THE GOVERNMENT OF THE KINGDOM

OF

SWAZILAND

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

SWAZILAND COUNTRY REPORT

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Prepared by the
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Foreword

The 2007 UNGASS report as a follow-up of the 2005/6 report has provided valuable information on the status of the country programmatic achievements. The preparation of the report was guided by the M&E technical working group with representation of key partners among them civil society organisations, the public sector, the business coalition, the UN and PLHIV. This reporting round has witnessed significant improvements in the quality and quantity of data and information due to improvements in M&E systems, availability of data from the first demographic and health survey and cooperation of partners particularly in undertaking the special surveys.

The respondents included policy makers and programme managers of various national and international agencies. Following data collection, the draft findings were disseminated to stakeholders and principal secretaries for validation and adoption.

The findings of this report highlight the fact that the country has made some great progress in a number of areas, namely

educational support to OVC's and PMTCT coverage, but has a long way to reach universal access targets in many program areas including ARV's, HIV testing and counselling, life-skills education and condom use, among others.

A major lesson learnt during the UNGASS preparation is the importance of establishing strong M&E systems in order to track progress made in the implementation of HIV programmes as well as to inform the UNGASS, Universal access and the MDG reports, etc. There is therefore need for further investments to strengthen the M&E systems in the country through provision of both technical and sufficient financial assistance.

It is hoped that policy makers and program managers will focus on their respective indicators and targets to ensure improvements in implementation as well as in resolving existing bottlenecks in order to close the gaps in provision of high quality services to the Swazi population.

On behalf of the NERCHA, I would like to express my gratitude to the UNGASS TWG core team, the MOH&SW, Central Statistics Office, the Public Sector, development partners, PLHIV, civil society agencies and all stakeholders who participated in the process. Lastly, I would like to acknowledge the technical and financial support provided by UNAIDS and hope that this support is maintained in the years to come.

Derek Von Wissell

NERCHA Director

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The National Emergency Response Council on HIV and AIDS (NERCHA) extends its sincere gratitude to all partners and stakeholders who contributed to the process of developing the UNGASS 2008 Country Progress Report. Special appreciation to UNAIDS for providing both financial and technical support and to the government, particularly the Ministry of Health and Social Welfare (MOHSW) and Ministry of Economic Planning and Development (MEPD) Central Statistics Office for providing information on most of the UNGASS indicators. Most importantly, NERCHA conveys its gratitude to the Monitoring and Evaluation (M&E) Technical Working Group and the entire core team for their diligence, dedication and tireless efforts in ensuring that this work was completed in an acceptable manner. Finally, NERCHA gratefully acknowledges the Prime Minister's Office for organising the presentation to senior government officials, and extends its appreciation to the stakeholders, key informants and consultants for their individual and collective contributions to this report.

Acronyms

ABC	Abstinence, Be faithful and Condomise
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
AZT	Zidovudine
BCC	Behaviour Change Communication
BVE	Bereaved Vulnerable Elderly
CANGO	Coordinating Assembly of Non Governmental Organisations
CBO	Community Based Organizations
CCM	Country Coordinating Mechanism
CMTC	Crisis Management and Technical Committee
CSO	Central Statistical Office
CT	Counselling and Testing
DNA	Deoxyribonucleic Acid
DPM	Deputy Prime Minister
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
FAO	Food and Agricultural Organization
FLAS	Family Life Association of Swaziland
GDP	Gross Domestic Product
HAPAC	HIV and AIDS Prevention and Care Program
HBC	Home-based Care
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HSRP	Health Sector Response Plan
HTC	HIV Testing and Counselling (Practitioner initiated)
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
MC	Male Circumcision
M&E	Monitoring and Evaluation

MDG	Millennium Development Goal
MEPD	Ministry of Economic Planning and Development
MOAC	Ministry of Agriculture and Co-operatives
MOE	Ministry of Education
MOHSW	Ministry of Health and Social Welfare
MTCT	Mother-to-Child Transmission
MTPI	First Medium Term Plan
MTPII	Second Medium Term Plan
NAC	National AIDS Committee
NAP	National Action Plan
NBTS	National Blood Transfusion Service
NCP	Neighbourhood Care Points
NCPI	National Country Policy Index
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Governmental Organisations
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV and AIDS
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RHMs	Rural Health Motivators
SCCS	Schools as Centres of Care and Support
SDHS	Swaziland Demographic and Health Survey
SHAPMoS	Swaziland HIV and AIDS Programme Monitoring System
SMP	Strategic Management Plan
SNAP	Swaziland National AIDS Program
STIs	Sexually Transmitted Infections

SW	Sex Workers
SWANNEPHA	Swaziland National Network for People Living With HIV and AIDS
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children Fund
USA	United States of America
USG	United States Government
VAC	Vulnerability Assessment Committee
WFP	World Food Program
WHO	World Health Organisation
WLSA	Women and Law in Southern Africa

Chapter II: Status at a Glance

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

The process of compiling the UNGASS report in Swaziland began in September 2007, with a preliminary planning meeting held by the M&E Technical Working Group. A collective decision was made on the report compilation process. A core team (steering committee) was selected to drive the process forward and serve as focal persons to respond to the data and information required for the report. NERCHA was selected to be the secretariat and coordinator of the process.

The core team was comprised of the NERCHA M&E Coordinator, UNAIDS M&E Advisor, MOHSW M&E Focal Person, Public Service M&E Focal Person, Central Statistics Office National Surveys Advisor, CANGO M&E Coordinator, and SWANNEPHA M&E Focal Person. The core team carried out the following activities:

- ✓ Review of the previous UNGASS report and comments
- ✓ Review of the 2008 reporting guidelines
- ✓ Decision to engage consultants to compile the report
- ✓ Identification of sources of data and focal persons for the UNGASS indicators
- ✓ Drafting of terms of reference for the consultancies
- ✓ Development of the timeline for the process

This report was compiled through an extensive desk review, interviews with selected key informants, surveys (school life skills training and sex work surveys), and stakeholder meetings for validation and endorsement.

Data and information for the indicators was obtained from the Swaziland Demographic and Health Survey (SDHS) preliminary results report 2006/7, ANC (Antenatal Care) HIV sentinel report 2006, MOHSW HIV/AIDS M&E routine database, school life skills and sex workers survey and the 2007 HIV estimates and projections report and other relevant reports. It should be noted that the M&E TWG agreed on a reporting timeframe for this UNGASS report to be July1st, 2005- to 30th June, 2006, and July 1st 2006-30th June 2007. This is because the deadline set for preparation and submission of

the report makes it impossible to stick to the calendar year (January-December).

Key informant interviews for the National Composite Policy Index (NCPI) were conducted with policy makers and programme heads of various agencies. For the government policy section, the respondents were MOHSW and NERCHA. Respondents for the NGOs, bilateral and multilateral agencies PLHIV, represented by the Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA), Coordinating Assembly of Non-governmental Organisations (CANGO), Women and Law (WLSA), AMICAALL, the UN, the Italian Cooperation and United States Government (USG).

The consultative and validation forums for the stakeholder constituency and for senior government officials (Principal Secretaries), took place on the 22nd and 29th November 2006, respectively. The meeting on the 22nd involved stakeholders from civil society organisations, the private sector, development partners, government departments and community based organizations (CBOs). Draft indicator findings were presented and adopted following a discussion with the stakeholders. A meeting with principal secretaries was held on the 29th November to share the findings and create a platform for information use and adoption at senior government level.

b) The status of the epidemic

Swaziland is among the countries hardest hit by the HIV/AIDS pandemic. Since the first AIDS cases were reported in the country in 1986, the disease has spread at an alarming rate. The general mode of HIV transmission remains heterosexual, with some new infections occurring as a result of mother-to-child transmission.

The prevalence of HIV among pregnant women rose from 3.9% in 1992 to 42.9% in 2004 (Sentinel Surveillance Report 2004). However, the 10th sentinel surveillance in 2006 showed a slight drop to 39.2%. HIV prevalence in the 15-24 age group remained steady at 39.4% between 2002 and 2004 and showed a decline to 34.6% in 2006. A consistent decline in the 15-19 year age group (from 32.5% to 26%) was recorded between 2002 and 2006.

According to the 2006/7 SDHS, the overall HIV prevalence in the population aged 15-49 is 26% with women (31%) more likely to be HIV positive than men 20%).

The estimated number of people living with HIV/AIDS (PLHIV) that are in need of combined ARV treatment has increased from approximately 43,157 in 2004 to 58,250 in 2007 (HIV Estimation and Projections for Swaziland, Draft Workshop Report, November 2007).

Swaziland has made remarkable progress in prevention of the spread of HIV infection through behaviour change campaigns addressing issues of multiple sexual partners, intergenerational sex and the youth. Also, Prevention of Mother to Child Transmission (PMTCT) scale up and uptake has increased since initiation of the program. However, prevention efforts continue to be hampered by limited behaviour change in the population at large. In addition, HIV testing is not widely utilized, with only 15 percent of the general population between 15-49 years old, having tested. More women than men are tested for HIV, according to the preliminary results of the SDHS (2006).

One of the major impacts of the HIV and AIDS epidemic on Swaziland is the increase in the number of orphans and vulnerable children. It is generally presumed that orphans are marginalized in accessing social services, including education. The Government of Swaziland and development partners have made considerable efforts to mitigate the impact of the HIV/AIDS epidemic on orphans and vulnerable children (OVC) by providing education, food, health, psychosocial support and shelter. Currently, there is no major difference in the level of school enrolment between orphans and non-orphans in Swaziland. According to the 2006/7 SDHS, the ratio of school enrolment between orphans and non-orphans was 90:93.

The government is addressing the situation of orphans through policy and the development of the National Action Plan for Children. Despite these efforts, the scale of current programs addressing OVC issues remains inadequate. Only 42% of OVC reported to have received at least one type of support (2006/7 SDHS). This calls for aggressive approaches for expansion of interventions in this area.

Critical challenges remain in Swaziland's response to HIV. In general, vulnerability to HIV infection continues to be high due to the combined effects of poverty, gender inequality and some harmful cultural practices. Furthermore, the drivers of the epidemic which include multiple concurrent partnerships, intergenerational sex, low condom use, low HIV testing and disclosure levels, and high prevalence of sexually transmitted infections, are yet to be fully strategically addressed.

c) The policy and programmatic response

During the past seven years, Swaziland has developed systems to drive and manage the national response to HIV and AIDS. One major achievement has been the institutionalization of NERCHA as the organisation to lead and coordinate the response. Through this institution, Swaziland has formulated and launched an HIV and AIDS Policy, a National Strategic Plan and National Action Plan to guide the implementation of HIV and AIDS activities by various agencies. These documents were formally launched in June 2006, with the involvement of all stakeholders including PLWHIV, civil society organizations, bilateral and multilateral organisations. Strategic priorities of the response include prevention, treatment care and support, and impact mitigation. The National Monitoring and Evaluation Framework has become entrenched and decentralized to the regional level to improve documenting and reporting. With these three pillars in place, Swaziland is now fully operating under the "Three Ones" principles. Financial support from the Global Fund facility, the United Nations, the European Union, the Italian cooperation among others, has enhanced the performance of sectors on the HIV/AIDS multi-sectoral response.

The response to the AIDS epidemic in Swaziland is a collective effort of the government, multilateral and bilateral donors, national and international NGOs, CBOs, faith-based organizations (FBOs), the private sector, PLWHIV organizations and individuals.

d) UNGASS indicator data in an overview table

The progress that Swaziland has made towards responding to the HIV and AIDS epidemic is summarized in Table 1, which highlights the trends of UNGASS indicators over the past two years. Programmatically, a major achievement for Swaziland has been evident in the decreasing HIV prevalence among youth less than 25 years old. Similarly, awareness and

knowledge of HIV and AIDS continues to be reasonably high in all sections of the national population, although the challenge of genuine translation of knowledge to positive behaviour change is still deficient in many respects. With regards to blood, the country has been able to maintain 100% blood screening for HIV and other diseases, while complementary efforts are underway to strengthen adequate blood screening quality assurance mechanisms.

Table 1: UNGASS Indicators for Swaziland

Swaziland UNGASS Indicators 2007			
Core Indicator Number	Indicator	2005	2007
1.	Domestic and international AIDS spending by categories and financing sources	USD 4,000,000	NASA currently underway. Results due by March 2008

Policy development and implementation status (National Composite Indicator): 0 = poor, ..., 10 = good.

		2005	2007
2. Government Response	Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?	5	7
	Overall, how would you rate political support to AIDS programmes in 2007 and in 2005?	5	7
	Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?	5	6
	Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?	5	7
	Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?	4	7
2. Non-governmental organizations, bilateral agencies, and UN organizations' response	Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?	2	5

	Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2007 and in 2005?	2	3
	Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?	4	4
	Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?	5	6
	Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?	3	5

National Programs (blood safety, antiretroviral therapy coverage, PMTCT, co-management of TB and HIV treatment, HIV testing, prevention programs, services for OVC, and education)

Core Indicator Number	Indicator	2005	2007
Indicator 3.	Percentage of donated blood units screened for HIV in a quality assured manner.	100%	100% (All blood is screened for HIV and other transfusion transmissible diseases with a local external quality assurance)

Indicator 4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	47.7%	2006 = 26.5% 2007 =35.4% (The 2005 estimates of people in need of ART were crude estimates. These have however bees revised using spectrum to yield more reliable figures)
Indicator 5.	Percentage of HIV-positive pregnant women who received anti-retroviral drugs to reduce the risk of mother-to-child transmission	52%	2006 = 62.4% 2007 = 64.8%
Indicator 6.	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV		Incomplete data for the numerator to report fully on this indicator
Indicator 7.	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	New indicator	Overall: 16.0% Women: 22% Men: 9%
Indicator 8.	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results.		Overall = 76.40% <25 years: 77.8% 25+ years: 75%

<table>
<tr><td>Indicator 9.</td><td>Percentage of most-at-risk populations reached with HIV prevention programmes.</td><td>Not reported</td><td>Overall: 76.9%
<25 years: 75.7%
25+ years: 80%.</td></tr>
<tr><td>Indicator 10.</td><td>Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.</td><td>Incomplete</td><td>At least one type: 41.2%
Received all: 0.2%</td></tr>
<tr><td>Indicator 11.</td><td>Percentage of schools that provided life skills-based HIV education in the last academic year</td><td>Not Reported (Changed)</td><td>Total: 50.5%
Primary School: 43.5
Secondary & High Schools: 70.8%</td></tr>
<tr><td>Indicator 12.</td><td>Current school attendance among orphans and among non-orphans aged 10-14[1] (Ratio of orphans to non-orphans school attendance percentages).</td><td>Incomplete (Changed)</td><td><table><tr><th></th><th>Orphans</th><th>Non-orphans</th></tr><tr><td>Female</td><td>85.6%</td><td>73.2%</td></tr><tr><td>Male</td><td>94.7%</td><td>91.6%</td></tr><tr><td>Total</td><td>89.7%</td><td>92.6%</td></tr></table></td></tr>
<tr><td>Indicator 13.</td><td>Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</td><td>Incomplete</td><td>Women: 52.1%
Men: 52.3%</td></tr>
</table>

[1] A Millennium Development Goal indicator.

Indicator 14.	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Incomplete	Overall: 46.2% <25 years: 48.6% 25+ years: 40%.
Indicator 15.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Incomplete	Women: 6.9% Men: 4.8%
Indicator 16.	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Not Reported	Overall = 5.85% Female:2.3% Male: 22.9%
Indicator 17.	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Incomplete	Women: 56.6% Men: 56.2%
Indicator 18.	Percentage of female sex workers reporting the use of a condom with their most recent client.	Incomplete	98.0%

Indicator 19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	Not reported	Not reported on as no data is available
Indicator 20.	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	Not reported	Not reported on as no data is available
Indicator 21.	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	Not reported	Not reported on as no data is available
Indicator 22.	Percentage of young people aged 15-24 who are HIV infected	All: 39.4% 15-19: 29.3%	ANC Sentinel: 34.6 % SDHS: 14.3%
Indicator 23.	Percentage of most-at-risk populations who are HIV infected.	Not reported	Not reported on as no data are available
Indicator 24.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	Incomplete	Children: 65% Adults: 63.5% All: 64.5%
Indicator 25.	Percentage of infants born to HIV-infected mothers who are	2%	To be modelled at UNAIDS Headquarters using data in Country Progress Reports

	infected.		

Chapter III: Overview of the AIDS epidemic

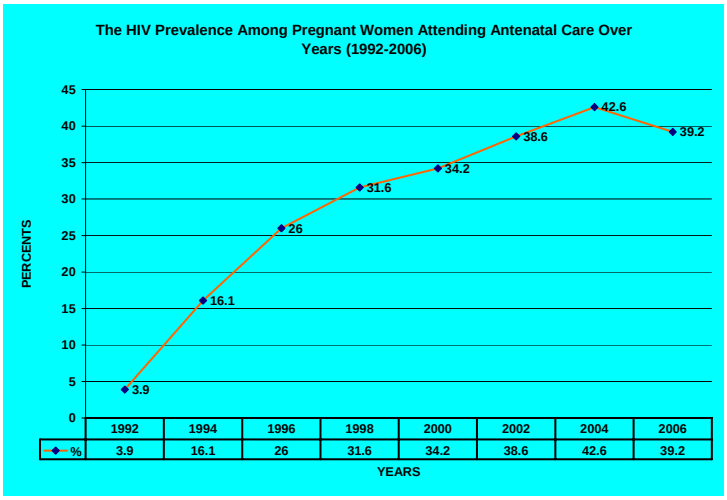
Swaziland is one of the countries worst affected by the HIV epidemic in the world. Since the first case of HIV was diagnosed in Swaziland in 1986, the prevalence has increased dramatically from 3.9 percent in 1992 to 42.9 percent in 2004. In order to respond to the crisis the government of Swaziland established the Swaziland National AIDS Programme (SNAP) 1987 and later formed the Crisis Management and Technical Committee in 1999. In 2001, the National Emergency Response Council (NERCHA) was formed with a mandate to coordinate the national response to HIV and AIDS guided by the national multisectoral HIV and AIDS strategic plan developed by the CMTC. With the expiry of the 2000-2005 National Multisectoral Strategic Plan, NERCHA commissioned a joint review whose recommendations guided the development of the 2nd National Multisectoral Strategic Plan 2006-2008.

National Prevalence of HIV

Since 1992, when the government started conducting antenatal clinic (ANC) sentinel surveillance, HIV increased dramatically from 3.9% to a high of 42.6% in 2004 (Figure 1)[2]. In 2006, ANC-based prevalence estimates showed a slight drop to 39.2% with pregnant women aged 25-29 years being the most affected with a HIV prevalence of 56.3% in 2004 and 48.9% in 2006 (see figure 2 below). In 2006-07 the country conducted its first Demographic and Health Survey (SDHS) which included HIV testing at national level.

[2] he 10th Round of the National HIV Serosurveillance in Women attending ANC, STI Clients and TB Patients at Health Facilities in Swaziland, Survey Report, 2006.

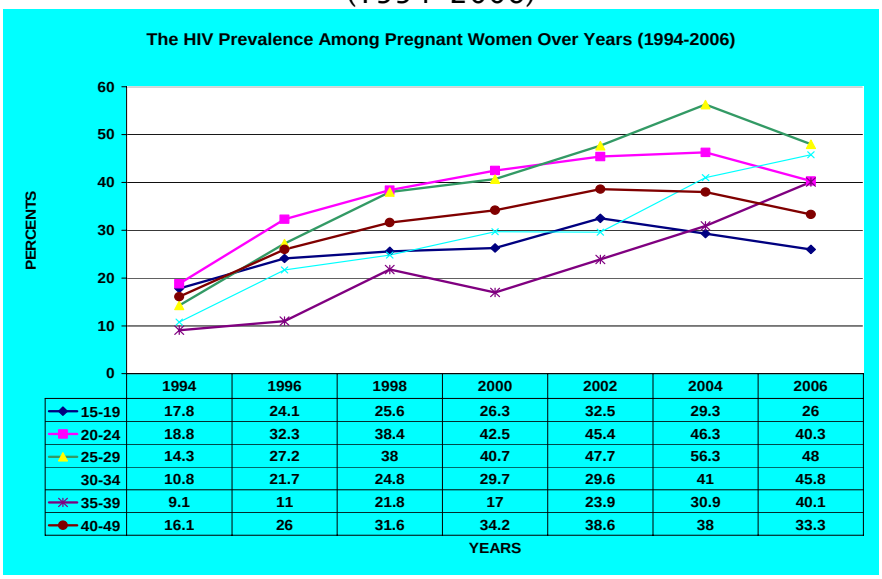
Figure 1: The prevalence of HIV among antenatal clients from 1992 to 2006



Source: 10th Sentinel Surveillance Report, 2006

HIV prevalence among the 15-24 age group stabilized at 39.4% between 2002 and 2004 and declined to 34.6% in 2006. A consistent decline among the age group 15-19 between 2002 (32.5%) and 2006 (26%) was also reported.

Figure 2: Trends in HIV prevalence among antenatal clients by age group (1994-2006)



Sentinel surveillance survey results have shown consistently increasing HIV prevalence among pregnant women in rural and urban areas. Data from

urban areas show higher HIV prevalence as compared to rural areas, although the differences are not statistically significant. A decrease in prevalence was also recorded in the urban/rural data, with prevalence rates of 44.5% (urban) and 40.3% (rural) in 2004, and 41% (urban) and 36.9% (rural) in 2006.

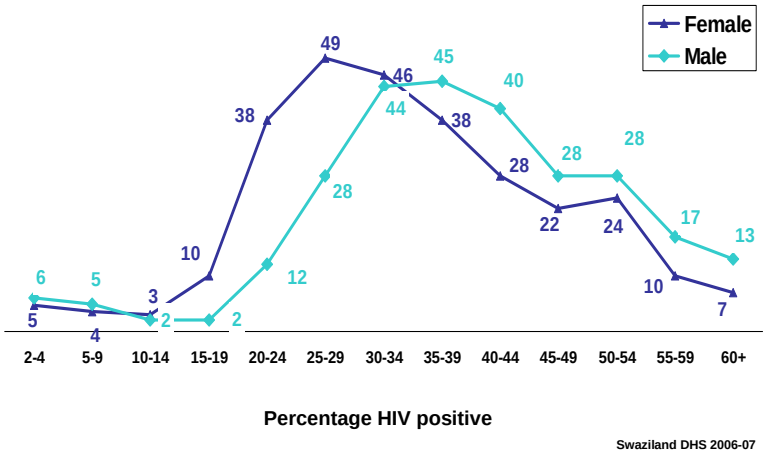
Swaziland Demographic and Health Survey[3]

The preliminary results of first Swaziland Demographic and Health Survey (SDHS) confirmed that Swaziland was in a crisis as the HIV prevalence in the population of women and men aged 15-49 was estimated at 26%. The findings further revealed that women aged 15-49 were more likely to be HIV positive than men in the same age group (31 percent and 20 percent, respectively). The findings indicate that the age patterns of HIV infection differ for women and men. HIV prevalence is higher among women than men in age categories younger than 35, while it is higher among men in the age categories 35 years and older (Figure 3). In 2006, HIV prevalence peaked at 49 percent among women in the age group 25-29, while among men, the infection rate was at its highest level among those in the 35-39 year age category (45 percent). Interestingly, HIV prevalence continues to be moderately high among both women and men in the age category 50 and older; for example, around one-quarter of women and men age 50-54 were infected while 7 percent of women and 13 percent of men age 60 and older were infected with HIV in 2006-07.

Figure 3: HIV Prevalence among Population Aged 2 and Older by age and Sex

[3] Preliminary findings of the Swaziland Demographic and Health Survey, Ministry of Economic Planning (SDHS 2007).

HIV Prevalence among Population Age 2 and Older by Age and Sex



Swaziland DHS 2006-07

Impact of the Epidemic

As the epidemic has progressed towards maturity, its impact is becoming visible through an increasing number of patients suffering from AIDS opportunistic infections, an increase in mortality rates and a rapidly growing population of orphans and vulnerable children. It has been previously estimated that the number of orphans, which was about 32,000 in 2001, will increase to more than 120,000 (approximately 15% of the population), by 2010 (Stanecki 2001, Swaziland HIV/AIDS Modelling Mission Report). More recent modelling using both ANC and DHS data however puts the number of OVC's in the country at approximately 110,000 by 2007/8. The increasing numbers of orphans are already overwhelming the capacity of the extended family to cope, given that majority of families are already poor. This situation has further resulted in increased numbers of child headed households; school drop outs and hunger.

Furthermore, it has also been reported that the quality of education is declining due to increased HIV and AIDS-related deaths among teachers, and an increase in destitution and poverty among families, which prevents children from attending school. It was also projected that primary school

enrolment of eligible children will decrease from 96.5% in 1999 to 70% by 2015 due to HIV and AIDS[4] .

The country has made considerable efforts to mitigate the impact of HIV on OVC. The government has made significant efforts to ensure that OVC are attending school. This was confirmed by the SDHS which reported that OVC are not significantly disadvantaged with respect to school enrolment compared to other children, with 92% of both OVC and non OVC reported to be attending school.

In 2003, Swaziland embarked on the provision of antiretroviral therapy at selected sites. It was estimated that approximately 26,000 PLHIV needed antiretroviral treatment (ART) in 2003 and was projected to increase to 42,000 in 2006. At the end of 2005, 13,400 PLHIV had access to treatment in Swaziland[5]. Recent spectrum estimates revealed that about 58,000 adults and children will be in need of ART treatment in 2007[6].

A 2004 study of the links between HIV and AIDS, demographic status and livelihood in Swaziland, gave a succinct picture of the epidemic in the country[7]. The study showed that HIV was already having a great impact on the country's economy, productivity, food security, and aspects of service delivery. According to the study, the disease was also negatively affecting the social fabric of the country, as well as leading to a collapse of traditional practices and support mechanisms.

National reports also indicate that there have been decreases in both land cultivated and crop production, directly related to AIDS. The 2007 FAO/WFP Crop and Food Supply Assessment Mission report to Swaziland stated that prolonged dry spells and high temperature levels decimated Swaziland's maize crop, making 2007 the lowest annual harvest on record. The high prevalence of HIV only exacerbates the already severe impact of adverse livelihoods through ill health, food insecurity, income inequality and poverty.

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[4] Ministry of Education, Impact Assessment of HIV and AIDS on the Education Sector, 1999

[5] Annual Report on ART Programme in Swaziland for 2005

[6] HIV Estimation and Projections for Swaziland, Workshop Report. October 2007.

[7] Assessment of the Impact of HIV and AIDS On The Central Ministries of The Government Of Swaziland, Final Report, June 2002, Impact Assessments of HIV/AIDS on Education 1999, Agriculture 2002 and Health 2006

Chapter IV: National Response to the AIDS Epidemic

The National Policy Environment and Strategic Framework

During the past seven years, Swaziland has developed systems to drive and manage the national response to HIV and AIDS. One major achievement has been the institutionalization of the National Emergency Response Council on HIV and AIDS (NERCHA) as the body to lead and coordinate the response. Through this institution, Swaziland has formulated and launched an HIV and AIDS Policy (2006), a National Strategic Plan(2006-2008) and a National Action Plan to guide the implementation of HIV and AIDS activities by various agencies. These documents were formally launched in June 2007 with the involvement of all stakeholders, including PLWHIV, civil society organizations, bilaterals and multilaterals. The overall objective of the Policy and Strategic Plan is to guide the implementation of the national response to prevent the spread of HIV, decrease vulnerability of individuals and communities to HIV/AIDS, to care for those living with HIV/AIDS and to reduce the adverse socio-economic consequences of the epidemic. A Monitoring and Evaluation Framework of the NSP (2006-2008) was also developed by the M&E Technical Working Group and launched jointly with stakeholders. The National Monitoring and Evaluation Framework has become entrenched and decentralized to regional level to improve reporting on the response. With these three pillars in place, Swaziland is now implementing under the "Three Ones" principles.

These national HIV response planning documents, particularly the NSP, have outlined expanded responsibilities and roles for all partners who are contributing to the fight against HIV and AIDS in the country. In addition, NERCHA has introduced the National Minimum Package (NMP) as the basic service delivery package for implementation at community level throughout the country. The NMP is a planning tool for service delivery, resource mobilization and M&E at the community level in the areas of: prevention, care, support and mitigation for the infected and affected. All partners contributing to the national response are encouraged to implement the NMP as the basic package in all communities.

INDICATOR 1: NASA Domestic and international AIDS spending by categories and financing sources

The country is currently conducting the first NASA which was to inform this indicator. However, due to challenges with data collection the process has taken longer that anticipated and it is now expected that the report will be finalised by March 2008.

INDICATOR 2: National Composite Policy Index (NCPI). Areas covered: gender, and support, human rights, civil society involvement, and workplace programs, stigma and discrimination, prevention, care monitoring and evaluation

The national composite index measures the extent to which countries have developed policies and strategies on HIV/AIDS in the broad areas of: strategic planning; political support; HIV prevention, treatment, care and support; human rights; and civil society involvement. A number of specific policy indicators were identified for each of these policy areas. The composite index is an average of rankings (on a scale 0 – 10) of the components.

Part A of the NCPI questionnaire was administered to policy makers and focal persons at NERCHA and the Ministry of Health and Social Welfare and other

government ministries. Part B of the instrument was administered to civil society PLHIV, human rights organization the UN and other development partners. The results of the assessment are shown in Table 2.1. As the table shows, the NCPI for 2007 was 8.3 points higher, up from 6.15 in 2003.

There is strong political support in the response to HIV/AIDS in the country. This is evident in the Government making effective HIV/AIDS response a priority and pre-requisite for national development, recognition and appreciation of NERCHA as the coordinating body, and the continuing and increasing Government budget allocation for HIV/AIDS.

A joint national response review was done in 2004. The process involved all stakeholders and informed the 2006-2008 national strategic plan, which was costed and policy launched in 2006. An improvement has been recorded in involving and ensuring participation of all stakeholders including civil society organizations and people living with HIV/AIDS in the planning and implementation of the national response.

M&E efforts have improved since 2005 whereby strengthening of the national M&E unit at NERCHA with support from government and partners has been done and coordinated systems for the collection, analysis and reporting on HIV/AIDS health and non health data developed. Also, the first Swaziland DHS with an HIV biological component was conducted in 2006/7

While the 2006-2008 NSP and policy promotes recognition and respect of human rights, there are no explicit structures yet for supporting the implementation of indicated intentions, and some of the enabling policies are not finalized, hence impeding implementation. However, strides have been made in discouraging discrimination on the basis of being HIV positive and ensuring equal access to HIV/AIDS prevention, care and support and impact alleviation services.

The Civil Society Perspective

The Civil Society in Swaziland believes that its involvement in the response to the HIV/AIDS epidemic has improved over the years, but scored its involvement as 40% in 2007, the same score as in 2005. Civil society organizations are involved in Global Fund activities, as they are members of the Country Coordinating Mechanism, but have very limited involvement in

non-Global Fund funded activities. To establish more meaningful and effective involvement on an ongoing basis in the national response, civil society recommends that:

a) It should be included in the overall policy and planning processes at all times, since it is responsible for a reasonable bulk of the response in home based care (HBC), care and support, clinical care, information, education and communication (IEC), and BCC programmes.
b) It should have more targeted representation in decision-making forums, whether at the local, regional or national level.
c) It should be more involved in technical forums or working groups, such as research committees, planning and budgeting committees and guidelines developing committees.

Table 2: National Composite Policy Index in 2007

1. Policy development and implementation status (National Composite Indicator): 0 = poor, 10 = good					
Indicator	Year and Score				Comments
1.1. Part A – Government point of view	2003	2005 Reported	2005	2007	
1.1.1. Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?	6	8	(4.5)	7	The new strategic plan has targets and is costed
1.1.2. Overall, how would you rate political support to AIDS programmes in 2007 and in 2005?	5	5	(4.5)	6.5	No comments
1.1.3. Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?	5	6	(4.5)	6	• The prevention strategy has been developed but not fully or systematically implemented • Efforts are being made to revive the technical committees for implementation and review for the 2005 HIV/AIDS communication strategy, since it has been overtaken by events, such as male circumcision

1.1.4. Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?	7	2	(5)	7	• Some achievements have been made in education/school fees, health care, psychosocial support, feeding, etc of OVC
1.1.5. Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?	1	6	(4)	7	• In October 2005, the M&E system was launched together with the programme monitoring system for non health. The 1st DHS was conducted in 2006/7 and the challenge with baseline population information has been reduced
Average score: Government only			4.5	6.7	
1.2. Part B: NGOs, bilateral agencies, and UN organizations' view					
1.2.1. Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?			(2)	5	• Issues of informed consent and confidentiality have always been promoted, even by 1998 policy. The labour sector has even taken it up since 2005 adopting and following the ILO code of practice

1.2.2. Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2007 and in 2005?			(2)	3	• Formulation of policies needed to guide stakeholders is a very slow process in Swaziland. Some policies have remained in a draft form
1.2.3. Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?			(4)	4	• Civil society is involved in implementing of the GF through participation in the CCM. However, participation in non GF driven activities is limited
1.2.4. Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?			(5)	6	• Since 2005, there has been the addition of PMTCT, which has been scaled up
1.2.5. Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?			(3)	5	• National policies and guidelines have been developed to create a enabling environment to improve access to ART
1.2.6. Average score Civil Society, Bilateral and Multilaterals			3.4	4.6	

Prevention

Swaziland has embarked on a number of HIV prevention efforts to reduce the spread of HIV. The prevention interventions include voluntary counselling and testing (VCT), condom promotion, information, education and communication, prevention of mother to child transmission and blood safety amongst others.

Numerous preventive activities are taking place in the country, including behaviour change communication approaches, specifically targeting adults and youth. Community response includes targeted strategies for peer education, involvement of traditional leaders and community health workers.

INDICATOR 3: Percentage of donated blood units screened for HIV with an external quality assured scheme [100%]

A policy on Blood Safety was developed in 2000, and national guidelines for blood screening, storage, distribution and transfusions were adopted in 2001. The country requires about 18,000 to 20,000 units of blood annually (based on a standard of 2% requirement of the total population). All blood collected for transfusion is centrally screened at the blood transfusion centre in Manzini. All blood is screened for HIV as well as other transfusion-transmissible infections such as HBsAg, HCV and syphilis. Donated blood units from malaria infested areas are also tested for the malaria parasite using a rapid test kit.

All donated blood units are tested for transfusion transmissible infections in a quality-assured manner, which is currently heavily reliant on internal quality control, close supervision and adherence to procedures by all staff. In 2006, the Swaziland National Blood Transfusion Services (SNBTS) collected 6,162 units of blood, of which 5,705 were usable and distributed as safe blood to hospitals. Out of the 6,162 units, 135 units (2.2%) were HIV positive, none tested positive for syphilis, 318 units (5.2%) tested positive for Hepatitis B and 4 (0.06%) were positive for Hepatitis C.

The Blood Transfusion Services however, uses the National Reference Laboratory for external quality assurance since the National Reference Laboratory is independent of the Blood Transfusion Services; hence the

indicator is 100%. Participation in an External Quality Assessment Scheme out of the country, for all the infectious markers was suspended for lack of funding. The country is currently mobilizing resources for external quality assurance at an accredited laboratory outside the country.

INDICATOR 5: Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission [62.4%]

According to sero surveillance data from the ANC, about 40% of pregnant women in Swaziland are HIV-infected. Given this scenario, and without any intervention to prevent mother-to-child transmsion of HIV, it is estimated that 6,000 babies will be infected with the virus each year and half will die by their second birthday. HIV/AIDS is responsible for 47% of under-5 mortality in Swaziland reversing hard-won child survival gains and threatening the achievement of MDG 4 in reducing infant and under 5 mortality rates.

Prevention of Mother to Child Transmission (PMTCT) interventions include primary prevention of HIV infection among child-bearing women; prevention of unintended pregnancies among HIV positive women; reduction of MTCT among HIV positive pregnant women, and care and support among infected mothers and children. As stated in the national strategic plan the objective of the PMTCT programme in Swaziland is to reduce the proportion of children (0-4 years) who are HIV positive by 30% by 2008. The Universal Access PMTCT target is to ensure that 80% of pregnant HIV positive mothers access PMTCT by 2010[8]

The government of Swaziland, with the support of partners, has made considerable effort in PMTCT having developed its first PMTCT guidelines in 2002 and begun service implementation in 2003. The number of PMTCT sites increased from 44 sites in 2004 to 110 (71% of health facilities) in 2006[9]; HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. Swaziland uses single dose-NVP as the primary method of ARV

[8] The Road towards Universal Access to Prevention, Treatment and Care and Support in Swaziland, November 2007.

[9] Service Availability Mapping Draft Report, Ministry of Health and Social Welfare, 2006

prophylaxis, with a few sites in 2007 beginning to use combination therapy following updated guidelines on more efficacious regimens[10].

The PMTCT coverge presented in the table below show that in 2006 and 2007, the number of women receiving ARVs to prevent MTCT were 8221 to 8542 respectively. Women needing PMTCT in Swaziland as projected in spectrum in 2006 and 2007 were 13208 and 13278 respectively. There has been a slight increase in the proprtion of women receiving PMTCT in the 2 years of reporting.

Table 3: Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission, 2006 and 2007

	2006	2007
Number of mothers given ARVs	8221	8542
Number of women needing PMTCT	13208	13278
Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	62%	64.8%

(Source: MOHSW M&E Second Quarter report, 2007 and HIV Estimates and Projection for Swaziland

INDICATOR 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results [Overall: 16%; Women: 21.9%, Men: 8.9%]

[10] Prevention of Mother to Child Transmission of HIV (PMTCT) and Paediatric HIV/AIDS Care, Treatment and Support, Joint IATT Technical Support Visit to Swaziland, May 2007

Swaziland started HIV testing and counselling in 2002 and as at June 2007, Swaziland had 118 facilities offering HTC services out of the 162 health facilities. Nine (9) of these were free standing facilities offering client initiated HTC/VCT and 109 were health care facilities offering provider initiated HTC (this includes HTC services offered in PMTCT).

By 2007, the country was offering HTC using three different models which are free standing centres offering client initiated or VCT services, integrated HTC services and outreach HTC services. Integrated HTC services are provided within health facilities in the context of clinical care and disease prevention where the provider initiated approach to HTC is utilized. The provider initiated approach is expected to facilitate early diagnosis, treatment of opportunistic infections, enrolment into the pre ART programme and to ensure the long term sustainability of the programme. HTC services have been integrated into outreach health care services to increase access to HIV testing.

The SDHS 2006-7 findings revealed that about 16 percent of the population between 15-49 years had been tested for HIV and know their results, with more women (22%) knowing their results than men (9%) as shown in table below. The national target is to increase the proportion of adults who have ever tested for HIV to 40% by 2008. The ambitious universal access target for this indicator is to have 50% of the population 15-49 tested for HIV by 2010. Of the estimated 16% who have accessed HIV testing services in Swaziland, it is estimated that 3% accessed the services with the initiation of health care providers. Given the current level of this indicator (16%), there is a need to scale up the provider initiated approach and expand mobile outreach services to reach workplaces and rural communities. Scaling up HIV testing and counselling - provider initiated (HTC) will minimize missed opportunities and institutionalize HIV testing.

Table 4: HIV testing among women and men aged 15-49 and who received results.

Age	Female			Male			Total		
	%	Number*	Total	%	Number*	Total	%	Number*	Total
15-19	10.0	127	1274	1.8	24	1323	5.81	151	2597
20-24	27.9	292	1046	6.9	61	886	18.27	353	1932
25-49	25.3	675	2667	14.7	286	1947	20.83	961	4614
Total	21.9	1094	4987	8.9	371	4156	16.02	1465	9143

*Number of people who received an HIV test in the 12 months prior to the survey and know their results.

Source: SDHS 2007 Preliminary results report.

INDICATOR 8: Percentage of most-at-risk populations∞ that have received an HIV test in the last 12 months and who know their results [94%]

The Ministry of Health and Social Welfare (MOHSW), the National Emergency Response Council on HIV/AIDS (NERCHA), UNAIDS and UNFPA in Swaziland commissioned a study to carry out a rapid assessment of commercial sex work and the needs of sex workers in the country[11]. This was in recognition of the plight of the disadvantaged groups in the prevention of HIV transmission. This research which was carried out in November and December 2007 as part of a SADC regional program, seeks to provide a framework for HIV programming for sex workers.

∞ For the purposes of reporting on most at risk population indicators, it was agreed that focus would be on the sex workers.

[11] Situational analysis on Sex Work in Swaziland, UNFPA, UNAIDS, MOHSW, NERCHA, 2007

Data was collected from sex workers who were identified from all the four regions (Manzini, Shiselweni, Lubombo and Hhohho) of the country and assembled at one site in Shiselweni. Lack of knowledge of population size, posed a significant threat to the representativeness of the sample. A nomination method was used to identify the respondents*.

Bringing the sex workers to one site enabled collection of comprehensive data with the full attention and participation of the respondents. Of the 61 commercial sex workers, 53 were female while 8 were male. Due to the limited sample size of male sex workers, their data is not included in the UNGASS report.

The rapid assessment had some limitations. Firstly, it was conducted within a very short period of time making it difficult to obtain a highly representative sample of this fluid and nebulous population. Secondly, sex work is not legal in Swaziland making this a highly sensitive and private process. In addition, there is limited literature on the size of the population of sex workers in the country.

Table 5 gives the results from the rapid assessment on females that tested and received their result. The number of respondents is too small to make definitive conclusions, but there is an indication that sex workers who test for HIV know their results in both age groups.

* Nomination methods start with the small but visible fraction (popular influencers) of a larger hidden population. Popular Influencers were contacted and asked to provide contacts for other individuals who share their risk behaviour, even if they did not operate from the same venue. These individuals then contacted others and in a snowball effect, recruitment of the sex workers was successful from some common hot spots[12] in the country.

Table 5: Percentage of Female SW reporting to have an HIV test and received results

Age	Total number	Testing and receiving results	
		Yes	%
15-24	24	22	91.7
25+	9	9	100.0
Total	33	31	93.9

(Source: Situational Analysis on Commercial Sex Work in Swaziland. 2007)

INDICATOR 9: Percentage of most-at-risk populations* reached with HIV prevention programs [Total = 76.9%; <25 years= 75.7%; 25+ years =80%]

In Swaziland, vulnerable populations have been identified as young people (in and out of school); people living with HIV (PLHIV), of whom the majority are young women; OVC; and the bereaved and vulnerable elderly (BVE), because they are disproportionately infected and affected.

Since sex work is illegal in Swaziland, this group is usually not easy to identify as they fear being arrested or stigmatized Attempts are however being made by various organisations including Population Services International (PSI) to reach sex workers with HIV prevention programmes. Establishing a framework for provision of targeted and user friendly HIV prevention services to this group is therefore key in curbing the spread of HIV infections.

Table 6 gives the results from the rapid assessment on the female sex workers who knew where to go for an HIV test and had received condoms in the last 12 months. About 77% of the sex workers (76% were less than 25 years old and 80% were 25 years and above) knew where to go for HIV

* For the purposes of reporting on most at risk population indicators, it was agreed that focus would be on the sex workers.

prevention services. This is an indication that there is a gap in knowledge of accessing HIV/AIDS/STI services by sex workers.

Table 6: Percentage of Female SW reached with HIV prevention services

Age	Total number	Reached with HIV Prevention	
		Yes	% yes
<25	37	28	75.7
25+	15	12	80
Total	52	40	76.9

(Source: Situational Analysis on Commercial Sex Work in Swaziland. 2007)

INDICATOR 13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [Overall: 52.2%; Women: 52.1%, Men: 52.3%]

Behaviour change communication (BCC) is one of the main strategies under prevention. BCC approaches targeting adults and youth have been adopted to prevent the spread of HIV in the country. The risk of acquiring HIV infection among young people has been known to be high driven by amongst other trans-generational sexual relationships, multiple concurrent partnerships. Swaziland has embarked on a number of mass media campaigns targeted at youth sexual behavior and encouraging youth to "preserve themselves" for the future, e.g. the *Likusasa ngelami* ("The Future is Mine" campaign). Another major campaign targeting both adults and youth, which aimed at reducing the number of partners (Makhwapheni Campaign) was also implemented. While attempts are being made to educate young people on risky sexual behaviour, lack of knowledge and misconceptions still prevail.

Preliminary results of the SDHS survey showed that of the overall percentage of respondents aged 15-24 who both correctly identified ways of preventing

HIV and who rejected major conceptions (with comprehensive knowledge[13] about AIDS), 52.1% were female and 52.3% male as shown in Table 7, The SDHS showed that men and women are equally knowledgeable about ways of preventing the sexual transmission of HIV and rejection of misconceptions about HIV transmission.

Table 7: Comprehensive Knowledge of HIV transmission among young people aged 15-24

Age	Female			Male		
	%	Number*	Total	%	Number*	Total
15-19	52.0	662	1274	50.4	667	1323
20-24	52.2	546	1046	55.2	489	886
Total	52.1	1208	2320	52.3	1156	2209

* Number of respondents who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

INDICATOR 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [Total = 46.2%; <25 years= 48.6%; 25+ years = 40%]

Several factors are believed to heighten sex workers' vulnerability to HIV. In Swaziland, sex work is highly stigmatized and sex workers are often subjected to blame, labelling, disapproval and discriminatory treatment. This is further worsened by the fact that sex work is illegal and considered a criminal act in the country. In such a situation, it is likely that sex workers may not have easy access to condoms, HIV prevention information and sexual health services.

[13] *Comprehensive knowledge* is defined as: knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus; knowing that a healthy looking person can have the AIDS virus; and knowing the two most common local misconceptions about HIV transmission or prevention.

The rapid assessment conducted on sex work in the country was used to inform this indicator[14]. Out of 52 female respondents, only 24 (46.2%) correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. This lack of correct knowledge on the prevention and transmission of HIV is worrying considering the current high levels of HIV infection in the country and the potential of increased spread of HIV through the practice of multiple sexual partners.

Table 8: Comprehensive Knowledge of HIV transmission among female sex workers

Age	Comprehensive Knowledge		Total
	% yes	Yes	
<25	48.6	18	37
25+	40	6	15
Total	46.2	24	52

(Source: Situational Analysis on Commercial Sex Work in Swaziland, 2007)

INDICATOR 15: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 [Overall = 5.9%, Women: 6.9%, Men: 4.8%]

The country has embarked on a number of mass media campaigns targeted at youth sexual behaviour and encouraging youth to "preserve themselves" for the future, e.g. the *Likusasa ngelami* ("The Future is Mine" campaign). Efforts aimed at keeping youth in school and providing life skills education, as well as innovative programs targeting out of school youth, have also been implemented. Delay of sexual debut is an important impact indicator as it provides a measure of the various interventions aimed at promoting abstinence among youth. The goal of this indicator, reported on for the first time, is to monitor over time the trend of the proportion of youth having sex before the age of 15 years. Results from the 2006/7 SDHS reveal that 7% and 5% of female and males respectively, aged 15-24 had sexual intercourse

[14] Situational analysis on Sex Work in Swaziland, UNFPA, UNAIDS, MOHSW, NERCHA, 2007

before the age of 15 years (Table 9). The national universal access targets are 5% and 3% for females and males respectively by 2008. A scaling up of strategies targeting the youth is therefore planned through schools, youth centres and community level activities.

Table 9: Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

Age	Female			Male		
	%	Number*	Total	%	Number*	Total
15–19	7.4	94	1274	4.9	65	1323
20–24	6.4	67	1046	4.7	42	886
Total	6.9	161	2320	4.8	107	2209

* Number of respondents who had had sexual intercourse before the age of 15.

(Source: Swaziland Demographic and Health Survey 2006–07. Preliminary Report, CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

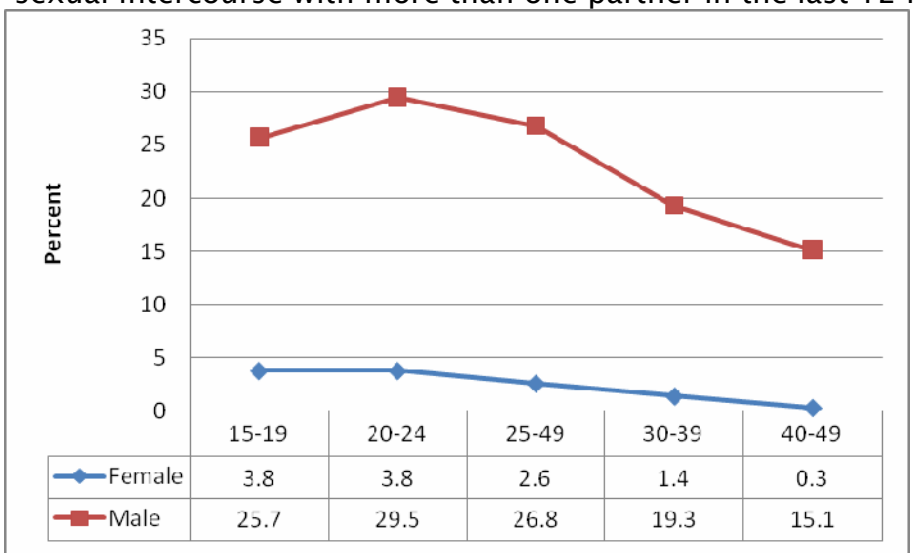
INDICATOR 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months [Overall: 12.6%; Women: 2.3%; Men: 22.9%]

A report on the epidemic in Swaziland points the drivers of HIV spread to include multiple concurrent sexual partnerships, low male circumcision, low status of women, low condom use, cultural beliefs and practices and intergenerational sex among others. To address these drivers, prevention programs such as Makhwapheni, Likusasa, condom promotion, promotion of HIV testing as well as school based programmes have been promoted.

Preliminary results of the SDHS show that among the population aged 15–49 years, the percentage of those who have had sexual intercourse with more than one partner (higher risk sex) in the last 12 months is 2.3% for women and 23% for men. These results, shown in Figure 4, show that regardless of their age, women were far less likely than men to report having multiple

sexual partners during the 12-month period prior to the survey. Women were also less likely to report having engaged in high risk sex than men. Women aged 15-49 years reported having on average 2.4 sex partners during their lifetime, while men reported 6.6 partners. Older men reported having had an average of nearly 10 partners while women age 50 and older have had an average of about 2 partners.

Figure 4: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months



(Source: Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

The SDHS shows that a higher percentage of women who reported having two or more sexual partners or engaged in higher risk sex were located in urban (4.0%) than rural areas (1.7%). Among men, those residing in rural areas were marginally more likely (23.7%) to report such practices compared to their urban counterparts (21.4%).

INDICATOR 17: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse [Overall: 51.2%; Women: 56.6%, Men: 56.2%]

The country has been promoting use of male condoms as part of the prevention of HIV since the beginning of the national HIV response in the country. The promotion of condoms has become more widespread in the general population with the advent of AIDS, as they are one of the most effective methods of protection from HIV infection. Maintaining an adequate supply of condoms was prioritized in 2005, and a National Condom Strategy was drafted in response to condom purchasing, stock-outs and the need for improved supply chain management. Condom distribution has increased over the years from about 1.3million condoms distributed in 2000 to about 6 million in 2004.

The 2006/7 SDHS shows that 56% of males and 57% females aged 15-49 years who reported to have had more than one sexual partner in the last 12 months used a condom in their last sexual encounter. Despite the high awareness about HIV prevention this knowledge is not translated into safer sex practice as about half of sexually active respondents aged 15-49 years report engaging in non-regular sexual contacts and not using condoms.

Table 10: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Age	Female			Male		
	%	Number*	Total	%	Number*	Total
15-24	50.7	25	49	66.7	143	215
15-19	54.2	(9.21)	17	74.8	37	50
20-24	48.9	16	32	64.3	106	165
25-49	64.5	20	31	49.9	286	351
Total	56.6	45	80	56.2	286	566

* Number of respondents who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

‡ There were too few women in the age group 15-19 for meaningful indices for this age group.

(Source: Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

There were too few women in the age group 15-19 hence the two youngest age groups were combined. There are no significant differences in the reported use of condoms between women and men in the two age groups: 15-24 and 25-49. Generally, without factoring in issues of under reporting, women in Swaziland are less likely than men to report having multiple partners and are less likely to be engaged in higher risk sex than men.

INDICATOR 18: Percentage of sex workers reporting the use of a condom with their most recent client [All: 98%; Aged 15-24years: 100%; 25+ year old: 92.9%]

Data for this indicator was generated from the rapid assessment on sex work in Swaziland discussed under Indicator 8. Table 11 gives the results from the assessment on the female SW's use of condoms. The number of respondents is too few to make definitive conclusions, but it does provide a tentative indication that female SWs in Swaziland are using protective measures against HIV infection.

Table 11: Percentage of sex workers reporting the use of a condom with their most recent client

Age	Used a condom		Total
	% yes	Yes	
15-24	100.0	36	36
25 and over	92.9	13	14
Total	98.0	49	50

(Source: Situational Analysis on Commercial Sex Work in Swaziland, 2007)

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

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

INDICATOR 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

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

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

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

INDICATOR 22: Percentage of young people aged 15-24 who are HIV infected [ANC Results: 34.6%, SDHS Results: 14.3%]

HIV prevalence has been monitored since the country initiated its massive response against the epidemic. The main source of information on HIV prevalence has been from sentinel surveillance surveys of women attending antenatal clinics. The most recent biannual HIV sentinel surveillance survey in 2006 reports a prevalence of 39.2% among pregnant women aged 15-49. In the age group 15-24, HIV prevalence was reported to be 34.6%. Young women, 15-19 years, had a prevalence of 26%, while 20-24 years, had a prevalence of 40.4%. These figures are shown in Table 12. Although HIV prevalence among young women aged 15-24 is showing some decline, HIV infection in this group is still unacceptably high.

Table 12: Percentage of young people aged 15-24 who are HIV infected [ANC Results)

Age group	Number tested	Number positive	% positive	95% CI
15-19	576	150	26.0	22.5 - 29.9
20-24	857	346	40.4	37.1 - 43.8
Total	1433	496	34.6	32.2 - 37.1

Source: 10th HIV sentinel surveillance report

HIV prevalence results from the SDHS showed that HIV prevalence among young people aged 15-24 in the general population was 14.3% (table 13).

Females recorded a higher HIV prevalence (22.6%) compared to the males (5.9%) in the same age group.

Table 13: Percentage of young people aged 15-24 who are HIV infected (SDHS Results)

Age	Female			Male			Total		
	% HIV+	Positive	Total	% HIV+	Positive	Total	% HIV+	Positive	Total
15-19	10.2	118	1161	1.9	24	1277	5.8	142	2438
20-24	38.2	354	926	12.3	97	787	26.3	451	1713
Total	22.6	472	2087	5.9	121	2064	14.3	593	4151

(Source: Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

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

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

Care and Support

The National Multi-sectoral HIV and AIDS Strategic Plan (2006-2008) and Policy as well as the Health Sector Response Plan (2006-2008) address the areas of treatment, care and support by highlighting the need for increased access and proper utilization of ART; clinical management of opportunistic infections; diagnostic testing and counselling; institutional and home based care; and palliative care. The importance of nutrition and mental health services are also included in the policy.

The advent of affordable ARVs has added a new dimension to the care and support of PLWHA. There are 21 health facilities in the country offering free ART services (initiation and refill) and 24 clinics offering the minimum package of ART services, which includes treatment with ARV drugs (refill basis), counselling and support services, and treatment of opportunistic infections. The provision of ART services was also rolled out to private hospitals and clinics, which are included in the figures above. The human resource and infrastructure capacity of hospitals and health centres have been strengthened with support from the Global Fund and other partners, to provide these services. All efforts are channelled towards achieving the universal access targets.

INDICATOR 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy [Overall: 35%; Children: 31%; Adults: 35.1%]

The roll-out of the ART began in 2003, and underwent a massive scale up to 21 ART sites by the middle of 2007. The WHO 3 by 5 Initiative was instrumental in the scale up of treatment, and resulted in the country achieving the 3 by 5 target of 13,000 patients initiated on ART by 25. The ART roll out programme was supported with funding from the Global Fund, WHO, U.S. Government and other development partners; this included support for the development of the patient tracking and drug management system. In 2006, a new protocol for the initiation of clients on ART was put into use. With a newly designated pool of doctors that will focus on ART, medical staff are now in a better position to initiate clients on treatment following the standard protocol.

A cumulative number of 14,009 people with advanced HIV infection, out of 52,909 needing ART (26.5%), were enrolled in the ART programme by the end of June 2006. By the end of June 2007, 20,610 people with advanced HIV infection, out of 58,249 (35.4 %) were reported to be on ARVs, as shown in Table 15 (Table 14 and 15 give age and sex breakdown of people on ART at the end of 2006 and 2007 respectively). The national target is to have 50% of the people in need of treatment on ART by 2008 whilst the ambitious universal access target for 2010 is 60%.

Table 14: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (June 2005–July 2006)

	Under 15			15& over			Total		
	On ARV		Total in need	On ARV		Total in need	On ARV		Total in need
Women	541	27.2%	1989	8241	29.1%	28353	8782	28.9%	30342
Men	549	27.0%	2032	4678	22.8%	20535	5227	23.2%	22567
Total	1090	27.1%	4021	12919	26.4%	48888	14009	26.5%	52909

Source: MoHSW M&E Unit for adult numerators. Denominators are modelled through SPECTRUM. People on ARVs taken as reported up to end of June 2006

Table 15: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (June 2006–July 2007)

	Under 15			15& over			Total		
	On ARV		Total in need	On ARV		Total in need	On ARV		Total in need
Women	881	39.3%	2241	12027	38.4%	31296	12908	38.5%	33537
Men	895	39.1%	2288	6807	30.4%	22422	7702	31.2%	24712
Total	1776	39.2%	4529	18834	35.1%	53720	20610	35.4%	58249

Source: MoHSW M&E Unit for adult numerators. Denominators are modelled using SPECTRUM.

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

Generally, TB is the single most common cause of death in HIV infected individuals. Thus, effective management of TB has a significant impact in reducing mortality. According to the 10th sentinel surveillance report in 2006, nearly 80% of TB patients were found to be infected with HIV. There are 15 health facilities providing TB services in the country (6 public hospitals, 5 health centres, 3 industrial health centres and 1 major TB clinic).

By the end of June 2007, 43.2% (4,166) of the total 9,644 TB patients were referred for HIV testing and counselling services. Of those referred for HTC, 42.9% (1,786) accepted testing and 89% (1,590) of those who tested were HIV positive. The corresponding figure for the first quarter of 2007 is 86%.

Although data from WHO on the estimated number of incident TB cases in people living with HIV (the indicator denominator) is available and is given as 6.9 thousands, this indicator cannot be reported on due to inability of the system to capture the numerator values (number of people on ART started on TB.

INDICATOR 24: Percentage of adults and children with HIV known to be

on treatment 12 months after initiation of antiretroviral therapy [Overall: 64.5% Children: 65.4%; Adults: 63.5%]

The ARV programme started in the country in 2003 and the Patient and Drug Management System was initiated with support from Global Fund, WHO and later by USG. The Ministry of Health and Social Welfare routine ART data from July 2006 to June 2007 show that 73.3% and 64.5%, of adults and children with HIV/AIDS were on treatment 12 months after initiation of treatment respectively. This is shown in Tables 16 and 17. There are no differences in year-specific survival levels between female and male recipients of ART. However survival rates are slightly lower for July 2006/June 2007, compared to the period July 2005/June 2006.

Table 16: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy, 2006

	Female			Male			Total		
		Survivors	Enrolled		Survivors	Enrolled		Survivors	En
Children	79.3%	262	330	69.8%	226	324	74.6%	488	(
Adults	70.8%	3672	5181	73.2%	2305	3149	72.0%	5977	8
All	71.4%	3934	5511	72.9%	2531	3473	73.3%	6465	8

Source: MoHSW M&E Unit)

Table 17: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy, 2007

	Female			Male			Total		
		Survivors	Enrolled		Survivors	Enrolled		Survivors	En
Children	63.9%	416	651	66.9%	457	683	65.4%	873	1
Adults	64.7%	6580	10177	62.4%	3856	6176	63.5%	10436	1
All	64.3%	6996	10828	64.7%	4313	6859	64.5%	11309	1

Source: MoHSW M&E Unit.

INDICATOR 25: Percentage of infants born to HIV-infected mothers who are infected

This indicator is to be modelled at UNAIDS Headquarters using data in Country Progress Reports for the coverage of services to prevent mother-to-child transmission indicator (UNGASS indicator 5).

Impact Mitigation

One of the goals of the national strategic plan is to mitigate the social and economic impact of the epidemic. The strategies in pursuit of this goal include livelihood support, social rights provision and protection, food and nutrition security and educational support among others. The strategy further outlines the vulnerable to include orphaned and vulnerable children (OVC), people living with HIV, bereaved and elderly, and widows and persons living with disabilities.

Despite the lack of standard guidelines for OVC identification, service delivery and monitoring, innovative activities have been implemented in the country to mitigate the impact of the epidemic on OVC. Traditional structures have been revived, and new ones have been established through Global Fund support, to provide OVC with education, psychosocial support, food, shelter and protection from abuse.

The government, through the Ministry of Agriculture and Co-operatives, development partners and other NGO's are supporting selected vulnerable communities with food security through capacity building, agricultural inputs, food rations, *Indlunkhulu* communal fields, school farms and backyard gardens. These are particularly for child headed households, bereaved, vulnerable and elderly (BVE), and PLHIV. There is concern however, that food grown from the *Indlunkhulu* communal fields is not sufficient for the neediest PLHIV or elderly guardians of OVC. Micro credit schemes have also been implemented by government and civil society agencies to improve the livelihoods of vulnerable populations, particularly youth and women. Support groups for PLHIV, OVC and widows have emerged in communities to provide home care for the terminally ill and to mentor OVC.

INDICATOR 10: Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child [Received At least One Type: 41%; Received All Types: 0.2%]

HIV/AIDS has orphaned a large number of children in Swaziland. In 2007, it was estimated that approximately 108,000 children were orphaned and/or

vulnerable[15]. A National OVC plan of Action was developed with a focus on children's rights; right to protection, to participation in issues that affect them, to freedom of expression, food, health, and education. Targeted programs based on the national plan for OVC have been initiated. These programs include; establishment of Neighbourhood Care Points (NCPs) and *KaGogo* centres, both of which provide basic services to orphans, such as food, support, general care, and some basic health care services, education bursaries, psychosocial support and shelter.

It is projected that the number of orphans and vulnerable children will increase from 108, 000 in 2007 to 113,000 in 2010the present estimate of 130,000 to more than 198,000, by 2010 (The Kingdom of Swaziland's National Plan of Action for Orphans and Vulnerable Children, 2006-2010). The preliminary findings from the SDHS reveal that 31% of children below 18 years old are OVC. The impact of HIV and AIDS on the physical and emotional wellbeing of children in Swaziland is extreme. The majority of these children are subjected to social and economic circumstances that heighten their vulnerability, increasing their risk to exploitation and of adopting risky and dangerous behaviour. This in turn increases their susceptibility to contracting HIV as well as threatens their optimal social, physical and psychological development.

The SDHS found that 23.3% of all children are orphans (defined as a child with one or both parents deceased) and 11.7% of children are classified as vulnerable, which is defined as a child whose parent(s) are chronically ill or who live in a household where an adult has been very sick or died in the last 12 months[16]. This means that 31.3% of all children in Swaziland are now classified as OVC.

Increasing levels of illness and death has disrupted the traditional network of support that existed in communities. The traditional family support system is strained by the high disease burden, persistent drought and high levels of poverty, among rural communities in particular. This weakening of

[15] HIV estimates and projections for Swaziland, workshop report,, NERCHA, UNAIDS, USG and MOHSW, 2007

[16] Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA

the traditional social network calls for external additional support to communities to provide for the needs of OVC and other vulnerable groups. Currently, the SDHS shows that 41% of OVC received basic external support, mainly in the form of educational support, in the 12 months prior to the survey, and 0.2% reported receiving all types of support. These figures are shown in Table 10.1. The universal access interim target for 2008 is 51% of OVC receiving free external support and the ambitious 2010 target is 61%.

Table 18: Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child

External support for OVC	%	No.	Total
None of the types of support	58.8	2104	3576
At least one of the types of support	41.2	1472	
All types of support	0.2	7	

(Source: Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

INDICATOR 11: Percentage of schools that provided life skills-based HIV education in the last academic year [Overall: 50.5%; Primary: 43.5%; Secondary: 70.8%]

Life-skills based HIV education in Swaziland has been integrated with subjects such as biology, basic science, English and other subjects. Common school-based HIV/AIDS prevention activities include: seminars and workshops for teachers and Anti-AIDS clubs; conducting dramas, debates and songs; commemoration of World AIDS Day; IEC activities; and media (electronic and paper) focusing on subjects such as HIV/AIDS and reproductive health.

1. A rapid assessment on Life skills in schools was conducted in order to collect data for this indicator. In consultation with the Ministry of Education and Central Statistics Office, a total of 93 schools out of 756 (556 primary and 200 secondary and high schools) in the country were sampled for the assessment of life-skills based HIV education in schools. These included both private and public schools. Out of 93 sampled

schools, 35 were government schools, 53 were government assisted schools and 5 were private schools.

The survey showed that out of the 93 schools, about 51% of the schools reported having provided at least 30 hours of life skills training in each grade during the last academic year. Approximately 71% of secondary and high schools and 43.5% of primary schools reported offering up to 30 hours of life skills training (Table 19). The disaggregated result by ownership also showed that 45.7%, 56.6% and 20% of government, government aided and private schools respectively reported training in their schools on life skills in the last academic year. Only 27% of the schools had life skills training included in the school curriculum, with 22% in primary and 42% in secondary and high schools.

Table 19 Percentage of schools that provided life skills-based HIV education in the last academic year:

School Level	Life skills education survey				
	% schools with at least 30 hours of life-skills training	Number of schools with at least 30 hours of life-skills training	Number of schools with life-skills training in the curriculum	% schools with life-skills training in the curriculum	Total Number of schools surveyed
Primary School	43.5	30	15	21.7	69
Secondary and High School	70.8	17	10	41.7	24
Total	50.5	47	25	26.9	93

(Source: Special Life skills based HIV education assessment, 2007)

There was no significant statistical difference between rural and urban schools: 47.6% of rural schools and 56.7% of urban schools provided life skills training. The majority of schools provided life skills education to their students on a non-regular basis by integrating it with conventional subjects.

INDICATOR 12: Current school attendance among orphans and among non-orphans aged 10-14 [Orphans: Females 85.6%, Males 97.7%; Non-orphans: Females 93.7%, Males 91.6%]

Swaziland recognises that education is a vital element in enhancing the development of the country. With the increasing number of OVC out of school, the government of Swaziland has set aside special funds to address the plight of OVC. Government support to the education of OVC has been increasing over the years from E16 million in 2003 to 47million in 2007. Complex issues contribute to withdrawing or continuing with school for most of the children in Swaziland. These issues include including poverty, HIV and AIDS and other chronic illnesses. In recent years, poverty has been associated with school drop-outs, particularly in the rural areas. The situation has been linked to HIV as well. Providing financial and other support to orphans and other vulnerable children in schools is therefore one of the priority interventions in the response to HIV and AIDS in Swaziland.

The 2006/7 SDHS collected information on school attendance among children aged 10-14 years old. Out of 1,600 children with both parents alive, 92.7% were in school. School attendance levels among orphans were reported to be 89% with 94.7% male and 85.6% female. (Table 20). The results of the SDHS indicate that, in general, orphaned and vulnerable children are not disadvantaged with respect to school attendance in comparison to other children. The ratios of orphan: non-orphan schooling are presented in the table below[17].

Table 20: Current school attendance among orphans and among non-orphans aged 10-14

Status	Female			Male			Total		
	%	At school	Total	%	At school	Total	%	At school	Total
Orphan	85.6	131	153	94.7	122	129	89.7	253	282
Non-	93.7	812	867	91.6	788	860	92.6	1600	1727

[17] Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

orphan			
Ratio	0.91	1.03	0.97

(Source: Swaziland Demographic and Health Survey 2006-07. Preliminary Report. CSO, Mbabane and MEASURE DHS, Macro International, Calverton, Maryland USA)

Chapter V: Best Practices[18]

Swaziland recently won an award on an innovation dubbed "*Helping Communities Help Themselves".* This innovation consists of three initiatives which are the *KaGogo* Social Centres, Neighbourhood Care Points and *Indlunkulu* Field Projects.

KaGogo Social Centres

The *KaGogo* (literally meaning grandmother's house) has traditionally been a part of every homestead, serving as a safe haven or place of refuge. *KaGogo* is also known as the central gathering place for family; a neutral place for discussing family matters and resolving disputes. NERCHA revived the concept to mobilize and empower communities in the response to HIV, choosing to construct *KaGogo* Social Centres in every chiefdom.

NERCHA, with help from the Deputy Prime Minister's office, began mobilizing communities on the *KaGogo* Social Centre concept in 2003. NERCHA felt that participation and ownership of *KaGogo* Centres by community members was a key element to their success. The community mobilizations brought together the key players in the community to work as a team. Communities were enthusiastic about the *KaGogo* Centres because the concept is one rooted in tradition and maintains its significance in the era of AIDS. All the *KaGogo* Centres were built by the communities themselves.

While NERCHA supplied financial and technical contributions with the help of a Global Fund grant, the communities provided labour and much of the local building materials. This ensured the community members would feel a sense of pride and ownership in the building and how it is used.

While the *KaGogo* Centres were being developed, the communities were encouraged to elect community coordination committees to oversee the

[18] Helping Communities Help Themselves: Swaziland's innovative Community –Based Response to HIV and AIDS, NERCHA, 2007

running of the Centres. The committees use the Centres to collect basic data about OVC and other vulnerable groups within the community. This data helps to shape national policies and responses to HIV and AIDS. The *KaGogo* Centres also provide a formal and physical centre for coordinating community initiatives and a forum for discussions and meetings about how to respond to the epidemic's impact in the local area. The Centres have been used to coordinate and distribute emergency food in areas affected by drought and food insecurity. NERCHA envisions that the *KaGogo* Social Centres will eventually be able to provide other essential services for OVC and other community members, such as schooling and other trainings.

More than 50% of the centres have been completed nationwide and more than 30% have been constructed up to roof level. NERCHA also recently allocated funds to hire full-time managers for each *KaGogo* Social Centre.

Neighbourhood Care Points

The community coordinating committees established for the *KaGogo* Social Centres performed the essential task of identifying orphans in the community, drawing up a list of those needing assistance and authorizing the list for the government. But something more was needed. The lists of names had faces and stories attached; they were more than mere statistics. The government needed to respond to these children in need. An idea, taken from a rural community in Swaziland, was born. Several women in a small rural community had realized the scale of the orphan problem in their area and began cooking for and looking after these children in their own homes or under a tree, with food and money from their own households. This concept sparked the Neighbourhood Care Point (NCP) initiative. NCPs were established to provide day-to-day support to orphaned and vulnerable children and enable them to be cared for in the communities in which they were raised. Coordinated by the Deputy Prime Minister's Office and NERCHA, a massive mobilization campaign began around the issue. The government also enlisted the help of UNICEF. Meetings were called with chiefs, local leaders and volunteers from each community to work together to establish NCPs. Volunteer care workers approved by each chiefdom were trained to provide psychosocial support to the children, as well as to cook and teach

OVC basic survival skills. NERCHA/UNICEF initially provided cooking pots and food, but eventually the communities supplied the food themselves or began vegetable gardens for the NCP. The Deputy Prime Minister's office and World Food Program also supply food for those NCPs that need it. Water tanks and gutters were donated and the communities constructed structures and pit latrines with technical support from the Deputy Prime Minister's office and other partners.

Many NCPs provide informal education to children, but perhaps more importantly, they highlight the numbers of children who fall outside the formal education system. NCPs have become an effective means of directing children into formal school education. In addition, NCPs provide a safe environment for older siblings to leave younger brothers and sisters so that they may attend school.

There are more than 625 NCPs in Swaziland serving more than 40,000 children, and these numbers are expanding. With food assistance and coordination from *KaGogo* Centres, NCPs provide at least one hot meal a day to children. These care points have given communities a sense of empowerment and hope by providing a cost-effective, stable and caring structure for children who would otherwise have nothing. NCPs enable children to come together daily with other children in a safe environment to eat, learn and play. Above all, NCPs have made OVC visible within the communities in which they live, and brought people together to find solutions to the challenges they face.

Indlunkhulu Fields

Indlunkhulu fields were a traditional practice that had long since lapsed in Swaziland, whereby a chief allocated land for the community to grow food for the area's vulnerable members. The reinvigoration of the *Indlunkhulu* fields programme began in 2002. NERCHA facilitated a process of consultation with traditional leaders and the Ministry of Agriculture, and helped mobilize the communities. NERCHA also provided silos for communities to store food from *Indlunkhulu* to be distributed to needy members of the community. Silos and food distribution are coordinated through *KaGogo* Centres.

All community members participate in both the growing of crops and distribution of the food/harvest, ensuring the process is transparent and trusted so the food goes to those who most need it. The main beneficiaries of the fields, orphaned and vulnerable children, also participate in the farming, gaining agricultural skills and knowledge they would no longer receive from their parents.

Other innovations recorded in the country include: creating synergies between PMTCT and other child health programs and schools serving as centres of care and support (UNICEF Annual Report 2006).

Chapter VI: Major Challenges and Remedial Actions

Progress Made on Key Challenges Reported in 2005

The 2005 UNGASS report highlighted the following challenges:

- Weak M&E system
- Lack of positive Behaviour Change
- Difficulties in quantifying and coordination of OVC
- Coordination structures to support the HIV response
- Poor patient management and follow up system for ART patients

- **Weak M&E systems**

In 2005, the country launched the Multisectoral HIV and AIDS M&E system to track the implementation of the national response. Because the system was at its infancy, challenges around data availability, quality, capacity and operationalisation of the system were observed. The major achievements made in monitoring and evaluation are capacity building of HIV implementers on M&E, HIV modelling and projections, operationalisation of the Swaziland HIV and AIDS Programme Monitoring System, establishment of Health Sector M&E Office, the 2006/7 Swaziland Demographic and Health Survey and the undertaking of 2007 Swaziland Census. This has resulted in improved M&E skills all of which has resulted in availability of quality data.

- **Lack of positive Behaviour Change**

Adopting positive behaviour change was and continues to be a major challenge in the country. Positive behaviour change is influenced by adequate information and advocacy. A variety of behaviour change approaches have been implemented amongst them community mobilisation, public education campaigns emphasising abstinence, delayed initiation of sexual debut and reduction of multiple concurrent partnerships (Likusasa and Mkhwapheni campaign). Despite the fact that communication strategy has been developed it is still a draft and yet to be operationalised.

- **Difficulties in quantifying and coordination of OVC**

Due to the magnitude of the HIV epidemic coupled with poverty and food insecurity, vulnerability and destitution has increased among children. Coordination of the OVC initiatives has been fragmented until the recent establishment of the Children's Coordination Unit within the deputy Prime Minister's office. In addition to this, coordination structures at community level have been strengthened to monitor OVC registration and service provision. Although the systems of registering OVC's are still being piloted, it is worth noting that the recently concluded SDHS provided data on the proportion of population who are OVC's as well as the proportion of OVC's who received an external support. Also, recent estimates and projections using spectrum have been generated to provide the country with fairly reliable data for programming.

- **Coordination structures to support the HIV response**:

Swaziland has made enormous efforts to establish and review structures and policy in order to respond effectively to the challenges posed by the HIV and AIDS epidemic. A major step forward was the formulation of a Multi-sectoral National HIV and AIDS Policy and the 2006-2008 National HIV and AIDS National Strategic Plan, to give strategic guidance to programme design, implementation and evaluation, as well as improved coordination.
Swaziland recently initiated a process to decentralize the HIV response to the four regions. The process aims to build robust capacity at regional level to strengthen regional coordination and monitoring of implementation.

- **Poor patient management and follow up system for ART patients**

At the time of drafting the 2005 UNGASS report, the ART programme was faced with serious challenges relating to patient monitoring, and particularly, poor record keeping and an absence of a patient follow-up mechanism. With support from Global Fund and other partners, efforts to strengthen the patient and drug management systems are underway, with some results already being noted. It is envisaged that when the new system is up and running, it will be able to generate reports on various parameters such as number of patients enrolled, survival and adherence to treatment among others.

Challenges in 2007

Human resource capacity: Although the ministry of Health plays a critical role in the response, human resource capacity issues have continued to be a major challenge. These have been documented in the Universal access report as well as the health sector response plan among others. For instance, skilled and semi skilled manpower is generally lacking, hence hindering the performance of the health sector. It is worth noting that the country has only 15 ART doctors to serve a population of one million people.

Strategic work planning: Despite success in various areas in the response to the epidemic, the country has been faced with a number of challenges. Key among these is the fact that despite having a national strategic plan for the last two years, many implementing partners do not have an action plan.

Coordination of the response: the NSP highlighted challenges relating to the coordination of the response which are unclarified roles of partners, underdeveloped coordination function and limited decentralisation to name a few. In order to address these NERCHA has been extensively engaged in a process of redefining its coordination role resulting in a change in its coordination approach from thematic to decentralised approach. Also NERCHA has engaged in strengthening partnership for harmonisation and alignment of the response. However, coordination of the response remains a daunting and complex task.

Financial resources; – Despite the scale of the HIV pandemic, the country largely depends on very few sources of funding amongst them the government, the Global Fund, the UN and other bilateral agencies thereby posing a major threat to the implementation and sustainability of the response and the country may not national and internationally agreed upon targets.

Monitoring and Evaluation and Research – although the country has made significant strides in the operationalisation of the M&E framework, M&E capacity, culture of reporting, quality of data, utilisation of data for policy and planning remain a challenge. HIV research as well as research structures

remains underdeveloped in terms of funding, prioritisation and skilled capacity.

Remedial Actions

Based on the Universal Access recommendations, the government of Swaziland has agreed to scale up the HIV response by tackling various challenges in the response as follows:

- Human resource capacity – The government should facilitate the creation of key posts relevant to the effective functioning of the major sectors in the response particularly the Ministry of Health and Social Welfare

- Funding – NERCHA to develop a resource mobilisation strategy to fill the financial gaps in the response. There is also need to develop a health sector resource mobilisation strategy to ensure activities in the health sector response plan are implemented.

- Strategic work planning – Plans are already underway to assist implementing partners to develop costed prioritised and evidence informed action plans.

- Coordination of the response – NERCHA together with partners continues to play strategic role in assisting the partners in defining their roles and responsibilities for improved coordination of the response.

- Monitoring and Evaluation –strengthening of implementing partners on M&E continues to be a priority as plans for capacity building at all levels are underway. Strengthening of HIV research is also a priority.

Chapter VII: Support from the Country's Development Partners

Over the years, financial support for HIV and AIDS activities has increased significantly, especially with the support from Global Fund. However the number of multilateral and bilateral donors present in the country is minimal.

In 2006, Swaziland was allocated approximately US $42 million funding for HIV/AIDS activities from its major contributors. Over US $40 million of this was allocated by its five major donors shown in the figure below. It is further noted that a significant amount of unaccounted funds also enters the country from other international and national donors. Swaziland's overall 'known' funding figures are low compared to other countries when considering its prevalence of nearly 40% among pregnant women attending ANC[19].

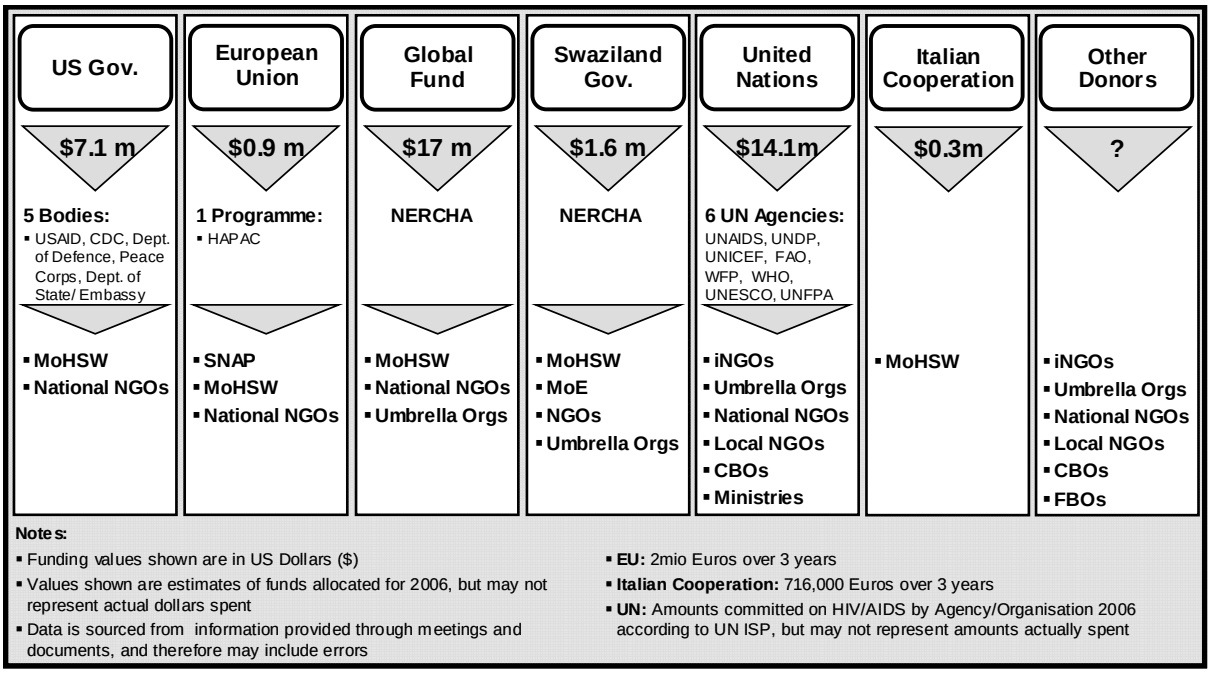


Figure 5: 2006 HIV/AIDS Allocated Funding by Major Contributors

[19] UNAIDS Annual Accenture Financial Flow Project, Swaziland, February 2007

These figures represent approximate funds allocated and may not give an accurate picture of actual funds spent. Swaziland has embarked on a National AIDS Spending Assessment which will give detailed information on HIV spending.

Chapter VIII: Monitoring and Evaluation Environment

The NERCHA Monitoring and Evaluation System, within the Three Ones Principle, is dependent on sectoral M&E subsystems. It is particularly dependant on the MOHSW's HIV and AIDS M&E System to track health-related indicators through the MOHSW Health Management Information System (HMIS). In line with the Three Ones Principle, Swaziland has formed the M&E Technical Working Group (TWG), which launched the National Monitoring and Evaluation Framework for HIV and AIDS in late 2005. The costed HIV M&E work plan for the period 2006 to 2008 was approved by the TWG. Funds are still needed, however for the implementation of the work plan.

The M&E TWG met in January 2007 to review progress of the system using the 11 components of a fully functional M&E system. It was established that Swaziland had made significant progress towards improving M&E capacity. Implementation of the M&E system is informed by the results of the assessment of the two routine programme monitoring systems: that of the Ministry of Health and the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS). The Ministry of Health Programme Monitoring System was deemed as weak and needing support in order to ensure accurate and timely data. At the time of the review, the MOHSW had a draft M&E framework. The framework is now finalized and a work plan is being drafted to feed into the National M&E work plan. Technical and financial support is needed to implement this MOHSW framework. First and foremost is the harmonization of the HMIS Unit together with the HIV M&E unit for strengthening the systems. An assessment conducted by the Health Matrix Network recommends that these systems be integrated to avoid parallel systems, to improve on the data flow challenges and also to strengthen the HMIS in the country.

The routine system for non health data (SHAPMoS) was launched in 2006 and NERCHA supported the Ministry of Regional Development and Youth Affairs with resources for engaging M&E Officers responsible for the monitoring of HIV response at the regional level. A number of implementers were trained in its operation and are reporting quarterly on the HIV related activities. More implementing partners are yet to be trained to ensure that reporting is harmonised and improved. The Ministry of Regional Development has

appointed Chiefdom clerks that will coordinate the implementation of the NMP at community level. A mapping exercise at community level response is necessary to generate information on the coverage of HIV and AIDS activities at community level.

Realising that the M&E system still faces challenges of data availability and quality, there is need for technical assistance at national and sub-national levels for both the non-health and health systems. The technical assistance required is mainly in terms of M&E training for the HIV implementers and provision of adequate expertise to advice on M&E (e.g. M&E advisors, GAMET support). Human resource capacity for M&E and Research are scanty at both national and sub-national levels. Therefore there is need for additional support for skilled manpower to address this challenge.

A recent assessment of research capacity in the country highlighted the fact that research in the country is generally weak. The assessment further revealed National Research Council is not fully functional and that HIV- and AIDS-related research is not currently coordinated, with some research taking place without ethical approval. It was also revealed that the amount and quality of HIV research that has been undertaken is not known[20]. Therefore technical assistance is required for conducting research, research capacity building and utilisation of research findings.

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16. UNICEF Annual Report 2006/7
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ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

	Yes	No
1.Which institutions/entities were responsible for filling out the indicator forms?		
a) NAC or equivalent	Yes	
b) NAP		No
c) Others (please specify)		
2) With inputs from		
Ministries of:		
Education	Yes	
Health	Yes	
Labour	Yes	
Foreign Affairs		No
Others (please specify) Economic Planning, Housing and Urban Development	Yes	
Civil society organizations	Yes	
People living with HIV	Yes	
Private sector	Yes	
United Nations organizations	Yes	
Bilaterals	Yes	
International NGOs	Yes	
Others(please specify)	?	?
3) Was the report discussed in a large forum?	Yes	
4) Are the survey results stored centrally?	Yes	
5) Are data available for public consultation?	Yes	

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Sanelisiwe Tsela (Ms)	M&E Coordinator

Signature:	Date:
Full contact information Address:	
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ANNEX 2: National Composite Policy Index questionnaire

Part A

[to be administered to government officials]

I. Strategic plan

Has the country developed a national multisectoral strategy/action framework to combat AIDS? Yes

Period covered: 2006-2008

IF YES, complete questions1.1 through 1.10

1.1 How long has the country had a multisectoral strategy/action framework with a specific HIV budget for their activities? **7 Years**

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

Sectors included	Strategy/Action framework	Earmarked budget
Health	Yes No	Yes No
Education	Yes No	Yes No
Labour	Yes No	Yes No
Transportation o	Yes No	Yes (Some) No

Military/Police	Yes	No	Yes		No
Women	Yes	No	Yes	(Some)	No
Young people	Yes	No	Yes		No
Other*: *[write in]* No Agriculture, Regional Development & youth, Justice, SWANNEPHA, Traditional sector, Public service	Yes	No	Yes		No

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, how is the money allocated? **There is no specific earmarked budget for some institutions, however support is provided depending on perceived initiatives and innovation considered to be effective in the response**

Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes No
b. Young women/young men	b. Yes No
c. Specific vulnerable sub-populations15	c. Yes No
	d. Yes No

d. Orphans and other vulnerable children	
Settings	e. Yes No f Yes No
e. Workplace	g. Yes No
f. Schools	
g. Prisons	
Cross-cutting issues	h. Yes No
h. HIV, AIDS and poverty	i. Yes No
i. Human rights protection	j. Yes No
j. PLHIV involvement	k. Yes No
k. Addressing stigma and discrimination	l. Yes No
l. Gender empowerment and/or gender equality	

1.4 Were target populations identified through a process of a needs assessment or needs analysis? Yes

IF YES, when was this needs assessment /analysis conducted? Year: 2004

1.5 What are the target populations in the country? *[write in]*

Whole population – generalized epidemic

Traditional sector

Young people

Vulnerable population groups – OVC, PLWHA, Disabled

1.6 Does the multisectoral strategy/action framework include an operational plan? Yes / No

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals? Yes / No

b. Clear targets and/or milestones? Yes / No

c. Detailed budget of costs per programmatic area? Yes / No

d. Indications of funding sources? Yes / No

e. Monitoring and Evaluation framework? Yes / No

1.8 Has the country ensured "full involvement and participation" of civil society16 in the development of the multisectoral strategy/action framework? Yes – Active Involvement

IF active involvement, briefly explain how this was done: Involved in sectoral meetings, strategic planning and policy documents development processes, as well as feedback meetings

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)? Yes / No

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework? Yes, all partners

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/

United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach? Yes

2.1 ***IF YES***, in which development plans is policy support for HIV and AIDS integrated?

a)__X__ b)__ X__ __ c)__ X__ __ d)____ e) other

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

Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	Yes	Yes		N/A	
Treatment for opportunistic infections	Yes	Yes		N/A	
Antiretroviral therapy	Yes	Yes		N/A	
Care and support (including social security or other schemes)	Yes	Yes	Yes	N/A	
AIDS impact alleviation	Yes	Yes	Yes	N/A	
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and/or		Yes	Yes	N/A	

support				
Reduction of **income** inequalities as they relate to HIV prevention/ treatment, care and /or support		Yes	Yes	N/A
Reduction of stigma and discrimination	Yes	Yes		N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	Yes	Yes	N/A

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes? Yes / No / N/A

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

Low to High - 0 1 2 3 4 5

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc? Yes / No

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

Behavioural change communication	Yes	No
Condom provision	Yes	No
HIV testing and counselling*	Yes	No
STI services Yes No	Yes	No
Treatment	Yes	No

Care and support	Yes	No
Others: *[write in]Male Circumcision,*	Yes	No

**What is the approach taken to HIV testing and counselling?* Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain: Voluntary and Provider initiated Approaches

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006? Yes / No

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly? Yes / No

5.2 Have the estimates of the size of the main target population sub-groups been updated? Yes No

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy? Estimates and projected needs / Estimates only / No

5.4 Is HIV and AIDS programme coverage being monitored? Yes / No

(a) ***IF YES***, is coverage monitored by sex (male, female)? Yes / No

(b) ***IF YES***, is coverage monitored by population sub-groups? Yes / No

IF YES, which population sub-groups?

Adults

Children

Sex (Male and Female)

OVC or Non OVC status

(c) *IF YES*, is coverage monitored by geographical area? Yes / No

IF YES, at which levels (provincial, district, other)?

Regional and Health Facility

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs? Yes / No

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005? *8 and 5 respectively.*

Comments on progress made since 2005:

The new strategic plan (2006-2008) with targets has been developed and costed.

II. Political Support

Strong political support includes government and political leaders who speak out often about

AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS

programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

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

President/Head of government Yes / No

Other high officials Yes / No

Other officials in regions and/or districts Yes /No

2. Does the country have an officially recognized national multisectoral AIDS anagement/coordination body? (National AIDS Council or equivalent)? Yes / No

2.1 *IF YES*, when was it created? Year: 2002

2.2 *IF YES*, who is the Chair?

[Write in name and title/function]: Chief Ndabankulu Simelane (Chair Person)

2.3 ***IF YES***, does it:

Have terms of reference?	Yes	No
Have active Government leadership and participation? Yes No	Yes	No
Have a defined membership?	Yes	No
Include civil society representatives?	Yes	No
IF YES, what percentage? *[write in]* 42%		
Include people living with HIV?	Yes	No
Include the private sector?	Yes	No
Have an action plan?	Yes	No
Have a functional Secretariat?	Yes	No
Meet at least quarterly?	Yes	No
Review actions on policy decisions regularly?	Yes	No
Actively promote policy decisions?	Yes	No
Provide opportunity for civil society to influence decision-making?	Yes	No
strengthen donor coordination to avoid parallel funding and Duplication of effort in programming and reporting?	Yes	No

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes? Yes / No

3.1 ***IF YES***, does it include?

Terms of reference Yes / No

Defined membership Yes / No

Action plan Yes / No

Functional Secretariat Yes / No

Regular meetings Yes / No

Frequency of meetings: Quarterly

IF YES, What are the main achievements?
✓ Sharing of information ✓ Feedback forums ✓ Governing of the Global Fund ✓ Resource utilization – Country Coordinating Mechanism

IF YES, What are the main challenges for the work of this body?
✓ Keeping the mandate clear and separate for both bodies ✓ Maintaining interest to highest level (too much delegation for meetings) ✓ Streamlining the role of CCM versus Council

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

Percentage:

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes	No
Technical guidance/materials	Yes	No

Drugs/supplies procurement and distribution	Yes	No
Coordination with other implementing partners	Yes	No
Capacity-building	Yes	No
Other: *[write in]In some cases* ✓ General program support ✓ Administration support	Yes	No

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies? Yes / No

6.1 ***IF YES***, were policies and legislation amended to be consistent with the National AIDS Control policies? Yes / No

6.2 ***IF YES***, which policies and legislation were amended and when?

Policy/Law: Employment Act Year: 2006, Awaiting parliament approval

Policy/Law: Sexual Offences Act Year: 2007

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005? 7 and 5 respectively.

Comments on progress made since 2005:

Efforts have been made to involve all stakeholders in the planning of HIV/AIDS programs. In addition, to the national plan, some sectors, such as health have developed, drawing from the national plan, their sector specific plan and response framework

III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*? Yes/ No/ N/A

1.1 ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	✓
Delay sexual debut	✓
Be faithful	✓
Reduce the number of sexual partners	✓
Use condoms consistently	✓
Engage in safe(r) sex	✓
Avoid commercial sex	✓
Abstain from injecting drugs	✓
Use clean needles and syringes	✓
Fight against violence against women	✓
Greater acceptance and involvement of people living with HIV	✓
Greater involvement of men in reproductive health programmes	✓

Other: *[write in]* ✓ **Male circumcision** ✓ **Discouraging cross generational sex** ✓ **STIs management**	✓

1.2 In the last year, did the country implement an activity or programme to promote accurate

reporting on HIV by the media? Yes / No

1. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people? Yes / No

2.1 Is HIV education part of the curriculum in?

Primary schools? **Yes** / No

Secondary schools? **Yes** / No

Teacher training? Yes / **No (Ad hoc)**

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women? **Yes** / No

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

Yes / **No**

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations? **Yes** / No

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

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other subpopulations* *[write in]*
Targeted information on risk reduction and HIV education	**No**	**No**	**Yes**	**Yes**	**No**	
Stigma & discrimination reduction	**No**	**No**	**Yes**	**Yes**	**Assumed**	
Condom promotion	**No**	**No**	**Yes**	**Yes**	**No (not official)**	
HIV testing & counselling	**No**	**No**	**No**	**No**	**No**	
Reproductive health, including STI prevention & treatment	**No**	**No**	**Yes**	**Yes**	**Yes**	
Vulnerability reduction (e.g. income generation)	N/A	N/A	**No**	**Yes**	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringe exchange		N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005? 6 and 3 respectively.

Comments on progress made since 2005:
Since 2005, behavior change campaigns have been done. The messages focused on abstinence , having one sexual partner and promotion of faithfulness

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes? Yes / No

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

(A Generalized epidemic in Swaziland)

HIV prevention programmes	The activity is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Blood safety	Yes		
Universal precautions in health care	Yes		

settings	
Prevention of mother-to-child transmission of HIV	Yes
IEC on risk reduction	Yes
IEC on stigma and discrimination reduction	Not quite
Condom promotion	Yes
HIV testing & counselling	Yes
Harm reduction for injecting drug users	
Risk reduction for men who have sex with men	Not yet
Risk reduction for sex workers	Yes
Programmes for other vulnerable subpopulations	Yes
Reproductive health services including STI prevention & treatment	Yes
School-based AIDS education for young people	Yes
Programmes for out-of-school young people	Yes
HIV prevention in the workplace	Yes
Other *[write in]*	

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005? 6 and 4 respectively.

Comments on progress made since 2005:

- ✓ A behavior change strategy has been developed, but not fully implemented.
- ✓ Also, there are efforts to revive the technical committee, and
- ✓ There is a plan to review the 2005 strategy

IV. Treatment, care and support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care). Yes / No

1.1 ***IF YES***, does it give sufficient attention to barriers for women, children and most-at-risk populations? Yes / No

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services? Yes / No / N/A

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

- ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Antiretroviral therapy	Yes		

Nutritional care	Yes – but weak		
Paediatric AIDS treatment	Yes		
Sexually transmitted infection management	Yes		
Psychosocial support for people living with HIV and their families	Yes		
Home-based care	Yes		
Palliative care and treatment of common HIV-related infections	Yes		
HIV testing and counselling for TB patients	Yes		
TB screening for HIV-infected people	Yes		
TB preventive therapy for HIV-infected people	Yes		
TB infection control in HIV treatment and care facilities	Yes		
Cotrimoxazole prophylaxis in HIV infected people	Yes		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Yes		
HIV treatment services in the workplace or treatment referral systems through the workplace	Yes		
HIV care and support in the workplace (including alternative working arrangements)	Not yet		Yes (Private sector)
Other programmes: *[write in]* ✓ VCT ✓ PMTCT	Yes		

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV? Yes / No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs? Yes / No

4.1 ***IF YES***, for which commodities?: *[write in]* Global Fund Price Reporting Mechanism

5. Does the country have a policy or strategy to address the additional HIV- or AIDS-related needs of orphans and other vulnerable children (OVC)? Yes / No / N/A

5.1 ***IF YES***, is there an operational definition for OVC in the country? Yes / No

5.2 ***IF YES***, does the country have a national action plan specifically for OVC? Yes / No

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions? Yes / No

IF YES, what percentage of OVC is being reached? 41.2% *[write in]*

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children? 7 and 5 respectively.

Comments on progress made since 2005:

Progress was made in ensuring OVC education and access to health care (such as immunization, HIV/AIDS care and support, some nutrition supplementation)

V. Monitoring and evaluation

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

Yes Years covered: *[write in]* *2006-2008* / *In* progress / No

1.1. ***IF YES***, was the M&E plan endorsed by key partners in M&E? Yes / No

1.2. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV? Yes No

1.3. ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan? Yes, all partners / Yes, most partners / Yes, but only some partners / No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes	No
behavioural surveillance	Yes	No
HIV surveillance	Yes	No
a well-defined standardized set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing quality and accuracy of data	Yes	No
a data dissemination and use strategy	Yes	No

3. Is there a budget for the M&E plan? Yes / Years covered: *[write in]* *2006-2009* / In progress / No

3.1 ***IF YES***, has funding been secured? Yes / No

4. Is there a functional M&E Unit or Department? Yes / In progress / No

4.1 ***IF YES***, is the M&E Unit/Department based

In the NAC (or equivalent)? Yes / No

In the Ministry of Health? Yes / No

Elsewhere? *[write in]*

4.2 ***IF YES***, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:	4	
Position: *[write in]* M&E Coordinator	Full time / Part time?	Since when?: 2006
Position: *[write in]* M&E Officer	Full time / Part time?	Since when?: 2004
Position: *[write in]* M&E Officer	Full time / Part time?	Since when?: 2006
Position: *[write in]* *SHAPMos Officer*	Full time / Part time?	Since when?: 2006
Number of temporary staff:	None	N/A

4.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports? Yes / No

IF YES, does this mechanism work? What are the major challenges?

The system is at its infancy stage only operationalised in 2006 March. Challenges include completeness of data, quality of data and timely reporting and dissemination of reports for use in planning.

4.4 *IF YES*, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low High Scale: 0 1 2 3 4 5

5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities? No / Yes, but meets irregularly / Yes, meets regularly

IF YES, Date last meeting: *[write in]* *September 2007*

5.1 Does it include representation from civil society, including people living with HIV? Yes / No

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

The civil society and PLHIV representatives are instrumental in ensuring that the interests of Civil Society and PLHIV are addressed in the monitoring of the response and that they report on what Civil Society and PLHIV are doing.

6. Does the M&E Unit/Department manage a central national database? Yes / No / N/A

6.1 *IF YES*, what type is it? *[write in]*

6.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations? Yes / No / N/A

6.3 Is there a functional* Health Information System?

National level Yes / No

Sub-national level Yes / No

IF YES, at what level(s)? *[write in]* ***Regional***

6.4 Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data? Yes / No

7. To what extent is M&E data used in planning and implementation?

Low to High: 0 1 2 3 4 5

What are examples of data use?
The quarterly Service Coverage report disseminated to stakeholders and findings are used to inform planning for service delivery

What are the main challenges to data use?
✓ Capacities to use the data to inform programs is minimal Delays in dissemination of information emanating from delayed reporting

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

At national level?	Yes	No
IF YES, Number of individuals trained: *[write in] 79*		
At sub-national level?	Yes	No

IF YES, Number of individuals trained: *[write in] 79*		
Including civil society?	Yes	No
IF YES, Number of individuals trained: *[write in] 36*		

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005? 7 and 4 respectively.

PART B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. Human Rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions)or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.). Yes / No

1.1 IF YES, specify: [write in]

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations? Yes / No

2.1 IF YES, for which sub-populations?

Women Yes No	Yes	No
Young people	Yes	No
IDU Yes No	Yes	No
MSM Yes No	Yes	No
Sex Workers Yes No	Yes	No
Prison inmates Yes No	Yes	No
Migrants/mobile populations Yes No	Yes	No
Other: [write in] ✓ Orphans	Yes	No

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:

The poverty reduction strategy and plan, as well as the constitution and OVC plan of action (2006-2010) addresses non-discrimination issues for women and children in particular. Key challenges are in the implementation of these legal instruments

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

some of these instruments are not yet fully implemented or still exist in draft form

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations? Yes No

3.1 IF YES, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: [write in]	Yes	No

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

- ✓ Sex work, IDU and MSM are illegal in Swaziland, hence making it difficult to reach the population groups
- ✓ Provision of condoms to young people , especially in school, and prison inmates is still prohibited

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy? Yes / No

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at- risk populations? Yes / No

IF YES, briefly describe this mechanism

While the NSP 2006-2008 promotes recognition and respect of human rights, there are structures at the moment supporting the implementation of the intentions

6. Has the Government, through political and financial support, involved most- at-risk populations in governmental HIV-policy design and programme implementation? Yes / No

IF YES, describe some examples

Yes to a limited degree in the case of women and young people and not all , in the case of sex workers, MSM, IDUs and prison inmates

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

HIV prevention services Yes / No

Anti-retroviral treatment Yes / No

HIV-related care and support interventions Yes / No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

- ✓ In the case of ART, only ARVs and related diagnostic and monitoring tests are free. Medicines for OIs have to be paid for. Government is providing ARVs, school fees for OVC and food for targeted populations
- ✓ Plans of action, strategies, policy and guidelines are used to implement

policies and interventions

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and child birth? Yes / **No**

There are no explicit policies, but programmatic approaches that promote universal access

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support? Yes / **No**

9.1 Are there differences in approaches for different most-at-risk populations? Yes / **No**

IF YES, briefly explain the differences: **N/A**

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)? **Yes** / No

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee? **Yes** / No

11.1 IF YES, does the ethical review committee include representatives of civil society and people living with HIV? **Yes** No

IF YES, describe the effectiveness of this review committee

The committee is fairly new and still faces challenges, and is in the process of developing terms of reference and guidelines

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

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform

commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work? Yes / **No**

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment Yes **No**

- Performance indicators or benchmarks for

  a) Compliance with human rights standards in the context of HIV efforts Yes / **No**

  b) Reduction of HIV-related stigma and discrimination Yes / **No**

IF YES, on any of the above questions, describe some examples: **N/A**

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work? Yes / **No**

14. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS casework Yes /**No**

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV Yes / **No**

- Programmes to educate, raise awareness among people living with HIV concerning their rights **Yes** / No

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance? **Yes** / No

IF YES, what types of programmes?

Media	**Yes**	No
School education	**Yes**	No
Personalities regularly speaking out	**Yes**	No
Other: [write in ✓ **The Prime Minister with regular business meetings where HIV/AIDS is an agenda**	**Yes**	No

✓ In some for a, PLWHIV do speak		

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005? 5 and 2 respectively.

Comments on progress made since 2005:

Issues of informed consent and confidentiality have always been promoted even by the 1998 AIDS policy. The labour sector has taken it up even more since 2005

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005? 3 and 2 respectively.

Comments on progress made since 2005:

Some policies still in draft, not finalized and therefore partially implemented

II. Civil society participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation? Low to High 0 1 2 3 4 5
   No organized approach
2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts) Low to High 0 1 2 3 4 5

Involvement in the formulation of the strategic plan was high, plus joint planning and budgeting is not functional

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

   a. In both the National Strategic plans and national reports? Low to High 0 1 2 **3** 4 5

   b. In the national budget? Low to High 0 1 **2** 3 4 5

4. Has the country included civil society in a National Review of the National Strategic Plan? **Yes** / No

   IF YES, when was the Review conducted? Year: [write in] **2004**

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity? Low to High 0 1 2 3 **4** 5

List the types of organizations representing civil society in HIV and AIDS efforts:

- ✓ PLWHIV
- ✓ NGOs
- ✓ Human Rights
- ✓ Coordination
- ✓ Youth
- ✓ Faith Based Organization
- ✓ Community Based Organization
- ✓ Private Sector

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

   a. Adequate financial support to implement its HIV activities? Low to High 0 1 2 **3** 4 5

   b. Adequate technical support to implement its HIV activities? Low High 0 1 **2** 3 4 5

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005? 4 and 4 respectively

Comments on progress made since 2005:
Civil Society is involved in implementing of the Global Fund through participation in the CCM. However, participation in non Global Fund driven activities is limited

III. Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes? **Yes** / No

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

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety	✓		
Universal precautions in health care settings	✓		
Prevention of mother-to-child transmission of HIV	✓		
IEC on risk reduction	✓		
IEC on stigma and discrimination reduction	✓		
Condom promotion	✓		
HIV testing & counselling	✓		
Harm reduction for injecting drug users	**N/A**		
Risk reduction for men who have sex with men	**N/A**		
Risk reduction for sex workers	**N/A**		
Programmes for other most-at-risk populations	✓		

Reproductive health services including STI prevention & treatment	✓		
School-based AIDS education for young people	✓		
Programmes for out-of-school young people	✓		
HIV prevention in the workplace	✓		
Other programmes: [write in]			

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005? **6 and 5 respectively**

Comments on progress made since 2005: **Since 2005, there was the addition of PMTCT which has been scaled up**

IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services? **Yes** / No

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

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

- ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
Antiretroviral therapy	✓		
Nutritional care	✓ – **to a limited extent**		
Paediatric AIDS treatment	✓		
Sexually transmitted infection management	✓		
Psychosocial support for people living with HIV and their families	✓		
Home-based care	✓		
Palliative care and treatment of common HIV-related infections	✓		
HIV testing and counselling for TB patients	✓		
TB screening for HIV-infected people	✓		
TB preventive therapy for HIV-infected people	✓		

TB infection control in HIV treatment and care facilities	✓		
Cotrimoxazole prophylaxis in HIV-infected people	✓		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	✓		
HIV treatment services in the workplace or treatment referral systems through the workplace			✓ Some
HIV care and support in the workplace (including alternative working arrangements)			✓ Some
Other programmes: [write in]			

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005? 5 and 3 respectively

Comments on progress made since 2005:

Since 2005 the ART program has been scaled to all hospitals and health centers in the country including some private sector clinics. Also, outreach services for ART has been established in 2004

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society? Data not available

3. Does the country have a policy or strategy to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children (OVC)? Yes / No / N/A

5.1 IF YES, is there an operational definition for OVC in the country? Yes / No

5.2 IF YES, does the country have a national action plan specifically for OVC? **Yes** / No

5.3 IF YES, does the country have an estimate of OVC being reached by existing interventions? **Yes** / No

IF YES, what percentage of OVC is being reached? **41.2%** [write in]


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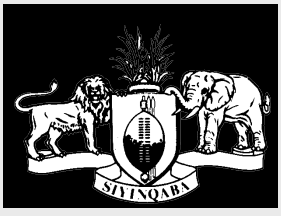
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