

**The Government of the Kingdom of  
Swaziland**

**THE SECOND NATIONAL  
MULTISECTORAL HIV AND AIDS  
STRATEGIC PLAN 2006 – 2008**

**An Executive Summary**

**‘A Nation At War’**

**June 2006**

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## OVERVIEW

There is no doubt that the country is under siege from an epidemic that has been spreading silently over the years. So far national efforts to address this challenge have only yielded heightened awareness of the problem but have failed to stimulate levels of sexual behavior change that are necessary for turning the epidemic around. As a result, the epidemic has continued to grow to a point that it has become generalized, mature and very deeply entrenched.

Because of the extensive nature of the epidemic, this plan seeks to contribute towards achievement of the vision to halt and reverse the HIV and AIDS epidemic in the country by 2015. It aims to:

- reduce new HIV infections, morbidity and mortality
- mitigate the socio-economic impact of the epidemic,
- create an enabling environment for the national response and,
- track implementation of the response.

While this plan builds on the achievements of the past it also calls for up-scaling an intensification of the response as well as implementation of a comprehensive and truly multisectoral response.

The plan addresses strategies under four thematic areas namely; Prevention, Care, Support and Treatment, Impact Mitigation and Management of the national response. Under each thematic area, the plan presents the strategic issues, objectives, strategies and core indicators. The plan designates an urgent priority response agenda and a comprehensive response agenda.

It has now become urgent for the response to be intensified. Given that factors that drive risk and vulnerability to HIV infection as well as susceptibility to the effects of the epidemic have multisectoral origins, remedial measures similarly require inputs from all sectors based on their mandates and comparative advantages. “*Lena yindzaba yetfu sonkhe*” - this is everybody’s business. All must support implementation of this strategic plan inline with the principles of the three ones (one national plan, one national coordinating entity and one monitoring and evaluation framework).

### **The face and reality of families affected by HIV and AIDS**

*In one of the homes of a person living with HIV/AIDS in Maphungwane, AIDS had claimed the lives of three out of a family of five. The only two still alive were a 3 year old girl and her mother who was intermittently ill and physically unable to find food, cook or bath herself. The 3-year old girl practically assumed all household chores: the ill bed-ridden mother would tell the child to light the fireplace and move the cooking pot back and forth for her to stir as the child looked on. She would then tell the child to wake her up once the food was cooked and bring the food by the bedside. The child would dish for herself and the mother and eat together. To the mother the child was the only care giver and to the child the sick mother was the only care giver. To the community worker taking the child away meant removing the only care giver for the mother and separating the child from her remaining family member.*

## VISION

By 2015, the people of the Kingdom of Swaziland shall have halted and reversed the AIDS epidemic resulting in improved quality of life which will be characterized by reduced HIV and AIDS related morbidity, mortality and socio-economic impact.

## MISSION

Through this strategic plan, the country seeks to scale-up the multi-sectoral national response to HIV and AIDS and create an effective, comprehensive, decentralized, expanded, well coordinated and sustainable enabling environment at all levels.

## NATIONAL RESPONSE AGENDA

### 1. PREVENTION

In order to reduce the risk and vulnerability to HIV and to deal with the stigma, fear and discrimination, communities must understand the urgency of the epidemic. **The goal is to** reduce the number of new HIV infections.

**Included in the prevention strategy are interventions such as:**

- **Discouraging multiple concurrent sexual partners**—Multiple sexual partnerships are quite common in Swaziland. Many of these partners are concurrent multiple partnerships, which results in a wide sexual network that fuels the virus. Furthermore, a high proportion (70%) of the out-of-school youth reported in 2003 to have experienced sexual intercourse.
- **Delay sexual debut**— The average age at first sexual experience is estimated to be 15 – 16years, which is low compared to that in other countries (BSS 2002). While the 2004 sentinel survey report indicates a slight decline in the prevalence of HIV among young people from 32.5% in 2002 to 29.3% in 2004, it is still substantially high. According to the report, 30% of in-school youth and (70%) of out-of-school youth are sexually active.
- **Prevention of mother to child transmission by** reducing the proportion of children (0-4 years) who are HIV positive by 30% by 2008. This will be done through the expansion and intensification of primary HIV prevention among men and child-bearing women; and creating an enabling environment for the up-scaling, provision and support of PMTCT services including access to voluntary counseling and testing by pregnant women and partners, comprehensive reproductive health services and antiretroviral prophylaxis.

- **Prevention of HIV and AIDS in the workplace by** increasing the proportion of sexually active employees who use condoms consistently by 25% by 2008; reducing the proportion of sexually active employees who have sex with more than one sexual partner by 30% by 2008; and reducing the proportion of employees who have experienced workplace-based sexual abuse by 50% by 2008. This will be achieved by developing an enabling environment for implementation of HIV and AIDS workplace programs; expanding HIV and AIDS workplace programs to include all categories of workplaces; promoting public - private partnerships to provide low cost, affordable housing for employees; and introducing a national program that addresses the vulnerability and risk of domestic workers to HIV infection.
- **Improving condom logistics, promotion and management by** increasing the number of available male condoms from 6,286, 800 in 2004 to 10,000,000 by 2008; the number of available female condoms from 19,966 in 2004 to 80,000 by 2008; the proportion of sexually active persons who use condoms consistently by 25% in 2008; and the number of new condom outlets per region by 200 by 2008. This will be done by strengthening national capacity to ensure that good quality male and female condoms are available, accessible, acceptable, and affordable as well as used.
- **Ensuring blood safety by** reducing HIV prevalence among blood donors from 2% in 2004 to 0.5% by 2008 and increasing the number of donated blood units which are collected per year from 6, 000 in 2004 to 10,000 in 2008. To do this it is important to create an enabling environment for the appropriate management of blood transfusions; develop sufficient national capacity to collect and screen adequate donated blood for transfusion; and encourage a culture of donating blood among young people.
- **Prevention and management of sexually transmitted infections (STI) by** reducing the incidents of ulcerative sexually transmitted infections by 20% by 2008. This will be achieved through strengthening of behavior change communication for sexually transmitted infection; improving national capacity to provide quality STI services; strengthening of partner notification and establishment of active contact tracing system; and strengthening health management information systems to include sexually transmitted infections.
- **Providing post exposure prophylaxis (PEP) and universal precautions by** increasing to 100% by 2008 the proportion of high risk occupational service areas that have PEP and universal precaution interventions; increasing to 100% by 2008 the number of persons reported to have been raped or exposed to incest who receive PEP services; and ensuring that by 2008, all (100%) persons who have experienced occupational related accidental exposure receive PEP

services. To do this, the plan aims to strengthen national and institutional capacity to provide quality PEP services; improve availability and accessibility of PEP equipment, materials and supplies; intensify PEP and universal precaution awareness among members of the public and populations at risk of accidental exposure to HIV infection; strengthen health management information system for PEP; and strengthen psychosocial support for people who are considering or have tested for HIV infection at facility and community levels.

- **HIV Testing and Counseling by ensuring** that by 2008, one hundred percent (100%) of people who have been tested for HIV received pre-and post-HIV test counseling; increasing to 40% by 2008 the proportion of adults (15-49 years of age) who have ever tested for HIV; and increasing to 30% by 2008 the proportion of adults (15-49 years of age) who know their HIV status. The plan intends to strengthen national capacity to provide country expanded facility and community based quality and confidential HIV counseling and testing services according to the specified national guidelines; strengthen human rights protection and reduction of stigma and discrimination in facilities and communities; articulate a national system to support and supervise counselors; and strengthen facility and community based psychosocial support capacity for people who are considering or have been tested for HIV infection.

## 2. CARE, SUPPORT AND TREATMENT

The management of HIV and AIDS will include a set of interventions designed to prevent the onset of opportunistic infections as well as promote early detection and treatment of infections. This care will include but not limited to: treatment using antiretroviral drugs, management of opportunistic infections including tuberculosis, HIV counseling and testing, Community Home-Based Care, palliative care, traditional and alternative care therapies. The goal is to reduce morbidity and mortality due to HIV and AIDS.

**Included in care, support and treatment are:**

- **Increasing antiretroviral therapy by increasing** the number of eligible people living with HIV and AIDS receiving antiretroviral therapy from 13,000 in 2005 to 51,000 in 2008; and increasing the proportion of eligible people living with HIV and AIDS who receive food packages as part of HIV and AIDS related clinical management by 60% in 2008. This will be done by improving antiretroviral therapy literacy among members of the public; developing a national capacity to up-scale and provide quality and affordable antiretroviral therapy services that address the needs of both adults and children; developing facility and community-based support services for ensuring follow-up and adherence among clients; and nutritional support as part of a comprehensive antiretroviral therapy package.
- **Manage tuberculosis and HIV infection by** increasing the proportion of persons diagnosed with tuberculosis who are tested for HIV from below 50% in 2005 to 100% in 2008; increasing the cure rate of tuberculosis from 15.3% in 2003 to 75% in 2008; and reducing the incidence of tuberculosis in the country from 700 cases per 100,000 in 2003 to 350 cases per 100,000 in 2008. To this it is necessary to improve literacy on tuberculosis among members of the general public; scale-up of routine HIV testing for tuberculosis cases and improvement of early detection of tuberculosis especially among HIV positive clients; strengthen national capacity for provision of tuberculosis services for both adults and children including support services; scale-up of Directly Observed Treatment and development of both facility and community based support services for ensuring follow-up and adherence among clients; introduce nutritional support as part of a comprehensive tuberculosis package; and prevent the onset of new cases.
- **Manage opportunistic conditions (OIs) and pre-antiretroviral therapy by** increasing to an average of 7 years by 2008 survival of people living with HIV before progression to clinical AIDS. The plan aims to improve literacy on pre-antiretroviral therapy among members of the public; develop and introduce comprehensive national pre-antiretroviral therapy program as part of the care package, including the use of prophylaxis such as co-trimoxazole and INH; and develop a national capacity to provide rehabilitation services (physical and mental).

- **Expand HIV Counseling and Testing in order to** increase the proportion of clients who receive facility-based routine HIV counseling and testing by 25% in 2008; and increase by 20% in 2008 the proportion of clients who have had contact with health care facilities and know their HIV status. This will be achieved through public awareness on routine offer of HIV testing in the context of clinical care; providing routine HIV counseling and testing in clinical care; and reducing facility-based stigmatization and discrimination of people living with HIV and AIDS.
- **Promoting community home-based care in order to** increase by 60% in 2008 the proportion of chronically ill people that receives quality and appropriate care as well as support within their homes; and increase by 40% in 2008 the proportion of health care facilities that have arrangements with Community Home-based Care services and communities. The plan seeks to create positive health seeking behaviour for home-based care services; expand and strengthen the coordination and provision of community home-based care services, including the involvement of the private sector that are integrated into community impact mitigation services.
- **Increasing palliative care by** increasing by 20% in 2008 the proportion of health care facilities that offer the basic palliative care services to terminally ill clients; and increasing by 25% in 2008 the proportion of community home-based care clients receiving appropriate palliative care services (including children). This will be achieved through the creation of positive health seeking behaviour for palliative care services; and the expansion and strengthening of national capacity to provide quality palliative care services.
- **Promoting traditional and alternative health therapies** in order to increase the proportion of registration of traditional and alternative health care practitioners to 100% by 2008; and increase the proportion of traditional/ alternative health practitioners who have been trained in HIV and AIDS issues to 100% by 2008. The plan seeks to improve the national capacity of traditional /alternative health practitioners on HIV and AIDS related issues; develop a national collaborative framework for conducting research on herbal and alternative medicines; and regularization and rationalization of tradition /alternative health practice.

### 3. IMPACT MITIGATION

Mitigating the impact of HIV and AIDS includes the provision and protection of legal, ethical and social rights; social protection and livelihoods support; counseling and emotional care; food and nutrition security support; educational support; and community-driven impact mitigation programs. **The goal is** to mitigate the social and economic impact of the epidemic in Swaziland.

In order to mitigate the impact of HIV and AIDS, the plan prioritizes:

- **Food and nutrition security support** in order to increase to 100% by 2008 the proportion of eligible vulnerable OVC, PLWH/A, BVEs who have access to at least one nutritious meal a day. The plan seeks to develop and implement a comprehensive food security strategy for vulnerable households; and provide nutritional support for OVC, PLWHA, BVE and other vulnerable groups.
- **Educational support** by ensuring that by 2008, at least 100% OVC aged 6-14 years have access to free formal or non-formal education; and that by 2008, at least 80% OVC and disadvantaged youth have access to formal and non-formal education. To do this the plan will improve the quality and expansion of coverage of formal education and non-formal education including institutionalization of education for marginalized children; and promote school-community linkages for better identification and maintenance of OVC in schools.
- **Legal, ethical and social rights provision and protection** in order to ensure that by the end of 2006, 100% of draft policies are adopted, and 100% of draft bills are enacted; that by 2007, 100% of policies are translated into Acts; that by 2008, 100% of ratified impact mitigation-related international conventions are domesticated; and increase to at least 80% by 2008 public awareness about the rights and obligations of PLWHA and other vulnerable groups. To do this, the plan emphasizes the need to facilitate the enactment of outstanding and new policies, laws and structures that promote the ethical, legal and social rights of OVC and other vulnerable groups; strengthen of legislation and systems for promoting the ethical, legal and social rights of OVC and other vulnerable groups; and strengthen of initiatives that promote the ethical, legal and social rights of OVC and other vulnerable groups.
- **Social protection and livelihoods support** in order to increase the proportion of eligible households with child heads, PLWH/A, PWD and BVEs that have access to basic services (clean water, sanitation and shelter) to 50% by 2007; establish a national social security system by 2008; and ensure that by 2008, 50% of eligible households have access to micro-credit and development finance. The plan intends achieving this by harmonizing the provision of basic services to vulnerable households headed by OVC, PLWHA, PWD and the elderly (e.g. shelter, clean water and sanitation services); introducing a comprehensive national social security system, which covers vulnerable groups particularly the OVC, PLWHA, PWD and the elderly; and improving and

scaling-up of access to economic and livelihood development schemes for the affected individuals, households and groups including care givers.

- **Counseling and emotional care so as to** ensure that by 2008, at least 50% of registered OVC, PLWHA, BVEs, PWD, and caregivers receive counseling and emotional care; ensure that by 2008, at least 50% of registered OVC, PLWHA, BVEs, PWD, and caregivers receive appropriate mental health services; and ensure that at least 10% of registered needy OVC are adopted and/or fostered by locally- based families by 2008. This will be done by scaling-up of the provision of counseling and emotional care for OVC, caregivers, the elderly, PLWHA and PWD; strengthening of mental health services for vulnerable groups; strengthening of family adoption and socialization of the extremely needy OVC; promoting positive living among PLWHA and expansion of initiatives that minimize stigmatization and discrimination in the community.
- **Facilitating community driven impact mitigation programs** in order ensure that by 2008, 100% of chiefdoms and towns have the capacity to provide basic impact mitigation services. The plan seeks to strengthen the capacity of community structures (such as extended family structures, PLWHA, community groups, *Umphakatsi*, *Inkhundla*) to provide integrated basic impact mitigation services; and develop the capacity of partners to deliver comprehensive psychosocial support services at community level.

## 4. MANAGEMENT OF THE NATIONAL RESPONSE

The management of the national response includes addressing institutional arrangements, planning and program development, resource mobilization and financial management, advocacy and communication, community mobilization, research, as well as monitoring and evaluation. The goal is to create an enabling environment for the effective management and co-ordination of the national response.

### **Managing the national response includes addressing:**

- **Institutional arrangements** in order to improve co-ordination of HIV and AIDS activities at all levels; increase ownership and support of the national response by all responding partners and members of the general public; and ensure an appropriate structure at NERCHA that facilitates, manages and supports use of strategic partnerships. To do this, the plan addresses the improvement of political commitment and leadership to support the national response; rationalization, harmonization and decentralization of the governance and coordination structure of the national response through consensus; empowerment of all designated coordinating agencies with adequate capacity (financial, technical, human resource and logistical) for them to effectively perform the coordination function; articulation of a comprehensive and a well rationalized framework, for the improvement of capacity for the coordination of the health sector HIV and AIDS response as well as the social welfare sector HIV and AIDS response; and strengthening coordination of the national response and the management capacity of NERCHA.
- **Community mobilization** so as to improve involvement and participation of grass-root communities, people living with HIV and AIDS and vulnerable groups in the national response; and improve coordination of local community responses. The plan seeks to improve the capacity of communities, people living with HIV and AIDS and vulnerable groups to participate meaningfully to the national response especially at the local level; promote partnership development among partners who provide support to community responses; and promote, strengthen and use community based mobilization response methodologies that are both acceptable and feasible.
- **Planning and program development** by upscaling the national response and strengthen effective priority actions against HIV and AIDS; and harmonizing and ensuring coherence of actions of all cooperating partners especially development partners, civil society organizations and government sectors. To do this, the plan will introduce a decentralized national annual planning and budgeting process for improving, intensifying, up-scaling the national response and ensuring that it is both inclusive and based on a bottom-up approach; and strengthen planning capacities at all levels using a program rather than a project based approach.
- **Resource mobilization and management** in order to increase available funding at all levels on a scale capable of making an impact to the epidemic; and ensure appropriate, effective and swift use of available resources at all levels of the national response. The plan addresses this by consolidating a national response total resource needs as a basis

for increasing funding by the government of Swaziland; improving government funding to the Ministry of Health and Social Welfare in line with the 15% of the national budget recommended by the Abuja Declaration; creating an appropriate grant and sub-grant mechanism for funds available for the national response allowing for flexible and prompt disbursement to all stakeholders; strengthening planning, financial management and reporting capacities of sub-grant recipients and all other implementing partners; creating and operationalising a framework for tracking resources; and improving and intensifying resource mobilization initiatives internally, regionally and internationally to broaden funding base.

- **Advocacy and communication** in order to create an enabling social, religious, cultural, political, legal and economic environment for the national response to thrive; and improve information availability on the national HIV and AIDS response as well as responsiveness to misinformation. This is achieved through the promotion of a culture and development of capacity to mount advocacy and lobbying activities at all levels of the national HIV and AIDS response; and improvement of opportunities and national capacity for stakeholders to share and exchange information on HIV and AIDS activities of the national response.
- **Cross-cutting issues** which ensure that by 2008, one hundred percent (100%) of responding agencies have integrated human rights, gender, poverty, socio-cultural practices and disability into their response activities; and that by 2008, one hundred percent (100%) of registered responding agencies have at least one staff members who has training in HIV and AIDS related areas such as human rights, gender, poverty, socio-cultural practices and disability. The plan seeks to develop public awareness on the relationship of human rights, gender, poverty, socio-cultural practices and disability to HIV and AIDS; and develop national capacity to mainstream human rights, gender, poverty, socio-cultural practices and disability into HIV and AIDS related interventions.
- **Monitoring and evaluation** which will produce accurate information and data on achievement of the objectives and outputs of the national response to HIV and AIDS; and utilizing available HIV and AIDS data for planning and decision making. The plan seeks to refine and implement a national monitoring and evaluation system for the national response; develop a national monitoring and evaluation technical capacity for all responding partners at all levels of the national response including NERCHA; strengthen all sectoral HIV and AIDS monitoring and evaluation systems in the country including the Health Management Information System and the monitoring and evaluation plan for the health HIV and AIDS sector response; align the national HIV and AIDS monitoring and evaluation system with that of sectoral HIV and AIDS monitoring and evaluation systems; and generate and disseminate data on the national response.
- **HIV and AIDS research** in order to increase the number of HIV and related studies that are carried in the country; and reduce the number of research studies that are carried out without approval by the health ethics and scientific committee to facilitate the utilization of research results. The plan will strengthen the health ethics and scientific committee and development of appropriate ethical standards and ethical approval procedures; establish a national HIV and AIDS research agenda; develop national capacity to

undertake HIV and AIDS related research; and improve dissemination of HIV and AIDS related research products.

## IMPLEMENTATION OF THE NATIONAL STRATEGIC PLAN

