also observed that prevention interventions were being carried out as 'business as usual'; they were not adequately informed by evidence, best practices, and consumer acceptability surveys. They were found to be frequently generic in nature and failing to address specific challenges within key populations. Equally, communities were found to be inadequately mobilised and not engaged in a meaningful manner to ensure their active and sustained participation, involvement, commitment and retention in prevention initiatives.

The NSF interventions are prioritised to achieve the following impact level results and are grouped into two categories. Priority One interventions are those which evidence suggests have the potential to reduce Swaziland's HIV incidence rate from 2.9% in 2006 to 2.3% by 2014. NSF will also promote and encourage the use of emerging new technologies for prevention, particularly microbicides and male circumcision.

Impact level results	1. The Annual adult HIV incidence rate is reduced from 2.9% in 2008 to 2.3%[49] by 2014.
	2. % of HIV infected infants born to HIV positive mothers is reduced from 21.5%[50] in 2008 to 10% in 2011 and 5% by 2014
	3. % of young people aged 15-19 years who are HIV infected is reduced from 10.1% for women in 2007 to 8% in 2014 and from 1.9% in 2007 for men to 1.5% in 2014
	4. % of pregnant women aged 15-24 years who are HIV infected reduced from 38.1% in 2008 to 37% in 2011 and 35% by 2014
	5. % of female sex workers[51] who are HIV positive is reduced from 23% in 2007 to 20% by 2014

Priority One interventions are the following:
- Social and behaviour change communication programmes
- Reduction of multiple concurrent partnerships among all sexually active population
- Increased and deepened knowledge of HIV and AIDS
- Scaling up PMTCT
- Male circumcision particularly of HIV negative men aged 15-24 and new born children.
- Integration of prevention programmes targeting key populations at risk (migrant populations, sex workers, male and female youths)

Priority Two interventions are those that need to continue because of their importance in sustaining the gains already achieved in prevention or within the general response to HIV and AIDS. These interventions include the following:
- HIV Testing and Counselling (HTC)
- Blood safety and Universal Precautions
- Post Exposure Prophylaxis (PEP)

•Treatment of Sexually Transmitted Infections (STI)

Strategic Direction: The NSF strategic goal is to implement interventions that will reduce HIV incidence rates to a level (2.9% to 2.3%) where the epidemic cannot sustain itself. By doing so, Swaziland will halt and starting reversing the epidemic.

Priority Strategies: The following are the core prevention strategies that cut across the prevention programme:

i.Implement programmes that that will **support changes in societal norms, values and practices** influencing adoption of key prevention behaviours. Interventions will include improving comprehensive knowledge about HIV, addressing sexuality and reproductive health, and multiple concurrent partners, and empowerment of women.

ii.Implement interventions that **reduce exposure to HIV infection,** focusing particularly on multiple concurrent partners, early sexual debut, inter-generational sex and condom use, especially at first sex.

iii.Implement interventions that will **reduce the probability of infection,** notably provision of ARV for PMTCT, ARV for PLHIV, PEP, and male circumcision.

iv.Advocate for the creation of a supportive environment that in particular enhances the chances for preventing exposure to infection and empower women and girls to make informed decisions on their sexual reproductive health.

The following programme will be implemented, aiming to achieve the outcomes listed.

5.2.1 Social and behaviour change communication programmes for the general population

Prevention Programme Outcomes Targets
At the individual level, there will be less risk of exposure to possible HIV infection if:
Fewer persons have concurrent partners: % of people aged 15-49 years who had concurrent partners in the last six months is reduced from an estimated 2% in 2007to1.5% in 2011 and 1% for women by 2014 and 23% to 13% in 2011 and 6% for men by 2014[52].
Fewer persons have multiple partners: % of people aged 15-24 years who had sex with more than one partner in the last 12 months is reduced for men from 28.5% in 2007 to 23% in 2011 and 14.3% by 2014 and for women is maintained at 3.8% by 2014.
Young men and women wait longer before having sex (delay sexual debut): % of young women and men aged 15-24 years who had sexual intercourse before age 15 years is reduced from 6.9% in 2007 to 6% in 2011 and 3.5% for women by 2014 and from 4.8% in 2007 to 4% in 2011 and 2.5% for men by 2014.
Fewer young women have fewer older sexual partners: % of women aged 15-24 years who had higher risk sex with a partner 10 or more years older than them is decreased from 7.1% in 2007 to 5% in 2011 and 4% by 2014.

Prevention Programme Outcomes Targets
Fewer unplanned pregnancies amongst women living with HIV: % of women aged 15 to 49 years who did not want any more children when they fell pregnant, has decreased from 36.9% in 2007 to 27% in 2011 and 20% by 2014.
At the Community and structural level, HIV prevention efforts will be successful if
Social norms that are protective against HIV transmission are reinforced: % persons who agree that married men should only have sex with their wives increases from 86% in 2007 to 87% in 2011 and to 90% by 2014.
More community leaders take a public stand against those behaviours that put people at risk of HIV transmission: % of community leaders and other popular opinion leaders[53] who have spoken against multiple and concurrent sexual partnerships in the last 12 months is increased to 80% by 2014.
More young people get information about HIV from their family members, as opposed to in the media or from friends: % of young people aged 10-24 who cite a member of the family as a source of HIV and AIDS information is increased from 39.2% in 2006 to 60% by 2014.
More people have comprehensive knowledge of HIV: % of persons aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from 52% in 2007 to 63% in 2011 and 78% by 2014.
There is less stigma and discrimination against people living with HIV: % of men and women aged 15 years and older who express accepting attitudes towards PLHIV is increased from 25.5% for women and 29.4% for men in 2007 to 30% for women and 34% for men in 2011 and 40% for both men and women by 2014.

Situation Analysis: At the individual level, much work has been done to try to change the course of HIV epidemic by educating individuals about HIV risks and advocating individual-level behaviour change (behaviour-change communication (BCC)). However, recent studies show that people often knowingly engage in sexual behaviour that places their health at risk. Campbell (2003) writes: *"The forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions, based on simple factual knowledge about health risks, and the availability of medical services".* Sumartojo (2000) comments in a similar way: "*Many view behaviour as personally motivated or resulting exclusively from a person's conscious decisions. The role of the structural environment is often overlooked, and structural interventions may be perceived as going beyond the traditional role of public health."* There is conclusive evidence that BCC programmes focused on individuals only have not been very successful in changing the course of the HIV epidemic. They appear to be necessary, but not sufficient.

Therefore, social change communication is a necessity – "*there is now a growing consensus that BCC strategies must be complemented by more participatory approaches that work through and address broader underlying social and economic influences"* (Gregson et al., 2004). It is a relatively new concept, and is an evolution of the commonly adopted BCC approach. Whereas BCC is a collection of

communication tools, messages and techniques to motivate individuals to change their own behaviour, social change communication involves also changing norms in society about acceptable and unacceptable sexual behaviour. How to bring about such social change is still a matter for more debate and evidence-gathering (Gorgens-Albino et al., 2008) but it can and must be done.

From the epidemiological data about the drivers of the epidemic in Swaziland (higher risk sexual behaviours that drive the heterosexual transmission of HIV), community leaders need to be targeted with social change communication programmes to change social norms regarding those behaviours, and populations who display these behaviours need to be targeted with behaviour change communication programmes. Priority populations for SCC/BCC efforts are:

a) *Couples who live together or are married:* (dealing with extramarital relationships, condom use and multiple and/or concurrent sexual partnerships

b) *Youth aged 15 to 24* (married and unmarried, because there are high rates of premarital sex, age-disparate sex, transactional sex, and low levels of marriage – combined with high prevalence amongst young women aged 20 to 24 and low HIV prevalence amongst 15 to 19). The NSF will prioritise age groups where there is potential for significant impact in preventing new infections -- girls 10-14 years (3%),15-19(12%) and boys 15-24 with emphasis on age group 15-19 (2%), and 20-24 (12%).

c) *Persons who migrate temporarily for work purposes:* (as HIV prevalence was higher amongst those who travel regularly or frequently than those who seldom travel); and

d) *Community leaders and other public persons* who set and influence norms and values about sexuality, sexual behaviour and HIV related stigma. They include chiefs, parliamentarians, Government senior staff, teachers, pastors, and traditional health practitioners and healers.

e) *Populations at risk and people with disability.* Prevention interventions will also target key population such as sex workers and OVC. OVC are more vulnerable to sexual abuse.

Achievements: In Swaziland, the focus has been on IEC and BCC – a draft national strategy on Behaviour Change Communication for prevention of Sexually-Transmitted infections (2006 – 2008) was developed, and communication activities were implemented in schools, through the media, and peer education. Comprehensive knowledge in Swaziland is estimated at 52% for

Figure 2: Comprehensive HIV knowledge amongst males in Africa

both women and men, while awareness is approximately 90% for both men and women (Figure 2).
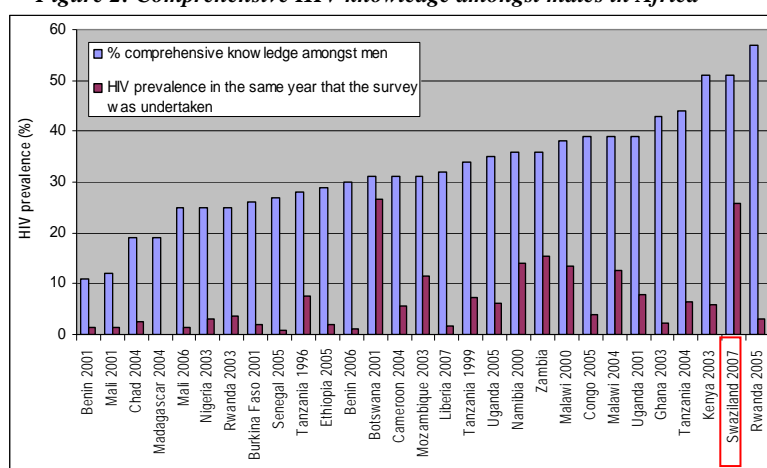
Gap analysis: The 2008 HIV Response Joint Review identified the gaps in terms of the intensity and sustainability of BCC efforts, as well as the fragmentation of efforts, limited involvement of the community, including faith based organisations and the media, and a focus on individual behaviour

change, instead of changing social norms, values and attitudes around acceptable sexual behaviour, stigma and discrimination.

Strategic direction: The strategic orientation of the intervention is to influence change in social norms and values that influence the spread of HIV at community level and support adoption of key prevention behaviours at individual levels. This is a shift from IEC and general BCC, to a sharp focus on changing specific risk behaviours

Strategies: The implementation of this intervention will be guided by the following strategies:

i.   A national strategy to guide stakeholders in planning MCP interventions will be developed.
ii. Develop targeted and/or strengthen existing prevention programmes to increase coverage, intensity, and improve the synergy of social and behaviour intervention, and strategies. Such strategies will also promote inter-organisational collaboration based on comparative advantage to reduce fragmentation, and duplication of efforts. Programme planning will be informed by evidence, best practices, and consumer acceptability. Interventions will also target community leaders to influence change in negative social norms and community behaviours.
iii. Specific interventions that focus on reduction of risk behaviours will be developed bearing in mind key populations most at risk. Such interventions will address multiple and concurrent partners at community level (as well as individual BCC to discourage MCP).
iv. Identify and promote programmes that keep girls in school and empower them to make informed decisions on their sexual reproductive health.
v.   Develop and use targeted specific social and behaviour change communication materials that focus on specific behaviours, especially key epidemic drivers.

5.2.2 Male Circumcision

MC Outcome Results
More young men circumcised: % of young men aged 15 – 24 who are circumcised is increased from 5.1% in 2007 to 30% in 2011 and 80% by 2014
More mothers support the notion of their children being circumcised: % of mothers who support their newborn sons or teenage boys to be circumcised is increased to 20% in 2011 and 50% by 2014.

Situation Analysis: It has been proven that male circumcision reduces the probability of transmission from HIV positive females to HIV negative males by 60%[54]. As a result WHO and UNAIDS recommend the inclusion of male circumcision in HIV prevention in high prevalence countries (WHO and UNAIDS, 2007). Swaziland will focus on young people aged 15-24 years as a priority target group. This age group has been identified by the National Policy (draft) on Safe Male Circumcision for HIV Prevention for a number of reasons. First, the age group 15-19 has a low prevalence rate (2%), so there is high potential for preventing infections. HIV rates begin to rise among men aged 20 to 24 (12%), and their female peers already have very high prevalence (38%), so male circumcision provides an additional key prevention strategy for these young men. It will also target new born children. Advocacy work will also continue to encourage other age groups to consider male circumcision.

Tsela & Halperin (2006) found high acceptability of male circumcision with only 2% saying that MC "is not culturally acceptable" in Swaziland. Concerning MC's protective effects, only 21% of men in 2006

believed it reduces HIV risk and 31% did not know of any disadvantages (FLAS, 2006). Of the men who had been circumcised, only 63% were counselled before the procedure (FLAS, 2006). Catch up strategies to conduct mass male circumcision will be required to reach this target. In order to avoid such mass male circumcision fifteen years down the line, neonatal male circumcision services will be offered in the main hospitals.

Achievements: Male circumcision has been included in the package of prevention interventions to reduce HIV infection in Swaziland, but has not yet been rolled out nationally. A policy on male circumcision was developed in November 2007, and an operational plan in 2008. Some male circumcision procedures have already taken place: Family Life Association of Swaziland (FLAS), for example, has performed 1,961 MC procedures since October 2007. Hospitals have carried out MC for various reasons.

Gap analysis: The SDHS confirms that only 8% of men reported being circumcised in 2007. Facilities designated to perform MC are not able to cope with current demand for circumcision services. If male circumcision is not supported with strong education campaigns, coupled with advocacy for continued condom use, it may have negative impact on the success already achieved in condom use. Anecdotal information indicates that some men see circumcision as an alternative prevention strategy to condom use. Women are most likely to be affected by any potential relaxation on condom use that male circumcision may trigger.

Strategic Direction: The inclusion of MC as an additional prevention strategy aims to reduce the probability of male infection and hence to reduce exposure among women partners.

Strategies: The following strategies will be used to support male circumcision
  i. Conduct advocacy campaigns and education on male circumcision with strong advocacy for continued use of condoms.
  ii. Disseminate the male circumcision policy among key stakeholders.
  iii. Strengthen the capacity of health facilities to cope with demand for male circumcision services.
  iv. For long term sustainability and to avoid future need for "catch up" mass circumcision, NSF will also promote and support circumcision of neonates.

5.2.3 Prevention of Mother to Child Transmission (PMTCT)

PMTCT Outcome Results
More HIV pregnant women receiving ARVs to reduce risk of transmission to child: % of HIV positive pregnant women who received a course of ARV prophylaxis to reduce MTCT in the last 12 months is increased from 65% in 2007 to 80% in 2011 and 90% by 2014.

Situation Analysis: The risk of mother to child transmission (MTCT) can be reduced to less than 2% by interventions that include antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant in the first weeks of life, as well as obstetrical interventions including elective caesarean delivery, and safer infant feeding practices[55]. Provision of other sexual and reproductive needs of HIV positive persons increase the opportunities for achieving a comprehensive HIV response. Persons living with HIV continue to be sexually active, and therefore need services to support them to (a) use contraceptives to avoid unwanted pregnancies; and (b) gain practical advice on how they could negotiate for safer sex to avoid transmission in their sexual partnerships (Eisele et al, 2008).

Achievements: In Swaziland, a four pronged approach to prevention of HIV infection in women and infants has been adopted including primary prevention of HIV; prevention of unintended pregnancies among HIV positive women; reduction of mother to child transmission among HIV positive women and provision of treatment, care and support for HIV positive women and their families. Care of HIV exposed infants and diagnosis of HIV infection in infants are part of PMTCT services. Currently, PMTCT services are available in 110 out of 162 health facilities[56] which means that 68% of health facilities offer the minimum package for prevention of HIV infection in infants and young children (MOHSW 2008). The minimum package of services for PMTCT consists of comprehensive ANC for pregnant women, HTC; ART or ARV prophylaxis for prevention; infant feeding and young child counselling and support; follow up services and a continuum of care including linkages to care and treatment. In 2007, out of the estimated 40,000 expected pregnancies, 34,690 (87%) pregnant women were tested for HIV. Out of the total number of women in need of PMTCT services, about 65%[57] received ART for PMTCT in 2008. New guidelines for provision of combination ARV therapy and HAART for PMTCT have been developed and are being implemented in a few sites and roll out is planned to ensure all ANC clients receive combined ART for PMTCT and ART for eligible women.

Gap analysis: Due to health systems related challenges, HIV infected women are not able to receive the care they need in a timely manner for various reasons including the following:

　　i.Laboratory services are centralised at hospitals and health centre level,
　　ii.Due to lack of regular transport, HIV positive women tested at rural clinics do not receive test results quickly. The turn-around time is estimated at 4 weeks.
　　iii.Current maternal and newborn care services in the country are sub-optimal.
　　iv.Management of labour, immediate postpartum and newborn care in hospitals remains inadequate. This may increase the risk of MTCT.
　　v.Linkages and referral to other care programmes are weak and tend to compromise the provision of comprehensive PMTCT care services.
　　vi.Inadequate male involvement, stigma and insufficient public awareness around PMTCT have compromised acceptance and uptake of PMTCT services.
　　vii.While PMTCT data capture is going on very well, tracking of specific indicators for quality improvement has not yet been established. The rapid expansion of PMTCT services in the country requires periodic quality improvement measurements and hence the need to establish a quality improvement system. Community education, engagement and male involvement are crucial for PMTCT uptake, and so is reduction of stigma associated with HIV.

Strategic Direction: The thrust of PMTCT is to enable HIV+ women to avoid unwanted pregnancies, to reduce transmission to children born of HIV positive mothers, and increase longevity of children born HIV positive.

Priority Strategies: the following strategies will be used:

　　i.　Strengthen and expand PMTCT service provision at community level health facilities.
　　ii.　Implement innovative programme interventions to involve male partners, significant family members and communities to create a supportive environment for PMTCT
　　iii.　Intensify awareness and education on PMTCT among communities, in particular among male spouses.
　　iv.　Strengthen tracing mechanisms of ANC clients and their infants at birth.
　　v.　Strengthen the linkages between PMTCT and paediatric ART.

5.2.4 Condom Use and Distribution and Management

Condom Use Outcome Results
More youth uses condoms when they have non-regular partners: % of young people aged 15-24 reporting the use of condom at last higher-risk sexual intercourse is increased from 62% in 2007 to 72% in 2011 and 75% by 2014. % of young people aged 15-24 who report using a condom during first sex is increased from 43.2% for women and 49.3% for men in 2007 to 50% for women and 60% for men in 2011 and 70% for women and men by 2014.
More condoms used by people with multiple partners: % of people aged 15 - 49 with more than one partner who have reported using a condom during last sex is increased from 54.6% for women and 56.2% men in 2007 to 60% for both in 2011 and 65% for both by 2014.
More condoms used by sex workers: % of female commercial sex workers reporting the use of a condom with their most recent client is maintained at 98% by 2014.

Situation analysis: Condoms form a barrier between the HIV virus and an individual and if used correctly, reduce the risk of exposure to HIV (Holmes et al, 2004). However, it is essential that condoms are used correctly and consistently – only then are condoms 90% to 95% effective against HIV transmission (Pinkerton and Abramson, 1997).

Achievements: A zero-draft national condom strategy was developed to inform and guide the procurement, distribution, education and social marketing of condoms. Condom logistics and warehousing has improved with the building of a condom warehouse in the regions, and new outlets for distribution of socially-marketed condoms. To improve coordination and management, a national condom technical committee has been established.

Gap analysis: Condom use levels are between 50 and 60% during higher risk sex (SDHS, 2007). Knowledge of the female condom is low with only 46% of women and 28% of men knowing where to source it (SDHS 2007). The majority of women are not able to negotiate successfully for condom use. The national condom policy is yet to be finalised, and condom logistics are inadequate in-spite of the establishment of regional warehouses. Although it is generally acknowledged that unprotected sex takes place in schools and prisons, government policy does not encourage provision of condoms in either. Disposal of used condoms is also problematic. Critical gaps in the condom management programme are (a) challenges with the distribution system (need to get the commodity as close to end user as possible); and (b) measuring usage of condoms. There are also challenges in condom education, which is sporadic, ad hoc and fragmented, rather than sustained and consistent.

Strategic direction: The NSF interventions will continue to increase and expand the availability and distribution of condoms, and focus on promoting increased, consistent and correct use of male and female condoms.

Priority Strategies:

    i.   Finalise and disseminate the national condom strategy.

ii. Intensify education on male and female condom use with emphasis on consistent and correct use all the time.
iii. Expand condom distribution through community-based institutions including KaGogo Centres and NCPs.
iv. Strengthen condom management systems and distribution logistics at all levels and in particular at community level.

5.2.5 HIV Prevention for Most-at-Risk Populations at Risk

Prevention for Most-at-Risk Population Outcome Results
Most At-Risk Populations have Comprehensive knowledge of HIV: % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from 46.2% in 2008 to 56% in 2011 and 70% by 2014.

Situation Analysis: Key populations at risk are those populations who have higher HIV prevalence and display behaviour that puts them at higher risk of HIV infection. From an epidemiological view, in a generalised epidemic, controlling HIV infections amongst these key populations at risk may not have a significant impact on reducing new infections (depending on the distribution of new infections) and does not prevent the HIV epidemic from sustaining itself. However, as a human rights issue prevention interventions will be targeted at some of these key populations at risk. The key populations at risk, for which some evidence exist, are prison populations, sex workers, and migrant workers with oscillatory migration patterns, and uniformed services. Other potential key populations at risk, for which no data exist and for whom data need to be collected, are: men having sex with men (MSM) and injecting drug users.

In Swaziland, men and women who spend time away from home are much more likely to be HIV positive than those who do not travel for work purposes[58]. Therefore, it is imperative that public and private sector employers protect their workers against HIV transmission to augment the support and information that these persons will receive in their communities through other HIV prevention programmes (such as programme targeting married couples and the youth).

Hence the need for employers to develop and implement HIV and AIDS workplace programmes, that offer a minimum package of services. Workplace programmes for workers in the informal employment sector, such as domestic workers, have been found not to be cost effective; they are difficult to execute and monitor, and are virtually non-existent in Swaziland. Where workplace programmes exist they are fragmented and mainly in large and well resourced companies.

Achievements: HIV workplace policy has been developed for public sector employees, and for the uniformed forces. MOH has expanded its workplace programme to cover all employees in the health sector. A few private sector institutions have developed HIV and AIDS workplace programme. Private sector response is coordinated by the Business Coalition on HIV and AIDS (BCHA). The MOH has started a programme for sex a worker that focuses on provision of condoms and STI treatment.

Gap analysis: Several workplace policies are still in draft form and have not been finalised due to lack of capacity, skills and experience. Only a few companies have developed workplace programmes and, in the absence of an agreed minimum package, such programmes are not standardised. The problems with workplace programmes are compounded by the fact that there is no mandating factor to assign

people to be responsible for workplace programme, people have their own jobs, and HIV programmes are seen as of secondary importance.

Quality and reliable data are largely lacking for most of the key populations. This is attributed to lack of prioritisation of such populations in prevention programmes. Similarly, programmes that specifically target key populations are lacking.

Strategic Direction: The NSF has not only used the RBM approach but also a human rights based approach to planning, and hence the need to address population groups that have higher HIV prevalence and display risky behaviours, from a human rights perspective.

Strategy:
   i.   Develop and distribute targeted social and behaviour change communication materials.
   ii. Develop and disseminate guidelines for establishing HIV and AIDS workplace programmes
   iii. Sensitise sectors whose primary responsibility is not health and HIV and AIDS to mainstream HIV and AIDs in sector programmes and corporate functions.
   iv. Programmes that target specific key populations will be developed and implemented by the appropriate stakeholders.

5.2.6 HIV Testing and Counselling (HTC)

Situation analysis: There is no evidence to support HTC as a prevention strategy. However, testing and counselling is an essential service for people to know their HIV status. A recent meta-analysis of research about the effectiveness of VCT as an HIV prevention measure has shown that "VCT recipients were significantly less likely to engage in unprotected sex when compared to behaviours before receiving VCT, or as compared to participants who had not received VCT. VCT had no significant effect on the number of sex partners. While these findings provide only limited evidence in support of VCT as an prevention strategy, neither do they negate the need to expand access to HIV testing and counselling services" (Denison et al., 2007:363). Other studies have shown positive behavioural outcomes for HIV positive persons (Eisele et al., 2008), but negative outcomes for HIV negative persons who either increase or maintain their high risk behaviour after testing negative (Corbett et al., 2007; Potts et al., 2008). This raises the importance of ensuring that HTC quality control is ensured, so that all persons are given comprehensive information to reduce their high risk behaviour.

 In Swaziland, HIV Testing and Counselling (HTC) is both provider and client initiated. One hundred and nineteen (119) facilities were offering HTC out of 162 health facilities. Services include testing and counselling for PMTCT, and HIV testing for survivors of sexual violence. HTC Services are offered through free standing centres, VCT and Outreach HTC services. While HTC is not a preventive strategy, it is an important entry point for HIV prevention. Knowing one's status helps people to make informed decisions and choices on their sexuality. A key strategy that has worked is couples counselling. Promoting couples testing and counselling makes it possible to identify the long-term sexual partners of HIV positive persons and then empower them with the information and education they need to make informed decisions about their sexual and other practices to avoid re-infection, or infecting their partners.

HTC will also provide the opportunity to identify HIV negative persons and work with them to ensure that they remain negative. This proposition will require the development and operationalisation of community-based interventions that empower people with life skills that keep them HIV negative.

Achievements: By 2007 26.5% (SDHS 2007) of the population had ever taken a HIV test and had received their results (SDHS 2007). HTC was provided in 119 facilities. In 2007 alone a total of 53,246 tested for HIV and knew their status (QSCR). HTC guidelines were developed and disseminated to sectors. A training manual and strategy for provider initiated HTC were developed by adapting the WHO guidelines. A draft standard operating procedure manual for client initiated HTC was developed and a National HTC Task Force was established.

Gap Analysis: Provision of counselling and testing for children under the age of 12 years is not well articulated or supported by policy guidelines. This has implications in requiring consent from a parent as opposed to any other person taking care of the child who is seeking support from counsellors. Stigma remains a major barrier to testing and disclosure of one's HIV status. The Joint Review noted a general lack of experienced and skilled counsellors for minors (children under 12 years) and discordant partners. It was noted from regional consultations that testing supplies and commodities (testing kits) in some facilities were inadequate, limiting the number of people who can test at certain times. The review established that the challenge related more to distribution than supply. Overall HIV testing was found to be inadequate.

Strategic direction: The NSF thrust is to promote the concept of people knowing their HIV status and hence facilitate making informed decisions and choices on the sexual and social practices that influence infections.

Priority Strategies:
  i.   Develop an advocacy strategy focusing on "know your HIV" status.
  ii. Expand VCT services in the community, by decentralising services to qualified and competent organisations including civil society.
  iii. Advocate for VCT as a core component of HIV and AIDS workplace programmes, and support public private partnerships to scale up VCT.
  iv. Develop programmes that support people who test HIV negative to remain negative. NSF will identify best practices in the region and adopt them in Swaziland.

5.2.7 Blood safety

Blood Safety Outcome Results
% of sampled blood units that meet the WHO quality assurance standards[59]

Situation Analysis: Since the transfusion of blood or its products is an extremely efficient way of transmitting HIV, screening blood and blood products for HIV before using them is an essential public health intervention as it directly reduces possible accidental exposure of patients to HIV.

Achievements: Swaziland has established a blood donor recruitment department, and developed a blood safety policy in 2000 and guidelines in 2001. Swaziland uses WHO clinical guidelines on the use of blood and has trained phlebotomists. The country has initiated a voluntary blood donor system targeting school children aged 15 to 19 years. The strategy helped to increase the number of blood units collected from 6,000 to 7,700 units by 2007. Swaziland has attained 100% blood safety.

Gap analysis: Despite the achievements, the voluntary blood donor system has not been able to collect a sufficient quantity of blood units to meet demand for safe blood. In 2007, Swaziland met only

75% of the hospital demand for safe blood. This was in part due to loss of adult blood donors as they were not motivated enough to donate blood. While there is need to encourage adults to donate blood, the potential to achieve targets could be realised by targeting school children whose potential as safe blood donors has not been exploited fully. There are 42,450 children aged 15 to 19 in secondary schools in Swaziland – a large potential pool of new blood donors.

Strategic Direction: The objective is to maintain the 100% blood safety.

Priority Strategies:
  i.   Strengthen and maintain technological capacity to screen blood and blood products to ensure 100% blood safety.
  ii. Recruit additional donors by conducting community and school outreach education and advocacy programmes focusing on young people as potential safe blood donors.

5.2.2 Post-Exposure Prophylaxis (PEP)

PEP Outcome Results
Persons who have been accidentally exposed to HIV are given drugs to reduce the risk of primary infection taking place: % of people reporting to be in need of PEP and have received PEP services as per national guidelines is increased to 50% in 2011 and 80% by 2014.

Situation Analysis: In a country such a Swaziland with a high HIV prevalence of 19%, it is expected that a sizeable proportion of health care patients are HIV positive. It is also expected that there will be increased risk of infection with rape considering the trauma to the genital tract. Post-exposure prophylaxis (PEP) is a necessary secondary prevention measure in health care settings, since there will always be instances in which primary preventions fail and healthcare workers or patients may be accidentally, or through unsafe procedures, exposed to the risk of HIV transmission. The vast majority of incidents of occupational exposure to blood borne pathogens, including HIV, occur in health care settings. PEP for HIV consists of a comprehensive set of services to prevent infection developing in an exposed person, including: first aid care; counselling and risk assessment; HIV testing and counselling; and, depending on the risk assessment, the short term (28-day) provision of antiretroviral drugs, with support and follow up.

Achievements: Since the last NSP in which concerns were raised about the limited sensitization and availability of PEP services, national PEP guidelines have been developed and disseminated. Staff from emergency services, fire, police, prisons and health sectors were trained in PEP and services are being made available to those in need, including victims of sexual abuse. PEP registers from the 22 health facilities which provide PEP services showed that 432 clients accessed PEP in 2007.

Gap analysis: The main gaps identified were the limited availability of PEP services in health facilities and insufficient human capacity to provide PEP services country wide. There is also low awareness of PEP among people: people do not know what it is or how to access it. There is also no clarity as to whether PEP is for the general population or not.

Strategic Strategy: The strategic orientation for NSF is to ensure that PEP services are rolled out throughout all health facilities and are accessible to those who qualify based on the criteria set in the national guidelines, especially for victims of rape.

Strategy:
  i. Strengthen the capacity of health sector especially nurses to provide PEP at community-based health facilities.
  ii. Create awareness of PEP services among the general population.
  iii. Implement innovative PEP programme interventions aimed at reducing risk of HIV transmission among sexually abused children, young girls and women

5.2.9 Sexually Transmitted Infections

Situation analysis: The prevalence of STIs in Swaziland continues to escalate. Data from the HIMS indicate that they are amongst the top 4[60] conditions reported in the country's outpatient department and clinics. Available evidence shows that the presence of an STI in a HIV negative person, especially genital ulcerations, increases the risk of sexually transmitted HIV as interruption in the skin enables infection. New epidemiological data suggest that that there has been an increase in genital herpes, a viral STI responsible for most genital ulceration. According to a genital ulcer survey conducted in 2003 in Swaziland, genital herpes increased from 12% in 1980 to 60% in 2003. Epidemiological findings in Swaziland show that genital herpes is a leading cause of genital ulcer syndrome in the country. According to the sentinel surveillance data (10th round, 2006), 62% of patients with genital ulcers were found to be HIV positive. These data have facilitated changes in the STI treatment protocol to incorporate management of viral STIs. Furthermore research has proved that HIV infected women are at a higher risk for cervical cancer, which in 99% of the time is caused by the human papiloma virus.

Although other studies indicate that STI is not a very effective prevention strategy, this does not change the fact that STI treatment is an important public health intervention in its own right and as such STI control for the general population should be a priority intervention as part of sexual reproductive health. Moreover, on an individual level, presence of ulcerative STIs increases susceptibility to HIV infection, further reason for STI treatment.

Achievements: Swaziland has incorporated the treatment of all possible STI aetiologies including viral infections in the STI treatment protocol. 24 health facilities have been designated as STI clinical surveillance sites. Capacity development to deal with STIs is a continuous activity under the Ministry of Health. The number of STI cases declined by 13.3% from 115,886 in 2006, to 100,501 in 2007. This includes a decline in genital ulcers from 22% in 2006 to 20% in 2007.

Gap analysis: While STI treatment was available throughout the country, interventions have not adequately targeted key populations such as sex workers, men who have sex with men (MSM) and long distance truck drivers. STI patients frequently delay seeking health care, making it difficult to treat infections on time and contact tracing remains a challenge. Other challenges facing the management of STIs include inadequate laboratory diagnostic capacity for STIs, monitoring of drug resistance, and training of doctors in syndromic management.

Strategic direction: In the context of the NSF, the thrust of the STI interventions will be to prevent and reduce the prevalence of sexually transmitted infections among people aged 15-49 years with a key focus on ulceratic STIs.

Priority strategies
  i. Strengthening behaviour change communication for sexually transmitted infections.
  ii. Strengthening national capacity to provide STI services.

iii.   Strengthening partner notification and establishment of an active contact tracing system.
iv.   Include STI treatment as part of the package for sexual reproductive health services.
v.   Scale up cervical cancer screening among HIV positive females.

5.2.10 Management of Prevention Programmes

The Prevention thematic area has more active stakeholders than any other area of the national response. Involvement of all stakeholders, in particular civil society organisations, will be critical to successful implementation of the planned activities. The active stakeholders in prevention represent all government and non-governmental sectors.

At national level, a Prevention Technical Working Group, operating under the auspices of NERCHA facilitates the coordination of the national interventions, meeting quarterly. The TWG provides technical guidance on prevention issues across sectors. The membership of the technical working group is drawn from interest groups. The key role of the TWG is the development of programme policies, technical guidelines and protocols, standards, and operational manuals to ensure compliance with the set quality standards. The technical working group is supported by a number of technical sub committees that focus on individual programme areas, ensuring adequate information dissemination on critical issues to all stakeholders, and playing a key role in programme development and operationalisation of policies and technical guidelines. The TWG recommends to NERCHA the establishment of other prevention technical sub committees as need arises. The existing sub committees are the following.

i. PMTCT Sub Committee. This emanated from the formation of the Clinical Technical Working Group (CTWG) which was spearheaded and led by the Ministry of Health. This is a functional and effective committee.
ii. National Condom Committee: This committee requires strengthening. It is not very functional. The absence of a national condom strategy is one potential reason for the challenges around this sub-committee.
iii. National Male Circumcision Technical Sub-Committee:
iv. HTC Technical Sub Committee
v. Blood Safety Sub-Committee.

5.3 Treatment, Care and Support

HIV has severely impacted mortality and morbidity trends in Swaziland. According to the 10th Sentinel Surveillance Report, the crude death rate in Swaziland has increased as a result of AIDS mortality from 9.9 to 22.7 deaths per 1,000 population and is projected to reach 30.2 deaths per 1,000 population by 2011. WHO estimated that in 2006, 64% of all deaths in the country were due to AIDS (WHO 2007). Life expectancy at birth has fallen from 56 years in 1997 to 40.2 years in 2008[61].

Compounding the HIV disease burden is the high and escalating Tuberculosis (TB) epidemic. TB is a leading cause of death for PLHIV in the country given the high HIV/TB co-infection (80%, MOHSW (2006). Multi-drug-resistant (MDR) TB and extensively drug resistant TB (XDR-TB) have been identified in some patients. In 2007, 98 cases of MDR-TB were identified[62]. The death rate amongst patients with MDR-TB is estimated at around 30%, while the death rate associated with XDR-TB is around 50% (Brandon Keim 2008).

HIV treatment, care and support should be provided by the health sector for people living with HIV, to help reduce morbidity and mortality due to HIV and AIDS and to improve their quality of life. The health sector is defined to include public and private institutions and traditional health systems providing health care services in the country. It also includes alternative medicine that has not been formally integrated in the health sector. It is anticipated that implementation of the interventions outlined below will result in more years of healthy life. Quality of life requires detailed surveys, so the following simpler impact level result for treatment, care and support was selected:

Impact-level Result	Life expectancy increased from 40.2[63] years in 2008 to 44 years, by 2014

The priority focus for NSF for treatment, care and support is three pronged. First NSF will support provision of HIV Testing and counselling (HTC) as strategy to get people know their HIV status and seek health care early enough. Second, NSF will promote and support provision of Pre-ART services to delay the enrolment on PLHIV on ART and finally to have as many people in need of ART as possible receiving ART.

The NSF has articulated interventions that will reduce AIDS-related mortality and morbidity and delay PLHIV progressing to the 4th clinical stage of HIV infection to full-blown AIDS. Antiretroviral Therapy will be provided and adherence to treatment regimens will be promoted. The prevalence of TB will be reduced by successfully treating TB cases in addition to treating opportunistic infections and chronic conditions related to HIV and AIDS. The success of the programme will depend on a number of factors; additional resources, and active collaboration between key stakeholders including public and private health care providers and traditional health practitioners will be critical.

The following programmes will be implemented to achieve the above stated outcome level result:
  i. HIV Testing and Counselling
  ii. Pre-ART and Opportunistic conditions
  iii. Anti-retroviral therapy that will also include paediatric ART.
  iv. Tuberculosis and HIV co-infection
  v. Community Home Based Care
  vi. Care and Support by Traditional Health Practitioners

5.3.1 HIV Testing and Counselling (HTC)

HTC Outcome level results
More PLHIV know their status and seek: % of People aged 2-59 years who know their HIV status has increased from an estimated 20%[64] in 2008 to 70% by 2014.

Situational Analysis: HIV Testing and counselling (HTC) has been identified as the entry point for HIV prevention, treatment, care and support in Swaziland[65]. It is seen as a strategy to empower individuals at a personal level to make informed choices and decisions in seeking appropriate health care. People who do not know their status may delay seeking prophylaxis, diagnosis of opportunistic conditions and enrolment on antiretroviral treatment. HTC services will be provided to increase testing opportunities

and enable people who test positive to seek appropriate care and prevent transmission to their partner/s. HIV testing and counselling (HTC) services will be both provider and client initiated.

Achievements: One hundred and nineteen (119) facilities out of 162 health facilities were offering HTC in 2007. Services are also offered through free standing centres, Voluntary Counselling and Testing (VCT) and Outreach HTC services. In health facilities, HTC is provided as part of clinical care and disease prevention. HTC services have been integrated into outreach health care services to increase availability and access to HIV testing. By 2007, 26.5% (37% women and 17% men) of the population age 15-49 had ever taken a HIV test and had received their results[66]. In 2007 alone, 53,246 people tested of whom 47% were HIV positive[67]. In 2006, the National HTC Guidelines and training manual were developed. A national HTC Core Team/Task Force was formed and operational at decentralised structures. Over 80% of health workers were trained on HTC, based on a standardised manual. A draft HTC Quality Assurance Strategy was developed.

Gaps: The current HTC campaign has primarily focused on the nursing cadre while other cadres are not adequately targeted. Provider initiated testing and counselling was not offered in all health facilities. The SDHS (2007) reports that 65% of women who gave birth during the two-year period reviewed received HIV counselling during antenatal care for their most recent birth. The quality of counselling is not sufficient to effect behaviour change that results in disclosure and access to services. Male uptake of HTC was low as reflected by the 17% of men reporting ever having been tested and received test results for HIV at the same time (SHDS 2007). For both males and females, testing rates are lower among those in rural areas and with less education. Stigma and cultural barriers are believed to be the main cause. The review reported that young people did not find HTC facilities in health settings to be user friendly. Young people said they preferred VCT facilities in the community and preferably to be managed by young people. The review also noted that currently children under 12 years were not receiving testing and counselling services. Problems with distribution of test kits resulted in stock-outs in some facilities. Anecdotal information indicated that low levels of disclosure of status, particularly by women attending antenatal care could be improved by more couple testing and counselling.

Strategic direction: the strategic direction for the NSF for HTC is to promote the concept of people knowing their HIV status and seeking health care as early as possible.

Strategies for the HIV Testing and Counselling Intervention

The NSF focus for the HTC intervention should direct itself to the following strategies:

i. Scaling up HTC service by a) increasing the number of both free standing and provider initiated testing and counselling sites nationwide, b) targeting both key and rural populations, c) improving the ratio of male to female counsellors, d) increasing youth friendly facilities and e) Integrating HTC in reproductive health services and antenatal services.

ii. Expanding the scope for provision of HTC by involving other cadres and groupings in the delivery of HTC including traditional health therapists, PLHIV and communities.

iii. Development of targeted programmes aimed at increasing couple/partner testing and counselling and disclosure of HIV status among spouses and partners.

iv. Strengthening quality assurance for testing and counselling services. Consideration should be given to task shifting some services to lay counsellors.

v. Operationalise task shifting among nurses, coupled with capacity building.

vi. Strengthening advocacy work to improve service delivery and service uptake with special emphasis on hard to-reach places and groups.

5.3.2 Pre-Art and Opportunistic Infections

Situational Analysis: Management of opportunistic conditions (OIs)[68] decreases morbidity and mortality related to HIV infection. Early diagnosis of HIV enables better management of infections and can slow progression to AIDS. The existence of a pre-ART programme also is known to reduce morbidity due to HIV infection and increase the period before clients become eligible for antiretroviral treatment. The most common opportunistic conditions in Swaziland were identified in the 2006 Annual Report on ART Programme as tuberculosis, chronic diarrhoea, herpes zoster, pneumocystis, bacterial pneumonia, Kaposi's sarcoma, oral pharyngeal candidiasis, generalized pruritic dermatitis, cytomegalovirus, cervical cancer and toxoplasmosis. (TB is addressed separately given its epidemic nature). The 2008 NSP review observed that Swaziland's health system has made significant efforts in management of opportunistic conditions. However in some cases those efforts have been undermined by inadequate availability of drugs, particularly at clinic level. Some patients have been referred to hospitals that also did not have the required drugs. The cost of some opportunistic infection drugs appears to be an inhibiting factor to procurement. Also, the central medical stores do not have a budget line for some drugs needed for HIV-related opportunistic conditions.

Achievements: Monitoring data are not available to report on achievements in this area.

Gaps: The country's pre-ART programme is still in its infancy but plans exist for its strengthening. Only seven facilities consistently report on clients who receive pre-ART services so there is significant under reporting of the number of clients enrolled in pre-ART. The pre-ART programme lacks a monitoring system that would track services provided, the number of patients progressing to ART and the average period of progression. The referral system from HTC into care and treatment is inadequate, resulting in many HIV clients not being enrolled into pre-ART.

Procurement of some drugs for the treatment of opportunistic conditions is not consistent and drug stock-outs interrupt the provision of services. There is also inadequate capacity for procurement planning including quantification and forecasting drugs needed for opportunistic conditions. Only doctors are allowed to prescribe certain drugs for opportunistic infections and conditions, yet a majority of the patients are seen by nurses in peripheral health facilities. While this has been the tradition, currently nurses have demonstrated the knowledge and experience to handle some of the prescriptions but operational policy guidelines limit their involvement. In the absence of a vibrant Pre-ART programme, a number of patients start ART too late, with low CD4 cell counts and often very sick, leading to high mortality among patients initiating ART.

Strategic Direction: Introduction of a comprehensive package of care that defines pre-ART services to be made available to PLHIV that would delay the development of symptomatic disease, ensure retention and appropriate progression to ART.

Priority Strategies:
  i. Strengthening systems - primarily those that address registration, monitoring and tracking of clients, and procurement planning of drugs for opportunistic conditions.
  ii. Strengthening linkages and referral systems between the ART programme and other complementary programmes such as HTC and PMTCT
  iii. Policy review in relation to the essential drug list and task shifting

iv. Build and strengthen capacity to transfer skills in the context of task shifting in order to improve diagnosis and enable effective operationalisation of the task shifting concept.

v. Conduct a cost benefit analysis for drugs to treat opportunistic conditions.

5.3.3 Antiretroviral Therapy (ART)

ART Outcome Results
More PLHIV survive longer on ART: % of adults and children with HIV still alive and known to be on treatment 36 months after initiation of ART is increased from 64%[69] in 2008 to 75% in 2011 and 85% by 2014.

Note: It is anticipated that 85% of adult males and females 15 years and above in need of ART and 90% of eligible children (under 15) will be enrolled on ART by 2014. The strategic focus of NSF goes beyond access and enrolment to ensuring adherence and enhancing survival rate.

Situational Analysis: PLHIV are likely to develop AIDS within several years of becoming infected, unless they are provided with ARVs that reduce viral replication and therefore increase the time until their immune systems have been compromised to the extent where they develop AIDS. By 2008, 62,769 PLHIV were in need of ART, compared to 52,909 in 2007[70]. Effective treatment with ARVs will result in numerous benefits including a longer life, disappearance of symptoms, improved quality of life, delayed disease progression and decreased hospitalization. Drug resistance can occur if patients on ARVs do not adhere strictly to their treatment regimens. In Swaziland 64% women and 36% men were accessing treatment and 53% (2,510) of eligible children were accessing ART by 2nd quarter 2008.

Stigmas, fear of abuse and youth unfriendly services remain obstacles for people to access treatment. Some women are unable to disclose their status within their families and to their in-laws for fear of rejection and stigmatisation, and often drop out of treatment. Other women are said to hide their tablets from their husbands in fear of being ostracized, resulting in poor compliance with treatment schedules. Men are said to stigmatise themselves and are afraid to test for HIV. When they test and are found to require ARVs, they default on treatment as they do not want their communities to know that they are on ARVs. Available records also indicate that most men who are on ARVs access treatment from private service providers rather than from the public health facilities.

Youth are said not to be accessing testing because they prefer young counsellors who are not readily accessible in most health facilities. This has impacted negatively their knowledge of their status and accessing the appropriate services, including timely treatment.

Achievements: By September 2008, 30,337 (48% of people in need) people were receiving ART, compared to 13,000 in 2005. 98% of PLHIV on ARVs are on the first line ARV regimen, with the others (2%), on the 2nd line regimen as a result of their inability to tolerate first line drugs and absence of other options.

Provision of ART services has improved with the development of treatment guidelines, protocols and an operational plan. The number of facilities providing ART increased from 17 in 2005 to 29 public and private facilities in 2008. In addition, 40 outreach sites were established and serviced by personnel from the 29 sites. Swaziland has developed a public-private partnership between government and private practitioners. The partnership allows government to purchase and supply ARVs to private doctors who in turn provide ART services for free, and subsequently report to the Ministry of Health. Laboratory services for CD4 counts have greatly improved. The overall quality of ART services has improved

through training more than 40% of health workers (doctors and nurses) working in ART clinics from public and private sites, in integrated management of adult and adolescent illnesses. The introduction of a) early Infant Diagnosis with DNA PCR in some health facilities in 2007; b) fixed dose combination tablets from time of birth; and c) management of malnutrition in HIV positive children and provision of nutritional supplements has improved paediatric HIV and AIDS care and treatment.

Swaziland has also introduced a computerised (electronic) patient and drug management system that enables keeping track of patients on ART and ARV stock levels to prevent stock-outs.

Gap Analysis: Despite the commendable progress, the ART programme still faces a number of challenges. ART service delivery is time consuming given limited delegation to nurses and community health workers. Patients start ART too late when their CD4 cell counts are very low, raising mortality among patients on ART. ART is not yet available in all health facilities and some regions have more sites than others which impacts on equity of services, coverage and adherence. As mentioned above there are some observable gender disparities in accessing ART.

There is relatively poor integration of PMTCT, ART programmes and VCT centres. Claims by some alternative medicine therapists, traditional health therapists and faith healers that they are able to treat HIV and AIDS have had a negative effect on adherence to treatment. The cost of drugs for opportunistic infections is considered to be high. There is also inadequate capacity for procurement planning including quantification and forecasting. As noted in the situation analysis, stigma and denial among individuals, groups and communities results in fear of disclosure by some ART patients, contributing to poor adherence to treatment. Physical rehabilitation needs have largely gone unrecognized or sometimes even been ignored due to lack of information on the links between ART and disability (ART side effects can include a variety of disabling neuropathies).

Strategic Direction for ART: The NSF hopes to increase access to ART by all people in need and improve adherence, retention on treatment, and treatment outcomes.

Priority Strategies:

The following strategies will be implemented to achieve the outcome level results.

   i.   Develop a strategy to strengthen and expand the provision of paediatric ART that would also facilitate building linkages between ART and PMTCT.
  ii.   Strengthen and improve laboratory services for ART, and related services.
 iii.   Roll out ART services countrywide to increase availability and access.
  iv.   Promote community involvement and participation - particularly people living with HIV and other groupings including men, traditional health practitioners (THPs) to play a significant role as treatment partners, expert clients and advocates for ART.
   v.   Strengthen collaboration between TB and HIV programmes, with a focus on integration and coordination of services to optimise the use of resources and increase access to HIV and TB care. The strategies should also strengthen the capacity for testing for HIV and diagnosis of TB at the respective HIV and TB facilities.
  vi.   Develop strategies in critical areas, such as task shifting, to expand service delivery and maximise the use of available human resources to provide comprehensive services.
 vii.   Strengthen support services and system strengthening for procurement and monitoring delivery of services.
viii.   Conduct a national study on gender impact of access to ART
  ix.   Strengthen community strategies for reducing stigma and discrimination.

5.3.4 Management of Tuberculosis and HIV co-infection

TB and HIV Co-infection Outcome Results
Fewer PLHIV have opportunistic infections, including TB: % of smear-positive TB cases registered under DOTS who are successfully treated has increased from 63% in 2007 to 80% by 2014.

Situational Analysis: Tuberculosis is a chronic disease caused by Mycobacterium tuberculosis bacilli, and is spread through the air, when a person with TB disease coughs or sneezes. In Swaziland the TB epidemic is escalating with notified cases rising from 8,664 (781 per 100,000) in 2005 to 9,659 (1008 per 100,000) in 2007. The detection rate for pulmonary smear positive TB cases increased from 44% in 2005 to 57.7% in 2007.The WHO target is 85% TB case detection. The treatment success rate for pulmonary smear positive TB cases remained at a low rate of 42% in 2007[71]. Infection with HIV is currently the most common cause of immune-suppression in Swaziland and people with a TB infection and HIV have a 20-30 times higher risk of developing TB disease during their lives than people without HIV infection[72]. TB is curable with 6 months of treatment done in two phases for new cases. Multi-drug resistance among TB cases (MDR-TB) has emerged with 98 MDR-TB cases recorded[73] in 2007 in the country. The rapid survey on MDR-TB and XDR-TB conducted in 2007 identified some cases of extensively drug resistant tuberculosis (XDR-TB) in the country. MDR-TB and XDR TB are of special concern for persons with HIV infection or other conditions that can weaken the immune system. These persons are more likely to develop TB disease once they are infected, and also have a higher risk of death once they develop TB disease[74]. With MDR-TB, the chance of dying is 30%, and even higher at 50% for XDR-TB[75]. It is imperative that the response to TB/HIV co-infection does not only focus on finding and treating positive cases, but also ensures that no stock-outs of drugs occur, supports patients to adhere to and complete treatment, and actively detects TB cases in communities to prevent drug resistance from spreading.

Achievements: The 2008 NSP II review noted that there has been increased political commitment to TB since 2006, following the Maputo Regional Meeting of Health Ministers on the threat of multi-drug resistant tuberculosis and extensively drug resistant tuberculosis. Efforts have been made to restructure the National TB programme which has resulted in the separation of programme management from clinical management of tuberculosis and the creation of regional coordinator positions. Collaboration between TB and HIV programmes has been established through formation of the TB/HIV national coordinating committee which oversees all TB/HIV collaborative activities. Activities include training TB nurses in HIV Testing and Counselling and TB screening in HIV care settings. ART nurses have also been trained in TB screening. A standardized TB and HIV data collection tool has been developed for capturing HIV-related data in TB facilities. Sixty percent (60%) of all TB cases (5,804) registered were tested for HIV in 2007. These efforts are supported and complemented by development partners and the private sector. Support from the Centres for Diseases Control and the WHO has strengthened case management as well as skills and institutional development. Similarly, private sector companies are also handling cases of TB at their operational levels.

Gap Analysis: Lack of isolation facilities has compromised effective infection control and optimal management of MDR-TB cases. A number of sputum positive patients are not isolated prior to sputum conversion (ie cure, indicated by negative sputum cultures). The review in 2008 reported that capacity of laboratory services was limited and, as a result, 55% of TB cases begin treatment without sputum

smear examination. While the emerging problem of drug resistance is recognised, there is little reliable information on the extent of MDR-TB/XDR-TB. In addition, the country does not have isolation facilities for MDR-TB/XDR-TB cases. There is no robust TB literacy programme to address drug resistant TB and TB/HIV co-infection. Diagnosis of TB in children is a problem. TB treatment is compromised by inadequate TB recording and reporting at all levels. The detection rate of pulmonary TB is too low at 57.7% compared to the WHO target of 85% and the treatment success rate is also low at 42%. Despite the high rate of co infection, HIV testing and counselling services are not routinely offered to patients diagnosed with TB. The involvement of non-health personnel in TB control, prevention and treatment is minimal. Recent studies have revealed that "the combination of antiretroviral treatment (ART) and tuberculosis (TB) treatments could more than halve the mortality rate among patients co-infected with HIV and TB". The country's TB/HIV policy guidelines have not yet fully taken this finding on board to optimize its benefits to the patients.

Strategic Direction for the Management of Tuberculosis and HIV Co-infection: Improve the diagnosis and management of TB/HIV co-infection among patients.

Priority Strategies:

In order to pursue the outcome results stated for this intervention these strategies should be implemented:

i. Sustain political commitment by government with increased and sustained financing for the implementation of a scaled-up DOTS programme and Stop TB Strategy.
ii. Strengthen active and passive TB case detection.
iii. Increase the cure rate to at least 85% of TB cases, leading to a decline in rates of TB cases and deaths
iv. Strengthen active collaboration between TB and ART programmes and facilitate integration of services where practical.
v. Provide adequate, skilled and competent human resources to provide comprehensive services.
vi. Strengthen partnerships between the NTBP and other stakeholders including traditional health practitioners, communities and civil society organisations.
vii. Strengthen provider-initiated testing and counselling for HIV as part of all TB services.
viii. Initiate a multi-sectoral community mobilisation for TB/HIV treatment literacy.
ix. Support health and community systems strengthening to enable monitoring of all TB services.

5.3.5 Community-based Care and Support, Palliative and Rehabilitative Services

CHBC and Palliative Care Outcome Results
More PLHIV are cared for in their communities: % of households with vulnerable persons who have reported that the CHBC services that they have received in the past 12 months were timely, relevant, comprehensive, and of good quality is increased to 80% by 2014.
More PLHIV with advanced HIV infection are managed: % of people who are chronically ill who have received palliative care is increased to 50% by 2014.

Situational Analysis: Community-based care and support (CBCS) services are meant to alleviate the burden of care in health facilities given the impact of HIV and AIDS and other chronic illnesses. CBCS services are provided through clinic home based care nurses and community health workers (Rural Health Motivators (RHM) and community Care givers from NGOs and support groups). CBCS materials are usually sourced from Tinkhundla CBCS containers, Hospice at Home and health facilities. These materials include latex gloves, detergents, soap, Vaseline, disposable napkins, bandages, first aid medication (e.g. panado, oral rehydration salt) and in some cases food supplements. The family care givers concept has recently been introduced and is being piloted in Sithobela Inkhundla, to address the problem of turnover among community carers and volunteers. There is risk of infection with TB when supporting TB patients if the carer does not apply universal precautions.

Palliative Services: Palliative care helps to improve the quality of life of patients and their families through prevention and relief of suffering by early identification, assessment and treatment of pain and other problems including physical, psychosocial and spiritual concerns (WHO). In health facilities, provision of palliative care is compromised by existing guidelines. None of the existing clinics (and only some hospitals) can carry out pain management for the most common opportunistic conditions (Herpes zoster, peripheral neuropathy, skin cancer-Kaposi's Sarcoma, cervical cancer and meningitis) given that most clinics cannot prescribe certain drugs. Provision of palliative care outreach services is very limited in the country.

Physical Rehabilitation Services: Physical rehabilitation of PLHIV has become an urgent priority with the rise in side effects (a variety of disabling neuropathies) as a result of ART drugs. Rehabilitation of such patients improves their quality of life while continuing on ART. Rehabilitation services are currently provided at one facility only.

Achievements:

Community-based Care Services (CBCS): There were 5,443 home based care clients of whom 40% were men and 60% women by the end of first quarter 2008. Swaziland has developed a manual for supervisors of community health workers and Community-based Care Guidelines with the intention of improving quality of services. CBCS include support for community-based initiatives such as gardening, managed by support groups to improve household food security. CBCS has provided a good entry point for community mobilisation and support for clients who are on ART. CBCS also provides an opportunity for PLHIV participation in the response to HIV and AIDS as volunteers, peer educators or expert clients. The MOH Environmental Health Department is piloting a double pit latrine initiative (using 1000 latrines) where the pit latrine would also be used for waste disposal management. CBCS has attracted partnerships with community-based and civil society organisations. These partnerships will strengthen government's working relationship with civil society and other community-based organisations not only to implement CBCS programmes but also to empower communities to cope with the challenges of HIV and AIDS.

Palliative Care and Physical Rehabilitation Services: The review of the NSP in July 2008 did not identify any documented achievements in the area of palliative care or rehabilitation services since 2005

Gap Analysis: the joint review of the NSP II identified the following gaps

CBCS: There is lack of data and documentation of CBCS activities as a result of the lack of a proper monitoring system and the lack of capacity among CBCS service providers, combined with the fact that most of them are volunteers who have no obligation to produce reports. Coordination of CBCS was identified as problematic and ad hoc, while the referral system is weak and uncoordinated as result of

lack of adequate patient discharge planning and the absence of linkages between the caregivers and health facilities. CBCS is inadequately resourced and hence provision of comprehensive and quality services is compromised. Male involvement in CBCS services is low only 2% of volunteers are male. The burden of care on girls and women is likely to contribute to burnout which will subsequently compromise the health of girls and women. Availability, access and distribution of CBCS materials to all stakeholders has been limited and largely compromised by lack of adequate management and coordination systems.

Palliative Services: Palliative care services are limited to a few health facilities and resources are not available to improve palliative care service. In health facilities, provision of palliative care is compromised by lack of guidelines.

Rehabilitation Services: Due to a lack of understanding, little attention is paid to rehabilitation services. Services are not widely available and accessible to people who need them. This is an area that is equally under-resourced.

Strategic Direction: Provision of a continuum of quality care and rehabilitation services for people in need of such services.

Priority Strategies:

The NSF strategies for this intervention are:

   i.   Finalise and disseminate the guidelines for coordination of CBCS services at the various levels. The dissemination should be coupled with support to stakeholders to operationalisation the guidelines.
  ii.   Identify and develop programme interventions that reduce the burden of care on girls and women and increase involvement and participation of males in the provision of care at the community level.
 iii.   Strengthen linkages and referral systems between health facilities and community home based care services.
  iv.   Strengthen capacity for caregivers to apply universal precautions for protection while providing care and support.
   v.   Promote the concept of family members being carers for people at home with an emphasis on encouraging men to become caregivers.
  vi.   Strengthen the provision of CBCS materials and other supplies, through a decentralised mechanism to ensure easy access and availability at community level.
 vii.   Expand rehabilitation services to all four regions. This is an area where potential for public-private partnership could be explored especially with civil society organisations.
viii.   Improve and strengthen procurement, logistics and distributions systems for home based care services materials.

5.5.6 Care and Support for Healthcare workers

Care and Support for Health Workers Outcome Results
Healthcare workers are able to cope with the demands of their job: *% of health care workers requiring psychological support services is reduced.*

Situation Analysis: The NSF defines the health sector as including people and organisations in public, and private sectors including traditional health practitioners who provide some form of health care. Healthcare workers are pivotal to the success of the national response to HIV and AIDS given that many interventions are health sector based. However, in Swaziland's hyper-epidemic, the health sector is overwhelmed with the provision of care and support. Given the work load, health care workers often suffer from psychological trauma associated with dealing daily with severely ill patients and potential deaths. In-spite of the role they play, there are few programmes that provide care and support to them
.
The Psychological Care and Support unit of the Swaziland National AIDS Program (SNAP) is tasked with providing psychological support to health workers. However, the unit is focused on health workers in the public sector only, not the whole health sector. For health workers across the health sector to continue providing quality HIV services, both their physical and psychological well-being must be addressed adequately.

Achievements: The provision of psychological support to healthcare workers was initiated in 2005 with the establishment of the Psychological Care and Support Unit under the Swaziland National AIDS Program (SNAP), under the Ministry of Health and Social Welfare. Psychological Care and Support Guidelines and a training manual have been developed; individual counselling sessions are being offered for public health care workers in addition to debriefing sessions; stress management retreats and exchange visits. Training and refresher courses have been conducted. By 2008, approximately 630 healthcare workers had received psychological support

Gap Analysis: The coverage of psychological support is limited given that there are only four Psychologists. Psychological Support is under resourced compromising its ability to provide adequate services.

Strategic Direction: The NSF strategic orientation in providing care for carers is to support institutionalisation of services and service roll out in the entire health sector.

Priority Strategies
- Develop and disseminate policy guidelines on the provision of psychological support for carers.
- Develop appropriate programmes on psychological support and advocate for increased resources to support the programmes.
- Strengthen technical skills to provide quality and comprehensive psychological support.
- Coordinate the health sector workplace wellness program

5.3.7 Care and Support by Traditional Health Practitioners

Situational Analysis: There are over 8,000 traditional health practitioners in the country. It is estimated that over 80% of Swazis use their services. Traditional Health Practitioners (THP), herbalists and faith

healers refer patients to facilities and also receive self-referring patients from health facilities. The NSP Joint Review 2008 noted that some people opted out of ART in favour of care and support from traditional health practitioners and substituted ARVs with other therapies. This could compromise treatment adherence and cause drug resistance. The views and opinions of traditional health practitioners matter to Swazis and their involvement is key to a successful multi-sectoral response to HIV and AIDS. Traditional Health Practitioners can support STI and HIV prevention, care and treatment[76]. The 2008 draft collaborative framework between MOHSW and traditional healers concurs with this notion, and further suggests that traditional healers can play a critical role in identifying signs and symptoms of HIV infection and encouraging their clients to go for HTC and engage couples and family members to assist pregnant women to be tested so that they can access PMCTC. There is potential for traditional healers becoming ART and TB supporters to promote and support adherence and provide ongoing counselling to their clients, distributing condoms and advocating for increased access to PMTCT and for male involvement.

Achievements: The Swaziland Government has drawn in this sector by involving the traditional health practitioners association in the NERCHA Council, Global Fund Country Coordinating Mechanism, and ensuring their representation in other HIV-related Technical Working Groups. MOH has developed a draft framework for collaboration between the health sector and traditional health practitioners. MOH has also reviewed the Swaziland National Pharmaceutical Policy (SNPP) to incorporate a provision for the establishment of a Medicines Regulatory Authority and a Pharmacy Council that would be responsible for the regulation of the pharmaceutical profession and all aspects of medicine including traditional remedies / alternative therapies.

Gaps: The draft collaborative framework with traditional health practitioners and revised SNPP have not been finalised, and have caused delays with setting up the Authority and the Council. A key concern with alternative therapies is quality assurance as currently there is no mechanism for this or to control their importation in Swaziland. The joint review noted that some traditional health practitioners had received some training on HIV. However there is no documented evidence on who was trained and areas of training covered.

Strategic Direction: Strengthening collaboration between traditional health practitioners and the health sector in the provision of care and support services.

Priority Strategies:

The strategies for the NSF in the area of care and support by traditional health practitioners are:

i. Accelerate the finalisation of the framework for cooperation and collaboration between traditional practitioners and the health sector.
ii. Facilitate the establishment of a regulatory body for the practice of traditional health practitioners and setting of a liaison office for traditional health practitioners' in the Ministry of Health.
iii. Strengthen the capacity of traditional practitioners to provide quality services in respect of HIV/TB co-infection to their clients as agreed between them and the Ministry of Health and Social Welfare.
iv. Facilitate the registration of all traditional health practitioners in the country.

5.3.8 Coordination for Treatment, Care and Support

Coordination of treatment, care and support will adopt a multi-sectoral approach and apply the three ones principles. From a multi-sectoral perspective the involvement of all stakeholders active in this thematic area will support successful implementation of the planned activities. The key stakeholders in this thematic area include government health institutions under the Ministry of Health, private sector, traditional health practitioners, civil society organisations, bilateral and multilateral development partners.

The Ministry of Health, by virtue of its technical responsibility will need to play a major coordination and management role of the thematic area. The Ministry has designated **Swaziland National AIDS Programme (SNAP)** as the coordinating unit for health sector-based HIV and AIDS programmes.

At national level the multi-sectoral **Clinical Technical Working Group** (CTWG) will continue to provide technical guidance on the health sector response at national level. Members of the technical working group are technical experts representing key stakeholders. The CTWG will continue meeting quarterly during the period of the NSF. The key role of the CTWG is development of programme policies, technical guidelines and protocols, standards, operational manuals in order to ensure compliance with the set quality standards. Where necessary the CTWG will recommend to the Ministry the establishment of other health sector based programme technical sub committees as need arises.

For efficiency and effectiveness, technical sub committees have been established and where they don't exist and are considered essential they will be formed during the period of the NSF. Currently technical Sub Committee's exist for Pre-ART, ART, HTC, HIV-TB Co-infections and Nutrition. The Technical Sub Committees will play a key role in programme development and operationalisation of policies and technical guidelines in addition to ensuring adequate information dissemination on critical issues to all stakeholders. The technical working groups and sub committees will be decentralised to the regions as appropriate.

5.4 Impact Mitigation Programmes

The impacts of HIV and AIDS are felt across all sectors of society and economy. The impacts at household, homestead, and community levels, are reflected in growing food insecurity, deepening poverty, narrowing of livelihood options, loss of socio-economic support networks, and weakening of delivery systems intended to support livelihoods improvement (FARNPAN, 2007; WFP, 2007). One-fifth of the population is chronically reliant on food aid, and 30% of the rural population is reported to be food insecure (World Bank, 2007).

The epidemic has increased mortality and morbidity. The National Plan of Action for OVC estimates the number of vulnerable children to be 130,000 of whom 70,000 are orphans. In the 2005/06 Budget speech, the Minister of Finance in Swaziland stated that high unemployment, food insecurity and HIV and AIDS had together resulted in a 3% increase in poverty in the last fiscal year. The latest estimate of life expectancy is 40.2 years (40.4 for women and 39.9 for men)[77]. It is anticipated that the annual population growth rate will decline from 2.9% in 1997, to about 2.1% by 2015. AIDS is robbing communities of their bread winners, leaders and the knowledge and skills necessary to sustain livelihoods. Because of this, HIV threatens traditional family and community coping mechanisms (safety nets) and food security[78] [79]. Swazi families are organised around a homestead system, with multiple

households living in a single compound (or within a limited geographical area around a main compound. The homestead system offers support to extended family members, a mechanism to protect households from social and economic challenges that could undermine livelihoods.

As more people succumb to the epidemic, a vicious cycle is created - the capacity to absorb and utilize existing resources for socio-economic development is reduced contributing to deepening poverty. Increased expenditures on health care and funerals, and lower income (due to morbidity) reduce personal savings and investment, and increase overall health care and labour costs[80]. The Gini Coefficient shows a sharp rise in income inequality to 60.9 on a scale of 1 to 100 (with 1 representing full equality and 100 full inequality), from 51 less than a decade earlier (World Bank, 2007).

Although it is difficult to measure the specific impact of HIV and AIDS on agriculture, it is generally accepted that the epidemic is reducing productive capacity through people falling sick and becoming unable to work as well as through absenteeism to attend funerals or provide care. The cost of replacing highly skilled personnel is high, especially in skills-scarce economies such as Swaziland. AIDS is reversing the socio-economic gains since independence[81], compromising investments in health care, education, agriculture and human capital.

The NSF will target selected vulnerable groups including the OVC, PLHIV and the elderly. The interventions focus on the root causes of vulnerability, and factors that undermine the ability of vulnerable persons to positively cope with their situation.

OVC are the most visible impact of the epidemic in the society today. Their need for care and support exceeds family and community capacity to deliver. Some of the critical needs of OVC include support for education, psychosocial support, food and nutrition, health care, protection and socialisation. The Government of Swaziland has developed a National Plan of Action for Orphans and Vulnerable Children 2006 – 2010. The plan's objectives and strategies are consistent with the NSF and hence its implementation will contribute to the realisation of the NSF results. A key strategy of both the NAP and NSP is to ensure that adolescent OVC are enrolled and retained in schools in addition to being provided with HIV and AIDS life skills education.

While PLHIV are receiving ART and nutrition, psychosocial and impact mitigation needs have not been adequately addressed. The challenges include issues of stigma and discrimination, loss of income and increasing food insecurity.

The impact of HIV and AIDS on the elderly has been two-pronged. First, the elderly have suffered loss of care through the death or incapacitation of their own children who previously provided care and support to them. As they lose their bread winners they experience deepening poverty and inability to meet basic needs. On the other hand the elderly are increasingly assuming the role of caregivers for their own children who are sick, or grandchildren whose parents have died. Many elderly persons no longer have the ability to work and neither do they have income to support the OVC. External support is limited, ad hoc and short term. In most cases the support is provided on the basis of the presence of OVC they support and not to meet their own needs.

The broad goal of NSF impact mitigation programme is to reduce the socio-economic impact of the epidemic on homesteads, communities, families and individuals. The interventions aim to strengthen the capacities of individuals, families and communities dealing with the socio-economic impacts of HIV on vulnerable groups.

Strategic data on these groups and impact mitigation interventions will be collected through Quality of Impact Mitigation Services (QIMS) surveys. QIMS will be institutionalised under the M&E framework. The impact mitigation programmes will contribute to the following impact level result.

Impact-level results	% of households with vulnerable individual/s[82], that are able to cope with the impact of HIV[83] is increased from 72% in 2008 to 80% by 2014[84].
	% of households that report that all the services they received were relevant, timely, comprehensive and of good quality has increased to 70% by 2014

The NSF has prioritised the following programmes for the impact mitigation thematic area:
   i.   Food and Nutrition Support
   ii. Education Support for OVC
   iii. Protection and Socialisation of OVC
   iv. Psychosocial Support
   v.   Community Systems Strengthening

5.4.1 Food and Nutrition Support for Vulnerable Households

Food and Nutrition Outcome Results
% of children under five who are stunted is reduced from 29% in 2008 to 25% in 2011 and to 20% by 2014
% of women and men aged 15-49 whose BMI is <18.5 has reduced from 3% for women and 10% for men in 2007 to 1% for women and 5% for men by 2011 and 1% for women and 3% for men by 2014.

Situation analysis: Swaziland has experienced several successive years of below average agricultural production. This has a direct impact on food and nutrition support for vulnerable households and employment for the majority (80%) of the population[85]. While the decline in agricultural production is mainly attributed to drought and erratic weather conditions, HIV-related factors play some part: loss of productive members of the family to AIDS leaving behind female- and child-headed households and an increased number of orphans. The loss of productive members of households has reduced production and household income. Illness and deaths have also reduced the land under cultivation thereby increasing food insecurity and HIV vulnerability at household and at community level[86]. As food insecurity at household increases so does malnutrition, and vulnerability to opportunistic infections. In 2008 The Vulnerability Assessment Committee Survey estimated that 28% of Swazi population was classified as vulnerable and food insecure[87]. OVC, the elderly, PLHIV and widows are among the most vulnerable.

Overall the nutritional status of Swazi children has not changed over the past six years. The 2007 Swaziland Demographic and Health Survey found a national prevalence of stunting of 29%, wasting of 3% and underweight of 5%. Similar figures were reported for these anthropometric indices in 2000 (Multiple Indicator Cluster Survey). There are disparities between urban and rural children, children from rich and poor households, and children orphaned by AIDS. Urban children (23% stunted) are less likely to be stunted than their rural counterparts (30% stunted). Stunting among children of the

wealthiest quintile is 17% compared to 38% for the poorest. Eleven percent of OVC are underweight compared to seven percent of non-OVC.

Malnutrition is likely to accelerate disease progression, and increase morbidity and mortality. Three factors contribute to malnutrition in patients with HIV and AIDS: inadequate intake of food, nutrient mal-absorption and increased energy expenditure[88]. The food and nutrition status of OVC (particularly the under fives), the elderly and PLHIV is an important area of focus by NSF. Malnutrition in children negatively affects their physical and cognitive development[89].

Achievements: The programme interventions under NSP II increased access to food for OVC through NCPs, KaGogo Centres, school feeding programmes, food gardens and a revival of the tradition of food production by the chief for disadvantaged members of society. Food distribution by development partners improved access to food for vulnerable households. Significant progress was made to improve breastfeeding and provision of micronutrients to eligible age groups. Efforts were also made to target food distribution to households with PLHIV. To strengthen nutrition initiatives Swaziland has established a National Nutrition Council.

Gap Analysis: The policy environment for improving nutrition for all vulnerable children, PLHIV and the elderly is inadequate. While the Nutrition Council is in place, the Food and Nutrition policy is yet to be finalised. Efforts to provide food and nutrition support to OVC through KaGogo Centres and Neighbourhood Care Points (NCPs) did not adequately support their elderly caregivers. In the case of PLHIV, food and nutrition remain a major gap in efforts to improve their quality of life. Of particular concern is the effort to improve provision of micronutrients and address malnutrition of PLHIV. Similarly efforts to improve food security especially in households with PLHIV need to be strengthened.

Strategic Direction: NSF will focus on improving food security and nutrition of key target groups children, PLHIV and the elderly.

Priority Strategies:

   i.   Develop quality standards for impact mitigation services.
  ii.   Strengthen school feeding programmes.
 iii.   Strengthen provision of food and micronutrients to children out of school in particular through the KaGogo Centres and NCPs and to PLHIV and the elderly. These efforts should also include nutrition counselling for PLHIV.
  iv.   Strengthen the capacity of relevant sectors and in particular the Ministry of Agriculture and the Nutrition Council to support improved food security at household and community level.
   v.   Develop effective strategies for monitoring nutrition status of PLHIV and Under Fives in health settings and at community sites.
  vi.   Strengthen the policy environment for improving sustainable production of food at community level. Finalisation and implementation of the Food and Nutrition Policy is critical to create an enabling environment for sustainable food security and nutrition.

5.4.2 Educational Support for OVC

Educational Support Outcome Results
School attendance among orphans and non orphans aged 10-14 is increased from 92% for orphans and 91% for non orphans in 2007 to 95% for all children by 2011 and maintained at 95% by 2014.

Situation Analysis: Swaziland has performed relatively well in facilitating access to primary education for children. By 2007, 90% of double orphans and 93% of non-orphans were attending school. However, the gross attendance ratios (GARs) for primary school[90] for males and females exceed 100 (males 123 and females 116), and GARs for secondary school are low. It was noted during the consultations for the NSF that low enrolment at secondary school was due to several reasons including high rates of school dropout due to economic hardship, girls' pregnancy, high cost of secondary education, and inadequate infrastructure for secondary schools particularly in rural schools. Consequently retention of children in school remains a challenge.

The joint review indicated that child grants for education support can improve enrolment and retention of children in school. The review further noted that grants targeting secondary school levels are especially helpful given the higher costs of fees, books and other supplies[91]. Though data are scanty, HIV-related morbidity and mortality of education personnel have resulted in the quality of education being compromised.

Strategies for OVC education should start with Early Childhood Care and Development (ECCD). This is an important stage in a child's development and yet it is the least developed. This is a critical period when the child's brain develops to 90% of its capacity and extra attention is required for a child to successfully make the adjustment into formal schooling[92].

Of the 10% of children not attending school, some are orphans or vulnerable children, including some who head households. Few programmes exist that address their needs. However, the Sebenta programme provides the opportunity to teenage mothers to go back to formal education after delivery. It is worth noting that Swaziland's constitution ratified in 2005 includes a clause providing that within three years of adoption of the constitution all children would have the right to free primary school education.

Achievements: 90% of OVC attend school (2008). School grants and materials (uniforms, shoes and books) support were being provided to OVC. According to the SDHS (2007), 35% of OVCs under the age of 18 received school-related support. School feeding programmes were introduced, contributing to better performance in schools. Government funding for the education sector increased from E16 million in 2003, to E47 million in 2007[93] and is E130 million for 2009. Out-of-school children were provided with opportunities for basic literacy skills[94] outside the formal school system.

Gap Analysis: 10% school-aged OVC are not in school. For the 90% enrolled, retention strategies are inadequate and not comprehensive enough, consequently absenteeism and school drop-out are challenges. The ECCD programme which serves as a strategic entry point for primary education is under-developed and under-resourced. The ECCD strategy and policy is still in draft form.

Poverty and economic hardships continue to negatively impact access to secondary education. On the other hand, the supply of adequate infrastructure for secondary level education remains a major gap.

Although data were not disaggregated by level of education, only 35% of children under the age 18 received school related support.

Strategic Direction: The NSF strategy is to expand and sustain enrolment and retention of all children (including OVC) in ECCD, primary and high school.

Priority Strategies:

  i.   Political commitment to improve enrolment and completion in ECCD, primary and secondary school levels through policies and allocation of resources.
 ii.   Facilitate the finalisation of the ECCD strategy and policy document.
iii.   Develop strategies to improve the quality of education.
 iv.   Strength and expand strategies for retaining children, in particular girls, in school.
  v.   Expand the opportunities for out of school learning including vocational training for out of school youth aged 19-24 years.
 vi.   Provide Child Grants for support at high school level education for OVC
vii.   Advocate for development partners to provide block grants to high schools to cover tuition, books, stationary and other needs. Block grants give financial resource to a school as opposed to an individual child. Such support could include: construction of classroom blocks, provision of text books, desks and chairs.

5.4.3 Socialisation and Protection of OVCs

Socialisation and Protection of OVCs Outcome Results
% of OVC aged between 10-14 whose three basic needs[95] have been met, is increased from 60% in 2007to 70% in 2011 and 80% by 2014.

Situation Analysis: The future of a child is greatly influenced by their childhood experiences and socialisation. Traditionally socialisation takes place in a family environment supported by the larger family and community social network. AIDS has orphaned many Swazi children at a very early age denying them the opportunity to benefit from parent or close relatives. AIDS is equally dismantling traditional safety nets that serve as backup systems for OVC. Consequently OVC lack basic life skills, moral guidance and their opportunity to develop self esteem is diminished. Their primary source of knowledge on reproductive health, relationships and positive cultural norms that constitute a self defence mechanism for children is lost when parents die. In the absence of a parental figure to impart such knowledge, orphans may grow up poorly socialised or even delinquent[96]. This challenge is compounded by a lack of adequate Early Childhood Care and Development (ECCD) programmes[97]. Child socialisation has significant impacts on children's education, social standing among peers, and ability to cope in a world with AIDS, poverty, and without parents. Many OVC are left vulnerable and un-prepared to cope during their passage from childhood through adolescence. This situation, compounded by poverty, makes them more vulnerable to HIV.

OVC are vulnerable to abuse, emotional, sexual and physical violence. In 2007, a study by UNICEF found that one in three females experienced some form of sexual violence.[98] The Swaziland Demographic Health Survey (2007) also indicated that 9% of OVC compared to 6% of non OVC children had sex before the age 15. The UNICEF study indicated that among 13-17 year old females, 10.6% described their first sexual experience as either coercion or rape. One in four females experienced physical violence as a child and approximately three in ten females experienced emotional

abuse as a child. Among 13-17 year old females the prevalence of physical violence by an adult prior to age 18 was 28.1% compared to 22% among 18-24 years. The research findings by UNICEF and SHDS (2007) were confirmed by the recent impact mitigation services survey by NERCHA, in which 40% of OVC had been hit with an item such as a belt and 78% shouted, yelled or screamed at[99]. Other studies have noted that OVC are often neglected and sometimes dispossessed of their parents' property.

A critical challenge for OVC is lack of access to "access documents" such as birth and marriage certificates that are essential for their protection and to enable them to access education and health care, and secure their inheritance.

Achievements: Swaziland has developed a number of initiatives that support programmes for child socialisation and protection. An OVC Programme of Action is in place. Swaziland is a signatory to the UN Convention on the Rights of the Child. A National Children's Coordination Unit has been established at the Deputy Prime Ministers Office indicating the importance the government attaches to the welfare of children. In collaboration with other development partners, the government is working towards having all children obtain a birth certificate and secure marriage certificates for their parents in case the parents are dead.

At community level, institutions such as the KaGogo Centres and NCPs are in place to provide services to OVC. A key component of community level interventions is availability of an OVC caregiver and shelter.

Gap Analysis: Despite the existing institutions, protection and socialisation services are inadequate, and not readily accessible by OVC. There are no specific socialisation and protection programmes that target OVC. The referral system between service providers is inadequate and under-utilised. Although child abuse of any form is prohibited, the capacity to monitor violations and to enforce existing laws is inadequate.

Strategic Direction: The NSF will promote and adopt a family- and community-centred focus in social protection of orphans and vulnerable children, in strengthening existing socialization and protection systems for OVC and designing new innovative programmes to expand such services. Pre-requisite capacities and systems will be strengthened to ensure that families and communities are able to effectively play their role in OVC protection.

Priority Strategies:

i.   Develop an advocacy strategy focusing on the rights of the child.
ii.   Strengthen existing institutions and community structures that promote and support socialisation and protection of OVC.
iii. Strengthen the referral system between service providers.
iv.   Strengthen the national database on child abuse and domestic violence.
v.   Develop a national programme for child protection that takes cognisance of the issues and rights of the child as contained in the CRC.
vi.   Strengthen programmes for in- and out-of-school children for life skills development, incorporating ECCD.
vii. Ensure that all OVC have at least a shelter and a caregiver.
viii. Strengthen school-based child protection programmes.
ix.   Strengthen the monitoring system for OVC receiving support under the HIV and AIDS socio-economic impact mitigation programme.

    x.   Strengthen strategies to address gender based violence and economic empowerment for women and girls

5.4.4 Psychosocial Support

Psychosocial Support Outcome Results
% of vulnerable persons who needed psychosocial support[100] and who did not received it is reduced to 20% by 2014.

Situation analysis: The psychosocial impacts on orphans and vulnerable children have been noted to compromise their physical and psychological development[101]. Available evidence (SDHS 2007) indicates that children are exposed to conditions that they are not psychologically prepared for and consequently experience trauma and depression. Close to 8,000 children live in households where at least an adult died or had been very sick[102]. The impact of losing parents or living with sick parents is compounded by pressures from the external environment including being extremely vulnerable or exposed to sexual exploitation and abuse, child labour, early sexual debut, teen pregnancies, poor attendance and performance in school, poor physical and mental health[103]. Children living with HIV and AIDS also experience stigma and discrimination at school, in the community or at home.

HIV also has a negative psychosocial impact on caregivers, including elderly people providing care and support for PLHIV. Many of them have assumed the roles of parenthood, caring for OVC and also for their own adult children who have fallen sick and need care.

PLHIV also go through moments of trauma, depression and sometimes feel hopeless. This is worsened by stigma and discrimination related to HIV and AIDS.   For these reasons, provision of comprehensive psychosocial support to OVC as well as to caregivers, the elderly and PLHIV is a strategic component of the national response. The interventions are aimed at improving the psychosocial well being of people affected by HIV and AIDS, making them more resilient to the impacts and challenges they face.

Achievements: Psychosocial support has been adopted as one of the core national strategies for responding to HIV and AIDS. In 2007, UNICEF supported a national survey on Psychosocial Support for Children in Swaziland. During implementation of the NSP-II, psychosocial support services were provided to vulnerable groups. About 10,000 caregivers from 360 chiefdoms and religious organisations provided counselling services to individuals in need. Some caregivers were trained (University of Natal) in psychosocial support. Efforts have been made to mainstream psychosocial support in home based care with support from the Regional Psychosocial Support Initiative (REPSSI). A Psychosocial Support Manual and training kit were developed in 2006. A National Psychosocial Curriculum has been drafted. A National Psychosocial Support Strategy 2008-2010 is also in place. The government of Swaziland has established the National Children's Coordination Unit in the Deputy Prime Ministers Office. Efforts are underway to integrate Early Childhood Care and Development (ECCD) and psychosocial support.

Gap Analysis: Demand for psychosocial support exceeds supply. Given the increasing demand, the need for scaling up services and quality assurance has also been identified. Mental health issues are not adequately incorporated in the psychosocial services provision systems and in the training of psychosocial service providers. The Joint review of the NSPII recommended involving mental health personnel in training counsellors, creating baseline data for groups in need of the services, and tracking

service recipients. Given that many OVC spend most of their time in school, strengthening the capacity of teachers to address the psychosocial needs of children is critical.

Strategic Direction: Scaling up quality psychosocial services in schools and expanding coverage in the communities to ensure adequate reach to other people in need including the elderly, caregivers, and PLHIV themselves.

Priority Strategies:

    i. Support the implementation of the national psychosocial support strategy.
    ii. Strengthen the capacity of schools and community caregivers to provide quality and sustained psychosocial support services.
    iii. Strengthen capacity of carers at NCP and KaGogo centres. This is particularly important in ensuring psychosocial support for out-of-school OVC.
    iv. Increase coverage of psychosocial support services to elderly and other vulnerable caregivers, OVC and PLHIV.
    v. Incorporate mental health issues in psychosocial support services.
    vi. Train psychosocial service providers to improve quality of services and also increase the numbers of qualified psychosocial service providers.

5.4.5 Community Systems Strengthening for Impact Mitigation Services

Community Systems Strengthening Outcome Results
% of households that have had to implement coping mechanisms to deal with financial shortages is reduced to 20% by 2014.

Situation analysis: Meaningful community engagement and participation in the HIV response are critical to the success and sustainability of interventions[104]. Communities are involved in a number of ways including being service providers and service beneficiaries. Participation is through organised community groups such as support groups or as individuals as is the case of caregivers.

Community participation has two core objectives. First, the communities are working towards improving the quality of life of people living with HIV and AIDS through care and support. Secondly they are initiating community-based interventions aimed at mitigating the socio-economic impacts of the epidemic not only on affected individuals also on the general community. Community-based structures and systems have been developed to support community interventions within the broad context of community development. The key institutions include the Chief's kraal, KaGogo centres and NCPs. It is through these structures that involvement of community leaders (Chiefs, Headman, Bandlancane, Tidvuna Telutsango, Bagijimi) has been promoted.

Capacity building and strengthening of community leadership, traditional community coordination and operational systems, and structures are vital to the success and sustainability of community-based HIV and AIDS response[105]. A key focus of community systems strengthening has been to develop systems that allow for adequate, equitable and sustained provision of services aimed at care and support and impact mitigation. Second, a core component of community systems strengthening is building the skills and competencies of community-based service providers and in particular caregivers, both formal and informal. Most of the services providers termed as formal operate under the auspices of organised

institutions such as community based organisations (CBOs), faith based organisations (FBO), or support groups of people living with HIV or home based care support groups. Informal service providers are usually community volunteers and family members such as the elderly providing care and support to their own relatives.

The majority of OVC and PLHIV caregivers are women, accounting for two thirds of all caregivers in Africa. Women also constitute 70% of the worlds' poor[106]. In Swaziland the majority of caregivers are community based and a significant number are elderly. The heavy demand for care at the community level --in homes, at Kagogo Centres and NCPs and through other community groups offering care services to sick and OVC-- often leave caregivers in stressful and depressing conditions that can also lead to burn out. It is anticipated that by strengthening community systems, caregivers will be able to access psychosocial support easily.

A key component of strengthening community systems is strengthening sustainable livelihood systems. These range from increasing household incomes, building and strengthening life skills to strengthening food security. It is anticipated that by focusing on key and effective sustainable livelihoods, community initiatives will eventually support poverty alleviation, and help households to shift from being vulnerable to being able to meet their basic needs including nutrition, shelter, sanitation, access to health care and education. Apart from focusing on vulnerable households, the NSF will also pay special attention to promoting sustainable livelihoods for adolescent OVC. The Swaziland Poverty Reduction Strategy Action Plan (Volume1) notes that enabling the poor to earn their own income is the most sustainable approach to poverty reduction. Improving the poverty status of households and communities could build a supportive environment

Achievements: Swaziland has established government and non-government community structures that are providing care and support for vulnerable households and people. Among them are KaGogo Centres and Neighbourhood Care Points. CBOs also operate complimentary services through their own systems and structures. Community-based coordination committees exist and work in a multi-sectoral environment. KaGogo centres serve as coordination centres for impact mitigation services. The *Lutsango Lwaka Ngwane* (women's "regiments" and community volunteers) have transformed themselves to be caregivers to OVC. They care and support OVC at the homestead level. As of 2007, in 279 communities, there were 3,301 caregivers responsible for 33,733 OVC.[107]

In the context of impact mitigation, cash grants are being provided, the Junior Farmer micro-credit Scheme has been initiated, and community members have started backyard gardens. Micro projects on livestock and crop production have been initiated in addition to other income generating activities. Government agencies, in collaboration with other development partners, are providing shelter and water and sanitation for vulnerable households.

Gap analysis: Community participation in decision making and planning for interventions at community level has been limited. Capacity building, planning and budgeting for community-based interventions are mostly externally driven. This is attributed to lack of capacity and inadequate systems at community level.

Strategic Direction: The strategic direction for the NSF is to strengthen community systems to enable communities to take ownership and responsibility for planning and implementation of community-based interventions. Strengthening community systems will focus in three critical areas; i.e. community-based institutions, community leadership, and strengthening skills and competencies of community members in respect of their functions.

It is anticipated that through improved and strengthened community systems, the number of households considered as vulnerable will be reduced. Improvements in poverty, health care, nutrition and education could potentially contribute to improved life expectancy.

Priority Strategies:

i.   Develop a minimum package of impact mitigation services that should be provided to all vulnerable communities.
ii. Review and strengthen community structures such as CHIMSHACC, and KaGogo Centres to play a more pro-active and effective role in coordination and facilitation of community level identification and planning of HIV and AIDS response initiatives that are focused on community priorities and solutions.
iii. Strengthen community skills for monitoring their initiatives and reporting back to their coordinating structures.
iv. Expand the scope and mandate of community-based institutions such as KaGogo Centres and NCP to address broader socio-economic community challenges.
v.   Support communities to develop and operationalise sustainable livelihoods that mitigate the impacts of HIV and AIDS, and poverty.
vi. Train communities in result based management approaches and in gender and human rights mainstreaming.
vii. Strengthen community leadership skills, including amongst women in the community.
viii. Recognising the recent UN Commission on the Status of Women and also the SADC Gender Protocol to which Swaziland is signatory, this NSF will identify and support interventions that support economic empowerment of women particularly the elderly and women from vulnerable households and communities. This includes recognising the economic value of care provided by mainly women and the girl child.
ix. Strengthen existing service delivery systems at community level.

5.4.6 Coordination of the Impact Mitigation Programme

The coordination of impact mitigation interventions will adopt a multi-sectoral approach and apply the three ones principles. From a multi-sectoral perspective the involvement of all stakeholders active in this thematic area will be strategic in the successful implementation of the planned activities. The key stakeholders in this thematic area include government institutions, civil society and development partners. Critical government ministries include Ministry of Agriculture, Ministry of Education, Ministry of Health and the Department of Social Welfare, which all have specific responsibilities.

Other important committees for coordination of this thematic area are the Vulnerability Assessment Committee, the Child Development Committees, and The National Children's Coordinating Unit.

At the national level, a Multi-sectoral Technical Working Group (TWG) for impact mitigation already exists, with membership mainly composed of institutions actively involved in provision of impact mitigation services. The TWG meets quarterly or as the need arises. TWG Sub-Committees can be established around sub-programme areas such as OVC, to enable more frequent meetings and specific technical focus. Task Forces can also be constituted by the TWG or Sub-committees to deal with specific emerging issues.

The TWG will continue to provide technical guidance on impact mitigation response at national level. The key role of the TWG is development of programme policies, technical guidelines and protocols, standards, and operational manuals in order to ensure compliance with the set quality standards.

5.5 Response Management

5.5.1 Response management: A conceptual analysis and overview

The management of the HIV and AIDS response worldwide has evolved as the epidemic unfolded and new knowledge and understanding of the complexity of the epidemic emerged. Response management focuses on narrowing the gap between supply and demand of HIV and AIDS services, harmonising services to avoid duplication, rationalising resource use, and ensuring equitable distribution of services.

HIV and AIDS response management systems differ from one country to another depending on the level of political commitment, institutional arrangements and availability of adequate financial resources, and skilled and competent human resources[108]. Systems that are effective and efficient[109] are characterised by clearly defined mandates, roles and responsibilities, a functional participatory planning and programme development process and an effective and functional monitoring and evaluation system. Equally such systems are decentralised and take cognisance of the strategic role of communities in coordinating community-based interventions.

Swaziland's Coordination and Management Arrangements

Swaziland has demonstrated strong political commitment and has laid the foundations for effective management of the multi-sectoral response. Swaziland established a National Emergency Response Council on HIV and AIDS (NERCHA) in 2003. Subsequently, Swaziland established regional coordinating structures and sectors that have enhanced and expanded multi-sectoral partnerships and community involvement in the response management.

NERCHA has the overall legal mandate to coordinate the national multi-sectoral response. At regional level coordination is a partnership between NERCHA and the Ministry of Local Government and Housing (MLRD) through the regional coordinating mechanisms. These structures include the Regional Multi-Sectoral HIV and AIDS Coordinating Committee (REMSHACC), Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee (TMSHACC), and Chiefdom Multi-sectoral HIV and AIDS Coordinating Committee (CHIMSHACC). From an institutional arrangement these structures are HIV and AIDS sub-committees of the Regional Development Committees. Other coordinating structures include the Regional Health Management Teams (RHMT) under the Ministry of Health, and the Municipality HIV and AIDS Teams that coordinate the urban response. The regional coordination structures are in line with the National Decentralisation Policy of 2005. At community level, KaGogo Centres also play an important role in coordinating community services.

In addition to regional coordination, Swaziland has identified government (government ministries and departments) and non-governmental sectors that support sectoral coordination of the response. The roles and responsibilities for these sectors have been further articulated during the process leading to the development of the NSF. The key shift from the NSP II to NSF in the context of sectors is the re-

categorisation of sectors and clearer articulation of links between non-governmental and government sectors. The non-governmental sectors previously classified as sub-sectors have been elevated to sector level. The specific sectors are outlined in annex 2, and the linkages are articulated in the diagram attached as annex 3

The role and coordination of development partners has been crucial in the national response. Current development partners are the bilateral, multi-lateral and private donor agencies supporting the planning, development and implementation of the national response, and providing financial support. The UN agencies are coordinated through the Joint UN Team on AIDS. Mechanisms for coordinating other development partners have not been effectively institutionalised. The Swaziland Partnership Forum has served as networking and information sharing platform as opposed to playing a significant role in coordination and partnership strengthening.

The expansion of the response has had its own management challenges ranging from increased number of partnerships and service providers, to lack of clarity of roles and responsibilities. A key concern of the multi-sectoral approach has been the coordination, harmonisation and alignment of development partners' programmes with national action plans, and monitoring of donor support and civil society and private sector interventions. These concerns have resonated globally, leading to the re-thinking of the multi-sectoral response approach. In response to these concerns, UNAIDS took the lead in 2003, and introduced the Three Ones principles. The principles emphasise the need for one national coordinating authority, one national HIV and AIDS strategic framework, and one monitoring and evaluation framework. The Three Ones principles presuppose that key stakeholders will align and harmonise their response to the national frameworks. While this has had some success, not all stakeholders have mainstreamed the principles in their operations.

Swaziland has adopted and operationalized the Three Ones principles at national level and through the decentralised coordination mechanism at regional and sector levels. To a large extent the regional approach has expanded the "space" for meaningful involvement by stakeholders and created the opportunity for strengthening national and community ownership, good governance and accountability. The regional coordination approach has been used in Botswana, Malawi, Rwanda and Uganda among other countries and is considered to be best practice[110]. The regional coordination structures in Swaziland are in line with the National Policy on Decentralisation of 2005.

The NSF puts emphasis on strengthening regional coordination of the response for two reasons. First, the regional response approach is considered to be best practice; and second, the approach creates a unique opportunity for decentralising HIV and AIDS planning. The NSF supports and promotes Regional Action Plans (RAP) that feed into the National Action Plan (NAP) and serve as the vehicle for operationalising the NSF. This approach strengthens the implementation of the three ones principles and the National Decentralisation Policy of 2005. The approach also creates a great opportunity for public and non-governmental sectors to plan and focus on areas of their comparative and competitive advantage, shifting the HIV and AIDS response from "business as usual" to a more strategic approach.

The NSF is designed to strengthen national response coordination and management mechanisms, and has identified specific outcome results around seven service delivery areas. These are a) coordination and partnerships, b) strategic and action planning, c) programme development and project management, d) mainstreaming, policy formulation and advocacy, e) capacity development, f) resource mobilisation, and g) monitoring and evaluation.

It is anticipated that these outcome results will contribute towards the achievement of the following impact level result for response management:

Impact Level Result	% of mid-term and end-of-NSF service coverage targets (output level result targets) that have been met in the areas of HIV prevention, treatment, care and support, and impact mitigation has increased to 50% of midterm targets by 2011 and 75% of end-of-NSF targets by 2014

The following is the "Response Management – Results Framework"

Strategic Direction: The overall strategic direction for national multi-sectoral response management is to ensure equitable distribution of quality and effective HIV and AIDS services that are demand- and evidence driven, with anticipated specific impact and outcome results.

Priority Strategies: The following strategies will apply across all the aspects of the response management.

   i.   Regional coordinating structures will be strengthened to provide effective coordination and leadership, and to support joint regional multi-sectoral planning processes.
   ii. Roles and responsibilities of different partners will be clarified.
   iii. Advocacy will be carried out across all sectors to mainstream and operationalise the three ones principles at sector, regional and community levels.
   iv. Capacity will be strengthened for results based management and to further mainstream gender and human rights.
   v.   As part of the NSF, operational guidelines will be developed to inform and guide stakeholders in the implementation of the NSF interventions that relate to them.

5.5.2 Coordination and Partnerships

Coordination and Partnerships Outcome Results
National Composite Policy Index Score is increased from 5.6 in 2007 to 6.5 in 2011 and 7.5 by 2014.
% of partners and sectors that express satisfaction with the level and type of services provided by NERCHA to 40% in 2011 and 75% by 2015

Situation analysis: Coordination of the national response is complex, dynamic, and transcends institutional boundaries, hence the demand for a multi-sectoral approach based on "one" of the three-one principles i.e. one national coordinating authority. Swaziland has not only moved systematically to realise this principle but has also gone further to operationalise and decentralise the coordination mechanism to ensure meaningful involvement of all stakeholders. National coordination is facilitated by NERCHA, while regional coordination is carried out by decentralised structures as discussed above and as illustrated in annex 3. Government and non-governmental sector coordination is facilitated by designated government ministries or civil society organisations based on their operational and

development mandates. Non-governmental organisations are coalitions or groupings of civil society or private sector institutions that share common goals or ideals.

The strategic aim is to provide the means and strategies for effective coordination and management of the response that will ensure
   i.   Effective, efficient and equitable service delivery, particularly with adequate reach of vulnerable key populations.
   ii. Harmonisation of services to avoid duplication of efforts and to rationalise use of available human and financial resources with the aim of getting value for money in preventing infections and improving the quality of life of PLHIV and those affected.
   iii. Harmonisation and alignment of key stakeholders plans and programmes with the NSF.
   iv. Development of strategic partnerships and capacities between sectors to ensure co-operation and collaboration in the planning and implementation of NSF interventions at all levels

Effective coordination is also expected to present valuable opportunities to leverage additional resources, technical assistance, transfer of skills and best practices, and capacity for implementation at regional and sub regional levels.

Swaziland has already established the necessary coordination structures at the regional and sector levels. The specific roles of these structures are outlined in the NSF Operational Guidelines that accompany the NSF. NERCHA will provide space, and technical support for the structures to coordinate the national response in their respective jurisdictions.

Institutional arrangements for NSF coordination are articulated below. Specific coordination guidelines have been developed and accompany the NSF.

NERCHA

NERCHA will reposition itself to provide strategic leadership of the response particularly in the areas of policy development, strengthening an enabling environment, coordinating and spearheading HIV and AIDS mainstreaming in sectoral and corporate functions. NERCHA will further strengthen coordination with development partners, civil society and the private sector to allow harmonisation of programmes within the context of the three ones principles.

NERCHA will reposition itself to provide effective coordination and leadership in knowledge management, exploration of new and innovative approaches and development of new ideas and interventions that would contribute to the achievement of the NSF results. In this context NERCHA will coordinate with partners to develop a research agenda, and identify, conceptualise and articulate areas for research and knowledge building. At an operational level, NERCHA will coordinate advocacy work, resource mobilisation and information and knowledge management.

Decentralised Regional Coordination

Decentralised regional coordination will be facilitated through regional multi-sectoral structures including REMCHACC, TIMSHACC and CHIMSHACC. These structures are responsible for ensuring effective coordination of the Regional Action Plans and other community action plans in their respective areas.

They are also responsible for facilitating the cascading of the three ones principle of "one coordinating authority" at sub regional levels.

Government Sectors Coordination

Government sectors are all public ministries including relevant departments, directorates and units. These sectors are responsible for spearheading the national socio-economic development and health agendas. Given the impact of HIV and AIDS on the sectors and sector programmes, the sectors will be expected to strengthen their capacities to effectively coordinate their internal and external response to HIV and AIDS. Ministries that are lead agencies in areas such as health, education and agriculture are expected to provide technical assistance to their collaborating partners. In their external response to HIV and AIDS (ie with regard to their clients) government sectors are expected to adopt a multi-sectoral approach.[111]

The Ministry of Health, through the Swaziland National AIDS Programme (SNAP) is responsible for coordinating the health sector response that includes government institutions, private sector, traditional health practitioners and selected civil society organisations.

Non-Governmental Sectors Coordination

Non-governmental sectors include civil society and private sector umbrella bodies (see annex 2). Umbrella organisations are coalitions or groupings of civil society or private sector institutions that share common goals or ideals. They are expected to play a key role in sectoral coordination, and in particular facilitate liaison and coordination with NERCHA, regional coordinating institutions, government sectors, and development partners. For NGO coordinating structures to be effective in their coordination role, they must focus on their core business and mandate -- coordination of others, and need to decentralise implementation of interventions to their affiliates at regional and community level. The private sector will be coordinated through the Swaziland Business Coalition on HIV and AIDS (SWABCHA).

Development Partners Coordination

Coordination of development partners will be facilitated through existing structures including the Donors Forum and the Swaziland Partnership Forum. UN coordination will be through the UN Theme Group on HIV and AIDS.

Strategic Direction: the strategic direction for coordination is to improve and harmonise coordination modalities among the key stakeholders in order to ensure effective and efficient implementation of the NSF.

Strategies: the following are the core strategies envisaged:
    i.   Mainstream the three one principles.
   ii.   Publish and disseminate the coordination guidelines to all stakeholders.
  iii.   Build capacity for coordination in the regions and sectors.

5.5.3 Strategic and Action Planning

Situation Analysis: Joint planning for HIV and AIDS was adopted as a multi-sectoral approach in 2000 during the development of NSP I and was further strengthened during the development of NSP II and Global Fund proposals. The joint planning process is embraced by all stakeholders, as it expands the opportunities for meaningful involvement and participation. Over time, stakeholders have learnt that joint planning is not merely a process of consolidating individual institutional programmes into an action plan but rather a process that starts with joint reviews of previous interventions at all levels and involves as many stakeholders as possible. Joint planning facilitates collective identification of priorities and setting of targets. In the past, joint planning has taken place at central level. With the current NSF, joint planning is being decentralised to regions and sectors and eventually to communities.

Achievements: Swaziland has used joint planning and reviews for two consecutive strategic plans i.e. NSP I and II. A joint planning process was also used to develop GFATM proposals. The government has also used joint planning in developing National Development Strategies (NDS) and the Poverty Reduction Strategy and Action Plan (PRSAP). Joint planning for HIV and AIDS has been mainstreamed to some degree through the thematic Technical Working Groups (TWG).

Gap analysis: During the joint review of the NSP II, the key challenge in joint planning for HIV and AIDS was found to be inadequate capacity and experience of most stakeholders[112]. The roles and responsibilities of the various stakeholders i.e. sectors and regions were not clear. It was further noted that planning was mainly done at central level and was not decentralised to the regions. At sector level, 11 sectors had developed their own strategic plans. The use of human rights approaches and gender mainstreaming in planning was also found to be inadequate.

Strategic direction: The NSF hopes to promote meaningful evidence-based joint planning that uses a result based management approach, and mainstreams gender and human rights at all levels of HIV and AIDS planning. NSF will inform and guide the development of regional, sector and community action plans.

The step by step process of initiating and undertaking joint planning is articulated in the NSF Operational Manual.

Priority Strategies: The planning process will adopt the following key strategies:
  i.   The use of evidence and a result based management approach.
  ii.   Decentralise planning to regions, sectors and eventually to communities.
  iii. Use joint planning to mainstream gender and human rights into HIV and AIDS interventions.
  iv.   Provide support to sectors to review sectoral plans and align the plans to the NSF.
  v.   The NSF mid-term review will be conducted in 2011, and the final evaluation will be conducted in 2014. The National Action Plan will be reviewed and updated in 2011. The periodic reviews will include assessment of NSF, NAP, RAP performance both in programme implementation and resource utilisation. The process of review and evaluation of the action plans is illustrated in Annex 2.

5.5.4 **Programme Development and Project Management**

Situation Analysis: Programmes are the building blocks of strategic plans and frameworks. Individual programmes are more detailed and focus on specific interventions. HIV and AIDS programmes fall within three categories i.e. prevention, treatment, care and support, impact mitigation and response management. Under each of these broad programme categories specific sub programmes are identified and developed.

Programme development and project management in a multi-sectoral environment is a shared role between the national HIV and AIDS coordinating authority (NERCHA) and technical line ministries. NERCHA provides overall strategic programme policy direction aligned to national priorities. The Ministry of health is responsible for technical programme development and project management for health based interventions. Other sectors, especially education, agriculture, local government and NGOs, develop non-health programmes that respond to both internal and external needs in consultation with NERCHA.

The specific programmes determine the nature of services, coverage and strategies for service delivery. Programme development is informed by the following factors:

  i.The demand for the service based on the magnitude and extent of the epidemic.
  ii.The need for national coverage and equitable distribution of services.
  iii.Availability of human, financial and technical capacities to support particular interventions and the use of existing structures and systems.
  iv.The need for community involvement and ownership to ensure access and utilisation of services by intended beneficiaries.
  v.Sustainability of the interventions.

In section five of the NSF, specific programmes have been identified within the broader thematic areas of prevention, treatment, care and support, and impact mitigation. Prevention remains the national priority.

Achievements: Swaziland has developed and implemented specific programme interventions including PMTCT, HTC, Blood safety, PEP, ART, TB, CBHC, and OVC support. Most interventions are available and accessible country wide. Most prevention interventions are multi-sectoral and multi-layered and involve relevant stakeholders in implementation.

Gaps Analysis: Programme development and coordination remains a challenge, primarily due to lack of clarity on the mandate and roles of institutions developing programmes. The consequences have been poor quality of some services, inadequate coordination and sustainability. Planning has focused on projects rather than an integrated and harmonised programme. While the project approach is sometimes necessary, it creates challenges when interventions are not harmonised or lack synergy between them or between the organisations responsible for implementation. The NSF has attempted to address these challenges by using a results based management approach that focuses on collective (project) contributions to a common impact level result.

Strategic direction: The strategic direction for NSF is to ensure that programmes are harmonised and contribute to the common impact level results outlined in the NSF results framework. In addition, NSF will ensure that HIV and AIDS services are available and accessible to all intended beneficiaries.

Strategies: The following strategies will contribute to the achievement of the outcome level result.

    i.Build capacity in lead agencies to develop quality and comprehensive programmes using results based management, and incorporating gender and human rights based approaches.
    ii.Work with partners to align and harmonise programmes and projects with NSF in order for all stakeholders to contribute to the agreed impact and outcome level results.
    iii.Support sectors to develop appropriate programmes that enable them to respond to both internal and external issues of the epidemic within the sector, aiming for comprehensive adequate coverage, and effective coordination and resource utilisation.

5.5.5 Mainstreaming, Policy Development and Advocacy

Situation analysis: The impacts of HIV and AIDS transcend institutional boundaries and hence demand concerted action. All government and non-governmental sectors are called upon to mainstream HIV and AIDS in their corporate functions and programmes to address internal and external needs. Mainstreaming HIV and AIDS in sector policies and integrating interventions into their development programmes creates a framework within which the sectors take on obligations to provide services to mitigate the impacts of HIV among their staff, and the people who benefit or are recipients of the service they provide. Clearly identifying the accountability of service providers[113] is crucial to the implementation of NSF and in particular in scaling up essential services. However providers cannot be held accountable if they lack the conditions and skills necessary to fulfil their relevant duties[114].

Achievements: Swaziland has defined government and non-governmental sectors (Annex 3 list of sectors). Some sectors have attempted to mainstream HIV and AIDS to the extent possible using guidelines for mainstreaming that were developed and disseminated. A number of sectors have also been trained in HIV and AIDS, and gender mainstreaming. Advocacy has been going on throughout NSP implementation. However, results are unlikely to be realised in the short term but rather in medium and long term. The government of Swaziland has made a policy decision that approximately 2% of sector budgets be earmarked for HIV and AIDS interventions. This demonstrates Swaziland's political commitment to reverse and halt the spread of HIV by mainstreaming the funding of sectoral internal and external responses in core sector budgets.

Gap analysis: The key challenge in mainstreaming HIV and AIDS, gender and human rights has been lack of adequate capacity, skills and experience coupled with inadequate technical guidance on how to develop HIV and AIDS integrated programmes and services. With regard to advocacy, Swaziland does not have a common HIV and AIDS advocacy agenda. Hence advocacy work has remained fragmented and seen as the domain of activists rather than a way to influence service providers to provide comprehensive and quality services. This challenge is compounded by inadequate recognition by some partners of their roles and responsibilities for service provision.

Strategic direction: The strategic orientation of the NSF is to ensure adequate mainstreaming of HIV and AIDS in sector programmes to ensure that all sectors are actively involved in the national response and that they are able to address both internal and external needs.

Strategies: The following strategies will be applied to support mainstreaming, policy development and advocacy work.
    i.Sectors will review their operational plans and development programmes, and integrate NSF interventions.

ii.Sectors will review sector policies and mainstream HIV and AIDS and integrate gender and human rights dimensions in their development programme planning including human and financial resource planning.

iii.Advocacy will be conducted with policy and decision makers to build political leadership and support for policy formulation, adoption and integration of NSF interventions into sector programmes.

iv.Advocacy with policy makers, including parliamentarians and development partners to ensure that HIV and AIDS issues are on the social, development and political agenda.

v.Capacity will be built and strengthened in all sectors to formulate and review policies and mainstream HIV and AIDS and gender in sectoral policies and programmes. Sectors will explore the possibility of outsourcing services using private-public partnership (PPP) arrangements. Where capacity does not exist, sectors will identify and facilitate strengthening of selected institutions that can then become capacity development hubs in the country.

vi.Identify and address ethical, legal and human rights gaps in the national response.

vii.Strengthen community mobilisation and community advocacy capacity for an effective response at community level.

viii.Promote cross border policy initiatives and partnerships to address mobile populations and migrant labour issues common to neighbouring countries.

ix.Support interventions to improve legal strategies and human rights protection for all vulnerable populations including the involvement of PLHIV.

5.5.6 Resource Mobilisation and Management

Resource Mobilisation and Management Outcome Results
100% of NSF financial resource mobilised and effectively used by 2014.
AIDS spending in the last 12 months by categories and financing source is increased by 2014.

Situation analysis: Funding for the national multi-sectoral response has primarily come from two sources: the Government of Swaziland and development partners. Access to government funding is based on annual budgets submitted to government by NERCHA and key ministries. Additional resources have been mobilised from development partners on the basis of proposals submitted. Donor funding has been project specific, and a mix of single-year and multi-year. Individual sectors have mobilised their own resources from a variety of donors. It is anticipated that sectors will continue resource mobilisation for sector specific interventions.

Achievements: Swaziland has conducted the first ever comprehensive National AIDS Spending Assessment (NASA). It found that total expenditure[115] on HIV and AIDS increased from SZL 257,218,500 to SZL 346,128,488 between 2005/06 and 2006/07, a 34.5% increase.

70% of the funding came from international sources in 2005/06 and 60% in 2006/07. The NASA estimates per capita spending for the two fiscal years at SZL 270 (US$40) and SZL 363 (US$52) respectively. Government funding for HIV and AIDS increased from SZL 79,245,808 (30.8%) in 2005/06 to SZL 140,354392 (41%) in 2006/07. Funds from international sources came mainly from the GFATM (85%), Italian Cooperation, and European Union (EU), United States Government (USG) / PEPFAR and United Nations (UN) system. Some funding was received from international NGOs such as SAFAIDS, and Action AID. Available data indicate that the Ministry of Education mobilised 48.94%

(SZL 68,693,065) of all public sector funds for HIV and AIDS, followed by NERCHA 47.26% (SZL 66,336,212) and Ministry of Health and Social Welfare 3.66% (SZL 5,133,218). Other ministries (combined) mobilised 0.05% (SZL 73,093).

With regard to spending on priority areas during 2006/7 fiscal year; OVC attracted the most funding (31%), followed by treatment, care and support (19%), and prevention (17%).[116] ART and opportunistic infections attracted the most funding within treatment, care and support. In prevention, most funding was spent on communication for social and behaviour change programmes.

Gap analysis: Resource needs continue to increase (Joint Review 2008). The challenges facing Swaziland are capacity to absorb available funds given limited human resources and inadequate service delivery systems. The NASA (2007) found that spending for HIV prevention declined 2.4% from SZL 61,434,631 ($9.17 million) In 2005/6 to SZL 59,972,039 (US$8.57 million) in 2006/7 in spite of HIV prevention being a critical national priority. Inadequate funding for prevention may in the long term compromise the effectiveness and sustainability of other interventions.

The joint review noted that non-governmental organisations were under-resourced in spite of the overall increase in financing for HIV and AIDS. The potential for civil society had not been realised due to lack of resources and inadequate capacity for resource mobilisation. Given the challenges in tracking resources, it is evident that there is need to institutionalise resource tracking for HIV and AIDS to better manage supply and monitor demand.

Strategic direction: It is anticipated that by using the NSF as the core tool for resource mobilisation at all levels, Swaziland will be able to mobilise 100% of all resource requirements for implementing planned programmes.

Strategies: The NSF, NAP and the RAP will be fully costed to assess financial resources required to implement the planned activities. The strategies listed below will contribute to the outcome result for resource mobilisation and management:

  i. Capacity for resource mobilisation will be strengthened, especially capacity for HIV costing and budgeting, and non-governmental sectors' capacity to develop fundable proposals.
  ii. Financial management systems will be strengthened where they are insufficient and built where they don't exist. In particular, regions and sectors will be supported to improve their accounting practices and financial record keeping.
  iii. With regard to supporting community-based organisations, the NSF will make provision for small grants to be administered by regional coordinating structures.
  iv. A resource mapping exercise will be conducted annually to establish annual financial gaps that stakeholders will focus on in resource mobilisation. The NSF financial gap analysis will calculate the difference between the identified need and the available (committed and projected) funding over the NSF five year period.

Table 6 summarizes the total financial need for implementation of the NSF. The information is presented by thematic, programme areas and year of funding. The table shows cost allocation by programme and sub programme areas. The data used to determine the costs are based on the NSF targets and performance projections, and recent actual costs. These figures will be reviewed annually during the review of the National Action Plan.

With regard to resource mobilisation and management the following strategies are planned:

i. **Financial Management systems:** strengthen financial management systems at all levels to ensure proper allocation, mobilisation, disbursement, efficient utilisation, accountability and tracking of resources for HIV and AIDS.

ii. **Expansion of the donor base**: Swaziland will seek to expand the donor base supporting NSF implementation. The strategy will be to ensure that the programme is not dependent on a single donor.

iii. **Government funding:** funding from government sources will be accessed through the normal annual budget system.

iv. **Development Partner Funding and Donors**: development partners and other donors will be encouraged to support the national response by funding NSF. If donor-specific proposals cannot be avoided, they will be harmonised and aligned with the NSF priorities.

v. **Funding Round Table**: organise a round table forum to encourage donors to pledge support for NSF.

5.5.7 Capacity development

Situation analysis: Capacity development is a continuous intervention throughout the lifecycle of the NSF. In the past, capacity has been developed around programme and project development and management, and in particular in service delivery. Capacity needs range from basic skills to more complex and technical skills depending on the intervention or service. It is evident that the implementation of NSF, NAP and RAPs will depend on the availability of adequate capacity among the personnel assigned specific responsibilities for the implementation of NSF interventions at all levels of the response.

Specific capacity needs have been identified in human resources (adequacy, skills and competencies) organisational capacity (operational systems, financial resources and technology) and availability of strategic information[117] to inform choices and decision making for the national HIV and AIDS response. These capacity needs apply across all sectors i.e. government and non- governmental sectors and the regions.

Achievements: Swaziland has made significant efforts in developing capacity for implementing the national multi-sectoral strategic plans. The following have been achieved:
   i. Coordinating structures have been established and decentralised. Human resources and finance has been provided to manage the decentralised structures.
   ii. Financial support has been provided to non-governmental sectors and in particular civil society umbrella organisations have been funded to strengthen their coordination roles and to support their community interventions.
   iii. HIV and AIDS M&E systems at NERCHA and the Ministry of Health have been developed and are functional. Training has been conducted for M&E personnel. Reporting systems are in place and functional.
   iv. Other sectors have also been trained in M&E skills. This has improved the level of data collection, analysis and reporting.
   v. Specific programme-related skills have been developed and strengthened. Services are available country-wide in most service delivery areas
   vi. Key stakeholders have been specifically trained in financial management, gender and HIV and AIDS mainstreaming. A few organisations have also been oriented in results based management approaches.
   vii. Operational systems such as the referral system and national social security system have been established and capacity developed for their implementation.
   viii. Technical assistance has been mobilised to support regions and sectors in improving their programmes.

Gap analysis: The joint review of the NSP II identified the following capacity gaps:
   i. Inadequate skilled human resources especially in M&E, strategic planning and advocacy.
   ii. Inadequate financial resources to support planned interventions.
   iii. Weak service delivery systems, especially community level systems to deliver impact mitigation services.
   iv. Capacity to absorb financial resources earmarked for HIV and AIDS was a challenge across all the sectors and could compromise service delivery. However strategies have been identified to strengthen absorptive capacity.

Strategic direction: The NSF hopes to initiate a process where capacity development will be strengthened across sectors, regions and programmes, and at community level. The focus will be on strengthening health and community systems.

Strategies: The implementation of the strategies identified below will result in achieving the outcome level result of developing adequate capacity for implementing the NSF:

i.   **Institutionalising capacity building**: Efforts will be made to institutionalise capacity building programmes in existing training institutions. This will allow a systematic, professional and more efficient approach and standardise capacity development efforts.

ii. **Comprehensive capacity assessment:** In order to identify and prioritise the NSF strategic capacity gaps, Swaziland will conduct an institutional and human resources capacity assessment.

iii. **Institutional capacity**: The focus will be on strengthening health and community systems in all sectors and regions. Health systems will be strengthened to support the expansion and scaling up of specific programmes while strengthening of community systems and structures will enable communities to plan, coordinate and implement community-based interventions.

iv. **Public-Private Partnerships**: The NSF will promote and support effective public-private partnerships to allow strategic outsourcing of technical services where applicable and necessary.

v.   **Resource Mobilisation**: The NSF will be costed and used for resource mobilisation. A national costed action plan (NAP) will be developed to guide the operationalization of NSF. NERCHA has the responsibility to mobilise sufficient resources for the response, however stakeholders and partners are also encouraged to undertake independent resource mobilisation initiatives in line with the NSF. Sectors will be strengthened in results based management planning, costing and budgeting, in proposal writing and to undertake independent resource mobilisation to address strategies identified in the NSF.

vi. **Human resources:** Human resources development will focus on making sure there is adequate staff with appropriate technical skills and competencies. NSF will also promote the concept of volunteerism among the people of Swaziland to complement existing human resources.

5.5.8 Monitoring and Evaluation

Monitoring and Evaluation Outcome Results
A functional HIV M&E system provides timely and quality assured HIV data by 2014.

The mandate for coordinating the national HIV M&E system in Swaziland rests with NERCHA, as defined in the national multi-sectoral HIV policy and consistent with the three ones principles. The Swaziland national HIV M&E system was launched in 2005 by NERCHA and the M&E TWG. For the NSF period from 2009 to 2014, the focus on M&E will be to: (i) Create an enabling environment for M&E systems at national, regional, sectoral, sub-`regional and implementer levels; (b) Generate accurate, timely and relevant HIV data; (c) Support HIV research and evaluation, and; (d) Increase HIV M&E data demand and information use for planning and decision making. The functional HIV M&E system in Swaziland will report on the: magnitude, trends and impact of HIV; knowledge and behaviour related to HIV; demand or need for and supply of HIV services; management of the HIV response; Inventory of HIV implementers, and; information required for international HIV reporting.

(a) Create an enabling environment for monitoring and evaluation

An enabling environment to make the national M&E system functional consists of organisational structures for M&E, adequate human capacity for M&E, defined M&E partnerships, sound M&E plans and work plans, and targeted advocacy, communications efforts to create a positive M&E culture.

Achievements: During the NSP-II period, NERCHA, SNAP and some stakeholders created M&E units, strengthened capacity of their M&E staff, developed M&E plans, and designed and implemented costed M&E work plans. The national multi-sectoral M&E TWG and a Health Information Coordinating Committee (HICC) were also established to oversee and coordinate health-related M&E activities.

Gaps: Existing gaps include staff attrition and inadequate human capacity. Not all stakeholders have developed M&E plans and where plans exist they are not always aligned to the M&E indicators, making it difficult for data collection and subsequent reporting.

Strategies:
   i. Update and implement the national M&E plan, work plan and guidelines to align with NSF 2009-2014 and international reporting requirements.
   ii. Strengthen the capacity of M&E structures in NERCHA, sectors and regions to manage various aspects of the national multi-sectoral HIV M&E system.
   iii. Strengthen the M&E TWG and HICC to coordinate and oversee M&E activities at national level.
   iv. Mainstream M&E planning in all sector plans.
   v. Advocate for harmonization of stakeholder M&E plans with the national system

(b) Generate accurate, timely and relevant HIV data

Routine data enable M&E systems to measure implementation of work plans, supply of and demand for HIV services, and use of resources. Periodic surveillance and surveys track magnitude, trends and HIV risk factors.

Achievements: During the implementation of the NSP-II, surveys and surveillance which took place include: ANC sentinel surveillance; Swaziland Demographic and Health Survey (SDHS); a Modes of Transmission analysis (MOT); National AIDS Spending Assessment (NASA), community-level Service Availability Mapping (SAM), Quality of Impact Mitigation Survey (QUIMS), and community-level monitoring of HIV needs. The SHAPMoS (Non-clinical data) and the Ministry of Health and Social Welfare (Clinical Data) monitoring systems are in place through which Quarterly Service Coverage Reports (QSCR) are produced.

Gaps: There is no national integrated HIV database that captures all HIV routine monitoring, surveys, surveillance and research information. In the regions and communities challenges include: not all implementers report M&E data; vertical health-sector HIV programmes like VCT, PMTCT and ART are not fully integrated into the HMIS; vertical programmes submit different data sets directly to MOH; there is no system to monitor and forecast demand for and supply of drugs and commodities to health facilities from Central Medical Stores (CMS); donors' reporting requirements vary causing duplication in

reporting; supportive supervision and data auditing of implementers does not take place as scheduled due to capacity constraints like shortage of transport and of trained data auditors.

Strategies:
  i. Establish a system to map and update the inventory of HIV implementers and their activities in all regions.
  ii. Develop simple KaGogo centre community monitoring guidelines and procedures.
  iii. Establish a functional integrated national HIV database at NERCHA.
  iv. Establish and strengthen a system for mentorship, data auditing and verification for MOHSW, NERCHA, sectors and regions.
  v. Establish and strengthen resource tracking for clinical and non-clinical monitoring systems.

(c) Support HIV research and evaluation

HIV research and evaluation complements the existing M&E information by providing detailed information that routine data and surveys cannot capture.

Achievements: In Swaziland an assessment was undertaken in 2006 which revealed the strengths and weaknesses of HIV research coordination, capacity and implementation in the country.

Gaps: The main challenges to HIV research and evaluation in Swaziland are: underfunding of HIV research; the need to strengthen coordination and regulation of ethically approved research; low capacity for HIV research, and; research findings are not all disseminated and used for planning and decision making.

Strategies:
  i. Strengthen the national mechanism to regulate and coordinate HIV research and evaluation activities in Swaziland.
  ii. Develop a prioritized HIV and AIDS research and evaluation agenda, mobilize resources, and implement it.
  iii. Build capacity to undertake research and evaluation and forge partnerships which meet HIV research and evaluation needs for Swaziland.
  iv. Support research initiatives to strengthen surveillance systems to capture robust data on high risk populations.

(d) Increase HIV M&E data demand and information use

A functional HIV M&E system responds to stakeholders' information needs in a flexible, friendly and timely manner within an environment that nurtures open access to HIV information which is relevant for decision making by appropriately packaging, distributing and disseminating HIV information to stakeholders.

Achievements: In the NSP-II period, NERCHA collaborated with stakeholders to produce and disseminate Quarterly Service Coverage Reports (QSCR), an M&E annual report, UNGASS reports, synthesis and projection studies on sources of HIV infection, and survey and surveillance reports. HIV

information was mainly disseminated through feedback meetings, websites, databases and mass media.

Gaps: Not all HIV data is being used for decision making mainly because information is not always disseminated to stakeholders.

Strategies:
i.   Strengthen NERCHA, sectors' and regions' capacity to consolidate regional and sectoral reports, and produce and disseminate national M&E information products and HIV reports.
ii. Promote and build stakeholders' capacity to use M&E information for planning and decision making at national, sector, regional, and implementer levels.
iii. Advocate for accessing and using research and evaluation results in policy, practice, planning and decision making at national, sectoral, regional and service delivery levels.
iv. The NSF will institutionalise Quality of Impact Mitigation Surveys to facilitate data collection and use and research on impact mitigation issues.

Annexes

Annex 1: NSF Sustainability Strategies

The following table lists what needs to be done to achieve sustainability of the NSF interventions around the five pillars of financial sustainability, community ownership, organizational development, services availability and coverage and accountability.

Financial Sustainability	i. Develop skills and effective strategies in resource mobilization, proposal writing, and grant negotiation. ii. Strengthen financial management systems. iii. Effectively track resources provided for HIV and AIDS interventions iv. Improve the level of financial accountability.
Community sustainability	i. Effective community mobilisation leading to community-driven interventions and ownership. ii. Engage communities through participatory approaches to ensure meaningful participation in implementing national priorities and identifying community solutions to community challenges. iii. Strengthen community capacity to determine their own actions and develop community action plans. iv. Strengthen community leadership, community management and operational systems.
Organisational sustainability	i. Strengthen the capacity of sectors and CBOs in action planning, community mobilisation, membership awareness, recruitment and retention of skilled and experienced staff, leadership and good governance. ii. Improve the policy environment to be conducive for NSF implementation.
Services Sustainability	i. Equitable distribution of services, including to vulnerable and key populations ii. Ensure gender sensitivity, adherence to basic human rights iii. Put in place effective strategies to ensure improved services uptake, social and behavioural changes. iv. Ensure services are relevant and responsive to community needs, and incorporate community identified solutions. In most cases community solutions are cost effective, and hence can be sustained for longer periods. v. Establish community-based alternative livelihoods to generate income to support their community-based initiatives.
Accountability	a. Strengthen sectors' and implementing partners' accountability for finances and for their actions.

Annex 2:   Joint Annual Review and Planning Process

The NSF has focused on the principle of "managing for results'. This requires that one plan with results in mind, and then focus strongly on results during implementation. Thus it is essential to define how the NSF will be used during implementation of the HIV response in Swaziland.

The NSF forms the basis for all stakeholders' participation in implementing the national response. The specific activities planned and undertaken by all stakeholders must contribute to the NSF impact and outcome level results. The following guidelines will help ensure this:

a) Stakeholders will conduct an annual review of sector operational plans.

b) The annual sector reviews will feed into the joint multi-sectoral evaluation of the 2-year National HIV and AIDS Action Plan (NAP) at the end of the second year of NSF implementation, with the view to update and verify action plans for the follow up two years.

c) A mid-term review evaluation of the NSF will be conducted at the end of the first two years (i.e. in 2011). The review will focus on answering the questions - "Are we implementing – on time, to the necessary quality, and in a cost efficient way – all the planned activities? What progress is being made with implementing the national response?"

d) Stakeholders will participate in an end-of-term summative evaluation of the NSF, and the development of a successor National HIV Strategic Framework. The end of term evaluation of the NSF will determine 'What impact has been made? What results have been achieved?" And, for any shortfalls in results, "What barriers prevented achievement of planned targets/results?"

The reviews of NAP and NSF will be facilitated by NERCHA, and will involve all stakeholders. Reviews of the RAPs will led by the REMSHACCs and sectors.

The reviews of the NAP and RAPs will focus on efficiency of the national HIV response, whereas the mid-term review and end term evaluations of the NSF will focus on effectiveness. The timelines are presented in the table below
.

Annex 3: Sectors

Public Sectors	Non Governmental Sectors			Development Partners
Public sector	Civil society	Traditional sector	Private Sector	Development partners
i.Prime Minister's Office ii.Deputy Prime Minister's Office iii.Ministry of Finance iv.Ministry of Economic Planning and Development v.Ministry of Commerce Industry and Trade vi.Ministry of Public Service vii.Ministry of Natural Resource and Energy viii.Ministry of Education and Training ix.Ministry of Health x.Ministry of Agriculture xi.Ministry of Information, Communication and Technology xii.Ministry of Justice and Constitutional Affairs xiii.Ministry of Local Government and Housing.	i.Coordination Assembly of Non Government Organisations (CANGO) ii.Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA iii.Church Forum iv.Media Institute for Southern Africa (MISA) v.Traditional Healers organisation (THO) vi.Federation of Disabled Persons in Swaziland (FODSWA)	i.Khulisa Umntfwana ii.Regiments	i.Business Coalition on HIV and AIDS (BCHA) ii.Unions iii.Academia	i.United Nations agencies ii.Bilateral partners iii.Other donors and technical assistance partners

Annex 4: Institutional Arrangement on Coordination of the Multi-sectoral Response to HIV and AIDS
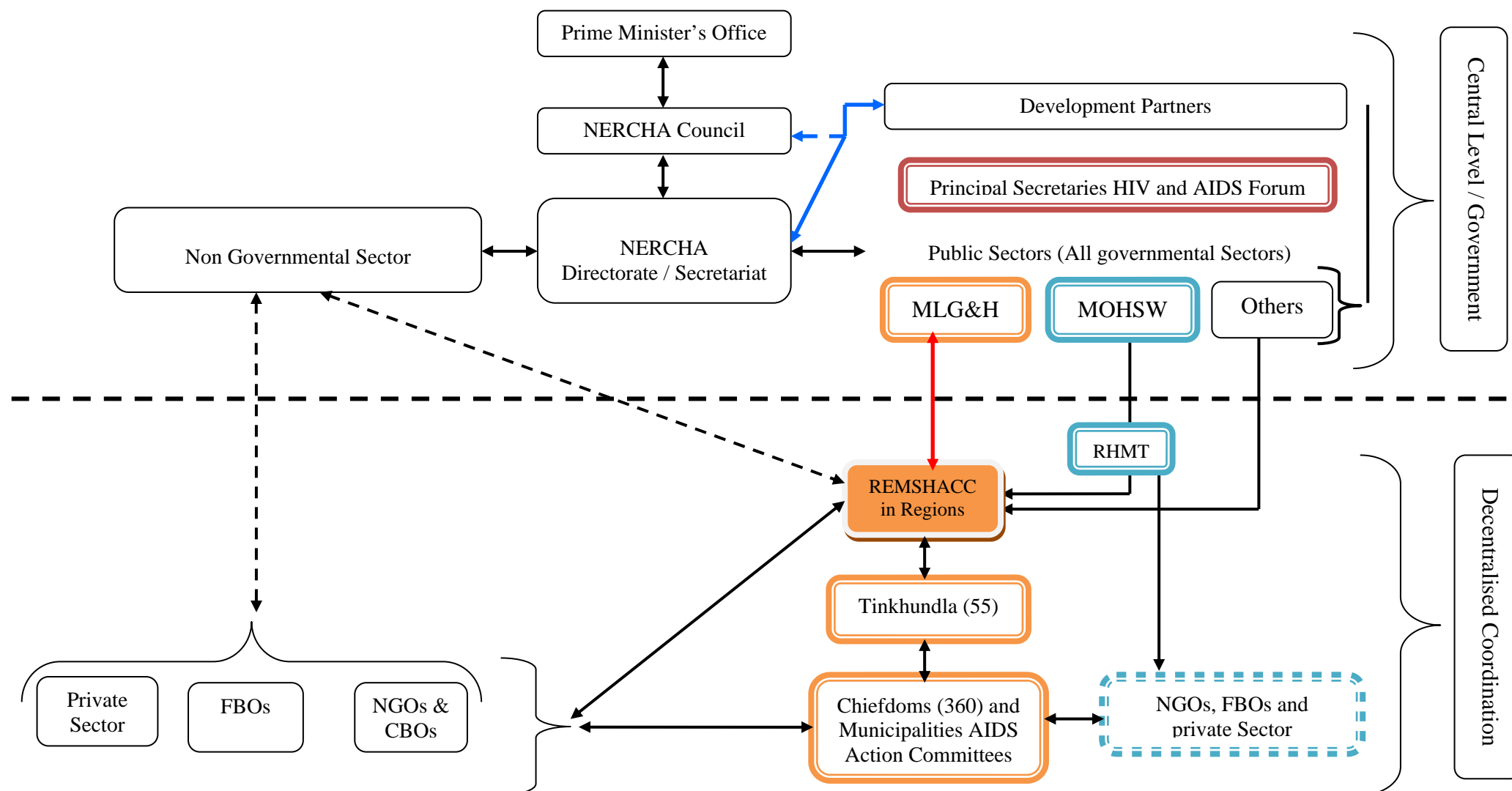
Figure 3: *Sequence of National Action Planning Events and Stakeholders Involved*

Event	Lead Agency	2009/10 Q1	Q2	Q3	Q4	2010/11 Q1	Q2	Q3	Q4	2011/12 Q1	Q2	Q3	Q4	2012/13 Q1	Q2	Q3	Q4	2013/14 Q1	Q2	Q3	Q4
Implement 2009 – 2010 National Action Plan	Sectors and REMSHACCs	■	■	■	■																
Review implementation of National Action Plan 2009 - 2010, and develop a new NAP for 2010 – 2011	Sectors and REMSHACCs			■																	
Implement 2010 – 2011 National Action Plan	Sectors and REMSHACCs					■	■	■	■												
Review implementation of NAP 2010 – 2011, and develop a new NAP for 2011 – 12	Stakeholder joint review							■													
Implement 2011 – 2012 NAP	Sectors and REMSHACCs									■	■	■	■								
Participate in national mid-term summative evaluation of the NSF	NERCHA, with stakeholders and independant evaluation team									■	■										
Revise National Action Plan 2011 – 2012 and develop a new National Action Plan for 2012 – 2013	NERCHA, Sectors and REMSHACCs											■									
Implement 2012 – 2013 National Action Plan	Sectors and REMSHACCs													■	■	■					
Review implementation of National Action Plan 2012 – 2013 and change the plan as needed	NERCHA, Sectors and REMSHACCs															■					
Implement 2012 – 2013 National Action Plan	Sectors and REMSHACCs																	■	■	■	■
Conduct a national end-of-term evaluation of NSF 2009 to 2014	NERCHA with stakeholders																	■	■		
Develop a new NSF and new NAP	NERCHA with stakeholders																			■	■

[1] The HDI is a measure of achievements in three basic dimensions of human development: a) life expectancy b) education and adult literacy, and c) standard of living as measured by GDP per capita in purchasing power parity (PPP)-adjusted US Dollars. It is calculated and published annually by UNDP.

[2] The epidemic threshold is the reciprocal of the average duration of infection (11 years). Therefore, the epidemic threshold is 0.09. If the incidence or prevalence ratio is lower than this level (in 2007, it was 0.116), then the epidemic will not continue to grow. If we assume that the HIV prevalence remains constant over the next 5 years, then incidence has to reduce to 2.0% or lower for the incidence-to-prevalence-ratio to be lower than 0.09 and for the epidemic to start contracting.

[3] Government of Swaziland (2008) National HIV/AIDS Monitoring and Evaluation - Annual Report 2008, pg 12

[4] International practice of measuring sex work tracks female workers. This indicator will be improved to include male sex workers.

[5] UNDP 2008 Human Development Statistical Update

[6] These individuals include OVC, PLHIV, and the elderly

[7] 'Able to cope' is defined by a composite measure asked in the QIMS, where vulnerable persons are asked about a number of aspects of their lives, so as to determine whether they can cope with the impact of HIV in their lives.

[8] The number of households in Swaziland calculated by using data about the total number of persons in Swaziland, SDHS data about the sample demographic characteristics (table 2.1) (the number of persons in rural and urban households) and data from the VAC Report (2008) about the number of vulnerable persons.

[9] 2007 Population and Housing Census Swaziland

[10] Population and Housing Census 2007 –as quoted in the census official broshure

[11] World Bank, World Development Indicators, 2008

[12] ADB (ESTA) Bank data base, 2006

[13] Sentinel surveillance reports (various) – Ministry of Health and Social Welfare, Swaziland.

[14] CSO Swaziland, 2007, Swaziland Demographic and Health Survey

[15] NERCHA, et al 2008 Analysis of Prevention Response and Modes of Transmission Study

[16] CSO,2007 Swaziland Demographic and Health Survey,

[17] CSO,2007 Swaziland Demographic and Health Survey,

[18] MOHSW, 2006, 10th Round of National Serosurveillance among women attending antenatal care services at health facilities in Swaziland.

[19] (NERCHA and UNAIDS, 2007a).

[20] (NERCHA and UNAIDS, 2007a). Swaziland HIV Estimates and Projections: Workshop Report. Mountain Inn Hotel, Mbabane, October 8th 2007

[21] Family Health International (FHI) 2002: Swaziland Behavioural Surveillance Survey

[22] The Swaziland Modes of Transmission Study, 2008, NERCHA, UNAIDS and GAMET.

[23] NERCHA 2008, Monitoring and Evaluation Annual Report.

[24] According to the UNAIDS Guidelines in Intensifying HIV Prevention, **risk factors** are those behaviours and practices over which an individual has control, whereas **drivers** are those broader factors in the community, or at the society level that influence the individual risks that a person may take, or the risk reduction behaviour that they might decide to adopt.

[25] Family Health International (FHI) 2002. Swaziland Behavioural Surveillance Survey

[26] CSO 2007, Swaziland Demographic and Health Survey (SDHS)

[27] Mishra V et al. 2007. HIV infection does not disproportionately affect the poorer in Sub Saharan Africa. AIDS, 21 (suppl 7)S17-S28

[28] CSO 200, Swaziland Demographic and Health Survey

[29] Vissers DCJ, Voeten HACM, Urassa M, Isingo R, Ndege M, Kumogola Y, Mwaluko G, Zaba B, De Vlas SJ and Habbema JDF. Separation of spouses due to travel and living apart raises HIV risk in Tanzanian couples. Sexually Transmitted Diseases, August 2008, Vol. 35, No. 8, p.714–720

[30] (Leclerc-Madlala, 2008).

[31] Examples of investigated gender discriminatory beliefs: men should control significant decisions in relationships; it is more important for women to respect her spouse or partner than for a man to do so; women should not insist on condom use if their partner refuses; a man can marry a second wife if his current spouse does not bear children.

[32] Defined as: Person has been physically forced to have sexual intercourse; had sexual intercourse because of being afraid of what the partner might do; or been forced to do something sexual found degrading or humiliating

[33] Any type of violence directed at groups or individuals on the basis of their gender (HIV/AIDS and gender based violence literature review, Harvard School of Public Health, 2006)

[34] Auvert B, Taljaard D, Lagarde E, et al(2005). Randomised controlled intervention trial of male circumcision for reduction of HIV infection risk: ANRS1265 Trial. PloS Med 2(11):e298

[35] Bailey C, Moses S,Parker CB, et al (2007). Male Circumcision for HIV prevention in young men in Kisumu Kenya: a randomised controlled trial. Lancet 369:643-56

[36] Gray H,Kigozi G, Serwadda D, et al (2007). Male Circumcision for HIV prevention in young men in Rakai, Uganda: a randomised trial. Lancet 369:657-66

[37] NERCHA, 2008. Mode of Transmission Study

[38] Kalichman et al 2007 as quoted in Swaziland Mode of Transmission study 2008.

[39] SDHS 2007

[40] CIETtrust, 2007, rev. 2008. Audience reception and impact evaluation of the Lusweti programme

[41] Swaziland HIV Estimates and Projection Report (2007)

[42] Prevalence for the whole population (all ages) is 19% (SDHS 2007). Prevalence among adults aged 15-49 is 26%.

[43] Bringing HIV to Scale – An Urgent Global Priority, Report, June 2007

[44] Vulnerability Assessment Committee report (2007).

[45] UNDP 2008 Human Development Statistical Update.

[46] SADC 2006: Reviewing the Epidemic in Botswana, Lesotho, Namibia and Swaziland. report

[47] Whiteside A et al, (2006) The Economic Impacts of HIV/AIDS in Swaziland

[48] Whiteside A et al, (2006) The Economic Impacts of HIV/AIDS in Swaziland

[49] The epidemic threshold is the reciprocal of the average duration of infection (11 years). Therefore, the epidemic threshold is 0.09. If the incidence or prevalence ratio is lower than this level (in 2007, it was 0.116), then the epidemic will not continue to grow. If we assume that the HIV prevalence remains constant over the next 5 years, then incidence has to reduce to 2.0% or lower for the incidence-to-prevalence-ratio to be lower than 0.09 and for the epidemic to start contracting.

[50] Government of Swaziland (2008) National HIV/AIDS Monitoring and Evaluation - Annual Report 2008, pg 12

[51] International practice of measuring sex work tracks female workers. This indicator will be improved to include male sex workers.

[52] This is the point prevalence of concurrency. Swaziland intends to also measure the point prevalence of concurrency through other studies – the BSS, and a new planned MCP study. It should also be noted that the baseline percentages in this indicator is based on the CIET study, which measures a proxy for concurrency. Therefore, care should be taken to compare similar surveys in the future with each other, and not to compare baseline values from one survey with that of another survey with a different sampling method. The upcoming MCP study should yield more accurate estimates of the baseline values.

[53] Teachers, pastors, members of parliament, bandlancana, Tindvuna tetinkhundla, Tindvuna temcuba, and Kagogo Centre Managers

[54] Bongaarts et al., 1989 ; Moses et al., 1990; Auvert et al., 2005; Drain PK et al., 2006, Bailey RC et al., 2007; Gray et al., 2007.

[55] WHO, UNICEF, IATT; Guidance on global scale-up of the prevention of mother to child transmission of HIV: towards universal access for women, infants and young children and eliminating HIV and AIDS among children. Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children.

[56] MOHSW, 2008, Services Availability Mapping report

[57] Need = 30,115, receiving 9,481

[58] MOT study, 2008 (using data from SDHS, 2007); and RSSC, 2008.

[59] Systems to monitor quality are still to be developed hence this result is not included in the results framework.

[60] HMIS Data, 2006, Ministry of Health and Social Welfare, Swaziland

[61] UNDP, 2008 Human Development Statistical Update.

[62] MOHSW, (2007) National TB Programme Annual Report,

[63] UNDP 2008 Human Development Statistical Update

[64] Calculation: To calculate the PLHI who know their status, take the total population, multiply by the % of population who know their HIV status, and multiple this by the % of the population who are HIV positive. This gives you the number of the population who know that they are HIV positive. Divide this by the total number of PLHIV (from Spectrum estimates) and this gives you the % of PLHIVs who know their status.

[65] HTC and Counselling National Guidelines, 2006.

[66] CSO (2007) Swaziland Demographic and Health Survey

[67] NERCHA (2007) Quarterly Services Coverage Report

[68] OI is an acronym for opportunistic infections, but this document uses a broader term "opportunistic conditions" to include all the infectious and other conditions usually included as OIs.

[69] This is the percentage who have survived up to 24 month, but it is the only analysis tool available.

[70] NERCHA and UNAIDS, 2007.

[71] MOHSW (2007) Swaziland National TB control programme Report

[72] MOHSW (2006): National TB Guidelines

[73] MOHSW (2007) National TB Programme Annual Report 2007.

[74] CDC 2008.

[75] Brandon Keim 2008.

[76] Shisana et al., 2005

[77] UNDP (2007/2008): Human Development Report (Global), and 2008 Human Development Statistical update

[78] SADC 2006: Reviewing the Epidemic in Botswana, Lesotho, Namibia and Swaziland. report

[79] SADC 2006: Reviewing the Epidemic in Botswana, Lesotho, Namibia and Swaziland. report

[80] Whiteside A et al, (2006) The Economic Impacts of HIV/AIDS in Swaziland

[81] Whiteside A et al, (2006) The Economic Impacts of HIV/AIDS in Swaziland

[82] These individuals include OVC, PLHIV, and the elderly

[83] 'Able to cope' is defined by a composite measure asked in the QIMS, where vulnerable persons are asked about a number of aspects of their lives, so as to determine whether they can cope with the impact of HIV in their lives.

[84] The number of households in Swaziland calculated by using data about the total number of persons in Swaziland, SDHS data about the sample demographic characteristics (table 2.1) (the number of persons in rural and urban households) and data from the VAC Report (2008) about the number of vulnerable persons.

[85] Whiteside A, et (2007): Reviewing 'Emergencies for Swaziland – Shifting the paradigm in a New Era

[86] Dlamini A. (2008) Formative research for Undertaking Quality, Relevance and Comprehensiveness of Impact Services Survey (QIMS) in Swaziland.

[87] Whiteside, et al (2006), The socio-economic impact of HIV in Swaziland.

[88] Jean, W-C Hsu et al 2005: 'Macronutrients and HIV and AIDS: A Review of Current Evidence'. Consultation on Nutrition and HIV and AIDS in Africa: Evidence, Lessons an Recommendations for Africa

[89] Linda Richter, Lorraine Sherr and Chris Desmond (2008): Learning Group 1: Strengthening Families: Integrated Report.

[90] GRA primary education = total # of primary school age population as a percentage of the official school age

[91] Ibid.

[92] NCCU (2008): National Response to Psychosocial needs of children; a three year strategic Plan 2008-2010 (draft)

[93] Swaziland, 2008, HIV/AIDS Monitoring and Evaluation Annual Report 2008

[94] NERCHA (2005) "Report of the Joint Review of the national Response to HIV and AIDS in Swaziland Mbabane

[95] The basic needs are identified as shoes, two sets of clothes, and a least one meal a day. They are considered essential to enable children attend school

[96] www.nercha.org.sz

[97] Linda Richter et all (2008) Learning Group 1. Strengthening Families; Integrated Report.

[98] UNICEF 2007: A national study on violence against children and young women in Swaziland.

[99] (2008) Draft Pilot and Report: Quality, Relevance and Comprehensiveness of Impact Mitigation Services Survey (QIMS) in Swaziland.

[100] Psychosocial support consists of trauma and grief counseling, emotional counseling and substance abuse counseling

[101] Michell Adato and Lucy Basset (2008) What is the potential of cash transfer to strengthen families affected by HIV/AIDS: A review of evidence on the impact of key policy debates.

[102] Extrapolation from the SDHD data on OVC. .

[103] NCCU (2008): National Response to Psychosocial Needs of Children: Three Year Strategic Plan 2008-2010.

[104] Dickson, C(2007): A Synthesis of institutional Arrangement on National AIDS Commission in Seven Africa Countries, (HLSP-Work in Progress)

[105] United Nations and Partners Alliance on OVC Sustainable livelihood and social Protection (2007) Regional Workshop "Catalogue of promising Initiatives and national Strategy of Support" Workshop Report.

[106] Joint United Nations programme on HIV/AIDS (2008) Caring in the Context of HIV/AIDS.

[107] Swaziland Global Fund Proposal Round 7, 2007.

[108] Dickson, Clare 2007, A Synthesis of Institutional Arrangement on National AIDS Commissions in Seven African Countries, HLSP (work in Progress document)

[109] UNAIDS, Global HIV and AIDS report, 2005.

[110] UNAIDS, 2006, Helping Ourselves – Community Response on AIDS in Swaziland, UNAIDS Best Practices collection.

[111] Internal response refers to interventions directed toward staff, while external response addresses those they serve.

[112] NERCHA, Joint review of NSP I (2005) and II (2008) reports

[113] HACI / UNICEF 2004, Guidelines for HIV and AIDS programming for OVC interventions in post conflict environments.

[114] Jonsson, 2003 – Human Rights Approach to Development Planning, UNICEF

[115] Funding from international development partners and government, but excluding private sector funding.

[116] NASA 2006/07. The other categories were: programme management, enabling environment, human resources (including salary supplements), social protection other than OVC, and HIV/AIDS research.

[117] UNDP /and the UN Africa Capacity Building Initiative 2006, Joint Review of the Regional Support Programme for HIV and AIDS, UNOPS.