THE KINGDOM OF ESWATINI

NATIONAL MULTISECTORAL HIV AND AIDS STRATEGIC FRAMEWORK 2018-2023

NERCHA

THE LAST MILE ENDING AIDS BY 2022

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JUNE 2018

FOREWORD

The Kingdom of Eswatini has made its commitment to End AIDS as a public health threat by the year 2022. This target was initiated in 2015 as a pledge towards a First World Eswatini and is in line with the global HIV/AIDS targets for 2030. Our commitment has seen an elaboration of plans and strategies to prevent new HIV infections and AIDS deaths through a multisectoral response, with the most recent being the extended National Strategic Framework (eNSF) and the Umgubudla Fast Track to End AIDS programme.

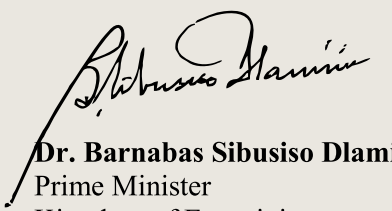
Through implementation of these initiatives, the Kingdom is proud to report that new infections have reduced by 44 percent since 2014, against a target of 50 percent. Over 80 percent of people living with HIV are alive and on treatment, and over 90 percent of those are virally suppressed. Moreover, the country has made large domestic investments in its HIV response, with public funds supporting 40 percent of the total cost and Government paying for virtually all antiretroviral drugs, since 2010.

In spite of all the gains, HIV and AIDS will continue to be high on the national agenda. This is because some sub- populations have not benefited from the strides made in prevention and treatment, with more than 2,500 new HIV infections occurring each year among young people aged 15-24, and with 15% of people living with HIV (PLHIV) not having tested and enrolled in care, the majority of whom being men and children under the age 14 years. Furthermore, other disease co-morbidities have emerged that pose a threat to the lives of those living with HIV.

To reverse this, we must continuously remain aware that AIDS is preventable and manageable. We must intensify and expand the measures at our disposal to prevent its spread and impact. The most important is to, firstly, make HIV prevention for the over 700,000 emaSwati who are HIV negative a priority, and, secondly, equally important to ensure that those who are living with HIV receive timely and quality HIV treatment to prevent their progression to AIDS. Thirdly, we must recognise that a multisectoral response is imperative to sustain the gains made, and we should collectively reduce all structural vulnerabilities that impede progress. This includes a broad economic resuscitation to support the fiscal demands of the lifetime treatment programme, economic empowerment of young people and the creation of a resilient social support system for those who are disproportionately affected by its impact.

This NSF 2018-2023 has been developed to super-fast track those ideals by detailing strategies that reach individuals, social networks, communities, and promote social change. It has been developed against the backdrop of an unstable and unpredictable financial resource climate, owing to the global flat-lining of resources for HIV/AIDS. Furthermore, our Government is faced with resource constraints in the light of extensive development priorities. In recognition of the realities, the NSF has included a chapter on innovative measures to support the fiscal sustainability of the response.

Finally, I again call for renewed commitment from all stakeholders in government, civil society, communities, people living with HIV/AIDS and the country's development partners to make this dream possible. Our dream is to End AIDS by 2022.



Dr. Barnabas Sibusiso Dlamini
Prime Minister
Kingdom of Eswatini

ACKNOWLEDGEMENTS

The National Emergency Response Council for HIV/AIDS (NERCHA) would like to thank His Majesty's Government and NERCHA Council for sanctioning the development of the National Strategic Framework 2018-2023. The NSF is presented as the multisectoral plan to build from the Umgubudla Roadmap for Ending AIDS by 2022. Whereas the Umgubudla recommends five high level strategic interventions to be fast tracked, the NSF expands to include externalities that can be harnessed through integration with other development programmes and considers the existing financial realities during which the framework will be implemented.

NERCHA is grateful for the support provided by the Technical Advisory Teams from the United Nations offices in the Kingdom of Eswatini, UNAIDS, and United States Government's PEPFAR team. The World Bank is commended for providing an independent external peer review of the NSF.

This NSF is the cumulative effort of the National Steering Committee led by Dr. V. Magagula-Ministry of Health, together with the Thematic Technical teams and the National Health Financing task team. NERCHA is indebted to all multisectoral stakeholders; Government Ministries, development bilateral and multilateral partners, People Living with HIV and AIDS (PLHIV), implementing partners, Civil Society Organisations (CSO) and local communities; who collectively provided useful insight into the process. Central government ministries of Finance (MoF), Economic Planning and Development (MEPD) and Public Service were engaged to guide the capacity of government's financial commitment to fulfilling this strategy as well as to promote mainstreaming of HIV synergies within the development sector.

I wish to recognise the commitment and passion of His Excellency the Right Honourable Prime Minister, Dr. Barnabas Sibusiso Dlamini for leading the national multisectoral HIV and AIDS response of the Kingdom. The NERCHA Directorate would like to express appreciation for the unprecedent support, guide and oversight provided by the NERCHA council.

Lastly, I would like to thank the consultancy team that was supported by UNAIDS Mr. Tom Mogeni Mabururu and Mr David Masengu and Dr Zara Shubber from the World Bank. The hard work by the NERCHA team for coordinating and leading the process is duly recognised

Mr. Khanya Mabuza
National Executive Director
National Emergency Response Council on HIV and AIDS (NERCHA)

TABLE OF CONTENTS

LIST OF TABLES

List of Tables

LIST OF FIGURES

List of figures

ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno Deficiency Syndrome
ALHIV	Adolescents Living with HIV
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Antiretroviral Therapy
AYP	Adolescents and Young People
BMU	Basic Management Unit
BSS	Behavioural Surveillance Survey
CANGO	Coordinating Assembly of Non-Governmental Organization
CBMIS	Community Based Management Information System
CHIMSHACC	Chiefdom Multisectoral HIV and AIDS Coordinating Committee
CMIS	Client Management Information System
CMS	Central Medical Stores
Comm-ART	Community Antiretroviral Therapy
CPT	Cotrimoxazone Preventive Therapy
CSOs	Civil Society Organisations
DNA	Pdeoxyribonucleic Acid
EID	Early Infant Diagnosis
eNSF	Extended National Multisectoral HIV and AIDS Strategic Framework
EQA	External Quality Assurance
FP	Family Planning
FPE	Free Primary Education
FSWs	Female Sex Workers
GBV	Gender Based Violence
GFATM	Global Fund for AIDS Tuberculosis and Malaria
HCWs	Healthcare Workers
HIV	Human Immuno Virus
HIV-DR	Human Immuno Virus Drug Resistance
HIV-RNA	Human Immuno Virus Ribonucleic Acid
HMIS	Health Management Information System
HTS	HIV Testing Services
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IPD	In Patient Department
KP	Key Population
LSE	Life-Skills Education

LTFUP	Lost To Follow UP
MDR-TB	Multi Drug Resistant Tuberculosis
MEPD	Ministry of Economic Planning and Development
MICS	Multiple Indicator Cluster Survey
MOF	Ministry of Finance
MoPS	Ministry of Public Service
MSM	Men who have sex with men
MTAD	Ministry of Tinkhundla Administration and Development of Health
MTCT	Mother to Child Transmission of HIV
NASA	National AIDS Spending Assessment
NCDs	Non-Communicable Diseases
NERCHA	National Emergency Response Council on HIV and AIDS
NMRL	National Molecular Reference Laboratory
NOP	National Operational Plan
NSF	National Multisectoral HIV and AIDS Strategic Framework
NTRL	National Tuberculosis Reference Laboratory
OIs	Opportunistic Infections
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PHU	Public Health Units
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child HIV Transmission
PNC	Post-Natal Care
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PSHACC	Public Sector HIV and AIDS Coordination Committee
RDT	Regional development Team
REMCHACC	Regional Multisectoral HIV and AIDS Coordinating Committee
REPS	Royal Eswatini Police Services
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SADC	Southern Africa Development Community
SBC	Social and Behaviour Change
SDG	Sustainable Development Goal

SDHS	Swaziland Demographic and Health Survey
SGBV	Sexual and Gender Based Violence
SHACO	Swaziland HIV and AIDS Consortium
SHAPMoS	Swaziland HIV and AIDS Programme Monitoring System
SHIES	Swaziland Household Income and Expenditure Survey
SHIMS	Swaziland HIV Incidence Measurement Survey
SHLS	Swaziland Health Laboratory Services
SI	Strategic Information
SID	Strategic Information Department
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SUSAH	Swaziland Uniformed services Alliance on HIV/AIDS
SWABCHA	Swaziland Business Coalition on Health and AIDS
SWANNEPHA	Swaziland National Network of People Living with HIV/AIDS
TB	Tuberculosis
TB/HIV	Tuberculosis and Human Immuno Virus
TIMSHACC	Tinkhundla Multisectoral HIV and AIDS Coordinating Committee
TLD	Tenofovir Disoproxil Fumarate Lamivudine and Dolutegravir
TPT	Tuberculosis Preventive Therapy
TWG	Technical Working Group
VAC	Violence Against Children
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision

EXECUTIVE SUMMARY

Overview

The National Multisectoral HIV and AIDS Strategic Framework (NSF) 2018-2023 is a five-year policy and planning document that has been developed to guide focused resource allocation, programming and implementation of the HIV response in the Kingdom of Eswatini. The vision for this NSF is to End AIDS as a public health threat by 2022 through epidemic control by focusing on drastically reducing new infections and AIDS-related deaths.

To achieve this, the NSF has laid down innovative strategic directions that build from the Umgubudla Roadmap for Ending AIDS (2016) to super-fast track the national response in the next five years. These include:

- Delivering comprehensive HIV prevention, treatment, care and support services as an integrated package to fast track the reduction of new infections and improve mortality.
- Timely quality HIV treatment services that integrate prevention and curative services of HIV co-morbidities to sustain the survival rates of people living with HIV and AIDS and contribute to fewer new infections through viral suppression.
- Developing local HIV responses to effectively micro-target priority and key populations.
- Transforming HIV coordination to effectively support the implementation of localised and differentiated responses.
- Mechanisms to facilitate sustainable financing of the response.
- Making available and use of granular data to inform localised response programming.
- Holding stakeholders accountable for NSF results.

This framework is premised on: the 2016 UN Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030; Sustainable Development Goals (SDGs); HIV Prevention 2020 Road Map; the African Union catalytic framework to end HIV/AIDS, TB and eliminate malaria in Africa by 2030; SADC policies on HIV and AIDS; The Swaziland Development Index 2022; the Umgubudla: Swaziland HIV Investment Case and recent technical policy guidance on HIV prevention, treatment and care.

NSF Goal and Impact targets

Eswatini has made major strides in its HIV response. New HIV infections have reduced by 44% in the past five years since 2014 and by year 2017, the initiation of PLHIV on ART had been accelerated to reach 85% of PLHIV; 92% of those are virally suppressed. Over 70,000 AIDS-related deaths have been averted since the introduction of antiretroviral therapy in 2003. This indicates that the country is on the trajectory to End AIDS as a public health threat. However, if this target is to be fulfilled by year 2022, the current incidence rate of 1.5% among those aged 15-49 is not sufficient to achieve epidemic control as younger people bear higher new infections, and some (15%) of PLHIV have not been tested nor enrolled in care, while more children and men living with HIV are not virally suppressed.

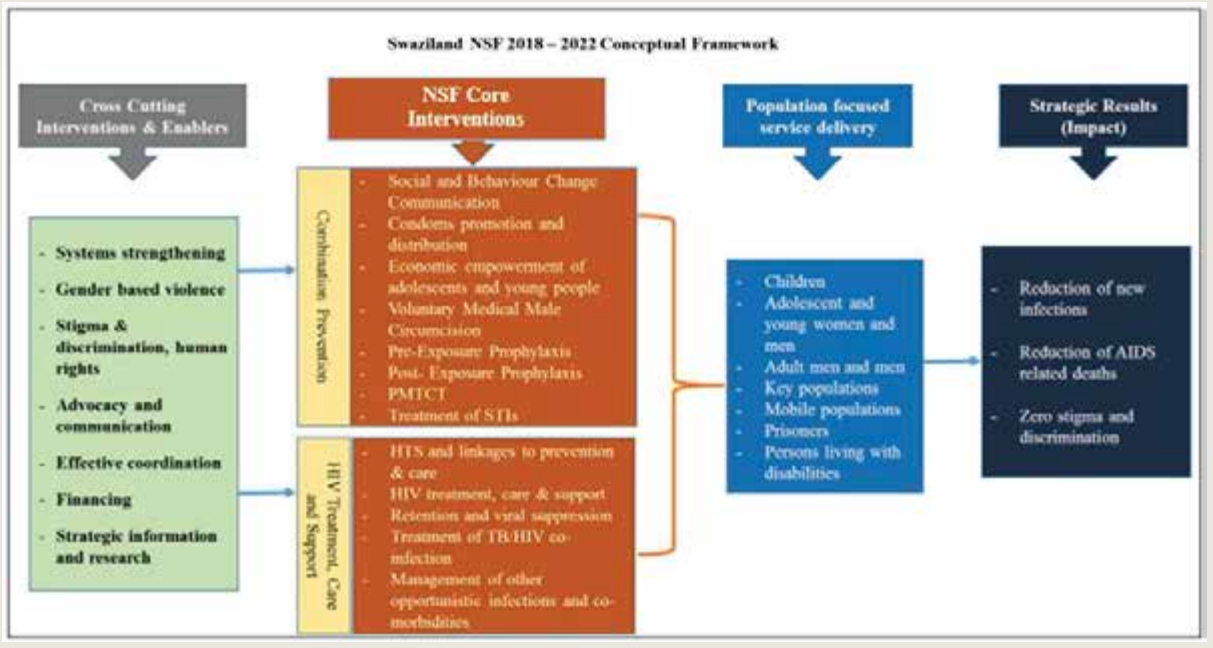
To support the goal to End AIDS by 2022, the NSF has made achieving the following population-level impact targets a priority:

1. Reduction of HIV incidence among persons aged 15-49 years by 85%.
2. Reduction of HIV incidence among persons aged 15-24 by 85%.
3. Reduction of new HIV infections among infants aged 0-1 year to less than 0.05%.
4. Reduction of AIDS deaths by 50%.

NSF CONCEPTUAL FRAMEWORK AND CORE INTERVENTIONS

The conceptual framework illustrated below shows the approaches for achieving impact targets of the NSF. This is premised on implementing selected NSF core interventions that are centred towards (i) Combination HIV prevention strategies to drastically reduce new infections, (ii) Scaling up treatment and care services of PLHIV to achieve viral suppression and reduce AIDS related deaths and (iii) Strengthening cross-cutting areas to create an enabling environment for improving gender equity and women's empowerment, addressing gender based violence, and promoting and protecting human rights including the elimination of HIV stigma and discrimination. These will be supported by improved coordination and strengthened systems to ensure efficient and effective delivery of HIV and AIDS services.

Figure 1: NSF conceptual framework



The strategic orientation of each of the core programmes (interventions) is as follows:

1. **Social and behaviour change (SBC)** as a cross-cutting programme to deliver risk reduction education and generate demand for the uptake of HIV services. Its focus will be on ensuring that people who are HIV negative remain uninfected and that those who are HIV positive have access to and adhere to treatment. SBC will target priority populations including adolescents and young people, men 25 years and older, key populations and the general public.
2. **Condom promotion and distribution** will ensure that condoms and lubricants are available at the right places for different populations. Strategic focus will be to promote consistent and correct condom use. The programme will be integrated in other programmes including VMMC, PrEP, STI, HTS, MNCAH, SRH, ART and general men's health. Innovative strategies for demand creation, developing positive risk perception and promoting consistent condom use will be promoted and barriers to condom use investigated to develop new approaches.
3. **Economic empowerment** will address structural vulnerability to HIV infection caused by poverty and unemployment, among adolescents and young people. These will be offered opportunities to improve their livelihoods through: entrepreneurship training; reintegration of teen mothers into schools; and facilitating access to income-generating opportunities. Economic empowerment components will be integrated into other HIV programmes.

4. **Voluntary medical male circumcision** will be scaled up to target younger men by using two approaches: (i) institutionalising MC in public health facilities and (ii) scaling up Early Infant Male Circumcision as a long-term sustainability strategy. Demand creation will be intensified to address the social norms and cultural and religious beliefs hindering VMMC uptake.
5. **Pre-Exposure Prophylaxis** will target sub-population groups that are at a substantially higher risk of HIV acquisition with priority given to adolescent girls and young women, pregnant and lactating women, sero-discordant couples, female sex workers and men who have sex with men.
6. **Post-Exposure Prophylaxis** will be offered to all persons who are exposed to HIV infection through sexual assault and accidental occupational exposure. Studies will be made to ascertain population-level efficacy and affordability for its roll-out for use in consensual high-risk sex in line with WHO guidelines.
7. **Prevention of mother to child transmission of HIV, syphilis and hepatitis** will embrace the double elimination of mother to child transmission of HIV and syphilis, and extend the scope to include hepatitis B. The programme will intensify the four PMTCT prongs to all HIV positive mothers, HIV negative mothers, their exposed infants and male partners. These services will be complemented with strong linkages to communities to support lifelong ART.
8. **The prevention and treatment of sexually-transmitted infections (STIs) programme** will be strengthened to contribute to the reduction of HIV infections through education, screening and treatment of STIs. Selected HIV services will be integrated at STI service points to include condom distribution and screening for PrEP eligibility, VMMC and HTS. STI clients who test HIV positive will be referred for ART.
9. **HIV testing services** will aim at ensuring that 95% of PLHIV know their status through case-finding methodologies that increase the chances of finding PLHIV and link them to care and treatment. Strategic approaches will be deployed to reach hard to reach populations such as adolescents and young people, adult men, key populations, mobile populations, prisoners and persons living with disabilities. Those testing HIV negative will be linked to HIV prevention services. Self-screening for HIV will be promoted to sustain regular testing for HIV negative persons.
10. **HIV care and treatment** will aim to ensure that 95% of PLHIV who know their HIV status are on treatment and that 95% of those on treatment are also virally suppressed by strengthening linkages from HTS to minimise loss of clients, deploying approaches to initiate priority and key populations and improving adherence to lifelong treatment. To support this, differentiated service delivery models, routine viral load testing and HIV drug resistance monitoring will be scaled up. Treatment regimens will be continuously reviewed to adopt those with better treatment outcomes and lower cost. The screening and treatment of TB/HIV co-infection will be sustained while the scope for HIV treatment will be expanded to screen for other related non-communicable diseases that are emerging as people age with HIV.
11. **Social protection and reduction of structural vulnerabilities** will include support for the full mainstreaming and institutionalisation of OVC programmes whilst programmes will continue to target OVCs for HIV prevention, treatment and care. The prevention and management of gender-based violence, reduction of stigma and discrimination, and promotion and protection of human rights will be a priority.
12. **System strengthening, enabling environment and HIV mainstreaming** includes strengthening health, community and social services systems as critical enablers to deliver quality HIV services and scale up the mainstreaming of HIV synergies in private and public sectors.
13. **Coordination and advocacy for HIV response** will be designed to support localised responses and planning for impact. The capacity of coordination structures will be strengthened while mechanisms will be established for programme coordination and for regular reviews of the NSF at national and regional levels. Advocacy will also be undertaken to rally all stakeholders to support the vision of ending AIDS by 2022.

14. **Mechanisms for sustainable financing** will be intensified since this NSF will be implemented in a resource-constrained environment. A two-pronged strategy has been proposed to mobilise resources from domestic, private and international sources and to maximise allocative and implementation efficiencies.
15. **Strategic information and research** will be strengthened to produce regular granular data to inform local responses and ensure efficient data flow and decision-making at national and regional levels. Financial data will also be produced to inform cost-efficiency analyses and identify ways of maximising resources

IMPLEMENTATION OF THE NSF

The NSF will be implemented through a multisectoral approach at national and decentralised levels. All sectors -public, private and civil society- will be involved in its implementation with the support of technical and development partners. Implementation will take the form of policy, planning, financing, implementation, advocacy and monitoring. The processes for implementation will include:

1. **The National Operational Plan:** A costed 2-year rolling National Operational Plan (NOP) will be developed to transform NSF strategies into action in order to achieve output level results shown in the NSF Results Framework (see Annex 1). The NOP will be updated annually.
2. **Advocacy and communication:** Advocacy and communication for the response will be undertaken at national, regional and community levels as well as internationally to sustain commitment to the response, ensure that implementers align to the NSF, influence integration, strengthen community systems and community involvement; and to showcase Eswatini's successes in the HIV response.
3. **Sustainable Financing:** An HIV financing committee will be established to lead resource mobilisation and implement the financing strategies outlined in section 4 of this document. Mechanisms to undertake regular expenditure tracking and other efficiency analyses will be put in place to support a consistent flow of funds, and an effective and efficient response.
4. **Thematic and Programme technical working groups:** TWGs will be established to review progress in the implementation of all key areas of the NSF and provide feedback for policy and decision making.
5. **Coordination structures:** Sectors will be streamlined to coordinate the implementation of NSF strategies within their constituencies, review progress, identify bottlenecks and develop solutions. Decentralised regional and community committees will play a similar role at local levels.
6. **Monitoring, Evaluation and Research:** M&E and research will be strengthened to produce granular and localised information through strategies laid out in section 3 of this document. A costed M&E and research (Strategic Information) framework will be developed to guide all monitoring, evaluation and research activities. Annual reviews of the NSF will be conducted each year. While the mid-term and end-of-term evaluations will be conducted in 2020 and 2022, respectively.

1. INTRODUCTION

1.1 Country context

The Kingdom of Eswatini is in the Southern African region and has a total land area of 17,364 square kilometres. The country is administratively divided into four regions, namely Hhohho, Manzini, Lubombo and Shiselweni. It has a population of 1.1 million people almost evenly distributed between males (48.6%) and females (51.4%). Population distribution varies across the four administrative regions with Manzini having the highest proportion (32.6%) followed by Hhohho (29.3%), Lubombo (19.4%) and Shiselweni (18.7%). Children aged 0-14 years constitute 35.5% of the population while adolescents and young people aged 15-24 years are 20.7%[1].

On the economic front, Eswatini's economy is experiencing its weakest performance in 34 years. Gross National Product contracted by 0.9% in 2016 largely due to a persistent drought, currency depreciation and weak regional economic conditions. Additionally, over the years government's public-sector wage bill has increased in a context of declining revenues, threatening fiscal sustainability[2]. The country's Human Development Index decreased between the years 1990 and 2015, from 0.548 to 0.541 in 2015, showing a decline of 1.3%. When discounted for inequality, the HDI falls to 0.361, reflecting a loss of 33.3%[3]. In the same period, life expectancy decreased by 10.6 years, while mean years of schooling increased by 2.0 years and the Gross National Income (GNI) increased by 13.2%. These social development indicators demonstrate the need to accelerate service delivery, especially for the poor.

Neonatal mortality rate per 100 live births is 21.4 (2016); under five mortality rate is 70.4/per 1000 live births (2016); maternal mortality is estimated at 389 per 100,000 live births, total fertility rate is 3.1 while contraceptive use (modern methods) among women 15-49 years is estimated at 65.5%[4]. The HIV response, therefore, is being implemented within a context of limited fiscal space, high poverty level, gender and income inequalities, and weak primary healthcare.

1.2 Overview of HIV and AIDS

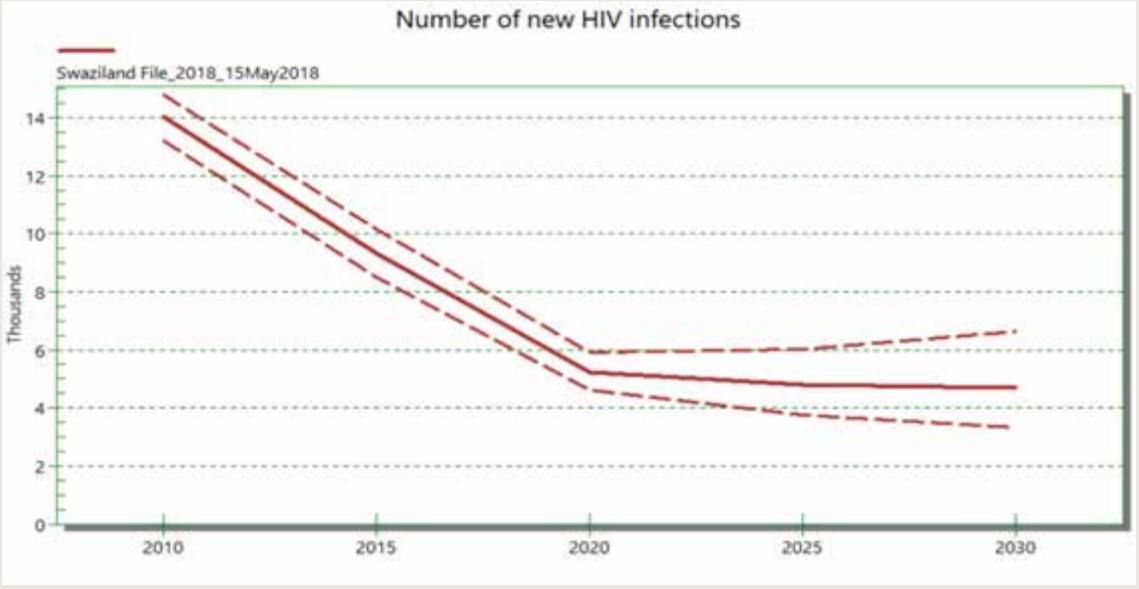
The Kingdom of Eswatini has made major strides in its HIV response. At the political level, commitment to the response has been sustained at the highest levels and a target to End AIDS as a public health threat by 2022 has been established since 2015. The extended National Strategic Framework (eNSF) was supported by the Umgubudla fast track targets to make this vision operational through an HIV investment case approach which maximizes resources for implementing technically effective interventions for combination prevention, and comprehensive HIV treatment for all people living with HIV(PLHIV).

As a result, the HIV prevalence rate has stabilised to 27.4% and new HIV infections have reduced by 44% in the past five years, from 2.9% to 1.5%. Figure 2 below shows the steep reduction in the number of new HIV infections since 2010[5], levelling off from year 2020 onwards as the impact of current programmes reach their maximum effect. Initiation of PLHIV on ART has been accelerated to reach 85% by 2018.

To date, over 70,000 AIDS-related deaths have been averted since the introduction of antiretroviral therapy in 2003. These are key indicators suggesting that the country is on the right trajectory to Ending AIDS as a public health threat.

1 Population Census Preliminary Report, 2017
2 World Bank, 2016
3 Swaziland Human Development Report, 2015
4 World Health Organization Data
5 In figure 2, the middle line is the mid-point (average new infections) while the dotted lines represent the upper and lower bounds.

Figure 2: Trends in new HIV infections, 2010-2030



Source: HIV Estimates and Projections (prelim.201

Despite these achievements, there is more work to be done. Evidence shows that the epidemic has shifted from what was known traditionally as a generalised epidemic to higher micro-epidemics impacting adolescent girls and young women aged 15-24, adult men aged 25 and older, mobile and migrant populations, and key populations. Moreover, evolving structural vulnerability factors such as poverty, unemployment and gender based abuse render certain populations to be most affected by the epidemic.

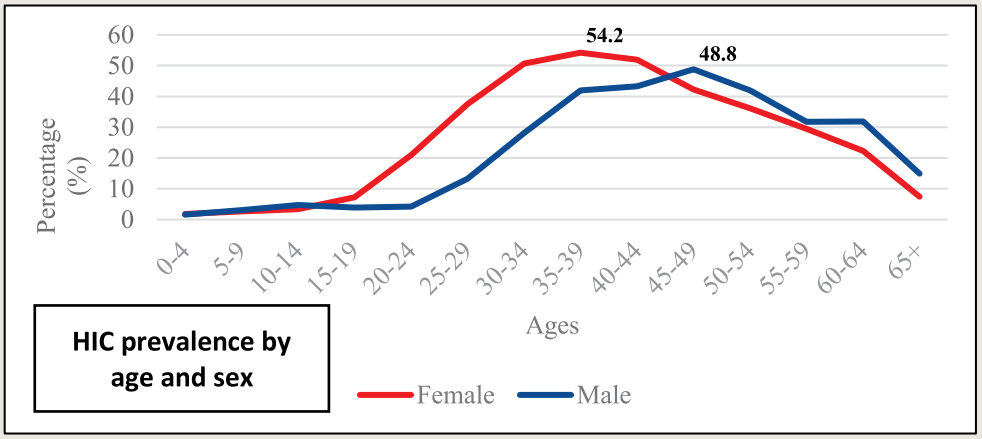
These dimensions present a new challenge since the HIV response can no longer be provided as a 'one size fits all'. Thus, the NSF ushers in the era of micro HIV responses that are tailored for sub-populations and locations in order to achieve the ideal of ending AIDS by 2022.

8)

1.3 Epidemiological context

Prevalence by age and sex: According to the SHIMS 2016/17, HIV prevalence increases with age for both sexes, reaching an earlier peak in women at 35-39 years (54.2%) and later for men at ages 45-49 (48.8%). Disparity in prevalence by sex is most pronounced among adolescents and young people with 20-24-year-old females having five times higher (20.9%) prevalence than their male counterparts (4.2%). One in every five young women 20-24 years is HIV positive, increasing to one in every three for women aged 25-30 [6]. HIV prevalence among adolescents and young people is indicative of new infections acquired rather than a survival effect of the treatment programme.

Figure 3: HIV Prevalence by age and sex, Eswatini

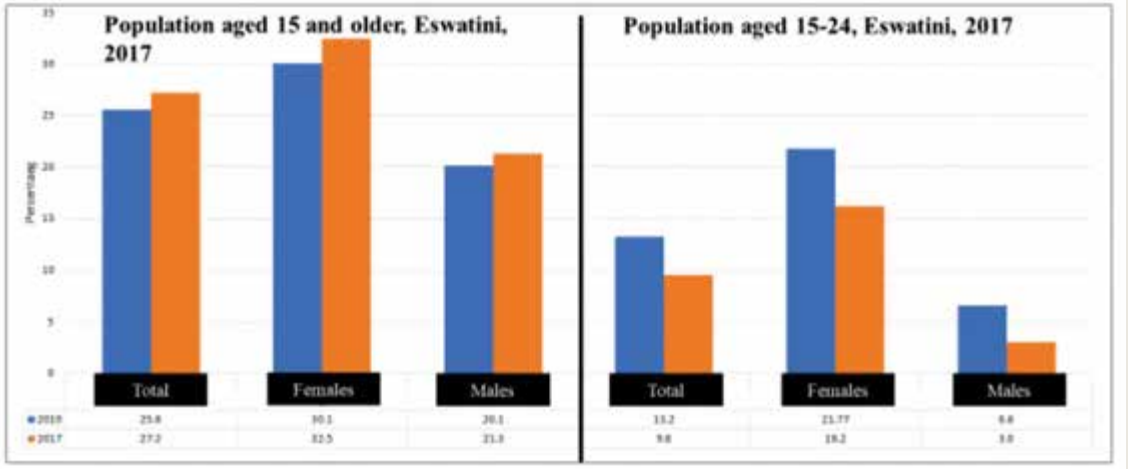


6 SHIMS 2016/17

Source: SHIMS 2016/17

HIV prevalence among people 15 years and older was 27.2% in 2017 with women being more affected (32.5%) than men (21.3%). In the same year, prevalence among adolescents and young people aged 15-24 was estimated at 9.6% (16.2% for females and 3.0% for males)[7].

Figure 4: HIV prevalence among 15+, and youth and adolescents aged 15-24, Eswatini



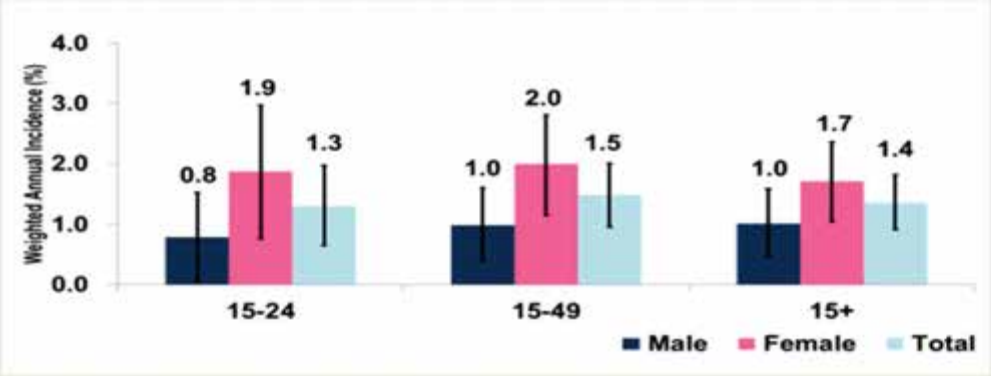
Source: Spectrum HIV Estimates, 2018

Prevalence among key populations: Key populations are particularly vulnerable to HIV infection due to their high-risk sexual behaviour and higher internal and external stigma and discrimination which constitutes as a major barrier to their service uptake. HIV prevalence among FSW is estimated at 60.5% while prevalence among MSM is 12.6%. Although the population size of the two key populations is relatively small compared to the general population[8], they contribute a significant proportion of HIV infections relative to their population size. On the other hand, prevalence of syphilis among MSM was 1.2% and 6.6% among FSW[9].

HIV incidence: Incidence among people 15+ years decreased from 2.70% in 2010 to 1.4% in 2017. Incidence is higher among women (1.37%) than men (0.93%) aged 15 years and older. The variation in incidence by sex is most pronounced among adolescents and young people (AYP) aged 15-24 with females having an incidence of 1.9% compared to 0.8% among males[10]. The number of annual new infections was estimated at 7,000 in 2017 broken down to 6150 infections among people 15 years and older and 850 among children 0-14 years[11].

7 Spectrum, 2018
8 Population size for FSWs estimated at 12.300 and MSM at 5,700 in 2017
9 HIV among Female Sex Workers and Men Who Have Sex with Men in Eswatini study, 2013
10 SHIMS2, 2017
11 Spectrum, 2018

Figure 5: HIV incidence by age and sex, Eswatini



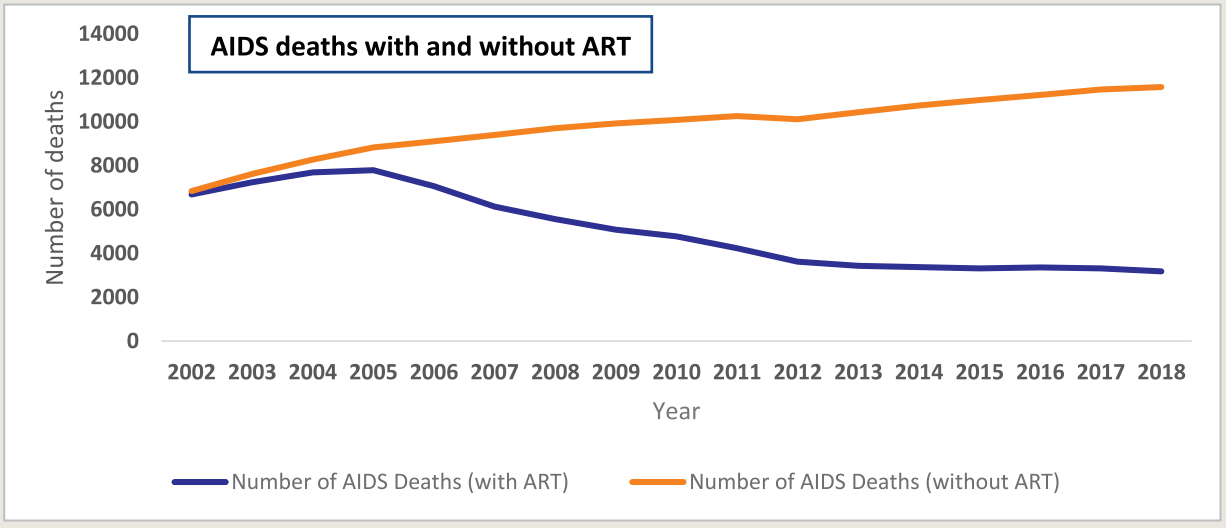
Source: SHIMS 2016/17

People living with HIV: An estimated 210,000 people are living with HIV comprising 90,000 males and 120,000 females. 13,000 children are living with HIV while 197,000 are adults[12]. 84.7% of the PLHIV know their HIV status, 87.4 % of those diagnosed with HIV are on ART and 91.9% of those that are on ART are virally suppressed[13].

HIV and opportunistic infections and co-morbidities: TB/HIV co-infection is estimated at 60% and mortality among TB/HIV co-infected persons is 14%. With an increasing number of people ageing with HIV, non-communicable diseases (NCDs) are emerging as a major concern. These include but not limited to cancers, diabetes, hypertension and mental illnesses.

AIDS deaths: Annual AIDS deaths have steadily decreased over the years to 3,500 in 2017, and almost evenly distributed among women and men[14]. The number of orphans due to AIDS-related causes decreased by 16% between 2013 and 2017. The number of orphans due to AIDS-related causes is higher than those orphaned by other causes[15].

Figure 6: AIDS deaths with and without ART, Eswatini



Source: Spectrum 2018

12 Spectrum, 2018
13 SHIMS, 2017
14 Spectrum, 2018
15 Spectrum 2018

1.4 Drivers of the HIV epidemic

Low comprehensive knowledge about HIV among adolescents and young people: comprehensive knowledge about ways of preventing HIV infection among young people declined from 58.2% in 2010 to 49.1% in 2014 among females and from 53.6% to 50.9% among males in the same period[16]. Further, knowledge levels among children 10-14 years is estimated at 34.6% with a slight difference between males (33.8%) and females (35.6%)[17]. This underscores the relevance of a dynamic life-skills programme for in- and out- of school youth.

Early sex debut: the SDHS 2007 and MICS 2010 and 2014 show that more females aged 15-24 (6.9%, 3.8% and 3.0% respectively) have sex before the age of 15 compared to males (4.8%, 2.6% and 2.8% respectively). Although this shows a downward trend, 48% females and 34% males have begun sex by age 18 indicating a rapid increase in debut between the ages of 15 and 18[18].

Dropping out of school: Education is a key factor in determining sexual debut and activity. A survey carried out in 2017 found that 30% of girls aged 15-22 years were sexually active compared to 80% of their counterparts who were out-of-school. Resultantly, HIV incidence and prevalence are almost four times higher among girls out of school than those in school[19]. A female with tertiary education is more likely to delay sex debut (less than 1% reporting sex before age 15) compared to those with primary education only (8%)[20]. Therefore, keeping girls in school has a protective effect on reducing HIV spread.

Poverty and unemployment: According to the labour force survey of 2016, unemployment among adolescents and young people aged 15-24 is estimated at 51.6% and poverty levels are estimated at 63.0% based on the 2009/10 Swaziland Household Income and Expenditure Survey (SHIES). Poverty and unemployment are interrelated factors that deprive adolescents and young people (especially girls and young women) access to secure livelihoods and expose them to risky sexual relationships with power imbalances.

Intergenerational sex: Although intergenerational sex between adolescent girls and young women (AGYW) 15-24 and older men has declined from 14.4% in 2011[21] to 8.7% in 2017[22], it is still a significant problem that contributes to HIV infections. AGYW engage in sex with older men who are within age groups with a higher HIV prevalence. This is shown by the higher HIV prevalence among girls between the age groups 15-19 and 20-24, which are 7.2% to 20.9% respectively, while prevalence for boys aged 15-19 is 3.9% and increases marginally to 4.2% for those aged 20-24. On the other hand, HIV prevalence starts increasing at a higher rate when men reach age 25 years, and above which could imply that these men start engaging in sex with women within their ages who already have higher HIV prevalence. AGYW are vulnerable to risky sexual interactions partly due to gender norms which make it difficult for them to negotiate safe sex, poverty and unemployment and low knowledge on HIV prevention.

Multiple sexual partnerships and low condom use: Condom use among persons aged 15-49 years during high risk sex has declined in the last five years. The proportion of men 15-49 years with more than one partner who reporting using a condom in the last sexual encounter declined from 82.6% in 2014[23] to 66.2% in 2017[24] and from 66.0% to 63.5% among women during the same period.

16 MICS 2010 and 2014
17 SHIMS 2016/17
18 SDHS, 2007
19 Sitakhela Likusasa Impact Evaluation
20 MICS 2014
21 Comprehensive HIV Epidemiological and Prevention Response Analysis report 2017
22 SHIMS 2016/17
23 MICS 2014
24 SHIMS 2016/17

Condom use among young people 15-24 engaged in high risk sex also declined from 69.6% in 2014[25] to 61.8%[26] and from 94.8% in 2014 to 74.7% among males in the same period.

Low levels of male circumcision: The prevalence of circumcision among males 15 years and older is relatively low (26.7%) and is lower in older men, from 38.2% among 15-19-year olds to 7.5% among those aged 65 years and older[27]. Negative social norms and cultural and traditional beliefs are reported as barriers to uptake of male circumcision.

High onward transmission rate from those recently infected and not yet on treatment: about 15% of PLHIV are not on ART and it is becoming harder to identify, test and put this cohort on ART. This group also comprises of persons likely to have been recently infected, who have no knowledge of their HIV status and are involved in onward transmission. Finding PLHIV who do not know their status and initiate their treatment is a key strategy for reducing new infections and AIDS deaths.

HIV stigma and discrimination: Although recent data on stigma is not available, focus group discussions held with men, adolescents and young people, people, community leaders and PLHIV indicated that the prevalence of self and external stigma is high and hinders service update[28].

Gender-based violence: 1 in every 3 women will experience some form of sexual violence by the time they are 18 years old[29]. Recent evidence shows that 6.6% of adults 15 years and 1.9% of children aged 10-14 experienced sexual abuse while about 4.6% of married women aged 15-49 experience physical and sexual violence from a male intimate partner. This shows that children start experiencing violence very early in their lives. Experience from GBV programmes shows that coercion and fear of repercussions prevent survivors of SGBV from reporting and seeking care and redress.

1.5 Vision and goal of the National Multisectoral Strategic Framework 2018-2023

Vision and Goal of NSF

The National Multisectoral HIV and AIDS Strategic Framework (NSF) is a five-year policy document designed to guide the national multisectoral HIV and AIDS response between 2018 and 2023. The vision of the national HIV response is to End AIDS as a public health threat by 2022.

The goal of the NSF is to super-fast track the HIV response to reduce new HIV infections by 85% and AIDS related mortality by 50% from 2017 levels by 2022.

NSF Impact level targets

To realise its vision, Eswatini aims to achieve the following impact targets by 2022:

1. Reduction of HIV incidence among persons aged 15 -49 years by 85%.
2. Reduction of incidence among persons aged 15-24 by 85%.
3. Reduction of new HIV infections among infants aged 0-1 year to less than 0.05%.
4. Reduction of AIDS deaths by 50%.

1.6 Innovative approaches to Super Fast-Track the HIV response

Eswatini seeks to super-fast track the HIV response to achieve the vision of ending AIDS within an environment of complex micro sub-population epidemics and constrained fiscal space amid declining international financing for HIV. The following innovative strategic directions will be pursued:

25 MICS 2014
26 SHIMS 2016/17
27 SHIMS 2016/17
28 Stigma Index 2010 and NSF evaluation report 2017
29 Study on Violence against Children & Young Women, UNICEF 2017

(i) *Delivering HIV prevention, treatment, care and support services as an integrated package to fast track reduction of new infections:* This includes a mix of biomedical and non-biomedical approaches with proven efficacy for direct and non-direct prevention efforts. These include male circumcision, condoms, prevention of mother to child transmission, pre- and post-exposure prophylaxis, prevention and treatment of STIs, HIV testing services and other behavioural interventions for risk reduction. These will be delivered as a package to provide individuals with options that work best for them through different platforms in private and public-sector settings, including community outreach, at schools, and health facilities. The strategy recognises ongoing clinical trials for preventive vaccines and supports their introduction thereafter.

(ii) *Developing local HIV responses to effectively micro-target priority and key populations:* This will be a shift from one national HIV response to localised HIV responses that address the specific needs of local communities and sub-populations given their epidemiology. Localised responses will be planned at Tinkhundla and chiefdom levels. The ambitious national level targets will be cascaded to local levels and disaggregated by population, sex and age among other factors. This approach will ensure that "no one is left behind".

(iii) *Making available and use of granular data to informal local responses:* The development of local responses and effective micro-targeting of priority and key populations will be driven by granular data. M&E systems will be configured to collect granular data, make the data available in real-time and allow progress reviews and analysis of gaps and sub-population needs at local levels.

(iv) *Transforming coordination to effectively support implementation of localised and differentiated responses:* The focus of response coordination has so far been at the national level. This strategic framework transforms coordination to local levels in order to put communities at the centre of the response, ensuring young people's participation and specifically adolescent girls and young women. This approach will propel implementation of localisation and micro targeting approaches. This will also harmonise coordination with M&E strategic directions.

(v) *Holding stakeholders accountable for results:* In addition to the transformation of coordination, mechanisms will be in place to hold implementing partners accountable for results and ensure that all NSF strategies are being implemented and targets being met. Accountability mechanisms will be established at national and regional levels.

(vi) *Sustainable financing of the response:* Given the limited fiscal space and significant reliance on donors to fund critical areas of the response, the NSF proposes a two-pronged resource-mobilisation strategy. The first will be to mobilise resources from traditional and non-traditional domestic sources which will include a private equity investment fund and other innovative options. The second approach is to maximise allocative and implementation efficiency through improved expenditure tracking, efficiency and cost-benefit analyses and improving effectiveness of implementation strategies.

1.7 Alignment of the NSF to global, regional and national frameworks

The NSF is inspired and aligned to key policies and frameworks guiding the fight against the HIV epidemic at the global, regional and national levels.

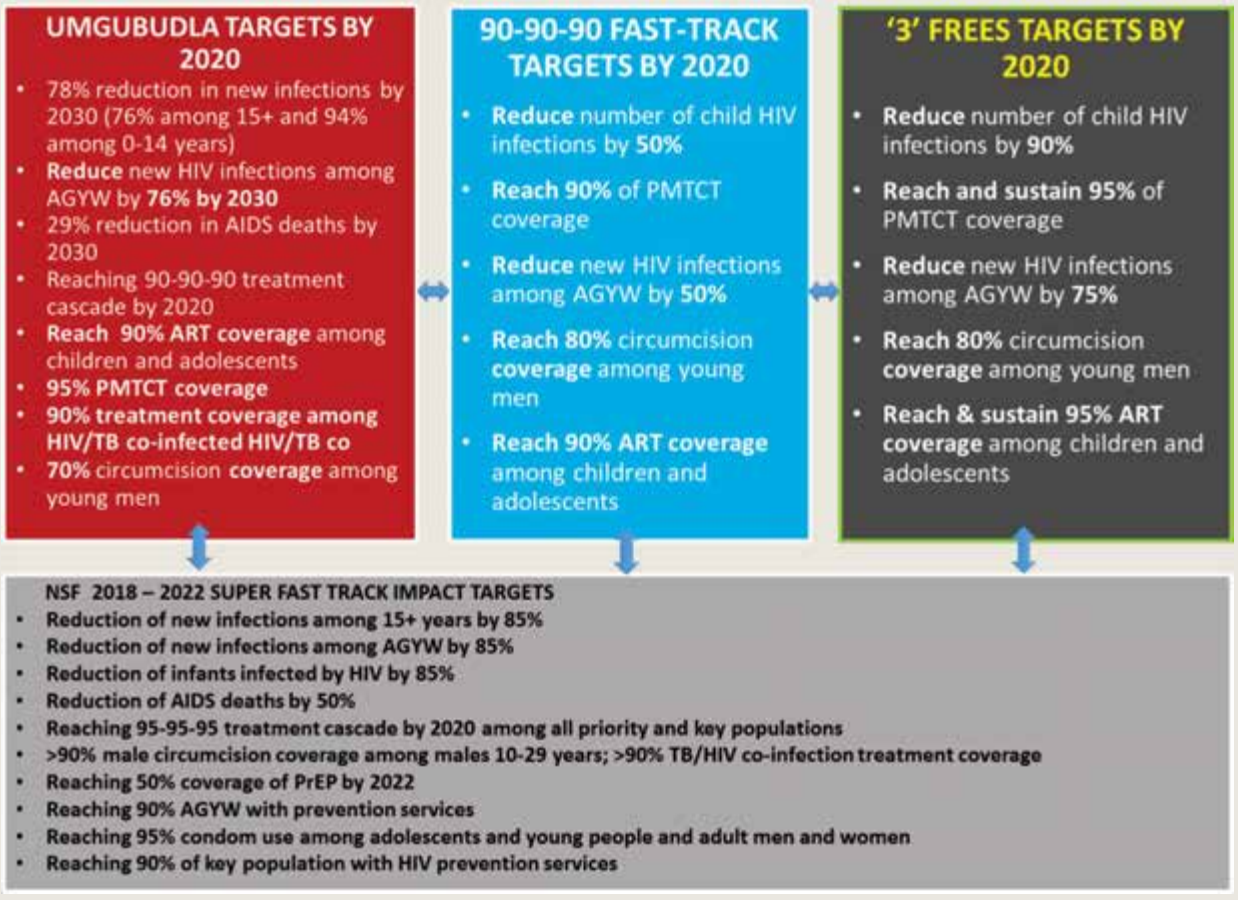
At the global level, the NSF is aligned to the Sustainable Development Goals (SDGs) in particular goals 2, 3, and 16. The NSF is also aligned to the 2016 UN Political Declaration on HIV and AIDS, the HIV 2020 Prevention Road map, the "three frees" targets, the Global Strategy for Women's Children's and Adolescents' health (2016-2030), and WHO guidance on treatment and care.

At the regional level, the NSF is aligned to the African Union Agenda 2063, Southern African Development Community (SADC) declarations and policy frameworks for combating HIV: The Regional Indicative Strategic Development Plan (RISDP) for strengthening HIV prevention, treatment and care,

socio-economic impact mitigation and monitoring; and the SADC declaration on Gender and Development.

At the national level, the NSF is also aligned to the National Development Strategy (NDS), Swaziland Development Index 2022, Umgubudla: Swaziland Investment Case and recent technical policy guidelines for delivering HIV prevention, treatment and care and support services. Figure 7 illustrates the alignment of the NSF with key global, regional and national targets.

Figure 7: Alignment of the NSF and other key frameworks



2. NSF STRATEGIC INTERVENTIONS

2.1 HIV prevention

Introduction

Preventing new HIV infections is a major focus of the HIV and AIDS response because over 800,000 people are HIV negative. The primary objective of the prevention programme is to accelerate the reduction of new infections among all populations by giving priority to populations with higher vulnerability to HIV acquisition and transmission based on geographic locations, behaviour, sex, economic status and other factors.

FIVE PILLARS OF HIV PREVENTION

1. Combination prevention for adolescent girls and young women
2. Combination prevention with key populations
3. Voluntary medical male circumcision and sexual and reproductive health services for men and boys
4. Comprehensive condom programmes
5. Rapid introduction of pre-exposure prophylaxis

Biomedical advancements as well as an increased understanding of routes of transmission have contributed to evidence-based models and strategies for preventing new infections. The NSF makes high impact combinations of behavioural, biomedical and structural prevention interventions a priority based on their efficacy to accelerate the reduction of new infections among populations with high vulnerability to acquiring or transmitting HIV. Combination prevention packages will be offered using differentiated approaches that are appropriate for each priority and key population at granular levels in response to geographic incidence and other vulnerabilities.

This priority is also premised on the 5 pillars of the global HIV prevention road map. It is also based on the 3 frees framework to ensure that AGYW remain HIV negative. People living with HIV will also be provided with key prevention interventions.

2.1.1 Social and behaviour change (SBC)

Programme objective: To promote delayed sexual debut among young people and reduce risky sexual behaviour among all sexually active individuals whilst concurrently promoting the uptake of HIV services.

Target populations: Young people, and all sexually active individuals targeting adolescents and young people aged 15-24 years, key populations, people with disability and adult men 25 years and older are the focus of social and behavioural change

Key outcome targets

Table 1: SBC outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of young people aged 10 to 14 who answered correctly to all HIV knowledge questions	ALL aged 10-14	34.6% (MICS, 2014)	52%	60%
% of people aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission	ALL	50% (MICS 2014)	69%	75%
	Male	50.9% (MICS 2014)	69% %	75%
	Female	49.1% (MICS 2014)	69%	75%
% of women aged 15-24 who had sex with a partner who is 10 years or older than them	-	8.7% (SHIMS 2016/17)	5%	3%

SITUATIONAL ANALYSIS

SBC aims to promote delayed sexual debut among young people, promote positive sexual behaviour and uptake of HIV services. Interventions addressing risky sexual behaviours are provided at national and community levels, targeting young people who are in and out of school, women, men and adolescents and community leaders. Key and most-at-risk populations are reached with tailored interventions. SBC is also implemented as an overarching intervention consolidating all communication for all HIV response interventions and critical enablers.

Despite this, comprehensive HIV knowledge is very low among adolescents and young people. The percentage of females aged 15-24 with comprehensive knowledge declined from 58.2% in 2010 to 53.6% in 2014 while there was a slight increase in the percentage of males with comprehensive HIV knowledge from 49.1% to 50.9% in the same period. Only 34.6% of males aged 10-14 have comprehensive knowledge about HIV. Shiselweni region has the lowest proportion of both females (26.6%) and males (25.3%).

Risky sexual behaviour such as early sexual debut, having multiple and concurrent sexual partners and intergenerational sex exposes young people, especially young women, to HIV infection. The median age at first intercourse is 16 years for girls and 18 years for boys, but 4% young women aged 15-19 had sex before age 15. Trends in intergenerational sex show that 14.1% of young women aged 15-24 years engaged in intergenerational sex in 2014 (MICS) and dropped to 8.74% in 2017 (SHIMS2). The proportion of people who have multiple sexual partners remains higher among men while casual sex, on the other hand, has increased among both sexes as 13.4% and 40.9% of men aged 15-49 have multiple sexual partners and casual sex respectively, while 37.3% of same aged women engage in casual sex[30].

During the NSF period, SBC programme processes and systems will be strengthened to deliver cross-cutting services that address risk factors, target by geographic and population risk, and promote uptake of HIV services. SBC will also focus on increasing demand for all aspects of the HIV continuum of care to achieve better treatment outcomes.

Gaps and Challenges

- Inadequate funding and coverage of SBC interventions.
- Lack of coordination mechanisms to harmonise programmes and service providers to ensure quality SBC interventions.
- Weak linkage and referral between SBC and other HIV services. This limits the extent to which
- SBC messages translate into behaviour change.
- Data gaps and inadequate evidence to inform SBC programming.
- Weak monitoring and evaluation of SBC interventions.

Strategies

I. *Develop and enforce a multisectoral coordination mechanism for all SBC programmes:* identify lead coordinator and institutionalise SBC coordination.

II. *Develop and implement a comprehensive national SBC programme with standards and service delivery procedures that targets priority and key populations*: Review and roll out the prevention core package, deliver it in all communities tailored to targeted populations.

III. *Strengthen integration of SBC in all HIV prevention, care and treatment services:* Make SBC an entry point for all HIV interventions, consolidate all SBC activities from all interventions to structure and harmonise delivery.

30 MICS 2014

IV. *Improve service targeting for key and vulnerable populations:* Format existing SBC interventions for the needs of persons living with disabilities, key populations, young people living with HIV (YPLHIV), and OVCs.

V. *Improve the quality and effectiveness of SBC:* build capacity and develop tools for implementers and standards for endorsement of all SBC materials.

VI. *Improve systems for SBC monitoring and data use at all levels*: undertake geographical mapping of HIV risk, note hot spots and most-at-risk populations to improve overall targeting and localisation of HIV prevention services.

VII. *Improve monitoring and evaluation systems for SBC and data use at all levels:* Review and strengthen the monitoring and evaluation system for SBC. Establish the geographic visual system for mapping SBC interventions. Identify research needs.

2.1.2 Condom Promotion and Distribution

Programme objective: To increase consistent and correct condom use among all sexually active persons.

Target population: All sexually-active people targeting young people and adolescents, adult men and women engaged in high risk sex, female sex workers and their clients, men who have sex with other men, STI patients, family planning clients, and pregnant and lactating women.

Outcome targets

Table 2: Condom promotion and distribution outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of young people aged 15-24 years with more than one partner in the past 12 months who report the use of a condom during last sex	Total	69.3% (SHIMS 2016/17)	90%	95%
	Male	74.7%	90%	95%
	Female	61.8%	85%	95%
% of men and women aged 15-49 years with more than one partner in the past 12 months who report the use of a condom during last sex	Total	64.3% (SHIMS 2016/17)	80%	90%
	Male	66.2% (SHIMS 2016/17)		
	Female	63.5% (SHIMS 2016/17)		
% of men who used a condom at last sex with a sex worker	Total	82.3% (SHIMS 2016/17)	90%	95%
% of female sex workers reporting the use of a condom with their most recent client	Total	No Baseline	90%	95%
% young women aged 15-24 years currently unmarried or not in union who report using a condom as a contraceptive	Total	31.8% (SHIMS 2016/17)	50%	95%
% of young women aged 20-24 who had at least one live birth by the age 18	Total	16.7% (MICS, 2014)	10%	5%

Situational analysis

Condom promotion and distribution has been intensified through targeted mass media, sub-population campaigns and integrated into other HIV services including medical male circumcision, HTS, PMTCT, ART, STI and Family Planning. Condom distribution outlets are strategically placed to reach all priority and key populations at health facilities, social places, public toilets, branded shops, work places and key

population hot spots. As a result, condom distribution increased from 18 million male condoms in 2015 and 26 million in 2017. Female condom distribution has remained low with just 172,613 condoms being distributed in 2016. About 212,000 lubricants were distributed in 2017.

Condom distribution has not translated into use. Condom use at last sex among young people aged 15-24 who engage in high risk sex with a non-marital and non-cohabiting partner reduced from 90.6% to 74.7% for men and from 73.1% to 61.8% for women in 2010 and 2014, respectively. Similarly, condom use among people aged 15-49 reduced from 69.2% to 66.2% for men and from 73.1% to 63.5% for women during in the same period[31]. Condom use with high risk populations is low as just 74.2% of men aged 15 years and older who reported buying or selling sex from a commercial sex partner used a condom at last act. The high rates of STIs and teenage pregnancy reflect poor condom use. Only 32%[32] of adolescent girls and young women aged 15-24 years indicate using a condom as a contraceptive while 16.7% of young women aged 20-24 years had at least one live birth before 18 years of age. Integrating FP services into condom programming provides an opportunity to delay or avoid pregnancy while at the same time reducing the risk of HIV infection.

During the NSF period, the condom programme will reinvigorate condom promotion and demand creation among all populations using strategies that target persons likely to engage in high risk sex. To broaden opportunities and motivation for condom use, condom promotion will be intensified at all relevant service points, with paid focus within the sexually transmitted infections and family planning programmes.

Gaps and challenges

- Low and inconsistent condom use among persons engaged in high risk sex.
- Negative perceptions towards the free to user condoms being distributed because some of the young people view these to be of inferior quality to those that are colour-branded or sold in commercial outlets.
- Limited acceptability and uptake of the female condom by both men and women.
- Unfriendly condom outlets at community level to young people and men due to social barriers.
- Some of the outlets are not youth friendly while adult men have difficulties accessing condoms in
- outlets manned by younger people.
  the focus on condom promotion for HIV overshadows their benefits for family planning and preventing STIs.
- Weak focus on broader health needs which hinder condom use, especially men's health.
- Weak coordination of condom distribution and reporting.

Strategies

I. *Scale up condom promotion, demand creation and distribution:* Integrate condoms into other interventions and implement targeted distribution.

II. *Strengthen availability of condoms and other commodities:* Provide condoms and supportive commodities according to target population preferences. Improve procurement, supply and distribution systems. Support continuous operational research to identify condom distribution outlets and client feedback on condoms.

III. *Strengthen integrated condom promotion strategies:* make the STI, family planning, ANC and ART programmes also prominent

31 MICS 2010 and 2014
32 SHIMS 2016/17

IV. *Strengthen men's health programmes*: address men's primary health concerns that hinder condom use.

V. *Improve condom monitoring:* Review current condom reporting system.

2.1.3 Economic empowerment for adolescents and young people

Programme objective: To build self-esteem and promote empowerment opportunities to mitigate structural risk factors to HIV infection among young people.

Target population: Adolescents and young people, survivors of gender-based violence, teenage mothers and AIDS-impacted OVC.

Outcome targets

Table 3: Economic empowerment outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of vulnerable young people aged 15-24 reached with at least one economic empowerment intervention	ALL	No baseline	70%	80%
	Male		65%	75%
	Female		70%	80%
% of female school drop outs who return to formal school	Total	No baseline	60%	80%

Situational analysis

Economic empowerment focuses on addressing the vulnerability to HIV infection and mitigating the impact of HIV and AIDS among vulnerable populations. Structural factors such as economic dependence and unequal economic opportunities, gender inequality, and poverty render vulnerable groups susceptible to high risk sex. Lack of assets and secure access to livelihoods, coupled with a lack of social protection against abuse and exploitation exacerbates the susceptibility. These pressures contribute to high risk behaviour such as multiple and concurrent partnerships, intergenerational sex and vices like sex work and transactional sex.

According to the Labour Force Survey of 2016, 51.6% of the youth aged 15-24 years are unemployed, with more (56.7%) women being unemployed than men (46.6%). 33.3% males and 32.3% females are discouraged and have stopped looking for employment, becoming susceptible to sexual abuse and exploitation. Some adolescents and young people who have dropped out of school, especially females, have limited skills and find it difficult to engage in economic activities.

The country has put in place several economic empowerment opportunities, including: the youth development fund; free primary education; and the recent Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) initiative.

The NSF will focus on providing economic empowerment opportunities to young people in order to reduce their vulnerability to high risk behaviour. Empowerment initiatives across sectors will be consolidated to facilitate accountability and contribution to the HIV response. These will be provided within the wider social protection framework including gender empowerment.

Gaps and challenges

- Poor coordination of economic empowerment initiatives.
- Weak mainstreaming of economic empowerment into HIV programmes. There are few HIV programmes that have economic empowerment components partly due to funding limitations.
- Inadequate capacity of HIV implementers to design economic empowerment initiatives.
- Weak implementation of the education policy regarding reintegration of girls and boys dropping out of school.

Strategies

I. *Strengthen economic empowerment models for HIV prevention:* Map existing economic empowerment initiatives and create linkages for AYP, integrate economic empowerment into existing HIV programmes and capacity building for HIV prevention implementers.

II. *Strengthen vulnerability reduction initiatives:* Intensify the retention of girls in schools and reintegrate drop-outs into schools.

III. *Strengthen systematic engagement of economic empowerment initiatives for HIV prevention:* Scale up evidence-informed economic empowerment models targeting AYP and roll out models that target adolescents and young people who are more vulnerable to HIV infection.

IV. *Institutionalise economic empowerment training*: Promote skills-based initiatives in vocational and entrepreneurship education and training and include these in national education curricula.

2.1.4 Voluntary Medical Male Circumcision (VMMC)

Programme objective: To increase the uptake of medical male circumcision among men.

Target population: HIV negative males aged 0-49 years, with a close focus on males aged 10-29 years and infants.

Outcome targets:

Table 4: VMMC outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% males aged 10 to 49 year who are circumcised	0-49	24.3% (MICS 2014)	50%	70%
	<1 year	6.6% (MICS 2014)	40%	60%
	10-29	No baseline	70%	80%

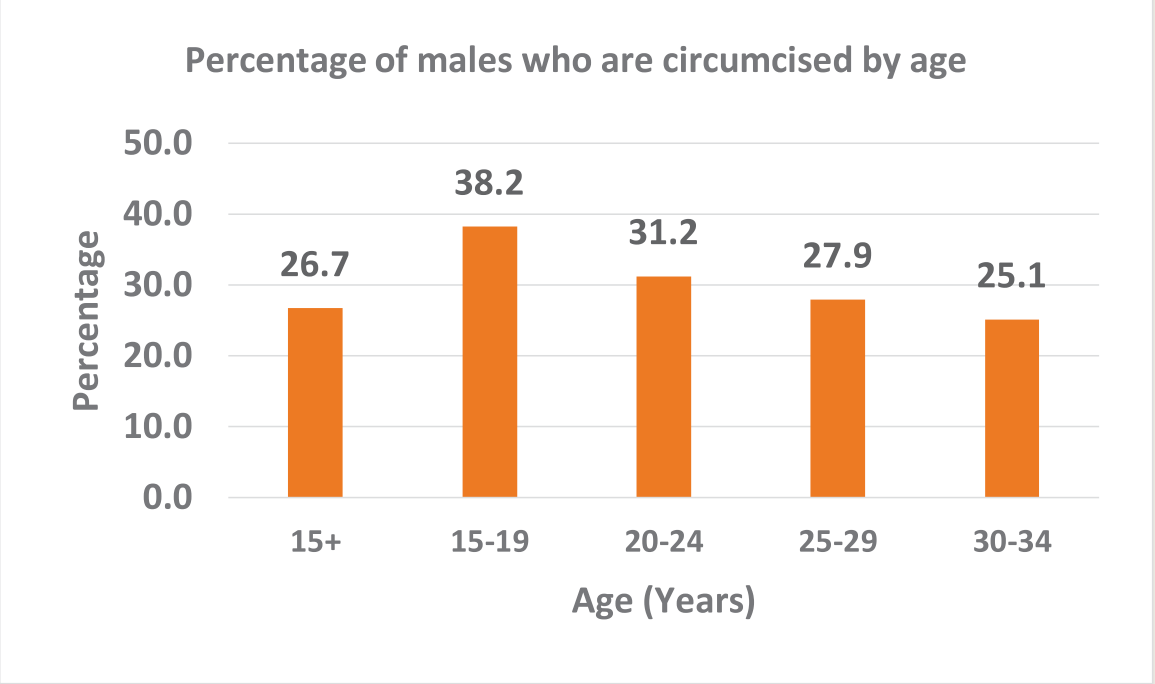
Situational analysis

VMMC aims to circumcise men and boys and is also an entry point for men to access all HIV services with emphasis on prevention services after the procedure. The programme makes younger males the priority, although older males over the age 30 are provided with the service. Early Infant Male Circumcision (EMIC) is limited. VMMC services are currently offered as a vertical programme through three approaches: fixed sites; outreach services which create demand and link to health facilities; and mobile VMMC services. Condom promotion and HTS have been integrated into VMMC.

The proportion of males aged 15 years and older who are circumcised increased from 19.1% in 2010 to 26.7% in 2017. There is higher coverage among males between 15-29 years compared to other age

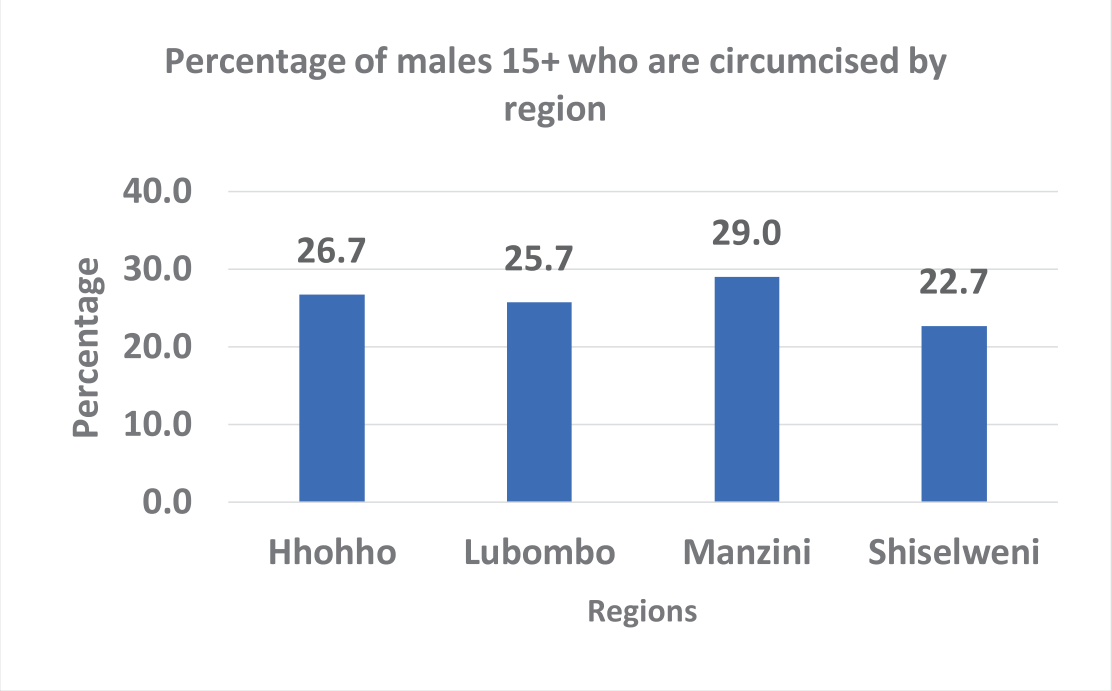
groups[33] as shown in the figures below. Male circumcision rates vary across regions ranging from 22.7% in Shiselweni to 29% in Manzini. Male circumcision coverage by region and by age is shown in the figures below.

Figure 8: Males who are circumcised by region, Eswatini



33 SHIMS 2016/17

Figure 9 : Males who are circumcised by region, Eswatini



Source: SHIMS 2016/17

During the NSF period, the focus will be to increase service availability by integrating the programme into routine health services and scaling up Early Infant Medical Circumcision (EIMC) as a long-term sustainability strategy. Integration with the other prevention packages, including risk reduction education, condoms, HTS and PrEP, and linking those found to be HIV positive to care and treatment will be promoted.

Gaps and challenges

Low uptake of VMMC services.
Inadequate demand creation for VMMC.
Inadequate integration and linkages of VMMC to other HIV services.
Unsustainable funding since programme is heavily reliant on donor support.

Strategies

I. *Accelerate VMMC service integration*: Integrate in public health facilities including Early Infant Male Circumcision into post-natal care services, address social norms and cultural beliefs against
II. *Scale up integration of other prevention services into VMMC*: Establish VMMC as an entry point for other HIV services, provide a prevention core package of services and link men to care and treatment.

2.1.5 Pre-Exposure Prophylaxis (PrEP)

Programme objective: To provide PrEP to people at higher risk of infection.

Target populations: All population groups at higher risk of HIV infection, including sexually active adolescent girls and young women, pregnant and lactating women, sero-discordant couples, adult men, female sex workers and men who have sex with men (MSM).

Key outcome targets

Table 5: PrEP outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of people on PrEP who adhere to it 1 month from initiation	Females (15-25)	No baseline	50%	70%
	Pregnant and lactating mothers			
	Sero-discordant couples			
	FSWs			
	MSM			

Situational analysis

Pre-exposure prophylaxis of HIV (PrEP) is the use of an antiretroviral medication to prevent the acquisition of HIV infection by uninfected persons. In September 2015, WHO recommended that people at substantial risk of HIV infection should be offered PrEP as an additional HIV prevention option.

Eswatini introduced PrEP in 2017 as a demonstration project to learn lessons that will inform its adoption to high risk groups. The project identified people in substantial risk as those who had unprotected sex with a person with either known or unknown HIV positive status. The key entry points for the PrEP demonstration project have so far been family planning, outpatient, ANC and HTS sites. One third (33%) of those with substantial risk and clinically eligible have agreed to initiate PrEP, 75% of those being females. The difference between those eligible and those initiated is largely attributed to low awareness about PrEP and that clients need time to decide whether to initiate. Most clients initiating PrEP are women because of the entry points utilised, given that fewer men visit health facilities.

During the NSF period, the programme will draw lessons from the pilot to develop comprehensive national PrEP guidelines that target high risk populations and improve access for all eligible populations.

Gaps and challenges

PrEP is a new technology not widely known by target populations.
Limited access for men, adolescents and young people, and key populations.
Low capacity among healthcare workers to initiate PrEP.
Low initiation rate among those at substantial risk of HIV infection and clinically eligible for PrEP.

Strategies

I. *Scale up PrEP services:* Integrate PrEP into health services entry platforms, intensify collaboration between community level actors and health facilities and mainstream PrEP into the HIV prevention package.
II. *Strengthen the demand of PrEP*: Intensify PrEP awareness and create demand through tailored approaches for eligible populations using non-stigmatising approaches.
III. *Strengthen collaboration between community level actors:* Ensure effective referral and follow up of PrEP clients.
IV. *Strengthen the M&E for PrEP:* Integrate PrEP indicators into the HMIS monitoring and reporting system: Identify and mainstream PrEP indicators.

2.1.6 Post-Exposure Prophylaxis (PEP)

Programme objective: To reduce the risk of HIV infection among people who have been exposed to body fluids in occupational and non-occupation settings.

Target populations: Eligible victims of sexual violence, health care workers, community health carers, firemen and all other emergency services cadre personnel.

Key outcome targets

Table 6: PEP outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of eligible sexually abused people receiving PEP	Male	No baseline	90%	95%
	Female			
% of exposed service cadres receiving PEP	Health Care Workers	No baseline	90%	95%

Situational analysis

Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. PEP services are widely offered in health facilities to occupational cadres and sexual assault victims. Within the health sector, PEP is offered as part of the comprehensive universal precautions package that reduces healthcare workers' exposure to infectious hazards at work.

The 2014 WHO guidelines on PEP have simplified the prescription for PEP to improve adherence and completion rates by recommending better-tolerated drugs. The guidelines also recommend PEP to cover all types of exposure, in all population groups, including adults, adolescents and children. This provides an opportunity for Eswatini to scale up PEP services as a prevention measure for all exposures.

During the NSF period, PEP will be included as part of the comprehensive HIV prevention package and offered to all eligible persons who are exposed through sexual assault and accidental exposure at work. Research will be undertaken to assess the feasibility and affordability of using PEP for non-accidental exposure or consensual sex.

Gaps and challenges

- Limited awareness of availability of PEP for accidental exposure.
- Limited knowledge of PEP and non-supportive attitude by HCWs limit PEP uptake.
- Low referral and uptake of PEP by survivors of sexual violence.
- Late reporting for PEP by survivors of sexual violence.
- Weak monitoring and surveillance system.

Strategies

I. *Create awareness and demand for PEP services among eligible populations:* Promote target for PEP uptake.

II. *Generate evidence on expansion of PEP provision to the general population*: Undertake research on the feasibility of providing PEP to people who had consensual unprotected sex.

2.1.7 Prevention of Mother to Child Transmission of HIV (PMTCT)

Programme objective: To eliminate pre- and post-natal mother-to-child transmission of HIV, syphilis and hepatitis B and to keep HIV positive mothers, their partners and children alive and on treatment.

Target populations: Sexually active women aged 15-49, their partners and all HIV-exposed infants.

Key outcome targets

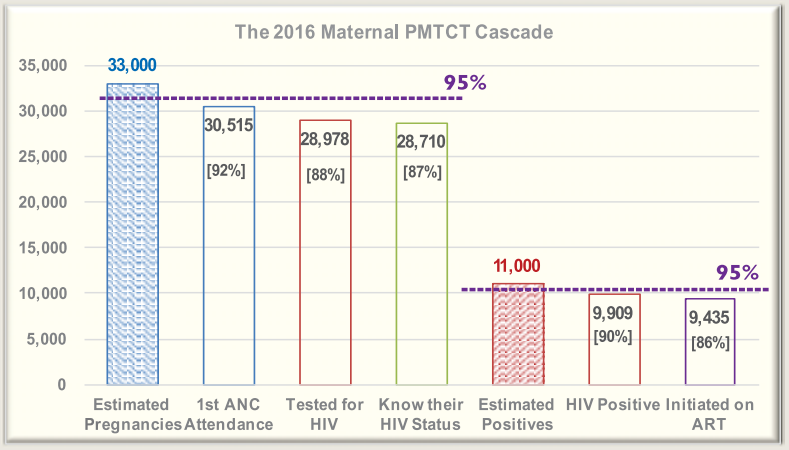
Table 7: PMTCT outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of HIV infected infants aged 6-8 weeks who are born to HIV positive mothers	Total	3% (HMIS,2017)	2%	>1%
% of pregnant and lactating women alive and on treatment 12 months after ART initiation	Total	No baseline	>85%	>90%
% of HIV positive children under 1 year who are retained on ART	Total	No baseline	80%	>90%

Situational analysis

PMTCT strategies are guided by four prongs: primary prevention of HIV infection among women of child-bearing age; prevention of unwanted pregnancies among women LHIV; prevention of HIV transmission from women infected with HIV; and treatment, care and support for women infected with HIV, their infants and partners. The country has developed the National Strategic Plan for Ending AIDS and Syphilis in children 2018-2023, which calls for zero new HIV infections in exposed infants and the elimination of congenital syphilis.

Figure 10: PMTCT maternal cascade, Eswatini



While the annual HIV incidence rate has decreased, females have a relatively higher incidence of 1.7% compared to males (1.08%), with younger females between the ages 15 to 24 years at higher risk of HIV infection [34]. Contraceptive use to prevent unwanted pregnancies is 66.1% while 15.2% of women aged 15-49 have unmet needs for family planning. HIV positive women are provided with sexual reproductive health rights and family planning services at HIV care and treatment sites.

In 2016, out of an estimated 33,000 pregnancies, 11,000 pregnant women tested HIV positive and 86% were initiated on ART. About 90% of pregnant women were screened for syphilis and an average of 2.5% tested positive. Of those, about 85% were treated.

During the same year, maternal sero- conversion rates were 1.3% during ANC, 1.5% during labour and delivery, and 1.9% at post-natal care.

34 SHIMS 2011 and SHIMS2016/17

Almost all (97%) exposed infants that were seen at 6-8 weeks were given cotrimoxazole prophylaxis; 96% were tested for HIV using DNA/PCR and 2% tested HIV positive. 68% of those who were found to be HIV positive were linked to ART.

Syphilis screening and treatment among pregnant women has been fluctuating year-on-year. The country does not have a national hepatitis programme but there are some existing policies guiding the prevention and control of hepatitis. These include policies regarding vaccination of infants at 6, 10 and 14 weeks, screening of pregnant women, and screening of blood and blood products for hepatitis B. Data from blood donor screening indicates hepatitis prevalence at 3.7% in 2016.

During the NSF period, the focus will be on addressing the "last mile" bottlenecks to achieve a >0.05% MTCT rate. The programme will focus on providing testing all pregnant women for HIV, syphilis and hepatitis; testing exposed infants for HIV; and getting all HIV positive pregnant and lactating women, their HIV positive partners and infants, initiated on ART as soon as possible.

Gaps and challenges

- Limited access to reproductive health and family planning services by adolescent girls and young women.
- Maternal sero-conversion during pregnancy and lactating period.
- Critical gaps in the PMTCT cascade with 5% pregnant women not tested for HIV and 15% HIV positive pregnant women have not initiated ART.
- Low uptake of postnatal care services as only 86% of women who delivered attend PNC.
- Weak linkages to care and treatment for infants as only 68% HIV positive infants are linked to ART and there are low viral suppression rates among infants 0-1 years.
- Low screening and treatment of syphilis
- Limited awareness and knowledge of viral hepatitis among policy makers, health workers and the public.
- Seroconversion of exposed children who are born HIV negative.

Strategies

I. *Strengthen HIV prevention among women of child bearing age:* Provide comprehensive HIV prevention that includes counselling, PrEP, PEP, Condoms, STI treatment etc.

II. *Strengthen PMTCT provision to optimize reach target population*: integrate PMTCT into sexual and reproductive health (SRH) services. Optimise initial and HIV retesting for all pregnant and lactating women and their partners, screen and treat pregnant women for STIs.

III. *Reduce the MTCT transmission of hepatitis and syphilis:* Integrate and scale up initiatives for prevention of MTCT of hepatitis B into the PMTCT programme.

IV. *Optimise ART for pregnant and lactating women:* Ensure adherence, retention and viral load suppression for pregnant and lactating women, their HIV positive partners and infants: Facilitate follow up mechanisms to identify and retain breastfeeding women and their infants in the continuum of care.

V. *Prevent sero conversion of infants and mothers:* Strengthen follow up mechanisms to identify and retain breastfeeding women and their infants in the continuum of care.

2.1.8 Management and Treatment of Sexually Transmitted Infections (STI)

Objective: To reduce STI cases and thereby control HIV transmission by minimising the risk factor.

Target population: All STI clients, sexually active adolescents and young people, and key populations.

Key outcome targets

Table 8: STI outcome results

Indicator	Disaggregation	Baseline	Targets for years	
		(Source)	2020	2023
% of people aged 15-49 years who had a sexually transmitted infection in the past 12 months	Total	No baseline	≤10%	≤5%

Situational analysis

Sexually transmitted infections (STI) and HIV share the same transmission routes and the risk factors for each increase the risk of the other. Persons infected with sexually transmitted infections are more vulnerable to HIV acquisition and genital inflammation attributed or resulting from gonorrhoea, chlamydia, trichomonas, and HSV-2 is reported to increase the risk of HIV infection among women[35]. Therefore, proper prevention, screening and treatment of STIs has several benefits for HIV prevention.

National STI guidelines are in place and services are offered routinely in health facilities across the country with HIV services including HTS, condoms, male circumcision and risk reduction education being integrated. STI sites are also used as key entry points for HTS index case testing and the PrEP pilot services. STI clients found to be HIV positive are linked to HIV care and treatment.

An STI study among women carried out in Eswatini in 2017 covering four STIs – *Chlamydia trachomatis (CT), Neisseria gonorrhoea (NG)*, *Trichomonas vaginalis (TV)*, and *Treponema pallidum* (syphilis) found that STI prevalence was high (19.4%) and that 6.3% of women had multiple STIs. Single women and women living with a partner (but not married) were found to have the highest prevalence compared to married women (26.4% vs 11.2%). STI prevalence was higher among younger age groups.

During the NSF period, the STI programme will strengthen STI prevention and management, intensify the integration and referrals to prevention services, and promote linkages for early ART treatment for those who are HIV positive.

Gaps and challenges

- High internal stigma among clients with STIs.
- Myths and misconceptions of STI transmission and treatment.
- Weak STI screening and syndromic management approach.
- Weak adherence to STI treatment.
- Poor partner notification and treatment.
- Lack of a surveillance system to track STI syndromes and treatment management.

35 Masson, L, Genital inflammation and the risk of HIV acquisition in women, 2015

Strategies

I. *Strengthen STI screening and management:* Integrate SRH and HIV care and treatment services and build capacity to provide comprehensive STI services.
II. *Strengthen national capacity to provide comprehensive STI services:* Create awareness for the control, prevention, and treatment of STIs.
III. *Generate evidence to inform STI programme management:* Strengthen STI monitoring and surveillance.

2.2 HIV treatment, care and support

Introduction

The provision of quality HIV treatment and care services is a priority for the estimated 210,000 people living with HIV and AIDS (PLHIV) in Eswatini. The country rolled out HIV treatment in 2003 with the provision of antiretroviral therapy (ART) using eligibility thresholds, and in 2016 expanded the programme to test and treat all PLHIV. In the next five years, the country seeks to scale up treatment, care and support services to achieve 95-95-95 percentages in the treatment cascade by 2023 by getting 95% of all people living with HIV to know their status; 95% of PLHIV with an HIV diagnosis to receive sustained antiretroviral therapy; and 95% of PLHIV receiving antiretroviral therapy to achieve viral suppression.

2.2.1 HIV testing services (HTS)

Programme objective: To increase the proportion of PLHIV who know their status.

Target populations: All sexually active persons; children, adolescents and youth (0- 24 years), men, and key populations will be the priorities.

Key outcome targets

Table 9: HTS outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of people living with HIV aged 0-14 year who know their status	All PLHIV	84.7% (SHIMS 2016/17)	90%	95%
	Male	77.5% (SHIMS 2016/17)		
	Female	88.6% (SHIMS 2016/17)		
	0-14 years	66.1 (SHIMS 2016/17)	90%	95%
	15-24 years	72.1 (SHIMS 2016/17)		
	25 and older	87.1 (SHIMS 2016/17)		
% of key populations who are living with HIV that know their status	Female sex workers	61.7 (Special Assessment, 2013)	90%	95%
	MSM	51		

Situational analysis

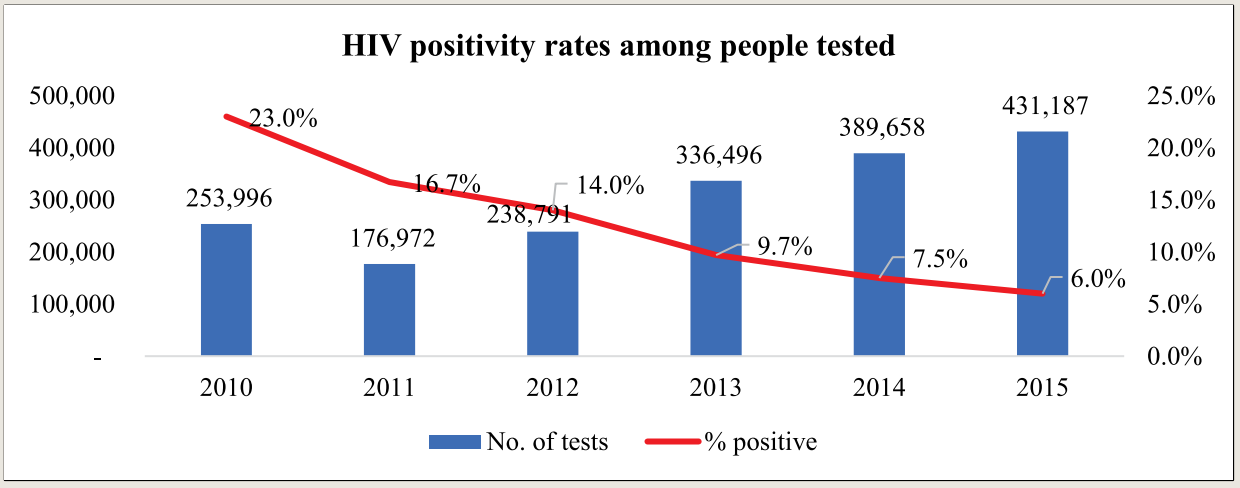
HIV Testing Services (HTS) is an entry point to HIV prevention, and HIV treatment and care services. Eswatini has a robust HTS programme that has been scaled up in all four regions through health facility and community-based methods. Facility HTS is provided at several service points using the provider-initiated testing and counselling approaches at the Out Patients Department (OPD), ART, ANC (PMTCT), STI, TB, VMMC programmes and In-patient Department (IPD), amongst others. Community-based testing utilises both provider and client-initiated testing approaches through outreach campaigns, mobile HTS and static VCT centres. The country has recently adopted HIV self-testing for self-screening HIV in more personal scenarios.

The scale up of HTS has resulted in an increase in the number of HIV tests done annually from 179,000 in 2011 to 445,000 in 2017. The SHIMS2 survey found that 84.7% of all PLHIV know their status, the majority of whom are women and persons older than 15 years. HTS uptake is lower among men, adolescents aged 15-24 years, couples, and children 0-14. Infant testing is done at 6 to 8 weeks after birth and periodically thereafter up to 18 months of age. The age of consent has been lowered from 16 to 12 years and the policy on persons to give consent for children testing reviewed to include care-givers, health workers and other persons who can act in the best interests of the child. However, only 66.1% of PLHIV under 15 years are aware of their HIV status.

Innovative approaches to provide HTS to key and hard-to-reach populations include moonlighting outreach services to hot spots targeting female sex workers and MSM. Approaches to reach men include the integration of HTS in the HIV package offered along the transport corridor and collaborations with Swaziland Uniformed Services Alliance on HIV/AIDS (SUSAH) institutions, namely Umbutfo Eswatini Defence Force (USDF), Royal Eswatini Police (REPS), His Majesty's Correctional Services (HMCS) and the Fire Department.

Since a majority of PLHIV already know their status, it has become harder to identify the remaining 15% who have not tested. As shown in the figure below, although the number of tests done have continued to increase, the positivity rate has been declining and is now stagnant at 6%.

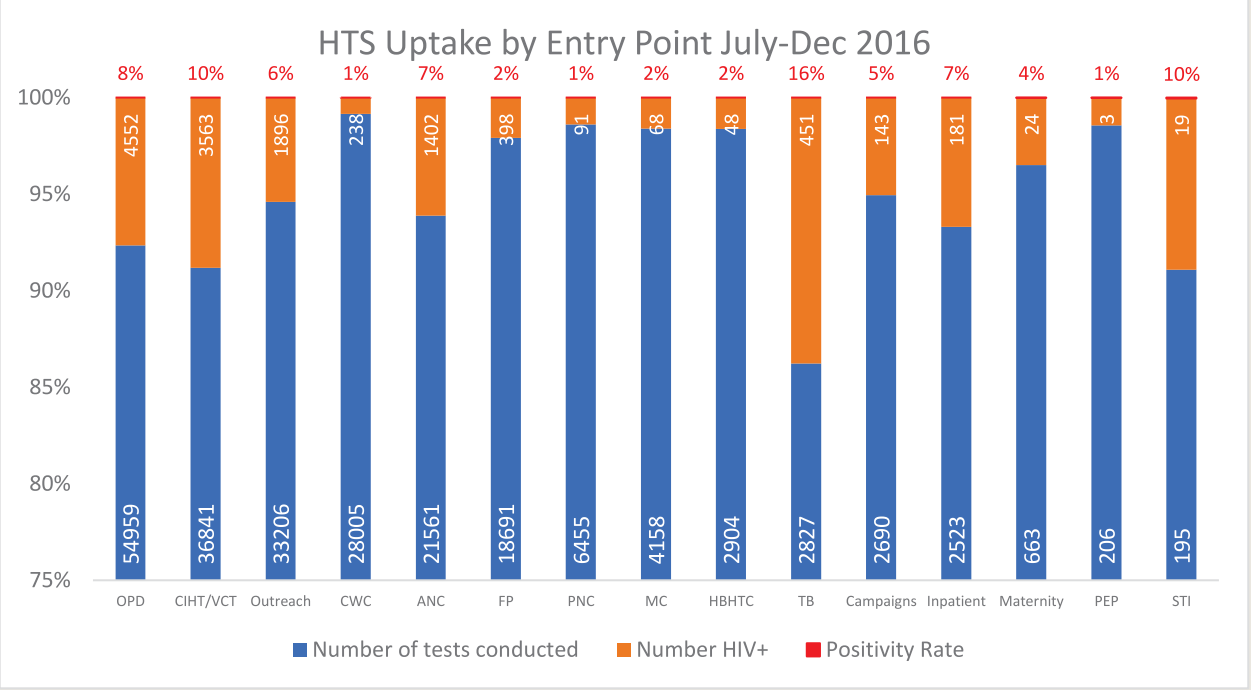
Figure 11: HIV positivity rates among people tested, Eswatini



Source: HMIS, 2016

HTS uptake by service point shows that although most tests are conducted at OPD, the highest yields based on diagnosing more positives are within the TB (16%), STI (10%) and HTS (10%) sites. As shown in figure 12 below,

Figure 12: HTS uptake by service point, Eswatini



Source: HMIS, 2016

In the next five years, the HTS programme will intensify case finding in populations with low coverage– children, adolescents and young people; men and discordant couples; and those at high risk of HIV infection. Regular routine testing for the general populations will be maintained.

Gaps and challenges

- Low HIV status awareness among children under 15 years, men, adolescents aged 15-24 and key populations.
- Low service uptake among men and couples.
- Limited testing approaches for children between the ages 2to 14 years, when children exit the post-natal and immunisation programmes.
- Inadequate focus and targeting of vulnerable populations including the disabled and their families.
- Weak linkages between HTS and HIV prevention and Treatment and Care services.
- Weak referral between community HTS and health facilities.
- Weak mechanisms for community level HTS quality assurance.
- Absence of unique patient identifier.
- Limited data on testing coverage among key populations.

Strategies

I. *Intensify HTS approaches that have proven to reach priority and key populations with yield:* HTS will shift from mass testing to targeted testing (case finding). Differentiated approaches to ensure that children, adolescents, young people (0-24 years), men and key populations are reached will be scaled out.

II. *Strengthen procurement, supply chain management and quality assurance for HTS:* Focus will be on timely procurement of HIV testing kits and stock management.

III. *Strengthen referral system to prevention and linkages to treatment and care services:* Focus will ensure successful referral of clients from HTS to prevention, care and treatment, including same-day initiation.

IV. *Strengthen HTS monitoring and evaluation systems:* A unique patient identifier will be introduced for identification and use throughout the continuum of care.

2.2.2 HIV treatment Services

2.2.2.1 Antiretroviral therapy (ART)

Programme objective: To increase the proportion of PLHIV with known diagnosis who are on antiretroviral therapy (ART).

Target populations: All PLHIV with focus on children, adolescents and youth (0- 24 years), men, and key populations.

Outcome targets

Table 10: ART outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of people with a known HIV+ diagnosis receiving antiretroviral therapy (ART)	All PLHIV	87.4% (SHIMS 2016/17)	90%	95%
	Male	88.6% (SHIMS 2016/17)		
	Female	86.9% (SHIMS 2016/17)		
	0-14 years	No baseline	90%	95%
	15-24 years	81.7% (SHIMS 2016/17)		
	25 and older	88.0% (SHIMS 2016/17)		
% of key populations with a known HIV+ diagnosis receiving antiretroviral therapy (ART)	Female sex workers	41.5% (Special Assessment, 2013)	90%	95%
	MSM	33%		

Situational analysis

The ART programme began in 2003 and since 2016, the country adopted the "Test and Start" strategy for provision of Antiretroviral Therapy (ART) to reach 90% of PLHIV who have been diagnosed. "Test and Start" means all PLHIV are eligible to initiate ART regardless of their CD4 count or clinical status, preferably within 2 weeks of HIV diagnosis. This strategy is recommended by WHO to accelerate early ART uptake, retention and viral suppression to reduce HIV transmission, and morbidity and mortality among PLHIV. The country aims to enrol 95% of PHIV with a known positive status.

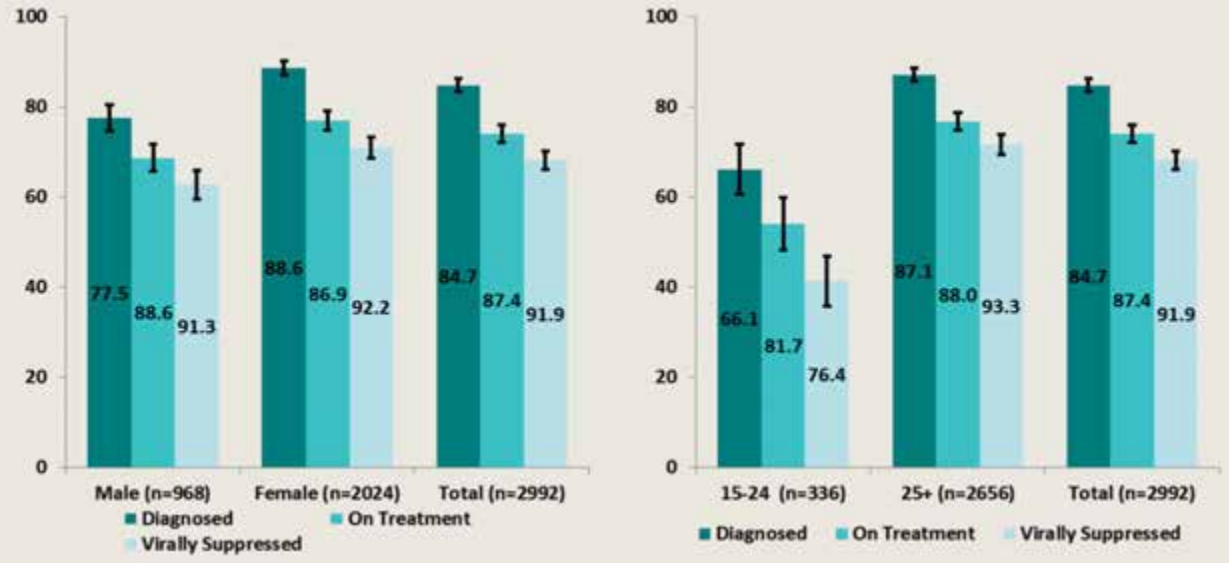
ART services have been scaled up through the decentralisation of ART initiation to the lowest level health facilities. In 2015, 70% of ART initiations took place at community clinics compared to 30% at ART initiation in hospitals and health centres. A referral system is in place to link those who are tested in communities to ART initiation sites. Decentralisation is facilitated by task shifting and capacity building for health care workers to initiate and provide ART services. Special focus on treatment for children living with HIV is made through Early Infant Diagnosis (EID), early initiation to ART and psychosocial support for children and their families.

Same day ART initiation is promoted for clients who are assessed as ready by health care workers to minimise the loss of clients between HIV testing and ART initiation. More than half (57%) of PLHIV

testing positive are enrolled within the same day, but the average period is 2 weeks[36]. The national ART coverage is at 85% (174,103 by December 2017). These figures show that out of the estimated 210,000 PLHIV (Spectrum 2018), about 36,000 PLHIV are currently not on ART. Coverage is lower among children aged 0-14, adolescents aged 15-24 and men who are 25 years and older. An assessment among key populations was carried out in 2013 and found that 51.0% of MSM had tested for HIV and 33.0% of those who knew their HIV status were on ART, while 61.7% FSW had tested for HIV and 41.5% of those were on ART. The SHIMS 2016/17 found the same disparities in ART coverage.

Overall, the country has made tremendous progress towards achieving the 90-90-90 treatment targets, with 84.7% of PLHIV knowing their status; of these, 87.4% are on ART and of those on ART 91.9% are virally suppressed. However, when the cascade is distributed by age and sex, adolescents and men 25+ years have lower coverage at all stages of the treatment continuum as shown in figure 13 below.

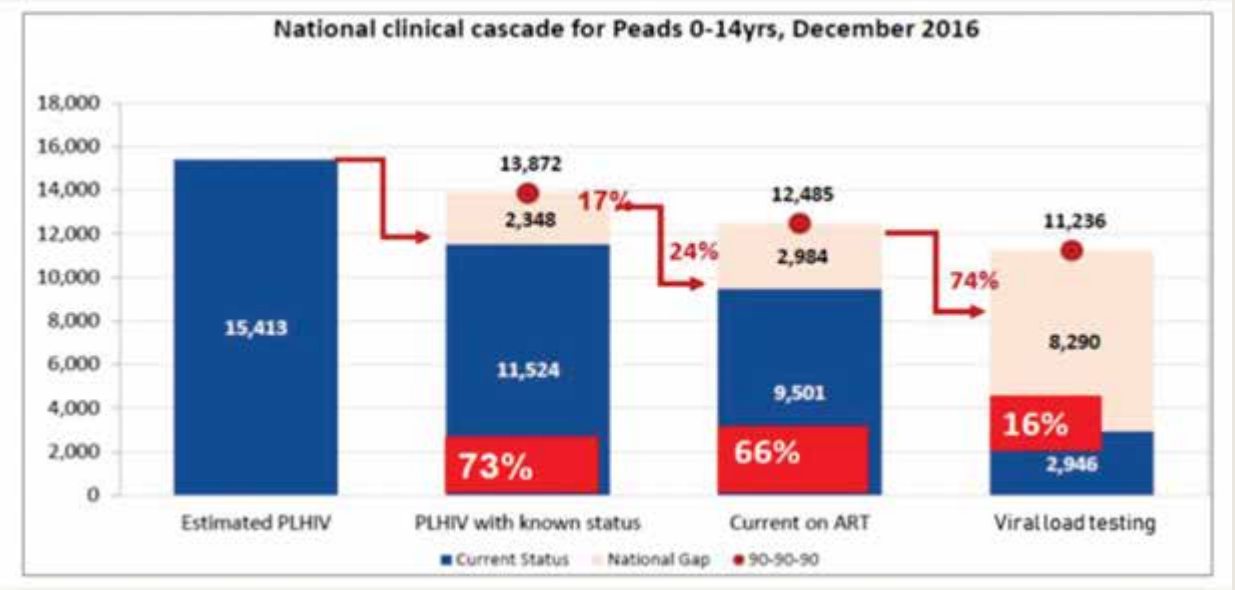
Figure 13: HIV Treatment cascade by age and sex, Eswatini



Similarly, when programme data (HMIS) is used to assess the treatment cascade for children 0-14 years, significant gaps are revealed throughout the cascade, revealing that of 73% of children PLHIV who have been diagnosed, only 66% are on ART and a lowly 16% had access to viral load testing, as shown in Figure 14.

36 ART programme data, HMIS, 2016

Figure 14: HIV treatment cascade for children aged 0-14 years, Eswatini



Source: HMIS, 2017

During the NSF period, the focus will be to accelerate the scale up of ART to reach the 95% of PLHIV. This can be achieved by improving coverage among children, adolescents, men and key populations. The country will also continue to evaluate and adopt new drug regimens as they come onto the market in order to optimise treatment outcomes and reduce costs, beginning with tenofovir disoproxil fumarate, lamivudine and dolutegravir (TLD) in 2018.

Gaps and challenges

(i) General

Inadequate targeting of vulnerable populations for ART including orphans and people with disabilities.

Limited human resource capacity to sustain the increasing work load in the provision of care and treatment services.

Weak coordination and monitoring of services provided at community level and in the private sector.

Delay in release of funds and/or release of funds in small tranches increasing risk of stock shortage of drugs and laboratory essentials.

Heavy dependence on development partners' funding for some cadres of human resources, threatening sustainability of the programme.

Weak community structures including PLHIV support groups.

Weak referral system between HTS and care and treatment, especially from community level.

Self-stigma and fear, stigma in the community and within the health system, limiting access to ART.

Emerging Resistance to Non-Nucleoside Reverse Transcriptase Inhibitors in country (> 10%).

Weak Pharmacovigilance surveillance systems.

(ii) Adult ART

Low uptake by men and key populations.

(iii) Paediatric HIV care and treatment

Low ART uptake among children and adolescents.
Some parents and care givers declining HIV testing and treatment for their children due to stigma.
High frequency of children presenting without or with different caregivers at health facilities
Long turnaround time (2 to 4 weeks) for EID results.

(iv) Key populations

No differentiated service delivery model for Key Populations is in place. Such models (e.g. CommART) are MoH supported models and have not been taken up by NGOs providing services to Key Populations.
Mobile clinics do not provide holistic HIV services. For instance, children and intimate partners of the Key Populations are not served in these clinics.
Difficulty in accessing treatment services due to high mobility in and outside the country.

Strategies

I. *Strengthen linkages between HTS and ART services to improve referral and early ART initiation:* Focus will be on strengthening the linkage of people testing HIV+ by providing one-to-one peer counselling; adherence; and support services at community level, which include having clients accompanied to ART sites and early initiation to ART at community level.

II. *Scale up targeted ART uptake for priority and key populations:* Specific strategies for each priority population are as follows:

Population	Key interventions
(i) Children (0-9 years) and adolescents (10-19 years)	Actively educate caregivers (including males) on the benefits of ART in children and establish systems to facilitate the linkage of HIV positive children to early initiation to ART. Integrate paediatric HIV prevention, care and treatment services within IMCI and EPI and continue to encourage PITC at every encounter with health service provisions for children 0-4 years old. Establish a monitoring system for mother-baby linkage within CMIS and HMIS. Strengthen adolescent responsive HIV care and treatment services including a "one stop shop" that offers a range of services from testing to treatment to routine viral load monitoring. Use all media platforms to increase demand for HIV testing, ART and adherence to treatment as well as SRH for young people.
(ii) Key Populations including those in closed settings including prisons	Develop and scale up differentiated care models for Key Populations, preferably community-based ART services. These can be offered through mobile clinics, community outreach and drop-in centres. Offer emergency stock of ARVs outside of "home or registered" facility. Scale up the establishment of Key Population focal persons or peer navigators in MoH facilities.
(iii) Young adults (men and women): AGYM 15 – 24 years, Men 15 – 34 years	Use electronic media to increase demand for ART and promote treatment adherence. Strengthen and scale up the provision of youth-friendly services for testing, treatment and retention in care. Support youth-led and community based organisations to scale up HTS and care and treatment services for both out-of-school and in-school youth.
(iv) Pregnant and Lactating Women	Engage partners, improve counselling and conduct one-on-one follow up to facilitate disclosure and subsequent support for pregnant and lactating mothers. Strengthen follow up and monitoring of pregnant or lactating mothers with detectable viral load to ensure quick viral suppression and interruption of HIV transmission.

(v) People with disabilities	Collaborate with the Federation of Disabled in Swaziland (FODSWA) to customise strategies and develop a comprehensive package of care.

III. *Strengthen the procurement and supply chain management system for HIV commodities:* PSM systems strengthening will focus on improving accuracy of forecasting and quantification by using accurate and up-to-date data; strengthening the quality assurance system for HIV commodities; adopting new cost-effective and efficacious ARVs and new laboratory technologies as they come to the market; and strengthening the laboratory system to improve quality.

IV. *Improve the coordination and quality of HIV care and treatment in the private sector:* Private health practitioners (doctors, nurses, counsellors, carers and managers) will be trained on comprehensive HIV/AIDS care and treatment and the reporting system for private health facilities will be strengthened. The number of private facilities that receive government and/or donor support will be increased to ease the burden of providing HIV care and treatment on the public health system.

V. *Enhance meaningful community engagement in HIV treatment, care and support:* Mechanisms will be established to strengthen coordination of public health and community responses at national level and develop a community engagement plan. Community leaders will also be sensitised.

2.2.2.2 Retention and viral suppression

Programme objective: To ensure that all PLHIV who are retained on ART are virally suppressed.

Target population: All PLHIV, focusing on pregnant and lactating women, children 0-14, adolescents 15-24, men and key populations.

Outcome targets

Table 11: Retention and viral suppression outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of people living with HIV receiving antiretroviral therapy that are virally suppressed	Total	91.9% (SHIMS,2016/17)	90%	95%
	Male	91.3% (SHIMS,2016/17)		
	Female	92.25 (SHIMS,2016/17)		
	0-14 years	No baseline (SHIMS,2016/17)	90%	95%
	15-24 years	76.4% (SHIMS,2016/17)		
	25 and older	93.3% (SHIMS,2016/17)		

Situational analysis

Viral suppression is the last stage in the treatment cascade and defined as a condition when a PLHIV who is on ART has a viral load (HIV RNA) that is reduced to less than 1000 copies/ml of blood. For viral suppression to be attained, PLHIV must be enrolled, retained, adhere to HIV treatment and timely switched to higher regimens once treatment failure is diagnosed.

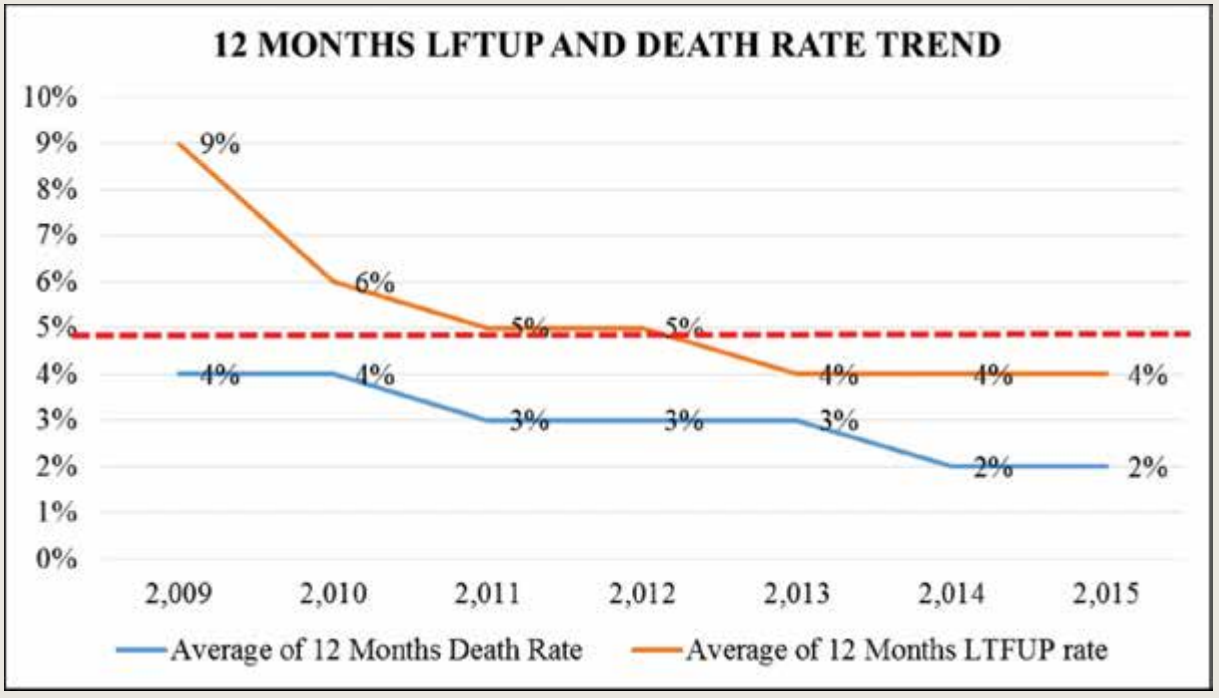
Viral load testing was rolled out to all sites in 2017 yet fewer ART clients are routinely tested. The programme has established a strong patient tracking system to improve patient retention where patients receive phone reminders and are followed up if they do not honour an appointment. Expert clients and rural health motivators have been deployed in communities to track loss to follow up clients and link them back to facilities. Differentiated ART service delivery models (COMM ART) have also been introduced. These include a family-centred approach which has also been adopted and implemented through Care-givers' Groups, Family Support Groups, and structured PLHIV Teen Clubs. PLHIV support groups have been established in communities to provide peer support.

The SHIMS 2016/17 shows that 73.1% of all PLHIV are virally supressed and suppression is higher (91.9%) among those who are on ART. Of those on ART, viral suppression rates are higher among those who are 25 years and older (93.3%) than those aged 15-24 (76.4%). Lowest suppression rates are observed among children on ART, where only 16% were suppressed in 2016[37].

Patient tracking systems, differentiated ART delivery models, and psychosocial support initiatives have improved the retention of PLHIV on ART. From 2012 to 2015, 12-month retention rates for PLHIV on ART ranged between 93% and 95%, well above the national target of 90%. Regional variations showed that Shiselweni had retention rates that were less than 90% retention but Lubombo region had over 95%. Retention rates are lowest among infants and adolescents. PLHIV who fail treatment are provided with palliative care.

Early enrolment and improved retention of PLHIV on ART has reduced average morbidity rates. The figure below shows the trend in loss to follow up and death rate among PLHIV on ART 12 months after initiation on ART. Lost to follow up cases dropped from 9% in 2009 to 4% in 2015 and the death rate declined from 4% to 2% in the same period.

Figure 15: Trends in loss to follow up and deaths among PLHIV, Eswatini



37 Programme data, 2016

During the NSF period, priority will be given to rolling out routine viral load testing and ensuring that all patients on ART are retained, achieve and sustain an undetectable viral load: especially infants, children 1-14 years and adolescents.

Gaps and challenges

- Current differentiated care models focus on community vs facility service provision but are yet to offer differential service based on patient clinical profiles.
- Low retention of infants, children 0-14 years and adolescents 15-24.
- Weak community level support for the ART programme.
- Weak system for return of results of viral load tests from the laboratory to clients. Not all viral load test results are communicated to clients.
- Low coverage of viral load testing among infants and young children.
- Weak systems for monitoring retention and viral suppression among pregnant and lactating women.
- Inadequate and unsustainable nutritional assessment, counselling and support.
- Low viral load literacy among PLHIV with some misinterpreting "undetectable" status to mean they are no longer infected.
- Weak system for surveillance and monitoring of HIV drug resistance, and monitoring of early warning indicators for HIV-DR.
- Inadequate palliative care for those patients who require the service, both at facility and at home.
- Inadequate PSM systems leading to stock shortage of some medicines.

Strategies

I. *Institutionalise and build capacity for quality affordable viral load testing and monitoring to achieve universal coverage:* Laboratory infrastructure and monitoring systems will be strengthened for timely delivery of results. Optimising the use of existing lab technologies such as GeneXpert for PoC testing and introducing globally negotiated reduced access price for VL and CD4 testing will be a priority.

II. *Scale up services across all populations, with a focus on pregnant and lactating women children 0-14 years, adolescents 15-24 years, men, key populations and people living with disabilities:* Existing differentiated ART delivery and care models will be scaled up. Partnerships will be strengthened with community and private sector systems to support ART at work places and communities. Interventions will be developed to strengthen multisectoral responses that support children on ART.

III. *Develop and implement a comprehensive nutrition programme for PLHIV:* Will make the empowerment of PLHIV support groups to promote good nutrition and food security a priority.

IV. *Scale up psychosocial support:* To be integrated into differentiated care models offered at facility and community levels. Family-centred and peer support for children and adolescents will be the focus.

V. *Scale up and improve quality of palliative care services:* Through training healthcare workers and establishing linkages with community systems through PLHIV support groups and community health workers.

VI. *Strengthen national health systems for monitoring and management of HIV drug Resistance:* Healthcare workers will be updated routinely on HIV-DR and an integrated system for monitoring of Early Warning Indicators and surveillance for HIV drug resistance will be improved.

2.2.3 Management and treatment of TB/HIV co-infection

Programme objective: To reduce incident TB and mortality among HIV co-infected patients.

Target population: All HIV and all TB patients.

Outcome targets

Table 12: TB/HIV co-infection outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
TB Death rate per 100,000 population	Total	104/100,000 (WHO Global TB report, 2017)	80	40
TB Treatment success rate	Co-infected Non-resistant Drug TB	78% (WHO Global TB report, 2017)	90%	95%
	D/X/M-TB	70% (WHO Global TB report, 2017)	90%	95%

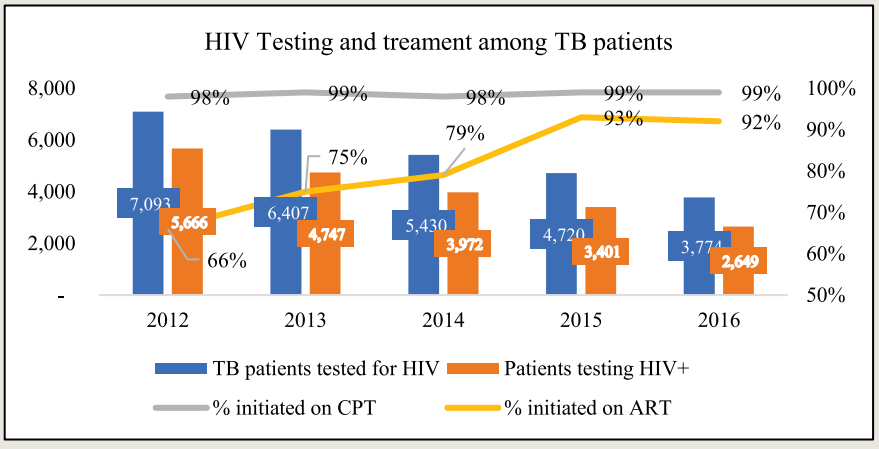
Situational analysis

Tuberculosis is the leading cause of morbidity and mortality among PLHIV, while the risk of developing TB is 20-30 times greater for a person living with HIV. Incidence of TB and MDR-TB are observed to occur disproportionately among men than women. The current TB incidence rate in Eswatini is 398/100,000 and there has been a gradual decline over the years from a peak of 1,382/100,000 in 2013.

According to national guidelines, all HIV patients should be screened for TB and presumptive cases are referred to TB diagnosis sites. Similarly, all TB patients are tested for HIV and those who are HIV positive are put on ART, while those who are negative for Active TB are provided with Tuberculosis Preventive Therapy (TPT). TB/HIV services have been integrated and there is timely ART initiation on correct regimens for co-infected patients. Facilities are providing TPT and CTP and infection control plans are being implemented.

These efforts have seen the TB/HIV co-infection rate being reduced from 80% in 2012 to 70% in 2016. 2016. In the same year, over 95% of TB patients were tested for HIV, and the uptake of ART uptake of ART amongst TB/HIV patients was up to 92%, as shown in figure 16 below. As a result, the TB treatment success rate among co-infected patients is 78% and lower (70%) among drug resistant patients.

Figure 16: HIV testing and treatment among TB Patients, Eswatini



Drug-Resistant TB/HIV co-infections remain high as 79% of co-infected patients had drug resistant TB strains in 2016. Almost all (97%) of those were provided with CPT and the same proportion put in ART.

Within the HIV programme, almost all (99%) HIV patients were screened for TB and those with non-active TB were provided with TPT. Comprehensive data for HIV patients on APT is lacking[38].

Although TB/HIV services have been scaled up, mortality rates among TB/HIV co-infected patients have remained high, ranging between 11-14% and higher (16-21%) for drug resistant TB.

During the NSF period, the programme will focus on providing vigilant integrated TB/HIV co-infection prevention, control and care services that make equitable access to diagnosis and treatment of drug-resistant TB strains a priority.

Gaps and challenges

There is a large gap between estimated incident cases and actual cases notified.
Lack of reliable data on TPT provision in health facilities.
Inadequate standard enforcement and capacity to control, diagnose and treat drug resistant TB.
Weak community focus and social protection systems for continuity of care for patients on treatment.
Low uptake of TPT due to stock outs, inconsistent supplies and patients worried about pill burden/ misconception and health workers' reluctance to prescribe given lack of supplies
Poor access to TB/HIV services for children under 5 years.
Weak infection control for TB in HIV settings due to congestion, old and poorly designed infrastructure, and lack of personnel to mentor facilities on infection control.
Weak Pharmacovigilance surveillance system.

Strategies

I. *Decentralise TB/HIV services by expanding point-of-care TB diagnostics at health centres:* All ART sites will serve as TB BMUs while community cadre staff will be trained to provide basic HIV and TB services.
II. *Scale up the provision of TPT:* Focus will be on ensuring that TPT is provided to all eligible patients, improving the TPT monitoring system, strengthening the supply system and training service providers.
III. *Strengthen TB Infection control at facility and community level:* Infection control will be strengthened within the context of universal precautions and some facilities will require renovations.
IV. *Strengthen continuum of care to community level:* To ensure that co-infected patients receive support from their communities and families enabling them to adhere to treatment.

2.2.4 Management of HIV opportunistic infections and co-morbidities

Programme objective: To ensure that all PLHIV are provided with preventive and curative services for opportunistic infections and co-morbidities.

Target population: People living with HIV.

38 Health Sector HIV, TB, PMTCT and Hepatitis Programmes Review, 2017

Outcome targets

Table 13: Management of HIV opportunistic infections and co-morbidities outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for year	
			2020	2023
% of PLHIV with reported OI or co-morbidity who are receiving treatment for it	Total	No baseline	70%	≥80%
	PLHIV			
	Male			
	Female			

Situational analysis

Antiretroviral therapy has increased longevity for people living with HIV and, as a result, there will be evolving health care needs for people aging with HIV. With an increased number of PLHIV aging with the disease, their risk of acquiring opportunistic infections and non-communicable diseases (NCDs) is rising. While PLHIV will experience the common diseases of aging, illnesses of the cardiovascular system; cancers; kidneys; liver; cognitive function; malignancies; and metabolic bone disease appear to be more common among HIV-infected patients. As a result, co-morbidity may have a prolonged effect on health outcomes of HIV infected individuals and their survival. As it is cardiovascular diseases are now the second most common cause of mortality in people living with HIV.

Since PHLIV on ART are observed regularly, there is real opportunity to identify, screen and refer for NCD illnesses appropriately. Currently, PLHIV on ART are screened and treated for common OIs such as cryptococcal meningitis and cervical cancer amongst others.

During the NSF period, programme focus will be to strengthen the integration of screening and referral for treatment of common opportunistic infections and co-morbidities into routine HIV care and treatment services.

Gaps and challenges

Poor clinical outcomes for patients with advanced disease.
Limited capacity of HIV service providers to manage emerging opportunistic diseases and co-morbidities.
Low literacy among PLHIV regarding emerging OIs and co-morbidities.
Weak M&E systems to monitor patients with OIs and co-morbidities.
No local research on prevalence of non-communicable diseases among PLHIV.

Strategies

I. *Strengthen the management of OIs and co-morbidities among PLHIV:* Existing referral systems will be strengthened and new ones established to link patients to relevant service points where various OIs and co-morbidities are managed.
II. *Scale up preventive services for OIs and co-morbidities:* Awareness and education on prevention of OIs and co-morbidities will be integrated into treatment literacy for PLHIV.
III. *Improve research and routine data availability on OIs and co-morbidities among PLHIV:* Research on emerging OIs and co-morbidities will be conducted and data tools will be integrated into the CMIS/HMIS.

2.3 Social Protection and Reduction of Structural Vulnerabilities

Introduction

Social protection and reduction of structural vulnerabilities programmes in this NSF aim to reduce the negative social impacts associated with HIV and AIDS on households and individuals by addressing strategic issues of primal vulnerability. The relationship between HIV and vulnerability is reciprocal. On one hand, pre-existing social and economic circumstances such as poverty, gender imbalances, gender based abuse and level of education increase an individual's susceptibility to HIV infection and fuel HIV transmission. On the other hand, an HIV positive status can generate and reinforce vulnerabilities that worsen the quality of life of the affected person. Vulnerable groups that the programmes focus on include OVC, adolescents and PLHIV.

2.3.1 Support to orphaned and vulnerable children (OVC)

Programme objective: To ensure that orphaned and vulnerable children (OVC) receive social protection services to reduce their vulnerability to HIV infection and improve adherence to treatment.

Target population: All orphans and vulnerable children.

Outcome targets

Table 14: OVC support outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of eligible OVC who progress from primary to secondary school	Total	No baseline	85%	90%
% of AIDS orphans receiving comprehensive package of HIV services	Total	No baseline	70%	90%

Situational analysis

Government, civil society organisations, faith-based organisations, and communities have been supporting orphans and vulnerable children in Eswatini for several years. Support has evolved from the establishment of Neighbourhood Care Points (NCPs) to provision of household and OVC individual targeted support. Currently, Government is implementing social protection programmes that have had a positive impact on OVCs such as the Schools' Feeding Programme, Free Primary Education (FPE), OVC school grants, OVC direct grants and grants for the elderly.

Over seventy percent (71%) of children under 18 years in Eswatini are classified as orphaned and vulnerable[39]. HIV estimates predict that 71,000 of children were orphans in 2017 and from those, 42,000 are AIDS orphans. The number of AIDS orphans is reducing because AIDS deaths have declined rapidly to a large extent due to an increased number of PLHIV being put on and retained on ART.

In the next five years, the country aims to reduce AIDS deaths by over 50%, which should further reduce the number of AIDS OVCs. Given this trend, the priority for the HIV response will be to provide sustained social services for orphans that are mainstreamed in respective line ministries, while core HIV programmes will continue targeting OVCs to prevent new HIV infections and provide those infected with comprehensive treatment services.

39 MICS 2014

Gaps and challenges

- Lack of a national system for identification, assessment and graduation of OVC from support.
- Lack of policy guidance on OVC support since key policy documents on protection of OVCs are outdated, including the Children's Policy and National Action Plan for Children.
- Lack of a well-defined minimum package of services for OVCs. There are no standard guidelines for the livelihood support programme.
- Failure of OVCs to access essential national documents means they are unable to access key services such as education and health.
- Weak coordination of OVC support resulting in weak planning, targeting, monitoring and reporting on OVC services.
- Lack of a harmonised M&E system that collects and consolidates data from the wide range of institutions that provide support to OVCs (government ministries, civil society, faith-based organisations and the private sector).

Strategies

I. *Mainstream and institutionalise HIV structural interventions into normative programmes in line ministries:* Mechanisms will be put in place to effectively coordinate all programmes. HIV services provided to OVCs will be mainstreamed into the existing OVC support programmes at line ministries.

II. *Improve targeting of OVCs for services:* Guidelines and corresponding systems will be developed for the identification, assessment and graduation of OVC from support.

III. *Strengthen the system for OVC case management:* This will involve improvement of the registration system and management of service delivery. A bi-directional referral system will be put in place to increase access to services for highly vulnerable children. The HIV response will utilise this database to target OVC for HIV prevention, care and treatment.

IV. *Scale up and sustain the provision of comprehensive HIV prevention and treatment programmes including social services that target OVC:* On-going support including the retention of OVC in secondary school level; provision of youth friendly health services and psychosocial support to improve retention of ALHIV on care and treatment; providing OVCs with HIV prevention services including: awareness and education; HTS; PrEP; PEP; and VMMC among others. With this strategy, economically empowering households with OVC will be sustained. Efforts will be made to improve the economic empowerment of OVC families and access to social protection services.

2.3.2 Gender Based Violence (GBV)

Programme objective: To ensure that GBV is reduced and that survivors of sexual violence are provided with post SGBV care.

Target population: All women, especially female adolescents.

Outcome targets

Table 15: GBV outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of women who experience sexual abuse	Children 0-14 years	1.9 % (SHIMS 2016/17)	≤1%	≤1%
	Adults 15 years and older	6.6% (SHIMS 2016/17)	3%	≤3%

Situational analysis

HIV programmes are an important entry point for addressing violence against women. Underlying gender inequalities contribute to gender-based violence and HIV consequences. GBV affects women's health, particularly their sexual and reproductive health, and rights by compromising their ability to negotiate for safer sex through condom use and to timely test for HIV. If testing positive they may fear to initiate and retain themselves in care. Addressing GBV is therefore key to curbing the spread of HIV and mortality due to AIDS.

The prevalence of Gender Based Violence (GBV) in Eswatini is estimated at 26.0% among people 15-49 years. About 4.6% of ever married or partnered women experience physical or sexual violence from their male partner, a reduction from 7.7% in 2014[40]. Violence is highest in Lubombo region (6.0%) and lowest in Manzini region (3.9%). Adults (both men and women) 15 years and older experiencing sexual abuse are 6.6% while 1.9% of the children aged 0-14 experience sexual abuse[41]. Violence against children (VAC) manifests itself in various ways. More than 1 in 3 girls aged 18-24 years experienced some form of sexual violence during childhood, while 3 in every 10 (28.5%) experienced emotional violence mostly from family members. The ingrained culture of "keeping family secrets" is the leading barrier to reporting GBV[42].

Sexual and Gender Based Violence is currently addressed by a cross section of Government Ministries and civil society organisations. The country has developed a National Strategy and Action Plan to End Violence in Eswatini (2017–2022) and guidelines for the provision of legal, health, psychosocial care and support services. GBV prevention, response and referral networkers have been established in the regions, comprising members from the police, health workers, social welfare officers, prosecutors, magistrates, representatives of education, and civil society organisations. Sexual violence interventions extend to provide eligible GBV survivors with post-exposure prophylaxis (PEP).

During the NSF period, priority will be on strengthening GBV policy, coordination and joint planning, surveillance and data management systems.

Gaps and challenges

High levels of sexual violence against children. 33.3% of women experience sexual violence prior to the age of 18.
Low reporting rates of GBV.
Weak systems for response, documentation, reporting and referral of SGBV cases. The newly developed case management system is not fully operational at all levels.
Weak coordination.
Weak implementation of legislation and policy on GBV interventions.
Inadequate monitoring, evaluation and surveillance of SGBV across institutions. As a result, SGBV data is not up to date and is incomplete.

Strategies

I. *Strengthen the coordination and implementation of GBV programmes:* Mechanisms will be established and capacity for coordination built within the Deputy Prime Minister's Office as the lead institution. Coordination will focus on joint planning, budgeting, partnerships in implementation with civil society, and establishment of a system for effective management and care continuum.

40 MICS 2014
41 SHIMS 2016/17
42 A National Study on Violence Against Children and Young Women in Eswatini 2007

II. *Strengthen integration of GBV in all HIV services:* This will include integrating GBV in HIV risk reduction counselling, HTS, treatment, care and support services, and integrating HIV in services for survivors of violence. Women living with HIV will be screened for GBV at HIV service sites and provided with appropriate GBV care and support services.
III. *Promote and implement laws and policies related to reduction of violence against women, gender equality and HIV:* This will involve strengthening partnerships between government institutions and civil society to advocate for implementation of relevant policies and legislation and raise awareness about these policies at community level.
IV. *Transform social and cultural norms related to gender:* This will focus on scaling up interventions that address the social and cultural norms that foster gender-based violence through community-based activities and via electronic, social and other forms of media.
V. *Strengthen GBV case management:* Protocols and regulations to guide the management of GBV cases will be updated and the SGBV case management system improved.
VI. *Scale up innovative GBV service provision models:* This involves strengthening the One Stop Service Centre model where multi-sector services are provided in one site and explore other innovative service delivery models to improve access to services.
VII. *Advocate for financial and technical resources for the GBV response:* Focus will be on advocating for mainstreaming GBV into the budgets of line ministries and mobilising resources for external sources.

2.3.3 HIV related stigma, discrimination and human rights

Programme objective: To reduce HIV related stigma, discrimination and human rights violations.

Target population: PLHIV, OVC, people living with disability and key populations.

Outcome targets

Table 16: HIV stigma outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of PLHIV who report experience of stigma and discrimination in the past 12 months	Total	No baseline	30%	≤10%
% of people aged 15-49 who report discriminatory attitudes towards people living with HIV	Male	36.2% (MICS 2014)	≤10%	≤5%
	Female	37.4% (MICS 2014)		
% of key populations who avoided seeking healthcare in the last 12 months	Female sex workers	38.1% (KP Study, 2013)	15%	5%
	MSM	61.8% (KP Study, 2013)	30%	10%

Situational analysis

Stigma, discrimination and human rights prohibitions are barriers that hinder access to HIV services. Among PLHIV, self-stigma and fear partly accounts for late initiation on ART especially among men, and hinders status disclosure and adherence to treatment. As a result, most people testing HIV positive prefer to seek treatment services in distant health facilities where they are not known. In addition, adolescents living with HIV face challenges in accessing treatment and/or taking medication in a school setting as they do not wish to disclose their HIV status. There are also policy hindrances in accessing

sexual and reproductive health and HIV prevention services. Self-stigma coupled with a perception of unfriendly service delivery points hinder key populations from accessing health services.

The proportion of people expressing accepting attitudes towards people living with HIV reduced from 47.1% in 2010 to 37.4% in 2014 among women and from 45.7% in 2010 to 37.0% in 2014 among men. Focus group discussions with adolescents and young people, men, women and PLHIV identified self-stigma and fear as some of the reasons for not accessing HIV services. These also indicated the existence of external stigma and discrimination in the community and among service providers[43].

FSWs and MSM are unwilling to disclose their sexual orientation and practices[44]. One-third of FSWs and MSM have experienced discrimination. 37.1% of the FSWs report strained interactions with law enforcement including being refused police protection while 36.2% of MSM have experienced torture due to their sexual orientation. FSW and MSM report perceived and experienced stigma related to their sexual orientation in health care settings and among families and partners. Over one-third (38.1%) of FSWs and two-thirds (61.8%) of MSM are afraid of seeking healthcare due to their sexual orientation or practices. Due to the multi-layered stigma and poor access to services and social support structures, most key populations have an ever-present threat to their mental health.

Other legal and policy barriers hindering access to services include criminalisation of the practices of key populations and on age of consent policies that hinder young people from accessing information and sexual and reproductive health services. In other instances, existing policies are not effectively implemented, such as the policy on reintegration of girls who dropped out of school especially due to pregnancy.

During the NSF period, interventions for the reduction of HIV related stigma and discrimination, and human rights promotion will be championed.

Gaps and challenges

Lack of a comprehensive HIV related stigma and discrimination reduction programme.
Weak mainstreaming of a human rights approach to HIV programming.
Lack of recent data on stigma and discrimination and human rights.
Negative perceptions towards the promotion of the rights of key populations.
Legal and policy barriers hindering access to health services by key populations and other priority populations.
Weak enforcement of girls' reintegration into schools' programme.

Strategies

I. *Generate evidence on stigma and discrimination and human rights situation:* Data and evidence generation mechanisms will be institutionalised to inform advocacy initiatives and overall programming.
II. *Develop and implement a comprehensive stigma, discrimination and human rights programme:* A programme will be developed to empower the network of people living with HIV/AIDS (SWANNEPHA) to promote rights and effectively coordinate efforts to eliminate stigma and discrimination, including rights violations. Capacity building for law enforcement officers and health service providers including community awareness on stigma and human rights among priority and key populations will be promoted.

43 Focus Group Discussions held during the end term evaluation of the Extended Multisectoral HIV and AIDS Strategic Framework 2014-2018

44 A quantitative and qualitative study of HIV among FSW and MSM in Eswatini, 2013

III. *Strengthen the system for documentation and reporting to human rights violations among priority and key populations:* Mechanisms will be explored to effectively document and report cases of HIV related human rights violations to enable survivors to seek legal redress. Such mechanism will include reporting desks and hotlines run by the priority and key populations themselves and/or supported by civil society actors; and a system for referring cases to relevant institutions.

IV. *Strengthen rights-based programming:* The capacity of core NSF programme implementers will be built to effectively reduce stigma and mainstream human rights in their respective programmes.

V. *Conduct legal and policy advocacy to improve access to services:* This will include removal of policy and legal impediments as well as promote effective implementation of existing progress policies and legislation.

3. MANAGEMENT OF THE HIV AND AIDS RESPONSE

Introduction

Effective management of the HIV and AIDS response is focused 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 for the attainment of NSF objectives. This includes ensuring coordination of all stakeholders, that implementing partners implement their NSF strategies, mobilising resources for the NSF and tracking progress.

3.1.1 Multisectoral Coordination of the HIV response

Programme objective: To improve efficiency and effectiveness in the coordination of multisectoral stakeholders at national, regional and community levels

Outcome targets

Table 17: Multisectoral coordination outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of NSF outcome level targets that have been met	Total	35% (eNSF Evaluation, 2017)	75%	85%

Situational analysis

Eswatini has well-established HIV coordination structures and mechanisms premised on the "Three Ones principle": One Coordinating Authority (NERCHA), One National Strategic Framework (NSF), and One Monitoring and Evaluation system (SHAPMoS). Effective coordination of the HIV response is presently anchored on the involvement of all sectors in society to use their mandate and comparative advantage in addressing the HIV and AIDS epidemic.

Multisectoral coordination of the HIV response is performed by many diverse stakeholders, based on their population constituencies. These have different mandates, roles and responsibilities, governance structures and accountability lines. For most, the HIV response is not their core business. Therefore, there is a need for effective coordination of all the stakeholders to enable them to contribute to the achievement of NSF targets, and to minimise duplication and overlaps whilst simultaneously maximising synergies.

The key coordination structures are as follows:

(i) **National Emergency Response Council on HIV and AIDS (NERCHA)**: Mandated to provide the oversight function of the multisectoral response. This includes facilitating, coordinating and monitoring implementation of the national multisectoral response. This has seen the adoption of national level and decentralised coordination approaches to create opportunities for diverse stakeholders to be involved in the HIV response.

(ii) **Sectoral coordination**: Sectors currently involved in the implementation of the multi-sectoral response in Eswatini include Government (public sector), civil society, the private sector and development partners. Each sector has its own coordination mechanism as follows:

a. Public Sector: The public sector comprises of all government ministries. Government ministries are able to take the lead role in operationalising the HIV & AIDS response in their sectors. These ministries will be responsible for the development of programmes, lead the implementation of the programmes and interventions given their technical mandate. The Ministry of Health (MoH)

coordinates all biomedical interventions and has established the Swaziland National AIDS Programme (SNAP) to coordinate health sector HIV programmes. The Ministry of Public Services (MoPS) has established the Public Sector HIV and AIDS Coordination Committee (PSHACC) to coordinate the work place HIV programme that targets public servants and their families. On the other hand, each ministry coordinates its external mainstreaming of HIV synergies in its sector. Within the legislative arm of government, Parliament has allocated some Members of Parliament into the HIV/AIDS and Health sessional committees in both Houses.

b. Civil society sector: Civil society comprises of diverse stakeholders including Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs), Faith Based Organisations (FBOs) and the network of people living with HIV among others. These are coordinated by the Coordinating Assembly of Non-Governmental Organisations (CANGO) through the Swaziland HIV and AIDS Consortium (SHACO).

c. Private Sector: Private sector players comprising of employers' associations and labour unions have established the Swaziland Business Coalition on HIV and AIDS (SWABCHA) to lead the coordination of the private sector HIV response.

d. Development partners: Development partners meet under the Development Partners Forum platform convened by UNAIDS and NERCHA.

(iii) **Decentralised coordination:** The decentralised coordination of the HIV response is organised along two approaches: rural response coordination and urban response coordination.

a. Rural response coordination: The rural response coordination takes place at chiefdom, Tinkhundla and regional levels through the Community Multisectoral HIV and AIDS Coordinating Committee (CHIMSHACC) and Regional Multisectoral HIV and AIDS Coordinating Committee (REMSHACC). The Ministry of Tinkhundla and Development (MTAD) chairs the REMSHACC and has established the Regional Development Teams (RDT) for overall development.

b. Urban response: The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) supports the Ministry of Housing and Urban Development to coordinate the HIV response in the 13 municipalities in the country.

(iv) **Programme coordination:** Programme coordination is at two levels: sector/implementation and oversight of sector coordination.

a) At sector level lead ministries and HIV sectors coordinate programmes through sector plans. These use technical working groups as programme operational mechanisms.

b) At oversight level, NERCHA shall work with all sectors to ensure implementation of the NSF. NERCHA shall provide support for HIV prevention Treatment, Care and Support, Social Protection and Response Management areas of the NSF.

In this NSF, coordination of the response will be made to be more efficient, premised on integration, mainstreaming and equity. Coordination will be decentralised to community level to address local epidemics. Structures coordinating the response at the local level will be at the centres of service delivery. The coordination framework will be re-configured to translate these objectives.

Gaps and challenges

- Limited visibility of NERCHA as the "One Coordinating Authority" due to declining funding, inadequate communication and non-functioning of some of the coordination mechanisms.
- Non-functioning of some of the coordinating structures such as those at decentralised levels.

Inadequate funding and human resources allocation to coordination bodies such as PSHACC, SWANNEPHA, and Church Forum resulting in their ineffective coordination.

Lack of coordination mechanisms for development partners and programmatic coordination.

Lack of a mechanism for inter-sectoral coordination of stakeholders at the national level.

Lack of clear systems and processes for coordinating implementation of the national HIV and AIDS strategic framework, and monitoring and the evaluation framework.

Strategies

I. *Align the coordination architecture to the NSF:* Coordination structures at decentralised levels will be strengthened to support the localisation of the HIV response and ensure micro targeting of sub-populations.
II. *Strengthen the capacity for coordination at national and decentralised levels:* Needs-based capacity building for all coordinating bodies at national (sectoral) and decentralised levels will be undertaken.
III. *Build the capacity of NERCHA to effectively lead the entire coordination at national and local levels:* NERCHA will review its capacity needs and re-orient its organisational structure to effectively lead the coordination of the HIV response at all levels.
IV. *Establish mechanisms for coordinating development partners and public sector external mainstreaming:* Mechanisms for coordinating development partners and the public sector will be established considering the prevailing context in programming.
V. *Strengthening programme coordination:* Strategic working groups will be established at the national level to coordinate: prevention; treatment, care and support; social protection and reduction of structural vulnerabilities; systems strengthening; financing; and strategic information and research.

3.1.2 HIV mainstreaming

HIV mainstreaming is concerned with analysing how HIV and AIDS impacts all sectors now and in the future, both internally and externally, and to determine how each sector should respond based on its comparative advantage. Mainstreaming HIV and AIDS enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace. Internal and external mainstreaming of HIV interventions will be undertaken in the public and private sectors.

2.3.1.1 Internal mainstreaming

Programme objective: To provide Health and HIV services in workplaces to improve employee wellness and productivity.

Target population: Employed persons in both public and public sectors, and private companies.

Situational analysis

Internal mainstreaming in the public sector is coordinated by the Public-Sector HIV/AIDS Coordinating Committee (PSHACC) under the Ministry of Public Service. Focal persons have been identified in each Government Ministry to: coordinate internal mainstreaming activities; develop plans for their ministries; and facilitate implementation of activities. PSHACC has developed a strategic plan to guide the internal mainstreaming of HIV in the public sector. Major internal mainstreaming activities undertaken include: (1) provision of information to employees on HIV, health and wellness; 2) provision of counselling and debriefing on HIV, NCDs, male circumcision, gender-based violence, stress management, and sexual and family dynamics; (3) provision of psychosocial support and strengthening of support groups for PLHIV and other chronic illness; (4) HIV testing and screening for TB and NCDs; (5) condom promotion and distribution; and (6) linking employees to other HIV services such as VMMC and treatment and care.

Internal mainstreaming in the private sector is coordinated and implemented by the Swaziland Business Coalition on HIV and AIDS (SWABCHA). Key HIV interventions carried out by SWABCHA include wellness Policy Creation, Awareness Sessions, Condom Supply and Distribution, Peer Education Training, physical wellness through sports events and a Mobile Wellness Clinic to provide diagnostic services at workplaces. Over the years, private sector firms have made strides in providing HIV prevention, treatment and care services to their employees and their families. Most firms have integrated HIV into human resources management policies, and integrated HIV activities into performance management systems.

Some Non-Governmental Organisations also provide HIV prevention, treatment and care services to their employees. Key interventions include holding male engagement sessions focusing on HIV risk reduction, demand creation for voluntary medical male circumcision services, and demand creation and provision of HIV testing services as well as linking positive cases to treatment and care.

During the NSF period, the programme aims to ensure that more employees are reached with comprehensive HIV services. Priority will be made for its roll out to semi and self-employed industries.

Gaps and challenges

- Low coverage of HIV work place programme: only half of government ministries are implementing the PSHACC programme, few private companies have registered with SWABCHA and small and medium enterprises are not adequately serviced.
- Limited attention is provided to prevent sexual harassment at the work place.
- Fear and self-stigma among employees hindering access to services.
- Wellness coordinators are not dedicated to the programme as they have other core duties which do not include HIV services.
- Limited staffing of the PSHACC secretariat.
- Weak linkage between work place HIV programme/ wellness programme and the human resources departments in the ministries.
- Weak monitoring and reporting.

Strategies

I. *Build the capacity for coordination of internal mainstreaming:* Ensure that PSHACC secretariat has adequate capacity to deliver on its mandate. Capacity of private sector firms to effectively implement HIV interventions will be strengthened.

II. *Develop a comprehensive wellness programme using differentiated implementation approaches:* A comprehensive private sector HIV programme will be developed using approaches responsive to the needs of different age groups of employees.

III. *Scale up HIV internal mainstreaming countrywide:* Ensure that HIV activities are rolled out to all public service employees in all regions and at all levels. SWABCHA will roll out services to small and medium companies.

IV. *Strengthen monitoring of internal mainstreaming:* Targets will be set; data collection tools and reporting processes will be updated at all levels. A database of the individual firms will be updated and a mutually-agreed reporting process established.

V. *Increase resource allocation for HIV mainstreaming activities:* PSHACC and SWABCHA will advocate for each ministry or company to integrate HIV internal mainstreaming activities in their administration budget.

2.3.1.2 External HIV mainstreaming

Programme objective: To ensure a multisectoral response with clear accountabilities.

Target: Government ministries, private sector companies and development partners.

Outcome targets

Table 18: External mainstreaming outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of Government Ministries mainstreaming HIV in their plans and allocating funds	Total	30% (eNSF evaluation, 2017)	60%	90%

Situational analysis

External mainstreaming of HIV seeks to ensure that all government ministries use their comparative advantage and mandates to address relevant aspects of the HIV epidemic. The extent to which external HIV mainstreaming is taking place varies in scope and scale of implementation from ministry to ministry. Some HIV interventions that have been mainstreamed include the life-skills education programme for in-school youth, the free primary education programme, the school feeding programme, child-friendly courts, a one-stop-service centre for GBV survivors and domestic violence, and child protection and sexual offence units set up by the Royal Eswatini Police among others.

In the next five years, external mainstreaming of HIV will be scaled up in all ministries to leverage on their mandates. Each ministry will identify the aspect of the HIV epidemic that it is best suited to address and develop relevant interventions.

The table below shows HIV interventions relevant to each ministry.

Table 19: HIV Synergies in Government Ministries, private sector and development partners

Sector	HIV Synergies based on mandate
1. Prime Minister's Office	Provide national political leadership and commitment, good governance to ensure effective multisectoral coordination, supervision and proper management of HIV synergies for all Ministries and Departments.
2. Deputy Prime Minister's Office	Influence change in policies and legislation to address gender equality, gender based violence, OVC, social protection and delivery of social service.
3. Ministry of Finance	Mobilise resources for HIV and influence other sectors to mainstream HIV and AIDS through sector budgets.
4. Ministry of Economic Planning	Mobilise resources for HIV, ensure that HIV is mainstreamed in the development agenda, sectoral plans and facilitate sustainable economic development frameworks that alleviate poverty.
5. Ministry of Education and Training	Reach all children in school with HIV and AIDS and gender based violence prevention information and SBC interventions.
6. Ministry of Health	Lead the coordination of the health sector response to HIV and implementation of all bio-medical HIV interventions. Ensure universal access to quality HIV prevention,

	treatment, care, and support health services.
7. Ministry of Tinkhundla Administration and Development	Ensure that HIV services reach all people in rural and urban areas by ensuring adequate community systems and infrastructure. Mobilise communities to access HIV services and enhance HIV coordination of the response through local structures.
8. Ministry of Labour and Social Security	Ensure that all public and private sector institutions develop and implement HIV and gender sensitive workplace programmes, while at the same time promoting social protection for vulnerable adults and children. Support structural issues of job creation and decent minimum wages.
9. Ministry of Commerce, Industry and Trade	Promote income generation programmes for vulnerable populations and promote HIV and AIDS responses within commercial systems.
10. Ministry of Justice	Ensure that there are HIV and gender sensitive laws and policies, and that these are enforced.
11. Ministry of Foreign Affairs	Develop and administer a sound foreign policy on safeguarding national interest. Foster bilateral and multilateral relations. Support cross border treatment for Swazi nationals abroad.
12. Ministry of Agriculture	Ensure sustainable national and household food security and nutrition.
13. Ministry of information, communication and technology	Ensure the dissemination of HIV and AIDS information.
14. Ministry of Public Service	Provide workplace programmes.
15. Ministry of Sports Culture and Youth Affairs	Develop effective response strategies for young people based on sports, arts and culture.
16. Ministry of Tourism and Environmental Affairs	Develop effective HIV strategies that can reduce risk exposure among tourists and mobile population. Ensure that all Environmental Impact Assessments (EIA) include HIV externalities.
17. Ministry of Housing	Facilitate decent housing programmes in both rural and urban environments.
18. Ministry of Natural Resources	Ensure equitable access to natural resources, mainly potable water and sanitation.
19. Ministry of Public Works and Transport	Provide HIV prevention measures for construction workers and host communities. Provide HIV services for mobile transport operators.
20. Ministry of Defence	Empower forces to adopt positive prevention behaviours and support treatment.
21. Ministry of Home Affairs	Ensure that all persons have legal identification documents, especially vulnerable persons.
22. Private sector and civil society organisations	Effective engagement and implementation of the HIV response. The sectors can support community mobilisation, employer practices, and mobilise technical and financial resources for HIV response.
23. Bi-lateral and Multisectoral Partners	Mobilise technical and financial resources for HIV response.

Gaps and challenges

Not all Government ministries are mainstreaming HIV into their service delivery plans.
Lack of a focal person to lead external mainstreaming of HIV in each ministry.
Lack of mainstreaming guidelines and data on external HIV mainstreaming interventions carried out by Government ministries.

Strategies

I. *Advocate for improved coordination of external HIV mainstreaming in the ministries:* Advocacy will be targeted at policy makers to enable them to appreciate HIV synergies.
II. *Provide technical support and build capacity for external HIV mainstreaming:* Support ministries to identify and include HIV synergies in their annual plans and budgets.
III. *Strengthen monitoring and reporting on external HIV mainstreaming:* Develop mainstreaming guidelines, ministerial targets and indicators.

3.1.3 Strengthening Health, Community and Social Services Systems

Introduction

Equitable distribution, timely and sustainable delivery of NSF services is largely dependent on the capacity of related systems. Systems-strengthening initiatives will focus on health, communities and social services to increase their access, quality and sustain the HIV response.

This section outlines strategies for strengthening these key enablers of the response.

2.3.1.3 Health Systems Strengthening (HSS)

Objective: To strengthen the health system to support efficient, effective and sustainable HIV service delivery to all populations in need.

Target: The six Health Systems building blocks.

Outcome targets

Table 20: HSS outcome results

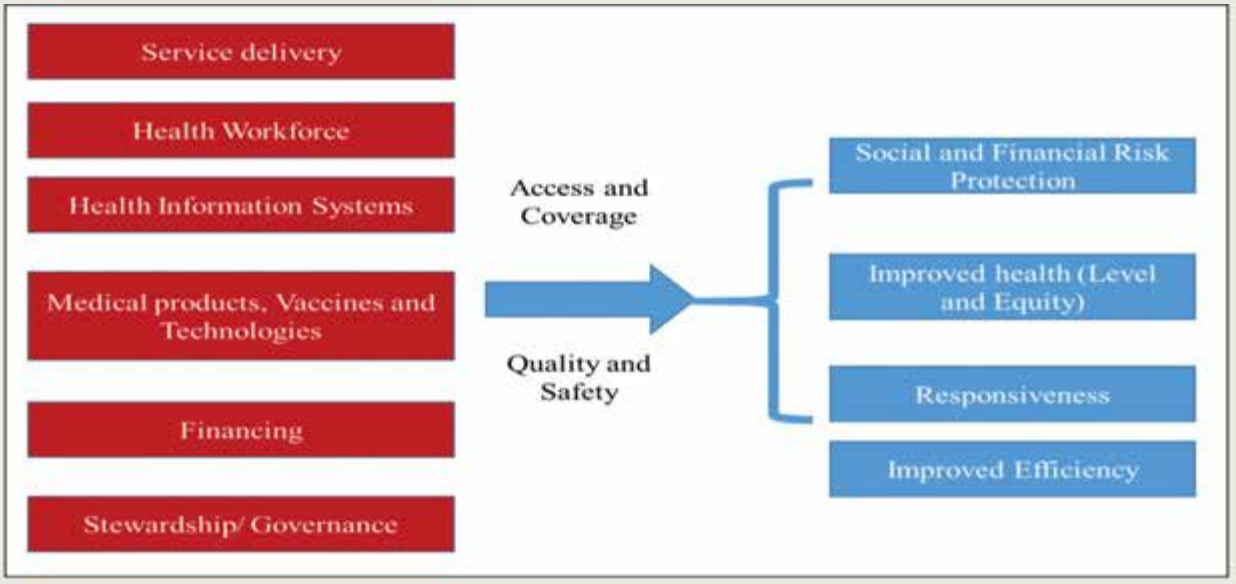
Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of health facilities that offer quality, comprehensive and integrated HIV and AIDS services	Total	65% (SAM, 2014)	80%	90%

Situational analysis

A strong health system is critical in ensuring that the gains made in the uptake of ART are sustained. This means that infrastructure, human and financial resources, health commodities including drugs, and the necessary technology are available and are functional. NSF focus will be on strengthening the health system to deliver sustained preventive, promotive, curative and rehabilitative interventions through a combination of public health actions in government and non-government facilities.

Health systems strengthening is premised on the six WHO building blocks for a health system outlined in the figure below.

Figure 17: Health System Building Blocks



(i) Governance

The Ministry of Health provides stewardship and governance for the health sector response. The Eswatini National AIDS Programme (ENAP) leads the health sector response to HIV and AIDS in collaboration with departments and units within the MoH. Key units and programmes collaborating with SNAP include the National TB Control Programme, the Sexual and Reproductive Health Programme, the Central Medical Stores, the Strategic Information Department, and the Laboratory Services, among others.

There are also several partner organisations providing financial, technical and logistical support to the programme. Given the wide range of partners working with SNAP and the collaboration with several departments and units in the MoH, there is a need to continuously strengthen coordination and governance systems. The NSF seeks to strengthen MoH's capacity to provide effective oversight and regulation, and enforce accountability from all partners supporting and implementing health sector programmes.

Gaps and challenges

Weak coordination between the HIV programme and development partners and implementing partners. There are no effective mechanisms for coordinating the planning, setting of priorities, and financial support of the programme at national and regional levels.

Weak coordination with non-clinical partners supporting the health sector HIV programme at community level.

Existence of many (17) technical working groups coordinating HIV and TB programmes.

Strategies

I. *Increase capacity to lead and coordinate the health sector response at national and regional level:* MoH will strengthen programme and donor coordination including decentralisation of coordination.

II. *Strengthen regional level coordination:* Effective systems for supervision will be established and joint reviews conducted.

(ii) Procurement and supply chain management

The Procurement and supply management system for drugs, diagnostics and other health products is managed by the Central Medical Stores (CMS). In 2017, an assessment of the status regarding the supply of medicines and medical supplies was undertaken, which identified gaps and challenges in critical areas such as quantification, warehousing, inventory management, distribution and security[45]. CMS is currently addressing these issues to support effective service delivery.

A five-year procurement and supply chain management strategy has been developed. A pharmacovigilance system is in place with active reporting and surveillance for ARVs and TB medicines. A comprehensive warehousing management system has been installed to improve management of stocks and the supply chain. The country has multiple warehousing locations for various items: essential medicines, medical supplies, ARV, vaccines, laboratory items. A warehouse integration plan has been developed to improve warehouse management. Distribution of drugs and other health products is done monthly based on orders received and according to an established distribution plan which is communicated to facilities. There are mechanisms in place to handle emergency orders. A Logistics Management Information System (LMIS) is used for forecasting, inventory management, distribution planning, stock management and dispensing and monitoring. The NSF seeks to strengthen equitable access to medicines, vaccines, and medical technologies.

Gaps and challenges

- No local quality assurance and registration of items.
- Parallel procurement drug systems by collaborating partners and direct donations to facilities contribute to drug expiries.
- Poor stock management at facility level, untimely ordering, local suppliers unable to supply, vendor lacking specific items and difficulty in reaching some areas contribute to stock outs.
- Low on-time reporting due to inadequate human resources (data collectors and clerks) at health facilities.
- Aged distribution fleet which is expensive to run.

Strategies

I. *Strengthen quality assurance system for pharmaceuticals and other health products:* Improve the capacity of the CMS quality control laboratory and, in the long run, establish the National Quality Control laboratory.

II. *Improve coordination of procurement and supplies of drugs by partners and through donations:* Roll out an inventory management system to facilities and establish a coordination mechanism at the national level to monitor all procurement and supplies.

III. *Improve inventory management and ordering practices:* The roll out of the inventory management system to facilities be extended to procurement, product selection and delivery management.

IV. *Renew the distribution fleet:* The on-going process of renewal of the distribution fleet will be sustained with both government and partner funding.

45 Report of the Prime Minister's Inter-Ministerial Task Team on Health Service Delivery, 2017

(iii) Laboratory services

Eswatini Health Laboratory Services (SHLS) consist of the National Molecular Reference Laboratory (NMRL) and the National TB Reference Laboratory (NTRL) at the national level, the Central Laboratory, and Regional Hospital Laboratories, Health Centre Laboratories and Clinic Laboratories which are mini-laboratories in the clinics. SHLS support the delivery of effective diagnosis and management of disease, monitoring of treatment, control of infectious diseases, and health promotion through research and surveillance of diseases at all levels of health care. The HIV response recognises the strategic role of laboratory services to ensure effective treatment and care of PLHIV.

A review of laboratory services carried out in 2017[46] found that both the NMRL and NTRL have adequate capacity and comprehensive standard operating procedures. Both the NMRL and NTRL have quality assurance systems in place covering both HIV and TB, among other diseases. Both are enrolled in External Quality Assurance (EQA) programmes. However, the NTRL has been declining in quality ratings from a quality score of 78% in 2014 to 59% in 2016 due to high staff turnover. The performance of NMRL has also been irregular in the past three years (66% to 54% to 66%) and is currently rated at 2 stars.

Gaps and challenges

- High staff turnover and vacancies in key positions.
- Infrequent support supervision for peripheral laboratory personnel.
- Inadequate machine calibration and maintenance and significant down-times for biosafety cabinets and GeneXpert machines at peripheral laboratories.
- Declining EQA performance by both NMRL and NTRL.

Strategies

I. *Improve quality assurance systems for laboratories at all level:* This includes improving EQA performance for national reference laboratories through filling all vacant positions; strengthening standard operating procedures and training; training laboratory staff at all levels; ensuring regular support supervision; and mentorship of laboratory staff at health centres and clinics.

II. *Roll out use of diagnostic equipment (GeneXpert):* GeneXpert machines for Viral Load testing will be expanded to all facilities to improve patient monitoring. In addition, maintenance of diagnostic equipment will also be improved.

(iv) Human resources

Human resources management responsibilities are spread across Government ministries. Recruitment of health care workers is carried out by the Ministry of Public Service at the request of the Ministry of Health. The country has a Human Resources for Health (HRH) Strategic Plan which guides all human resources management activities according to overall public service policies. The health sector falls short of the WHO benchmark for total workforce to population ratio. The total workforce to population ratio is

46 Joint Mid-Term Review of HIV/AIDS, TB and PMTCT Strategic Plans and Assessment of Viral Hepatitis, 2017

3.7 per 1000 population, below the WHO benchmark of 4.1 per 1000. Eswatini also has 1.6 per 1000 ratio for essential health workers (doctors and nurses) against WHO benchmark of 2.55 per 1000 population[47].

There are several health workforce positions that are not filled, either due to lack of Government funding or delays in the recruitment processes. Programmes have addressed this shortfall by using partner funding to fill the gaps in health facilities and community lay cadres. There are variations between the remuneration of staff recruited by Government and those recruited by development partners. Absorbing these staff poses a challenge as they are not recognised in the government system. The MoH has developed staffing norms for health care facilities but the same does not hold for programmes. The NSF aims to strengthen human capacity.

Gaps and challenges

- Several unfilled positions due to lack of funding from Government or delays in recruitment.
- Reliance on funding by partners for a sizeable proportion of staff in the programmes and at service delivery points.
- Variations in remuneration of staff recruited by Government and those recruited by partners.
- Difficulty in absorption of staff funded by partners as they are not recognised in the government's staff establishment.

Strategies

I. *Harmonise remuneration, staff cadres and grading system for partner funded staff:* Harmonisation will facilitate smooth absorption of these staff by Government to ensure service continuity and sustainability of programmes.

II. *Develop an HRH plan to ensure sustainability of programmes:* An HRH plan that takes into account the projected needs of the key programmes (HIV, TB, and SRH among others) will be developed.

III. *Advocate for increased allocation of funding for human resources for health:* Advocacy will be conducted to fill up vacant posts.

(v) Health Information Systems

Health Information Systems are managed by the Strategic Information Department (SID) of the Ministry of Health and links to the One M&E system at NERCHA. Data on the health sector response to HIV is also collected through the Health Management Information System (HMIS), Community Based Management Information System (CBMIS), and partner specific systems. Data from CBMIS and partner systems are not all readily accessible to SNAP or NERCHA. For TB/HIV interventions, data is captured by the National TB Control Programme which runs its own vertical system for collecting and managing TB data.

The Client Management Information System (CMIS) has been rolled out to all facilities providing ART services. However, not all facilities have been covered. CMIS assists health care workers to manage patients and monitor them over time, replaces the paper-based tools and enables real-time capturing of data. A unique patient identifier is also being developed. The NSF aims to ensure that health information systems should generate useful data on health determinants and health system performance.

47 Eswatini Human Resources for Health Strategic Plan 2012-2017

Gaps and challenges

- Multiple data collection and management systems for the health sector HIV response.
- Limited coordination of M&E efforts of SID, SNAP and NERCHA.
  No aggregated data portal or archiving system.
- Delays in reporting from health facilities making it difficult for the M&E unit under SID to meet timelines for reporting.
- New data requirements (e.g. age and group disaggregation) are not accommodated in HMIS.
- Community health systems data is not captured by HMIS/CMIS.
- Lack of reporting from private facilities as they are not part of the electronic ART patient management system.
- Inability to track patients across programmes/service points due to lack of a unique patient identifier.

Strategies

I. *Strengthen coordination of health sector M&E for the HIV response:* This includes establishing linkages across the multiple data collection and management systems to ensure CBMIS and partner systems report to the HMIS, and establishing a system for private sector reporting. One portal will be established to ensure all health sector HIV data is in place to improve accessibility by programmes (SNAP) and improve reporting to NERCHA. The HMIS HIV modules will also be reviewed to include new data requirements to better serve programming and overall decision-making.

II. *Improve reporting and data flow systems:* Electronic reporting will be explored and supervision and mentorship of staff intensified to identify and address reporting bottlenecks in a timely manner.

III. *Scale up CMIS including use of a unique identifier:* The scale up of CMIS will allow programmes to track patients across service points and even across facilities. The use of a unique identifier will be scaled up beyond the CMIS which currently focuses on HIV services.

(vi) Integrated service delivery

The focus of service delivery will be on the integration of HIV, TB and RMNCAH to increase service coverage and offer comprehensive services to client. There are still ART sites that do not serve as basic management units (BMUs) for TB (111 BMUs vs 170 ART sites). In addition, not all ANC sites offer ART (183 ANC sites vs 170 ART sites) which presents a missed opportunity for HIV and RMNCAH integration.

The unmet need for family planning is estimated at 24%; and this percentage is even higher among women living with HIV (63.7%)[48]. The assessment of the quality of maternal and neonatal care in Eswatini found that family planning is not fully integrated with post-natal care[49]. Given that HIV prevalence is higher among women than men, there is a need to ensure integrated RMNCAH services to prevent MTCT of HIV and improve the treatment and care outcomes for women living with HIV.

The essential health care package was revised in 2016. The revised package makes the building blocks of systems for health the priority in order to focus on the delivery of integrated packages of prevention and care at all levels of facilities. This package explicitly targets integrated services for mothers, children and

48 Quantification of family planning commodities for January 2014 to December 2018
49 Report on assessment of quality of maternal and neonatal care in Eswatini

people living with HIV. The HIV response has embraced integration as a key strategy in line with the new essential package and best practices.

Gaps and challenges

Whereas integration as a policy and strategy is well articulated both in the health sector and in the HIV response, implementation has been slow and uneven.
Limited staff capacity to offer all aspects of an integrated service package.
Data collection tools have not been modified to capture all integrated services offered at different service points.
Weak coordination of service integration.

Strategies

I. *Roll out updated guidelines for service integration to all facilities.*
II. *Train health care workers to deliver an integrated service package.*
III. *Review and update data collection tools for all service points offering integrated services.*
IV. *Strengthen coordination of service integration at regional and facility level.*

2.3.1.4 Community systems strengthening (CSS)

Objective: To strengthen the community system to support HIV service delivery to all populations.

Target: Non-Governmental Organisations, Community Based Organisations, support groups of people living with HIV, youth groups, faith based organisations, and traditional community structures.

Outcome targets

Table 21: CSS outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of households who report that the community HIV services they received in the past 12 months were comprehensive	Total	No baseline	50%	70%

Situational analysis

Eswatini has robust community systems supporting the implementation of the HIV response. Key actors in community systems include Non-Governmental Organisations, Community Based Organisations, support groups of people living with HIV, youth groups, faith based organisations, and traditional community structures. There are also cadres deployed by the health sectors linking health facilities to communities and providing services at community level. These include Regional Health Motivators, Expert Clients, Mother Mentors, Treatment Supporters, Lay Counsellors and Peer Navigators.

These actors provide a wide spectrum of HIV prevention services, create demand for HIV services, address barriers to access to services such as stigma and discrimination and human rights, provide avenues for community involvement in the response, provide social protection services to vulnerable populations and advocate for improved policy and legal environment. There are also several CBOs, NGOs and community cadres supporting TB case finding and adherence to treatment.

Gaps and challenges

Weak coordination of all the actors in the community systems. The entities implementing HIV at community level implement varied activities with different funding sources and report to different donors whilst operating in the same community. There is no common platform to coordinate the activities of these actors at community level.

Weak collaboration and linkages between health facilities and community level actors, impacting on referral of clients, follow up of clients at community level, reporting of community level data to HMIS and use of data by communities.

Weak system for quality assurance of services delivered at community level.

Weak monitoring and reporting systems for community based HIV interventions.

Limited engagement with community leaders in the coordination of HIV activities. Local leaders often are not fully aware of who is doing what in the community.

Limited involvement of beneficiaries in planning, implementation and monitoring of HIV programmes.

Capacity limitations among community level implementers due to lack of funding.

Strategies

I. *Strengthen coordination of community actors:* A common platform will be established to coordinate all actors providing HIV services at community level. This platform will be anchored in the traditional structures at chiefdom and Tinkhundla levels to ensure all partners report on their activities and that issues identified are addressed. This platform is detailed in the coordination framework for the HIV response.

II. *Strengthen linkages between health facilities and community actors:* The health sector will establish a mechanism for coordinating the lay cadres deployed in the communities. This will include developing standard operating procedures, guidance materials, reporting tools and periodically conducting supportive supervision at community level.

III. *Improve programming monitoring and reporting by community actors:* In line with the proposed changes in the HIV M&E system, real time reporting tools will be developed and rolled out to the community level to improve reporting. Implementers will also be required to report to the community coordinating structures at chiefdom and Tinkhudla levels. Relevant linkages in the reporting system with HMIS will also be established.

IV. *Build the capacity of community level actors:* The capacity of all the actors will be built to enable them to deliver quality services. Focus will be on new services and technologies such as PrEP and on new or revised guidelines as well as refresher trainings on all HIV services.

V. *Scale up civil society advocacy:* Community actors will have access to HIV data through a revamped SHAPMoS. This data will inform local advocacy efforts to address the issues relevant to each community. National level advocacy will also be carried out to address challenges facing key populations and young people as well as improve policy.

VI. *Increase resource allocation for the community response:* In line with global recommendations, advocacy will be carried out to have at least 30% of the HIV service delivery community led. This will require adequate funding for the community systems.

2.3.1.5 Social services delivery systems

Objective: To strengthen the delivery of social welfare services for sustainability of support to vulnerable populations including OVC and those living with disabilities.

Target: Deputy Prime Minister's Office, Ministry of Education, and Ministry of Home Affairs.

Situational analysis

Systems providing social protection and other social services to vulnerable populations cut across Government Ministries, civil society and private sectors. Strengthening these systems is important for

implementation of interventions that reduce social vulnerabilities and the impact of the HIV epidemic. Strengthening these systems will improve the provision of: social services to orphans and vulnerable children; cash grants to the elderly and persons living with disability; improved civil society support for OVCs; support for GBV interventions; and improved provision of services to in-school youth among others.

The NSF will focus on strengthening the social services system to play a role in reducing structural vulnerabilities to HIV and poor adherence to treatment whilst improving self-determination. Strong social systems will also create family resilience and strong social networks.

Gaps and challenges

Inadequate human resources capacity, in terms of numbers, skills and motivation, to effectively deliver social services including support to OVCs and people living with disabilities.
Lack of comprehensive and timely data to inform policies and programmes.
Lack of a harmonised M&E system to which all players providing social services report is limiting the effectiveness of coordination.
Weak coordination amongst all actors providing social services.

Strategies

I. *Improve capacity of DMP's Welfare department* to map and monitor services for vulnerable population including people living with disabilities.
II. *Develop coordination mechanisms for all Ministries providing welfare services.*
III. *Improve capacity for mainstreaming of HIV:* Ensure priority and key populations are targeted. This will include training of the key staff in the various line ministries on mainstreaming.
IV. *Support these sectors to institutionalise HIV* into their sector plans and budgets.

3.1.4 Advocacy and communication for the HIV response

Programme objective: To increase and sustain commitment to the country vision for the HIV response at international, national and community levels.

Target populations: Members of Parliament, traditional leaders, citizens and development partners.

Outcome targets

Table 22: Advocacy and communication outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of people aged 15-49 who are aware of country vision to End AIDS by 2022	Total	No baseline	80%	90%
% of young people aged 15-24 who cite social media as source of HIV information	Total	No baseline	70%	85%

Situation Analysis

Advocacy and communication is key for disseminating the vision of the response, enhancing and sustaining stakeholder commitment to the response, and mobilising resources. The eNSF was largely viewed as a technical document for use by programmers and was not cascaded to lower levels. In addition, the country developed the Umgubudla fast track programme which set out the vision of Ending

AIDS by 2020. But the link between the two plans has not been effectively communicated. Advocacy for implementation of the NSF was also limited to the political and policy levels.

During the period of the NSF 2018-2023, advocacy and communication will be critical for rallying political players, policy makers and communities around the vision of Ending AIDS. This will create an enabling environment for resource mobilisation and achievement of the NSF results, and contribute to their achievement.

Gaps and Challenges

Low and varying knowledge about Ending AIDS goal.
Capacity for advocacy and communication is not yet a priority and consequently limited resources and staff are allocated to this initiative.
Poor dissemination of HIV policy documents.
Poor dissemination of HIV response progress reports.

Strategies

I. *Disseminate information on the HIV response vision and results among key stakeholders at national and community level:* The vision of Ending AIDS as a health threat by 2022 will be communicated at all levels using appropriate channels. A clear identity or branding for the HIV response to rally the country around the vision will be developed.
II. *Develop and implement effective media tools to advocate for the HIV response:* Messages and programmes on the HIV response will be developed and disseminated through these platforms targeting diverse audiences.
III. *Advocate for the HIV response at national and international levels:* Advocacy will be undertaken via national and international platforms.
IV. *Build the capacity for advocacy and communication:* Adequate funding and staff will be allocated to this programme based on a costed implementation plan. Media personnel will also be trained on how to report on the HIV response to improve coverage of the HIV programmes in the country.

3.1.5 Strategic Information and Research

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

Target population: Sectors, implementing partners, government ministries, development partners.

Outcome targets

Table 23: Strategic information outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of NSF indicators that have data collection system reported on	Total	43% (eNSF Evaluation, 2017)	90%	95%

Situation Analysis

Eswatini is committed to the one national M&E system at NERCHA, which includes routine monitoring, evaluation and research coordination. NERCHA is responsible for collating, analysing and disseminating national HIV response data and information. All HIV implementers are responsible for reporting HIV programme data to the Eswatini HIV and AIDS Programme Monitoring System (SHAPMoS). SHAPMoS links to M&E systems that report on the indicators for HIV. These systems include the HMIS in the Ministry of Health; M&E systems for civil society and private sector entities; M&E systems of line ministries reporting on their mainstreaming of HIV activities; the Deputy Prime Minister's Office which reports on OVC and GBV programmes; and the Ministry of Education which reports on HIV intervention in learning institutions.

An HIV surveillance system was established in Eswatini in 1992 and since then several surveys have been conducted including the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), and Eswatini HIV Incidence Measurement Survey (SHIMS). Key population (FSW and MSM) size estimation and a Behavioural Surveillance Survey (BSS) was also carried out in 2015.

To effectively monitor implementation of the NSF, implementers will be required to collect and report programmatic data in real time, using standardised and appropriately disaggregated tools. Strategic information will allow policy makers and implementers to: plan using evidence; track and assess the HIV response, including inputs, coverage and quality of services delivered, outcomes and overall impact; and promote accountability for results. Strategic information and research will, therefore, be a central driving component of the response in the next five years.

Gaps and challenges

Inefficient data flows from collection to use and lack of real-time data.
Low reporting to the central M&E portal (SHAPMoS).
Lack of a platform to conduct regular M&E reviews for the overall HIV response.
Weak coordination of M&E.
Lack of a mechanism to facilitate the use of community-based information for HIV programming.
Limited capacity of local institutions in M&E and research.
Limited funding for HIV surveillance systems.
Weak data governance which limits access to data and efficient data sharing.
No multisectoral HIV research agenda.
Inadequate research coordination at all levels. Consequently, there is no systematic tracking of all HIV research being conducted in the country.
There is no up-to-date inventory of multi-sectoral HIV research conducted to date or ongoing or planned.
Lack of research funding by the government which limits access to research results.

Strategies

Monitoring

I. *Strengthen and promote the One National multi-sectoral M&E System and Framework:* An M&E plan for NSF III will be developed and disseminated to all partners to enable them to align their M&E systems to effectively report to SHAPMoS.
II. *Develop and make operational a real-time and geo-localised reporting and data management system:* Real-time granular data will be required to support super-fast tracking of the HIV response. Technology will be harnessed to develop an on-line and GIS-enabled SHAPMOS that collects, collates and makes national and granular data available to users at all levels.
III. *Promote a community-driven and community-owned M&E system:* A local community-driven monitoring system will be established to support the local response.

IV. *Improve M&E coordination and engagement of all stakeholders in NSF M&E:* The coordination of M&E for NSF will be strengthened by reconstituting the Strategic Information (SI) TWG and ensuring its roles are clearly defined.
V. *Build M&E capacity for relevant M&E systems:* Capacity for sectors and implementers will be developed to ensure that all indicators are reported on and thus improve data quality.
VI. *Advocate for implementation of M&E for the HIV response:* M&E advocacy forums will be held for policy makers, programme managers and local level structures.

Surveillance and surveys

I. *Improve timely access to surveillance and survey data:* A comprehensive data governance framework for the HIV surveillance and survey data in line with overall legislation and policies governing data in Eswatini will be developed.
II. *Strengthen and expand routine HIV, TB and STI epidemic surveillance*: These surveillance systems will be linked to the One M&E system platform to allow coordination, triangulation with programmatic data, and identification of geographical areas and population groups for deciding priority.
III. *Provide resources for priority surveillance and surveys:* The country will mobilise resources to conduct priority nationally representative and regionally powered HIV surveys.
IV. *Conduct special surveys*: These are surveys which will track quality of service provision, client satisfaction, and HIV burden and programme coverage in other populations, such as client satisfaction, workplace, school and hotspot mapping surveys.

HIV Research

I. *Strengthen coordination of HIV research:* An HIV research agenda will be finalised to guide the coordination of research activities.
II. *Undertake priority operational research, programme reviews and impact evaluations:* Based on the research agenda, priority research will be conducted to generate evidence on implementation of science and population-level impact of interventions and programmes.
III. *Build the capacity for translation of research findings into policy and programme recommendations into action plans:* Research findings will be translated into policy briefs and action plans to facilitate the use of research findings. These will be disseminated to the relevant audiences to motivate action.

4. SUSTAINABLE FINANCING OF THE HIV RESPONSE

Programme objective: To ensure efficient and sustainable financing of the HIV response.

Target: Government, private sector and development partners.

Outcome targets

Table 24: Sustainable financing outcome results

Indicator	Disaggregation	Baseline (Source)	Targets for years	
			2020	2023
% of total expenditure on HIV and AIDS provided by domestic resources	Total	48% (HIV expenditure Tracking, 2017)	55%	70%
% of HIV financing allocated to HIV prevention	Total	19% (NASA, 2015)	25%	30%

Situational analysis

Funding for the HIV and AIDS response comes through domestic and international sources from three partners: The Government of the Kingdom of Eswatini; the Global Fund for AIDS, TB and Malaria (GFATM); and the United States' PEPFAR. External partners account for an average 57% of total funding, and as shown in table 2 below, government's contribution has been increasing over the years to an estimated 48% in 2016. This is largely led by widening treatment thresholds leading up to cover all PLHIV under the test and start approach which has been rolled out since July 2016. Government spending on HIV represents 39.2% of the total budget for the Ministry of health, from which antiretroviral drugs form the major line item.

Table 25: HIV financing by source of funds, Eswatini

HIV/AIDS funding by source of funds, FY2013/14- FY2016/17						
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Internal (domestic) funding	39%	40%	46%	43%	41%	48%
External funding	61%	60%	54%	57%	59%	52%

Source: HIV expenditure tracking, 2017

Given Eswatini's ambitious targets aimed at eliminating new HIV infections and AIDS-related mortality, sustainable financing of the response takes strategic prominence, especially when viewed in the light of decreasing fiscal space for health and HIV, both locally and globally. It is unlikely that new external funding sources, or even the current sources, will substantially increase over the NSF period. It is, therefore, important to shift focus to inward-looking resource mobilisation and effective priority of interventions and development of strategies to gain efficiencies.

Gaps and Challenges

Global flatlining of resource commitments for HIV as the number of donors have reduced and and/or changed focus.

Funding for HIV is done in silo approaches and, as a result, synergies with universal health care coverage have not been realised.

There is no formal routine HIV expenditure tracking system in place. The country relies on National AIDS Spending Assessments (NASA) but the last was conducted in 2015. In the absence of such a system, efficiency analyses to establish the cost of delivering HIV programmes cannot be effectively undertaken.

Inadequate resources for HIV prevention.

Inadequate domestic resource mobilisation strategies in place and government is the major contributor.

Ineffective resource and donor coordination which in turn limits the extent to which resources are aligned to priority programmes and population.

While government provides the majority of ARVs, patients who have access to private medical aid schemes utilise the free HIV services from the public sector.

Strategies

I. *Design and implement an HIV/AIDS resource mobilisation and sustainable financing strategy and implementation programme:* A multisectoral HIV financing committee will be established to steer the country's efforts to mobilise adequate resources for the HIV response.

II. *Advocate for the establishment of an HIV investment trust:* As a long-term financing strategy for the HIV response, the country will explore various revenue sources to support the establishment of the investment fund.

III. *Institutionalise optimisation, programme efficiency and cost-effectiveness analyses of the response*: Expenditure tracking tools will be used to interrogate the efficiency of current implementation strategies, and cost efficiency studies will be institutionalised to inform allocative efficiencies. The country will also transition to lower cost treatment regimes and the use of new low-cost technologies.

IV. *Implement effective utilisation of National Sectoral Development Plans with budgets committed to HIV:* Develop and make operational HIV mainstreaming implementation mechanisms in collaboration with Government ministries.

V. *Develop and implement a policy for restricting the shift of the HIV cost burden from the private to the public sector:* Policy options will be explored to restrict the shift of cost burden. Advocacy will also be undertaken to encourage the private sector to fund HIV programmes.

4.1.1 Resource needs for implementing the NSF during 2018 – 2023

The total estimate of resources required to implement the NSF 2018-2023 to scale is $790.13 million over 5 years. Annual estimates are provided in the table below.

Table 26: Total cost of NSF 2018-2023

	2018/19	2019/20	2020/21	2021/22	2022/23	Total	%
PREVENTION							
Social Behaviour Change Communication	3.13	3.98	4.45	5.64	5.94	23.14	2.93%
Condoms	1.16	1.21	1.26	1.32	1.38	6.33	0.80%
Voluntary Medical Male Circumcision	5.56	5.57	5.57	8.35	8.35	33.40	4.23%
Prevention of Mother to Child Transmission	4.24	4.08	3.90	3.77	3.63	19.62	2.48%
Pre-exposure Prophylaxis (PrEP)	0.34	0.78	1.55	2.33	3.10	8.10	1.02%
Post Exposure Prohylaxis (PEP)	0.20	0.22	0.24	0.27	0.29	1.23	0.16%
Economic Empowerment	4.34	5.82	6.32	7.81	9.30	33.60	4.25%
Adolescent Girls and Young Women (AGYW)	6.43	6.91	7.41	7.91	8.42	37.07	4.69%
Men having Sex with Men (MSM)	1.51	1.53	1.54	1.56	1.58	7.72	0.98%
Female Sex Workers (FSW)	1.52	1.54	1.56	1.58	1.60	7.80	0.99%
Inmates	0.18	0.19	0.19	0.19	0.19	0.94	0.12%
Mobile/Migrant Populations	0.87	0.88	0.89	0.90	0.91	4.46	0.56%
TOTAL PREVENTION	29.50	32.70	34.89	41.62	44.70	183.40	
TREATMENT, CARE & SUPPORT							
HIV Testing Services	7.26	5.76	5.80	4.33	4.39	27.55	3.49%
Antiretroviral Therapy	54.30	56.12	57.33	57.47	57.55	282.76	35.79%
Treatment Monitoring (Viral Load)	6.00	6.40	4.48	4.74	4.74	26.36	3.34%
Treatment Adherence Support - Nutrition	1.21	1.25	1.28	1.29	1.29	6.32	0.80%
TOTAL TREATMENT, CARE AND SUPPORT	68.77	69.53	68.90	67.82	67.97	342.99	
SOCIAL PROTECTION							
Support Packages for Orphans and Vulnerable Children	2.13	1.71	1.00	0.63	0.30	5.77	0.73%
HIV-Sensitive Social Protection	0.28	0.26	0.23	0.21	0.19	1.17	0.15%
TOTAL SOCIAL PROTECTION	2.42	1.97	1.23	0.84	0.49	6.94	
SUB-TOTAL	100.68	104.20	105.01	110.29	113.16	533.34	
Program Support & Enabling Environment							
Human Rights and Gender Related Barriers to Access, Utilization and Delivery	1.01	1.04	1.05	1.10	1.13	5.33	0.67%
Community Systems Strengthening	5.03	5.21	5.25	5.51	5.66	26.67	3.37%
Health Management Information Systems	10.07	10.42	10.50	11.03	11.32	53.33	6.75%
Procurement and Supply Chain Management	15.13	15.30	15.16	14.92	14.95	75.46	9.55%
Laboratory Systems and Equipment	9.06	9.38	9.45	9.93	10.18	48.00	6.07%
Program Governance, Policy and Coordination	8.05	8.34	8.40	8.82	9.05	42.67	5.40%
Finance and Sustainability	1.01	1.04	1.05	1.10	1.13	5.33	0.67%
TOTAL PROGRAM SUPPORT AND ENABLING ENVIRONMENT	49.36	50.72	50.86	52.42	53.43	256.79	
Total Millions of USD	150.05	154.92	155.87	162.71	166.58	790.13	100.00%

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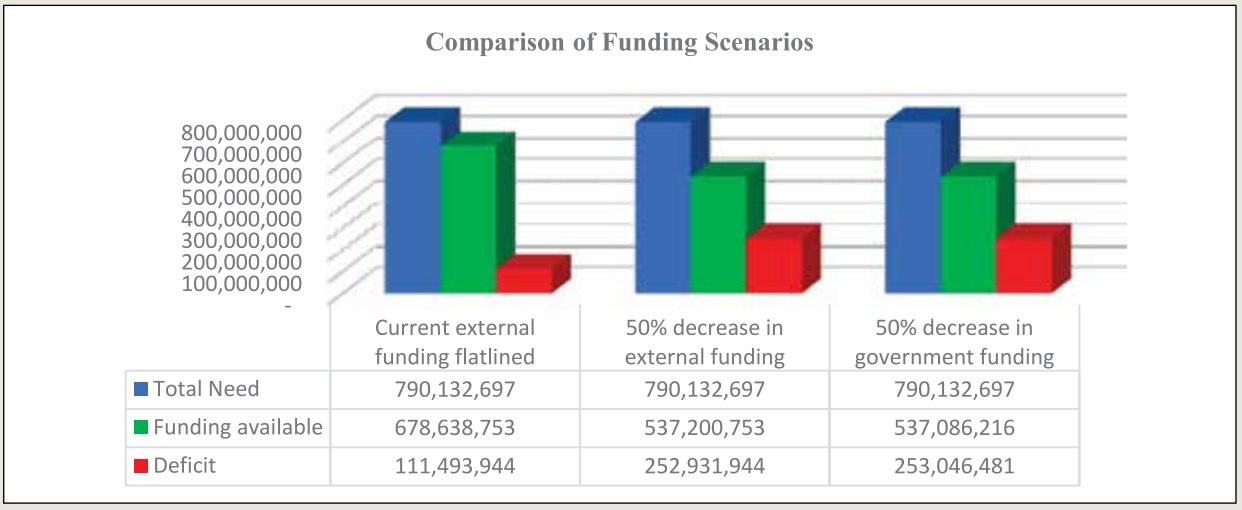
The annual resource estimate increases range from 0.6% to 4.4% as shown in figure 18 below.

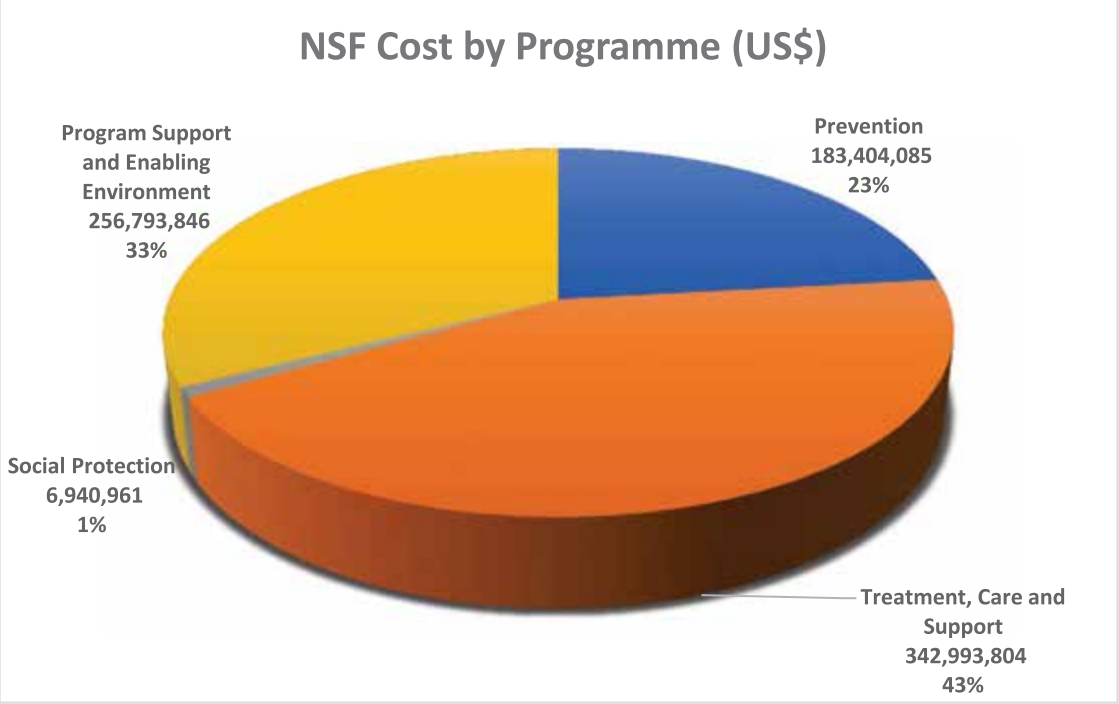
Figure 18: Annual costs of the NSF 2018-2023, Eswatini



	Current external funding flatlined	50% decrease in external funding	50% decrease in government funding
Total Need	790,132,697	790,132,697	790,132,697
Funding available	678,638,753	537,200,753	537,086,216
Deficit	111,493,944	252,931,944	253,046,481

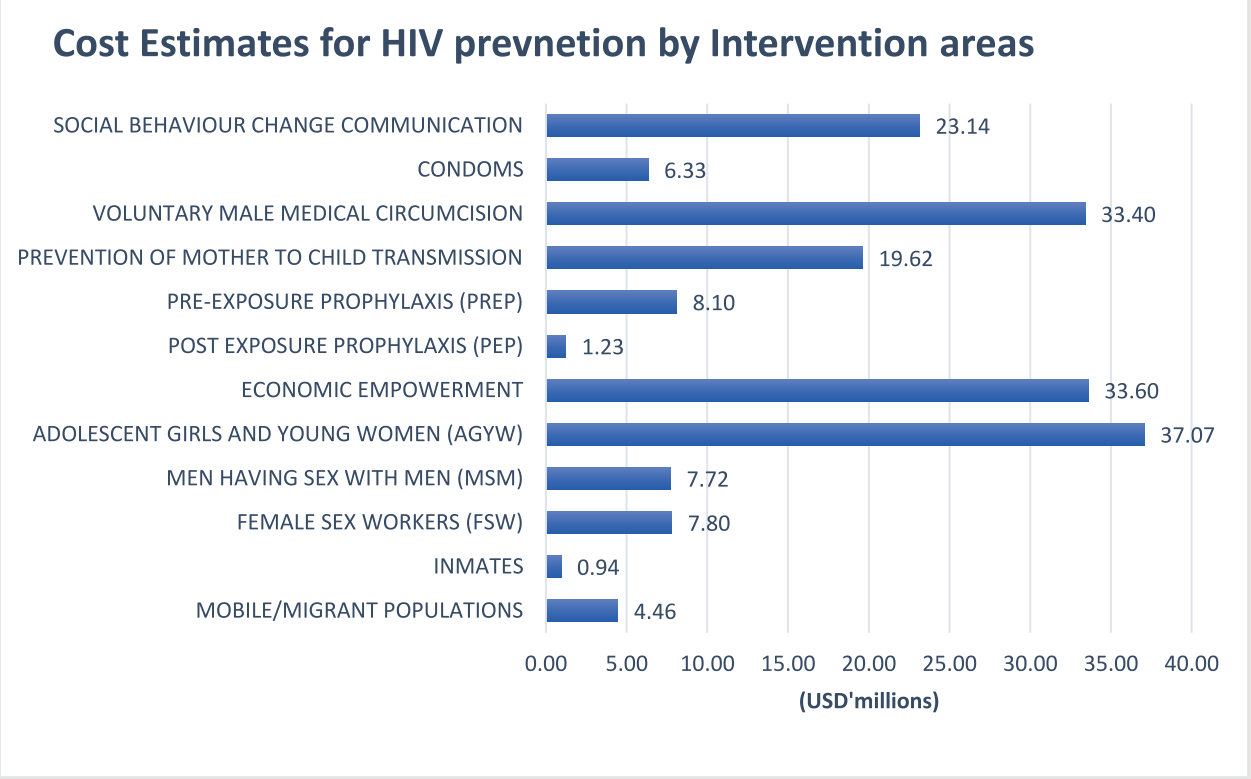
As shown in figure 19 below, resource estimation by thematic area reflects the strategic emphasis to sustain treatment, care and support, scale up prevention and strengthen critical enablers including sustainable financing, M&E and systems strengthening.

Figure 19: NSF cost by programme, Eswatini



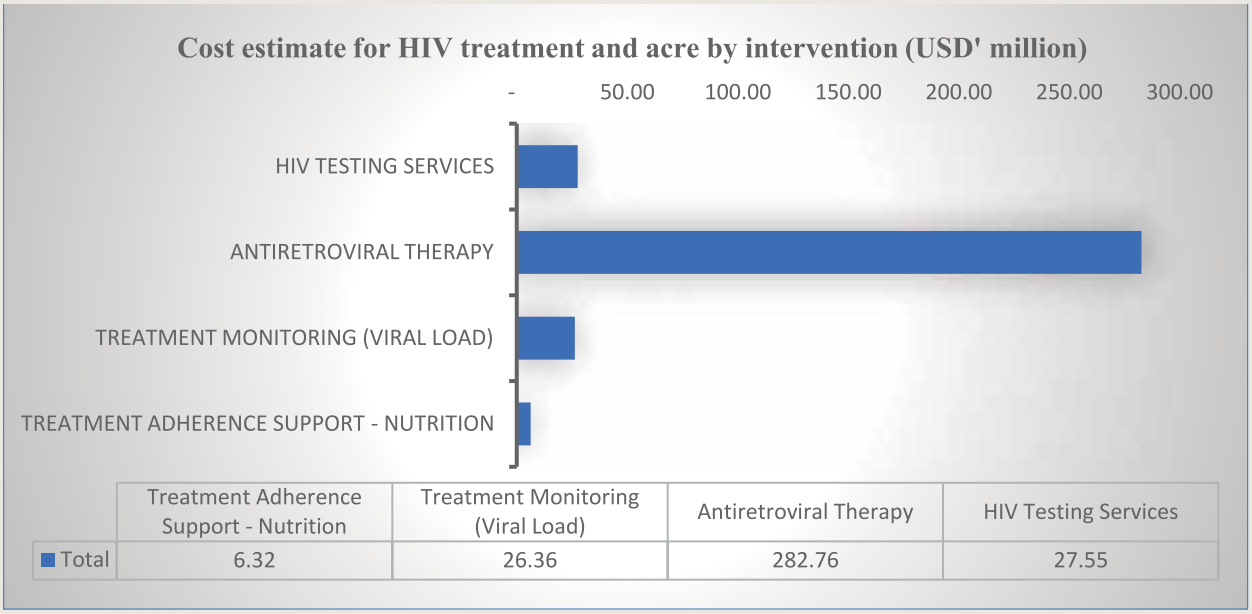
The total cost estimate for HIV prevention as shown in figure 20 below is driven by investments in adolescent girls and young women. Other significant investments include VMMC, PMTCT and SBC and Economic Empowerment for young people.

Figure 20: Cost estimate for HIV Prevention by intervention areas



With regards to treatment, care and support, the major cost drivers are anti-retroviral therapy, viral load testing and HIV testing services, as shown in figure 21.

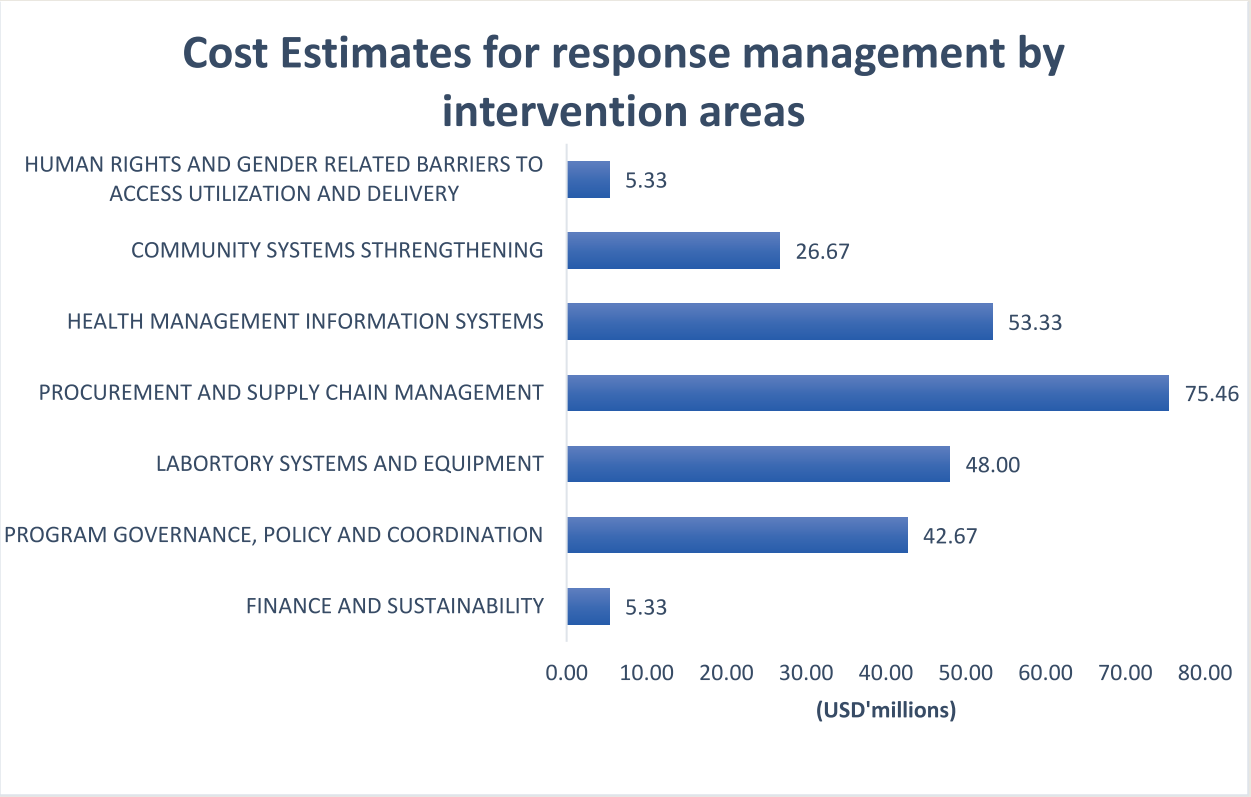
Figure 21: Cost estimate for HIV Treatment and Care by intervention areas



	Treatment Adherence Support - Nutrition	Treatment Monitoring (Viral Load)	Antiretroviral Therapy	HIV Testing Services
Total	6.32	26.36	282.76	27.55

The main drivers for the cost of the Programme Support and Enabling Environment are the community and health systems for delivering the HIV response.

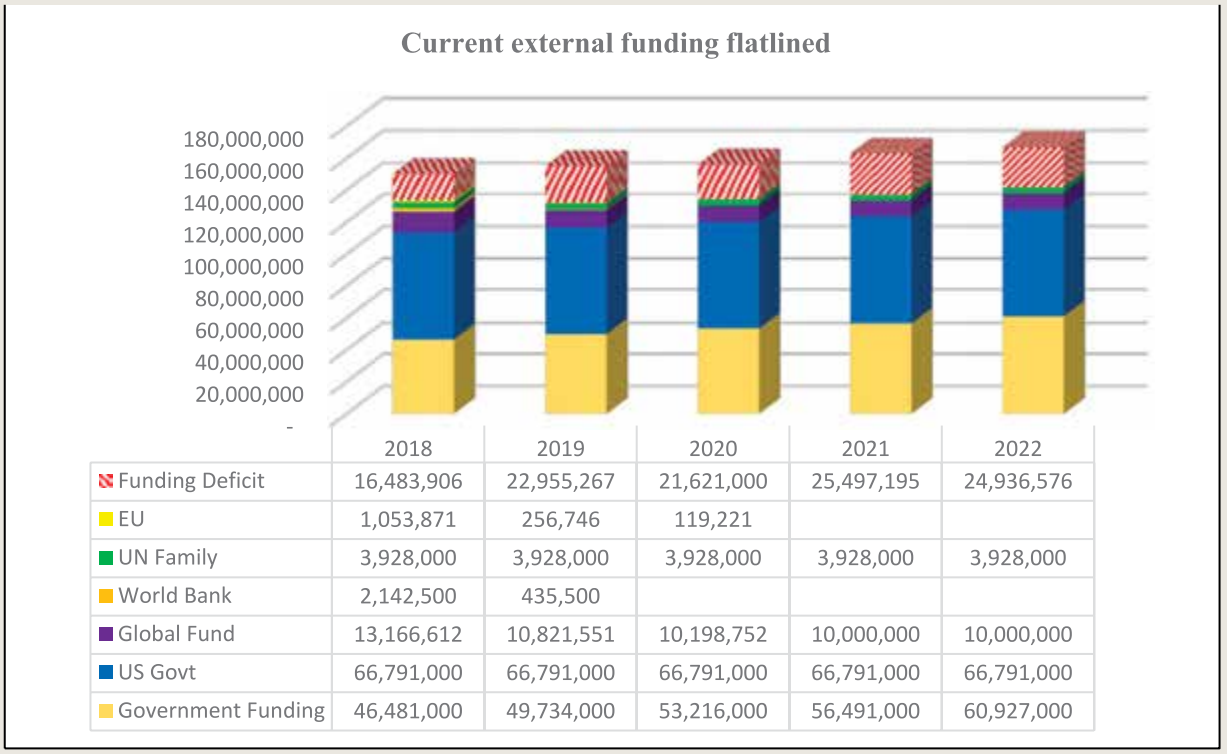
Figure 22: Cost estimates for Response Management by intervention areas



Funding commitment landscape and potential funding gaps

The Global Fund has committed funds for the next three years (up to 2020) and PEPFAR has committed funds for 2018 and 2019 through their Country Operational Plan (COP 18). If PEPFAR funding will continue and is flat-lined at the current level, the total funding landscape is shown in figure 23 below. The total funding deficit will amount $111 million over the five years of this NSF under this funding scenario.

Figure 23: Funding commitment for the NSF, Eswatini



	2018	2019	2020	2021	2022
Funding Deficit	16,483,906	22,955,267	21,621,000	25,497,195	24,936,576
EU	1,053,871	256,746	119,221		
UN Family	3,928,000	3,928,000	3,928,000	3,928,000	3,928,000
World Bank	2,142,500	435,500			
Global Fund	13,166,612	10,821,551	10,198,752	10,000,000	10,000,000
US Govt	66,791,000	66,791,000	66,791,000	66,791,000	66,791,000
Government Funding	46,481,000	49,734,000	53,216,000	56,491,000	60,927,000

In the alternative scenario that PEPFAR funding is reduced by 50% from 2019/2020 to end of NSF period, the funding deficit increases to $253 million. Given the fiscal constraints facing Government, there is also likelihood that government funding for HIV will reduce. In that scenario, the deficit will be $253 million over the five-year period. Figure 18 shows all three scenarios.

The best funding case scenario for HIV funding is where the current funding level from all the sources is flat-lined. However, there will still be need to mobile additional resources to address the funding gap.

5. NSF IMPLEMENTATION ARRANGEMENTS

Overview

The NSF guides the implementation of all interventions for HIV and AIDS at national and decentralised levels. It provides priority strategies for core programmes and critical enablers necessary to achieve the desired outcomes. The NSF will be implemented through different avenues – policy, planning, monitoring and direct service delivery. Implementation will take place at national, regional and community levels. Key implementers will include the Ministry of Health and other Government ministries, civil society organisations, community and non-governmental organisations(NGOs), the private sector, development partners and technical partners. Communities will be involved in service delivery as well as being beneficiaries. Each implementer will participate in implementation of the NSF according to its mandate.

The following structures and processes have been (or will be) put in place to support an efficient implementation of the NSF:

1. National Operational Plan (NOP)

A costed National Operational Plan (NOP) will be developed to transform NSF strategies into action to achieve the output level results shown in the NSF Results Framework (see Annex 1). This will be a 2-year rolling plan updated annually and coordinated by NERCHA. NERCHA will also facilitate the development of sectoral and line ministry operational plans to ensure that streamlining, localisation, planning for results, gender and human rights mainstreaming, and community involvement occurs at all levels. Lead implementing organisations will be identified based on mandate, comparative advantage, and existing technical expertise and resources.

During the first year of implementation, health sector programmes will be supported to become more multisectoral under the sector wide approach (SWAP) and community engagement platforms, while non-health sector based programmes will be equipped to strengthen their systems, develop programmes, standard operating procedures (SOPs) and monitoring tools.

The structure of the NOP will allow for expenditure tracking and implementation monitoring on periodic (preferably quarterly) basis and also annually.

2. Advocacy and communication

An HIV and AIDS response National Advocacy and Communication Strategy will be developed to sustain political support and to disseminate strategic information. Advocacy and communication will be undertaken at national, regional and community level as well as international level. At the regional level, advocacy aims to strengthen community systems and promote community involvement. At the national level, advocacy will be undertaken to sustain Government's commitment to the HIV response. International partners will be targeted for financial and technical support and to showcase Eswatini's successes in the HIV response.

3. Sustainable Financing

An HIV sustainable financing committee will be established to lead resource mobilisation for the NSF and promote efforts for domestic financing through strategies outlined in section 4. Mechanisms to undertake regular expenditure tracking and other efficiency analyses will be put in place to support a consistent flow of funds and an effective and efficient response.

4. Thematic and Programme Areas / Interventions

NERCHA shall facilitate coordination for the implementation of the five (5) national level thematic or programmatic areas: HIV prevention, treatment and care, social protection and reduction of structural vulnerabilities, response management, and sustainable financing by sectors. NERCHA shall liaise with programmes to ensure that all NSF strategies are implemented.

5. Coordination Structures

The coordination architecture will be realigned and streamlined to effectively coordinate the implementation of NSF strategies within constituencies. This will empower sectors to review progress, identify bottlenecks and develop constituency-focused solutions. Coordination structures will be decentralised at regional and community levels to support the localisation of the response.

The coordination framework will;

(i) Ensure the roles and responsibilities among institutions, stakeholders and sectors at national and decentralised levels are clearly defined.

(ii) Reconfigure the coordination of the response to put communities at the centre and improve the focus on local HIV needs.

(iii) Maximise efficiency and effectiveness by strengthening strategic partnerships, stakeholder participation and accountability at all levels of the HIV response delivery chain.

(iv) Ensure accountability for performance and results by all implementers to superfast track the end of AIDS by 2022.

6. Monitoring and Evaluation

M&E and research will be strengthened to produce granular and localised information through strategies laid out in section 3 of this NSF. A national HIV and AIDS Strategic Information Framework will be developed to measure performance of NSF interventions and inform policy development and programme planning. The M&E/SI Framework will provide strategic guidance for the coordination of multisectoral monitoring and evaluation efforts, and indicate evaluation methods (surveys and key research) for the NSF. Operational processes for M&E will be presented to ensure efficient data flow and use. The results framework (annex 1) will be disaggregated to granular targets at sector, regional and sub-population levels. High level indicators will be recommended for routine monitoring.

Annual reviews of the NSF will be conducted each year; mid-term and end-of term evaluations will be conducted in 2020 and 2022, respectively.

Annex 1: NSF Results Framework

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
Indicator	Baseline (Year)	Targets (Years)		Indicator	Baseline (Year)	Targets (Years)		Indicator	Baseline (Year)	Targets (Years)	
		2020	2023			2020	2023			2020	2023
				PREVENTION OF NEW HIV INFECTIONS							
				SOCIAL AND BEHAVIOUR CHANGE (SBC)							
Fewer people become infected with HIV				**More young people have comprehensive knowledge about HIV**				**SBC programmes target young people**			
HIV incidence rate among people aged 15-49	1.5% (2016)	1%	0.4%	% of young people aged 10-14 who answered correctly to all HIV knowledge questions	34.6% (2017)	52%	60%	Number of in-school youth who have attended life skills education at school	99'696 (2016)	181'795	222'845
HIV incidence rate among young people aged 15-24	1.3% (2016	0.7%	0.4%	% of persons aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	50% (2014)	69%	75%	Number of out-of-school youth reached with HIV prevention education	12'996 (2016)	68'242	95'864
% of HIV infected infants aged 18-24 months born to HIV+ mothers	3% (2017)	1%	0.1%	**Fewer young women have older sexual partners**				**Older men and women receive information on the HIV risk education**			
Fewer PLHIV die of AIDS-				% of women aged 15-24 who had sex with a partner who is 10 years or older than them	8.7% (2016)	5%	3%	Number of men and women 25+ years reached with SBCC	72'207 (2016)	240'896	386'680
								Number of formally employed workers reached with a minimum package of HIV prevention programmes	300 (2016)	50,000	150,000
								SBC programmes target community leaders			
								Number of community leaders' s	No baseline	500	800

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
related conditions Annual AIDS Deaths	3'200 (2017)	2'400	1'600					who have been reached with SBC programmes			
								Key populations receive information on the HIV risk education Number of sex-workers reached with HIV prevention programmes		1'000	5'000
								Number of MSM reached with HIV prevention programmes		300	1'000
				CONDOM PROMOTION AND DISTRIBUTION							
				Adolescents and young people use condoms % of young people aged 15-24 with more than one partner in the past 12 months who report the use of a condom during last sex	69.3% (2016)	90%	95%	**More condoms are distributed** No# of male condoms distributed	14'943'334 (2016)	29'203'200	31'586'181
								Number of female condoms distributed	319'911 (2016)	743'098	819'266
				Adult men and women use condoms during high-risk sex % of men and women aged 15-49 with more than one partner in the past 12 months who report the use of a condom during last sex	64.3% (2016)	80%	90%	**More condoms are available to young people** % of service delivery points that are typically accessed by young people aged 15-24 years that have condoms in stock at the time of the survey	No baseline	80%	95%
				% of men who used a condom at last sex with a sex worker	82.3% (2016)	90%	95%				
				Sex workers use HIV prevention measures % of female sex workers reporting the use of a							

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				% of female sex workers reporting the use of a condom with their most recent client	No baseline	90%	95%				
				Adolescent girls and young women use condoms to prevent teenage pregnancy and new HIV infections % young women aged 15-24 currently unmarried or not in union who report using a condom as a contraceptive	31.8% (2016)	70%	90%				
				% of young women aged 20-24 who had at least one live birth by the age 18	16.7% (2014)	10%	5%				
				ECONOMIC EMPOWERMENT OF ADOLESCENTS AND YOUNG PEOPLE							
				More young people are empowerment % of vulnerable young people aged 15-24 reached with at least one economic empowerment intervention	No baseline	70%	80%	**Young people receive economic empowerment support** Number of young people aged 15-24 who are out of school reached with entrepreneurship training	No baseline	20'000	50'000
				Teen mothers return to school % of female school drop outs who return to formal school	No baseline	60%	80%	Number of young people aged 15-24 who are out of school who receive a school subsidy	No baseline	5'000	10'000

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)							
				On the population level, more male adults and children are circumcised % males aged 10-49 who are circumcised % males who are less than 1 year who are circumcised % males aged 10-29 who are circumcised	24.3% (2014) 6.6% (2014) No baseline	50% 40% 70%	70% 60% 80%	**More males are circumcised** Number of medical male circumcisions performed	17'374 (2017)	30'516	45'773
				PRE-EXPOSURE PHROPHYLAXIS (PREP)							
				More people on PrEP adhere to it % of people on PrEP who adhere to it 1 month from initiation	No baseline	50%	70%	**More people at substantial risk of HIV infection are initiated on PrEP** Number of people at substantial risk of HIV infection initiated on PrEP **PrEP is available at all health facilities also providing ART** Number of PrEP sites	610 (2017) 20 (2017)	14'286 100	28'571 200
				POST-EXPOSURE PHROPHYLAXIS (PEP)							
				More victims of sexual assault are protected from contracting HIV % of eligible sexually abused people receiving PEP% of eligible sexually abused people receiving PEP	No baseline	95%	95%	**More people in need of PEP receive it** No# of people who received PEP	No baseline	14'090	16'704

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				More exposed service cadres are protected from contracting HIV % of exposed service cadres receiving PEP	No baseline	95%	95%				
				PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)							
				Fewer infants have HIV at 6-8 weeks % of HIV infected infants aged 6-8 weeks who are born to HIV positive mothers	3% (2017)	2%	≤1%	**Fewer HIV negative women seroconvert during pregnancy and postpartum period** % of women seroconverting during pregnancy and postpartum period	1.6% (2016)	≤0.5%	≤0.5%
				More HIV positive mothers, children and their partners are retained on lifelong ART % of pregnant and lactating women alive and on treatment 12 months after ART initiation	No baseline	>85%	>90%	**More pregnant women and their exposed infants are tested for HIV and those found HIV + receive appropriate regimen** % of HIV-positive pregnant and lactating women who received LLAPLa	95% (2016)	≥95%	≥95%
				% on HIV positive children under 1 who are retained on ART	No baseline	80%	>90%	% of infants born to HIV-positive women receiving ARV prophylaxis for prevention of MTCT in the first 6 weeks	72% (2016)	≥95%	≥95%
								More infants born to HIV positive women receive a virological test for HIV % of infants born to HIV infected women receiving a virological test for HIV within two months of birth	79% (2016)	90%	≥95%

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
								More pregnant women are tested for syphilis % of pregnant women tested for syphilis	89% (2016)	90%	≥95%
				MANAGEMENT AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI)							
				Fewer people have STIs % of people aged 15-49 who had a sexually transmitted infection in the past 12 months	No baseline	≤10%	≤5%	**More people with STIs are treated** Number of people with STIs who receive treatment for STIs **More people with STIs are tested for HIV** % of people with STIs who receive an HIV test and receive post test results	No baseline No baseline	5'000 ≥90%	10'000 ≥95%
				HIV TREATMENT AND CARE							
				HIV TESTING SERVICES (HTS)							
				More PLHIV know their status % of people living with HIV aged 0-14 who know their status % of people living with HIV aged 15-24 who know their status % of people living with HIV aged 25 and older who know their status **More key populations LHIV who know their status** % of female sex workers living with HIV who know their status	66.1% (2016) 72.1% (2016) 87.1% (2016) 61.7% (2013)	90% 90% 90% 90%	95% 95% 95% 95%	**More people test for HIV** Number of tests performed Number of HIV self-tests distributed	445,000 (2017) 9'970 (2017)	294'504 15'000	222'586 20'000

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				% of MSM living with HIV who know their status	51% (2013)	90%	95%				
				ANTIRETROVIRAL THERAPHY (ART)							
				More PLHIV with known diagnosis receive ART				**PLHIV enrol in ART**			
				% of people living with HIV aged 0-14 receiving ART	77.5% (2016)	90%	95%	% of PLHIV enrolled within 2 weeks of knowing their status	73% (2017)	95%	≥95%
				% of people living with HIV aged 15-24 receiving ART	69% (2016)	90%	95%	**More PLHIV are retained on ART** Number of PLHIV on ART	174'103 (2017)	209'615	210'314
				% of people living with HIV aged 25 and older receiving ART	85% (2016)	90%	95%	**PLHIV are on appropriate regimens** Number of PLHIV on 2nd line treatment	4'352 (2017)	5'240	5'258
				More key populations LHIV known diagnosis receive ART				**PLHIV receive routine health tests**			
				% of female sex workers living with HIV receiving ART	41.5% (2013)	90%	95%	%e of PLHIV on ART who had at least one viral load test in the past 12 months	13.5% (2016)	90%	95%
				% of MSM living with HIV receiving ART	33% (2013)	90%	95%				
				More PLHIV are virally suppressed							
				% of people living with HIV aged 0-14 receiving antiretroviral therapy that are virally suppressed	77.5% (2016)	90%	95%				
				% of people living with HIV aged 0-14 receiving	76.4% (2016)	90%	95%				

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				antiretroviral therapy that are virally suppressed % of people living with HIV aged 0-14 receiving antiretroviral therapy that are virally suppressed	91.4% (2016)	≥95%	≥95%				
				TB/HIV CO-INFECTION MANAGEMENT							
				Reduced TB mortality TB Death rate per 100,000 population	104 (2017)	80	40	**Co-infection is diagnosed** % of people living with HIV newly enrolled in HIV care with active TB disease	68% (2017)	90%	95%
				Co-infected patients are successfully treated for TB TB Treatment success rate among patients with non-resistant Drug TB	78% (2017)	90%	95%	**More co-infected patients receive TB/HIV integrated services** % of PLHIV on Treatment of Latent TB Infection (LTBI)	20% (2017)	70%	≥90%
				TB Treatment success rate among patients with D/X/M-TB	70% (2017)	90%	95%				
								% of estimated HIV positive patients' incident TB cases that received treatment for both HIV and TB	97% (2017)	≥97%	≥97%
				MANAGEMENT OF HIV OPPORTUNISTIC INFECTIONS AND CO-MORBIDITIES							
				More co-infected PLHIV receive treatment for OIs and co-morbidity % of PLHIV with reported OI or co-morbidity who are receiving treatment for it	No baseline	70%	≥80%	**More ART sites integrate OI and NCD screening** % of ART sites that have integrated the screening and referral of NCDs	No baseline	60%	≥95%

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
								More PLHIV are screened for OIs and Co-morbidities % of female PLHIV who were screened for cervical cancer at least once during the past 12 months	No baseline	80%	≥95%
				SOCIAL PROTECTION AND REDUCTION OF STRUCTURAL VULNERABILITIES							
				SUPPORT TO ORPHANED AND VULNERABLE CHILDREN (OVC)							
				More OVC receive social support % of eligible OVC who progress from primary to secondary school	85.5% (2014)	90%	95%	**More OVC are enrolled in school** Number of OVC aged 10-19 who are in primary school	29819		
								More OVC receive social support % of orphans receiving social grants	No Baseline	30'000	60'000
				More OVC receive comprehensive HV services % of AIDS orphans receiving comprehensive package of HIV services	37% (2016)	70%	90%	% of OVC whose households received economic strengthening support	No baseline	40%	60%
				GENDER BASED VIOLENCE (GBV)							
				Fewer women experience GBV				**More GBV cases are referred** % of GBV cases that have been referred to a service provider	41% (2016)	65%	80%

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				% of children aged 0-14 who experience sexual abuse	1.% (2016)	≤1%	<1%	**More eligible victims receive post-exposure prophylaxis** % of eligible victims of sexual assault who have received PEP services	No baseline	≥90%	≥95%
				% of women aged 15 and older who experience sexual abuse	6.6% (2016)	3%	<3%				
				HIV RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS							
				Fewer PLHIV experience HIV stigma or discrimination % of PLHIV who report experience of stigma and discrimination in the past 12 months	No baseline	30%	≤10%	**More PLHIV receive empowerment programmes** % of PLHIV reached with stigma and discrimination reduction programmes	No baseline	30'750	55'000
				% of people aged 15-49 who report discriminatory attitudes towards people living with HIV	36%	≤10%	≤5%	**More key populations receive empowerment programmes** % of FSW reached with stigma and discrimination reduction programmes	No baseline	1'000	5'000
				Fewer key population experience stigma % of female sex workers who avoided seeking health services in the last 12 months	38% (2013)	15%	5%	% of MSM reached with stigma and discrimination reduction programmes	No baseline	500	1'000
				% of MSM who avoided seeking health services in the last 12 months	61.8% (2013)	30%	10%				

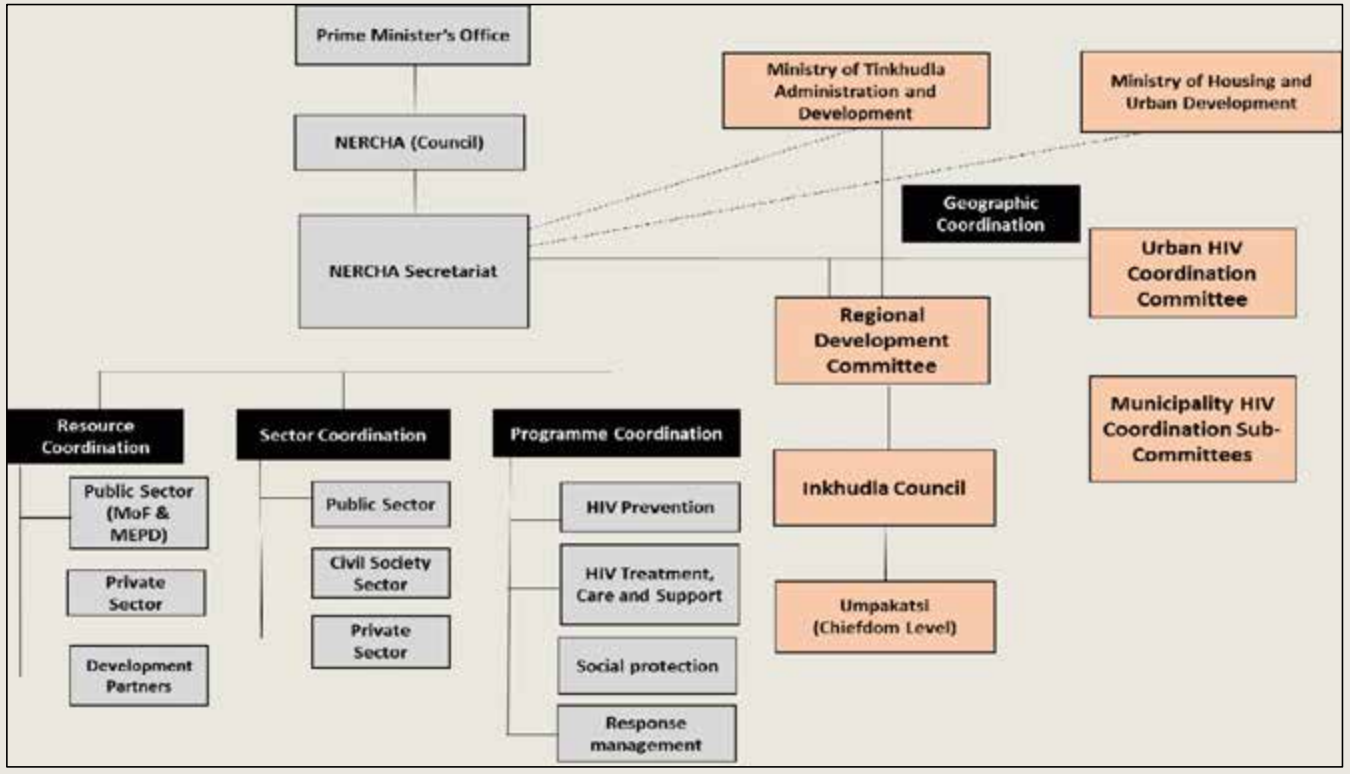
IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				MANAGEMENT OF THE HIV AND AIDS RESPONSE							
				MULTISECTORAL COORDINATION OF THE HIV RESPONSE							
				NSF targets are met % of NSF outcome level targets that have been met	35% (2016)	75%	85%	**implementing partners implement a sustainable multi-sectoral HIV response** % of NSF output level targets that have been met	61% (2016)	80%	90%
				HIV MAINSTREAMING							
				Government ministries implement sustainable multi-sectoral HIV response % of Government Ministries mainstreaming HIV in their plans and allocating funds	30% (2016)	60%	90%	**More formally employed workers receive comprehensive HIV services** % public service workers reached with a defined package of HIV services	No baseline	70%	80%
								% private sector companies providing a comprehensive wellness package	No baseline	80%	90%
				STHRENGTHENING HEALTH, COMMUNITY AND SOCIAL WELFARE SYSTEMS							
				Healthcare system offers quality HIV and AIDS services % of health facilities that offer quality, comprehensive and integrated HIV and AIDS services	65% (2014)	80%	90%	**Health facilities cater for increased demand for HIV care** % of health facilities dispensing ARV that experienced a stock-out of at least one ARV drug in the last 12 months	9% (2017)	5%	≤5%

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
				Communities coordinate their local HIV responses % of households who report that the community HIV services they received in the past 12 months were comprehensive	No baseline	50%	70%	**HIV core programmes are provided at community level** % of communities that provide the minimum package of HIV services % of Tinkhudla Councils who held quarterly meetings integrating HIV agenda	62% (2017) No baseline	80% 80%	95% 90%
				ADVOCACY AND COMMUNICATION							
				More people are aware about national HIV goal % of people aged 15-49 who are aware of country vision to End AIDS by 2022 % of young people aged 15-24 who cite social media as main source of HIV information	No baseline No baseline	80% 70%	90% 85%	**More people reached with HIV response information** % of people reached with HIV response media messages **Media personnel capacitated on HIV issues** Number of media personnel trained on HIV advocacy and communication	36% (2016) No baseline	70% 150	90% 250
				STRATEGIC INFORMATION AND research							
				Country's M&E system provides timely, quality assured data % of NSF indicators that have data collection system reported on	43% (2016)	90%	95%	**All HIV activity is reported** Number of implementing partners reporting to SHAPMoS	62% (2016)	90%	95%

IMPACT LEVEL				OUTCOME LEVEL				OUTPUT LEVEL			
								% of national M&E reports disseminated at national and subnational levels	No baseline	80%	90%
								More relevant and timely HIV evaluation and research is conducted % of planned evaluations, reviews, surveys and researches are conducted in line with the plan	No baseline	80%	90%
				SUSTAINABLE FINANCING OF THE HIV AND AIDS RESPONSE							
				HIV RESOURCES MANAGEMENT							
				NSF financial resources mobilised and efficiently used % of total expenditure on HIV and AIDS provided by domestic resources	48% (2017)	55%	70%	**Improved allocative and implementation efficiency** % of sectors with HIV expenditure tracking systems	3% (2015)	60%	85%
				% of HIV financing allocated to HIV prevention programmes	19% (2015)	25%	30%				

Annex 2: Multisectoral Response Coordination Architecture

Figure 24: HIV Coordination structure for the NSF 2018-2023, Eswatini



ENDING AIDS BY 2022

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