The Government of the Kingdom of Swaziland

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

June 2006

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Preface

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 behaviour 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.

The epidemic in the country is viewed as being generalized because it is no longer restricted to isolated localities and/or specified groups of the population. People who carry the virus come from all segments of Swazi society irrespective of age, sex, socio-economic status, education, marital status or religious affiliation. Consequently, the risk of getting infected has become a tangible reality for all sexually active persons in the country. The epidemic in our country can also be described as being very deeply entrenched in that almost 43 out of 100 pregnant women who were tested for HIV infection during the 2004 sentinel survey were reported to carry the virus. This characteristic of the epidemic makes it extremely challenging to halt and eventually reverse it. The epidemic in the country is described as being mature given that its impact has become overt. Illness and death and its consequences have become common to the extent that very few individuals, families and organizations can claim to have not experienced the effects of the epidemic. Based on the information which is noted above, the observation is that this epidemic requires an expanded, comprehensive and intensive multi-sector response which is well coordinated. It is the collective application of these principles that will make a difference in the effectiveness of the national response.

Expansion of the national response calls for increased resources, coverage in terms of geographical location and beneficiaries reached as well as number and types of interventions and responding agencies. In implementing this strategic plan care should be taken to ensure increased coverage of the response from all perspectives. The combination of the depth and maturity of the epidemic requires that the country address all aspects of the epidemic covering prevention, care, support and treatment as well as impact mitigation and management of the response. At this stage of the epidemic, the country cannot afford to ignore some dimensions of the epidemic. The country will therefore attempt to address all recommended sub-thematic areas with the belief that such collective action will generate synergy. However, issues of political leadership, coordination of both the national and health sector responses, reduction of multiplicity of sexual partners, the status of social welfare services and the needs of orphans and vulnerable children will be addressed as urgent and priority strategic actions.

It has now become urgent for the response to be intensified. Such intensification calls for systematic, repeated and sustained application of interventions from different perspectives over time to a point of saturation. Time has come for the people of Swaziland at all levels of society to be thoroughly persuaded to give genuine consideration to the threat of HIV infection and the impact thereof. 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 problem). Every individual and every sector in the country has a contribution to make to the national response. I call upon every government department including local government, every business entity, every civil society organization, every development partner and members of Swazi society to 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). Effective coordination of all proposed strategies and actions at all levels of the response is essential. As such, all responding agencies are required to act within the confines of this plan.

Mr A.T. Dlamini

Prime Minister Of The Kingdom Of Swaziland

Foreword

The national response has gone through five planning cycles since the AIDS epidemic emerged in the country. Every successive plan has to some degree represented an expansion of the response in line with growth and development of the epidemic in the country and introduction of new response tools by the international community. 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. This plan shall contribute to the attainment of this vision by reducing new HIV infections, morbidity and mortality as well as by mitigating the socio-economic impact of the epidemic, creating an enabling environment for the national response and tracking 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 designates an agenda for urgent and priority issues.

This plan puts in place a comprehensive response agenda that is in line with obtaining realities of the epidemic in the country. More specifically, it rationalizes and harmonizes the response into a coherent national effort; introduces a management thematic area, a monitoring and evaluation sub-thematic area as well as addresses an urgent and prioritized agenda. Under the prevention thematic area, this plan expands strategies for addressing risky sexual behaviour to include reduction of vulnerability over and above the reduction of risk. This is done by formalizing the following as mainstream HIV and AIDS strategies: compulsory and universal education; reduction of idleness; empowerment of women and children; promotion of human rights; regeneration of moral values; improvement of family life and reduction of alcohol and drug abuse. Previously, prevention strategies tended to focus more on risk level strategies such as promotion of abstinence; mutual faithfulness and condom use without addressing factors that drive these risks. Under prevention, this plan also explores emerging interventions such as circumcision, vaccine trials and microbicides.

Under Care, Support and Treatment, the plan introduces antiretroviral therapy which was not part of previous strategic plans. It also addresses public ART literacy; adherence promotion and introduction of nutritional support as part of ART. The plan also introduces the concept of pre-ART care; routine counselling and testing as part of the care process in health facilities; promotion of gender equity in the provision of home-based care and traditional and alternative health therapies

Under Impact Mitigation, the plan introduces the concept of establishing a comprehensive national social security system; provision of basic services such as shelter, clean water, proper sanitation to vulnerable segments of the population; promotion of adoptions and socialization of children; promotion of livelihood schemes for vulnerable groups and care givers

Management of the national response is a new thematic area. It introduces sub-thematic areas in institutional arrangements; planning and program development; resource mobilization and financial management; advocacy and communication; community mobilization and monitoring and evaluation. Under this thematic area, the document addresses rationalization, harmonization and decentralization of the coordination function; empowerment of sub-national level coordination structures; capacitation of the health sector; introduction of a decentralized annual planning process; introduction of sub-granting mechanisms; improvement of both the national

and sector funding by the Government of Swaziland; development of capacity to mount advocacy and lobbying activities at all levels of the national response; improvement of the capacity of communities constituencies and people who are living with HIV and AIDS to participate meaningfully in the response and improvement of opportunities and national capacity for stakeholders to share and exchange information. The plan also introduces a research sub-thematic area.

In chapter nine, the document proposes translation of this document into sector work plans and constituency plans. It fosters the concept of community based responses which are catalyzed by civil society organizations and further suggest resource mobilization and resource allocation approaches. The monitoring and evaluation section of this chapter discusses tracking of core indicators, mid and end of term reviews, data collection, information products, dissemination of Products and revision of the document.

Mr Njabulo Mabuza

Minister Of Health and Social Welfare

Acknowledgement

Many individuals, groups and organizations contributed to the preparation of this document. The National Emergency Response Council on HIV/AIDS therefore takes this opportunity to thank all those who supported and/or participated in the process in whatever manner. NERCHA is grateful to members of the National Steering Committee who provided oversight to the process and to the office of the Deputy Prime Minister, Regional Secretaries, Tindvuna Tetinkhundla, Tindvuna Temcuba and urban local government officials for mobilizing participation of community members in the process. Insightful contributions by Her Majesty the Queen Mother are greatly appreciated as well as views and ideas that were received from His Excellency, the Prime Minister; senior government officials; representatives of the private sector including organized labour and civil society organizations.

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Chief Ndzabankhulu Simelane

Chairperson, National Emergency Response

Council on HIV and AIDS

Acronyms and abbreviations

ABC	Abstinence, Be faithful and Condomise
AED	Academy of Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
ATF	AIDS Task Force
AZT	Zidovudine
BCC	Behaviour Change Communication
CANGO	Coordinating Assembly of non Governmental Organisations
CBOs	Community based organizations
CCA	Common Country Assessment
CDOS	Community Development Officers
CMTC	Crisis Management and Technical Committee
DOTs	Directly Observed Therapy short course
DPM	Deputy Prime Minister
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
FLAS	Family Life Association of Swaziland
FODSWA	The Federation of People with Disabilities in Swaziland
GDP	Gross Domestic Product
GPA	Global Program on AIDS
HAART	Highly Active Antiretroviral Therapy
HAPAC	HIV and AIDS Prevention and Care Program.
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICASO	International Council of AIDS Service Organization
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MEPD	Ministry of Economic Planning and Development
MICS	Multiple Indicator Cluster Surveys
MOAC	Ministry of Agriculture and Co-operatives
MOE	Ministry of Education
MOHSW	Ministry of Health and Social Welfare
MOHUD	Ministry of Housing and Urban Development
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
NDS	National Development Strategy
NERCHA	National Emergency Response Committee on HIV and AIDS
NGOs	Non-Government Organisations
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVCs	Orphans and Vulnerable Children
PCP	Carinii Pneumonia
PEP	Post Exposure Prophylaxis

PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSHACC	Public Sector HIV and AIDS Coordinating Committee
PWD	People with Disabilities
RHMS	Rural Health Motivators
RICA	The Royal Initiative to Combat HIV and AIDS
SASO	Swaziland AIDS Support Organization
Sebenta	Adult literacy program in Swaziland
SHAPE	School HIV/AIDS and Population Education
SNAP	Swaziland National AIDS Program
SNYC	Swaziland National Youth Council
SPEED	Smart Program on Economic Empowerment and Development
STIs	Sexually Transmitted Infections
STP	Short Term Plan
SWANNEPHA	Swaziland National Network for People Living With HIV and AIDS
TASC	The AIDS Support Centre
TASO	The AIDS Support Organization
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	Joint United Nations Program 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
WHO	World Health Organisation

Glossary

This is the definition of some of the terms used in this document.

Advocacy—Organized efforts to influence policy, leadership and opinion at various levels of action in the national response.

AIDS Competence—The ability of all elements of society (individuals, families, communities, business, government and non-governmental institutions of all sectors at all levels) to recognize the reality of HIV and AIDS, to analyze how it affects life at home and at work, and to take action to prevent its spread, maintain and improve the quality of life of PLWHA, families affected by AIDS and the community at large.

Comprehensive care and treatment—Holistic approach to care for PLWHA that involves clinical management, nursing care, palliative care and psychosocial support.

Coordination—A process of facilitation, communication, sharing, planning and monitoring of resources, risks and rewards for the purposes of efficiency and effectiveness in scaling-up all efforts in response to the HIV and AIDS epidemic.

Health worker—Any provider of health-related services, regardless of level of training or location of work.

Home-based Care—Any form of care given to sick people in their homes, which includes physical, psychosocial, palliative and spiritual activities.

Information product—Regular and routine report that will be produced by Monitoring and Evaluation system of the national response for the purpose of communicating progress made with the achievement of the objectives of the NSP.

Mainstreaming—Adapting a ministry or organization's core business to cope with the realities of HIV and AIDS.

Multisectoral Approach—A policy programming strategy which involves all sectors and sections of society in a holistic response to HIV and AIDS

Orphan—A child under 18 years old who has lost one or both parents

Palliative Care—An approach that improves the quality of life of patients and their families in facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual challenges.

Periodic reporting—A regular, routine reporting system that is required by NERCHA.

Psychosocial support—Interventions that are meant to enhance children's, families', and communities' ability to cope with HIV and AIDS and to achieve social, spiritual, mental, emotional, and physical well-being; enabling them to experience love, protection, self-worth and belonging.

Safe sexual behaviour—A practice that protects an individual from acquiring HIV and other sexually transmitted infections. These practices include primary and secondary abstinence, faithfulness and protected sexual intercourse.

Sexually Active—A description of individuals who engage in sexual intercourse, regardless of age.

Three by Five ("3 by 5")—The WHO and UNAIDS Global Initiative to provide Antiretroviral Therapy (ART) to 3 million people with HIV and AIDS by the end of 2005.

Vulnerable Child—A child under 18 years old whose parents or guardians are incapable of providing the required care; who is mentally or physically challenged; who is staying alone or with poor elderly grandparents; who lives in poor sibling-headed household; or who has no fixed place of abode.

siSwati terms and their English meaning:

Imiphakatsi	Chiefdoms
Indlunkhulu	Traditional Chief's homestead
KaGogo	Grandmother's hut, which has been a refuge for OVCs.
Lutsango LwakaNgwane	Traditional women's regiment
Tigodzi	Sub-chiefdom
Tinkhundla	Constituencies
Umcwasho	A cultural practice that aims at preserving chastity among girls by prohibiting sexual contact between girls and men.
Umphakatsi	Chief's residence, which is used as headquarters for the Chiefdom.
Yindzaba Yetfu Sonkhe	It is everybody's problem

PART A: BACKGROUND

1 Background

1.1 Introduction

This document shall be known as the Second National Multisectoral HIV and AIDS Strategic Plan. It represents the intention of the Kingdom of Swaziland to extend the national response to the AIDS epidemic beyond 2005 and to provide a framework for resource mobilization and coordination of all HIV and AIDS activities in the country. It is based on findings of a joint review of the 2000-2005 National HIV and AIDS Strategic Plan as well as countrywide consultations on drivers of the epidemic, how the epidemic is affecting individuals, communities and the country at large as well as what can be done differently. Consequently, all responding entities are obliged to act within the parameters of this plan and in support of its dictates in line with the principle of the "three ones" which calls for one national coordinating body; one national strategic plan and one national monitoring and evaluation framework.

In reading this plan it is important to note that it was developed in the context of the Millennium Development Goals (MDGs) and the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), the declaration on HIV and AIDS including a program of action which was adopted in April 2001 in Abuja in Nigeria, the Maseru Declaration on HIV and AIDS adopted by the SADC Summit in 2003, the New Partnership for Africa's Development (NEPAD) adopted in July 2001, Common Country Assessment and United Nations Development Assistance Framework as well as many other international and regional conventions that call for improved political commitment and the respect for human rights and the rule of law to which the country is signatory. It was also developed at a time when the country had just adopted a new constitutional dispensation and as part of many other government planning and development policies. This plan is therefore expected to interface closely with these important policies and plans of the country which among others include the: National Policy on HIV and AIDS; government policy outline on economic empowerment and development commonly known as the Smart Program on Economic Empowerment and Development (SPEED); draft National Policy on Children, 2003; draft Decentralization Policy; National Development Strategy (NDS); The Poverty Reduction Strategy and Action Plan, Health Sector Response to HIV/AIDS Plan in Swaziland 2003 – 2005; National Population Policy; draft social welfare policy; draft national policy on children including orphans and vulnerable children, Project Implementation Manual for Social Protection of Vulnerable Children including Orphans; National HIV/AIDS Communication Strategy for Swaziland 2004 and the Public Sector HIV/AIDS Strategic Plan, 2006 – 2008.

1.2 National demographic and socio-economic profile

Geographical setting—The Kingdom of Swaziland is a southern African country which shares borders with the Republic of South Africa on the north, west and south and with the Republic of Mozambique on the east. The country extends over a land mass of 17, 364 square kilometres.

Demographic and health profile—The country is host to a population of over 978,238 people, 78% of which live in rural Swaziland. The population of the country is generally young, with children under the age of 15 years and persons who are aged 65 years and above respectively accounting for 46 % and approximately 3% of the total population. The last national census (1997), estimated the population to be growing at a rate of 2.8% in 1997 compared to 3.2% in 1986. The Total Fertility Rate (TFR) has been declining over the years. It was reported to be 4.5 live births per 1000 women in 1997 compared to 5.4 in 1991 and 6.4 in 1986. Prior to the demographic impact of the AIDS epidemic, the quality of life of people living in the country had improved significantly from a life expectancy at birth of 44 years in 1966 to 60 years by 1997 with females (63 years) living slightly longer than males (58 years). The Crude Death Rate was on the decline from 18.5 per 1,000 in 1976 to 7.6/1000 in 1997. Infant mortality had dropped to 78 /1000 live births in 1997 compared to 99 in 1986, while Under-five mortality had decreased to 106/1000 live births in 1997 from 140 in 1986.

Education profile—According to the education statistics report of 2004, the country has a total of 546 primary schools and 218,352 students. Boys are slightly more (51.7%) than girls at the primary school level. Girls in secondary and high schools are respectively slightly more (50.5% and 50.3%) than boys. At university level, males are slightly more (51.9%) than female students. The 1997 census recorded literacy to be 81.3% with males having slightly higher rates (82.6%) than women (80.2%). Literacy levels were estimated much higher (92%) among young people who are aged 15 – 24 years compared to older generations of the population. Primary school enrolment stood at 230,000 in 2002 with 82% residing in rural Swaziland. Gender disparities in enrolment are very small. The teacher-pupil ratio was 1:34 at primary school and 1:18 at secondary and high school. Urban schools have a higher pupil-to-teacher ratio than rural schools.

Economic profile—The economy of the country is primarily agrarian even though the manufacturing sector has grown over the years. The economy is very closely linked to the economy of the Republic of South Africa. While the country experienced high economic growth levels of 9% on average in the late 1980s, in recent years the economic growth has seriously slowed down reaching an average rate of 3.4% in the period 1990-1992. However, the World Bank classifies the country as a lower middle income country with a GDP per capita income of US$1,387 (1999). Despite being perceived to be having a reasonable resource base compared to many developing countries, the majority of people (69%) in the country are classified as poor possibly due to poor distribution of available resources and rising unemployment which is estimated at 29%. Fifty-six point four percent (56.4%) of the wealth is estimated to be held by 20% of the population compared to only 4.3% being held by the poorest 20% of the population. While the country appears to have made a lot of economic development progress in the past, there is no doubt that these achievements are being significantly curtailed by the effects of the AIDS pandemic and difficulties in attracting meaningful direct foreign investment.

1.3 Outline of the document

The document is presented in five chapters of which this Background information on the country is chapter one. The description of the past and current situation of HIV

and AIDS in the country is chapter two. Chapter three describes the international, regional and national responses to the epidemic. Chapter four presents the vision and mission statement, strategic issues, objectives, strategies, indicators. Implementation of the national response covering coordination, funding, monitoring and evaluation and revision of the strategic plan is presented in chapter five. Overall, this document provides strategic guidance under four thematic areas of response which are designated as: Management; prevention; Care Support and Treatment and Impact Mitigation. Under management, the document presents sub-thematic areas in institutional arrangements; planning and program development; advocacy and communication; resource mobilization and management; community mobilization; research as well as monitoring and evaluation. Prevention has sub-thematic areas in: behaviour change communication; blood safety; prevention of mother to child plus, prevention of HIV and AIDS at the work place; condom logistics and management; sexually transmitted infection and clinical management; post exposure prophylaxis and universal precautions and HIV/AIDS Testing and Counselling. Impact mitigation includes the following sub thematic areas: legal, ethical and social rights provision and protection; social protection and livelihood support; counselling and emotional care; food security support; educational support; community driven impact mitigation program and mainstreaming of HIV, gender, disability and positive socio-cultural norms in impact mitigation interventions. The care, support and treatment thematic area covers these sub-thematic areas: antiretroviral therapy; management of opportunistic infections and pre-antiretroviral therapy; management of tuberculosis; home-based care; palliative care; counselling and testing as well as traditional and alternative practice.

2 HIV and AIDS in Swaziland

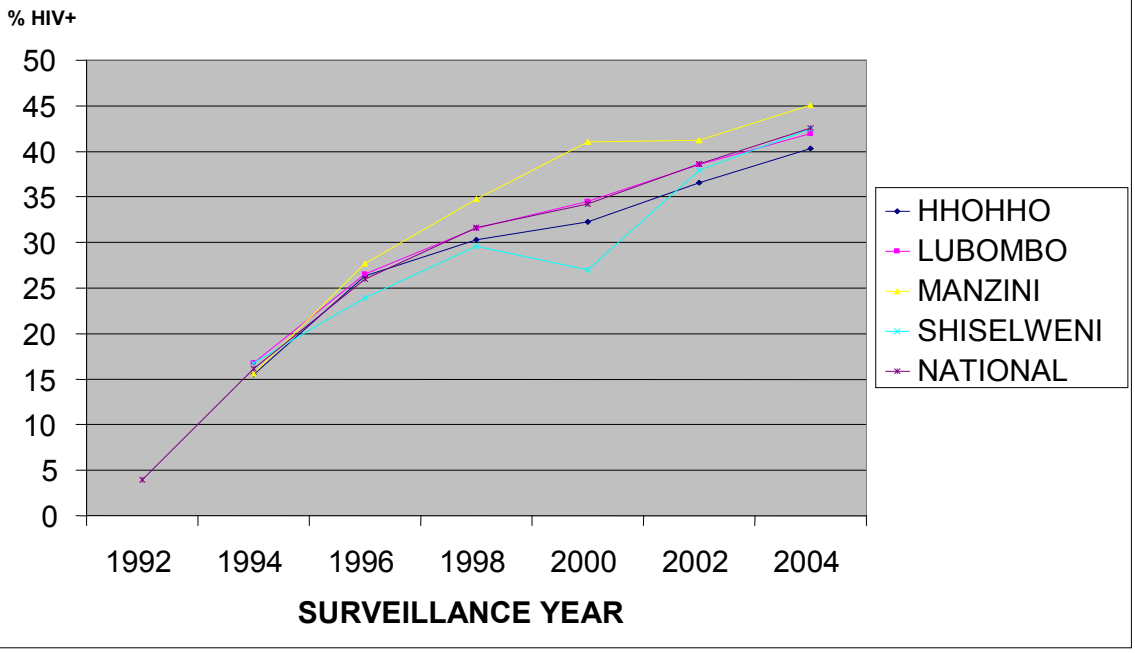
2.1 Introduction

The first case of HIV to be identified in Swaziland was in 1986 and since then the virus has spread extensively and developed into a generalized epidemic. This chapter presents an analysis of the levels, patterns, trends, drivers and impact of HIV and AIDS in the country as a way of describing the challenge which the country is facing.

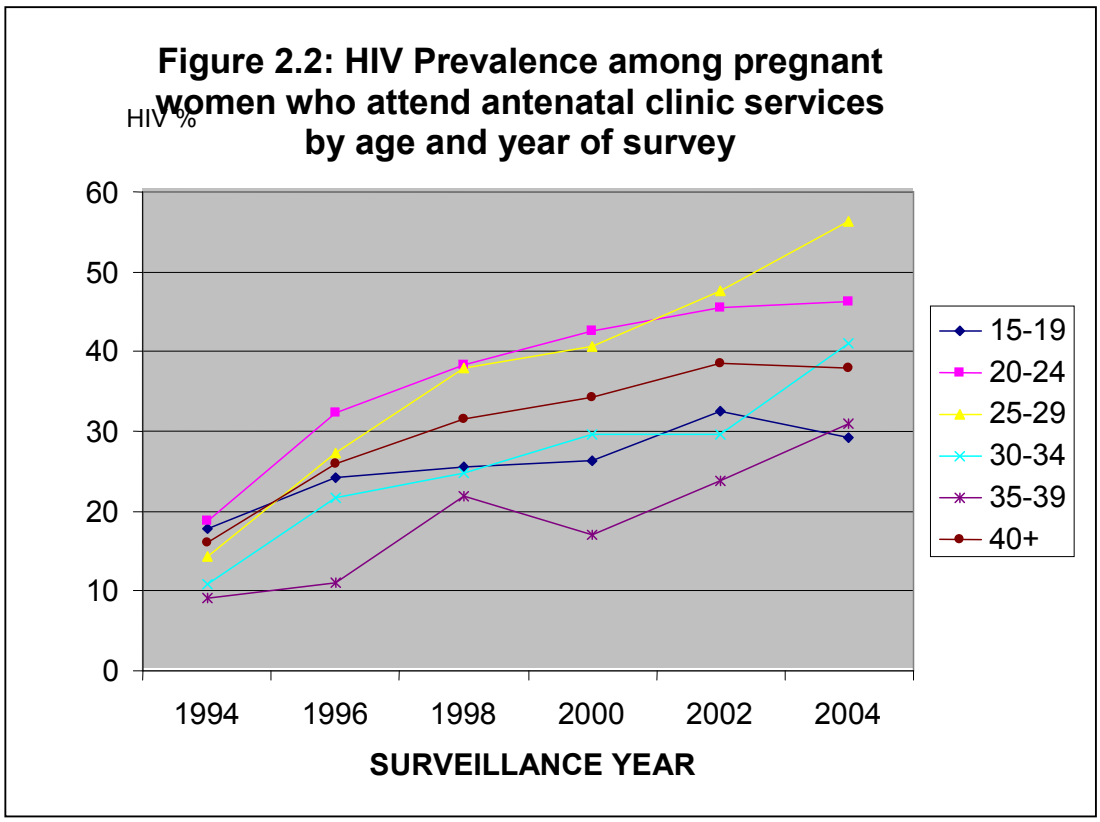
2.2 Levels, patterns and trends of HIV/AIDS

As can be seen in Figure 2.1, the overall national level of HIV prevalence at 42.6% recorded in the 2004 antenatal clinic surveillance survey is the highest in the world having rapidly multiplied by more than ten times from 3.9 in 1992 in a period of 12 years. Similar trends were observed in the four regions of the country with small variations from Hhohho region with the lowest prevalence of 40.3% in 2004 to Manzini region with the highest prevalence of 45.1%. Increasing prevalence since 2000 was also noted in both urban (from 35.6% to 44.5%) and rural areas from 32.7% to 40.3%), albeit with small differences between them. All educational levels experienced increasing prevalence rates.

Figure 2.1: HIV prevalence among pregnant women who attend antenatal clinic services by region and year of survey



Generally, people of all age groups have experienced increasing prevalence in the last decade as shown by Figure 2.2. A possible recent (2002 - 2004) stagnation of prevalence was noticed in ages 15-19 and 40 years and above. In terms of age group patterns, youth aged 20-24 and 25-29 have experienced the highest prevalence since 1996, followed by people aged 40 years and above.



2.3 Impact of the epidemic

Several studies conducted in the past show that the impact of the epidemic on the country and her people is very serious. According to the UNDP report of 2005 human development in Swaziland worsened between 1991 and 2003 with the Human Development Index (HDI) declining from 0.583 to 0.498. The observed decline is attributed to deteriorating social and economic indicators, mostly as a result of HIV/AIDS.

Health indicators—Annual AIDS related deaths are increasing and a study by the World Bank projects that by 2015 the number of deaths per year will reach about 22,000, eleven times more than the non-AIDS deaths estimated at 2,000. The Crude death rate has increased from 8.4 per 1,000 people in 1991 to 22.7 per 1,000 in 2002 and expected to rise to 30.2 per 1,000 by 2010. Life expectancy rate has dropped from 56 years in 1986 to 32.5 years in 2003. The demand for health care as measured by the proportion of hospital beds occupied by AIDS related patients is increasing. The total population of Swaziland is projected to increase to 1.58 million by 2015, which will be 41% below the expected number in the absence of AIDS.

Human resources—Both the quality and quantity of labour is being adversely affected by AIDS as highly trained and educated human resource is infected by HIV, gets sick for a long time and eventually dies, leading to lower productivity and loss of economic production. A study of the three central ministries of Finance, Economic Planning and Development and Public Service and Information shows that 32% of the staff will be lost to the epidemic in 20 years' time, requiring an annual staff replacement of 1.6% to maintain staffing levels. The epidemic will mean increased

pension fund contributions, sick leave, compassionate leave, training and other costs estimated at over E10.5 million between 2002 and 2010.

Agricultural sector—The impact of the epidemic on the agricultural sector is very devastating. A study of subsistence agriculture in the country found that due to AIDS related sickness and deaths 38.5% of the households suffered reduction in area under cultivation, 47% decline in crop yield, 42% change in cropping pattern, 31% diversion of labour to care for the sick, 22% increase in health costs and 39% loss of regular remittances. All this has contributed to the increased levels of poverty in the country from 66% in 1995 to 69% in 2002.

Private Sector—The business sector in the country has not been spared from the effects of the epidemic. A survey of the private sector managers found that the impact of HIV and AIDS on their organizations included high absenteeism, frequent sickness of workers, and loss of skilled labour, funeral expenses and retirement on medical grounds. These problems have reduced the profits of enterprises.

Education sector—The education sector is also just as negatively affected by the epidemic. The proportion of children not enrolled in primary school is projected to increase from 3.5% in 1999 to 30% in 2015 due to widespread poverty of households partially due to HIV/AIDS. A Ministry of Education study found that the quality of education was declining due to AIDS deaths of teachers as teacher-to-students ratios increased from 1:35 in 1997 to 1:52 in 2000.

Women—Women are adversely affected and infected by HIV. Because of their biological and physiological makeup and low socioeconomic status, women are more vulnerable to HIV infection than men. While they are the majority care givers of the AIDS patients, they are expected to produce food and provide other essentials for their families. When the male head of the household becomes sick, the women take on additional care responsibilities. Often widows lose their properties to the extended members of the family, which makes them poorer.

Children—The impact of HIV/AIDS on children is overwhelming. At the current high prevalence of HIV, the number of orphans in the country is projected to rise from 32,000 in 2001 to 120,000 in 2015. This number is about 15% of the children population and may rise to 24% in future, which is very high. Already the number of orphans has overstretched the extended family system and requires other ways of managing it. Many orphans face the challenge of accessing food and households can not afford the school fees and other related costs.

The elderly and person with disability—Elderly persons have also been adversely affected by the epidemic due to premature death of their children who leave them without adequate resources and a responsibility to bring up grandchildren. Many of these elderly persons are weak and sickly. The epidemic has increased the burden of care for families, communities and the health care system in general. This increased demand for care has had a negative impact on people living with disabilities as more attention is paid to sick able-bodied people.

2.4 Drivers of the epidemic

It is imperative that factors which fuel the rapid spread of HIV and AIDS in Swaziland are known in order to plan an appropriate national response. Countrywide consultations with the population at the chiefdom and town levels, various stakeholders and key informants together with past studies and the Joint Review of the current strategic plan suggest the following as the driving forces of the epidemic in the country:

Inadequate public awareness of the epidemic—Although several studies indicate that a high proportion of the population is aware of the AIDS epidemic and

understands its dangers, other studies show that misconceptions are still very common. This may be a result of denial and lack of correct information. Currently in the media there are many statements contradicting established facts about HIV and AIDS, such as claims of cure by some faith healers and traditional healers including the promotion of unproven drugs and treatments as well as practices such as sexual intercourse with virgins.

Multiple concurrent sexual partners—There is a common practice of multiple sexual partnerships among people of Swaziland including the youth. Many of these partners are concurrent multiple partnerships, where men have women/mistresses they have sex with regularly and frequently in addition to their official wives and regular girlfriends. These mistresses also have additional men they have sex with sometimes for financial benefits. Some married women also have concurrent sexual partners, who in turn have regular partners. This practice which results in a wide sexual network fuels the virus more than having casual sexual contacts with prostitutes. Furthermore, a high proportion (70%) of the out-of-school youth reported in 2003 to have experienced sexual intercourse.

Cultural beliefs and practices with negative implications—While cultural beliefs and practices are believed to have positive attributes, some are perceived to have a potential for contributing to the spread of the epidemic. These cultural beliefs and practices include *inhlanti* (a younger sister or child of the brother-in-law is given to men as wife); *kwendzisa* (girls are given away by parents under arranged marriages) and *kungena* (widow inheritance including those whose husbands died of AIDS).

Inter-generational sex—Intergenerational sexual partnerships are believed to be common in the country. In such relationships younger persons especially girls and young women engage in sexual intercourse with partners who are much older than themselves. This observation is supported by the fact that girls who are aged 15-19 years are more likely to be infected than boys of the same age. This practice has encouraged cases of incest which are increasing with many of them believed to be hidden by families for fear of shame and imprisonment of their breadwinners.

Secrecy and denial of HIV infection—Many infected people in the country do not want to know their HIV status. It is believed that most of those who know their status keep it a secret even to their sexual partners. As a result, many infected persons continue to have sex with their regular and/or casual partners without protection and as such pass on the infection both knowingly and unknowingly. In some cases these sexual relationships lead to pregnancy and subsequently to mother to child transmitted HIV infections. To console themselves, families and friends in some cases choose to believe that infected persons have been bewitched. Public disclosure is very low. When it occurs it is generally among low profile personalities. As a result, no political or professional leaders have made public disclosure of their HIV status. With a large number of new infections and an increasing pool of advanced AIDS patients with a high viral load in denial yet very infective, the virus is easily passed on to others.

Decline of moral values—Positive cultural practices are disappearing in the country in spite of the fact that the majority of people in the country have embraced Christianity which by nature promotes high moral values and standards. As part of the perceived moral decline, the family is breaking down. This is evident in that according to the census of 1997, the percentage of sexual relationships taking place in marital unions among women aged 15-49 years has dropped from about 90% in 1970s to less than 40% in late 1990s. The proportion of women of ages 15-49 years that had children out of wedlock increased by a third (33.2%) between 1986 and 1997. Although the age at first sex debut was around 15 years, the mean age at first marriage was almost double (28.3 years) in 1997, implying a very high rate of

premarital sex. Hence, sex is increasingly no longer a marital union. The increasing reported number of rapes, child abuse and incest is believed to be indicative of moral decay in the country.

Lack of seriousness in dealing with the epidemic—The epidemic is taken as "Business as usual" despite the high prevalence, morbidity and mortality. While the epidemic was declared a national disaster and is classified as one the three national priorities, it is allocated less than 0.25% of the national budget. The Ministry of Health and Social Welfare which is bearing the brunt of the epidemic receives less funding from government as a proportion of the national budget than it received in the early 1990s prior to its current challenges. Senior government officials challenge and dispute the validity of national statistics on HIV and are therefore publicly giving members of the public the impression that the situation is not as bad as it is made to appear. The print media and national radio station continue to carry stories and programs that promote misconceptions and risky male behaviour. At the personal level, the people continue to engage in multiple and unprotected sex. There has been no significant shift in sexual behaviour to indicate that Swaziland has the highest prevalence level among pregnant women in the whole world and the risk of getting infected in the country is very high.

High mobility of the population—Research based evidence shows that Swazis are highly mobile both internally and across the border. A 1993 survey found that 54% of urban households maintain contacts with rural homesteads. In 1998 it was estimated that over 10,000 Swazi men were employed in South African mines, while others were employed in both formal and informal sectors in South Africa. The number of Swazis who work in South African mines has declined over the years. Separation from regular sexual partners creates opportunities for unfaithfulness both among those who go away and those who remain behind.

Abuse of power by men in sexual relationships—Male promiscuity is celebrated in the country as *bunganwa* (being a stud) while women are expected to be faithful, a test which if they fail could lead to being "dumped", divorced or killed. Women are generally expected to be submissive and accepting of their promiscuous male sexual partners even if it is clear that the behaviour of their partners places them at risk of becoming infected with HIV. As a consequence of abuse of power by men in sexual relationships, most women cannot negotiate the use of condoms especially married women so that marriage in the context of the epidemic is no longer a safe institution.

Sexually transmitted infections—According to national HIV sentinel surveillance studies over the years, HIV prevalence among STI clients (11.1% in 1992 to 50.2% in 2000) compared to pregnant women (3.9% in 1992-34.2% in 2000) has been shown to be consistently higher indicating that having an STI increases the risk of acquiring HIV infection as sexually transmitted infections are still at epidemic levels in the country.

Poverty—Even though Swaziland is a middle income country, poverty is a common phenomenon. A survey carried out in 2002 indicated that poverty in the country has increased from 66% in 1995 to 69%. It is commonly believed that poverty lowers the ability of individuals to resist advances that may place them at risk of getting infected with HIV. At the same time those who buy sex from poor people stand the risk of acquiring HIV infection themselves.

Low condom use—Condom use in the country is still very low. This assertion is supported by the fact that in 2003, according to the BSS, less than 40% of sexually active out of school youth reported using a condom during their first sexual encounter. Even though the number of male condoms that are distributed in the country annually has increased significantly over the years, it is not high enough to produce a significant impact on new infections. The demand for condoms is

undermined by misconceptions and claims by some segments of the population that their use encourages promiscuity in the society. Use of female condoms is uncommon due to the fact that they are not as available and accessible as male condoms.

Early sex—While 30% of in-school youth are sexually active, most (70%) of out-of-school youth are sexually active. The average age at first sexual experience was estimated to be 15 years.

Population momentum—In the absence of extremely effective HIV prevention interventions, reducing the number of new infections in the country will continue to pose a big challenge due to the fact that the population of the country is young. This means that at any given time, a large cohort of young people begin sexual activity. This act exposes them to the risk of getting infected with HIV given the large pool of potential sexual partners who may already be infected.

Alcohol and drug abuse—A number of studies have identified the associations between alcohol intake and high-risk sexual behaviour. These studies have shown that men and women who frequently combine alcohol and sexual encounter are generally less likely to use condoms during sexual intercourse. Alcohol may influence high-risk behaviour by affecting judgement and inhibiting socially learned restraints.

2.5 Summary of community consultation findings

To promote ownership of the national response, wide consultations were carried out through community meetings in all the chiefdoms. Consultations were based on five questions: 'What is driving the epidemic in your community'; 'What can be done differently to address these drivers'; 'How does the epidemic affect individuals, families and the community'; 'What is currently being done in your community to address the AIDS epidemic' and 'What role can individuals, families, communities' government NGOs, and other partners play in responding to the epidemic with respect to prevention, care support and treatment, and impact mitigation'. The findings were presented as reports from individual chiefdom, towns, tinkhundla, and regions.

Below is a summary of responses that were frequently mentioned at chiefdom and town meetings as well as in at least 50% of regions.

Drivers—According to members of the public, the drivers of the epidemic are: early sex due to sex education and exposure to pornography; unemployment; inadequate HIV and AIDS knowledge; alcohol and drug abuse; rape and incest; children's rights; mobility; break-down of morals; unfaithfulness; lack of knowledge of HIV status; poverty; unprotected sex; prostitution; polygamy; wilful transmission and wife inheritance. These responses indicate that community members are generally knowledgeable about the epidemic even though it would appear that there is still a significant level of misconceptions. Otherwise community members know what drives the epidemic and what could be done to prevent infections.

Current responses—According to responses on the question of what is being done in individual your communities to deal with the AIDS epidemic, communities indicated that a wide variety of activities are taking place. It would appear HIV and AIDS education is the most commonly applied intervention. Others include condom promotion and distribution, feeding and food production, formation of support groups, promotion of testing, home-based care; sports, school-based programs and *umcwasho*. There was also an indication that parents are talking to their children about HIV and AIDS and that churches are promoting abstinence. Over all it would appear that while activities are taking place in some communities, geographical coverage and diversity of intervention are still inadequate. A high number of communities indicated that nothing was taking place in their communities.

Innovative responses—In response to the question: what can be done differently, over and above the interventions that were already being applied, communities called for up-scaling of public education activities especially targeting men, limitation of operating hours for alcohol outlets, making counselling and HIV testing compulsory including premarital counselling and testing, discouraging polygamy, revival of traditional practices of sex education and castration of HIV positive men.

Effects of the epidemic—While the intention of this question was to establish effects of the epidemic on individual and family in each community, responses seem to indicate that respondents giving general knowledge experiences. Effects that were frequently cited included stigma, rejection, denial of job opportunities, impoverishment, family disputes, increased demand for care of sick people within families and communities, guilt, depression, fear of death, increased orphan-hood, an increasing number of children who drop out of school, increased medical and funeral expenses, increased risk of getting infected from sick people during provision of care.

Role of different stakeholders—According to responses that were given, individuals should among other things adopt safer sexual behaviours, take an HIV test, declare HIV status, undertake regular medical checks and adopt a positive lifestyles. It was suggested that families should: stop wife inheritance, create an environment which encourages family members to talk freely about HIV and AIDS, support adherence to drugs, and provide financial support and show love and affection. Communities on the other hand are expected to discourage polygamy, organize community education programs, stop all-night activities, and establish standards for raising-up children. Government is expected to provide resources including finances, drugs, health and social services. Non-governmental organizations are expected to deliver services.

3 Response to the epidemic

3.1 Introduction

This chapter presents a summary of the international and regional response to the epidemic. The chapter also presents how the country's response has progressed from the time the first HIV infected person was identified in the country in 1986 to the year 2005 when this document, the Second National Multisectoral HIV and AIDS Strategic Plan, was developed. This chapter does not seek to present a response analysis but to give a historical perspective with highlights of achievements and challenges

3.2 The global response

Since the first cases of unusual immune system failures were identified among gay men in the United States in 1981, tremendous progress at the international level has been made in improving understanding of the epidemic and responding to it. In 1982 the Acquired Immunodeficiency Syndrome (AIDS) was defined for the first time and the three modes of transmission were identified as blood transfusion, mother-to-child transmission, and sexual intercourse. In 1983, the link between AIDS and the Human Immunodeficiency Virus (HIV) was made and a heterosexual AIDS epidemic was unveiled n Africa. By 1985 all regions of the world had reported at least one case of AIDS. In the same year, the Food and Drug Administration in the United States of America approved the first antibody test and blood donor screening was initiated.

In 1987, a lot of activities took place. Among these TASO was formed in Uganda leading the way for community-based responses. Secondly, the International Council of AIDS Service Organizations (ICASO) and the Global Network of People living with HIV/AIDS were established. Thirdly, in February of the same year, the World Health Organization (WHO) established a special program on AIDS which later became the Global Program on AIDS (GPA). Fourthly, the first therapy for AIDS using Zidovudine (AZT) was approved for use in the United States. In 1988, health ministers from around the world met for the first time in London to discuss the HIV/AIDS epidemic. In the period 1991-1993, HIV prevalence in young pregnant women in Uganda began to show signs of decline representing the first significant downturn of the epidemic in a developing country. Uganda's success is attributed to countrywide mobilization against the epidemic including high level political leadership. In 1994, the first treatment regimen for reducing mother-to-child transmission was developed. In 1996 The Joint United Nations Program on HIV/AIDS (UNAIDS) was established and mandated with the responsibility of coordinating the global effort following recognition that the epidemic is multisectoral in nature and as such required a multisectoral response. Evidence of the efficacy of Highly Active Antiretroviral Therapy (HAART) was also shown. In 1998 the first short-course regimen for preventing mother-to-child transmission was announced. In 1999, the first efficacy trial of a potential HIV vaccine in a developing country started in Thailand.

Additional to progress made by the international community in developing technical and scientific interventions, a lot of effort has been invested in mobilizing political commitment and funding at all levels under the leadership of the United Nations. As part of the international effort to advocate for improved political commitment, a United Nations Special Session of the General Assembly was convened in 2001 to deliberate on HIV and AIDS. Similarly, African heads of state and heads of government met in Abuja in 2001 and made a declaration which among other things called for political commitment in the fight against the pandemic. Efforts to mobilize resources at the international level have been very successful as exemplified by the establishment of the Global Fund from which many developing countries are

benefiting. Additional to contributions bilateral donors make to the Global Fund against tuberculosis, Malaria and AIDS: they also support regional and national programs directly. Funding of HIV and AIDS activities is also provided by private sources such as the private sector, Foundations and international civil society organizations from countries of the northern hemisphere . United Nations agencies have guided the global, regional and national response through provision of advocacy, technical and funding support where possible. Under the leadership of UNAIDS in September 2003, AIDS officials, bilateral and multilateral agencies, civil society organizations and the private sector agreed on the principle of the three ones which is applicable to all stakeholders in national level responses. The principle of the three ones calls upon all stakeholders to respond within the context of one agreed AIDS action framework, one national AIDS coordinating authority and one agreed country level monitoring and evaluation system (The three ones key principles, UNAIDS).

3.3 The regional response

While the Southern African Development Community (SADC) is host to 3.5% of the world's population, it accounts for 37% of the population of people who are living with HIV and AIDS which is approximately 11-18 million adults and children. It is also estimated that there are 5.5 million Orphans and Vulnerable Children who are aged 0-4 years in the region. The high number of OVCs is attributed to the heterosexual nature of the epidemic in the region which is estimated to account for 92% of HIV infections.

Given the observation that the epicentre of the epidemic is located in the southern region of Africa, a lot of regional activities have taken place as part of regional efforts to address the epidemic. At an official level, the response to HIV and AIDS has been declared a priority area of action and a standing agenda item in the SADC Summit meetings of Heads of State. Prior to the re-structuring of SADC which took place after the extraordinary meeting of the Summit in March 2001, HIV and AIDS activities were overseen by the Department of Health in South Africa, with the support of a regional Multisectoral Technical Committee on HIV and AIDS. In July 2004, Heads of States met in Maseru and made a declaration to track the epidemic in the region and support implementation of the regional strategic framework and program of action. The summit also outlined priority areas for the regional response. In November 2004, the SADC HIV and AIDS unit developed a five year strategic business plan which extends between the years 2005 - 2009. This plan is based on the 2003 - 2007 strategic framework and program of action. At the level of civil society organizations and the private sector, regional association such as the SADC AIDS Network of Nurses and Midwives (SANNAM), the Southern African Network of AIDS Service Organizations (SANASO), SAFAIDS, networks of people who are living with HIV and AIDS have been established. Bilateral and multilateral development partners are supporting regional and cross-border initiatives including research activities (SADC progress report 2000-2002, The SADC/EU project on HIV and AIDS).

3.4 The national response—historical overview

Short term plan period (1987 – 1988)—After the first HIV infected person was identified in the country in 1986 and the first AIDS case was subsequently reported in 1987, the Government of Swaziland initiated a national response to the epidemic through action of the then Ministry of Health with assistance of the Global Program on AIDS (GPA), an agency of the World Health Organization. Initially, the response was supervised by a National AIDS Committee (NAC) and facilitated by an AIDS Task Force (ATF). The NAC; a committee of Principal Secretaries, representatives of the Swaziland Medical and Dental Association, the private sector and non-governmental organizations; provided policy direction and oversight to the national

response while technical guidance was provided by the ATF. Membership of the ATF was primarily drawn from among health professionals. An Information, Education and Communication Action Group on AIDS was established in 1988 for the purpose of mounting a national public HIV and AIDS awareness campaign. Very early in the response, some civil society organizations initiated responses in support of government efforts. Among others, these included: Care International, Project Hope, the Traditional Healers Organization, Family Life Association of Swaziland, Baphalali Red Cross, Salvation Army, Save the Children Fund and the Women' Resource Centre.

As part of its activities, the AIDS Task Force designed and implemented a twelve months (1987-1988) plan which came to be commonly known as the Short-Term Plan (STP). Among its tasks, the STP sought to build national capacity to ensure blood safety, promote public HIV and AIDS awareness as well as safer sexual behaviour which promoted abstinence among children and young people, reduction of the number of sexual partners and condom use among sexually active persons. During this period, the program was primarily prevention-based. Achievements of the short term plan included the development of a national HIV testing capacity for both antibody and the western blot confirmation testing; introduction of mandatory screening of donated blood, mandatory reporting of AIDS cases and introduction of the in-school program. Challenges included high levels of denial based on the fact that during the HIV infection phase there were no visible signs of the epidemic and the perceptions that HIV infection was an external problem that affected only men who have sex with other men.

First Medium Term Plan period (1990 – 1992)—Subsequent to an external review and as an extension of the Short Term Plan, government prepared and implemented a first generation Medium Term Plan (MTPI). This plan extended over a period of three years (1990-1992). Additional to activities of the short term plan, the First Medium Term Plan was designed to determine the extent of HIV infection in the country; raise levels of HIV and AIDS awareness, promote safer sexual attitudes and practices; train health workers on HIV and AIDS, develop a national sexually transmitted disease prevention and treatment program, strengthen laboratory services and the Health Education Unit. During the First Medium Term Plan, the AIDS Task Force was transformed into the Swaziland National AIDS Program (SNAP); Project Hope was transformed into The AIDS Support Centre (TASC) and Care International into the School Health and Population Education program (SHAPE). In the first medium term planning period, the response continued to be prevention based with the addition of prevention of sexually transmitted diseases to the package of interventions. Achievement during the period included construction of substantive program offices in 1991 with funding from the Government of Canada; introduction of national HIV Sentinel Surveys and conducting of the first one in 1992. Denial persisted even during this period with members of the public demanding to be shown evidence of people who were suffering from AIDS.

Second Medium Term Plan period (1993 – 1996)—Subsequent to MTP I, the country developed and implemented a second medium term plan which extended over the period 1993 – 1996. MTP II was designed to address prevention of new infections, promotion of safer sexual practices, assurance of blood safety, promotion of universal precautions as well as reduction of the health and socio-economic impact of the epidemic. During the second medium term plan the national response package expanded to voluntary counselling and impact mitigation activities such as community home-based care, management of opportunistic infections and support groups reflecting maturation of the epidemic. Achievements during this period among other activities included: introduction of universal precautions, commission of a study on the socio-economic impact of the epidemic in the country by government with the

support of UNDP as an advocacy and planning tool; declaration of the epidemic a national disaster by His Excellency, the Right Honourable Prime Minister, Obed Dlamini in 1993; convening of a one-day Cabinet retreat on AIDS which took place in the then Protea Piggs Peak Hotel and was chaired by the Prime Minister; periodic briefing of Cabinet by SNAP on progress made by the response; creation of substantive posts for the AIDS program, establishing a dedicated government budget allocation to the AIDS program; establishment of voluntary counselling services by the Salvation Army and TASC; establishment of the Swaziland AIDS Support Organization (SASO) by TASC; initiation of the workplace-based program support by FLAS; increase in number of condoms being distributed and increase in HIV and AIDS related awareness. Denial persisted even among medical professionals who believed that the epidemic was made to look more serious than what it actually was. Behaviour change continued to be elusive and the epidemic continued to grow.

The pre-multisectoral plan period (1998 – 2000)—This period was guided by a plan which was known as the Strategic Planning Document. It extended over the period 1998-2000. The mission of the plan was to create an AIDS free nation through strengthening the expanded response to the epidemic, provision of support to people who are living with HIV and AIDS as well as to mobilize young people against HIV and AIDS. This period of the response was characterized by the establishment of the Crisis Management and Technical Committee. The response stagnated during this period because of inadequately articulated relationships between existing implementing agencies and the new structure. Otherwise achievements of this period included substantial increase of government funding to the national response reaching E13, 000, 000 in 1999; publication of the 1998 HIV and AIDS National Policy and development of the 2000 -2005 National HIV and AIDS Strategic Plan. During this period, growth of the epidemic appeared to be slowing down especially among young people aged 15 – 19 years and the age group, 15 – 24 years.

First National Multisectoral HIV and AIDS Strategic Plan (2000-2005)—In the middle of the Strategic Planning document of 1998-2000, His Majesty King Mswati III declared the epidemic a national disaster during opening of Parliament in 1999. Subsequently, a Cabinet Committee on HIV/AIDS and a Crisis Management and Technical Committee on HIV and AIDS under the office of the Deputy Prime Minister were formed in 1999. In September of the same year, the Crisis Management and Technical Committee developed the Swaziland National Strategic Plan 2000-2005. This plan which was reviewed reflected the first attempt by the country to transform the national response into a genuine multisectoral effort. The Crisis Management and Technical Committee was disbanded immediately after publication of the 2000-2005 National Strategic Plan and in its place the National Emergency Response Council on HIV and AIDS (NERCHA) together with its secretariat were established in 2001. During this period, the national response expanded in terms of available funding, the number and type of activities, beneficiaries, implementing partners and participating sectors. During this period, the Ministry of Health and Social Welfare also developed a strategic plan for the health sector response.

According to the report of the Joint Review of the National Response to HIV and AIDS in Swaziland, the national response has accomplished the following: establishment of NERCHA; assurance of a supply of safe blood; introduction of a program for preventing mother-to-child transmission of HIV; initiation of a public sector antiretroviral therapy program; establishment of sub-coordination structures; implementation of innovative impact mitigation activities; improvement of the food security situation for vulnerable people, especially orphans and vulnerable children; availability of micro credit schemes; mobilization of grass-root community structures to provide psychosocial support to orphans and vulnerable children; establishment of the monitoring and evaluation frame work. Similarly, the joint review noted the

following as challenges of the national response in Swaziland; unmet demand for safe blood; insufficient funding for a fully fledged free antiretroviral therapy program; inefficient systems for delivering antiretroviral therapy; limited antiretroviral therapy literacy; limited capacity of the health sector to implement national antiretroviral therapy; lack of national guidelines to facilitate identification, delivery and monitoring of orphans and vulnerable children; over-centralized and top down national response; weak link between monitoring and evaluation systems of partner institutions; limited funding for sentinel surveys.

3.5 The Second National Multisectoral HIV and AIDS Strategic Plan (2006-2008)

With the expiry of the 2000-2005 National Multisectoral Strategic Plan for HIV and AIDS at the end of 2005 and the continued spread of HIV infections in the country as well as the resultant social and economic impact, NERCHA commissioned a process for developing a successor plan which would provide guidance to the national response in the period extending between 2006 and 2008.

Recognizing the need for developing a successor plan, the National Emergency Response Council on HIV and AIDS put in place an institutional framework for supporting the development of new a national strategic plan. The framework constituted of a National Steering Committee, a Core Team and an office of the Process Administrator. The National Steering Committee was charged with the task of providing oversight to the process while the Core Team was tasked with the responsibility of planning and coordinating the process. The office of the Process Administrator was responsible for providing day-to-day support to the process. A team of external and internal consultants was commissioned to draft this document.

Development of this plan was based on findings of the joint review report, literature review, community focus group discussions as well as stakeholder and key informant interviews. Focus group discussions were conducted in all chiefdoms while stakeholder interviews were carried out among formations such as interest groupings, government and non-governmental entities as well as business establishments. Additional consultations with members of the public including one specifically for children and young people were conducted through radio and television call-in programs. Key informants interview were conducted with national leadership, opinion leaders and policy makers including Her Majesty the Queen Mother, His Excellency the Prime Minister, senior government officials, business leaders and representatives of international organizations amongst many others.

The work of consultants was supported by technical working groups in the different thematic areas of the strategic plan. Drafts were discussed first with technical working groups and subsequently with the Core Team, the National Steering Committee and stakeholders. Comments of the different interest groups were integrated into drafts before the final document was prepared and submitted to the National Steering Committee via the Core Team for adoption.

3.6 Key challenges and achievements

Key challenges are presented in chapter four under each thematic area as part of the sections on strategic issues.

Achievements of the Swaziland national response include the following:

- Universal HIV and AIDS related public awareness
- Introduction of mandatory screening of donated blood for HIV, Syphilis and Hepatitis B
- Reduced HIV prevalence and syphilis among blood donors

- Introduction of the HIV national sentinel surveillance system
- Declaration of the epidemic as a national disaster in 1993 and a national crisis in 1999
- Increased government funding to the national response from 1999
- Securing funding from the Global fund awards
- Introduction of a multisectoral national response
- Provision of a fund for supporting school fees for orphans and vulnerable children
- Introduction of a national antiretroviral therapy program
- Development of national guidelines in HTC, PMTCT, SRH, TB and HIV co-infection, Curriculum and national guidelines for HBC and STI protocols and ART
- Development of services in the areas of ART, HTC (23 sites), PMTCT (9 sites), HBC and Sexually transmitted infections
- Establishment of community initiatives such as *Indlunkhulu* and *KaGogo*, neighbourhood care points
- Introduction of a national monitoring and evaluation framework.

PART B: RESPONSE AGENDA

4 Strategic framework

4.1 Assumptions

The framework is built on the belief that involvement and participation of communities including special interest groups will be maximized, political leadership of the national response at the highest level will be enhanced, policies and legislation that are necessary for an effective national response will be put in place as matter of urgency, funding that is available to the response will increase, coordination of the national response will be decentralized both vertically and horizontally with the role of NERCHA being limited to institutional development, overall planning and program development, advocacy, resource mobilization, monitoring and evaluation as well as facilitation of HIV and AIDS related research, coordination of the health sector and capacity of the social welfare department be will be enhanced, capacity of the country to absorb available funding will be increased and gender, human rights and poverty alleviation will be central to all HIV and AIDS activities.

4.2 Risks

Failure to ensure that the assumptions which are described in 4.2 are put in place as part of this plan will undoubted compromise achievement of the vision and objectives of this the 2nd national multisectoral HIV and AIDS Strategic Plan 2006-2008

4.3 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.

4.4 Mission

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

4.5 General response guidelines

When planning for HIV and AIDS, responding agencies shall ensure that actions taken are: multisectoral; holistic; decentralized; evidence-based; targeted; adaptable; sustainable and driven by national and local leadership. Similarly, considerations shall be given to the concept of learning by doing, equitable distribution of services and resources; local and skills focused capacity building; respect for human rights and the dignity of human life; meaningful involvement, participation and ownership of the response by PLWHA and communities, as well as sensitivity to gender, age and disability; respect for positive cultural values and practices; adherence to ratified

international, regional and national instruments; good governance; appropriate partnership; and operations research

5 Thematic area: prevention

Goal: To reduce the number of new HIV infections.

This section presents the prevention thematic area outlining the overall goal, and sub-thematic areas with respective strategic issues, objectives, strategies and core indicators covering behaviour change communication, blood safety, prevention of mother-to-child transmission, prevention of HIV and AIDS at the work place, condom logistics, promotion and management, prevention and management of STI, post-exposure prophylaxis and universal precautions, and HIV/AIDS Testing and Counselling. It will focus more on community based interventions with emphasis on individual and community responsibility. The urgency of the epidemic must be understood by the individuals and communities in order to reduce their risk and vulnerability to HIV and to deal with the stigma, fear and discrimination.

5.1 Behaviour change communication

Strategic issues

In terms of behaviour change in general seven strategic issues are identified:

Insufficient behaviour change—The change of sexual and reproductive health behaviour is one of the key factors in reducing the transmission of HIV. Behaviour change is precipitated by adequate and accurate information. Although it has been found that different behaviour change communication (BCC) approaches have been used and HIV and AIDS awareness is high in Swaziland; they are not being translated into wide behaviour change (BSS 2002). Advocacy is not adequate yet it should be promoted in order to ensure that policy makers and opinion leaders approach the epidemic seriously. The role of families in instilling moral values around acceptable moral behaviour of their children has been found to be generally weak.

Limited coverage of BCC—There is an omission of BCC strategies that address special groups like people with disabilities. It has also been reported that HIV and AIDS information does not reach all communities, particularly the tigodzi level (sub-chiefdoms). Similarly, it has been observed that there is general lack of involvement and participation of communities in the development of IEC (BCC) materials. Media participation in the national response to HIV and AIDS is inadequate, yet research has for example indicated the radio to be highly cited as a source of HIV and AIDS information (BSS 2002).

Limited comprehensiveness and utilization of BCC—Current utilization of ABC and/or BCC models does not seem to be comprehensive, intensive, consistent, extended and effective enough to facilitate the expected change of behaviour. There is also no capacity to use other methodologies for delivery of behaviour change communication.

Lack of information on drivers of the epidemic—In addition, there is lack of information about drivers of the pandemic and the role of socio-cultural factors in the transmission and prevention of HIV infections in the country including information on sexual transmission patterns. One of the drivers is the report that some people who know their HIV positive status continue to engage in unprotected sex, with a possibility of infecting others. Other reported drivers include denial of the existence of the epidemic, prostitution, promiscuity, poverty, unfaithfulness, multiple sexual partners, gender-based violence, high mobility of the population and some socio-cultural practices such as wife inheritance (*kungenwa*).

Uncoordinated IEC production—Furthermore, coordination of the production of IEC materials by different organizations is lacking. Studies to ascertain utilization and acceptability of the IEC materials are wanting.

False claims of cure—In addition, the false claims of AIDS management and cure by some sectors like the traditional and faith healers and vendors prevent people/communities from accessing appropriate prevention interventions.

Alcohol and substance abuse—Consultations particularly at the chiefdom level cited alcohol as one of the high drivers of the HIV epidemic. The consultations revealed that consumption of alcohol leads to engagement in risky behaviour including indulging in multiple and unprotected sexual intercourse. A study by the MOHSW on substance abuse assessment in Swaziland (2002) revealed that the leading substance abuse is alcohol (60%) and the majority of alcohol users are within the age group of 20-29(28%). Forty-five percent (45%) of the respondents indicated that they commenced alcohol consumption between the ages of 10-19 years and that problems which could result from substance abuse are diseases which include HIV and AIDS.

In terms of behaviour development and modification among children and young people five strategic issues are identified:

Limited coverage of HIV and AIDS based life skills education—There are attempts in providing HIV information including life skills education in the country's education system. The school HIV and AIDS program is one of the oldest components of the national response, having been initiated by Care International in 1991 and passed on to School HIV and AIDS and Population Education (SHAPE). However, coverage of the school program is limited, given that some schools do not have career guidance teachers or administration support for HIV initiatives. HIV and AIDS issues have been integrated into the primary and high school curricula. The process of integrating issues at pre-school and tertiary levels is on-going.

Protective nature of being in school—Although NERCHA, in collaboration with the stakeholders has developed a menu of youth activities, interventions targeting out of school youth and younger children are insufficient and ad hoc. Gender and human rights dimensions are not integrated into the school curricula and in out of school youths HIV initiatives. It has been observed that a minority (30%) of in-school youth is sexually active indicating that keeping children in school is to some extent protective while on the other hand the majority (70%) of out-of-school youth is sexually active. Being out of school increases the likelihood of young people to engage in sexual activities.

Early sexual debut—Age at first sexual experience is low (15 -16.3 years) compared to what it is 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.

Factors preventing young people to access sexual and reproductive health— Factors that might be influencing the risk of young people to engage in sex in the country include lack of role models among adults due to a general decline of sound moral and sexual values, lack of communication between parents and children, idleness due to lack of recreation and sporting facilities as well as lack of job opportunities. The risk of acquiring HIV infection is also driven by trans-generational sexual relationships; sexual abuse including incest, sodomy and rape of children as well as the belief that engaging in sexual intercourse with a virgin cleanses HIV infection. While attempts are being made to educate all children and youth in the country, some young people and parents claim that sexual and reproductive health education, including HIV prevention encourages young people to engage in early

sex. In addition, youth-unfriendly services prevent young people from accessing sexual and reproductive health information including HIV and AIDS. Furthermore, it is believed that many youth programs do not sufficiently involve young people in development and implementation of activities that target them.

Limited positive family and community influence on the behaviour of children—Family members have been cited by a variety of consultations as very vital in development and change of behaviour of children and young people if HIV prevention is to be meaningful. It is believed that families and communities no longer effectively play the expected functions of caring, rearing and protecting children and young people in this country. Some of the HIV risk behaviours such as incest and rape are believed to be commonly perpetrated by family and community members. Reported cases are sometimes not handled properly.

Objectives

Objective 1: To reduce the proportion of sexually active persons who have sex with more than one sexual partner by 25% by 2008.

Objective 2: To reduce the proportion of in-school youth who are sexually active from 30% in 2005 to 20% by 2008.

Objective 3: To reduce the proportion of youth-of-out school youth who are sexually active from 70% in 2002 to 50% by 2008.

Strategies

- Expansion, intensification and promotion of a variety of complementary prevention approaches including community mobilization, family involvement, innovative and effective behaviour change models and public education campaigns that emphasize delayed initiation of sexual activity among children and young people, secondary virginity and reduction of multiple, concurrent and serial sexual partnerships.
- Creation of a conducive social, cultural, legal and economic environment for compulsory primary education and compulsory education for all school-going age children.
- Strengthening of programs that promote the reduction of idleness and those that facilitate livelihood among children and young people especially those who are out-of-school.
- Creation of a social, cultural, legal and economic environment in which individuals including women and children are empowered to reduce personal vulnerability to HIV transmission and prevent relapse into risky sexual behaviour.
- Regeneration of strong moral values and promotion of HIV and AIDS based life skills education among children and young people including tertiary education students which are supported by parents/guardians, the school system and communities.
- Promotion of emerging evidence based prevention strategies such as male circumcision, vaccination against HIV infection and microbicides.
- Creation of a social, legal, political and economic environment for facilitation of the reduction of stigmatization and discrimination and empowerment of people who are living with HIV and AIDS to contribute to HIV prevention.

- Strengthening and promotion of programs that address both HIV vulnerability and risk factors among special groups such as commercial sex workers, mobile population including migrant workers and their sexual partners, inmates, and people with disabilities.
- Initiation of a national program for the improvement of family life including enhanced communication between parents and children as well as between sexual partners.
- Improvement of the capacity of all health facilities in public and private sectors to deliver child and youth friendly sexual and reproductive health services.
- Promotion of peer driven interventions especially for children, youth and workers as well as men and women.
- Reduction of risky sexual behaviour related to substance abuse (alcohol).

Core indicators

- Percentage of sexually active persons who have sex with more than one sexual partner in the last twelve months (disaggregated by age groups).
- Percentage of persons who both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission (disaggregated by age groups and sex).
- Median and average age of sex debut.
- Percentage of schools with at least one teacher who has been trained in participatory life skills based HIV and AIDS education and who has taught it during the last academic year.
- Number of young people exposed to life skills-based HIV and AIDS education in the last 12 months (disaggregated by in-school youth/ out- of-school youth).
- Number of HIV and AIDS radio /television programs /newspapers produced and distributed in the last 12 months.
- Number of trained active peer educators in the last 12 months.
- A composite of safe sexual behaviour among young people.
- Percentage of young people who had sex before the age of 15.
- National index on policy related to young people and HIV and AIDS.
- Number of IEC material printed and distributed in the last 12months.

5.2 Blood safety

Strategic issues

Decline of HIV transmission through blood transfusion—Transfusion with contaminated blood is an extremely efficient way of transmitting HIV infection. However, the incidence of this type of transmission has declined and accounts for 5 to10% of all cumulative infections worldwide (WHO 2002). The decline is due to mandatory screening of blood, use of low-risk donors and promotion of appropriate clinical use of donated blood. A lot has been done in the country to improve the safety of donated blood. Since 1987, the country screens all donated blood for HIV1 & 2; syphilis and hepatitis B. As a result of improved blood donor selection procedures, HIV prevalence among blood donors has declined from 6.1% in 1993 to 1.84% in 2004. Similarly the prevalence of syphilis in the population has declined from 2.0% in 1993 to 0.05% in 2004. Blood safety in the country is enhanced by the fact that the country uses antigen screening which allows for detection of HIV

infection in the window period rendering, blood transfusions even safer than when anti-body screening is done.

Shortage of safe donated blood—Due to the high prevalence of HIV infection in the country, the potential population of safe blood donors has declined resulting in shortage of donated blood. To counter the loss of adult safe blood donors, the blood transfusion service now collects most donated blood from school children who are aged 15 to 19 years. It is estimated that the country currently collects approximately 6,000 blood units instead of the required 10, 000 blood units annually. In addition, the Swaziland National Blood Transfusion Service lacks adequate capacity to collect the blood from all regions of the country simultaneously in a year. The Baphalali Swaziland Red Cross Society which assisted in the collection of blood stopped this activity due to lack of funds.

Lack of human resource capacity and appropriate infrastructure—Development of the blood transfusion service in the country is compromised by the delay to adopt the National Blood Transfusion Policy and national guidelines for the rational use of blood. Other challenges include the National Blood Transfusion Service (NBTS) being centralized and sharing its annual budget and management with the Central Public Health Laboratory, resulting in inadequate funding for the transfusion service and unwarranted delays in procurement and delivery of blood transfusion related supplies. The transfusion service also lacks sufficient human resource capacity and appropriate infrastructure to ensure continuous cold chain maintenance from the blood bank to the recipient.

Objectives

Objective 4: To reduce HIV prevalence among blood donors from 2% in 2004 to 0.5% by 2008.

Objective 5: To increase the number of donated blood units which are collected per year from 6, 000 in 2004 to 10,000 in 2008.

Objective 6: To increase the availability of 100% safe blood and blood products for transfusion in the country by 2008.

Strategies

- Creation of an enabling environment for the appropriate management of blood transfusions.
- Development of sufficient national capacity to collect, screen and store adequate donated blood for transfusion.
- Popularization of a culture of donating blood among young people.

Core indicators

- Percentage of donated blood units that were HIV positive in the last 12 months.
- Percentage of blood units transfused during the last 12 months that have been adequately screened for HIV according to national or WHO guidelines.
- Percentage of patients requiring blood transfusion services within the last 12 months that was met.

5.3 Prevention of mother to child transmission (PMTCT)

Strategic issues

Reversal of child survival gains—Progress in child survival is being reversed by the HIV and AIDS epidemic in the country. This is evidenced by the increasing morbidity and mortality rates of infants and young children under the age of five (5) years. HIV and AIDS among infants has become a problem as the majority of HIV infections in this group are attributed to mother to child HIV transmission. Mother-to-child transmission is responsible for the majority (95%) of HIV infection among children, and occurs during pregnancy, labour and delivery and during breastfeeding. Without interventions, mother-to-child transmission ranges from 15% to 30% without breast feeding and 30% to 45% with prolonged breast feeding. It was estimated that of all the children who died in 1999 in Swaziland, 25% of the deaths were due to AIDS (UNAIDS Report on Global AIDS Epidemic, Walker et al, 2002).

Existence of opportunities for PMTCT—Prevention of mother to child transmission services are integrated in the MCH settings. Given that almost all (93%) pregnant women attend antenatal clinic services at least once; this presents a real opportunity for implementation of PMTCT. In addition, the availability of antiretroviral drugs provides an opportunity to offer women, children and their families identified through the PMTCT program, the needed care and support (PMTCT plus).The referral between PMTCT and care, support treatment services is currently limited.

Gender disparity—Lack of empowerment of women (abuse of power by men over women) and stigmatization of HIV and AIDS presents a challenge for implementation of a successful PMTCT program. Gender disparities make it difficulty for women to negotiate the use of safer sexual measures, prevent unwanted pregnancies as a result of a positive HIV status and to decide on the choice of infant feeding. Furthermore, some women are poor and cannot afford purchasing artificial feeding formulas.

Inadequate national capacity to implement PMTCT—Although PMTCT is being implemented in the country and national PMTC guidelines are available, it should be noted that there is currently no national PMTCT policy. Coverage of the service is limited and available guidelines are not comprehensive in that they lack mechanisms for follow-up of program clients and requirement for community support structures. It has also been indicated that Maternal Child Health facilities in the country lack human resource and infrastructural capacity for implementation of the PMTCT services. Not all relevant health care workers have received orientation on PMTCT.

Insufficient public awareness and heath education on PMTCT—The public is also not mobilized for PMTCT services. As a result, PMTCT-related public awareness is low. Despite the substantially high prevalence levels in the country, evidence shows that antenatal clinic services lack sufficient HIV and AIDS related education. According to an unpublished study report by a partnership of MOHSW, EGPAF, AED and AMICAALL, it was indicated that only 13% of the surveyed mothers in 2004 reported receiving health talks on PMTCT while 51% and 53% respectively, reported receiving talks on HIV transmission and HIV prevention. The study further points out that 27% did not know what a woman could do to reduce the risk of transmitting HIV to their babies during pregnancy and 4% indicated that nothing can be done.

Objectives

Objective 7: To reduce the proportion of children (0-4 years) who are HIV positive by 30% by 2008.

Strategies

- Expansion and intensification of primary HIV prevention among men and child-bearing women.

- Creation of an enabling environment for the up-scaling, provision and support of PMTCT services including access to HIV testing and counselling by pregnant women and partners, comprehensive reproductive health services, laboratory services and antiretroviral prophylaxis.

Core indicators

- Percentage of HIV infected infants born to HIV positive mothers.
- Percentage of HIV positive pregnant women receiving a course of ARV prophylaxis to reduce MTCT in accordance with nationally approved protocol in the last 12 months (disaggregated by age and region).
- Percentage of facilities offering the minimum package for preventing HIV transmission in infants and young children which have specific written guidelines on how to make referrals to facilities offering long term care and support services (disaggregated by region and type of facility).
- Percentage of pregnant women making at least one ANC visit who have received an HIV test result and post test counselling.

5.4 Prevention of HIV and AIDS in the workplace

Strategic issues

Negative consequences of the AIDS epidemic to the workplace—HIV and AIDS cause illness, disability and death to employees and employers, leading to severe economic and emotional distress of the workplace employees and their families. It also decreases productivity as workers may be absent due to illness or to care for their sick relatives. The employers are faced with the burden of health care, death benefits, pension and other related costs. The formal and informal business sectors are equally hit by the consequences of the HIV and AIDS epidemic, resulting in negative consequences on the human resources and productivity.

Limited availability of workplace policies and programs—Some workplaces have no HIV and AIDS programs. There is no national HIV and AIDS policy to guide institutional and organizational workplace policies and programs. While a number of big companies have put in place HIV and AIDS policies, most especially small to medium sized businesses and the informal sector have not. There is also lack of focus on domestic workers who were reported to sometimes experience sexual harassment within their work places. Similarly, some workplaces that have a potential for occupational exposure do not have substantive programs.

Stigmatization and discrimination—The existence of stigmatization and discrimination coupled with lack of codes of conduct and interpersonal communication on HIV and AIDS makes the implementation of workplace HIV and AIDS programs more challenging. Spousal separation due to work deployment creates an opportunity for HIV transmission through extra marital affairs. The limitation of most workplace programs is that they tend to focus on the index employees excluding sexual partners, the family in general and their communities. There is also lack of corporate social responsibility. Collective efforts in the fight against HIV demand the involvement of organized labour in the world of work which is currently lacking.

Objectives

Objective 8: To increase the proportion of sexually active employees who use condoms consistently by 25% by 2008.

Objective 9: To reduce the proportion of sexually active employees who have sex with more than one sexual partner by 30% by 2008.

Objective 10: To reduce the proportion of employees who have experienced workplace-based sexual abuse by 50% by 2008.

Strategies

- Development of an enabling environment for implementation of HIV and AIDS workplace programs.
- Expansion of the HIV and AIDS workplace programs to include all categories of workplaces inclusive of the informal sector, small to medium scale and big business as well as families and communities of employees.
- Promotion of public-private partnerships in the provision of low cost affordable housing for their employees especially in industrial estates.
- Introduction of a national program that addresses the vulnerability and risk of domestic workers to HIV infection.

Core indicators

- Percentage of large enterprises/companies which have HIV and AIDS workplace policies and programs (disaggregated by type of enterprise, public or private sector).
- Percentage of work place policies that address stigma and discrimination.
- Percentage of work places that provide affordable housing for their employees.
- Number of employees that have participated in or benefited from HIV and AIDS workplace programs in the last 12 months.

5.5 Condom logistics, promotion and management

Strategic issues

Differential availability and affordability of male versus female condoms— Promotion of male condoms has been an integral part of prevention since the beginning of the national HIV and AIDS response in this country. The numbers of male condoms that are distributed in the country annually have increased over the years. While a total of 1,275,000 male condoms were distributed in 2000, six million two hundred and eighty six thousand eight hundred (6, 286, 800) were distributed in 2004. Despite the increased distribution of female condoms over the years, their availability is substantially lower than that of male condoms. In 2000, a total of 10, 366 female condoms were distributed compared to 19,966 in 2004. The cost of female condoms is also comparatively much higher than the cost of male condoms.

Limited availability and accessibility of condoms—In general, availability and accessibility of condoms is limited by being mostly available through traditional outlets like health facilities and office toilets which have time restrictions. Some of these traditional outlets are unfriendly to young people. Some big establishments like hotels do not provide condoms in their toilets or rooms.

Low condom use—Despite the observed increase in the number of condoms that are distributed annually, there seems to be low condom use as demonstrated by the extent of unwanted pregnancies and the increasing prevalence of HIV infection. Though the BSS (2002) pointed out that knowledge of condoms was high among adolescents the condom use was noticeably low. While most condoms are

distributed free of charge, some are distributed through commercial outlets with the support of social marketing. The Government logistics and distribution unit does not have a specific marketing strategy.

Conflicting views and messages on the promotion of condom use including sexually active children—Condoms are generally not accepted, especially by traditionalists and the religious establishment who sometimes issue negative statements about condoms. Such conflicting messages about condoms confuse the public and hinder their wide acceptability and use. Myths, misconceptions and concern related to quality issues fuel unacceptability of the condoms. Consistent condom use is also compromised by the advent of antiretroviral therapy which is confused as a substitute for condom use. The higher charge for engaging in unprotected sex by commercial sex workers increases non-condom use and possible exposure to HIV transmission. There are also conflicting views on the promotion of condom use among sexually active children and young people, inmates and on sexual practices that are considered to be illegal and immoral such as commercial sex work, homosexuality and lesbianism. This situation is made more complex by lack of a national condom policy.

Objectives

Objective 11: To increase the number of available male condoms from 6,286, 800 in 2004 to 10,000,000 by 2008.

Objective 12: To increase the number of available female condoms from 19,966 in 2004 to 80,000 by 2008.

Objective 13: To increase the proportion of sexually active persons who use condoms consistently by 25% in 2008.

Objective 14: To increase the number of new condom outlets per region by 200 by 2008.

Strategy

- Strengthening national capacity to ensure that good quality male and female condoms are available, accessible, acceptable, and affordable as well as used.

Core indicators

- Number of male and female condoms distributed to end-users in the last 12 months (disaggregated by region and type of health facility).
- Percentage of randomly selected retail outlets and service delivery points that have condoms in stock at the time of a survey, of all retail outlets and service delivery points selected for survey (disaggregated by region and health facility).
- Percentage of condoms in central stock and in retail outlets that meet WHO quality specification (disaggregated by type of distribution point).
- Percentage of adults who are in favour of young people being educated about the use of condoms in order to prevent HIV and STI infection.
- Percentage of young people aged 15-24 reporting the use of a condom at last sex with a non-marital, non-cohabiting sexual partner in the last 12 months.

5.6 Prevention and management of sexually transmitted infections

Strategic issues[1]

Increase of HIV transmission in STI—Untreated sexually transmitted infections (STIs) increase the risk of HIV transmission in the event of unprotected sex, thus prevention, proper diagnosis, and treatment of sexually transmitted infections are an essential component of an effective preventive strategy (UNAIDS 2004).

Changing profile of sexually transmitted infections in the country—Sexually transmitted infections are common in the country and are a major cause of morbidity among Swazis aged 15 to 49 years. A biological sentinel surveillance study of sexually transmitted infections among antenatal clinic clients that was conducted in 2003 in two clinics indicated that the level of sexually transmitted infections is epidemic. Common infections include gonorrhoea (7.8%); Chlamydia (18.2%); syphilis (7.8%) and trichomonas infection (21.9%). According to a study of the aetiology of genital ulcerative diseases which was conducted by HAPAC in 2005, chancroid which was the most common cause of genital ulcers has declined from 40% in 1980 to less than 1% in 2004 compared to genital herpes which has increased from 12% in 1980 to almost 60% of all genital ulcers in 2004. The increase in genital herpes is possibly due to HIV infection while the decline of chancroid maybe attributed to improved management of sexually transmitted infections in the country. The study also observed a decline in the prevalence of syphilis between 1980 and 2004. Sexually transmitted infections also increase the risk of HIV transmission, evident in that the prevalence of HIV infection among patients with sexually transmitted infections is higher than that found among pregnant women who attend antenatal clinic services. While HIV prevalence was 11.1% in 1992 and 47.6% in 1998 among patients with sexually transmitted infection, it was 3.9% in 1992 and 31.6% in 1998 among pregnant women. Syphilis which had declined from 11.6% in 1994 to 4.2% in 2002 among pregnant women who attended antenatal services increased in 2004 to 8.1%.

Inadequate targeting of IEC activities and the high attrition rate of health workers—It has been indicated that IEC activities for different target groups and the application of syndromic management by clinicians is inadequate. The high attrition rate of clinicians, particularly nurses who have been trained in syndromic management, results in loss of human resource skills. According to a study that was carried out by HAPAC in 2003, fifty percent (50%) of sexually transmitted infection clients were not appropriately managed by health care professionals. Moreover, there is insufficient training and participation of private and informal STI care providers.

Limited capacity of clinical laboratories to support STI management and poor supervision of STI care providers—There is also shortage of clinical laboratory capacity to adequately support sexually transmitted infection diagnoses and management. Management of sexually transmitted infections is also compromised by poor supervision of STI care providers, occasional drug stock-outs and lack of sufficient equipment and supplies for syphilis tests.

Poor targeting of high risk populations and weak HIV monitoring and evaluation—In addition, the targeting of high risk populations including commercial sex workers, long distance drivers and sexual partners of clients who have been diagnosed with sexually transmitted infections is weak. Thus there is poor partner

[1] Note: for the purposes of this thematic area, HIV is not included as an STI.

notification and no active contact tracing. Furthermore, sexually transmitted infection monitoring and evaluation as well as surveillance systems are weak.

Objective

Objective 15: To reduce the prevalence of sexually transmitted infections by 20% by 2008.

Strategies

- Strengthening of behaviour change communication for sexually transmitted infection.
- Improvement of national capacity to provide quality STI services.
- Strengthening of partner notification and establishment of active contact-tracing system.
- Strengthening of health management information system to include sexually transmitted infection.

Core indicators

- Percentage of patients with sexually transmitted infections, who are appropriately diagnosed, treated and counselled at health care facilities (disaggregated by age and sex).
- Percentage of health facilities providing STI care that report no stock-outs of STI drugs of more than one week in the last 12 months (disaggregated by type of facility).
- Number of health workers trained on syndromic management of sexually transmitted infections according to national guidelines in the last twelve months (disaggregated by age, sex and region).
- Percentage of STI clients who were HIV positive in the last 12 months.
- Syphilis prevalence amongst pregnant women (disaggregated by location, age and region).
- Number of STI cases diagnosed in the last 12 months.
- Percentage of STI clients who were HIV positive in the last 12 months.
- Percentage of pregnant women testing positive for syphilis during sentinel surveillance at ante natal clinics.
- Percentage of persons aged 15-49 years who know two or more symptoms of STI.
- Number of young people that have accessed reproductive health services in the last 12 months (disaggregated by type of service).

5.7 Post exposure prophylaxis (PEP) and universal precautions

Strategic issues

Low awareness of accidental exposure to HIV—Prevention of accidentally acquired HIV in and out of health facilities is a new area of HIV intervention and therefore generally weak. PEP was formally launched in July 2005. There has not been a well articulated PEP strategy in the past. It would appear that awareness of HIV transmission risks in both health and non-health settings through contaminated instruments and bio-hazardous waste materials as well as through traditional practices such scarification is low.

Insufficient availability of protective materials—Currently, PEP services are not widely available: they are restricted to a few specialized health facilities. There is also no systematic national effort to educate as well as provide workers who are at risk with appropriate protective materials and equipment on a sustained basis.

Limited sensitization and availability of PEP services—In addition, the public, health care workers, police and fire brigades are not well sensitized about this PEP. Not all health facilities have technical and systems capacity to provide PEP, infection prevention and control as well as waste management programs. It has been indicated that in some cases even when services are available, health care workers are reluctant to utilize PEP services because of the requirement to undergo HIV/AIDS Testing and Counselling services. While there is an increase in the number of reported rape cases in the country, both survivors and the police are generally unaware of the PEP. Consequently the service is not available to rape survivors. There is also an indication that hairdressing salons have a real risk for HIV transmission yet there is no national effort to build the capacity of hair dressing salons to address HIV and AIDS issues that arise from their service.

Objectives

Objective 16: To increase to 100% by 2008 the proportion of high risk occupational service areas that have PEP and universal precaution interventions.

Objective 17: To increase to 100% by 2008 the number of persons reported to have been raped or exposed to incest who receive PEP services.

Objective 18: To ensure that by 2008, all (100%) persons who have experienced occupational related accidental exposure receive PEP services.

Strategies

- Strengthening of national and institutional capacity to provide quality PEP services.
- Improvement of availability and accessibility of PEP equipment, materials and supplies.
- Intensifying of PEP and universal precaution awareness among members of the public and populations at risk of accidental exposure to HIV infection.
- Strengthening of health management information system for PEP.
- Strengthening of psychosocial support for people who are considering or have tested for HIV infection at facility and community levels.

Core indicators

- Percentage of health facilities with adequate sterilization capacity, protective materials and antiseptic/disinfectants in stock.
- Number of health workers, police service personnel and fire brigade personnel that have been trained on PEP in the last 12 months.
- Percentage of health facilities that have guidelines for universal precautions in place.
- Number of eligible persons that have undergone PEP treatment in the last 12 months.
- Percentage of health facilities with PEP services

- Percentage of health care facilities that have guidelines to prevent nosocomial transmission of HIV, adequate sterilization procedures and surgical gloves in stock.

5.8 HIV/AIDS testing and counselling

Strategic issues

HTC[2] as a decision making tool in HIV prevention—HIV/AIDS testing and counselling (HTC) is a major element in dealing with the HIV and AIDS epidemic as potentially powerful intervention for the benefit of both the HIV infected and the uninfected. HTC serves as an entry point for prevention and care, support and treatment programs. Knowledge of HIV status is a pre-requisite for making informed decisions on behaviour change issues. This knowledge can be a motivating factor for both HIV positive and HIV negative people to practice safe sexual behaviour and decide whether or not they should have children or seek measures to prevent mother-to-child transmission of HIV.

Inadequate HTC coverage and accessibility—Swaziland provides facility-based and mobile HTC services that are guided by national guidelines for HIV/AIDS Testing and Counselling which were developed in 2002. However their coverage is inadequate and as a result, many HTC centres have long queues of clients, including those who are already very sick. Counsellors are overloaded and the quality of counselling may be compromised in the process. In addition, other deterrents for accessing HTC services include long waiting time and long travel distances to HTC centres. In 2004 there were 20 HTC sites nationally with an expected 10 more to be implemented before year 2006. Unfortunately, most HTC services are located in major urban areas and thereby not accessible to rural and small town communities. The majority of people in the country has not undergone HIV testing and do not know their status. It is estimated that less than 20% of people in the country know their HIV status. UNAIDS (2004) has also noted that many countries have relatively low numbers of people who know their HIV status (approximately 5% of the world's population).

Scaling-up of HTC services—Swaziland is signatory to the United Nations Declaration of Commitment to the rapid scaling-up of HTC services in general. New approaches to scaling-up of HTC have been piloted in Africa and include facility-based HTC, community based (door to door) HTC, and mobile HTC units and rapid testing. However scaling-up of testing requires scaling-up of post-test services especially on-going counselling, including couple counselling. Lack of couple counselling can lead to violence in the home and dissolution of family structures and separation of family members.

Client Initiated HTC and confidentiality—The voluntary aspect of HTC and confidentiality are a bone of contention as some people still maintain the importance of confidentiality while others suggest compulsory testing and disclosure of HIV positive status since some people continue with unprotected sexual relations even if they know that they are HIV infected. On the other hand others emphasize the need for shared confidential and beneficial disclosure of the status. Stigmatization, discrimination and denial still hinder access to HTC services in the country.

[2] HIV/AIDS Testing and Counselling (HTC) refers to both the client initiated (VCT) and provider initiated testing.

Objectives

Objective 19: To ensure that by 2008, one hundred percent (100%) of people who have been tested for HIV received pre- and post-HIV test counselling.

Objective 20: To increase to 40% by 2008 the proportion of adults (15-49 years of age) who have ever tested for HIV.

Objective 21: To increase to 30% by 2008 the proportion of adults (15-49 years of age) who know their HIV status.

Strategies

- Strengthening of national capacity to provide country expanded facility and community based quality and confidential HIV testing and counselling services according to the specified national guidelines.
- Strengthening of human rights protection and reduction of stigma and discrimination in facilities and communities.
- Articulation of a national system to support and supervise counsellors.
- Strengthening of facility and community based psychosocial support capacity for people who are considering or have been tested for HIV infection.

Core indicators

- Percentage of HTC counsellors who have received support counselling themselves in the last 12 months (by region)
- Number and percentage of the general population receiving an HIV test, the results, and post-test counselling in the last 12 months (disaggregated by age, sex and region)
- Percentage of health facilities with at least one operational counselling and testing site (disaggregated by level and type of health facility)
- Percentage of health facilities that have the capacity and conditions to provide basic HIV testing and counselling.

6 Thematic area: care, support and treatment

Goal: To reduce morbidity and mortality due to HIV and AIDS.

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 testing and counselling, Community Home-Based Care, palliative care, traditional and alternative care therapies.

6.1 Antiretroviral therapy

Strategic issues

Demand for Antiretroviral therapy—According to the 2004 Report on the global AIDS epidemic, by the end of 2003, Swaziland had an estimated total of 220, 000 people who were living with HIV infection inclusive of 200,000 adults of 15-49 years and 20,000 children of 0-14 years. Of the 200, 000 adults 110,000 were women. Deaths due to AIDS related infections were estimated to be between 13, 000 and 23,000. Given the high number of people who are living with HIV infection in the country, the demand for antiretroviral therapy is expected to exceed current national capacity to provide the service to all those who will require it especially given that the country lacks the human resource capacity and infrastructure to support further scale-up of comprehensive and quality antiretroviral therapy services. Sustainability of future funding for antiretroviral therapy is not guaranteed

Antiretroviral therapy in the country was launched in December 2003 by the Ministry of Health and Social Welfare, guided by the Health Sector Response to HIV and AIDS plan 2003-2005. Currently, the World Health Organization and UNAIDS estimate that there were about 36,500 people needing antiretroviral therapy in Swaziland. Before the introduction of the World Health Organization strategy of 'treating 3 million people by the year 2005 (3x 5 initiative) only 200 people were on antiretroviral therapy, mainly offered by the private sector (before the national guidelines were even developed). Generally at the time antiretroviral therapy was inaccessible to public sector patients. By June 2005, more than 10,000 patients had enrolled in the national antiretroviral therapy program. There are plans to increase this figure to 13,000 (covering 50% of eligible PLWHA) before the end of 2005; this number will increase by approximately 13,000 every year.

Limited capacity to provide antiretroviral therapy services—Antiretroviral therapy is provided by six public hospitals, five health care centres, and the private sector (The Swaziland Baphalali Red Cross Society Sigombeni clinic, South African Pulp Industry (SAPPI), Manzini Health Care and The Royal Swazi Sugar Clinics). According to the joint review, the majority (60%) of private sector clients were men whereas the majority (60%) of women were using public and mission based antiretroviral therapy services. Despite the facility-based distribution of antiretroviral therapy recipients, there is generally a high demand for the service against limited national capacity to provide it. Antiretroviral therapy services in the country are generally located in urban areas and patients have to travel long distances for services. Consequently, clients are forced to come very early and wait in long queues. This has negative implications for the quality of services.

Antiretroviral services are predominantly for adults and there is insufficient focus on paediatric antiretroviral therapy yet infant mortality and child mortality is believed to

have increased respectively from 78 per 1000 and 106 per 1000 in 1997 to 108.95 per 1,000 and 142-150 per 1,000 in 2003 as a result of HIV and AIDS indicating the reality of vertical transmission of HIV in the country. There are no national clinical guidelines for managing children who have been diagnosed as HIV positive, yet children living with HIV and AIDS require special care, support and treatment with regard to adherence to treatment, management of long term side effects, HIV testing and counselling logistics, nutritional needs and psychosocial support for the affected parents/care givers.

Inadequate capacity to provide support services—Laboratories in the six public hospitals offering antiretroviral therapy services have been strengthened. Currently in the public hospitals there are 24 laboratory technologists and 20 assistants. This number of trained laboratory practitioners is grossly inadequate for present and projected needs for antiretroviral therapy services. While new equipment has been commissioned, staffing remains a challenge. According to the joint review the additional workload due to antiretroviral therapy services creates the need for additional laboratory technicians. In order to improve and maintain good quality work, it is important that all laboratories supporting antiretroviral therapy centres in the monitoring of antiretroviral therapy patients put in place an external quality assurance system. In addition, it is necessary to establish a supervisory system for other laboratories by the National Referral Laboratory. It is important to note that the country has no capacity for conducting viral load tests. Under the national antiretroviral therapy program, antiretroviral drugs and medicines are available free. Antiretroviral therapy drugs and medical supplies are managed by the Central Medical Stores which is also facing human and infrastructural constraints. The national information management system for antiretroviral therapy is weak and yet crucial for clinical management, good follow-up and client adherence; currently, the defaulter rate is estimated to be 7%.

Inadequate human resource capacity—The delivery of antiretroviral therapy is putting a strain on the health workforce; according to the joint review when antiretroviral therapy was launched in December 2003, there were 56 nurses trained in antiretroviral therapy and two full-time antiretroviral therapy medical officers employed by the Ministry of Health and Social Welfare with support from the Global fund. Given the number of people living with HIV and AIDS who need antiretroviral therapy, nearly all centres were being handled by a core staff of just 2 or 3 nurses; resulting in long delays for patients to receive services. The joint review estimated that 410 staff nurses and 247 nursing assistants are presently needed to support antiretroviral therapy services. The staff shortage compromises effective delivery of antiretroviral therapy services. Much as developments have been made in training health care staff in antiretroviral therapy, this initiative is frustrated by high attrition rate, a small pool of qualified staff and a very low intake and output from the existing training institutions.

As antiretroviral therapy becomes available throughout the country, more pharmacists are needed to manage antiretroviral therapy services. Currently, the public sector has a limited number of pharmacists engaged for antiretroviral therapy-related services (2 at central medical stores and one at the National Referral Hospital, employed by the Global Fund), yet in order to scale-up antiretroviral therapy delivery in the public sector six pharmacists and ten pharmacy technicians are required. Other infrastructural adjustments, such as drug storage facilities, distribution vehicles, and drug and commodity management system require urgent attention. Additionally the National Pharmaceutical Policy needs to be updated to include antiretroviral therapy.

Limited access to food and micro-nutrients to complement antiretroviral therapy—Nutrition is an important requirement for antiretroviral therapy. Given

poverty levels in the country, many clients have limited access to food and micronutrients to complement antiretroviral therapy. The Ministry of Health and Social Welfare Report on antiretroviral therapy program (2005) acknowledges that poor nutrition of people living with HIV and AIDS does not only accelerate the evolution of HIV infection, but also affects response to antiretroviral therapy. Currently, few programs provide food packages. There are no national nutritional standards for food packages which are given to people living with HIV and AIDS. Similarly there is no national plan and infrastructure for distributing and storing food supplies and supplements. There is also lack of dieticians in hospitals making it difficult to roll out nutritional programs in public facilities; and there is also insufficient information on nutrition for people living with HIV and AIDS.

In cases where patients are receiving food packages, they are likely to share them with family members thereby compromising expected outcomes. There is therefore a need to go beyond food supplementation to longer term food security and economic empowerment strategies so as to prevent the occurrence of food dependency.

Objectives

Objective 22: To increase the number of people living with HIV and AIDS receiving antiretroviral therapy by 75% by 2008.

Objective 23: To increase the proportion of eligible people living with HIV and AIDS who receive food packages as part of HIV and AIDS related clinical management to 100% by 2008.

Objective 24: To increase by an average of 5 years by 2008 the survival of people on ART.

Strategies

- Improvement of antiretroviral therapy literacy among members of the public.
- Development of national capacity including capacity of laboratory services to up-scale and provide quality and affordable antiretroviral therapy services that address the needs of both adults and children.
- Development of both facility and community-based support services for ensuring follow-up and adherence among clients.
- Introduction of nutritional support as part of a comprehensive antiretroviral therapy package.
- Development of national capacity to provide rehabilitation services (physical and mental).

Core indicators

- Percentage of people still alive at 6, 12, 24 and 36 months after initiation of antiretroviral therapy.
- Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.
- Existence of national policies, strategies and guidelines for antiretroviral therapy.
- Percentage of health facilities providing antiretroviral therapy services for adults and children disaggregated by facility.
- Number of health workers trained on antiretroviral therapy delivery in accordance with national guidelines.

- Number of persons on Antiretroviral treatment who are receiving nutritional support from health care facilities in the last 12 months.
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- Number of health personnel trained in rehabilitative services.
- Number of patients who receive rehabilitative services.

6.2 Management of opportunistic conditions (OIs) and pre-antiretroviral therapy

Strategic issues

Inadequate national capacity to manage opportunistic infections—People with advanced HIV infection are vulnerable to infections and malignancies that are called opportunistic infections. These opportunistic infections include: bacterial; mycobacterial; fungal; protozoal; viral infections; neurological and other conditions and complications. In Swaziland, the most common opportunistic infections are cryptococcal meningitis, Carinii (PCP), fungal infections, respiratory conditions, dermatological conditions and candidiasis. Management of opportunistic infections is not well developed in the country, since clients usually report to health care facilities in the advanced stages of HIV. Additionally, Isoniazid Prophylaxis Therapy is currently not used in the country, risking eligible candidates to developing opportunistic infections. Guidelines for the management of opportunistic infections have been developed and are used in health care settings. Health workers have been trained on the management of opportunistic infections. However, there are constrains in accessing drugs and medicines for some opportunistic infections. Diagnostic services such as the laboratory and radiographic equipments are also limited in some health care facilities; consequently doctors have to rely on clinical symptoms for the management of opportunistic infections.

Objective

Objective 25: To increase to an average of 7 years by 2008, the survival of people living with HIV and AIDS after HIV testing and before ART.

Strategies

- Development and introduction of a comprehensive national pre-antiretroviral therapy program as part of the care package, including the use of prophylaxis such as co-trimoxazole and INH.
- Improvement of literacy on pre-antiretroviral therapy among members of the public.
- Availability of drugs for prompt treatment of opportunistic infections and pre-ART.
- Increase the availability of drugs for prompt treatment of opportunistic infections and pre-ART

Core indicators

- Number of health facilities offering comprehensive pre- antiretroviral therapy program.
- Number of people living with HIV and AIDS who have enrolled in the pre-antiretroviral therapy program.
- Percentage of health facilities providing rehabilitative services for people living with HIV and AIDS.

6.3 Management of Tuberculosis and HIV infection

Strategic issues

Epidemiology of Tuberculosis—The National Tuberculosis Control Program is one of the oldest national programs in the country, established in the 1960s. Over the years, the program has established 15 satellite treatment facilities across the country and a pilot project on DOTS in the Lubombo region. Tuberculosis drugs are provided by the Government of Swaziland free of charge to patients.

Re-emergence of the TB epidemic—Prior to the emergence of the AIDS epidemic the tuberculosis problem was on the decline. However, in recent years the number of tuberculosis cases has been increasing from 2000 cases in 1996 to 7,500 in 2001. The national prevalence of tuberculosis is estimated at 700 cases per 100,000 population and the case detection rate is below 50%. The country also has a low tuberculosis cure rate which was estimated to be 15.7% in 2003 and a high defaulter rate (14%), a relapse rate of 13.6% and evidence of drug resistance. The national tuberculosis patient follow-up system is weak, up to 29.9% of new pulmonary tuberculosis smear positive cases had no follow-up information in 2003, yet this is crucial for clinical management, psychosocial support and adherence to treatment.

Limited coverage of DOTS and emergence of drug resistance—With regard to treatment for tuberculosis; DOTS treatment was introduced in Swaziland in the year 2000, piloted at the Lubombo region where clients were directly observed by Rural Health Motivators (RHMs). The standard treatment used is a combination of Ethambutol, Isoniazid, Rifampazid, pyrazinamide and streptomycin. However, DOTS treatment is not applied uniformly across the whole country. This has negative consequences on drug compliance and recovery of patients. Recently, cases of multiple drug resistant tuberculosis have been reported but no national anti-tuberculosis drug resistance survey has been conducted since 1996.

Insufficient focus on paediatric tuberculosis care—Available tuberculosis services are predominantly for adults and there is insufficient focus on paediatric care (paediatric solutions); yet the immune system of young children is underdeveloped compared to an adult and the risk of developing active tuberculosis is therefore higher in children. However, BCG vaccine is given as a prophylactic treatment to infants at birth; over 90% national coverage of BCG has been attained since 2001. Furthermore, diagnosis of tuberculosis among children is difficult as early signs are usually missed. This is compounded by the fact that specimens are difficult to collect from children. Additionally, the national tuberculosis program has limited capacity for detecting paediatric tuberculosis; yet children diagnosed with HIV are at high risk of developing tuberculosis meningitis with often devastating complications such as deafness, blindness, paralysis and mental retardation. Currently there is limited national capacity to provide rehabilitative services to patients who have experienced the cited complications.

High levels of HIV/TB co-infection—There is high HIV and tuberculosis co infection in the country which was estimated to be 78% in 2004. Despite the high rate of HIV among patients diagnosed with tuberculosis, HIV testing and counselling services are not routinely offered and there is no routine tuberculosis screening for HIV positive people. Related support services such as clinical laboratory and radiography are generally weak, making it difficult to diagnose and manage tuberculosis as well as HIV and AIDS.

Limited access to food and micro-nutrients to complement treatment—Given the poverty levels in the country, many clients diagnosed with tuberculosis have limited access to food and micro-nutrients to complement treatment. While nutrition is an important element in the management of tuberculosis, there are no programs that

provide food packages to deserving patients, particularly children on tuberculosis treatment.

Fused clinical and program functions—One of the major contributing factors to the challenges that are faced by the program includes the fact that the clinical and program functions are fused, thus compromising both the quality of care and effectiveness of programming. The tuberculosis hospital which is under construction is expected to alleviate this problem by providing diagnostic and treatment services, while the tuberculosis central unit will focus on the management of the tuberculosis control program at the national level.

Objectives

Objective 26: To increase the proportion of persons diagnosed with tuberculosis who are tested for HIV from below 50% in 2005 to 100% in 2008

Objective 27: To increase the cure rate of tuberculosis from 15.3% in 2003 to 75% in 2008

Objective 28: To reduce the incidence of tuberculosis in the country from 700 cases per 100,000 in 2003 to 350 cases per 100,000 by 2008.

Objective 29: To establish the mechanisms for collaboration of TB/HIV activities at all levels.

Objective 30: To decrease the burden of TB in people living with HIV/AIDS from 50% to 35% by Dec 2008.

Objective 31: To decrease the burden of HIV in TB patients from 78% to 45% by 2008

Strategies

- Establishment of TB/HIV coordinating committees at all levels.
- Development of monitoring and evaluation for TB/HIV activities.
- Establishment of intensified TB case finding (or improvement of early detection of TB among HIV positive clients).
- Intensification of Isoniazide preventative therapy (children <5years, selected groups. Target will vary according to findings from research).
- Improvement of literacy on TB and HIV among members of the general public.
- Scaling up access to ART to TB patients co-infected with HIV.
- Scaling up of routine HIV testing for TB cases.
- Improvement of literacy on tuberculosis among members of the general public.
- Scaling-up of routine HIV testing for tuberculosis cases and improvement of early detection of tuberculosis especially among HIV positive clients.
- Strengthening of the national capacity for provision of tuberculosis services for both adults and children including support services.
- Scaling-up of Directly Observed Treatment and development of both facility and community based support services for ensuring follow-up and adherence among clients.

- Introduction of nutritional support as part of a comprehensive tuberculosis package.
- Prevention of the onset of new cases.

Core indicators

- Number of all persons diagnosed with tuberculosis who are HIV positive, expressed as a proportion of all newly registered tuberculosis patients in the last 12 months.
- Percentage of all new smear positive pulmonary tuberculosis cases that are successfully treated.
- Number of registered tuberculosis patients who are tested for HIV as a proportion of the total number of registered tuberculosis cases in the last 12 months.
- Percentage of health facilities that have guidelines for referral of HIV positive tuberculosis patients to care and support.
- Number of newly diagnosed HIV positive clients who are given treatment of latent tuberculosis infection (tuberculosis preventive therapy) expressed as a proportion of the number of newly diagnosed HIV positive people.

6.4 HIV testing and counselling

Strategic issues

Missed opportunities for early identification of HIV positive persons and early intervention—Within the service provision for care, support and treatment opportunities for HIV testing and counselling are missed due to the fact that the service is not being routinely offered to patients in general. National guidelines for HIV/AIDS Testing and Counselling acknowledge the need to link counselling and testing services with other health care services such as sexually transmitted infections, tuberculosis, family planning, prevention therapy for opportunistic infections, drug and alcohol abuse as well as welfare support. But due to limited national capacity, HIV testing and counselling services are not successfully integrated into health care services as proposed, yet HIV testing is an entry point to all aspects of HIV and AIDS care programs, including prevention of mother-to-child transmission of HIV, post-exposure prophylaxis and antiretroviral therapy. Similarly, failure by health care providers to routinely offer patients opportunities to test, compromises early identification of HIV positive persons and opportunity for early interventions. Consequently, clients may die without having been tested even when it is indicated. Since HIV testing and counselling facilities are not all integrated to clinical services, it is possible that even if patients are referred by health care providers for counselling and testing, some are lost in the process. Indeed, some of the HIV testing and counselling facilities may be inaccessible and unaffordable to very sick patients.

Compromised care due to the requirement for informed consent—Another issue that may pose a challenge to health care providers is seeking informed consent from a sick patient or relative (in case of a minor or an unconscious patient) before considering the test. The health care provider may have to consider ethical or legal issues before conducting the procedure. It is possible that some patients may not be motivated to know their HIV status at the point of death. Similarly, HIV testing is a private matter, many people may prefer their HIV positive status to remain a secret for fear of being stigmatized and isolated by family members. Stigma is further perpetuated by inaccurate information about the transmission of HIV and AIDS; as such many people fear living with HIV positive people.

Objectives

Objective 32: To increase the proportion of clients who receive facility-based routine HIV testing and counselling by 25% in 2008.

Objective 33: To increase by 20% in 2008 the proportion of clients who have had contact with health care facilities and know their HIV status.

Strategies

- Promotion of public awareness on routine offer of HIV testing in the context of clinical care.
- Introduction and provision of routine HIV testing and counselling in clinical care.
- Reduction of facility-based stigmatization and discrimination of people living with HIV and AIDS.

Core indicators

- Percentage of in-patients who have received HIV test results and post-test counselling in the past 12 months.
- Percentage of health facilities that offer free routine basic HIV testing and counselling services.

6.5 Community home-based care

Strategic issues

Limited capacity to provide effective CHBC services—Care for home-based clients is generally provided by family members (mainly by women and girls) who are in most cases not trained in providing quality care and without adequate support in terms of relief, materials and supplies. Communities and civil society have made substantial progress in providing home-based care but the Joint Review Report identified a number of challenges, which are: lack of proper and coordinated monitoring and evaluation system at national and regional levels; weak coordination between institutions offering community home-based care; weak referral system, limited care givers to cope with the challenges of care; absence of involvement of private clinics in home-based care; weak participation of males in home- based care and limited coverage of home-based care services to deserving patients. Nonetheless, there are emerging models from which lessons can be learnt and scaled up throughout the Kingdom. In addition, with the advent of antiretroviral therapy and DOTS there is need to up-date the national guidelines to link home-based care structures to patients on treatment for adherence support.

Differential implementation of CHBC services—Community Home-Based Care package offered by different stakeholders is not standardized, some include food packages, protective materials as well as transport to ferry patients to health care facilities. Similarly, the remuneration given to care givers by stakeholders is not standardized and this situation has consequences for commitment and provision of quality services.

Weak patient referral system—The patient referral system is not well articulated and coordinated. Patients have no direct access to health care services from their homes. If they need emergency care they have to follow the normal route of accessing health care services without being given preferential treatment as part of the continuum of care.

Limited access to CHBC materials and supplies—With regard to containers that stock supplies at tinkhundla, the people benefiting are fewer than those expected to get served. There is also a high turnover of volunteers who look after the containers of home-based care materials and equipments as some are young people who are mainly mobile. The role of Rural Health Motivators versus that of care givers is also not clearly defined. Stock-outs in some cases are common and extended in terms of time. Similarly, the coordination of home-based care services within the Ministry of Health and Social Welfare is not clear whether it falls within the public health unit or under SNAP. The reporting structure of community home-based service is not clear. The present situation is that it falls under the regional AIDS coordinator instead of the regional home-based care coordinator. Community health services such as those that are provided by Rural Health Motivators, Faith Based Organizations, community members and community home-based care givers are not considered as part of the formal health service.

Objectives

Objective 34: To increase by 70% in 2008 the proportion of chronically ill people that receives quality and appropriate care as well as support within their homes.

Objective 35: To increase by 40% in 2008 the proportion of health care facilities that have arrangements with Community Home-based Care services and communities.

Strategies

- Creation of positive health seeking behaviour for home-based care services.
- Expansion and strengthening of coordination and provision of community home-based care services, including the involvement of the private sector that is integrated into community impact mitigation services.

Core indicators

- Percentage of adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months whose households receive free user charges, basic external support including health, psychological or emotional and other social and material support.
- Number of person-visits for the purpose of home-based care in the last 12 months.
- Number of trained community home-based care volunteers.
- Percentage of volunteers who are males.

6.6 Palliative care

Strategic issues

Limited accessibility of palliative services—The country has two privately-owned health centres that provide care to terminally ill patients. These centres are located in the Manzini region and have established regional centres that provide care to about 1,600 patients per month. Since the centres are regionalized, they are perceived by the public as inaccessible to the majority of terminally ill patients. At the community level there are no palliative centre points where clients could access emergency care such as respiratory support, pain relief measures, or intravenous infusion. Apart from providing care to terminally ill patients, the Swaziland Hospice at Home, for example, is mandated by the Ministry of Health and Social Welfare to train care givers on

palliative and home-based care. To date, Hospice at Home has conducted an orientation course on palliative care to 120 nurses, related to community home-based care.

Inadequate human resource capacity—Much as developments have been made on training care givers in palliative care; the national capacity is still insufficient to meet the challenges of HIV and AIDS. Additionally, the morale of care givers is low because they are generally over worked, lack psychosocial support, are poorly rewarded and some have succumbed to HIV and AIDS. Additionally, there is inadequate collaboration at national and regional levels of palliative care activities. The activity area lacks critical support such as chaplaincy for spiritual support, social workers for social support, physicians for medical support, psychiatrists for psychological support as well as rehabilitative services. As such palliative care services are fragmented and information related to impact mitigation services is insufficient. Similarly, the available palliative care services are mainly designed for adults with less emphasis placed on paediatric services, yet paediatric life threatening illnesses are common. Consequently, paediatric palliative care services including child counselling are neglected.

Lack of national guidelines—There are no national guidelines for palliative care. Available guidelines are for community home-based care and there is a section which relates to palliative care services, yet a clear distinction between the two services is necessary. The patient referral system for palliative care is not well coordinated; patients have no direct access to health care services from their homes. If they need emergency care they have to follow the normal route of accessing health care services without the necessary support from their homes.

Objectives

Objective 36: To increase by 20% in 2008 the proportion of health care facilities that offer the basic palliative care services to terminally ill clients.

Objective 37: To increase by 25% in 2008 the proportion of community home-based care clients receiving appropriate palliative care services (including children).

Strategies

- Creation of positive health seeking behaviour for palliative care services.
- Expansion and strengthening of national capacity to provide quality palliative care services.

Core indicators

- Number of health facilities accredited to provide palliative care including morphine.
- Number of personnel trained to provide palliative care in the last 12 months.
- Number of terminally ill patients receiving palliative care before death in the last 12 months

6.7 Traditional and alternative health therapies

Strategic issues

Lack of recognition of traditional and alternative health care practice— Traditional and alternative health care practitioners are important partners in the fight against HIV and AIDS. In general, traditional and alternative health practitioners are

preferred by patients because they provide client-centred approach which is culturally acceptable. The Ministry of Tourism reports that there are about 3000 traditional healers in Swaziland; this number may have doubled lately in view of the increasing number of AIDS related illnesses. It is apparent that the number of traditional/alternative health practitioners far exceeds the population of medical doctors which is currently 186 (national record).

Lack of data relating to the actual number of practicing traditional and alternative health practitioners—Regarding care treatment and support for HIV and AIDS patients, efforts have been made by the Ministry of Health and Social Welfare to train traditional health care practitioners on aspects of HIV and AIDS. But, the country lacks data relating to the actual number of practicing traditional and alternative health practitioners; consequently efforts of building their capacity on HIV and AIDS may not be effectively evaluated by the Ministry of Health and Social Welfare.

Lack of licensure of traditional health practitioners/alternative health therapists—Similarly, the training and licensing of traditional health practitioners/alternative health therapists is not institutionalized, which makes it difficult to reach and train them regularly in a standardized manner. Additionally, the practice of traditional/ alternative health is not well regulated and there is limited information on the methods they use and there are no guidelines on the use of their medicines. In some instances traditional/alternative health practitioners make claims for AIDS cure that are not supported by scientific evidence and contrary to conventional facts.

Insufficient collaboration among western, traditional and alternative health care practitioners—There is also insufficient collaboration between the two health care systems, and there is no mechanism for referring patients between the two services despite the fact that 80 % of Swazis are believed to utilize services of traditional/ alternative health practitioners before coming to the western health care system. There is also no budget allocation from the Swaziland Government to develop this area of practice even though it is popularly used by Swazis.

Objectives

Objective 38: To increase the proportion of registration of traditional and alternative health care practitioners to 100% by 2008

Objective 39: To Increase the proportion of traditional/ alternative health practitioners who have been trained in HIV and AIDS issues to 100% by 2008.

Strategies

- Improvement of the national capacity of traditional /alternative health practitioners on HIV and AIDS related issues
- Development of a national collaborative framework for conducting research on herbal and alternative medicines
- Regularization and rationalization of tradition /alternative health practice.

Core indicators

- Number of traditional practitioners that have been registered
- Number of people that have visited a traditional practitioner for health reasons in the last 12 months.

7 Thematic area: impact mitigation

Goal: To mitigate the social and economic impact of the epidemic in Swaziland.

This section presents the goal, strategic issues, objectives, strategies and core indicators for the impact mitigation intervention areas. These include legal, ethical and social rights provision and protection; social protection and livelihoods support; counselling and emotional care; food and nutrition security support; educational support; and community-driven impact mitigation programs. For the purpose of impact mitigation, vulnerable groups include orphaned and vulnerable children (OVC), people living with HIV and AIDS (PLWHA), bereaved vulnerable elderly (BVEs), widows and persons living with disabilities (PWDs).

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.

7.1 Legal, ethical and social rights provision and protection

Strategic issues

Inadequate legislative framework for the protection of the rights of vulnerable groups—Swaziland is signatory to several international instruments; however, her policy and legislative environment make it difficult to respond to the challenges presented by the epidemic. In the first instance, policy development is inadequate, the processes of legislation are very slow and there is opposition to emancipation of women and children. Consequently, some of the international instruments have not been translated into national laws and policies. International instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) have been ratified but have yet to be domesticated. Gender inequality is fuelling the epidemic but even the newly enacted constitution does not recognize the cultural equality of men and women.

There have been efforts to legislate and create structures that provide a protective environment for the legal and social rights of orphans and vulnerable children (OVC), such as child protection committees and community courts. However, these structures are not backed by any existing legislations, and there is also low reporting and follow-up of socio-culturally-driven cases of child abuse.

A number of studies have been done on gender and child abuse and the results have informed the review process of the Marriage Act and the 1920 Girls and Women Protection Act. However, limited documentation on the nature and extent of stigmatization, discrimination and victimization still hampers the development of legislation, policies and ethical codes of conduct to address these issues.

Delays in the finalization and adoption of policies—Some polices that facilitate impact mitigation interventions have been developed but they remain in draft form. These include the: Land Policy, Gender Policy, Social Welfare Policy, Comprehensive Agriculture Sector Policy, Irrigation Policy, National Food Security Policy, NGO Policy, and National Policy on Children including OVC, Education Sector HIV and AIDS Policy, Rural Resettlement Policy, Disaster Management Bill, and the Poverty Reduction Strategy. A review of the adopted policies also indicates gaps regarding modalities for access to basic education and other social services, the lack of proper criteria for identification and monitoring of vulnerable children, inadequate HIV and AIDS programs in workplaces and weak mechanisms for the protection of the rights of vulnerable groups. As a stop gap measure, some arrangements for OVC identification and registration have been developed, which has facilitated delivery of social services to some needy OVC. Additionally, there is a general lack of knowledge of the processes for developing legislation and policy.

Inadequate institutional capacity for responding to the epidemic—Proper protection of the rights of vulnerable groups requires institutional capacity in the Ministry of Justice and in the Social Welfare Department which matches the legal and social protection challenges presented by the epidemic. With the increase in HIV/AIDS related deaths, the demand for the Master of High Court services has escalated and yet these services remain centralized, cumbersome and costly to access. Firstly, people have to travel long distances, wait for a long time before their problems are addressed, and the processes are inconvenient to the bereaved. Regarding social welfare issues, there is no proper implementation and coordination due to inadequate staffing in the Social Welfare Department and fragmentation of initiatives.

Objectives

Objective 40: To ensure that by the end of 2006, 100% of draft policies are adopted, and 100% of draft bills are enacted.

Objective 41: To ensure that by 2007, 100% of policies are translated into Acts.

Objective 42: To ensure that by 2008, 100% of ratified impact mitigation-related international conventions are domesticated.

Objective 43: To increase to at least 80% by 2008 public awareness about the rights and obligations of PLWHA and other vulnerable groups.

Strategies

- Facilitation of the enactment of outstanding and new policies, laws and structures that promote the ethical, legal and social rights of OVC and other vulnerable groups.
- Strengthening of legislation and systems for promoting the ethical, legal and social rights of OVC and other vulnerable groups.

- Strengthening of initiatives that promote the ethical, legal and social rights of OVC and other vulnerable groups.

Core indicators

- Number of abuse cases reported and action taken by type in the last 12 months.
- Number of persons trained on rights of PLWHA, Widows, OVC, PWD and elderly in the last 12 months.
- Number of policies and laws for vulnerability that have been enacted in the last 12 months.
- Percentage of the general population reporting positive attitude towards persons living with HIV/AIDS.

7.2 Social protection and livelihoods support

Strategic issues

Increasing vulnerability and poverty—In the Kingdom of Swaziland, about 69% of the population lives below the poverty line, while 42.6% are living with HIV and AIDS (MOHSW HIV Surveillance Report, 2005). It has been estimated that during the 2005/06 marketing year, about 226 640 people will suffer food shortages for 4-7 months in Swaziland (FAO/WFP 2005). The number is higher if people who will face shortages for shorter durations are included.

The ever increasing morbidity and mortality among the most productive age groups due to HIV/AIDS poses a great challenge to the socio-economic status of individuals, families, and communities. These conditions have increased the vulnerability among OVC, PLWHA, the elderly, widows and PWDs. The MOHSW Disability Profile (2000) indicates that disabled persons represent 3% of the population, and a large proportion has no access to formal education. About 77% of the disabled are economically inactive, as such very few of them are able to support themselves and their families.

Meanwhile, the abuse of power by men through condoning socio-cultural practices that promote their dominance contributes to vulnerability of women and children. Gender and disability issues have been identified by various studies as confounding factors for HIV/AIDS and poverty.

The agenda for impact mitigation corresponds with the goal of the country's Poverty Reduction Strategy and Action Plan. Several initiatives are being implemented to respond to poverty and vulnerability. Poverty, disability and disasters such as drought and HIV and AIDS have the same victims, and initiatives designed to respond to these risks target essentially the same vulnerable groups. However the funding and implementation for these initiatives tend to be parallel and the opportunity to harmonize and foster efficiency is lost. Mainstreaming poverty, HIV and AIDS, gender, disability and disaster management in development programs would lead to a coordinated and cost-effective response to the epidemic and other sources of vulnerability.

Over-stretched social safety nets—Regarding social protection, there is a public assistance program which provides social grants to the terminally ill, destitute, widows, and the elderly and disabled persons. Pension schemes and the provident fund also provide a safety net for retirees and their dependants. However, the social grants are small and cover a limited number of needy persons. The disbursements are also slow, irregular and highly centralized, which makes it difficult for those who live in the rural areas to access the grants. Above all, there is also no comprehensive social security system in Swaziland. At the community level, the

social safety nets through extended families are over-stretched due to poverty and HIV and AIDS.

Inadequate access to basic services—According to MEPD (2002), water and sanitation are basic needs which are essential to a healthy population. In the urban areas, 80% of the population has access to safe water, while in the rural areas the coverage was only 54%. Proper hygiene is a problem in the rural areas as only 60% of the population has access to proper sanitation. The poor represent a large proportion of the population without access to safe water and proper sanitation facilities. The need for water and proper sanitation increases in a household with a person suffering from AIDS, yet these households are increasingly unable to afford clean water and proper sanitation due to poverty.

Shelter is one of the basic needs which ensures good quality of life. MEPD (2002) estimated that 60% of the population in urban areas lives in hazardous shelter. In the rural areas shelter is also problematic, more so for the orphans and the elderly who are usually crowded in the same shelter. The epidemic has left the elderly as the sole providers of shelter and care at a time when they are economically and physically weak. It is also common that by the time parents eventually die, they have exhausted their assets, which leaves child-headed households with no finances to improve their shelter. Even though some NGOs and communities have constructed shelter for the needy elderly and OVC, many of them still live in dilapidated structures.

It is also worth noting that government has implemented micro credit schemes for youth, women and the general population as a strategy for improving livelihoods. However, the system of accessing the schemes is not comprehensive and well known by the intended beneficiaries. Only a few of the youth and women groups have been covered. Additionally, the amounts of the loans are limited, and the criteria for accessing the loans are particularly complicated for the households of those seriously affected by HIV and AIDS.

Objectives

Objective 44: 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.

Objective 45: To establish a national social security system by 2008.

Objective 46: To ensure that by 2008, 50% of eligible households have access to micro-credit and development finance.

Strategies

- Harmonization of the provision of basic services to vulnerable households headed by OVC, PLWHA, PWD and the elderly (e.g. shelter, clean water and sanitation services).
- Introduction of a comprehensive national social security system, which covers vulnerable groups particularly the OVC, PLWHA, PWD and the elderly.
- Improvement and scaling-up of access to economic and livelihood development schemes for the affected individuals, households and groups including care givers.

Core indicators

- Number of vulnerable persons covered by the expanded social security system in the last 12 months.

- Number of vulnerable persons and households accessing social grants in the last 12 months.
- Number of vulnerable households accessing water, sanitation and shelter support in the last 12 months.

7.3 Counselling and emotional care

Strategic issues

In Swaziland it is the norm for the extended family to absorb orphaned children and the elderly persons usually take care of the grandchildren. The advent of the epidemic has increased the burden of care on the extended family structure, making it difficult to provide emotional care, socialization, and economic support to vulnerable groups.

Inadequate mental and emotional care—Whereas the psychological and social suffering of orphans of terminally ill parents begins long before the parents die, most of the available services primarily address the needs that arise after death of the parent(s). The risk of depression, anxiety, personality and post-traumatic stress (PTS) disorders is especially high among the PLWHA, the elderly and OVC. However, Mental Health services in Swaziland are generally scarce, inefficient and underutilized. A limited number of nurses have been trained in community psychiatric nursing however, other care givers such as teachers, a majority of nurses, community caregivers and the general public have not been trained in recognizing the symptoms of mental illness nor have they been equipped with basic counselling and emotional care skills. The inability to recognize psychological disorders and the stigma associated with mental health disorders results in most of the mental health cases often going unattended, which increases the risk of severe mental disorders. Furthermore, there are no special institutional or community care and counselling services for children living with HIV and AIDS.

Inadequate training for caregivers—Community caregivers have been mobilized and trained in caring for the terminally ill and OVC. A comprehensive training manual was developed and is being used for the training. This manpower offers openings for initiation of community-based care including ART programs. However, the training is not standardized and is poorly coordinated and as such many care givers have not been trained in all the modules particularly in counselling of terminally ill patients. The current number of the trained caregivers is relatively low and their work is usually constrained by shortage of home care supplies. The procedures for replenishing these supplies are cumbersome.

Challenges in the caring and socialization of OVC—Fostering and adoption of children from outside the extended family is rare and some children are left to live on their own in child-headed households. These children are often vulnerable to abuse. There are also no support arrangements for families who adopt or foster these children. Some OVC have been placed under institutional care which has provided a safe home for them. However, there is no national framework to regulate the functioning of orphanages with regards to conditions and practices such as family socialization and emotional care during and after institutional care. Empowering orphans on issues of inheritance, family socialization and reintegration into communities presents society with unfamiliar challenges.

Limited support for PLWHA networks—The continual provision of HTC services and community sensitization about HIV/AIDS has facilitated disclosure and formation of some networks and support groups for PLWHA. There are about 46 individual support groups for PLWHA throughout the country. This has promoted positive living and advocacy which is contributing to alleviation of stigmatization and discrimination of PLWHA. Results of MICS (2000) indicate that 77% of the public had a positive

attitude towards PLWHA. Counselling of PLWHA is still limited to HTC centres, and there is slow progress in expanding AIDS-related counselling to schools, religious places and communities. The stigmatization and discrimination associated with HIV/AIDS also discourage people from testing and knowing their HIV status. Additionally, PLWHA networks or coordination structures are at their infancy due to minimal support given to them to facilitate their mobilization, organizational development, activity planning and implementation at all levels.

Lack of coordination of psychosocial support interventions—There has been an attempt to model interventions along cultural concepts such as *Indlunkhulu*, *KaGogo* centres and Neighbourhood Care Points to mitigate the impact of the epidemic on the vulnerable groups. These models have offered immediate measures for accessing psychosocial and emotional support to the needy OVC. However, there is no comprehensive national framework for coordination of these interventions; consequently, the coverage of the existing home-based care, counselling, nutritional and hygiene support services is fragmented, intermittent, limited to a few OVC, open to abuse, and inefficient as sometimes there is double support to the same individuals. The lack of coordination of service delivery at community level has also contributed to these problems.

Objectives

Objective 47: To ensure that by 2008, at least 50% of registered OVC, PLWHA, BVEs, PWD, and caregivers receive counselling and emotional care.

Objective 48: To ensure that by 2008, at least 50% of registered OVC, PLWHA, BVEs, PWD, and caregivers receive appropriate mental health services.

Objective 49: To ensure that at least 10% of registered needy OVC are adopted and/or fostered by locally- based families by 2008.

Strategies

- Scaling-up of the provision of counselling 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.
- Promotion of positive living among PLWHA and expansion of initiatives that minimize stigmatization and discrimination in the community.

Core indicators

- Number of persons (OVC, PLWHA, the elderly, PWD and caregivers) accessing appropriate counselling and emotional care in the last 12 months.
- Number of vulnerable groups accessing appropriate mental health services in the last 12 months.
- Number of OVC adopted or fostered in the last 12 months.

7.4 Food and nutrition security support

Strategic issues

Severe impact of HIV and AIDS on agriculture—According to MPED (2002), agriculture is one of the main sources of livelihood and therefore constitutes the

cornerstone for poverty reduction in Swaziland. Agriculture contributes 25% of the GDP and sustains at least 70% of the population. Nevertheless, HIV and AIDS has devastated people aged 15-50 years and reduced labour for farm and domestic work as the people become ill, die or spend time caring for the sick, mourning and attending funerals. This has resulted in less land being cultivated, and a decline in total crop production and income, particularly in households affected by HIV and AIDS.

Additionally, good nutrition is critical for persons living with HIV and AIDS particularly those on ART, but many of them do not have adequate access to food due to increase in poverty, persistent drought and the high cost of agricultural inputs.

No national food and nutrition security strategy for vulnerable groups—There has been provision of food aid and a revival of food production initiatives such as *Indlunkhulu* communal fields, school farms and backyard gardens. Through these initiatives, food has been provided to some OVC and other vulnerable individuals but they are still ineffective because of uncoordinated approaches, lack of clear criteria for identifying the extremely needy groups and the lack of a comprehensive plan for addressing food and nutrition security for vulnerable groups. The necessary crop research has also been done but community members are still unaware of the local nutritive crops to grow for better nourishment of PLWHA.

Objective

Objective 50: 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.

Strategies

- Development and implementation of a comprehensive food security strategy for vulnerable households.
- Provision of nutritional support for OVC, PLWHA, BVE and other vulnerable groups.

Core indicators

- Number of persons and households receiving food packages/ support in the last 12 months.
- Proportion of vulnerable persons (OVC, PLWHA, elderly) who have access to at least one nutritious meal a day.

7.5 Educational support

Strategic issues

Adverse effects of HIV and AIDS on school enrolment—According to the UNICEF-supported National OVC Action Plan for the period 2006-2010, the population of OVC will increase from 145, 290 in 2005 to 189,230 by 2010. The same document defines an “Orphan” as a child under 18 years old who has lost one or both parents while a “Vulnerable child” is a child under 18 years old whose parents/guardians are incapable of providing the required care; who is mentally or physically challenged; who is staying alone or with poor elderly grandparents; who lives in poor sibling-headed household; and who has no fixed place of abode. Children who are orphaned because of HIV and AIDS account for more than half of the OVC.

Government and other agencies have initiated the OVC school grant scheme which has enabled enrolment of at least 70% of OVC in school. There are also on-going

classes organized by Sebenta, who have enabled some youth who dropped out of school, to acquire basic literacy skills. However, 23% of vulnerable children and some out-of-school youth are still unable to access this service due to duplications and inefficiencies in selection criteria, which usually leaves out the deserving OVC. The planned implementation of the Universal Primary Education policy in 2006 should increase enrolment and retention of children in schools.

Negative impact of HIV and AIDS on girls' schooling—Women and girls face the greatest burden of domestic work including being primary caregivers for the sick and dying, in addition to their traditional responsibilities. The consequences of this is that women and girls end up using their time to take care of others and very little time to take care of themselves. Girls' education is also being affected as there have been cases of girls withdrawing from school to help care for the sick and lighten the family load. Girls also usually spend more time doing household chores which affect their performance in school and chances of career advancement.

Objectives

Objective 51: To ensure that by 2008, at least 100% OVC aged 6-14 years have access to free formal or non-formal education.

Objective 52: To ensure that by 2008, at least 80% OVC and disadvantaged youth have access to formal and non-formal education.

Strategies

- Improvement of the quality and expansion of coverage of formal education and non-formal education including institutionalization of education for marginalized children.
- Promotion of school-community linkages for better identification and maintenance of OVC in schools.

Core indicators

- Number of educationally marginalized children that receive education-related support in the last 12 months.
- Ratio of school attendance among orphans to that of non-orphans.

7.6 Community-driven impact mitigation program

Strategic issues

Lack of community involvement in the management of impact mitigation initiatives—Due to the HIV and AIDS epidemic and increasing poverty levels, the extended family structures have been weakened so much that many families cannot provide adequate protection to children, the sick and impoverished relatives. As a result, there is an increase in cases of child abuse such as abandonment, rape, defilement as well as education and food deprivations. While the *Indlunkhulu*, *KaGogo* centres and Neighbourhood Care Points have facilitated the provision of food and literacy skills, these interventions have not been packaged with other basic social services such as counselling. Additionally, these initiatives were conceived and delivered to communities without giving them the opportunity to reflect on their relevance and devise and implement their own responses. Referrals are also inefficient due to unsystematic mechanisms for linking the community psychosocial support services with hospital facilities.

Objective

Objective 53: To ensure that by 2008, 100% of chiefdoms and towns have the capacity to provide basic impact mitigation services.

Strategies

- Strengthening the capacity of community structures (such as extended family structures, PLWHA, community groups, Umphakatsi, Inkhundla) to provide integrated basic impact mitigation services.
- Development of the capacity of partners to deliver comprehensive psychosocial support services at community level.

Core indicators

- Number of community-based organizations trained in planning, implementation and management of HIV/AIDS initiatives in the last 12 months.
- Number of trained community-based organizations that have an action plan for impact mitigation activities in the last 12 months.

8 Thematic area: management of the national response

Goal: To create an enabling environment for the effective management and co-ordination of the national response.

This section presents the management thematic area which includes sub-thematic areas in institutional arrangements, planning and program development, resource mobilization and financial management, advocacy and communication, community mobilization, research, as well as monitoring and evaluation.

"To stand any chance of effectively responding to the epidemic we have to treat it as both an emergency and a long term development issue. This means resisting the temptation to accept the inevitability of AIDS as just another of the world's many problems……"The AIDS epidemic is exceptional: it requires an exceptional response that remains flexible, creative, energetic and vigilant" (Report on the global aids epidemic 2004 p 13, UNAIDS, 4th Global Report, Geneva 2004)

8.1 Institutional arrangements

Strategic issues

An effective national response requires a multisectoral approach and national ownership. Mainstreaming as well as harmonization needs to be used as guiding principles so that through these, coordination of the national response is improved using workable and appropriate institutional arrangements.

Enhanced political commitment—Initial leadership to the national response was provided by the Ministry of Health and Social Welfare under the Swaziland National AIDS Program (SNAP) until the multisectoral response was introduced. The initial multisectoral response was coordinated by the National Crisis Management and Technical Committee on HIV and AIDS (CMTC) established in the office of the Deputy Prime Minister in 1999 and indicative of heightened political commitment in dealing with epidemic. As the epidemic has evolved to the current national emergency, the role of national political leadership, if improved, can contribute immensely to influencing all stakeholders to turn the tide of the epidemic. A meeting of stakeholders on a draft of this strategic plan as well as community consultations strongly alluded to an urgent need for political commitment as one of the major priority areas for this strategic plan.

Un-clarified roles of partners in the national response—It appears that when the CMTC was established the role of the Ministry Of Health and Social Welfare was not redefined, (specifically SNAP) under the new multisectoral dispensation. Relationships of the CMTC to other existing implementing organisations at the time were also not articulated. Failure to clarify these new roles and responsibilities led to confusion and strained relationships resulting in the stagnation of the response. A major achievement of the CMTC was the development of the 2000-2005 national strategic plan. The CMTC was succeeded by the National Emergency Response Committee which was established under the office of the Prime Minister in 2001. As was the case with the CMTC, linkages of NERCHA to existing partners and stakeholders within a broader coordination framework were similarly not defined. The transition from the CMTC to NERCHA could have been handled better. As a result, NERCHA was received with suspicion and uncertainty by some implementing agencies. Some stakeholders believe that structurally NERCHA is not stakeholder

based and is bureaucratic and that she also oversteps her coordination mandate and sometimes implements activities directly. NERCHA, however, believes that such perceptions are a result of misunderstanding and not reality. NERCHA is generally also seen more as a funding agency than a coordinator.

Competition between NERCHA and implementing partners—NERCHA is mandated to co-ordinate the national response and also provide support in the form of funding and logistics to a wide variety of implementing partners which include government, the private sector and the civil society organizations. However her coordination role gets clouded when she demonstrates pro-active management characteristics of a learning organisation. She is then perceived as competing with implementing agencies such as NGOS and development partners.

Underdeveloped coordination function—Observers believe that the coordination function has not developed much because NERCHA has been preoccupied with the function of being a Principal Recipient of the Global Fund against Tuberculosis and Malaria (GFTAM) and government funding. For a new organization, NERCHA has given the national response a new impetus and has done reasonably well in managing resources from the Global Fund and the Government of Swaziland.

The MOHSW is endowed with technical expertise and infrastructure that is critical in the fight against HIV and AIDS and has political legitimacy. Co-ordination of the Health sector response is believed to be fragmented and poor. Observers note that the MOHSW in general, lacks capacity to co-ordinate health activities.

CANGO representing about 60 non-governmental organizations, initiated the formation of the HIV and AIDS consortium involving 16 of its members to co-ordinate civil society organisations. Some civil society organisations have found it challenging to work with NERCHA. These challenges tend to undermine the capacity of such organizations to effectively support the national response at the community level. Most concerns from civil society organizations have been described in other parts of this strategic plan.

Unclear mandates and functions of umbrella bodies—A number of self coordinating entities focusing on HIV and AIDS have been established during the past two years. They include umbrella organisations such as the Business Coalition on HIV and AIDS, Church Forum, SWANNEPHA, AMICAALL, and PSHAAC. There are other specialized networks that include the Swaziland National Youth Council (SNYC) FODSWA and Lutsango lwakaNgwane. However, there are no clearly established mechanisms to define their mandate, roles, functions and responsibilities in the national response.

Limited coverage of the business sector response—The private sector has made a good start. A business sector coordination structure (Business coalition on HIV and AIDS) has been put in place even though coverage of its activities is limited to large companies. Currently, activities and influence of the Business Coalition does not extend to Small and Medium size businesses or to the informal employment sector.

Limited decentralization of the response—The office of the Deputy Prime Minister is mandated to promote the decentralization of all services from the national level to the regions, Tinkhundla, chiefdom and sub-community level (Tigodzi). However, coordination of urban local government is a function of the Ministry of Housing and Urban Development and is regulated by the Urban Government Act of 1968. A national decentralization policy which is considering merging coordination of urban and local government agencies was approved in May, 2005. Similarly, the constitution of the country which was adopted in July, 2005 supports decentralization of services. It would appear however that what is proposed by the decentralization policy is de-concentration as opposed to decentralization. Even though the office of

the Deputy Prime Minister has been participating in the national response since 1999, it is only recently that work to develop a regional coordination framework for the national response has started. The office of the Deputy Prime Minister does not have a sector plan upon which action at community level and donor input should be based. As a result, it would appear that its role in response it not well defined.

Availability of opportunities for information sharing—United Nations agencies have established a number of HIV and AIDS coordinating groupings, these include; the UN Theme Group on HIV and AIDS which was expanded to include other partners in addition to representatives of UN agencies; an OVC network that involves all implementing partners who are dealing with orphans and vulnerable children and the Swaziland Partnership Forum on HIV and AIDS (SPAFA) whose membership is made up of a wider stakeholders. These forums present opportunities for stakeholders to share information on HIV and AIDS.

Competition between international development partners and national entities—It appears that some development partners choose to work directly with grass root communities rather than play a supportive role. In the process of doing this they side step civil society organizations and end up causing friction. Instead of helping to build the capacity of these organizations to provide sustained support to communities, such actions undermine civil society organizations and precipitate competition which becomes counter productive. This situation is made more complex by the fact that civil society organizations also compete amongst themselves instead of working together.

Direct delivery of services by civil society organizations and other implementing partners—Similarly, many organized formations including civil society, implement activities and deliver services directly to communities rather than help build the technical capacity of communities to drive the responses. These organizations do this even though they generally lack adequate capacity to implement the intended activities and services. Such action by these organizations ends up pushing communities into a passive role consequently delaying up-scaling of the response in the process.

Objectives

Objective 54: To improve co-ordination of HIV and AIDS activities at all levels.

Objective 55: To increase ownership and support of the national response by all responding partners and members of the general public.

Objective 56: To ensure an appropriate structure at NERCHA that facilitates, manages and supports use of strategic partnerships.

Strategies

- 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.
- Strengthening coordination of the national response and the management capacity of NERCHA.

Core indicators

- Percentage of responding partners that have expressed satisfaction with the level and type of services and support provided by NERCHA.
- Percentage of ministries, NERCHA units, umbrella bodies and constituencies that have developed annual work plans, with an approved budget, and that have implemented such plans.
- The existence of a functional organizational structure within the MOHSW to effectively manage all aspects of the Health sector response.

8.2 Community mobilisation

Strategic issues

Duplication, gaps and fragmentation in initiatives—Community mobilization is when local citizens use their talents, time and resources in cooperation with the government, business and civil society organisations to work together to creatively solve community problems and tackle issues in-order to build on local strengths for a better living. Community members at grassroots level are not formally recognized, yet all stakeholders involved in the national response target them as implementers of their various HIV and AIDS interventions. This has resulted in duplication, gaps and fragmentation of the response at community level. NERCHA, government, line ministries, umbrella bodies, development partners and donors should work in concert to maximize on their comparative advantages as they deal with communities.

Limited community ownership and commitment—Community involvement and participation in the national response has improved over the years especially since 2001. However, there is still a lot of room for improvement. Generally, communities are passive beneficiaries of activities which are developed without their input. This situation results in the implementation of activities that are not aligned with perceived community needs, leading to limited ownership of the response by communities and hence limited commitment and support. Because of this kind of relationship with development agencies, communities in the country have generally become dependant.

Lack of initiative by communities—They lack initiative and tend to look up to government, development partners and civil society organizations to bring them relief. It would appear that communities need to be organized and empowered to take responsibility for their own responses. Communities also need to develop a culture to communicate disagreements whenever they exist, in an acceptable and constructive manner.

Insufficient behaviour modification—The country has done a lot of HIV and AIDS awareness creation most of which has been impersonal through mass media, bill boards, leaflets, pamphlets etc. This approach has resulted in high levels of awareness but has not had a significant impact on behaviour modification and behaviour maintenance among children and young people. Most information communication activities have been based on written materials yet the people of Swaziland are not a reading population. The use of interpersonal and community based communication methodologies has been scanty. This could be due to limited technical capacity and resources to pursue such approaches.

Objectives

Objective 57: To improve involvement and participation of grass-root communities, people living with HIV and AIDS and vulnerable groups in the national response.

Objective 58: To improve coordination of local community responses.

Strategies

- Improvement of 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.
- Promotion of partnership development among partners who provide support to community responses.
- Promotion, strengthening and use of community based mobilization response methodologies that are both acceptable and feasible.

Core indicators

- Percentage of chiefdoms and towns that have rationalized and harmonized service delivery.
- Percentage of chiefdoms and towns that have developed local procedures for leadership, activities and service delivery of the response.
- Percentage of chiefdoms with representatives that have trained people in local leadership skills of the response.

8.3 Planning and program development

Strategic issues

Top down planning—Traditionally the response to HIV/AIDS in the country at the national level has always been guided by strategic plans. However, development of these plans tended to take a top to bottom approach which does not promote ownership and involvement of communities and stakeholders at large. The tendency thereafter has been to circulate the strategic plan without guidance on how it should be used. As a result, there has been failure to translate the strategic plan into elaborate work programs.

The same thing happened to the 2000-2005 HIV and AIDS national strategic plan which is now coming to an end. While attempts were made to develop a corresponding action plan for the 2000-2005 strategic plan, it was never completed. Consequently, the plan was not accompanied by an action plan, priority areas or issues and cost estimates. It also did not have indicators and targets for success thus rendering its assessment challenging.

Uninformed national response planning process—Mapping of response activities in the country to inform planning is limited and as such compromises targeting and rationalization of the national response. This has resulted in poor linkages between the strategic plan and actual activities on the ground. This could also in part explain that while a lot is being done in the country, the epidemic continues to grow at unacceptable levels.

Lack of an annual consultative planning and budgeting—One of the international set of characteristics on the One Agreed HIV/AIDS Action Framework principle from UNAIDS' "Three Ones" principles calls for systems for regular joint reviews and consultation on progress that include all partners. This may occur through annual

reviews, joint planning and budgeting by all sectors. Unfortunately, there is no joint annual national planning and budgeting system which is inclusive and based on national planning tools. It would appear that many implementing agencies lack the capacity to plan. As a result, opportunities for up-scaling and improving the effectiveness of interventions have been lost.

Fragmented planning—Planning has in the past been left to individual organizations which limited the involvement and participation of stakeholders, including communities and special groups such as youth, PLWHA and people with special needs. Work program development has also not been guided by a national planning system. The absence of an effective national planning system has left development partners without adequate guidance resulting in parallel, unlinked and fragmented planning which results in duplication, gaps and conflict among national stakeholders.

Objectives

Objective 59: To upscale the national response and strengthen effective priority actions against HIV and AIDS

Objective 60: To harmonize and ensure coherence of actions of all cooperating partners especially development partners, civil society organizations and government sectors.

Strategies

- Introduction of 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.
- Strengthening planning capacities at all levels using a program rather than a project based approach.

Core indicators

- Geographical coverage of the national response.
- Number of responding agencies and community constituencies with annual work plans in accordance with the NAP.
- Number of people trained in planning and budgeting.
- Number of organizations with people trained in planning and budgeting.

8.4 Resource mobilisation and management

Strategic issues

Insufficient local funding—The Government of Swaziland has always been committed to funding the national response. Very early in the epidemic the government created an AIDS budget line within the Ministry of Health and established substantive posts within the Swaziland National AIDS Program. Over time, funding from the Government of Swaziland has increased from less than E2 million per year prior to the financial year 1999-2000 to approximately E25 million in 2005/6.

Development partners including bilateral and multilateral partners as well as international non-governmental organizations and foundations have also contributed substantial amounts of resources over the years to the response. However, the country does not have information on the exact amount of resources that are being invested in the response given that there is no requirement for stakeholders to declare funding they may have access to. While funding for the national response

from different sources has increased overtime, it is not sufficient to address the response decisively. Consequently, the country still needs more resources given the extent of the problem

Limited funding and poor fund flows—Outside of the Global Fund and Government of Swaziland funding, the country has not been successful in mobilizing substantial additional resources. National efforts to mobilize additional resources are not well articulated. Similarly, allocation and disbursement of currently available resources from the two major sources is too centralized, slow and characterized by bureaucratic and inflexible procedures some of which are Global Fund regulations. These bottlenecks compromise timely approval and disbursement of funds.

The procedural requirement for implementing agencies to spend first and claim later yet many do not have the capacity to do so, hinders effective implementation of the national response activities resulting in low absorption levels that have been observed to be slow. This requirement for implementing agencies to spend first and claim later presents even more challenges for civil society and community based organizations. The practice of not giving implementation agencies advance lump sum payment denies them opportunities of generating additional income through bank interest.

Limited human resource capacity—The national human resource capacity is limited compared to the magnitude of the problem. The fact that the Ministry of Health and Social Welfare is also losing health workers to other countries continues to erode the capacity of the health sector to contribute to the national response. Paradoxically, there is an excess of the human capital in the country including university graduates who cannot be absorbed by the labour market. Many graduates are sitting at home due to unemployment yet there is no concrete intervention that has been put in place for deploying this human capital to supplement the national response resource gaps.

Uncoordinated response related funding—In addition to the contribution the Government of Swaziland makes directly to the Ministry of Health and Social Welfare and NERCHA, government also contributes to impact mitigation activities such as school fees for orphans where a total of E40 million was committed for the 2005/6 financial year and E10 million for assisting elderly persons in the same financial year under the department of social welfare. Management of all these different pots of funds is not well coordinated and planned for.

Objectives

Objective 61: To increase available funding at all levels on a scale capable of making an impact to the epidemic

Objective 62: To ensure appropriate, effective and swift use of available resources at all levels of the national response.

Strategies

- Consolidation of national response total resource needs as a basis for increasing funding by the government of Swaziland.
- Improvement of government funding to the Ministry of Health and Social Welfare in line with the 15% national budget spend recommended by the Abuja Declaration.
- Creation of an appropriate grant and sub-grant mechanism for funds available for the national response allowing for flexible and prompt disbursement to all stakeholders.

- Strengthen planning, financial management and reporting capacities of sub-grant recipients and all other implementing partners.
- Creation and operationalization of a framework for tracking resources.
- Improvement and intensification of resource mobilization initiatives internally, regionally and internationally to broaden funding base.

Core indicators

- Amount and percentage of HIV funding allocated to all sectors (disaggregated by type of sector).
- Percentage of coordinating bodies that have signed agreements with NERCHA.
- Average amount of funding allocated to sub-grantees on the NERCHA last financial year.

8.5 Advocacy and communication

Strategic issues

According to the International Planned Parenthood Federation (IPPF), advocacy is a process of communication which is different from mere dissemination of information and education (IEC). Advocacy goes beyond IEC and seeks support, commitment, and recognition of a problem by policy decision makers and the general public. Advocacy also provides support and solutions for tackling issues. If there is no strong advocacy and lobbying undertaken soon, the prevalence rate of HIV and AIDS in the country will continue to be high for the foreseeable future since the problem has not yet been accorded the attention it deserves. Even the media has not yet internalized and publicly acknowledged the devastating effects of the epidemic as warranting a change of attitude and approach in reporting.

"Business as usual"—As a result of the AIDS epidemic, numerous social, religious, cultural, political, legal and economic challenges have emerged in the country. To address many of these issues; policies, legislation and a variety of resources including political commitment are required. Even though Swaziland is the most affected country in whole world, visitors who come to the country make the observation that there is no sense of urgency among the people of Swaziland and that life is "business as usual".

Investment in the response by government is not commensurate with the extent of the problem—While government investment to the national response is commendable and has grown over time, it is not commensurate with the extent of the problem. Processes for creating an enabling environment for the response to thrive have not been adjusted to generate results at a more accelerated rate. As an example, a lot of important and critical policies are in draft form and require institutional and services reformation.

No strategy for addressing non-factual public statements that water down response efforts exists—While a lot of IEC related communication is going on, information on the nature of the response and emerging issues is limited. No strategy for addressing non-factual public statements that water down response efforts exists.

There are generally no organized platforms and publications for information exchange—With the exception of the recently established partnership forum, there are generally no organized platforms and publications for information exchange among partners of the national response.

Civil society organizations do not have the capacity to advocate and lobby for the required enabling environment—Civil society organizations do not have the capacity to advocate and lobby for the required enabling environment. Similarly, the

national response has never had a formal advocacy and communication strategy. Since inception, NERCHA has facilitated up-scaling of the national response, however, in doing so, it has acquired a negative image amongst some members of the public and responding agencies including some development partners. NERCHA also does not have an internal public relations strategy.

Objectives

Objective 63: To create an enabling social, religious, cultural, political, legal and economic environment for the national response to thrive.

Objective 64: To improve information availability on the national HIV and AIDS response as well as responsiveness to information.

Strategies

- Promotion of a culture and development of capacity to mount advocacy and lobbying activities at all levels of the national HIV and AIDS response.
- Improvement of opportunities and national capacity for stakeholders to share and exchange information on HIV and AIDS activities of the national response.

Core indicators

- Number of draft policies approved.
- Number of HIV and AIDS related pieces of legislation amended and enacted.
- Number of publications on the national response that have been disseminated.

8.6 Cross-cutting issues

Strategic issues

The document recognizes that there are cross-cutting issues which should be mainstreamed through-out all the other thematic areas. Issues that are considered under this sub-thematic include human rights, gender, poverty, disability and socio-cultural factors.

Very few behaviour change communication programs in the country address the relationship between gender, HIV and AIDS—Abuse of power by men in sexual relationships as indicated by community consultations is recognized by many Swazis to be one of the major drivers of the epidemic in the country yet not much emphases has been placed by the national response on this issues. It is believed that very few behaviour change communication programs in the country address the relationship between gender, HIV and AIDS. Similarly, not many HIV and AIDS practitioners have received training in gender, HIV and AIDS. As a consequence of gender disparities, women tend to carry most of the burden for mitigating the effects of the epidemic: they provide most of the care and psychosocial support.

Respect for human rights appears to be a challenge in country—In many instances during community consultations men tended to view promotion of women and children's rights as problematic and culturally unacceptable. Similarly, women tended to down play the importance of the children's rights. In fact, both men and women viewed children's rights as one of the drivers of the epidemic.

Limited interventions that address poverty, HIV and AIDS—Poverty is another cross cutting issue because it has implications for prevention, care, support and treatment as well as impact mitigation. It was identified by community consultations as another driver of the epidemic. Poverty is a common phenomenon in the country.

According to a study which was conducted by the Ministry of Economic and planning in 2002, approximately 69% of the people in the country are classified as poor particularly female headed households. Poor people are more vulnerable to HIV infection because some prioritize economic well-being over safety. Poverty also makes it difficult for people to access HIV and AIDS services and means of mitigation effects of the epidemic. Even though the relationship between poverty and the AIDS epidemic is well recognized, it is not part of the mainstreaming HIV and AIDS interventions in the country.

Socio-cultural practices are not addressed as mainstream HIV and AIDS interventions—Some socio-cultural practices are believed to have negative implications for prevention, care support and treatment and impact mitigation, yet as is the case for gender and poverty; socio-cultural practices are not addressed as mainstream HIV and AIDS interventions.

Objectives

Objective 65: 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.

Objective 66: Ensure 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.

Strategies

- Development of public awareness on the relationship of human rights, gender, poverty, socio-cultural practices and disability to HIV and AIDS.
- Development of national capacity to mainstream human rights, gender, poverty, socio-cultural practices and disability into HIV and AIDS related interventions.

Core indicators

- Percentage of members of the public who are aware of the relation of human rights, gender, poverty, socio-cultural practices and disability to HIV and AIDS.
- Percentage of implementing agencies with HIV and AIDS programs that have integrated human rights, gender, poverty, socio-cultural practices and disability.
- Number of trained implementers of HIV and AIDS activities.

8.7 Monitoring and evaluation

Strategic issues

Monitoring and evaluation is an integral part of strategic planning. It provides the basis for benchmarking actual results with desired levels of performance. This section addresses monitoring and evaluation issues in line with one of the UNAIDS three one's principle (One Monitoring and Evaluation Framework).

Insufficient monitoring and evaluation of previous national response plans—In line with the principle of the three ones and with the support of the World Bank, NERCHA facilitated the establishment of a monitoring and evaluation road map. Prior to this plan, the country did not have a monitoring and evaluation plan for the national response to HIV and AIDS. As a result, there was no system for collecting output data and generation of information on the status of previous plans. Similarly,

information products were not clearly defined nor disseminated in a systematic manner. This also meant that most interventions were not evidence based.

Absence of a national program for collecting non-health HIV and AIDS data as well a generally weak monitoring and evaluation systems of partner organization—MOHSW does not yet have a synchronised plan or operational process for collecting HIV indicators. There is also no national program monitoring system for collecting non-health sector data. Finally, the monitoring and evaluation systems of implementers and coordinating agencies of HIV and AIDS interventions are weak. Funding for monitoring and evaluation is generally poor.

Improved availability of data—Serological surveillance is done every two years at selected antenatal clinics in the country. A number of population-based behavioural surveillance studies have been planned for the next 4 years which includes the country's first Demographic and Health Survey planned for 2006. This survey will generate population based HIV data. A computer based information system capable of capturing current, mandatory and periodic data from different implementers of HIV and AIDS interventions has been developed and installed. This information system has not yet been populated with data given that no national level output data is currently being collected. NERCHA's financial system is able to track projects financially, but only for NERCHA-funded projects, and not for projects of other implementers of HIV interventions.

Objectives

Objective 67: To produce accurate information and data on the achievement of the objectives and outputs of the national response to HIV and AIDS

Objective 68: To promote utilization of available HIV and AIDS data for planning and decision making.

Strategies

- Refinement and implementation of a national monitoring and evaluation system for the national response.
- Development of national monitoring and evaluation technical capacity for all responding partners at all levels of the national response including NERCHA.
- Strengthening of 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.
- Alignment of the national HIV and AIDS monitoring and evaluation system with that of sectoral HIV and AIDS monitoring and evaluation systems.
- Generation and dissemination of data on the national response.

Core indicators

- Percentage of annual funding for HIV interventions that is spent on HIV and AIDS monitoring and evaluation.
- Existence of an monitoring and evaluation system in the Ministry of Health and Social Welfare that consists of: an MOHSW HIV and AIDS monitoring and evaluation strategy, an HIV and AIDS monitoring and evaluation unit, with full time skilled staff within MOHSW, and an annual work plan and budget.
- Percentage of pregnant women testing HIV positive during sentinel surveillance at selected antenatal clinics.

8.8 HIV and AIDS research

Strategic issues

Limited research capacity—Research in the country is perceived to be generally weak. The Nationals Research Council is not fully functional. Similarly, HIV and AIDS related research is not currently coordinated in Swaziland. Some research takes place without ethical approval because for a long time the country did not have an ethical and scientific research committee. Currently, there are no structures for approving social sciences research. The amount and quality of HIV research that has been undertaken is not known given that there is no directory of HIV research or HIV researchers.

Limited funding for research—Teaching at academic institutions is not always based on the latest research, but on the content of textbooks. Funding for research has also been lacking, and the results of research that has been undertaken, has not always been disseminated locally.

Objectives

Objective 69: To increase the number of HIV and related studies that are carried out in the country.

Objective 70: To 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.

Strategies

- Strengthening of the health ethics and scientific committee and development of appropriate ethical standards and ethical approval procedures.
- Establishment of a national HIV and AIDS research agenda.
- Development of national capacity to undertake HIV and AIDS related research.
- Improvement of processes for disseminating HIV and AIDS related research products.

Core indicators

- Number of persons trained in research methodology
- Number of research studies conducted and disseminated
- Proportion of studies that are carried out after having received approval of the health ethics and scientific committee

PART C: IMPLEMENTATION

9 Implementation of the national strategic plan

9.1 Introduction

This chapter presents a framework which describes how this document will be implemented, funded, monitored and evaluated as well as revised. Under implementation, the document discusses implementation principles, development of sectoral plans, and development of constituent plans and implementation of this plan. Under funding, it discusses funding principles, mobilization of resources, allocation and management of resources. With respect to monitoring and evaluation, the chapter discusses tracking of the national response, data collection, development and dissemination of information products. Finally, the chapter discusses the process for reviewing and revising the document.

9.2 Coordination

Implementation principles—The 2006 – 2008 National HIV and AIDS Strategic Plan together with its support document, the National HIV and AIDS Action Plan, will be implemented in line with the principles of the multisectoral response, three ones, decentralization and community based programming. Under these principles, implementation of the plan shall recognize that the national response requires a joint effort by all sectors including civil society, and that each sector shall provide leadership to its sectoral response based on its comparative advantage. Implementation of the document shall be decentralized and community driven. As part of implementation of this plan, the capacity of communities to develop annual plans will be built with the assistance of non-governmental organizations. In this regard, non-governmental organizations will play a catalytic and supportive role to community responses. This plan shall be translated into a national program of action at the national level and subsequently into sectoral and constituent operational work plans.

Development of sectoral work plans—NERCHA shall facilitate approval of the plan by Cabinet. Once approved, the plan shall be widely disseminated by NERCHA to implementing and supporting agencies. NERCHA shall be responsible for the overall coordination of the process for developing sectoral plans. In this regard, NERCHA shall ensure that all responding sectors translate the national strategic plan through the national plan of Action into annual sectoral operational work programs and that sectors have the capacity to do so. Development of such plans shall be articulated as part of the annual government planning and budgeting process. Sectoral work plans shall be developed as a prerequisite of constituent work planning.

Development of constituent work plans—Responding community constituencies and agencies shall translate sectoral annual work plans into annual constituent operational work programs. Each designated lead agency shall facilitate the

development of such plans with the full involvement and participation of implementing and supporting partners including civil society organizations, people with disability, youth and people living with HIV and AIDS.

Implementation of constituency plans—Responding communities shall implement their respective plans with the assistance of civil society organizations that shall be responsible for building the capacity of communities to implement their plans. They shall also be responsible for providing technical support and supervision.

9.3 Funding

Funding principles—This document shall be translated into a national program of action and annual work plan which will form frameworks for budgeting, resource mobilization and funding. Budgeting for the national response will be carried out simultaneously with the planning process and shall be guided by principles of transparency, accountability, equitable distribution of available resources and cost effectiveness.

The budgeting process shall be decentralized and community driven in line with the planning process. As part of the budgeting process for the national response, the capacity of communities to develop budgets will be built with the assistance of non-governmental organizations and umbrella bodies. Overall facilitation of the process shall be coordinated by NERCHA. The National Emergency Response Council on HIV and AIDS shall develop an annual budgeting framework which is similar to that of the government Public Budgeting Committee. Under this format, different constituencies will develop budget estimates and present them to a national budgeting committee which will be made up of representatives of different stakeholders. Consolidation of sectoral plans and budgets will thereafter be ensured.

Mobilization of funds—Resources for supporting the national response shall be sourced from the Government of Swaziland, bilateral and multilateral donors including United Nations agencies, development banks, foundations, private corporations, international civil society organizations, local communities and individuals. Mobilization of resources shall take place at all levels of the national response. While NERCHA will be responsible for overall resource mobilization for the national response, all responding partners shall also carry out their own specific mobilization exercises and shall be obligated to declare secured funding.

As part of the process for accessing the Government of Swaziland funding, NERCHA shall prepare a budget request that takes into consideration the needs of implementing agencies including communities. This shall exclude the needs of government sectors which will be considered as part of sectoral budget request. NERCHA shall also ensure that the budgeting process for the national response is completed in time for integration into the national government budget process. Government sectors shall integrate their HIV and AIDS budgetary requirements into their sectoral budget estimates.

In order to access funding from international funding agencies, NERCHA, with the support of the Ministry of Finance and the Ministry of Economic Planning and Development, shall convene periodic donor conferences at which comprehensive national response needs will be tabled. Implementing agencies shall continue to solicit support directly from their partners.

Allocation of resources—Government shall allocate to NERCHA, all funding for supporting both coordination and implementation of activities that are targeting members of the public. However, government shall allocate funding directly to the respective government ministries and the Public Sector HIV Program funding for the public sector workplace program. Similarly, the Ministry of Health and Social welfare shall receive funding directly from government for purposes of supporting the health

sector response. NERCHA shall in turn, disburse funding to implementing agencies through sub-granting arrangements using an imprest system which will require implementing agencies to account for the funds before further allocations are made.

Management of resources—Recipient organizations and communities shall be expected to manage resources that have been placed in their care through plausible stewardship processes and procedures including auditing and periodic performance reporting.

9.4 Monitoring and evaluation

Tracking the national response to HIV and AIDS—Tracking the national response to HIV and AIDS will be done through ongoing tracking of core indicators, midterm and end-of-term reviews of the National Strategic Plan for HIV and AIDS.

Ongoing tracking of core indicators—Core indicators for every sub-thematic area will be tracked. The core indicators defined in Chapter 4 will be used for this purpose. Indicator scores will be calculated on a quarterly basis for all output-level indicators, and on an annual or biennial basis for all outcome-level and impact-level indicators.

Midterm and end-of-term review of the NSP—In addition, the monitoring and evaluation unit at NERCHA will also lead the midterm and end-of-term review of the NSP. Such reviews will consist not only of the analysis of indicator scores, but also other consultative processes, using qualitative research techniques, to determine the challenges, implementation impediments and successes that have been achieved.

Data collection—In the national monitoring and evaluation operational plan for HIV and AIDS, core data sources will be defined. These core data sources will consist of both independent serological and behavioural surveillance, as well as the mandatory collection of HIV service coverage data from all implementers of HIV and AIDS interventions. Such mandatory data collection on the nature and extent of HIV and AIDS service coverage will be done using a new SHAPMoS system (Swaziland HIV and AIDS Program Monitoring System). The health management information system shall be responsible for collecting health service data.

Development of information products—NERCHA will develop quarterly reports for all output indicators in the NSP, and an annual report for all indicators in the NSP.

Dissemination of monitoring and evaluation products—The monitoring and evaluation unit at NERCHA shall be responsible for facilitating dissemination of information products. Different and appropriate dissemination channels will be used.

9.5 Revision of national strategic plan

This plan shall be reviewed twice during its life span. An internal joint mid-term review of the plan will be carried out after one and half years of implementation with the purpose of assessing the extent to which stakeholders are implementing strategies and corresponding activities of the plan. The initial assessment shall be conducted as a self appraisal exercise of how national response stakeholders have performed in implementing the plan in the first 1.5 years. The proposed mid-term review will give implementing agencies and partners an opportunity to make adjustments to their respective responses. In order to promote transparency and ownership, the mid-term will involve all partners in the response, including community constituencies. An end of term external review will be conducted by a joint team of local and external consultants. The purpose of the end of term review will be to assess the extent to which objectives of this plan have been achieved. Its findings will be used for informing development of a successor national strategic plan.

ANNEXES:

ANNEX 1: Bibliography

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ANNEX 2: Key informants and stakeholders interviewed

Prime Minister's office

HERH Themba Dlamini	Prime Minister
Mr. Sandile Ceko	Secretary to the Cabinet
Ms Nomathemba Hlophe	Principal Secretary Prime Minister's Office
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Mr. Mbongiseni Simelane	Undersecretary Prime Ministers' Office
Mr. Sam Dlamini	PPCU

Ministry of Finance

Ms Musa Fakudze	Principal Secretary
Ms Khangezile Mabuza	Under - Secretary Finance
Mrs. Mzungu	Ministry of Finance
Ms Nonhlahla Dlamini	HIV and AIDS Focal Person

Ministry of Economic Planning and Development

Mrs Lonkhululeko Sibandze	Principal Economist Economic Planning

Ministry of Education

Mr Jabulani G. Kunene	Principal Secretary

Ministry of Public Service and Information

Mrs. Nelly Dlamini	Director Management Services Division

Deputy Prime Minister's Office

Mr. Hamilton Dlamini	Community Development Officer
Mr. Gordon Dlamini	Community Development Officer
Mr. Jabulani Dlamini	Community Development Officer
Ms. Zodwa Dlamini	Community Development Officer
Ms. Cebsile Ginindza	Community Development Officer
Ms. Fortunate Ginindza	Community Development Officer
Ms. Zandile Maseko	Community Development Officer
Ms. Dudu Mashinini	Community Development Officer
Mr. Sibusiso Nhlengetfwa	Community Development Officer
Ms. Minah Zwane	Community Development Officer

Ministry of Health and Social Welfare

Dr. John Kunene	PS Ministry of Health and Social Welfare
Dr. Cesphina Mabuza	Director of Medical Services
Mr. Sikelela Dlamini	Under Secretary
Dr. Velephi Okello	ART focal person
Dr. Rosemary Mukasa	Medical officer in charge TB control Centre
Mr. William Qwabe	Principal personnel Office
Mr. Alson Kunene	Senior Health Administrator
Mr. Eric Maziya	Principal Social Welfare Officer
Mrs. Ellen Mabuza	Social Welfare Officer
Ms Gugu Made	Social Welfare Officer
Mr. Sibusiso Sibandze	Health Planner

Development partners

Dr. David Okello	WHO
Dr Allan Brody	UNICEF
Pelucy Ntambirweki	UNICEF
Mr. Jorge Nieto Rey	European Union
Ms Sharon Moynihan	HIV/AIDS micro project- EU
Dr. Jean-Marie	WHO
Dr. Augustine Ntilivamuda	WHO
Ms Chinwe Dike	UNDP
Mr. Lare Sisay	UNDP
Ms Kendra Phillips	Regional HIV/AIDS Program, USAID/South Africa
Ms Khanyisile Mabuza	FAO
Ms Mulunesh Tennegashaw	UNAIDS
Dr. Mauro. Almaviva	Italian Cooperation

NERCHA Directorate

Dr. Derek von Wissell	Director
Mr. Dumsani Kunene	Assistant Director - Technical
Ms Rosemary Shongwe	Assistant Finance and Administration Manager
Mr. Sibusiso Dlamini	Care & Support Coordinator
Ms. Zandile Mavuso	Assistant Care & Support Coordinator
Ms. Nozipho Mkhatshwa	Assistant Impact Mitigation Coordinator
Mrs. Faith Dlamini	Prevention Coordinator

Raleigh Fitkin Memorial Hospital (RFMH)

Mrs. Futhi Mdluli	Chief Executive Officer
Mr. Leonard Dlamini	Hospital administrator
Mrs. Veronica Bhembe	Chief Matron
Dr. Getahun Tsegaye	Senior Medical Officer/ Paediatrician

CANGO

Ms. Phumzile Dlamini	Program Manager
Mr. Dumsani Mnisi	Board Member – Treasurer
Ms Zanele Dlamini	Board Member – Chairperson
Father B. Malaza	Vice Chairperson
Ms. Lomcebo Dlamini	Board Member
Mr. Senzo Hlatsjwako	HIV and AIDS Consortium Member

FODSWA

Mr. Bheki Jele	Secretary General
Mr Dumsani Khumalo	Treasurer
Ms. Sozabile Simelane	Member

The Swaziland Hospice at Home

Mrs. Thulile Msane	Director Hospice at Home

Family Life Association of Swaziland

Ms. Dudu Simelane	Deputy Director

The AIDS Support Centre (TASC)

Mrs. Harriet Kunene	Acting TASC director
Mrs. Jennet Ongole	TASC Public Relationship Officer

Mrs. Lindiwe Mkhatjwa	TASC Counsellor

SWAGAA

Ms Nonhlahla Dlamini	Director

SWANNEPHA

Ms Thembi Nkambule	SWANNEPHA representative
Victoria Nyawo	Member
Garvin Khumalo	Member
Nomphilo Matsebula	Member
John Morais	Member
Vusi Matsebula	Member
Brian Dlamini	Member
Sikelela Tsabedze	Member

The Swaziland National Association of Teachers (SNAT)

Mr Musa PS Dlamini	Acting President/ convener HIV/AIDS Committee
Ms Stones N Ginindza	Deputy .Secretary General
Ms Poppy P Hlatshwayo	Gender Officer/ HIV/AIDS Committee
Mr. Evart Y Dlamini	HIVAIDS Co-ordinator

The Swaziland Nurses Association

Mr Masitsela Mhlanga	President
Mr Brian Cindzi	Secretary

Swaziland National Association of Civil Servants

Mr. Melusi Hlanze	President
Mr. Quinton Dlamini	Secretary General
Mr Sisimo Sihlongonyane	Treasurer
Mr. Noah Dlamini	Deputy Secretary
Ms. Zanele Nkambule	Recording Secretary
Mr. Kenneth Kunene	Administration

Correctional Services

Miss Phindile Dlamini	Chairperson of Prison HIV and AIDS Committee
Mr. Jetro Ndzimandze	HIV focal person
Mrs Anne Moba	Nurse and HTC counsellor
Mr Jetro Ndlovu	Social Welfare Officer

Lutsango LwakaNgwane

Make Bella Katamzi	National Coordinator
Make Aylline Dlamini	Executive Member
Make Tsenjiwe Dlamini	Executive Member
Make Olga Malinga	Executive Member
Make Authilia Nxumalo	Executive Member
Make Dellie Dlamini	Executive Member
Make Joyce Gama	Executive Member
Make Delisa Dlamini	Executive Member

ANNEX 3: Technical Working Groups

Technical working group on prevention

Valentine Gugu Phungwayo	Business Coalition
Gcebekile Dlamini	Church Forum
Beatrice Dlamini	SNAP
Africa Magongo	Health Education Unit
Nhlanhla Nhlabatsi	HAPAC
Stanley Mtemeri	Swaziland National Blood Transfusion Service
Faith Dlamini	NERCHA
Bonisile Nhlabatsi	PMTCT
Joven Ongole	EGPAF
Peggy Chibuye	EGPAF
Phumzile Mabuza	Sexual and Reproductive Health
Fabian Mwanyumba	UNICEF
Esther Sakala	Academy of Educational Development
Evart Dlamini	SNAT
Phindile Weatherson	Standard Bank
Nomsa Mulinga	Ministry of Health and Social Welfare
Richard Phungwayo	NERCHA
Patricia T. Mngadi	UNFPA
Dumisa Msibi	Sexual and Reproductive Health
Allen Waligo	EGPAF
Zodwa Mkhonta	SEB
Nomsa Magagula	AMICAALL
Mary Ndlela	Health Education
Sindi Dube	Disability Unit
Lucky Nkambule	Career Guidance Association of Swaziland
Desmond Maphanga	Swaziland National Council of Arts and Culture
Maxwell Jele	Swaziland National Youth Council
Victor Shabangu	Swaziland National Sports Council

Technical working group on care, support and treatment

Beatrice Dlamini	SNAP
Sibongile Mndzebele	SNAP
Rejoice Nkambule	SNAP
Valentia Phungwayo	Business Community Representative
Richard Walwema	Mbabane Government Hospital Laboratory
Nomvuyo Shongwe	Swaziland Infant Nutrition Action Network
Khumbulile Mdluli	HIT (Piggs Peak Public Health Unit)
Thoko Sibiya	UNISWA
Zandile Mavuso	NERCHA
Phumlile Mkhabela	HTC Mababane

Bongiwe Radebe	RSSC/Business Coalition for HIV/AIDS
Sthembile Dlamini	Faith Bible School
Bethusile Shabangu	TB Program
Agnes Mthethwa	Swaziland Council of Churches
Gavin Khumalo	SWANNEPHA
Lilly Simelane	HBC Lubombo
Dudu Magagula	HBC Hhohho
Salatia Ndzimandze	HBC Manzini
Pureen Ndzinisa	HBC Shiselweni
Victoria Masuku	PSI
Thabsile Dlamini	Mbabane Government Hospital
Dumsile Mkhize	Mbabane Government Hospital
Richard Lemmer	SAPPI Usuthu
Bennedict Xaba	NATICC
Nonhlanhla Dlamini	AMICAALL
Edwin B Simelane	PSI New start HTC
Augustin Ntilivamuda	WHO HIV/AIDS Program Manager
Collin Musamba	Cheshire Homes
Rejoyce Nkambule	HTC National Coordinator
Setsabile Hlophe	Swaziland Hospice at Home
Sindi Dube	Disability Unit
Sisana Gamedze	Mental Health Unit
Sibongile Mndzebele	CBHC National Coordinator
Valentine G Phungwayo	Business Coalition Against HIV and AIDS
Thuli Sibiya	Chief Pharmacist (MoH & SW)
Sibusiso Dlamini	NERCHA
Dumsile Mkhize	Swaziland Nurses Association executive member
Masitsela Mhlanga	Swaziland Nurses Association executive member
Thembisa Khanya	Ministry of Health & Social Welfare
Nhlavana Maseko	Traditional Health Practitioner
Thandie Dlamini	Parish Nursing Director
Mlungisi Mthethwa	Traditional Health Practitioner
Margaret Silulu	Hope House Representative
Dame Sarah Dlamini	Hope House Director
Dumsile Mavuso	SFTU Representative House
Lomalungelo Dlamini	National Psychiatric Centre
Sid Nirupam	UNICEF representative

Technical working group on impact mitigation

Mumcy Dlamini	DPP
Dzelisa Dlamini	Lutsango LwakaNgwane
Gcebile Ndlovu	ICW
Jabu Dlamini	Deputy Prime Ministers Office
Matthew Dalling	UNICEF
Lineo Vilakati	ETGPS/MoE
Goodness Mavuso	Psychiatric Centre
Muntu Simelane	Psychiatric Centre
Sindi Dube	Disability Unit MHSW
Thabile Ndlovu	SWANNEPHA

Doo Aphane	Independent Consultant
Michael Motsa	MISA
Skhulile Dlamini	RSSC
Thoko Sibiya	UNISWA
Tfobhi G Mdluli	Lutsango
Make Bella Katamzi	Lutsango
Themba Ginindza	NERCHA
Makhosini Mamba	UNICEF
Thuli Mamba	MoE
Pernille Hansen	SHAPE/Skillshare
Nozipho Mkhatshwa	NERCHA
Thembi Gama	NERCHA

Technical working group on management of the national response

Emmanuel Ndlangamandla	CANGO Director
Zakaria Yakubu	SIPAA Coordinator
Sikelela Dlamini	US - Ministry of Health & Social Welfare
Steven Motsa	US - Ministry of Economic Planning
Bongani Langa	Representative of Church Forum
Thembisile Dlamini	Representing UNAIDS
Andrew Lim	Representing AMICAAL Swaziland
Harinder Janjua	UNDP
Nana Mdluli	NERCHA
Khanya Mabuza	UNFPA
Dzelisa N. Dlamini	Lutsango LwakaNgwane
J.M. Rwangaluola	WHO

Technical working group on monitoring and evaluation

Thembisile Dlamini	UNAIDS
Tfobhi G. Mdluli	LLN
Thabile Ndlovu	SWANNEPHA
Nombulelo Dlamini	Ministry of Health and Social Welfare
Jean Marie Rwangaluola	WHO
Michael Yembe	SFL
Sophia Mashape	BCHA
Khosi Hlatswayo	BCHA
Sandile Dlamini	Ministry of Health and Social Welfare
Bongani Langa	Church Forum
Patricia Mngadi	UNFPA
Thuli Nhlengetfwa	Independent Consultant
Nhlanhla Nhlabatsi	HAPAC
Dr. M. Mkhabela	UNISWA Mbabane
Sibongile Maseko	Ministry of Health and Social Welfare
Nelisiwe Sikhosana	CSO

ANNEX 4: The Management of the NSP Development Process

NERCHA COUNCIL

Chief Ndzabankulu Simelane
Mr. Raymond Lomashikizela Nxumalo
Mr. John Hayter
Mr. Jimson Gwebu
Ms. Olga Malinga
Mr. Hani Dlamini
Mr. Elliot Sihlongonyane
Ms. Bongiwe Duma
Dr. Zibuse Dlamini
Rev. Aaron Matsebula
Ms. Thuli Dladla
Mr. Pat Muir,
Ms. Nomathemba Dlamini
Mr. Nhlavana Maseko
Mr. Sandile Ceko

STEERING COMMITTEE

Ms. Dudu Nhlengetfwa	BCHA
Mr. Bongani Langa	Church Forum
Dr. Alan Brody	UNICEF
Ms. Thuli Dladla	Sebenta
Dr. Mauro Almaviva	Italian Cooperation
Dr. David Okello	WHO
Ms. Mulunesh Tennagashaw	UNAIDS
Mr. Sam Dlamini	Prime Minister's Office
Mr. John Hayter	Chartered Accountant
Dr. L.T. Khanya	MOHSW
Ms. Marjorie Mavuso	NERCHA
Ms. Gcinaphi Dlamini	DPM's Office
Mr. Gavin Khumalo	SWANNEPHA
Ms. Chinwe Dike	UNDP
Mr. Zakaria Yakubu	ActionAid SIPAA
Mr. Patrick Muir	PSHAAC
Ms. Nonhlanhla Dlamini	Ministry of Finance
Mr. Elliot Sihlongonyane	Accountant General
Mr. Jimson Gwebu	SFL
Mr. Nhlavana Maseko	THO
Mr. Emmanuel Ndlangamandla	CANGO
Mr. Sizwe Dlamini	SNYC
Rev. Senzo Hlathswayo	World Vision

CORE TEAM

Mr. Pat Muir	PSHAAC
Ms. Thuli Dladla	Sebenta
Ms. Mulunesh Tennagashaw	UNAIDS
Mr. John Hayter	Chartered Accountant
Mr. Zakaria Yakubu	ActionAid SIPAA
Mr. Jimson Gwebu	Swaziland Federation of Labour
Ms. Marjorie Mavuso	NERCHA
Mr. Elliot Sihlongonyane	Accountant General

Process Administration Team

Cebile Manzini
Ntombifuthi Dennis

ANNEX 5: List of consultants

Professor James Ntozi, external lead consultant, Uganda

Mr. Rudolph Maziya, internal lead consultant, Swaziland

Dr. Nester T. Shongwe, prevention consultant, Swaziland

Dr. Isabella Ziyane, care, support and treatment consultant, Swaziland

Dr. Alex Coutinho, care, support and treatment consultant, Uganda

Dr. Patricia J. Musi, impact mitigation consultant, Swaziland

Dr. Stephen Kiiriya, impact mitigation consultant, Uganda

Mr. Vusumuzi Dlamini, resource mobilization consultant, Swaziland

Mr. Herbert Gama, co-ordination and management, Swaziland

Ms. Marelize Gorgen, monitoring and evaluation consultant, World Bank

Ms. Marjorie Mavuso, monitoring and evaluation consultant, NERCHA