National HIV Prevention Policy

SWAZILAND

2012
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This policy is a product of wide consultation involving various stakeholders in HIV prevention. Together, these elements of international best practices, thorough study of Swaziland’s previous response documents and strategies, and stakeholder consultation have contributed to a national policy that will serve Swaziland and its people far into the future.

The national HIV prevention Technical Working Group (TWG) and all the HIV prevention sub-thematic groups provided insight to the development of policy statements that are crucial for implementing HIV prevention interventions. The Public Policy Coordinating Unit (PPCU)—an entity that helps Government ministries in policy formulation—guided the development of this policy. The national HIV prevention TWG will provide the overall leadership and programme coordination. The HIV prevention sub-thematic programmes lead the implementation of HIV prevention programmes.

The National Multi-sectoral Strategic Framework (2009–2014) was used to determine national HIV prevention priorities. As a result, this policy has included new emerging evidence on HIV prevention, such as multiple concurrent partnerships as one of the drivers of the epidemic in Swaziland and male circumcision (MC) as one avenue for preventing HIV in men.

This policy is a guiding tool for HIV prevention, and it shall be used by a wide range of stakeholders, from policymakers to HIV prevention programmers and implementers.

Dr. B. Sibusiso Dlamini

PRIME MINISTER
The HIV and AIDS pandemic has relentlessly engulfed the country, impacting negatively on all the primary health care and development indicators, and tends to compromise the gains that the country has observed over the years.

The HIV prevalence rate in Swaziland is the highest in the world with an estimated 19% among the population aged 2 years and older, and 26% among the population of reproductive age group 15–49 years. The bi-annual sentinel surveillance data show that prevalence among women attending antenatal clinics increased from 3.9% in 1992 to 41.1% in 2010.

Though there has been some degree of stabilisation of the prevalence rate between the years 2004 (42.6%) and 2010 (41.1%), it is still at an alarmingly high rate. Through these disturbing statistics there is a glimmer of hope for Swaziland as the prevalence rate among the women of the age group 15-19 years is showing a declining trend, from 32.5% in 2002 to 20.4% in 2010.

Though the country has made positive strides in the HIV response over the years, the HIV incidence rate is still relatively high. The HIV incidence rate was estimated to be at 2.9% in 2008. It is in this regard that the prevention of new HIV infections is paramount if the country is to experience meaningful impact results of the reduction of the HIV incidence to 2.3% by 2014.

The Swaziland National Multi-sectoral HIV and AIDS Strategic Framework (2009–2014) has identified five strategies and programmes in an attempt to achieve reduction in the HIV incidence in Swaziland. These are to intensify social and behaviour change communication (SBCC) programmes, reduce multiple concurrent partners among the sexually active population, increase sensitisation and comprehensive knowledge of HIV and AIDS, scale up the prevention of mother-to-child transmission of HIV (PMTCT) and male circumcision of HIV negative men, with 15–24 being a priority age group and also focus on neonatal male circumcision (NMC). The other HIV prevention programmes and strategies for ensuring reduced incidence of HIV include, HIV testing and counselling (HTC), sexually transmitted infections (STIs) diagnosis and treatment, programmes targeting the most at-risk and vulnerable populations, scaling up of post exposure prophylaxis (PEP) and universal precautions and blood safety.

The HIV prevention policy will provide direction and guidelines on the HIV prevention programme implementation and on the response management to an extensive range of stakeholders, which includes policymakers, managers, programmers and implementers, taking into consideration the risk factors to infection and the key drivers to the epidemic. The policy identifies the key HIV prevention programme sub-thematic areas under the biomedical and non-biomedical HIV prevention pillars and provides specific sub-thematic policy statements for guiding implementation through universal guiding principles.

Benedict Xaba
HONOURABLE MINISTER OF HEALTH
The National HIV Prevention Policy is a product of widespread consultation and participation of many stakeholders and individuals in the HIV response. The policy provides broad guidelines for the design, implementation and management of HIV prevention interventions, programmes and activities at various levels. Guidance for the development and finalisation of this policy was provided by PPCU.

The process of the development of this policy was informed by a desk review of national and international policies and strategies, consultations with technical working groups and high-level meetings with stakeholders.

The National Emergency Response Council on HIV and AIDS (NERCHA) wishes to thank all the individuals and organisations that contributed during the process of the development of this policy. In particular, the members of the National HIV Prevention Technical Working Group and the HIV prevention sub-thematic technical working groups as follows: HIV Testing and Counselling, National Blood Transfusion Services, Male Circumcision, Prevention of Mother-to-Child Transmission, Social and Behaviour Change Communication, Sexually Transmitted Infections, Most at-risk Populations, Post Exposure Prophylaxis and the Condom Technical Working Group. We also acknowledge the critical contributions made by the Swaziland Network of People Living with HIV and AIDS, WLSA, the Gender Unit and other key stakeholders. HIV prevention team for coordinating, leading and facilitating the process include: Khanya Mabuza, Faith Dlamini, Innocent Mahlubi Hadebe and Futhi Dennis.

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Finally, thanks to all stakeholders, Government representatives, international development partners, and Parliamentarians for their participation and contributions during the consultations and discussions on the drafts of the policy document.

Derek von Wissell
EXECUTIVE DIRECTOR — NERCHA

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>CHIMSHACC</td>
<td>Chiefdom Multi-sectoral HIV and AIDS Coordinating Committee</td>
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<td>CSW</td>
<td>Commercial Sex Worker</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>FBO</td>
<td>Faith-Based Organisation</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>IDU</td>
<td>Intravenous Drug Users</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IPC</td>
<td>Interpersonal Communication</td>
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<tr>
<td>LGTB</td>
<td>Lesbian, Gay, Transgender, and Bisexual</td>
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<td>MARP</td>
<td>Most at-risk Population</td>
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<td>MC</td>
<td>Male Circumcision</td>
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<td>MCP</td>
<td>Multiple and Concurrent Sexual Partners</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MNCH</td>
<td>Maternal, Newborn, and Child Health Services</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOT</td>
<td>Modes of Transmission</td>
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<td>MTAD</td>
<td>Ministry of Tinkhundla Administration and Development</td>
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<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
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<td>NAP</td>
<td>National Action Plan</td>
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<td>National Blood Transfusion Services</td>
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<td>NCCU</td>
<td>National Children’s Coordinating Unit</td>
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<td>NERCHA</td>
<td>National Emergency Response Council on HIV and AIDS</td>
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<td>Non-governmental Organisation</td>
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<td>NMC</td>
<td>Neonatal Male Circumcision</td>
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<td>NSF</td>
<td>National Strategic Framework for HIV and AIDS</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>People Living with Disability</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>Prevention with Positives</td>
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<td>REMSHACC</td>
<td>Regional Multi-sectoral HIV and AIDS Coordinating Committee</td>
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<td>RHMs</td>
<td>Rural Health Motivators</td>
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<td>Rural Health Management Teams</td>
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<td>SBCC</td>
<td>Social and Behaviour Change Communication</td>
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<td>SAM</td>
<td>Service Availability Mapping</td>
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<td>SHAPMoS</td>
<td>Swaziland HIV and AIDS Programme Monitoring System</td>
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<td>SWANNEPHA</td>
<td>Swaziland Network of People Living with HIV and AIDS</td>
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<td>SDHS</td>
<td>Swaziland Demographic Health Survey</td>
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<td>STI</td>
<td>Sexually Transmitted Infection(s)</td>
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<tr>
<td>TMSHACC</td>
<td>Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>WLSA</td>
<td>Women in Law in Southern Africa</td>
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National HIV Prevention Policy

SWAZILAND
“Preventing new HIV infections in the Kingdom of Swaziland is vital to reverse the epidemic and achieve treatment, care and impact mitigation targets.”
1.1 Background

Preventing new HIV infections in the Kingdom of Swaziland is vital in reversing the epidemic and achieving treatment, care and impact mitigation targets. Prioritizing HIV prevention is cost-effective and impacts on the costs of providing treatment and care. Moreover, it is imperative in ensuring that the nation realises its human, social and economic development goals.

Swaziland is committed to achieving the Millennium Development Goal (MDG) 6 of “halting and reversing the spreading of HIV by 2015” and has prioritised HIV prevention within the national response to HIV and AIDS. The national response has adopted a comprehensive approach to HIV prevention which includes combination of behavioral, biomedical and structural interventions that are tailored to respond to the epidemic whilst meeting the needs of those most at risk.

1.2 Country Profile on HIV and Problem Statement

Swaziland has an endemic hyper epidemic with HIV firmly established in and spreading through the general population. The country’s HIV epidemic has reached unprecedented levels with a prevalence of 31% amongst the age groups 18-49 and is higher among women (39%) than men (32%) (SHIMS 2012). This figure matches the Demographic Health Survey findings for the same age group and is an indication that the HIV epidemic has stabilized over the past five years.

The Antenatalcare Surveillance Survey (2010) also indicated a stabilization of the HIV epidemic amongst pregnant women at 41%, while a downturn was seen among young women aged 15-24 from 39% in 2008 to 34%.

Amongst adults aged 50 years and above, HIV prevalence stands at 14% whilst amongst children aged 5-14 years the HIV prevalence stands at 3%(DHS 2007).
Of particular concern is the rapid increase in prevalence amongst women; from 12% at ages 15-19 to 38% between ages 20-24 and ultimately to 49% by age 25-29 (DHS 2007).

Below is a snapshot of figures sourced from HIV and AIDS documents in Swaziland:

- The HIV incidence rate is 2.4% (SHIMS 2012).
- Ninety-four percent (94%) of new infections occur through heterosexual contact. About 68% of new infections in adults occur in persons above 25 years of age, the majority of whom are married or co-habitate with a steady partner (MOT 2009).
- The majority of new infections are amongst females (MOT 2009).
- HIV prevalence among pregnant women rose from almost 4% in 1992 to 41.1% by 2010 (ANC 2010).
- The majority of new infections in children, 0-14 years, are due to a mix of exposures such as mother-to-child transmission during pregnancy, childbirth, breastfeeding and sexual violence (MOT 2009).
- 40.1% of the population aged 18-59 know their HIV status (MICS 2010).
- Only 19.1% of men aged 15-59 are circumcised (MICS 2010).
- Consistent and correct condom use is low.
- The probability of using a condom during higher risk sex increases with educational attainment in men and women, and is higher in younger age groups than amongst adults.

In Swaziland, 94% of new HIV infections occur through heterosexual contact (MOT, 2009)
1.3 Risk Factors and Key Drivers of the Epidemic

In Swaziland the main mode of HIV transmission is heterosexual, and the specific sexual behaviours described below are most likely to put people at-risk of HIV infection.

- **MULTIPLE CONCURRENT SEXUAL PARTNERS (MCP):** This is generally defined as sexual behaviour characterised by having more than one sexual partner in the same time period. MCP is the most immediate cause of new HIV infections and significantly correlates with the majority of drivers of the epidemic. Implicit in some prevailing cultural norms about manhood, social standing in the community and wealth, MCP is tacitly accepted in the Swazi socio-cultural dynamic and men are more likely to have multiple sexual partners than women (MOT 2009). The MICS (2010) reported that 2.7% of women and 15.4% of men aged 15–49 years who had sex in the 12 months preceding the survey had sex with two or more partners.

- **EARLY SEXUAL DEBUT:** The median age of sexual debut in Swaziland is low—estimated around age 16—and the average age at marriage is 26. The ten-year period between the two is usually characterised by premarital sex often with more than one partner. The MICS showed that 3.8% of young women and 2.6% of young men had sex before the age of 15. For both men and women, first sexual intercourse is in the age range 15–19, but this tends to occur earlier in rural females and urban males. There is a dramatic increase in HIV prevalence between the age ranges 15–19 and 20–24. These are also the age ranges wherein HIV prevalence amongst young women increases sharply from 12% (in 15–19 year olds) to 38% (in 20–24 year olds) and 49% (in 25–29 year olds). These sharp increases in HIV prevalence for younger women can be attributed to the fact that they willingly or coercively engage in sex with older, more sexually experienced men.

- **LOW AND INCONSISTENT LEVELS OF CONDOM USE:** In general there are low levels of condom use. Due to increased risk perception, the more casual the sexual encounter, the more likely that a condom will be used. According to the UNGASS 2010 a high proportion of sex workers (who account for a small proportion of new infections) use condoms (87.4%). Condom use among young people between the ages of 15-24 who have non-regular sexual partners is at 80.1% (MICS 2010). According to the MICS (2010), condom use among men aged 15-49 reporting to have more than one partner has increased to 71%, in 2010 from 56% in 2007. The MICS (2010) also found that condom use is higher among the youth than amongst adults for both men and women and lowest amongst married and long-term partners. One of the major factors affecting condom use amongst both young people and adults is trust between partners. As levels of trust increase, the likelihood of
condom use between partners declines. Other factors include inconsistent availability of condoms in communities, misconceptions regarding the quality of free-issue condoms, preference for branded condoms and the perception that condoms interfere with sexual pleasure.

- **LOW LEVELS OF MALE CIRCUMCISION:** Male circumcision (MC) in Swaziland remains low with only 19.1% of men circumcised (MICS 2010). MC has been shown to be an important prevention strategy in very high prevalence countries.

- **INTER-GENERATIONAL SEX:** According to the MICS 2010, 14.1% of young women aged 15-24 who had high risk sex, had sex with a partner who was 10 years or older. This figure has doubled from 7% in 2007 (SDHS 2007). On the other hand, less than 1% of men aged 15-24 had high risk sex with women who are 10 or more years older than themselves. Among older girls living in rural areas, this proportion is higher but decreases with higher levels of education.

- **INCOME INEQUALITY (POVERTY):** Various studies show that income inequality, which is high in Swaziland drives the epidemic. Income inequality is associated with more young girls engaging in what has been referred to as transactional sex, thus exposing themselves to greater HIV risks in the process.

- **MOBILITY AND MIGRATION:** A significant percentage of Swazis are mobile. Oscillatory migration is a significant factor in sexual behaviour and new HIV infections. The SDHS (2007) reported that 42% of men and women aged 15-49 were away from home for more than five days at a time, at least five times in the past 12 months, mostly for work-related reasons. A large majority are married or in long-term cohabiting relationships, and there is low condom use with non-regular sexual partners. HIV prevalence amongst these mobile populations is more than double the prevalence in the general population. Patterns of risky sexual behaviour differ for men and women who are away from each other. Focus on the non-travelling partner is also needed.

- **COMMERCIAL SEX:** In the past, commercial sex was associated with females, however, male sex workers are reportedly emerging. According to the BSS MARPS (2010) HIV prevalence among women aged 15-49 who participate in commercial sex and consider themselves to be sex workers is very high at 70%, more than double that of the general population of the same age bracket (31%). The majority of female sex workers are young women under the age 25. The study also found that there are some male sex workers. With an average of one client per day and a part-time approach to sex work, 28% of sex workers reported having other jobs.
According to the MICS (2010) the proportion of sex workers who reported always using condoms with new clients is 74.2%, whils condom use with regular clients was reported at 48.2%. Only 33.5% of the sex workers reported using condoms with non-commercial partners. The proportion of sex workers who reported that they always use a condom with all their partners was 23.5% (MICS 2010). Reported condom use with new paying clients was 90% (of which 74% consistent), and reported condom use with non-paying partners was 60%. The extent of transactional sex (sex in return for gifts or favours) remains unclear, but the ethnography conducted in 2011 showed that the transfer of money, gifts or services has long been and remains an important and expected part of courtship and sexual relationships in the region.

### Gender Inequalities and Sexual Violence:
Many cultural norms and values shape negative gender relations that help drive the epidemic. Culturally, men have a large degree of control over women and prevailing values and norms uphold men's privileges and have tended to constrain women's autonomy. These values and norms are deep-rooted and facilitate the tacit acceptance of multiple and concurrent sexual partnerships. The National Study on Violence against Children and Young Women in Swaziland (Lancet 2007) found that violence against female children is highly prevalent, with approximately one in four females having experienced physical violence as a child. Among 18–24 year old females, nearly two in three had experienced sexual violence. According to this study, 48% of females reported that they had experienced some form of sexual violence in their lifetime, and 21% said they had experienced some form of sexual violence in the preceding 12 months. Over half of all incidences of sexual violence were not reported and less than one in seven incidences resulted in a female seeking help from available services.

### Alcohol and Drug Abuse:
The SDHS (2007) noted that engaging in sexual intercourse while under the influence of alcohol can impair judgement, compromise power relations and increase risky sexual behaviour. The Alcohol Use and Sexual Risks for HIV/AIDS in Sub-Saharan Africa: Systematic Review of Empirical Findings (2007) showed a consistent association between alcohol and sexual risk taking. Men are more likely to drink and engage in higher risk behaviours, whereas women's risks were often associated with their male partner’s drinking. Alcohol and sexual risks are also linked with sexual coercion and poverty.
1.4 Rationale and Context for Policy Development

This National HIV Prevention Policy is informed by the Swaziland National Multi-sectoral Strategic Framework for HIV and AIDS (2009–2014), Swaziland HIV Estimates and Projections Report (2010), Swaziland HIV Prevention Response and Modes of Transmission Analysis (2009), Swaziland Demographic and Health Survey (2006), the Multi-indicator Cluster Suvery (2010), Swaziland Income and Household Expenditure Survey (SHIES 2010), Hearsay Ethnography Research Study (2011), the Behavioural Sentinel Surveillance among Most at Risk Populations (BSS MARPS, 2010), The Swaziland HIV Incidence Measurement Survey (2012) and Swaziland National Multi-sectoral HIV and AIDS Policy (2006). Also used to inform this document are national and international best practices and evidence on the most effective strategies and interventions required to achieve universal access to HIV prevention in Swaziland.

In the joint review of the National Strategic Framework it was highlighted that prevention efforts have not been effective enough to halt the HIV epidemic and major gaps included lack of evidence-based and targeted HIV interventions. With new evidence in HIV prevention that includes MC, MCP and treatment-as-prevention, it has become necessary to develop an HIV prevention policy that will guide implementation of HIV prevention interventions. The National HIV Policy (2006) articulates policy statements on HIV prevention. For prevention to be given the special attention it deserves, the National HIV Prevention Policy is critical and demonstrates a renewed emphasis on evidence-based and data-driven prevention programming. This policy will ensure that prevention interventions are consistent with best practices and firmly supported by strong epidemiological analysis and follow-up evaluations to monitor the effectiveness of programming and to improve quality.

This policy focuses on both biomedical and behavioural prevention interventions. In addition, the policy addresses structural and cultural factors that increase vulnerability to HIV infection to foster sustainable changes in both individual behaviours and social norms. The vision of the national HIV prevention Technical Working Group (TWG) is to translate this policy document to action. This will be achieved through operationalisation of the policy statements to ensure they are understood by all HIV prevention implementers in all the levels.

“The policy addresses structural and cultural factors that increase vulnerability to HIV infection to foster sustainable changes in both individual behaviours and social norms.”
This policy shall provide the policy framework, direction, and principles to guide prevention interventions. This policy also outlines broad policy measures for the management and coordination of the national HIV prevention response.

It shall apply to Government and all stakeholders in the public, civil society and private sectors involved in HIV prevention. In particular, all relevant Government ministries and bodies, local and international non-governmental organisations (NGOs), faith-based organisations (FBOs), private health practitioners, persons living with HIV/AIDS (PLHIV) and other partners are expected to adhere to the enunciated policy. This policy shall be implemented in conjunction with the National Multi-sectoral HIV and AIDS Policy (2006), and its revision process shall be informed by the availability of new evidence.

1.5 Policy Process

The development process of the policy was an extensively consultative process involving multiple stakeholders. These consultations were aimed at soliciting inputs on the policy statements now contained in this document. The national HIV prevention TWG guided the development process of this policy. Guidance was also sought from the Government Public Policy Coordinating Unit (PPCU), which provided standard policy guidelines used as a benchmark for all Government policies.

This document was reviewed at multiple stages by the HIV Prevention TWG and a wide range of stakeholders from various sectors. Consultations were also held with all HIV prevention sub-thematic TWG’s. The HIV Prevention iNdaba 2010 was also a forum that informed the policy development process. The findings and report of the HIV Prevention iNdaba were used as a guiding document to inform key policy statements and to ensure an innovative approach.
1.6 Policy Goal

The overall goal of this policy is to promote an enabling environment for the scaling up of biomedical and non-biomedical HIV prevention interventions to reduce the HIV incidence in Swaziland.

1.7 Policy Objective

The overall objective of this policy is to halt and reduce HIV infection in Swaziland. More specifically, it seeks to guide programmatic, institutional and social responses in priority and other strategic intervention areas for HIV prevention. Each of the priority interventions employs a different set of activities that contribute to behavioural outcomes, and all require social and behaviour change to succeed. Social and behaviour change communication (SBCC) interventions are essential to ensure the adoption of risk reduction behaviours and can improve the effectiveness of:

**NON BIOMEDICAL HIV PREVENTION INTERVENTIONS:**

- Social and behaviour change communication
  - Reduction of multiple and concurrent partnerships (MCP)
  - Comprehensive knowledge about HIV
  - Targeted prevention interventions with PLHIV and persons whose behaviours place them at greater risks for HIV infections

**BIOMEDICAL HIV PREVENTION INTERVENTIONS:**

- Male circumcision (MC)
- Prevention of mother-to-child transmission (PMTCT)
- Condom use
- HIV testing and counselling (HTC)
- Blood safety
- Post exposure prophylaxis (PEP) and universal precautions
- Sexually transmitted infections (STIs)
- HIV treatment as prevention
1.8 Guiding Principles

As a demonstration of political will and good governance, this policy is guided and underpinned by the National Multi-sectoral HIV/AIDS Policy, the National Strategic Framework, and the under listed principles:

- **ACCOUNTABILITY AND TRANSPARENCY:** The policy shall be publicly available and progress reviewed against benchmarks on an annual basis.

- **A CONTEXTUAL RESPONSE:** HIV prevention programmes shall be differentiated and locally adapted to the relevant epidemiological, economic, social, cultural, age and literacy contexts.

- **COMMUNITY PARTICIPATION:** Decentralisation of decision making shall ensure equal regional and community engagement and participation for ownership of prevention interventions.

- **COMPLIANCE WITH LEGAL INSTRUMENTS:** The policy shall be in line with national laws, international treaties, conventions and declarations signed and ratified by the Government of Swaziland.

- **EVIDENCE-BASED PROGRAMMING:** Interventions shall be designed based on the specific conditions of vulnerability and risk behaviours verified to be driving the epidemic within communities of focus.

- **GENDER RESPONSIVE PROGRAMMING:** Gender equality and equity shall be applied in all programming and prevention interventions to meet the unique needs of women, girls, men and boys.

- **HARMONIZATION:** Interventions shall be in line with and advance existing national and international commitments.

- **HUMAN RIGHTS:** The promotion, protection and respect for human rights shall be observed.

- **INCLUSION:** People with disabilities (PWD) and other marginalised populations shall have access to all HIV prevention services.

- **INTEGRATION OF SERVICES:** A continuum of HIV prevention services shall be built that are integrated into other intervention categories such as care and support of OVCs and ART treatment, thus ensuring quality continuum of services and messages are provided.

- **INSTITUTIONAL CAPACITY BUILDING:** Human and institutional capacity development shall be promoted within both the public, non-governmental, community and faith-based sectors.
MULTI-SECTORAL AND HOLISTIC APPROACH: various sectors, umbrella bodies, and relevant stakeholders shall be brought together to contribute to the national HIV prevention response.

PARTICIPATION OF PLHIV: Full, meaningful involvement of PLHIV in the design, implementation, monitoring and evaluation of HIV prevention information, education programmes and activities shall be sought.

POLICY DEVELOPMENT FOR HIV PREVENTION: There shall be systematic review, reform and strengthening of policies for effective evidence-based HIV prevention programming.

PROMOTION OF POSITIVE CULTURAL PRACTICES: HIV prevention interventions shall include positive and innovative cultural practices and address social and cultural norms that have been identified to fuel HIV transmission.

“PRINCIPLE OF THREE ONES”: Interventions shall be implemented within the principle of the Three Ones – One HIV and AIDS Action Framework, One National AIDS Coordinating Authority and One Monitoring and Evaluation System.

RESOURCES shall be mobilised, efficiently and effectively used and investments leveraged.

STIGMA AND DISCRIMINATION: The protection, non-discrimination, non-stigmatisation of PLHIV and all other vulnerable groups shall be apply across all HIV prevention intervention areas.

STRENGTHENED COORDINATION AND MANAGEMENT: NERCHA shall employ collaborative mechanisms, bring together and align stakeholders in the national prevention response.

UNIVERSAL ACCESS to HIV related services shall be guaranteed to all.

PARTICIPATION OF YOUTH: full, meaningful involvement of youth in the design and implementation of HIV prevention information, education programmes and activities; emphasis on youth/adolescents living with HIV, particularly perinatal infected adolescents shall be sought.
1.9 Scope of Application

This policy shall apply to public, private and all other stakeholders and partners involved in and supporting the national HIV prevention response. In particular, it obligates all Government ministries and organs, stakeholders and partners to mainstream HIV prevention in their plans and programmes. The Government of Swaziland shall commit to providing leadership in planning and implementation, strengthening coordinating mechanisms, include stakeholders at all levels, and ensure the adoption and enforcement of legislative reforms.

Multi-sectoral HIV/AIDS Policy (2006): The National Emergency Response Council on HIV and AIDS (NERCHA) as the national multi-sectoral HIV coordinating mechanism shall ensure the overall implementation of the policy through the office of the Prime Minister.
“Evidence-informed programming is highlighted as a critical component in the HIV prevention response, and is duly noted as a requirement for HIV prevention interventions.”
2.1 HIV Prevention Situation in Swaziland

The National Multi-sectoral HIV and AIDS Policy (2006) provided the legal framework for the implementation of the National Multi-sectoral Strategic Framework for HIV and AIDS. Since then, there have been significant changes in Swaziland’s response to HIV prevention in areas such as the prevention of mother-to-child transmission (PMTCT), male circumcision (MC), multiple concurrent sexual partnerships (MCP) and concomitant new ways of doing things.

Evidence-informed programming and using the UNAIDS investment framework is highlighted as a critical component in the HIV prevention response, and is duly noted as a requirement for HIV prevention interventions. The MOT analysis (2009) highlights the current lack of evidence required to inform interventions targeting priority populations, and in particular most-at-risk populations. This policy acknowledges that evidence showing that most-at-risk populations have a high concentration of risk behaviors which dramatically increase the risk of HIV transmission has since become available and therefore need focus in HIV prevention interventions. It is further noted that no age group or sex is homogenous and therefore interventions should take into account the different behaviors that exist withing populations which place them at differential risk of exposure. The use of evidence to inform targeting is therefore critical in this regard.

To address the multiplicity of factors that can fuel the spread of HIV infection in Swaziland, it is essential to adopt a comprehensive approach to HIV prevention. The policy shall address priority intervention areas using social and behaviour change communications, and target key risk behaviours.

In line with the National Strategic Framework for HIV and AIDS, this policy provides the framework for the implementation of four priority strategies—reduction of multiple concurrent partnerships, increasing comprehensive knowledge about

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1UNAIDS (2007). Globally MARPs are people with concurrent multiple sexual partners, including sex workers, clients of sex workers, and MSM, and infecting drug users, and also sexual partners of IDUs, female partners of MSM, and partners of sex workers, since their partners engage in risky behaviour.
HIV, PMTCT, Medical Male Circumcision (MMC). Other strategic interventions are needed to sustain the gains already achieved in the response to HIV and AIDS and these are: consistent and correct condom use, HIV testing and counselling (as an entry point to care and knowing one’s status), blood safety, post-exposure prophylaxis and the effective control of sexually transmitted infections (Multi-sectoral HIV/AIDS Policy 2006).

The country has a generalized epidemic which is largely heterosexually driven. Social taboos around homosexuality drive these populations underground and make it difficult to discover the extent to which men who have sex with men (MSM) and intravenous drug users (IDU) contribute to the spread of HIV in Swaziland. It is clear from evidence that women and girls are a particularly most at risk population.

The BSS MARPS, 2010 showed that HIV prevalence among SW is very high (70%), the behaviours of SW, MSM and IDU put them at high risk, however, there are fewer programmes specifically designed to target them. The NSF shall reclassify local MARPs as women and girls, whilst key populations shall include sex workers, MSM, IDU, prisoners and migrant or mobile sub-populations.

2.1.1 Social and Behaviour Change Communication (SBCC)

Social and behaviour change communication (SBCC) is recognized as cross cutting and must be based on the specific conditions of vulnerability and risk behaviours, guided by the key drivers of the epidemic, and demonstrated by evidence-based programming. SBCC interventions shall be directed at achieving targets aimed at preventing new infections amongst primary target audiences whilst creating an enabling environment for the uptake and maintenance of protective behaviors through appropriate targeting of secondary target audiences who influence change amongst primary target audiences.

In line with the National Strategy for Social Behavior Change Communication, SBCC strategies shall be utilized to promote uptake of services by addressing socio-cultural and structural barriers that impact on health-seeking behaviors.

2.1.1.1 SBCC interventions shall be available and accessible to all; these are expected to be culturally sensitive, age appropriate, gender differentiated, promote gender equity and take into consideration the literacy levels of the target communities.

2.1.1.2 Implementation of all SBCC interventions shall be guided by the National Strategy for Social and Behaviour Change Communication.
2.1.3 SBCC shall focus on changing specific risk behaviours in all HIV prevention areas through the development of evidence-based interventions, further it shall:

i. be directed at populations that practice behaviours which place them at heightened risks of HIV infection;

ii. engage agents of influence (role models), social, political and cultural leadership in target communities to drive social change aimed at reducing risk of HIV infection; and

iii. go beyond the individual and focus on the socio-cultural and structural context within which behaviors are practiced

iv. engage political actors through advocacy to address structural barriers that impact on individual sexual behaviors.

2.1.4 SBCC interventions shall take a long-term approach aimed at driving and maintaining positive social change through increasing exposure to interventions, achieving national coverage and targeting young people with the aim of influencing behavior formation.

2.1.5 SBCC interventions shall highlight anti-discrimination legislation for PLHIV, the disabled and other marginalised groups.

2.1.6 SBCC interventions shall address structural barriers that impact on sexual behaviors and on uptake of services through legal reforms that shall reinforce human rights, women’s rights, child protection and all people’s rights to services for prevention, care and support. It shall further sensitise the public on the existence of legal instruments, their rights, responsibilities and benefits in order to ensure their protection.

2.1.6 SBCC strategies shall promote uptake of clinical services by targeted populations in line with their specific needs.

2.1.2 Multiple Concurrent Partnerships (MCP)

Multiple sexual partnerships, particularly overlapping or concurrent partnerships by both men and women, lie at the root of Swaziland’s HIV epidemic and represent the most immediate response needed to prevent new infections (MOT 2008). According to the MICS (2010) only 13% of women in the country are in polygamous relationships. It is the practice of what is often described as modified polygamy: ‘monogamy de jure—polygamy de facto’(1), or (multiple concurrent sexual partnerships) that continues to fuel the epidemic in the country.

Whilst there is sensitivity around the issue of MCP, greater focus is needed to increase awareness and understanding of the heightened risk of infection that this
behavior presents. In turn, interventions must address the complexities of MCP, which include age-disparate relationships, gender power imbalances, gender-based violence, women's economic reliance on men, and negative cultural norms.

2.1.2.1 Partner reduction shall be the key message in all MCP communication with the aim of increasing risk perception amongst different populations. Critically MCP interventions shall integrate condom use, MC and PMTCT into their messaging to ensure that target populations are mobilized to utilize prevention services aimed to protect them from infection.

2.1.2.2 Sexually active Individuals, shall be the focus population for targeting the reduction of MCP. Young people of pre-adolescent age shall also be targeted with appropriate interventions with the aim of influencing behavior formation.

2.1.2.3 Increasing risk perception amongst target populations on how age-disparate relationships promote new infections and prevent an “AIDS free” generation to grow shall be one of the key approaches.

2.1.2.4 MCP messaging shall incorporate the promotion of condom use amongst targeted populations as a harm-reduction strategy.

2.1.2.5 Communities shall be engaged as equal partners and targeted community-led MCP interventions shall be promoted, strengthened and/or developed to change social and cultural norms around MCPs.

2.1.3 Abstinence

2.1.3.1 Primary abstinence from sexual intercourse and delaying sexual debut shall be encouraged and emphasized for both in-school and out-of-school youth.

2.1.3.2 Counselling on secondary abstinence shall be provided for the youth who have already engaged in sexual activities.

2.1.3.3 Abstinence interventions will integrate the following concepts:
  - faithfulness,
  - condom use

2.1.3.4 Abstinence interventions shall be structured to prepare the youth for the transition to becoming sexually active and as such MC and SRH shall be integrated into abstinence initiatives.

2.1.3.5 Messaging on abstinence will include raising awareness on sexual violence and shall aim to increase reporting of incidences of sexual violence.
2.1.4 Comprehensive Knowledge about HIV

According to the MICS (2010), only 56% (58% of women and men respectively) of persons aged 15–24 are able to correctly identify ways of preventing the sexual transmission of HIV, and reject major misconceptions about HIV transmission. This lack of comprehensive knowledge affects personalization of risk which further fuels HIV transmission. Comprehensive knowledge about HIV is critical in risk reduction and being able to utilise opportunities to cope with infection. Targeted information that is culturally sensitive will be aimed at increasing comprehensive knowledge and overcoming the myths, beliefs and prejudices associated with HIV and sexuality while also encouraging individuals to take action.

The NSF targets for this component are to increase comprehensive knowledge of HIV by 2014 to 78% amongst youth 15–24 years and to 70% amongst MARPs. The NSF also aims to empower the family to become the key source of information on HIV and AIDS for the youth aged 10-24 years.

2.1.4.1 Evidence-based culturally sensitive, age and sex appropriate HIV prevention information and education, shall be made available and accessible to different populations through popular electronic mediums such as websites and social media platforms.

2.1.4.2 Evidence-based, culturally sensitive, age and sex appropriate HIV prevention information and education, shall be made available at community level through the use of various community platforms for engagement.

2.1.4.3 SRH education shall be integrated into HIV and provided through life skills education programmes at all levels of formal and non-formal education settings as well as through community-based structures.

2.1.4.4 For in-school youth, the integrated SRH and HIV curricula shall be developed and integrated into the school curricula as an examinable subject; and promoted in primary and high schools, tertiary and vocational institutions.

2.1.4.5 For out-of-school youth, HIV prevention information, sexual and life skills education shall be made available through various interpersonal and mass media interventions that are tailor made for the youth.

2.1.4.6 A national HIV prevention minimum package on comprehensive knowledge about HIV that includes information on available HIV prevention services such as PMTCT, MC, ART, shall be developed and will include information on the risk factors and key drivers.
2.1.5 Sexual and Reproductive Health (SRH)

2.1.5.1 Sexual and Reproductive Health (SRH) services shall be integrated in all HIV prevention interventions and likewise, all HIV prevention interventions shall integrate SRH services.

2.1.5.2 All SRH services and commodities shall be made accessible to all individuals and provided in accordance with the national guiding protocols.

2.1.5.3 Dual protection against STIs, HIV and unintended pregnancy shall be emphasized.

2.1.5.4 SRH services shall be provided in line with the adolescent SRH policy and shall focus on the prevention of early pregnancies and sexually transmitted infections (STIs) and HIV.

2.1.5.5 SRH needs of PLHIV shall be upheld in compliance with protocols in Human Rights Convention.

81%

In Swaziland, 81% of men are not circumcised (MICS, 2010)

2.1.6 Male Circumcision (MC)

Swaziland has one of the lowest MC rates in the world with 81% of men not circumcised. Evidence from more than 45 studies over 20 years has shown that male circumcision significantly reduces the risk of heterosexual infection. Targeted medical MC of sufficient coverage is an integral component of the national HIV prevention response, and the Policy on Safe Male Circumcision of HIV Prevention (2009) provides a framework to support the scaling up of safe, accessible and sustainable MC. Three clear messages must be included in the scale up of MC services. First, MC partially protects men against HIV infection, secondly; MC should not be viewed as a vaccine and thirdly; MC must be coupled with correct and consistent condom use in order for it to be effective.

MC for neonates should be supported by informative educational campaigns targeting both women and men. The following policy statements are in addition to those outlined in the Policy on Safe Male Circumcision for HIV Prevention (2009):

2.1.6.1 Male circumcision services shall be made available to all males. It shall be administered based on accepted national and international standards of quality, be accessible at public and private sector health facilities, and be promoted in relevant settings in a culturally sensitive manner. The specific priority target age groups shall be based on the Policy on Safe Male Circumcision for HIV Prevention (2009).
2.1.6.2 HIV testing and counselling shall be routinely offered to all adult and adolescent men prior to circumcision. Testing HIV positive or refusal to take an HIV test shall not form the basis for denial of the service. The general health of the patient may preclude his eligibility for the minor surgery.

2.1.6.3 All men accessing MC services who test HIV positive shall be referred and linked to relevant HIV services.

2.1.6.4 MC services for adults and adolescents shall be integrated into HIV prevention, SRH and routine health services. MC services for neonates shall be integrated into maternal, newborn and child health services (MNCH). PMTCT programmes, antenatal care settings, the maternity ward, maternal waiting huts and neonatal immunization programmes shall provide entry points for health education about neonatal male circumcision in line with the National Policy, National Strategy and Surgical protocol for male circumcision (2009).

2.1.6.5 Demand creation is an essential component of a comprehensive MC programme. MC social and behaviour change communication shall be informed by evidence-based research. Comprehensive knowledge on MC shall highlight the benefits and unintended consequences of MC for themselves and their children.

2.1.6.6 Research shall be built into interventions to track changes in attitudes towards MC and risk compensation in order to inform proactive communication on MC.

2.1.6.7 MC communication shall be informed by the SBCC strategy and available evidence on factors influencing MC in the country.

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

With an HIV prevalence of 41% among women attending antenatal care, access to comprehensive PMTCT is crucial in reducing paediatric HIV infection and beyond. HIV-negative pregnant and breastfeeding women are susceptible to contracting HIV and PMTCT services shall be available and accessible to all women during pregnancy, labour and delivery, and the critical postpartum period of the first six weeks. Furthermore early infant diagnosis and HIV infection progresses faster in children, yet this is a neglected group for HIV testing and counseling (HTC). Tracking of exposed infants shall end at the age of two (2years) and as exposed infants graduate out of the PMTCT programme, there is need to for follow up to ensure linkages to HIV treatment services. The Swaziland PMTCT guidelines—in line with the World Health Organisation (WHO) PMTCT guidelines—state that services shall be implemented in four prongs:

- Primary prevention of HIV infection
■ Prevention of unintended pregnancies among HIV-positive women

■ Prevention of MTCT from HIV positive women during pregnancy, labour, delivery and breastfeeding

■ Provision of treatment, care and support of HIV positive women and their families

2.1.7.1 PMTCT information and services shall be accessible and available to all females to strengthen and expand mother-to-child transmission prevention programmes (PMTCT) and promote their effective uptake.

2.1.7.2 PMTCT services shall ensure that strategies for male participation are implemented.

2.1.7.3 PMTCT services shall be integrated into the maternal, newborn and child health services and support male involvement in PMTCT.

2.1.7.4 ART policies on the eligibility and non-eligibility of HIV positive women and their exposed infants shall be implemented and shall ensure early infant diagnosis for HIV exposed infants and access to treatment, care and support.

2.1.7.5 Promotion of PMTCT shall be informed by the SBCC Strategy and shall be made available and accessible to communities (this shall include correct messages for infant feeding).

2.1.7.6 All pregnant, breastfeeding women and their exposed infants shall have universal access to HTC; and HIV-negative pregnant and breastfeeding women shall have access to risk reduction services.

2.1.7.7 PMTCT information and services shall be provided within youth sexual and reproductive health services.
2.1.8 Condom Use

Evidence from extensive research shows that correct and consistent condom use significantly reduces the risk of HIV transmission. The MICS 2010 revealed that knowledge of the value of condoms for HIV prevention is high among all populations, however this knowledge has not yet translated into practice as consistent use of condoms among Swazis who are sexually active remains very low. For the promotion of condom use, the following strategies will be used:

2.1.8.1 Free male and female condoms shall be widely accessible and be of national and international quality standards.

2.1.8.2 Condom programming shall be strengthened in order to consistently provide quality condoms and uninterrupted services and shall:

   i. focus on demand creation, expansion of non-traditional condom outlets, supply chain management, distribution, and consistent and correct condom usage;
   ii. include strategies to creatively position condoms as safe and pleasurable; and
   iii. utilize social marketing strategies to promote condoms amongst targeted populations.

2.1.8.3 Targeting of condom programmes shall be guided by evidence of where new infections are coming from.

2.1.8.4 All sexually active young people shall receive special attention in programming, and their right to access and the use of condoms shall be promoted and protected:

   i. particular focus shall be on out-of-school males and females; and
   ii. include strategies to promote condom use by key population.

2.1.8.5 The correct and consistent use of condoms shall be integrated into all HIV prevention interventions.

2.1.9 HIV Testing and Counselling (HTC)

HIV testing and counselling is an essential service and entry point in the continuum of HIV prevention and serves as a gateway for access to treatment, care and support. In Swaziland, HTC is both provider- and client-initiated and allows for an individual to make an informed decision about knowing their status. Despite the adoption of an HTC policy in 2006, HIV testing rates remain low. The SAM
2010 indicated that out of the 242 health facilities, 201 provide HTC. According to the MICS, 40% of persons aged 15-49 (47.3% women and 32.2% men) self-reported having been tested for HIV and received their results. The same study showed that 73.3% and 45.5% of women and men respectively, had ever had an HIV test.

Furthermore, anecdotal evidence has shown a desire by under-16 year olds to test for HIV, but providers are often hesitant to provide them with services because they are below the age of consent. HTC shall be provided as follows;

2.1.9.1 High-quality, accessible, affordable, confidential HTC services shall be available to all, and the results provided in a timely manner.

2.1.9.2 HTC shall be routinely offered to all clients in all clinical and non-clinical settings, these will include community settings and opting out shall not be a barrier to accessing services.

2.1.9.3 HTC shall be encouraged and promoted as a pre-requisite to accessing medical care and ART services.

2.1.9.4 The age of consent for HTC is 12 years. HTC strategies shall ensure access to voluntary HIV counseling and testing and treatment and support for HIV-positive children. Consent for minors below the age of 12 shall be sought from parents, guardians, caregivers or health or social workers.

2.1.9.5 HTC services shall target youth and be offered in youth-friendly settings.

2.1.9.6 All clients who undergo HIV testing and counselling shall receive information on risk reduction. Couple/partner testing and counselling and disclosure of status among spouses and partners shall be promoted for risk reduction.

2.1.9.7 All male clients who test negative for HIV will be actively offered referral to male circumcision services.

2.1.9.8 All clients who test positive for HIV will be actively referred to HIV care and treatment services.

2.1.9.9 Strengthened referral systems shall be put in place to reduce loss to follow up.

2.1.9.10 All testing, whether client or provider-initiated, shall be conducted based on the “Three Cs” principles: informed consent, confidentiality and counselling. The result of any HIV test shall not be disclosed by the service provider without the expressed consent of the client and staff should be non-discriminatory towards clients.
2.1.10 Blood Safety

Transfusion of infected blood carries a 100% risk of transmitting blood-borne diseases, including HIV, hepatitis and syphilis. It is essential that the National Blood Transfusion Service assures blood safety at all levels: the time of donation, storage and transfusion.

2.1.10.1 Blood safety from donation to transfusion shall be guaranteed under the following conditions:

i. Mandatory laboratory testing for the blood supply, in order to maintain 100% blood safety, shall be guaranteed.

ii. The process and screening of donated blood will comply with internationally acceptable standards.

2.1.10.2 Safe blood products, timely available in sufficient quantities shall be ensured.

2.1.10.3 The recruitment of potential safe blood donors shall be voluntary through outreach to in-school youth, and other low-risk communities.

2.1.10.4 The recruitment and retention of voluntary non-remunerated blood donation shall be promoted through advocacy programmes and education.

2.1.11 Post Exposure Prophylaxis (PEP)

Post exposure prophylaxis (PEP) provides a window of protection and scientific evidence shows that using efficacious antiretroviral (ARV) drugs can reduce the risk of HIV infection by up to 75%. Universal precautions should be emphasized to all people, including workers who are at-risk of exposure and efforts should be put in place to provide the necessary equipment within the health care facilities to ensure their protection. Accidental exposure to, or increased risk of HIV infection can occur in institutional, workplace and home settings and in situations involving trauma, such as rape and accidental exposure during consensual intercourse. The prevention of exposure to blood, blood products and body fluids is the primary goal and the use of drugs and vaccines shall be the secondary intervention. Adult individuals, who are accidentally exposed to HIV in voluntary consensual sexual acts, including discordant couples, shall be referred to the medical officer on duty for assessment on the risk of exposure and shall be given relevant interventions.
2.1.12.1 PEP services shall be provided in compliance with national guidelines and protocols; these services will be of good quality, available and accessible to all in need and at all times at all health facilities providing ART services.

2.1.12.2 The practice of standard precautions for infection prevention and control shall exist in all health facilities.

2.1.12.3 PEP services shall be integrated across all service delivery areas.

2.1.12.4 PEP shall be offered to all eligible people, including survivors of sexual violence.

2.1.12.4 Individuals who are accidentally exposed to HIV through consensual sexual acts shall be provided with PEP in line with guidelines and protocols.

### 2.1.12 Sexually Transmitted Infection (STI)

The country has high prevalence of STI. Data from the SHIMS indicate that they are amongst the top 471 conditions reported in the country’s outpatient department and clinics. Available evidence shows that the presence of an STI in a HIV negative person, especially genital ulcerations, increases the risk of sexually transmitted HIV as interruption in the skin enables infection. New epidemiological data suggest that there has been an increase in genital herpes, an a viral STI responsible for most genital ulceration. According to a genital ulcer survey conducted in 2003 in Swaziland, genital herpes increased from 12% in 1980 to 60% in 2003. The country has a high prevalence rate of sexually transmitted infections. Ulcerative STIs significantly increase the risk of HIV infection and their effective control decreases the risk of HIV transmission. STI services are a key entry point to providing integrated HIV prevention services such as HTC, MC, and condom promotion. The process of administering the STI programme will follow the under listed guidelines:

“Accidental exposure to, or increased risk of HIV infection can occur in institutional, workplace and home settings and in situations involving trauma, such as rape and accidental exposure during consensual intercourse.”
2.1.13.2 The programme shall adhere to national STI guidelines and practices.

2.1.13.3 STI services shall be of good quality, accessible, confidential, client-friendly, non-discriminatory and available to all in need at all times;

2.1.13.4 Operational research shall be conducted in order to strengthen STI prevention, and the results used to inform behavior change interventions for STI.

2.2 Enabling Environment for HIV Prevention

Whilst Swaziland has made progress in developing or amending laws, policies, guidelines and protocols to improve an enabling environment for HIV programmes, barriers to the successful implementation of these policies and guidelines remain. These barriers include underlying traditional and cultural factors, laws and social norms, gender inequality, and increasing domestic and gender-based violence that continues to make it difficult for vulnerable populations to protect themselves from HIV infection. Other vulnerable populations such as youth, persons with disabilities, PLHIV and other emerging marginalised groups are exposed to HIV infection and most likely to suffer disproportionately from the negative consequences.

The policy statements outlined in this document have been adapted from the National Multi-sectoral HIV and AIDS Policy to ensure cohesion and alignment to the national guiding instrument.

2.2.1 Protection and Empowerment of People Living with HIV

2.2.1.1 The human rights and dignity of people living with HIV, including the right to privacy and confidentially shall be respected and protected.

2.2.1.2 Legislation shall protect the rights of PLHIV, including protection against any form of stigma and or discrimination; the HIV status of a person shall not form the basis for denial of services.

2.2.1.3 PLHIV shall, where relevant, be actively involved in the planning, development, implementation, monitoring and evaluation of HIV prevention-related plans and programmes, in order to combat stigma and discrimination associated with being HIV positive.
2.2.2 Positive Health Dignity and Prevention

2.2.2.1 Prevention with PLHIV shall be adopted as one of the national strategies for prevention and implemented within treatment, care and support across both facility and community settings.

2.2.2.2 PLHIV shall be actively involved in all efforts aimed at reducing HIV infection. A conducive and supportive environment for PLHIV shall be created to adopt and sustain positive living.

2.2.2.3 Minimum package for prevention with positives (PWP) services shall be delivered in a comprehensive and integrated manner for the adoption of safer sexual behaviours and practices.

2.2.2.4 Treatment shall be provided to all eligible PLHIV for their own benefit as well as to realize the prevention benefits of ART.

2.2.2.5 HIV treatment strategies shall ensure support for HIV-positive parents and their children to prolong their lives through encouragement of testing, provision of supportive counseling, nutritional-support and access to appropriate treatments including antiretroviral treatment.

2.2.3 Protection and Empowerment of People Living with Disability (PLWD)

2.2.3.1 Research shall be carried out to understand the needs of PLWD and to ensure that HIV prevention services meet their needs.

2.2.3.2 HIV services shall be made available and accessible to all PLWD, without any form of discrimination.

2.2.3.3 SBCC messages shall be designed to sensitise and educate PLWD on their risks and prevention strategies.

2.2.3.4 All interventions targeting PLWD shall be developed with full participation and involvement of PLWD.
2.2.4 Protection and Empowerment of Vulnerable and Most at-risk Populations

2.2.4.1 The rights of women and girls and vulnerable groups to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, shall be protected.

2.2.4.2 Women and girls and other vulnerable groups shall be protected against gender-based violence (including domestic violence), sexual abuse, traditional, cultural and other practices that may negatively affect their health.

2.2.4.3 Interventions aimed at protecting, improving access to basic needs and improving livelihoods of young people shall be encouraged, promoted, strengthened and supported.

2.2.4.4 The right of most at-risk populations to participate in interventions affecting them shall be promoted.

2.2.4.5 Policies, laws and traditional practices that put women and girls at risk of HIV infection shall be reviewed and corrective action taken to ensure protection of these population groups.

All HIV prevention-related services shall be made accessible to all vulnerable and marginalized social groups.

2.2.5 Gender and HIV and AIDS Mainstreaming

2.2.5.1 Government through NERCHA and MOH shall take measures that will integrate, promote, improve and protect the sexual and reproductive health rights as well as the health status of men, women, boys and girls.

2.2.5.2 All HIV prevention programmes, policies and action plans shall take into consideration issues of gender in terms of access, control and benefits by all population groups.

2.2.5.6 Government will create an environment where women, men and children are protected from all forms of violence and provide effective mechanisms for redress through gender transformative HIV prevention programmes.
2.2.5.7 Social and behaviour change interventions shall integrate messages to sensitise communities on gender and health issues highlighting practices that impact negatively on reproductive health, and HIV and AIDS prevention interventions.

2.2.5.8 All HIV prevention services and programmes shall promote equitable access by women, men, boys and girls.

2.2.5.9 HIV and AIDS prevention and gender mainstreaming shall focus on empowering women and extended family members with negotiation self-assertive and livelihood skills in order to take decisions on their sexual and reproductive health and rights, and confidently negotiate for safer sex with their partners.

2.2.5.10 Awareness mobilisation campaigns through media, mobile clinics, rural health motivators (RHMs) and community meetings shall encourage men to participate in HIV prevention interventions.

2.2.6 Protection in the Workplace

2.2.6.1 All workplace policies, guidelines and programmes shall comply with the national workplace guiding framework on HIV and AIDS.

2.2.6.2 All enterprises, for-profit and non-profit organisations shall have workplace HIV prevention programmes.

2.2.6.3 All employers shall ensure that employees have access to HIV prevention programmes.

2.2.7 Capacity Building

2.2.7.1 Government through NERCHA shall build capacity implementers to ensure effective and efficient delivery of HIV prevention interventions.

2.2.7.2 NERCHA with its partners shall support the development of volunteer services for HIV prevention activities.
2.2.8 Legal Framework

2.2.8.1 Government shall facilitate review and amendment of existing laws and facilitate the passing of new laws to ensure that the law adequately addresses the public health and human rights issues related to HIV prevention.

2.2.8.2 Access to legal services shall be made available for identified vulnerable populations.

2.2.8.3 Information explaining the relevant legal instruments and applicability shall be made available.

2.2.8.4 The legal framework facilitating the implementation of this policy shall be in compliance with the Constitution of Swaziland of 2005 and international conventions and declarations signed and ratified by the country.
“A strong and well defined coordination and management mechanism is needed for an **effective multi-sectoral response**, and will encourage greater collaboration among the contributing different partners.”
A strong and well-defined coordination and management mechanism is needed for an effective multi-sectoral response, and will encourage greater collaboration among the contributing different partners. Coordination, will therefore, ensure a harmonized service delivery mechanisms and increased collaboration and cooperation amongst the players. Coordination of the multi-sectoral national response shall be facilitated and promoted at national, decentralised levels and through the sector approach. It is therefore imperative that institutional capacity building is ensured for the execution of this policy.

The overall leadership and responsibility for the implementation of this policy rests with the Office of the Prime Minister.

3.1 Overall Coordination (Institutional Arrangements)

The effective implementation of this policy shall require, among other things, strong political will, leadership and commitment, the establishment and strengthening of committees at different levels to strengthen management and coordination of the national response, the enforcement of the “three ones” principle, the allocation of specific roles and responsibilities to all stakeholders, legislation reform, resource mobilisation, utilisation and tracking and monitoring and evaluation.

NERCHA, established by Government through an Act of Parliament (2003), has the overall legal mandate to coordinate the national multi-sectoral response.
NERCHA, under the Office of the Prime Minister, shall ensure that prevention interventions are within the ambit of the guiding principles of this policy and in line with the National Strategic Framework, and shall coordinate all relevant stakeholders in the HIV prevention response.

NERCHA shall coordinate the multi-sectoral response to HIV and AIDS and shall lead the implementation of this policy with regard to HIV prevention programmes. It shall collaborate with the Ministry of Health to mobilise the resources required to scale up the provision of HIV prevention services in the country.

At the regional level, coordination is a partnership between NERCHA and the Ministry of Tinkhundla Administration and Development (MTAD) through the regional coordinating mechanisms. These structures include the Regional Multi-sectoral HIV and AIDS Coordinating Committee (REMSHACC), Tinkhundla Multi-sectoral HIV and AIDS Coordinating Committee (TMSHACC) and Chiefdom Multi-sectoral HIV and AIDS Coordinating Committee (CHIMSHACC). These structures are HIV and AIDS sub-committees of the MTAD which is responsible for decentralized coordination.

Other coordinating structures include the Regional Health Management Teams (RHMT) under the Ministry of Health, and the Municipality HIV and AIDS Teams that coordinate the urban response. At community level, KaGogo Centres also play an important role in coordinating community services. NERCHA in collaboration with partners shall coordinate and facilitate:

a) the implementation, monitoring and periodic review of this policy;
b) the development of a national database of HIV-related policies and facilitate policy dissemination;
c) the development and implementation and periodic review of the National Strategic Framework and Action Plan on HIV;
d) the development and periodic review of sector HIV policies, strategies and action plans;
e) development and periodic review and maintenance of a database of responding organisations, institutions, departments and communities in the national response;
f) dialogues, consultations and information dissemination; and
g) the improvement of quality assurance mechanisms.
3.1.2 Key Ministries

Based on the priority intervention areas for this policy, the key ministries shall include the Ministry of Health; Ministry of Education and Training; Ministry of Sports, Culture and Youth Affairs; Ministry of Information, Communication and Technology; Ministry of Tinkundla and Development and the office of the Deputy Prime Minister.

3.1.2.1 Ministry of Health
The Ministry of Health shall lead the implementation of this policy with regard to health sector-based HIV prevention. In relation to the thematic areas outlined in this policy, the Ministry shall:

- Provide technical guidance and assistance for the implementation of biomedical interventions;
- Coordinate and provide HIV prevention services through the public health system;
- Ensure HIV prevention response is integrated within broader health services, such as the sexual and reproductive health (SRH) and primary health care (PHC) and tuberculosis;
- Drive institutional capacity building and infrastructure development of the health sector for execution of the policy.

3.1.2.2 Ministry of Education and Training
The Ministry of Education and Training shall be responsible for the provision of primary prevention and comprehensive HIV knowledge and information to the in-school youth. It shall provide HIV prevention information, education and life skills and sexual education in formal and non-formal education. Furthermore, the MOE shall integrate HIV prevention into the school curricular and promote it at all education levels.

3.1.2.3 Ministry of Sports, Culture and Youth Affairs
Young people are pivotal in changing the trajectory of the epidemic in Swaziland. They constitute a majority of the Swazi population: 56% of Swazis are under 20 years old and 73% are 30 years and younger. For children not yet sexually mature, there is the potential to shape their values, sense of self and sexual conduct. Children can be supported with developmentally appropriate sexuality education at home and in school, protected against sexual violence and supported in building skills for healthy, sex-positive development. Adolescents and youth need access to health services and continued educational, family and
social supports to motivate and equip them for the adoption of behaviours that safeguard their sexual health. The Ministry of Sports, Culture and Youth Affairs shall be responsible for the dissemination of comprehensive HIV knowledge and information to all the youth, with a particular focus to the out-of-school youth.

3.1.2.4 The Ministry of Information, Communication and Technology
The Ministry of Information, Communication and Technology shall be responsible for the popularisation and dissemination of the policy to key stakeholders, in particular the media. In addition, new and creative ways to disseminate information shall be sought.

3.1.2.5 The Office of the Deputy Prime Minister
The Constitution of the Kingdom of Swaziland (2005) provides a legal framework for the protection of the rights of children and the general population. The multi-dimensional impact of HIV and AIDS on Swazi society has meant that no sector has remained untouched, including children. The Office of the Deputy Prime Minister under the Swaziland Children’s Coordinating Unit (NCCU) shall ensure that children are protected from situations where they can be susceptible and or exposed to acquiring HIV. It shall ensure that children are supported with developmentally appropriate HIV and AIDS and sexuality education at home, at school and within the community and are protected against sexual violence and other situations where they can be made vulnerable to HIV infection.

3.1.3 Other Ministries
As HIV and AIDS is multi-sectoral and cuts across all Government ministries, there will be linkages to other Government ministries, which will be coordinated by NERCHA. Ministries have specific tasks and performance on HIV prevention, which are mainstreamed in the achievement of their own targets.

3.2 Decentralised (Vertical) Coordination
In line with the Decentralisation Policy of Government, NERCHA shall facilitate strengthening and or establishing mechanisms to coordinate HIV and AIDS interventions at the decentralised levels. This shall include:

- Regional HIV and AIDS Coordinating Committees;
- Inkhundla HIV and AIDS Coordinating Committees; and
- Chiefdom/Sub-Chiefdom HIV and AIDS Coordinating Committees.
3.3 Sector (Lateral) Coordination

This approach entails the strengthening of various sectors and umbrella bodies that bring together stakeholders with a common interest in the national response. The sectors and umbrella bodies shall ensure the involvement of relevant stakeholders and shall represent the collective interest of stakeholders. The sectors and umbrella bodies have cross-cutting interests and are uniquely mandated and positioned to contribute to the national HIV prevention effort. NERCHA shall:

3.3.1 Work in collaboration with partners to facilitate strengthening of the sectors and umbrella bodies;
3.3.2 Facilitate Government ministries coordination of sector responses in line with their respective mandates; and
3.3.3 Facilitate linkages to other sectors and stakeholders.

3.4 Development Partners

All development partners will work in support of this HIV prevention policy. National and international development partners and organisations involved in HIV and AIDS interventions in the country shall align with the National Multi-sectoral HIV and AIDS Policy, National Multi-sectoral HIV and AIDS Strategic Framework and Action Plan.

3.5 Programmatic Coordination

All HIV prevention programmes shall establish technical working groups to provide leadership and guidance for programme planning, implementation and monitoring and evaluation.
3.5.1 The overall HIV prevention programmatic coordination shall be led by the national HIV prevention TWG.
3.5.2 All HIV prevention sub-thematic programmes shall provide leadership for the implementation of the relevant HIV prevention programmes.
3.5.3 All HIV prevention programme coordination shall be decentralised for both the biomedical and the non-biomedical and regional coordination structures.
3.6 Stakeholders Role

3.6.1 The overall leadership and responsibility for the implementation of this policy rests with the Office of the Prime Minister.

3.6.2 This policy shall be implemented by all Government ministries and organs, the private sector, civil society organisations, community and faith-based organisations, PLWHA and all other stakeholders, including traditional healers associations, academic and research institutions, international development partners, the media, communities and traditional leaders and individuals in Swaziland.

3.6.3 The specific roles and responsibilities of the various stakeholders and partners shall be outlined in the operational guidelines.

3.7 Resource Mobilisation, Management and Tracking

3.7.1 The Government of Swaziland shall allocate a reasonable percentage of the national budget to HIV prevention and ensure allocated expenditure is utilised.

3.7.2 Government ministries shall mainstream HIV prevention and allocate a budget from their ministry budgets for HIV prevention interventions.

3.7.3 Government shall allocate funding to NERCHA for management and coordination of the national multi-sectoral response to HIV prevention.

3.7.4 Responding organisations, institutions, departments and communities shall access funding through joint planning in line with the National Strategic Framework and Action Plan.

3.7.5 NERCHA shall coordinate and facilitate development of an appropriate resource mobilisation and management framework for the national HIV prevention response.

“Young people are pivotal in changing the trajectory of the epidemic in Swaziland.”
3.7.6 NERCHA shall coordinate resource mobilisation efforts in line with the NSF and NAP and maintain a database of all HIV prevention implementing and funding partners to monitor the flow of financial resources.

3.7.7 NERCHA shall encourage targeted funding of interventions for specific higher-risk or vulnerable populations.

3.7.8 All stakeholders shall share information with NERCHA and relevant or umbrella bodies to avoid duplication in the allocation and use of available resources.

3.7.9 All organisations shall share information with NERCHA on barriers to access and use in all intervention areas, which shall be analysed and systematically addressed.

3.7.10 Stakeholders shall conduct resource mobilisation for HIV prevention activities and financial assistance received shall be reported to the relevant ministry responsible for coordinating external assistance to Swaziland in accordance with the Kingdom of Swaziland Aid Policy.

3.7.11 Transparent, efficient and effective use of resources shall be ensured.

3.7.12 The Kingdom of Swaziland AID Policy shall guide all external aid interventions by partners.

3.8 Communication and Advocacy

3.8.1 The National Communication Strategy on HIV and AIDS shall be implemented and reviewed periodically.

3.8.2 HIV prevention messaging for public consumption shall be submitted to the National Resource Centre, as the depository and the National HIV Prevention Technical Working Group as the clearinghouse of all HIV and AIDS-related information and research.

3.8.3 Information materials and products shall be reviewed and approved by NERCHA, in collaboration with the Ministry of Health, prior to dissemination, in order to standardise the quality and consistency of all messaging.

3.8.4 The Swaziland Journalist Code of Ethics shall be implemented when reporting on HIV prevention.
3.8.5 Ethical, sound and non-discriminatory information on HIV prevention shall be provided to mass media and local interpersonal communication channels (IPC).

3.8.6 Media institutions shall implement editorial, advertising and marketing policies that are responsive to the National Strategic Framework on for HIV and AIDS.

3.8.7 Advocacy on HIV prevention shall be a collaborative and coordinated effort of all partners involved in the national response and in PLHIV.

3.8.8 Capacity building initiatives for advocacy shall be facilitated and strengthened.

3.9 **National Strategic Framework on HIV and AIDS and National Action Plan**

3.9.1 Sectoral and thematic HIV policies, strategic plans and action plans shall be developed and aligned with this policy.

3.9.2 Government ministries and organs and all other stakeholders and partners shall mainstream HIV prevention into all their policies, strategies, action plans and programmes to promote an integrated focus on the HIV epidemic.

3.10 **Monitoring and Evaluation**

3.10.1 Government through NERCHA shall coordinate and facilitate monitoring and evaluation of the national response to HIV.

3.10.2 All HIV implementing partners shall report their activities to the national HIV M&E system through the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS)

3.10.3 SHAPMoS shall be implemented and reviewed in line with the NSF date.

3.10.1 **Research and Ethics**

3.10.1.1 The National HIV and AIDS Prevention Research Strategy and Agenda shall be implemented and reviewed from time to time.

3.10.1.2 NERCHA shall coordinate and facilitate ongoing research on HIV prevention intervention areas to generate evidence on “what works”; and quality assurance studies.
3.10.1.3 Operational research shall be conducted for all HIV prevention areas, and the results used to develop evidence-informed guidance for national strategies.

3.10.1.4 NERCHA shall oversee the national HIV and AIDS information depository mechanism and shall monitor the accessibility, storage and retrieval of information and data.

3.10.1.5 The National Multi-sectoral Ethics Committee on HIV and AIDS, established to safeguard the human rights and take into consideration all ethical issues relating to biomedical and social sciences HIV and AIDS research involving human subjects, shall regularly report to NERCHA.

3.10.1.6 The multi-sectoral HIV peer review mechanism shall be encouraged.

3.10.1.7 Capacity development for HIV prevention-related research shall be promoted.
CHAPTER 4

Implementation Mechanism

4.1 Policy Approval Process

The policy shall be submitted to the NERCHA Council and Ministry of Health and Public Policy Coordinating Unit (PPCU) for their consideration and recommendation to the Prime Minister who shall in turn present it to Cabinet and Parliament for final approval.

4.2 Policy Operational Guidelines or Regulation

NERCHA shall, in consultation with stakeholders, facilitate the establishment of operational guidelines for easy implementation of this policy.

4.3 Periodic Review of the Policy

4.3.1 NERCHA shall coordinate and facilitate the periodic review every five years of the National prevention policy and as is needed in light of any emerging issues.