Extended National Multi-sectoral HIV and AIDS Framework (eNSF)  
2014-2018

Final Evaluation Report

The National Emergency Response on HIV and AIDS
Acknowledgement

The National Emergency Response Council for HIV and AIDS (NERCHA) is pleased to present the evaluation report of the 2014-2018 extended National Multisectoral Strategic Framework on HIV and AIDS in Swaziland. The evaluation report is presented a guide to the development of the next strategy which will lead the country to ending AIDS by 2022.

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<td>Adolescent Girls and Young People</td>
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<td>AMICAALL</td>
<td>Alliance of Mayors’ Initiative for Community Action on AIDS at the Local Level</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>CANGO</td>
<td>Coordinating Assembly for Non-Governmental Organizations</td>
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<td>CHEPRA</td>
<td>Comprehensive HIV Epidemiological and Response Analysis</td>
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<td>CHIMSHACC</td>
<td>Chiefdom Multi-Sectoral HIV and AIDS Coordination Committee</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CMS</td>
<td>Central Medical Store</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>EIMC</td>
<td>Early Infant Male Circumcision</td>
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<td>eNSF</td>
<td>Extended Mutlisectoral HIV and AIDS Strategic Framework</td>
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<td>ECCD</td>
<td>Early Child Care and Development</td>
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<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>HTS</td>
<td>HIV Testing Services</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>KP</td>
<td>Key Population</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MICS</td>
<td>Swaziland Multiple Indicator Survey</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>MSM</td>
<td>Men Who Have Sex With Men</td>
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<td>NERCHA</td>
<td>National Emergency Response Council for HIV and AIDS</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NTCP</td>
<td>National TB Control Programme</td>
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<td>PLHIV</td>
<td>People Living With HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PNC</td>
<td>Post Natal Care</td>
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<td>PITC</td>
<td>Provider Initiated Testing and Counselling</td>
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<td>Public Sector HIV and AIDS Coordinating Committee</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>REMSHACC</td>
<td>Regional Multi-Sectoral HIV and AIDS Coordinating Committee</td>
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<td>RHMT</td>
<td>Regional Health Management Team</td>
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<td>SBC</td>
<td>Social and Behaviour Change</td>
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<td>SHAPMOS</td>
<td>Swaziland HIV and AIDS Programme Monitoring System</td>
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<td>Swaziland HIV &amp; AIDS Consortium</td>
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<td>Swaziland National AIDS Programme</td>
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<td>SWANNEPHA</td>
<td>Swaziland Network of People Living with HIV and AIDS</td>
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<td>SHIMS</td>
<td>Swaziland HIV Incidence Measurement Survey</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SWABCHA,</td>
<td>Swaziland Business Coalition on HIV and AIDS</td>
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<td>SUSAH</td>
<td>Swaziland Uniformed Services Association</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TIMSHACC</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>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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Executive Summary

Introduction

The evaluation of the Extended Multisectoral HIV and AIDS National Strategic Framework (eNSF) 2014-2018 was commissioned to assess progress in meeting the HIV and AIDS response targets as well as the country’s progress towards achievement of the Umgubudla targets. The findings of the evaluation will inform the strategic direction for a new strategy 2018-2022.

The specific areas covered by the evaluation are as follows:

- Performance of the HIV and AIDS response
- Contribution to national development efforts, in particular mainstreaming HIV in the development sector and Ending AIDS by 2022
- Inclusiveness of the HIV response
- Resources for the HIV response
- Strength of the ‘Three Ones’ Principles including coordination and implementation arrangements

The evaluation was conducted through a review of key documents providing secondary data, key informant interviews, consultations with various stakeholder groups at the national level. At the regional level interviews were undertaken with regional level leaders, consultations were held with REMSHACCs, TIMSHACCs and CHIMSHACCs while focus group discussions were conducted with men, youth, women and PLHIV. These data sources informed the findings and recommendations in this report.

Key findings

Relevance: eNSF is responsive to national development priorities, international goals and normative guidance. It also addresses the relevant drivers of the epidemic and targets the right populations. The framework was widely disseminated but some stakeholders found it too technical to understand and identify with.

Impact of the eNSF: New HIV infections are declining and the 2018 target of 1.4% has been met. The incidence rate declined from 2.9 in 2011 to 1.36 in 2017. This means new infections have decreased almost by half between 2011 and 2017. However, new infection are higher among adolescents and young people compared to other groups. AIDS deaths are declined by 24% between 2013 and 2016. A higher number of AIDS deaths occur among men partly because they present late for treatment. Life expectancy has marginally improved having increased from 48.8 years for men in 2010 to 49.6 years in 2015 while the increase among women was from 47.9 to 48.1 years in the same period. However, Swaziland is ranked last among the neighbouring southern Africa countries. The efficiency of the governance of the response is sub-optimal due to weak accountability, inadequate coordination and resource limitations. 27% of the service coverage targets achieved by 2015 (mid-term) and 49% of the output/coverage indicators had no data.

Umgubudla fast track programme: The country on track to achieve the ART, PMTCT and TB/HIV co-infection targets. Progress has been made towards the achievement of all the 90-90-90 targets. 84.7% of PLHIV 15 years and above know their HIV status. Of these, 87.4% are on ART treatment and out of this proportion, 91.9% are virally suppressed. Male circumcision programme has achieved low results and the target of 70% is not likely to be met unless huge investments are made and continuous innovation of approaches is maintained.
HIV prevention

a) HIV testing services: HIV Tests have been scaled up over time and the service is widely available. For instance, about 413,000 tests were conducted in 2015 compared to a target of 500,000 people to be tested. The scale up of HTS can be attributed to multiple strategies used at community and facility level testing including integration of HTS in several service delivery points. Men and adolescents less covered compared to women. In 2015, 64% of the people tested were women and 37% men. Although there is an increase in tests conducted, the positivity rate is declining which calls for innovative targeting of HTS. Referral especially from community to facilities is not working efficiently partly due to stigma and long distances to health facilities in rural areas where communities are poverty stricken.

b) Social Behaviour Change: Although SBC interventions have been scaled up, behavioural indicators have not improved. Young people 15-24 years having sex with more than one partner increased (women 2.7% in 2010 to 3.3% in 2014 and men 16% in 2010 to 21.1% in 2014) while knowledge of HIV prevention among adolescents and young people declined in the same period. SBC interventions are targeting all key populations including adolescents and young people, key populations, men and women. The increase in risk and vulnerability shows the challenge in translating education and awareness into behaviour change. Overall, coordination of SBC is inadequate and a quality assurance mechanism is not in place.

c) Condom promotion and distribution: MICS 2014 shows that 71% of men 15-49 years and 82.6% of women with more than one partner used a condom in last sex act. About 11million male condoms were distributed in 2015 compared to a target of 10million. Channels for condom distribution have been established both at facility and community level and condom promotion has also been intensified. However, despite this success, the high HIV incidence as well as high rates of STIs and teenage pregnancies show that either condoms distributed are insufficient or they are not consistently used.

d) Prevention of Mother to Child Transmission: PMTCT services have been scaled up country-wide with good results for pregnant lactating women and exposed children. HIV exposed infants on ART increased from 70% in 2011 to 86% in 2016 against a target of 90% and pregnant and lactating women on ART increased from 87% in 2011 to 94% in 2016 against a target of 95%. On the other hand infants infected by HIV increased from 2 to 3% over the same period. Low results were achieved for prongs 1 and 2. Pregnant women testing positive at ANC (who did not know their status) ranged from 16% to 21% between 2012 and 2015 while overall positivity among pregnant women is 37% while unmet family planning needs among married women increased from 13% in 2010 to 15.2% in 2015, an indications that overall unmet needs for FP is growing.

e) Male circumcision: Men 15-59 years circumcised increased from 19.1% in 2010 to 24.3% in 2014. 97,132 men have been circumcised since the programme was launched in 2009 representing 16% of total male population. The programme is well coordinated and implemented but the results are too low to achieve the 70% target by 2018. Early Infant Male Circumcision has not commenced and socio-cultural barriers and misconceptions on male circumcision have not been adequately addressed. Another key limitation for this programme is funding; the targets achieved are partly determined by the funds available.

f) Customized programmes for key populations: Comprehensive HIV prevention, treatment, care and support for KPs have been scaled up but stigma and policy/legal barriers remain. Key populations are being reached at the hotspots and are provided with a combination prevention services that include information and education, condoms and lubricants and HTS. They are also
referred to health facilities for treatment and care. Health workers in selected facilities have been trained on service provision to this population. However stigma is still a key barrier to access to service and the coordination mechanism for these programmes is not working efficiently.

Treatment, care and support

a) Antiretroviral therapy: The country is on track to achieving ART coverage targets partly due to the adoption of the “test and start” and the decentralization of ART initiation to lower level health facilities. Results achieved include an increase in number of people retained on ART and increased enrolment of PLHIV on ART. Retention of patients on ART at 36 months was at 84% for children 0-14 years and 83% for adults 15+ years by 2015. Progress has been made towards achievement of 90-90-90 targets with the treatment cascade analysis indicating 84.7%, 87.4% and 91.9% of PLHIV who know their status, are on treatment and are virally suppressed respectively (based on the definition of the 90-90-90 targets)

b) HIV/TB co-infection – Although coverage of HIV/TB has been scaled up with almost all HIV patients are screened for TB and offered treatment and prophylaxis while TB patients are tested for HIV and put in treatment; HIV/TB co-infection rates remain high (70%) and mortality rates are at 14%. IPT coverage is also low.

Socio-economic impact mitigation

a) OVC support: Data on results of OVC support is limited but there are a wide range of broad social protection and direct OVC support interventions which have contributed to increased school enrolment, access to livelihoods as well as HIV services. These include free primary education, school feeding programme, social transfers for OVCs, grants for the elderly, support to OVCs provided by civil society, faith based organisations and communities themselves. However, interventions are not well coordinated, community OVC support has been declining and family strengthening interventions are limited.

b) Gender Based Violence – Data to determine results for GBV interventions lacking. However, several GBV prevention and response interventions are being implemented by various government and non-government players. Such interventions include sensitization of communities, targeting girls and boys during cultural events, reaching adolescents and young people in schools, integrating GBV into empowerment programmes for adolescent girls; training police, treatment and care for GBV survivors in health facilities, reporting, investigation of cases and prosecution as well as recovery. Some of these interventions, however, are not consistent and then to be ad hoc; coordination mechanisms have only recently been established and a plan of action has been developed but is not being implemented. The referral system across institutions is weak and data on GBV is also limited.

Coordination of the HIV response

The coordination structures for the HIV response are defined in the coordination framework of 2011. Most of these structures are in place especially at national and sectoral level. At the decentralised level, REMSHACCs are no longer operational and TIMSHACCs and CHIMSHACCs were not fully constituted. Of the three ones, the “one coordinating authority” and “one M&E framework” are not functioning optimally. The systems, guidelines and processes to guide stakeholders in planning, monitoring and evaluation and reporting are not adequate and the platforms to review the response periodically and ensure accountability are not operational. Coordination activities have been scaled down partly due to declining funding. The current coordination architecture has been in place since the multisectoral HIV response was established and has not changed in tandem with the
transformation of the response and declining funding for the HIV response. The multi-sectoral focus of the response has weakened over time. In its place, a dichotomy between bio-medical and non-biomedical response has emerged and overshadowed the multi-sectorality of the response.

**Mainstreaming of the HIV response in development sectors**

Internal mainstreaming of HIV in the public and private sectors, targeting employees and their families, has been sustained. The focus has shifted from stand-alone HIV programme to integration of HIV in the employee wellness programme in order to provide holistic health services. PSHACC and SWABCHA have continued provide leadership and coordination of internal mainstreaming while focal persons are in place to coordinate the response in individual ministries and private sector firms. As a result, the stakeholders observed that there has been a reduction of absenteeism, AIDS related deaths and increased productivity. Uniformed Services institutions have also sustained a comprehensive response providing HIV services to their employees. Parliament is also involved in the response through engaging with communities to raise awareness, address stigma and discrimination and advocating for concerns voiced by communities to be addressed. The downside of the parliamentary programme is the limited time dedicated to HIV issues due to competing roles and funding constraints for the parliamentary wellness programme.

External mainstreaming has also been maintained across ministries although this varies. Some of the ministries with on-going HIV programmes include Prime Minister’s Office, Ministries of Health, Education and Justice. The Ministry of Agriculture involvement in supporting food production has come to an end. A focal point for coordinating external mainstreaming is lacking.

**Inclusiveness, human rights and gender**

The HIV response is to a large extent inclusive. Most key populations and vulnerable groups are being reached. Groups that are not adequately addressed include people with disability, the boy-child, and mobile populations. Gender is mainstreamed into most programmes as part of the best practices in programming while human rights mainstreaming is lagging behind.

**Recommendations**

Under each programme, priorities to be addressed going forward have been identified. The recommendations outlined below focus on the overall HIV response.

(i) The overall focus of the next strategic framework should be on achieving the vision of ending AIDS by 2022. It should also incorporate the Umgubudla targets, establish a sense of urgency and sustain the momentum created under the eNSF.

(ii) Increase the efficiency of the HIV response by adopting cost efficient and cost effective strategies to maximise impact through approaches such as resource tracking, service integration, collaborative implementation, value for money assessments and implementation of proven cost efficient approaches which include differentiated care models, micro-targeting and technology aided training platforms.

(iii) Develop and implement a financing strategy for the HIV response taking into account maximising of efficiencies, leveraging of international funding while establishing domestic financing options to sustain results achieved so far and further scale up interventions to end AIDS by 2030. This strategy should be based on a thorough analysis of the cost of ending AIDS.

(iv) Restructure the coordination architecture to address redundancies, inadequate capacities, funding constraints and to be in tandem with improvements made in the HIV response through reviewing the roles of coordination bodies, establishing TWGs, reconstituting REMSHACCs,
integrating HIV in lower level traditional structures and establishing stakeholder fora at national and regional levels.

(v) Conduct NERCHA organisational review to update NERCHA structure to be fit for purpose. This review will focus on overall the organisational structure, capacities and competencies, internal accountability, management systems and communication.

(vi) Strengthen strategic information, research and knowledge management through developing the M&E plan and operational guidelines; building capacity of M&E systems, establishing a coordination mechanism, finalising a research agenda and establishing a knowledge management platform.

(vii) Conduct research and generate evidence and knowledge to improve programming focusing in areas with data gaps and where evidence is needed to support programming

(viii) Strengthening community health systems and response through building the capacity of the community response to support HIV service delivery especially given the trend of having services offered at community level.

(ix) Strengthen linkages and synergies between prevention, treatment, care and support services to ensure continuity of care by addressing critical system areas such as referral, data sharing, cross programme communication, task shifting and multi-tasking and cross training.
1.0 Introduction

This report presents the findings and recommendations of a summative evaluation of the Extended National Multisectoral HIV and AIDS Strategic Framework (eNSF) 2014-2018 conducted between March and June 2017 under the auspices of the National Emergency Response Council for HIV and AIDS (NERCHA).

1.1 Background

The National Multisectoral HIV and AIDS Strategic Framework 2009-2014 was extended to cover the period 2014-2018 based on findings of a midterm review. The strategic framework was designed to contribute to the National Development Strategy, the Health Sector Strategy (HSS, 2015), Millennium Development Goals (MDGs, 2000), UN Political Declaration on HIV and AIDS (2011), the Paris Declaration of AID effectiveness and the SADC Declaration on HIV and AIDS among other framework. The eNSF serves as the “one strategic framework” within the Three Ones principle of coordination of the HIV response.

The goal of the ENSF is to halt the spread of HIV and reverse its impact on the Swazi society. This goal was to be achieved through reducing new infections by 90%, averting 15% deaths among PLHIV, alleviating socio-economic impacts of HIV and AIDS among vulnerable groups and improving efficiency and effectiveness of the national response.

The ENSF, using a results based planning, identified the core programmes expected to have the highest impact on the epidemic. The core programmes and the coordination, management and implementation arrangements of the strategic framework are summarized below.

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<th>Core programmes</th>
<th>Coordination and management arrangements</th>
<th>Implementation arrangements</th>
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<tr>
<td>HIV Testing and counselling</td>
<td>Strengthening institutional arrangements for HIV and AIDS response</td>
<td>National operational plan</td>
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<td>Social and behaviour change</td>
<td>Mainstreaming HIV synergies in the development sector</td>
<td>National advocacy and communication strategy</td>
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<td>Condom promotion and distribution</td>
<td>Strengthening the social, policy and legal enabling environment</td>
<td>National multisectoral HIV and AIDS M&amp;E framework</td>
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<td>Prevention of mother to child transmission</td>
<td>Systems strengthening – community, health and education sectors</td>
<td>Programme development and action planning</td>
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<td>Male circumcision</td>
<td>Resource mobilization and sustainable financing</td>
<td>Engaging communities, civil society organizations</td>
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<td>Customized interventions for key populations</td>
<td>Strategic information and knowledge management</td>
<td>and PLHIV</td>
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<td>Pre-Antiretroviral (Pre-ART)</td>
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<td>Antiretroviral therapy for PLHIV</td>
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<td>Family strengthening</td>
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<td>Gender based violence</td>
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The Umgubudla Fast Track Programme towards AIDS Free Swaziland launched in 2016 identified five of the ENSF core programmes to fast track the vision of His Majesty King Mswati III of an AIDS Free Swaziland by 2022. The five programmes included treatment and care, male circumcision, HIV prevention among girls and young women, elimination of mother to child transmission of HIV and TB/HIV co-infection.
This evaluation assessed the core ENSF programmes; and the coordination and management, and implementation arrangements and within this context analysed the extent to which the country is on a trajectory to achieving the Umgubudla vision.

1.2 Evaluation rationale

The eNSF is coming to an end in 2018 and new strategic framework will need to be developed taking into account the realities of the HIV epidemic in Swaziland, emerging evidence for controlling the epidemic and the global and local financial constraints. This evaluation was commissioned to evaluate progress in meeting the eNSF targets as well as the country’s progress towards achievement of the Umgubudla targets. The findings of the evaluation will inform the strategic direction for a new strategy 2018-2022.

The specific areas covered by the evaluation are as follows:

- Performance of the HIV and AIDS response
- Contribution to national development efforts, in particular mainstreaming HIV in the development sector and Ending AIDS by 2022
- Inclusiveness of the HIV response
- Resources for the HIV response
- Strength of the ‘Three Ones’ Principles including coordination and implementation arrangements

1.3 Evaluation approach, methods and limitations

Overall approach

The evaluation was conducted in phases addressing different aspects: (1) A comprehensive HIV epidemiological and Prevention Response Analysis (CHEPRA) which provided information HIV epidemiological and response analysis paying particular attention to prevention. (2) A joint review of the Health Sector Response Plan (2014-2018) which covered prevention, treatment, care and support programmes implemented by the Ministry of Health as well as coordination and management of the health sector response. (3) An evaluation of the HIV socio-economic impact mitigation programmes; HIV mainstreaming; gender and human rights mainstreaming; and coordination, management and implementation arrangements of the response. (4) Overall eNSF evaluation drawing information from and synthesizing data from the three reviews to establish overall performance of the HIV response.

Data collection

The evaluation used a mixed methods approach combining both qualitative and quantitative methods in order to enhance validity of the findings. However, it leaned largely towards qualitative methods with quantitative data being extracted from secondary sources.

(i) Documents review: documents review provided information on the background on the eNSF, data on progress in implementation, performance, coordination, and financial resources among others. Documents reviewed included the national response strategy, operational plans and programmatic documents; monitoring reports, surveys, progress and evaluation reports; documents on eNSF coordination and implementation arrangements as well as those providing financial data.

(ii) Key informant interviews: Interviews were held with key informants drawn from organisations supporting, coordinating, managing and implementing the national response. These included policy makers; officials involved in coordination and management of the
response; those managing implementation in government ministries, civil society, faith based organizations and private sector; parliament and development partners at the national level. Key informants provided information on the relevance, effectiveness, efficiency, sustainability and coordination of the eNSF.

(iii) Consultations at national level: Consultative meetings were held with members of the sector coordinating bodies – SHACO, SWANNEPHA, SWABCHA, PSHACC and SUSAH members.

(iv) Regional level consultations: At the regional level, consultations were held with regional secretaries, coordinators, and members of REMSHACCS, TIMSHACCS AND CHIMSHACCS.

(v) Focus group discussions: FGDs were held with Key Populations, women, youth, men and PLHIV. The FGDs provided perspective of beneficiaries on the HIV response focusing on access, availability and quality of HIV services.

Data analysis

Data was analysed through triangulation and trend analysis. Data relevant to each evaluation question was collated and disaggregated to allow for triangulation across the main data sources and emerging issues or common themes were identified. A trend analysis was also carried out using secondary quantitative data to assess the impact of the response and the performance of the HIV response against its targets at outcome and output levels. This analysis built a body of evidence to support the findings of the evaluation.

Limitation of the evaluation

Key limitation of the evaluation are as follows:

Data gaps: Up to date data for most of the outcome indicators was not available to allow for comparison between planned outcome targets and achieved results. Measurement Survey (SHIMS) 2017 results which could have provided latest data on most outcome indicators was not finalized by the time this evaluation was completed. To mitigate this gap, the evaluation used data for MICS 2014 and established a trend analysis to the extent possible in order to understand the direction of the response. Data gaps at output level were difficult to mitigate. The evaluation focused on progress made in implementation of interventions that were expected to contribute to the outputs.

Untimely completion of key reports: The Health Sector Review report was not completed on time to contribute this draft evaluation report. The following type of data was used to mitigate this shortfall: (i) presentations, thematic and regional reports on preliminary findings of the health sector review, (ii) data collected from stakeholders by the evaluation consultant on areas covered by the health sector review, and (iii) secondary data on health sector HIV programme

Financial data gaps: A recent National AIDS Spending Assessment (NASA) has not been undertaken. The last assessment was done in 2011/2012 which pre-dates the eNSF. Comprehensive data that incorporates all funding sources and which shows expenditure by priority areas or core programme was not available. The evaluation used financial data from the Global Fund Funding Landscape Analysis together with the NASA to create trends. For absorption rate analysis, data from selected Global Fund programmes and from the health sector expenditure on HIV was used as a proxy to demonstrate the absorption capacity of the response.
2.0 Relevance

Evaluation of eNSF relevance focused on the framework design, extent to which it addresses key drivers of the epidemic, programme alignment, relevance at implementation level, its relationship with Umgubudla and value addition. Findings are as follows:

Relevance of the eNSF was anchored in its alignment and being response to with national and international frameworks and global realities: The eNSF contributes to the improvement “Swaziland Development Index” health indicators for life expectancy and maternal and child mortality and the MDG goals 4, 5 and 6. Further, the eNSF was aligned to the UN Political declaration on HIV/AIDS (2011), SADC Declaration on HIV and AIDS; and Universal Access targets, UNAIDS strategy on getting to Zero by adopting the targets set out a the international level and prioritizing interventions aimed at achieving these targets. At a technical level, the framework was guided by WHO normative guidance for HIV treatment, care and support. At the time of developing the eNSF, the world was experiencing a financial crisis and international financing for HIV and overall healthcare was projected to decline over time and countries had to rethink on how to invest smartly to achieve efficiencies and maximize impact in the context of shrinking resources. The eNSF responded to this situation by adopting an evidence based “investing for results” approach to decide on the core programmes and the scale up of investment to achieve “maximum” targets.

eNSF was designed to address the key drivers of the HIV epidemic to ensure relevance of the selected core programmes and prioritised strategies: Using available evidence, an in-depth analysis of the HIV epidemic was undertaken to identify the key factors driving the epidemic and a cost-benefit analysis of a combination of various programmes was carried out to identify core programmes that maximize impact. The purpose of this approach was to scale up the response rapidly, achieve maximum outcomes in order to halt and start reversing the epidemic. Overall, the eNSF addresses the underlying risk and vulnerability factors for key and vulnerable populations and also adopted relevant strategies.

New normative guidance was adopted in the course of implementation to maintain eNSF relevance: Normative guidelines adopted include the 90-90-90 targets, 2015 WHO guideline and the HIV fast track strategy. Country targets and strategies for respective programmes were adjusted to align to these guidelines.

Relevance maintained through stakeholder involvement in eNSF development and its wide dissemination: The eNSF was developed through a participatory and data driven process. Stakeholders drawn from all sectors at national and regional level participated in planning of eNSF and used the evidence presented in these fora to identify the priority programmes and strategies. Stakeholders consulted during this evaluation pointed out that dissemination of the eNSF was done at national and regional level. Dissemination meetings for various sectors at national level and in the regional were held where the design and priorities of the eNSF were presented. These meetings popularized the eNSF, a key step towards encouraging its use. However, dissemination meetings were once off and no follow up was made to reinforce the use of the strategic framework. Some of the stakeholders also observed that the eNSF is too technical to unpack. They needed NERCHA to make follow ups to explain the strategic framework further in order for encourage its use. Although eNSF is not expected to be used as a programme document; there is merit in implementers identifying with and carrying its vision at operational level. There eNSF was not repackaged into shorter versions or brochures that could be easily understood and used by implementing entities.

Major HIV programmes are aligned to the eNSF as the “one strategic framework” : Programmes supported by development partners as well as government are aligned to the priorities set out in the eNSF. For instance the goals and strategies of the health sector HIV Response Plan are drawn from the eNSF while programmes supported by USG and Global (the main partners supporting HIV response)
Fund are aligned to eNSF core programmes and strategies and also contribute to the achievement of eNSF targets. This alignment is, by default, cascaded to the lower level implementers of these programmes.

**Umgubudla fast track programme vision widely known but linkage with eNSF not clarified:** The country developed the *Umgubudla (also called investment case)* identifying 5 out of the 11 eNSF core programmes to maximize impact and work towards ending AIDS by 2022. This programme set out the vision of ending AIDS by 2022 and provided renewed political support to the eNSF. However, guidance on how both eNSF and Umgubudla would be used concurrently was not provided and more specifically it was not clarified whether the 6 programmes not included by Umgubudla were still priority.

**eNSF is valued as a resource mobilization tool and a framework guiding alignment of programmes but improved communication needed:** Stakeholders view eNSF as a document that provides overall guidance for the HIV response; supports monitoring and reporting; forms a basis for resource mobilization and as a reference point on what the country should do in the fight against HIV. However, eNSF was not popularized and it was difficult for some stakeholder to understand and identify with it. Parallels were drawn with the Umgubudla programme whose core programmes and the vision of “ending AIDS by 2022” are fairly well know. Stakeholders observed that there is a need for the country to have an HIV strategic framework but the framework should be presented in a way that easily communicate its vision and priority strategies.
3.0 Impact

ENSF impact was evaluated based in defined impact indicators, using mainly estimates and survey data, to the extent it was available, and developing trends to understand the trajectory of the epidemic and the link to the HIV response.

HIV prevalence overview

Swaziland has the highest HIV prevalence in the world with a prevalence of 27% (22/5% for women and 20.4% for men) adults 15 years and older, translating to approximately 200,000 people living with HIV (PLHIV). The HIV prevalence peaks have remained the same between 2011 and 2016-17. According to SHIMS2 (2016-17), prevalence peaks at 54.2% among females age 35 to 39 years and 48.8% among males age 45 to 49 years. The disparity in prevalence by sex is pronounced among young people 20-24 years where prevalence is five times higher among women (20.9%) than men (4.2%). As shown in the figure below, HIV prevalence in Swaziland has stabilized at high level, women continue to have higher prevalence than men and young women are most affected.

Figure 1: Comparison of HIV prevalence SHIMS 2011 and 2016-17

Performance against impact targets

The impact of eNSF is measured against HIV incidence, life expectancy, AIDS related deaths and efficiency of the response. An overview of the current status of these indicators compared to baseline is shown in the table below.

<table>
<thead>
<tr>
<th>Impact</th>
<th>Baseline</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV incidence rate</td>
<td>2.9% (2011)</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.36%¹</td>
</tr>
<tr>
<td>% of HIV infected infants aged 18-24 months born to HIV+ mothers</td>
<td>16.4 (2011)</td>
<td>5%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>47.2 (women)</td>
<td>50 (women)</td>
<td>55 (women)</td>
<td>48.1 (Women)</td>
</tr>
<tr>
<td></td>
<td>43.2 (men)</td>
<td>45 (men)</td>
<td>50 (men)</td>
<td>48.9 (Men)</td>
</tr>
<tr>
<td></td>
<td>(2011)</td>
<td></td>
<td></td>
<td>49.6 (overall)²</td>
</tr>
</tbody>
</table>

¹ Swaziland HIV Incidence Measurement Survey, 2016-17
² World Bank and UNDP data – Human Development Index Report, 2016
### Maternal mortality rate

<table>
<thead>
<tr>
<th>Maternal mortality rate</th>
<th>320/100,000 (2010)</th>
<th>270/100,000</th>
<th>200/100,000</th>
<th>389/100,000³</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of midterm and end term</td>
<td>30% (2011)</td>
<td>50%</td>
<td>80%</td>
<td>65% of output targets achieved*</td>
</tr>
</tbody>
</table>

* Results based on analysis of eNSF results framework. Data was available for 51% of the output indicators.

### (i) HIV incidence and new infections

**Overall HIV incidence declining and the 2018 target of 1.4% has been met.** Incidence among 15-49 years declined from 2.9 (2011) to 2.23 (2013) and 1.36 (2016-17) which represents a 40% reduction. In 2016-17, incidence among women 15 and above was 1.7 and 1.02 among men. The incidence rate corresponds to approximately 2,600 new cases of HIV annually among adults 15 years and above. The figure below shows incidence by age and sex for people 15 years and above.

*Figure 2: HIV incidence by age and sex (SHIMS 2, 2016-17)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0.8</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>2013</td>
<td>1.3</td>
<td>1.5</td>
<td>2.8</td>
</tr>
<tr>
<td>2016</td>
<td>1.0</td>
<td>1.7</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Although incidence has reduced over the last five years, the general trend shows that adolescents and young people, especially females, 15-24 have emerged as a new centre of the epidemic. Both HIV prevalence and incidence are higher among this group.

The reduction of new infection can be partly attributed to the HIV prevention interventions, the scale up of PLHIV in ART and PMTCT services. There is a need to sustain and further scale up innovative strategies for HIV prevention and treatment particularly for adolescents and young women.

### (ii) HIV related deaths

**AIDS deaths still high but on a gradual downward trend:** Antiretroviral therapy it improves the survival of PLHIV overt time. Annual AIDS related deaths declined from 3,997 in 2013 to 3,034 in 2016 (Spectrum, 2015), a 24% reduction. If this trend is maintained up to 2020, annual AIDS related deaths decline by 31%. Cumulatively, about 63,000 lives have been saved between the ART program launched in 2003 and 2015. AIDS deaths are higher among men partly because men present for treatment late due to barriers in barriers in accessing HTS and referral. The impact of ART can be demonstrated by comparing AIDS deaths with and without ART. Without ART, AIDS deaths assume an increasing trend.

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(iii) Life expectancy

Life expectancy marginally improved from 2013 to 2015: The HIV epidemic has had adversely effects on the country’s social and economic gains, including reversing life expectancy in the last 2 decades. Life expectancy decreased by 10.6 years between 1990 and 2015. The scale up of the HIV response was expected to contribute to halting the declining trend and increasing of life expectancy over time. The country is making marginal gains in life expectancy. Life expectancy for men increased from 48.8 years in 2010 to 49.6 years in 2015 while for women the years increased from 47.9 to 48.1 in the same period. Swaziland is ranked last among the countries in southern Africa region as shown in the figure below.

(iv) Efficiency of governance of the multi-sectoral response

Efficiency of governance of the response is sub-optimal due to reasons that including inadequate coordination, weak accountability and resource constraints. The efficiency of the governance of the response was measured based on the percentage of mid-term and end-term core programs service coverage targets achieved. The target was set at 50% by 2015 and 80% by 2018. Out of the 37 output indicators in the eNSF results framework, 51% (19) had data while no data was available for 49% (18). The core programmes that lacked output data included customized programmes for key populations, pre ART, family strengthening programme. Mid-term targets for 27% of the indicators had been

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4 Human Development Report, 2016
achieved; targets for 11% of the indicators were partially achieved and targets for 14% of the indicators had not been achieved; falling short of the mid-term target. This reflects partly on the efficiency in implementation of the national response and partly the effectiveness of the M&E system.

3.1 Umgubudla fast track programme (HIV Investment Case)

The Umgubudla fast track programme prioritized 5 of the 11 eNSF core programmes to maximize impact of the national response. Results show that:

Treatment cascade: Good progress has been made in HIV testing and in enrolling PLHIV on ART. If the trend is maintained, the 90% targets are likely to be achieved, although this will require continued investments to sustain the current results as well as a further scale up of PLHIV on ART.

Male circumcision: Although outcome level data is not available, coverage data shows low coverage of VMMC. Since the programme started in 2009, a total of 97,132 circumcisions have been done, representing about 16% of the total male population. Significant investments and innovative approaches are required to achieve the 70% target.

HIV prevention targeting adolescent girls and young women (AGYM): Outcome level data is not available to determine progress. However, interventions for AGYM have been mounted by relevant government ministries, civil society and faith based organisations covering all aspects of HIV prevention, treatment, care and support. The impact of these interventions will be known after SHIMS is completed.

PMTCT: Umgubudla indicators for which data is available shows that targets have been achieved. There has been a scale up of PMTCT service coverage in health facilities across the country. The increase in HIV infected infants 6-8 weeks from 2% (2011) to 3% 2016 calls for improvement in programme quality in order to achieve the 2020 PMTCT targets.

TB/HIV co-infection: TB incident target of 700/100,000 has been surpassed. The TB/HIV response is also on track to achieving the treatment targets for TB co-infection. However, mortality among HIV/TB co-infected is at 14% pointing to improve programme quality.

<table>
<thead>
<tr>
<th>Strategic area</th>
<th>Progress indicator</th>
<th>Baseline</th>
<th>Target (2020)</th>
<th>Status by 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accelerated scale up of antiretroviral therapy (ART) for PLHIV</td>
<td>PLHIV who know their serological status</td>
<td>63% (SHIMS, 2011)</td>
<td>90%</td>
<td>84.7% (88.6% Women and 77.5% men)</td>
</tr>
<tr>
<td></td>
<td>PLHIV who know their status and are initiative on ART</td>
<td>49% (HMIS, 2014)</td>
<td>90%</td>
<td>87.4% (86.9% women and 88.6% men)</td>
</tr>
<tr>
<td></td>
<td>Viral load suppression among people on ART</td>
<td>85% (SHIMS, 20110</td>
<td>90%</td>
<td>91.9% (92.2% women and 91.3% men)</td>
</tr>
<tr>
<td>Scale up of VMMC</td>
<td>VMMC prevalence 15-49 years (15 years and above)</td>
<td>25% (MICS, 2014)</td>
<td>70%</td>
<td>26.7% (SHIMS 2)</td>
</tr>
<tr>
<td></td>
<td>10-34 years</td>
<td>25%</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neonates</td>
<td>-</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Innovative HIV prevention approaches for</td>
<td>Young women aged 15-24 years who have comprehensive knowledge about HIV and reject</td>
<td>49% (MICS, 2014)</td>
<td>80%</td>
<td>No data</td>
</tr>
</tbody>
</table>

5 Implementation of MC program for neonates has not started
<table>
<thead>
<tr>
<th>girls and young women</th>
<th>major misconceptions about HIV transmission</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Young women aged 15-24 years who have sex with partner 10 years or more older than themselves</td>
<td>14.5% (MICS, 2014)</td>
<td>8%</td>
<td>No data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elimination of mother to child transmission of HIV</th>
<th>Pregnant mothers living with HIV receiving ART</th>
<th>84% (HMIS, 2013)</th>
<th>90%</th>
<th>94% (2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet need for family planning – National Among PLHV</td>
<td>15.2% (MICS, 2014)</td>
<td>10%</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>65% (ANC, 2010)</td>
<td>40%</td>
<td>No data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Exclusive breastfeeding of infants under 6 months | 63.8% (MICS, 2014) | 70% | No data |

| Infants under 1 year LHIV receiving ART | 32% (HMIS, 2013) | 90% | 86% (2016) |

<table>
<thead>
<tr>
<th>Intensification of TB/HIV co-infection diagnosis and treatment</th>
<th>National incident TB rate</th>
<th>1349/100,000 (Programme data, 2013)</th>
<th>700/100,000</th>
<th>565/100 000 (Programme data, 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-infected patients that receive treatment for both TB and HIV</td>
<td>80% (Programme data, 2013)</td>
<td>90%</td>
<td>92% initiated on ART; 99% initiated in CPT (Programme data, 2016)</td>
<td></td>
</tr>
</tbody>
</table>

6 The baseline as at 2011 was 70%
4.0 Effectiveness/performance of the eNSF

The evaluation of the performance of the eNSF covered the eleven core programmes and focused on the extent to which the outcome and output level targets have been achieved, achievements or progress made in implementation of the prioritized strategies, current implementation challenges and priorities going forward. The evaluation also sought to find out the factors facilitating or hindering the achievement of planned results.

4.1 Prevention of new infections

4.1.1 HIV Testing and Services

The eNSF sought to address the following issues: low uptake of HIV testing and counselling among all populations and particularly among men; inadequate capacity to provide quality HTS and limited quality assurance outside health facilities; stigma and discrimination focusing on both self and external stigma as a barrier to testing; low provision of counselling and testing for children under age 16 partly due to the required parental or guardian consent.

Results achieved

HTS outcome: Up to date data on people tested for HIV and know their status in the last 12 months will be available once SHIMS 2017 results are released. However, data from MICs 2014 show that 66.5% women and 54.5% men aged 15-49 years had been tested and received their HIV results in the past 12 months against the eNSF target of 65% women and 55% men. Coverage data indicates that the proportion of people tested for HIV and know their results has been increasing over time.

HTS Output: The indicator for measuring HTS output is the number of people who tested for HIV in the last 12 months and know their status. The number of HIV tests done increased from 178,823 in 2011 to 413,660 in 2015. This is about 86% of the 2015 target of 500,000 people. However, it is not clear to what extent the target has been reached as this data includes repeat tests and therefore does not accurately represent the number of people tested for HIV. A significantly larger proportion of women are presenting for HIV testing compared to men. Of the total of 416,473 tests conducted in 2015, there were more females tested (64%) compared to men (37%) despite the eNSF prioritising men and various strategies being put in place to reach men.

Figure 7: Proportion of people tested for HIV and received their results by sex, 2015 (programme data)

8 Annual HIV Program Report, 2015
Achievements/progress

There has been increased access and uptake of HTS through multiple strategies and service delivery points over time: This was a key strategy of the eNSF aimed at scaling up HTS services among key target populations and in all regions as an entry point to other HIV services. The evaluation found out that:

(i) In the last three years, HTS services have been scaled up to reach key populations and vulnerable groups and across all the regions of the country through health facility and community bases HTS and using mobile/community outreach strategies and as well as offering services in static facilities. Facility based testing is done through Provider Initiated Testing and Counselling (PITC) where clients are offered an option to opt out. HTS has been integrated in various service delivery points in health facilities such as ANC (PMTCT), VMMC, STI and TB diagnostic sites and in-patient services. Index patient partner testing has also been adopted to reach out to those most vulnerable to HIV infection. According to programme data, the number of health facilities providing HTS has increased from 201 (out of 242) in 2010 to 221 (out of 242) in 2015.

(ii) Community based HTS is being conducted through outreach campaigns. Targeted groups in the community are mobilized in advance of the testing and counselling. Mobilization is mainly done by civil society organizations who work closely with community leaders; Faith Based Organisations (FBOs) who mount HTS boots during religious events and camps; and the municipalities that provide HTS in their clinics. Mobilization also takes place during the social and behaviour change sessions where communities are sensitized on HIV prevention. Community based partners collaborate with health facilities who provide staff as well as test kits.

(iii) Strategies have also been developed to reach men and adolescents and young people for testing and linking them to treatment and care. These interventions targeting adolescent girls and youth in schools for HTS information, adolescents and youth out of schools for HTS, and male engagement at community level.

(iv) Scale up has also been achieved by integrating HTS in the employee HIV prevention education and employee wellness programmes in the public and private sectors. HTS is integrated into the overall screening and testing for Non-Communicable Diseases. It was also noted that HTS services have also been scaled up within Uniformed Personnel Service Institutions (USDF, RSP, Fire Department, and HMCS). These institutions are undertaking a comprehensive internal HIV programme which includes HTS for their employees.

(v) Specific strategies have been deployed to provide HTS to key populations – Female Sex Workers (FSWs), Men Who Have Sex with Men (MSM), mobile populations such as those in the transport sector and prisoners among others. MSM and FSWs are being reached in hotspots at appropriate times (moonlight services). In some cases HTS is offered on-site while in other cases the clients are referred and/or assisted to access HTS in health facilities. For truck and bus drivers and other transport workers, HTS services are integrated to the package of services provided in hotspots along the transport corridor.

(vi) There has also been an improvement HTS for children. A policy impediment has been removed by lowering the age of consent from 16 to 12 years and by redefining person who can provide consent for children to be tested to include health workers, care givers and any other person who could act in the best interest of the child. This policy reinforces the guidelines that require children with negative or unknown status to be tested at 9 months and 18-24 months (or 8 weeks after cessation of breastfeeding) while all HIV exposed children should be tested at 6-8 weeks, 9 months, 12 months and 18-24 months.
**HTS integration onto other health services within and outside of health facilities has been scaled up:** HTS has been integrated to a wide range of health services which include TB patients being routinely tested for HIV, pregnant women tested for HIV at ANC, post natal care SRH service points, and HTS being offered to VMMC clients. Outside of the health facilities, HTS has been integrated into Social Behaviour Change and employee wellness programs. Integration has contributed to an increase in the number of HIV tests done annually.

**There has been increased community mobilization to create demand for HTS targeting key populations and vulnerable groups:** Interventions for demand creation for HTS are widespread. For instance, in the public and private sector, HTS information and education is integrated into employee wellness programmes; the service package for key populations includes HTS where KPs are sensitised and assisted to access HTS through mobile services or at health facilities; communities are mobilized through leaders to reach specific groups – men, women, adolescents and young people for HTS; and demand for HTS is also generated through teen clubs. Various government ministries, NGOs, CBOs, FBOs, private and public sector organizations, rural health motivators and peer educators are all involved in creating demand for HTS. Lastly, mass media is being used as a key instrument for demand creation by disseminating messages and information targeted at specific audiences to encourage people to test for HIV.

**Improved referral from HTS to other services especially at the health facilities:** The eNSF sought to improve referral from HTS to appropriate follow up HIV prevention, treatment and care services. Facility based referral between HTS and other services is working well. Clients tested are referred to treatment and care.

**Gaps and challenges**

Although there has been a huge scale up of HTS in the country, the following gaps needs to be addressed to further strengthen the programme:

(i) Low uptake of HTS by men, adolescents and young people: an estimated 60-70,000 people who are HIV positive are not on treatment. The groups with low ART enrolment are mainly men, adolescents and young people. The strategies being implemented to reach men and adolescent girls will need to be scaled up and sustained over time to achieve results.

(ii) Identifying people who are HIV positive is becoming harder: Although the number of HIV tests conducted over time have been increasing, the number of people testing positive have been declining. This could be an indication of a decline in prevalence in the general population or a manifestation of repeat testing in people who are low risk and are remaining HIV negative.

(iii) Quality assurance for community based HTS still remains a gap mainly due to the environment in which this service is provided.

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**Focus Group Discussions**

All groups – men, women and the youth indicated that HTS is widely available. There are many groups offering the service in their communities. Women do not have any specific challenge in testing for HIV. The youth face in disclosure to their partners. The youth do not know what to do in case they test positive. Most youth indicated that they will not disclose to anyone including their peers and least of all they will have a challenge disclosing to parents. Men prefer taking an HIV test in a location with privacy and not during community outreaches taking place in “public”. Fear of the unknown also prevents them from taking an HIV test.
(iv) Coordination of the community based HTS is weak compared to facility based HTS. The national programme is not always aware of who is doing what and where. Health facilities are not always part of the planning process for community HTS campaigns. Supplies needed for community HTS are not planned for in advance.

(v) Referral from HTS to treatment and care services weak and there are cases lost to follow up. For instance, individuals testing positive at community level take time to seek services and when they do, they seek services in distant health facilities for privacy. There is also a loss of patients referred from one service point to another or from one facility to another.

(vi) Self-stigma is a major bottleneck for uptake of HTS: men, adolescents and young people cited stigma and fear as a barrier to undertaking HIV testing. Implementing organizations also observed that stigma makes it difficult for key populations to access HTS in health facilities.

(vii) Implementation of the policy on consent for HTS for children faces challenges. Health workers and care givers are keen to give consent partly due to lack of commitment to make follow ups after HTS.

Priorities

(i) Improve coordination between technical working groups for HTS and treatment services is needed in order to strengthen guidance on linkage to care

(ii) Undertaken analysis of granular data to inform micro-targeting of HTS

(iii) Strengthen referral from HTS to other HIV services, especially from community based HTS to health facilities

(iv) Develop strategies to address HIV stigma and discrimination to increase access to services for men and adolescents

(v) Define interventions (service package) for clients that test HIV negative

(vi) Conduct research into the health seeking behaviour among men, adolescents and young people to inform programming

(vii) Establish mechanisms to improve quality of community based HTS

(viii) Improve HTS monitoring system to capture repeat tests and further disaggregate data by sex and socio-economic status
4.1.2 Social and behaviour change

The objective of the Social Behaviour Change (SBC) program was to strengthen and increase public awareness and comprehensive knowledge of HIV risks and vulnerabilities. Focus is not only on individual behaviour change but also on social change at community level. The eNSF sought to promote SBC interventions that promote individual knowledge and risk perception and change of behaviour. SBC interventions were to be guided by the SBC strategy of 2010, HIV Prevention Toolkit and Community Conversation Guide. SBC integrated other programmes – MC, PMTCT, HTS, Condoms and ART.

The key issues that the eNSF was set out to address included (i) low investment in prevention, (ii) weak coordination of prevention interventions, (iii) challenges in translating HIV awareness and knowledge into behaviour change, (iv) inadequate mobilization of communities to take up HIV services, and (v) SBC messages not tailored to specific target populations.

Results achieved

SBC Outcomes: Most recent data on SBC outcomes is not available. MICS 2014 data was used to assess progress from the baseline set out in the eNSF. A comparison of persons who have more than 1 partner in the last 12 months shows an increase in risky sexual behaviour between 2010 and 2014. Knowledge of HIV prevention among adolescents and young people 15-24 years declined during the same period. On the other hand, there was minimal change the proportion of adolescents and young people (15-24 years) who had sex before age 15. This trend shows the high risk and vulnerability to HIV infection especially among adolescents and young people. The table below shows assessment of the status of outcome targets.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Value</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people aged 15-49 who report having had sex with more than 1 partner in the last 12 months</td>
<td>2.7% (women) 16% (men) - 2010</td>
<td>1.5% (women) 12% (men)</td>
<td>1.5% (women) 10% (men)</td>
<td>3.3% Women 21.1% men MICS 2014</td>
</tr>
<tr>
<td>% of people aged 15-49 who agree that married men should only have sex with their wives</td>
<td>86% - 2007</td>
<td>90%</td>
<td>95%</td>
<td>No data</td>
</tr>
<tr>
<td>% of persons aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission</td>
<td>58% (women) 54% (men) - 2010</td>
<td>65% (women) 65% (men)</td>
<td>70% (women and men)</td>
<td>49.1% (Women) 50.9% (Men) MICS 2014</td>
</tr>
<tr>
<td>% of young women and men aged 15-24 who report having had sexual intercourse before age 15</td>
<td>3.8% (women) 2.6% (men) - 2010</td>
<td>2% (women and men)</td>
<td>1% (women and men)</td>
<td>3% (Women) 2.8%(Men) - MICS 2014</td>
</tr>
<tr>
<td>% of persons who report that they have heard about HIV transmission risk reduction measures from community leaders in the last 12 months</td>
<td>Not determined</td>
<td>80%</td>
<td>85%</td>
<td>No data</td>
</tr>
</tbody>
</table>

SBC Outputs: SHAPMOS data for 2015 was used to assess the extent of achievement of eNSF mid-term targets. The indicators measure the young people groups reached with SBC programmes as well as those at the work place and community leaders. All the mid-term targets had to a large extent been achieved by 2015 as shown in the table below. If this trend is maintained, it is likely that eNSF end-term targets will be achieved.
<table>
<thead>
<tr>
<th>Outputs</th>
<th>Baseline 2011</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Achieved results</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people aged above 25 years who have been reached with social and behavioural change programmes</td>
<td>26%</td>
<td>50%</td>
<td>75%</td>
<td>51%</td>
</tr>
<tr>
<td>% of formally employed workers reached with a minimum package of HIV prevention programmes in the last 12 months</td>
<td>11%</td>
<td>50%</td>
<td>75%</td>
<td>47%</td>
</tr>
<tr>
<td>% of young people aged 10-24 who have been reached with social and behavioural change programmes</td>
<td>51%</td>
<td>70%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>% of in-school youth aged 15-19 who have attended life skills education at school in the last 12 months</td>
<td>Not determined</td>
<td>74%</td>
<td>95%</td>
<td>85.5%</td>
</tr>
<tr>
<td>% of community leaders who have been reached with social and behavioural change programmes</td>
<td>Not determined</td>
<td>50%</td>
<td>65%</td>
<td>42%</td>
</tr>
</tbody>
</table>

There are two issues emerging from this data. First, the data underscores the challenge of translating knowledge to behaviour change given that coverage indicators have achieved while behavioural indicators (outcome indicators) show high risk sexual behaviour and high vulnerability to HIV infection. Secondly, the coverage denominator for the coverage indicators above is not defined and therefore it is not possible to assess the adequacy of coverage of SBC interventions.

**Achievements/progress**

*The SBC interventions have been intensified in all regions and sectors*: SBC programmes covering all aspects of the response (prevention, treatment and care) are being delivered through a variety of strategies:

(i) Community based SBC interventions involving sensitization of traditional leaders and holding of community sessions targeting women, men and adolescents and youth.

(ii) SBC targeting young people which include HIV sensitization and education during cultural events for boys and girls held annually; peer educators targeting out-of-school youth as well as in-school youth; story writing competitions on sexuality, HIV and GBV; debating competitions on HIV topics; using sports to reach out-of-school youth; and youth radio programmes.

(iii) A comprehensive culturally sensitive life skills education is being delivered in secondary schools. The teaching of life skills has been rolled out in about 233 schools; teachers have been trained on the curriculum while the Ministry of Education and Training (MEOT) plans to make life skills an examinable subject. School clubs have also integrated life-skills education. To sustain this programme, pre-service teacher training in life-skills education is being undertaken. At the primary school level, HIV is integrated into subject curricula. The MOET is reviewing the primary schools curriculum and developing a health, guidance and counselling subject to be examinable under the new curriculum. At tertiary level, the MOET is auditing materials used at tertiary education and lobbying to have sexuality education integrated into the curriculum.

(iv) SBC in the faith community is targeting all groups – youth, women and men. HIV is integrated into the church group activities for these populations such as youth camps, mothers and fathers unions, and couple counselling. HIV messages are also integrated in church sermons and in special meetings where speakers focus in HIV topics. Church leaders have also been trained to ensure the church speaks with one voice on HIV issues.

(v) Delivering SBC during special days and events such as the World AIDS Day, 16 Days of Activism among others. These SBC activities service to mobilize political and traditional leadership to raise awareness on HIV.
Integration of SBC in all core HIV programmes has been sustained and scaled: Social and behaviour change information/messages are incorporated into all services – HTS, condom promotion, PMTCT, treatment and care, male circumcision, and socio-economic impact mitigation. This integration provides a wide spectrum of channels through which HIV information is delivered.

Social behaviour change interventions tailored to specific target populations have also been launched and need to be sustained: In recognition of the need to specifically target key populations and specific vulnerable groups, the following SBC interventions have been scaled up and/or launched:

Interventions targeting key populations: SBC for FSWs and MSMs have been scaled up over the eNSF period to reach these populations in hotspots across the country. HIV information and education is delivered through one-on-one or small group sessions and peer educators. SBC is integrated with other services – condom and lubricant distribution, HTS, referral to treatment and care among others. A survey on the KPs size estimation, access to services and hotspots conducted in 2015 provided evidence that informed the HIV programming.

Interventions targeting mobile populations: these SBC interventions targeting drivers and other workers of long distance trucks and buses in the hotspots in the transport corridors.

Interventions for adolescent girls and young women: These interventions provide information and education on life-skills and behaviour change as part of the combination prevention strategy targeting AGYM in-school and out-of-school through teen clubs, spots and economic empowerment activities.

Interventions for men: A male engagement approach has been recently launched to increase service uptake by men. This approach involves reaching and holding SBC sessions in men-friendly environment at community level and in work places.

Community mobilization and community referral system for service update: The purpose of this strategy was to strengthen the link between SBC and service uptake. All SBC interventions are combined with either provision of certain services (such as HTS, MC) on site or linking clients to service delivery point. The challenge is ensuring that people to seek services after being sensitized.

Gaps and challenges

(v) Weak coordination of the SBC interventions. An SBC toolkit developed to standardize messages and ensure quality is not being used by all players and a technical working group put in place to serve as a clearing house and also guide message development is not operational.

(vi) Investment in community systems and response to deliver SBC has been declining to the extent that CSOs and CBOs activities have become ad hoc and/or short term.

(vii) Low coverage of SBC interventions for youth in tertiary institutions and primary schools. These two levels of education do not have a comprehensive HIV programme.

(viii) There is no specific SBC programme for parents and care givers especially those caring for OVCs

(ix) The life skills education for secondary schools is not complemented by a programme for parents to reinforce the HIV messages.

(x) Challenge in reaching youth-out-of school especially girls. Although programmes targeting adolescents and young people out of school are in place, it is still a challenge to reach the youth.

(xi) SBC interventions tend to be ad hoc and short term due to limited funding. Given the general decline in funding, the NGOs, CBOs, FBOs and AMICAAL have difficulties sustaining SBC interventions over a sufficient period of time to maximize impact.
The linkage or referral between SBC and other HIV services is weak. This minimizes the extent to which SBC messages translate into behaviour change. Referral from SBC to services is also hindered by the stigma.

There are data gaps for SBC outcomes and also evidence on effectiveness of the SBC strategies.

Priorities

(i) Develop comprehensive SBC programmes for tertiary and primary levels of education
(ii) Conduct relevant studies to generate evidence on SBC to inform programming
(iii) Strengthen programmes for youth-out-of-schools
(iv) Adopt SBC integration strategies to improve sustainability in the context of declining funding
(v) Improve coordination of SBC interventions

4.1.3 Condom promotion and distribution

Condom promotion and distribution is a key programme for prevention of new HIV infections given that most of the infection occur through heterosexual contact. The gaps and challenges the eNSF was designed to address included inadequate targeting of condom promotion and distribution on vulnerable groups and key populations including women and 15-24 year old; inadequate procurement and supply chain of condoms, low rates of correct and consistent use and inadequate data to inform programming.

Results achieved

Outcome: Outcomes achieved during eNSF period cannot be determine due to lack of up to date data. Data from MICS 2014 shows that men 15-49 years with more than one partner using a condom increased from 71% in 2010 to 82.6% in 2014 while women in the same age reduced from 74% to 66% in the same period as shown below.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Baseline</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Achieved result</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of young people aged 15-24 who report using a condom during first sex</td>
<td>43.2 (women) 49% (men) – 2007 (DHS)</td>
<td>55% (women) 60% (men)</td>
<td>65% (women) 70% (men)</td>
<td>No data</td>
</tr>
<tr>
<td>% of men and women aged 15-49 with more than one partner in the past 12 months who report the use of a condom during last sex</td>
<td>74% (women) 71% (men) – 2010 (DHS)</td>
<td>80% (women and men)</td>
<td>85% (women and men)</td>
<td>66% Women 82.6% men (MIC 2014)</td>
</tr>
</tbody>
</table>

Outputs: The target for condom distribution has been achieved and distribution of male condoms is on upward trend compared to female condoms. 10,733,323 male condoms and 376,051 female condoms were distributed in 2015 against a mid-term target of 10 million male condoms and 350,000 female condoms. Overall distribution of male condoms is in upward trend since 2013 and it is likely that the country will achieve the 2018 target of 14 million, while female condom distribution seems to have declined in 2016. As shown in the figure below most of the condoms are distribution though community based channels.
Achievements/progress

Condom forecasting, procurement and supply management system has improved and there are limited stock outs: Condom forecasting and quantification, which was an issue to be addressed by the eNSF, has improved given that no stock-outs have been reported. Quantification is done by SRH programme in collaboration with Central Medical Stores (CMS), Management Sciences for Health (MSH), USAID, UNFPA and SNAP. Quantification is informed by consumption data submitted by the various distributing entities. There is also adequate funding for condom procurement.

Access, demand creation and distribution of condoms has been scaled up and sustained using multiple approaches including integration to other healthcare services

A mechanism is in place to ensure coordinated demand creation and condom distribution. A technical working group bringing together key partners (SRH, CMS, SNAP, NERCHA, implementing NGOs and technical partners such as UNFPA, MSH among others) meets quarterly to review progress reports, conduct annual reviews, develop plans and strategies for condom promotion and distribution. The TWG also coordinates implementation of special events such as condom promotion during bushfire and international trade fair. Coordination has improved sharing of information on who is doing what where and the progress and challenges in condom promotion and distribution.

Condom promotion and distribution has been intensified in the last 2 years. A mapping of implementing partners was done and partners assigned areas of operation. Key partners include PSI covering rural areas, AMICAAL in urban areas, FLAS targeting young people, SWABCHA covering the private sector, PSHACC for the public sector and MoH providing condoms through health facilities while PSI, HC3, FHI, FLAS, MSF among others target key populations. These organizations conduct condom promotion activities targeting their respective populations to generate demand. Condom promotion is also routinely integrated into other services including HIV prevention education, male circumcision, HTS, PMTCT and ART. These strategies have contributed to increased uptake of condoms.

Men, women and youth access to condoms

Men, women and the youth concurred that condoms are readily available in the shops, public toilets and health facilities. It is only that mainly access condoms in health facilities. Men have challenges in condom use especially after use of taking alcohol. The youth shy away from picking condoms from shops and prefer public toilets. Further the youth perceive free condoms to be of inferior quality, can easily burst and have a bad smell. This calls for sustained and improved condom promotion, use of private distribution channels and purchase of condoms that appeal to the youth.
Condom promotion has been highly effective in increasing visibility to the public. New marketing campaigns have also been rolled out countrywide to create demand. Marketing strategies include targeted mass media, outdoor advertising such as use of billboards, and targeted campaigns to popularize condom use among the youth and young women who are particularly vulnerable to HIV infection. Condoms branded to appeal to the youth are also being distributed.

**Condom distribution coverage for specific targeted populations at high risk, including young people, MSM, FSWs and discordant couples has been scaled up:** Outlets for condom distribution have been expanded to key populations and vulnerable groups (adolescents, youth and men). A mapping of outlets was undertaken and outlets that reach these populations identified. Major outlets include health facilities, social places, public toilets and branded shops. Distribution through shops, social places and public toilets is meant to reach adolescents, young people and men. Civil society organisations have established strategies for condom promotion and distribution for adolescents such as distributing condoms through clubs of adolescents 20-24 years and using safe space approach to discuss condom use (what is discussed here stays here). For key populations, condoms and lubricants are distributed at hotspots where these populations operate and also integrated into the HIV prevention and treatment services package provided through awareness sessions, outreaches, mobile clinics and at selected health facilities.

**M&E for condoms has been strengthened and provides data for forecasting and quantification:** There is an effective monitoring and reporting system for M&E in place. All distributors are reporting on condom distribution to HMIS. Ordering of condoms is done against consumption data.

**Gaps and challenges**

(i) High HIV incidence as well as the high rates of STIs and teenage pregnancies indicates that either condoms distributed are insufficient or condom use is inconsistent in high risk situations as illustrated in the figure below.

*Figure 10: number of reported STIs and percentage of pregnancies among adolescents (programme data 2016)*

(ii) Key condom outlets (shops) are not friendly to adolescents, young people and men: Some adult shop owners are not agreeable to distributing condoms to adolescents and youth and the adolescents and youth also do not find such outlets friendly. Men also have difficulties accessing condoms from outlets managed by younger shop owners.
(iii) There is no national brand of condoms resulting in partners procuring a variety of condoms. The process of condom branding has commenced and it is envisaged that it will take about two years to finalize.

(iv) Negative perception of condoms especially by adolescents and young people: Condoms being distributed do appeal to the targeted populations, especially the adolescents and youth. They view these condoms to be of inferior quality.

Priorities

(i) Sustain condom education and promotion as a protective measure focusing on change of attitude to condom use

(ii) Develop a national brand for condoms to increase uptake and use

(iii) Conduct research on condom use to identify factors determining consistent and correct condom use among key and vulnerable populations

(iv) Equip young people with life skills combined with condom distribution to provide them an opportunity to make informed decisions

4.1.4 Prevention of Mother to Child Transmission

The PMTCT services include HIV testing and counselling, prevention of HIV transmission among pregnant and lactating women, ARV prophylaxis to both infected women and exposed infants; counselling and support for safe breastfeeding practices; and referral for long term ART for the child and the mother.

The key issues that eNSF was expected to address include high maternal sero-conversion (8%) among women at labour and delivery; high unmet need for family planning (13%) among women of reproductive age (MICS 2010) and 63% unmet need among pregnant women (ANC, 2010); high sero-conversion post 8-weeks; high maternal mortality rate estimated at 60% among HIV positive women; inadequate use of early infant diagnosis (EID) post 8-weeks; weak health systems for longitudinal follow up of mother and child pairs using the family service approach and stigma.

Results achieved

Outcome: The program is on track to achieving the eNSF targets for 2018. Infants receiving ART have increased from 70% in 2011 to 86% while pregnant and lactating women on ART have increased from 87% to 94% which reflects the scale up of PMTCT services over the years. However, there has been an increase of HIV infected infants at 6-8 weeks from 2 to 3% between 2011 and 2016.
Outputs: There has been an increase in coverage and utilization of the PMTCT services. 90% of pregnant women are tested for HIV up from 87% in 2011; and 96% of infants born to HIV positive women receive are tested for HIV within 6-8 weeks up from 73% in 2011. The proportion of health facilities providing PMTCT also increased by 18% between 2011 and 2016. (See the table below).

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Baseline</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Achieved results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of health facilities offering PMTCT</td>
<td>72% (2011)</td>
<td>100%</td>
<td>90.7%</td>
<td></td>
</tr>
<tr>
<td>% of HIV+ women aged 15-49 with unmet need for family planning</td>
<td>64% (2010)</td>
<td>40%</td>
<td>20%</td>
<td>Do data</td>
</tr>
<tr>
<td>% of HIV+ (pregnant) women who were tested for HIV and received their results</td>
<td>87% (2011)</td>
<td>95%</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>% of HIV+ pregnant women who received a course of ARVs to reduce MTCT in the last 12 months</td>
<td>86% (2011)</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>% of infants born to HIV infected women receiving a virological test for HIV within two months of birth</td>
<td>73% (2011)</td>
<td>90%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>% of HIV positive pregnant women assessed for eligibility for antiretroviral therapy by CD4 count or clinical staging</td>
<td>72% (2011)</td>
<td>90%</td>
<td>95%</td>
<td>No data</td>
</tr>
<tr>
<td>% of children aged 18-24 months who are born to HIV infected women receiving an HIV test within two months after cessation of breastfeeding</td>
<td></td>
<td>70%</td>
<td>90%</td>
<td>No data</td>
</tr>
</tbody>
</table>

Achievements/progress

The results above could be attributed to the implementation of a comprehensive PMTCT program based on the four prongs although there are variations in the extent success of each prong.

Intervention for primary prevention of HIV infection among women of child bearing age (prong 1) are not having optimal outcomes: Pregnant women visiting ANC who do not know their HIV status but test HIV positive range from 16% to 21%. The positivity rate amongst pregnant women is high with 37% of pregnant women being HIV positive. This result corroborates with the high risk and vulnerability to HIV infection among AGYM which include low condom use, low knowledge of HIV and early sex debut.

| Table 4: HTS for pregnant women, 2012-2015 (HIV annual report, 2015) |
|--------------------------|----------------|----------------|----------------|----------------|
| Years | No. of women making at least 1 ANC visit | No. of women who know their status prior to ANC | % of women offered HTS at ANC | % of women testing HIV positive at ANC | Total pregnant positive women |
| 2012 | 32,434 | 6,337 (20%) | 72% | 4,827 (21%) | 11,164 (34.4%) |
| 2013 | 29,835 | 6,809 (23%) | 76% | 4,496 (20%) | 11,305 (38.4%) |
| 2014 | 29,740 | 7,102 (24%) | 74% | 3,539 (16%) | 10,560 (35%) |
| 2015 | 30,433 | 7,074 (23%) | 67% | 3,339 (16%) | 10,012 (37%) |

On the other hand, there been a reduction of sero-conversion rates during ANC while sero-conversion rates during labour and delivery from 8% in 2010 to 2% in 2016 while sero-conversion at PNC has remained the same between 2014 and 2016. This shows improvement in the PMTCT programme performance.
SRH/ART service integration is on-going to prevention of unintended pregnancies among women LHIV but unmet family planning need among married women shows an upward trend: The SRH and HIV integration has been implemented since 2011 as one of the strategies for preventing unintended pregnancies among WLHIV. Focus of this intervention has been on integration of Family Planning (FP) into ART sites as well as integration of ART into FP service points. As at 2015, health workers in 14 facilities, all ART sites and PHUs and also RHMTs were trained in FP/ART integration. These facilities have been provided with equipment to facilitate the integration of these services. New FP guidelines have been developed encouraging long-term FP methods and dual protection with use of a condom to protect against HIV infection. Data specifically on unmet FP need among WLHIV is not available to determine the level of success of these interventions. However, data on the general population shows that unmet FP need among married women aged 15-49 increased from 13% in 2010 to 15.2% in 2015\(^9\).

Prevention of MTCT post 8 weeks and provision of treatment to mothers LHIV and their children has been scale up and has achieved increased results: Two types of interventions are being implemented:

(i) Community mobilization interventions: These interventions raise awareness and create demand for PMTCT is being conducted through door-to-door visits by civil society organizations and rural health motivators to explain the benefits of PMTCT and refer clients to clinics. Volunteers visit households and check patients’ cards and follow up to ensure clients are visiting clinics when required and provide family support to ensure adherence to treatment. These volunteers also hold meetings with health facilities personnel to ensure smooth referral to the facilities. Health facilities also refer pregnant women who need support to the volunteers for follow up.

(ii) Health facility provision of PMTCT services: The country has adopted the 2013 WHO treatment guidelines and is providing life-long ART among pregnant and lactating women LLAPLa). To reduce loss to follow up, pregnant women testing HIV positive are initiation on ART the same day. Further, pregnant women are also followed up by Mentor mothers (M2M), rural health motivators and expert patients at both the community and facility. Provision of ART is synchronized with PCR, PNC, EPI visits for mothers. HIV exposed children are traced and reached at 18 months through the measles booster which offers an opportunity to test them for HIV. There is adequate and regular availability of EID service and drugs for prophylaxis. As a result, 93% of HIV positive pregnant women were on ART in 2015 while 36% of the exposed infants were tested within 6-8 weeks.

\(^9\) MICS 2010 and 2014
### Gaps and challenges

(i) HIV infections among women of child bearing age at still high as evidenced by the HIV estimates data on women 20-24 years and the programme data on pregnant women testing HIV positive at ANC.

(ii) Unmet family planning needs are somewhat increasing despite efforts to scale up family planning

(iii) The percentage of exposed infants testing HIV positive has increased from 2% in 2012 to 3% in 2015. There is a need to investigate the factors contributing to this increase.

(iv) Staff rotation is affecting availability and quality of PMTCT/ EID service delivery. Human resources capacity to deliver integrated PMTCT and long term family planning services are inadequate.

(v) There is a stock out Nevirapine syrup at health facilities

(vi) Current CMIS system does not cater for most of PMTCT information needs

### Priorities

(i) Scale up HIV prevention among women of child bearing age, prioritising adolescents and young women 15-24 years

(ii) Review rotation policy to ascertain its impact on SRH service delivery

(iii) Improve ANC data to capture the parity and gravidity which can be used as a proxy for incidence among young women pregnant for the first time

(iv) Conduct mother baby pair based analysis to direct strategies to eliminate MTCT

(v) Review CMIS to capture all PMTCT data to general quality and complete PMTCT data

(vi) Improve logistics information management system to have up to date data on commodity stocks

(vii) Decentralize and integrate provision of long term FP methods to clinics

### 4.1.6 Male circumcision

Male circumcision (MC) is one of the proven effective strategies for HIV prevention and the eNSF placed high priority on this programme to reduce new HIV infections. The strategic framework prioritized adolescents and youth 10-24 years as well as infants from birth to 8 weeks as a primary target population. Men 25-35 were also to be targeted.

Both the eNSF and the MC strategic plan 2014-2018 recognised the low demand and uptake of MC services is a key challenge. Therefore, MC strategic plan targets males 10-29 years as a catch-up phase as well as routine provision of Early Infant Male Circumcision (EIMC) as a long term sustainability strategy.

The strategies laid out by the eNSF to scale up MC included strengthening and decentralising MC services especially for neo-nataals and males 10-35 years; intensification of education and awareness and community mobilization to generate demand; addressing socio-cultural, myths and misconceptions of MC and integrating MC services with other health services. The evaluation assessed the extent to which these strategies were implemented and the resulting outcomes and outputs.

### Results achieved

**Outcomes:** Prevalence of medical circumcision among males 15 years and above increased from 24.3% in 2014 (MICS) to 26.7% in 2017 (SHIMS 2016-17). Prevalence of medical circumcision decreases by age, from 38.2% among 15-19 year olds to 7.5% among males 65 years and above. One out of three 15-24 year olds is circumcised (34.8%) compared to one out of every five 25 years and older (21.9%).
Overall, the target of 70% prevalence for medical circumcision by 2018 is not likely to be met unless huge resources and innovative interventions are put in place.

**Outputs:** MC uptake results reflect the low coverage of the programme. A total of 97,132 circumcisions have been between 2009 and 2016. Annual circumcisions have been fluctuating since the programme launch in 2009. Except for 2009 which registered a low 2,825 circumcisions which is an outlier, the circumcisions undertaken annually have been ranging from 8,684 in 2013 to 16,618 in 2016. This range is within the eNSF mid-term target of 15,000 annual circumcisions but does not meet the end term target of 21,000 by 2018. The programme targets are too low to meet the 70% MC coverage by 2020.

There is regional variation in the male circumcisions undertaken with more circumcisions in HhoHho and Manzini regions compared to Shiselweni and Lubombo.

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**Figure 15: Male Circumcision By Age Groups - Total 2009-2016 (Programme Data)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>HhoHho</th>
<th>Manzini</th>
<th>Shiselweni</th>
<th>Lubombo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-9</td>
<td>3,486</td>
<td>3,379</td>
<td>8,218</td>
<td>2,524</td>
<td>14,601</td>
</tr>
<tr>
<td>10-14</td>
<td>38,461</td>
<td>38,461</td>
<td>75,1</td>
<td>751</td>
<td>171,678</td>
</tr>
<tr>
<td>15-19</td>
<td>21,678</td>
<td>21,678</td>
<td>48,85</td>
<td>1,137</td>
<td>93,59</td>
</tr>
<tr>
<td>20-24</td>
<td>14,601</td>
<td>14,601</td>
<td>35,39</td>
<td>3539</td>
<td>65,94</td>
</tr>
<tr>
<td>25-29</td>
<td>8,218</td>
<td>8,218</td>
<td>25,54</td>
<td>754</td>
<td>41,55</td>
</tr>
<tr>
<td>30-34</td>
<td>4,885</td>
<td>4,885</td>
<td>12,988</td>
<td>12,988</td>
<td>22,75</td>
</tr>
<tr>
<td>35-39</td>
<td>2,524</td>
<td>2,524</td>
<td>11,878</td>
<td>11,878</td>
<td>16,618</td>
</tr>
<tr>
<td>40-44</td>
<td>1,255</td>
<td>1,255</td>
<td>8,684</td>
<td>8,684</td>
<td>18,65</td>
</tr>
<tr>
<td>45-49</td>
<td>751</td>
<td>751</td>
<td>524</td>
<td>524</td>
<td>1,003</td>
</tr>
<tr>
<td>50+</td>
<td>1,137</td>
<td>1,137</td>
<td>13,953</td>
<td>13,953</td>
<td>27,906</td>
</tr>
</tbody>
</table>

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**Achievements/Progress**

Provision of MC has been scaled up through health and non-health facilities but coverage varies among age groups:

(i) The programme has adopted three approaches to delivery MC services: (1) Fixed sites of which they are four in the country. (2) MC outreaches where men are mobilized using chiefs and teachers to generate demand and those needing VMMC are brought to a health facility. (3) Mobile VMMC services involving advance sensitization and mobilization of the men to generate demand followed by a specific day when MC is offered on site to those who need the service. VMMC is also offered through MC Friday and Back to School strategies (BTS) which target young boys and account for the high numbers of youth 10-19 circumcised compared to other age groups. Given the strategies

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10 HhoHho 1 site, Manzini 2 sites and Shiselweni 1 site.
adopted and the priorities of the programme, most MCs are taking place in younger boys 10-14 years followed by 15-19 year olds. The number of circumcisions reduces with increase in age (see figure). The EIMC approach has not been rolled.

(ii) A coordination mechanism for the programme are in place: Coordination is done through the MC technical working group which meets when there is a need or quarterly to review programme data. It has a total membership of 15 comprising technical partners and implementers. The TWG review quality, decides or approves devices used for MC, develops strategies for demand creation and targeting among other issues.

(iii) The supply chain for MC commodities has been working efficiently. Procurement for MC is centralized and done through Central Medical Stores (CMS) while the programme also purchases local consumables.

(iv) There are adequate human resources to provide MC services at the current level of coverage. The programme has trained an adequate doctors (which is the cadre designated to conduct MC) and developed a database of those trained to facilitate deployment. Doctors trained are drawn from both government, private and NGO sectors. Nurses providing support services have also been trained. Therefore, it has not become necessary to pursue the task shifting of MC to nurses at the current level of service coverage and demand.

(v) The programme has a robust M&E system that collects data on all circumcisions undertaken by region and age group. All implementing partners report to the programme using common tools. A central MC database is in place to capture, manage and disseminate data to various audiences. However, MC data is reported to the programme while demand creation data is reported through SHAPMOS.

**Demand creation is well coordinated with service provision to ensure those who need the service have access to it**: Demand creation is key for the success of MC. The various regions of the country have been mapped and specific organizations assigned the areas where they conduct demand creation through engaging chiefs, teachers and other leaders to reach men in the community and in schools.

**Other HIV prevention and male health counselling has been integrated into the MC programme to make it comprehensive**: One on one counselling about combination HIV prevention, provision of HTS, screening for TB, hypertension and diabetes is carried out during VMMC. About 97% of those who come for VMMC also take up HTS. The table below shows the HTS uptake during MC.

<table>
<thead>
<tr>
<th>Table 5: Uptake of HTS by MC clients</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTC Results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Reactive</td>
<td>2210</td>
<td>13216</td>
<td>10637</td>
<td>11226</td>
<td>7518</td>
<td>10767</td>
<td>12309</td>
<td>15856</td>
<td>83739</td>
</tr>
<tr>
<td>Reactive</td>
<td>191</td>
<td>826</td>
<td>1066</td>
<td>655</td>
<td>466</td>
<td>381</td>
<td>421</td>
<td>531</td>
<td>4537</td>
</tr>
<tr>
<td>Indeterminate</td>
<td></td>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Unknown</td>
<td>424</td>
<td>2337</td>
<td>3009</td>
<td>1107</td>
<td>700</td>
<td>725</td>
<td>296</td>
<td>231</td>
<td>8829</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2825</td>
<td>16379</td>
<td>14712</td>
<td>12988</td>
<td>8684</td>
<td>11873</td>
<td>13053</td>
<td>16618</td>
<td>97132</td>
</tr>
</tbody>
</table>
Gaps and challenges

Major gaps in provision of MC are as follows:

(i) Uptake of MC is too low to have significant impact on HIV prevention. Based on MICS 2014 data, there is a gap of 56% men 15-59 who need to be circumcised to get 80% coverage.

(ii) Social cultural, myths and misconception about MC have not been adequately addressed and they form part of the barriers to the scale up of the MC uptake in the country.

(iii) Funding constraints are also hindering the scale up of MC. The program targets are to a large extent determined based on the available resources and not the country need.

(iv) Early Infant Male Circumcision is not prioritised because it is deemed not to have immediate benefits and due to funding constraints

(v) Waste management is a challenge. Service providers have to collect all waste for central disposal in one centralized incinerator

Priorities

(i) Mobilise or allocate adequate resources to MC programme in order to achieve significant impact

(ii) Develop innovative strategies for demand creation to scale up service uptake

(iii) Analyse data at granular level to expand successful models of MC service delivery and also micro-target the services

(iv) Scale up MC through cost effective strategies such as integrating it with other health services, rolling out EIMC and targeting men using male friendly approaches

(v) Conduct research into social cultural barriers to MC to inform programming

4.1.7 Customized interventions for key populations and vulnerable groups

The eNSF identified sex workers (SWs), men who have sex with men (MSM) as key populations and adolescents and young people, prisoners and mobile populations as vulnerable groups. Strategies laid out to address gaps and challenges in access to HIV services by these populations include the removal of policy and legal barriers that prevent provision of comprehensive HIV services to key populations; implementation of community and institutional based strategies that address gender, stigma and discrimination; customized interventions targeting key populations and research and size estimation to improve knowledge, understanding and interventions appropriate for key populations. This evaluation assessed the extent to which these strategies were implemented and the outcomes and outputs achieved.

Results achieved

Outcome and outputs: Results of customized interventions for key populations and vulnerable groups were to be measured through outcome and output indicators that required population based data as well as programme data. However, recent data from both sources that could be used to assess achieved results is not available.

Achievements/progress

Although service coverage for key populations has increased in recent years, specific focus on policy and legal barriers to access to services has been limited: Recent interventions aimed at improving the
policy and legal environment for KPs and vulnerable populations include a legal environment assessment which has been completed and dissemination is being planned through civil society platforms and other groups such as parliamentarians. Dialogue on HIV and the law has started and so far the police have been sensitized on access to healthcare by key populations. However, a comprehensive approach to identifying and addressing policy and legal barriers to health services for these groups has not been undertaken.

Community and institutional based strategies addressing gender, stigma and discrimination have been implemented targeting KPs and service providers. However, stigma remains a key barrier to service among these populations: A baseline assessment of stigma and discrimination in relation to key populations has been done. Recommendations of the study included the need to sensitize the police about the importance of working with key populations to fight against HIV which are being implemented. Organizations (MSF, WHO, URC, EGPAF, PACT and national CSOs) and health care workers have been trained on health service provision to key populations. A mentor nurse has been deployed or identified in selected facilities to assist with key issue of key populations; and peers have been identified to support KPs navigating to access HIV services. Forums such as health clubs and meetings have been established for key populations to discuss their challenges. A network of commercial sex workers has also been established and meets once a month and there are 12 health clubs that have been formed.

Customized interventions targeting key populations have been developed and are being scaled up in identified hotspots: HIV prevention, treatment and care services for these populations have been scaled up. The hotspots where these populations can be reached were identified through a comprehensive survey and services are offered in all identified hotspots. The implementing organizations have devised appropriate strategies to reach the key populations including (1) providing services through outreaches conducted at night hours (moonlight approaches, (2) using of peers to reach out to the key populations; and (3) training health workers in selected facilities to provide KP friendly services. The services offered include:

- A package of HIV information (through small group sessions, peer education and IEC), and condoms and lubricants. A common curriculum for training KP peer educators have been developed.
- HIV testing services and referral or linkage to care as well as encouraging those negative to maintain their status
- STI, cervical cancer and TB screening and referral for treatment
- Provision of clinical services which include ART, TB and STIs diagnosis and treatment in a few NGO operated sites, mobile clinics and in public health facilities
- Peer navigators are assisting KPs to access health facilities. The KPs also report to the navigators on challenges they face at the health facilities.
- Holding support groups sessions for KPs to reflect on their own issues and challenges
- Providing HIV prevention and linkage to care for transport workers and mobile populations
- Pre-Exposure Prophylaxis offered in two sites
- Health workers are being trained on stigma and discrimination to enable them provide services to KPs. Self-stigma is being addressed by holding focused discussions on one-on-one or small groups discussions with KPs
- Sensitisation of the police on human rights and public health
- Training of KP organizations on organizational and programme management
• Targeting super-groups bringing together select sex workers to the KP TWGs to share their activities, be involved in planning and increase their knowledge on HIV prevention, treatment and care.

With regard PWID, there is limited data to support programming. A study has been conducted and results will inform programming.

Interventions targeting prisoners for HIV prevention, treatment and care as well as TB screening and treatment has had success. Prison staff have been trained on HIV, drug use and other issues to increase their understanding; peer education has been up scaled; inmates are oriented and trained on HIV and TB prevention, treatment and care; and a referral tool has been developed that helps to ensure linkage of discharged prisoners to health facilities for continuity of ART and general medical care;

*Research and size estimates to improve knowledge, understanding and interventions appropriate for key populations has been undertaken.*

A mapping study of key populations (MSM and FSWs) has been done providing data on size estimation, hotspots, vulnerability factors exposing these groups to HIV infection, challenges and barriers to service, and facilities where they seek service. The study makes critical recommendations on programming for key populations. The executive management of police and senior management including station commanders are being sensitized about key issues pertaining to key populations using the results. Secondly, a behavioural study on people who inject drugs has been conducted although was of a small scope to effectively inform programming.

*HIV services for adolescents and young people (AYP) have been scaled up:* Interventions for these populations include the teen clubs set up in over 50 health facilities as well as in schools providing HIV and SRH information and services; clubs for adolescents and youth LHIV supporting treatment adherence and providing psychosocial and SRH services; radio programmes targeting adolescents and youth; school health programmes involving MoET and MoH collaboration; and sensitisation meeting held for adolescents and youth in the community mainly by civil society and faith based organisations; provision of a comprehensive HIV services to and economic empowerment of adolescent girls in selected Tinkhundla.

**Gaps and challenges**

- Key population sexual practices are legally criminalized and little effort has been made to remove legal and policy barriers
- HIV services provided to the KPs are not uniform across all implementers
- KPs especially those in the rural areas are difficult to target because they do not identify themselves due to stigma and fear
- Self and external stigma in a major bottleneck for KPs to access services.
- M&E system to track KP interventions and service uptake is weak. Data specific to these groups is not comprehensive.
- Retaining KPs on ART is challenge given high mobility and stigma among this group
- Data on risks, vulnerability factors and access to services by KPs is limited
- Mechanisms for coordination of HIV services for KPs are weak. Implementers do not meet regularly to share their plans, coordinate their visits to hotspots and also to share data.
- Age disaggregated data is lacking to inform AYP programming
- Parental involvement in the AYP programmes is lacking; programmes are not targeting parents.
• Frequent movement/transfers of trained health workers necessitating frequent need for training new ones.

Priorities

• Develop a comprehensive HIV service package for key populations. This could include mapping implementers to specific locations to minimize duplication.
• Establish/strengthen a coordination mechanism for KP interventions
• Develop differentiated strategies given that KPs is not a homogeneous group. Particularly, there is need for strategies for reaching KPs in rural areas.
• Addressing stigma at all levels – individual, health system, community and institutional level
• Establish quality improvement mechanisms for KP services
• Conduct research into risk, vulnerabilities and barriers to access to services for KPs
• Conduct an assessment of PWID in Swaziland
• Integrate parental involvement into the ADY programmes
5.1 Treatment, care and support

Treatment, care and support covers pre-antiretroviral services, antiretroviral services and TB/HIV co-infection.

5.1.1 Pre-Antiretroviral (Pre-ART) services

The eNSF sought to address several challenges in the provision of Pre-ART services which included Pre-ART package not being comprehensively implemented; a weak M&E system that resulted in high patient loss to follow up; weak referral from HTC to Pre-ART especially for newly diagnosed individuals; inadequate capacity for procurement and supply of drugs and commodities for opportunistic infections; limited task shifting with only doctors allowed to prescribe drugs for OI yet majority of patients are attended to by nurses; and lack of integration of SRH into Pre-ART to address needs of women LHIV.

Results achieved

Outcome and outputs: Although data to measure Pre-ART outcomes and outputs is not available, the country has continued to provide Pre-ART by linking HTS clients to care, monitoring the patients on care and transitioning patients to ART based on prevailing staging criteria. Partial data from 2015 shows that 12449 PLHIV (5% children and 95% adults) were enrolled into Pre-ART. Of these, 77.1% were screened for TB while 55.4% were started on contrimoxazole11.

Achievements/progress

Linkage of clients between HTS and Pre-ART at facility level has been improved but linkage from community HTS to Pre-ART is weak: There are mechanisms in place to link clients from facility and community based HTS to treatment, care and support services. At facility level, clients are referred from HTS service points to Pre-ART service point within the same facility or from facility to facility. Clients from HTS offered at community level are referred to health facilities of their choice. A referral system from the community to a health facility (including the required tools) is in place. However, follow up to ensure clients referred access Pre-ART services and feedback from health facility to the community partners is inadequate.

A comprehensive Pre-ART package with strong referral and linkage to other programmes is in place: A comprehensive Pre-ART service package is being offered which includes biannual CD4 cell count testing, regular screening for TB, provision of Cotrimoxazole, Isoniazid preventive therapy, prophylaxis for cryptococcosis, family planning services and NCD screening. There is an efficient transition of clients from Pre-ART to ART. The programme maintains longitudinal data for several years for both Pre-ART and ART services provided.

Integration of gender sensitive SRH services has been strengthened: SRH and HIV integration has been implemented since 2011. Focus has been on integration of FP and cervical cancer screening into ART sites as well as integration of ART into FP service points. To strengthen this integration, training of health workers on FP/ART integration has been conducted in facilities, all ART sites and PHUs; Regional Health Management Teams (RHMTs) have been sensitized on the integration; and facilities have been provided with equipment to ensure integration of services is not compromised. The SRH programme has adopted the cervical cancer screen and treat approach (being offered in 12 facilities) to minimize the loss to follow up for cervical cancer patients. However, MICS data shows an increase in unmet

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family planning need among married or “in union” women from 13.0% in 2010 to 15.2% in 2014; an indication that more work needs to be done on provision of SRH services to WLHIV.

**Strengthen involvement of community structures to increase demand for TB and HIV services and reduce stigma and discrimination:** Community structures involved in generating demand for HIV treatment, care and support services include civil society organisations (NGOs and CBOs), community leaders, PLHIV support groups, peer educators and rural health motivators. These structures conduct community sensitisation and awareness on HIV prevention, treatment and care including stigma and discrimination, mobilise communities for HTS as key entry point to other services, support those who test positive and link clients with facilities. Capacity building of these structures has been ad hoc and poorly resourced and their interventions have been short-term and largely ad-hoc; most PLHIV support groups are not operational while traditional leaders get involved when targeted by implementing entities who want to gain access to the community.

**Gaps and challenges**

(i) Monitoring and Evaluation – all health facilities are not capturing Pre-ART data resulting in patient loss to follow up.

(ii) Weak linkage from HTS to Pre-ART - Clients testing HIV positive during community based testing take time to seek HIV treatment and care services. In most cases, they prefer distant health facilities where they are not known to service providers. There is limited follow up to ensure clients self-refer and no feedback loop between the referring and receiving entities. This presents difficulties in tracking clients from HTS to treatment and care sites.

(iii) Involvement of community structures in demand creation for HIV and TB services and reduction of stigma faces several hurdles. Support for PLHIV support groups has been declining and the involvement of these groups has waned over time; and CSOs and CBOs that are instrumental in mobilising communities and supporting peer educators also face resource constraints.

(iv) Stigma and discrimination is still a key barrier to demand generation. Focus group discussions held with men and adolescents indicated that although they attend HIV outreaches and awareness sessions, they are reluctant to take up HTS during such public events. PLHIV support groups also indicated that individuals testing positive are reluctant to disclose their status and to seek services due to stigma.

**Priorities**

Following the launch of the “test and start” approach to HIV treatment and care, the Pre-ART serviced will be integrated with the ART programme. There will also be need to build capacity and support community structures to generate demand for test and treat as an entry point to the ART programme by partly addressing address stigma and discrimination.
5.1.3 Antiretroviral therapy for PLHIV (ART)

At the time of development of the eNSF, ART was provided to PLHIV based on the eligibility criteria of CD4<350. During the eNSF period, the country adopted the 2013 WHO treatment guidelines which increased eligibility criteria to CD4<500 and provided for test and treat pregnant and lactating women, sero-discordant couples, HIV+ children, TB/HIV co-infected persons and those co-infested with HIV and Hepatitis B. Further, in 2015 the country adopted the 90-90-90 treatment targets and, in 2017, launched the “test and start” for all PLHIV approach.

The eNSF was designed to address the following gaps and challenges: weak referral and patient tracking especially from HTS to ART resulting in low and late enrolment on ART and poor treatment adherence; inadequate system for identifying children exposed to or have HIV; occasional stock-outs of CD4 and viral load reagents; stigma and discrimination; inadequate focus and targeting of key and vulnerable populations; and weak palliative care because lower level facilities could not prescribe some medicines for pain management and OIs.

Results achieved

Outcome: eNSF outcome indicator for this programme is percentage of adults and children with HIV still alive and known to be on treatment 36 months after initiation on ART has increased from 68% for adults in 2011 to 75% in 2015 and 80% in 2018 and from 66% in 2011 for children to 70% in 2015 and 75% in 2018. A cohort analysis conducted in 2015 shows a retention rate of adults and children of 83% and 84% respectively at 36 months which indicates an achievement of the eNSF 2015 target. A detailed analysis of the ART retention rates for adult and children is shown in the table below.

Table 6: ART Retention rates for children (0-14 years) and adults (15+ years) by cohort - 2008-15

<table>
<thead>
<tr>
<th>Cohort</th>
<th>6 months</th>
<th>12 months</th>
<th>24 months</th>
<th>36 months</th>
<th>48 months</th>
<th>60 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&lt;15 yrs</td>
<td>15+ yrs</td>
<td>&lt;15 yrs</td>
<td>15+ yrs</td>
<td>&lt;15 yrs</td>
<td>15+ yrs</td>
</tr>
<tr>
<td>2008</td>
<td>88%</td>
<td>85%</td>
<td>82%</td>
<td>78%</td>
<td>75%</td>
<td>71%</td>
</tr>
<tr>
<td>2009</td>
<td>87%</td>
<td>85%</td>
<td>81%</td>
<td>78%</td>
<td>74%</td>
<td>71%</td>
</tr>
<tr>
<td>2010</td>
<td>87%</td>
<td>86%</td>
<td>80%</td>
<td>80%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td>2011</td>
<td>89%</td>
<td>88%</td>
<td>82%</td>
<td>80%</td>
<td>69%</td>
<td>69%</td>
</tr>
<tr>
<td>2012</td>
<td>84%</td>
<td>87%</td>
<td>76%</td>
<td>77%</td>
<td>87%</td>
<td>82%</td>
</tr>
<tr>
<td>2013</td>
<td>85%</td>
<td>86%</td>
<td>91%</td>
<td>88%</td>
<td>87%</td>
<td>87%</td>
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<td>2014</td>
<td>97%</td>
<td>96%</td>
<td>93%</td>
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<td>93%</td>
<td>92%</td>
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<tr>
<td>2015</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Data source: Programme data, 2015

Outputs: The country is on track to achieving the ART targets though some of the target had not been met by mid-term. See the table below.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Baseline (2011)</th>
<th>Target 2015</th>
<th>Target 2018</th>
<th>Achieved result</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of eligible adults aged 15+ who are currently receiving antiretroviral therapy</td>
<td>84%</td>
<td>90%</td>
<td>95%</td>
<td>83% - 2015 (based on ART eligibility criteria – CD&lt;500)</td>
</tr>
<tr>
<td>% of eligible children aged 0-4 who are currently receiving antiretroviral therapy</td>
<td>63%</td>
<td>80%</td>
<td>90%</td>
<td>72% - 2015 (based on 2013 WHO guidelines)</td>
</tr>
<tr>
<td>% of people living with HIV (adults and children) enrolled in care who are malnourished who receive nutritional support</td>
<td>60%</td>
<td>85%</td>
<td>85%</td>
<td>Comprehensive data not available*</td>
</tr>
</tbody>
</table>

12 HIV Annual Report, 2015
34% of PLHIV (with known HIV status) enrolled in PLHIV support groups

11%  50%  80%  51% (2015) — SHAPMOS

* Data for nutritional support is available for the major hospitals and health centres through the Swaziland National Nutrition Council. Data is not available via MoH M&E. Efforts to integrate the nutritional indicators into the national HMIS are still ongoing

The country aims at achieving the 90-90-90 treatment cascade targets by 2021. SHIMS 2016-17 results on the treatment cascade are as follows:

- HIV diagnosis: By 2017, 84% of the PLHIV 15 years and above report knowing their HIV status (88.6% females and 77.5% males).
- On HIV treatment: Of these 87.4% self report to be on ART (86.9% females and 88.6% males).
- Virally suppressed: Among the PLHIV 15 years and above who self-report to be on ART, 91.9% are virally suppressed including 92.2% of HIV positive females and 91.3% of HIV positive males who self report to be in ART. When based on all PLHIV with viral load results (irrespective of HIV-positive status and ART status, a total of 73.1% of PLHIV are virally suppressed. These comprise 67.6% men and 76.0% women.

The figures below shows the treatment cascade by age and sex (SHIMS 2016-17).

There is progress towards the 90-90-90 goals demonstrating that the national response to HIV has made strides against the epidemic but more work needs to be done to sustain the results. The results among men and among adolescents and young people 15-24 are lower compared to other groups. These two groups should be prioritised.
Achievements/progress

The system for referral and tracking PLHIV on ART has been strengthened; consequently retention of PLHIV as increased over time: The ART programme has an established system for patient referral and tracking. Patients are given appointments on the specific date to visit the health facility and are reached by phone in case they don't turn up. If unsuccessful, then expert clients assist to track clients and link them back to facilities. Rural Health Motivators and PLHIV support groups (where they are active) are also used to remind and encourage patients to keep their appointments and adhere to treatment. This system will be adjusted to fit the introduction of differentiated care models.

Nutritional support is provided in major hospitals but can be improved in lower level facilities: Maltreated adult PLHIV in the 12 hospitals and health centres receive specialized food supplements. Services can be scaled up in clinics.

Mechanisms for follow-up of HIV exposed infants and children with HIV are in place and efficiently implemented with adequate support from national level: The national ART programme has established early infant diagnosis (EID), early initiation of ART and psychosocial support for children and their families. EID is centralized, with the National Reference Laboratory conducting the tests supported by an efficient system for collecting samples from peripheral facilities. Dedicated weekly pediatric ART days are being held in all regions, HCWs have been trained in psychosocial support for children and families, monthly teen clubs and support groups for children have been scaled up, and caregiver and family support groups have been established.

Integration of ART services with other health care services has been enhanced: ART has been integrated with several other health services to improve outcomes for PLHIV. Integrated services include ART/TB involving screening and testing PLHIV for TB and those TB positive are put on TB treatment while those testing negative are provided IPT while on TB patients are also tested for HIV and referred for treatment if positive. ART is also integrated with SRH to address FP needs of WLHIV and conduct cervical cancer screening.

Community systems to enhance quality of ART are in place but capacity of PLHIV could be strengthened to enhance their involvement: The programme has adopted differentiated care approaches including CommART to improve adherence and retention. 52 facilities are implementing at least one model of differentiated care. A community system is also in place linking patients to health facilities and supporting patients to improve adherence. This system comprises expert patients placed in health facilities to provide counselling; rural health motivators, PLHIV support groups as well as PLHIV family members educated to support PLHIV to promote adherence and visit health facilities according to set appointments.
Efficiency of procurement and supply management of drugs and related commodities has improved; however logistics data could be improved to ensure no stock outs: There is adequate funding for drugs with support from government and partners; quantification and forecasting of drugs and other commodities and management of stocks is being done in collaboration between SNAP and CMS. CMS in charge of supply chain management and stock status updates are provided in TWG meetings for review and decision making to ensure commodity security. Overall stock outs of drugs are minimal. PLHIV observed that they have experienced shortage of drugs and they always have their refills as scheduled.

Task shifting and capacity development of lower level health workers has contributed to ART scale up and is critical for implementation of differentiated care: The programme has achieved effective decentralization of ART to PHU, PHC and TB units. SOPs for ART initiation are available in most facilities. The decentralization has led to 70% of ART initiation taking place at primary healthcare level compared to 30% ART initiation in hospitals and health centres. This has been partly facilitated by task shifting (Nurse Led ART initiative) and capacity building for health workers at lower level facilities. A continuous capacity development and mentorship programme is being implemented to address growing training needs as patients mature on drugs.

Palliative care for HIV patients: Service providers’ capacity in palliative care has been enhanced but community based palliative care services are limited. Twelve healthcare teams have been established, standards operating procedures developed and dissemination and health workers have been trained in these SOPs; a home based care (HBC) commodity assessment tool has been developed and is being used to determine HBC commodity needs; and palliative care registers are being reviewed on an ongoing basis and data collected. At community level, home based palliative care is limited due to funding constraints. PLHIV support groups that have been involved in HBC no longer receive support from SWANNEPHA and health facilities.

Gaps and challenges

(i) There are gaps in standard operating procedures which include lack SOPs or guidance on how to support unstable patients, those not adhering to treatment and those in depression needing psychosocial support; the SOP for referral is not yet aligned to the Test and Start policy; and a policy and plan on management of HIV DR is also not yet in place.

(ii) Weak community structures providing psychosocial support and linking patients with facilities: PLHIV support groups have very limited support from SWANEPHA and other partners; most of these groups are not active and rarely meets.

(iii) M&E gaps: Lack of adequate data on food by prescription and data on procurement; and there is weak monitoring of early warning indicators for HIVDR. VL testing data is not updated regularly and is not utilized by clinicians to take action. Routine programme data as well as data from research does not get to all TWGs thus affecting utilization and decision making.

(iv) Funding: In some cases, release of funds for drugs and laboratory essentials by government is delayed or funds are released in low tranches resulting in risk of stock outs.
Paediatric ART: Inadequate systems for identifying children aged 0-14 years who are exposed to HIV infection, stigma that prevents parents and care givers from allowing testing for children; poor support for adolescents on ART in relation to ART and addressing their SRH needs.

Home Based Care (palliative care) is limited and PLHIV support groups that provided this service are largely inactive.

Limited provision of nutritional supplements. Nutritional assessment for PLHIV is conducted at the ART clinics and those that need nutritional support are advised accordingly. However, nutritional support is offered in major hospitals.

Priorities

1. Strengthen collaboration with and engagement of community level partners that support the HIV programme in order to strengthen patient support systems as well as identify underserviced populations. A holistic approach to HIV programme implementation (and not just focus of clinical perspectives) is needed.

2. Promote and develop more guidance for differentiated care models including a package to prevent or diagnose early co-infections and management of treatment of experienced clients.

3. Scale up viral load monitoring to ensure it is offered routinely and improve data collection and reporting.

4. Strengthen pharmaco-vigilance and monitoring of Early warning signs of HIVDR.

5. Improve timely release of government funds for ART drugs and other commodities (laboratory reagents).

6. Improve communication/reporting on inventory/stock levels. There is a need to carefully manage introduction of new drugs and management of stock to limit waste and stock outs. Improve stock control systems and processes, and sensitize clinicians on new drugs.

7. Review training needs for nurses (NARTIs) to address needs that are arising (such as interpretation of viral load results. Investment in evaluation or NARTIs.

8. Strengthen capacity of and support PLHIV support groups to assist in supporting retention and treatment adherence initiatives.

9. Strengthen interventions addressing disclosure among children LHIV and transitioning to adult care.

10. Develop stronger linkages with community stakeholders to support pediatric HIV case finding and care.

11. Establish a systems for provision of HBC by mapping of NGOs and PLHIV support groups, providing commodities and establishing a reporting system.

12. Strengthen health systems to support the “test and start” approach. This includes investing in laboratory system, human resources and infrastructure.
5.2.1 TB/HIV co-infections

There is a high TB/HIV co-infection estimated at about 70%. Multidrug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) forms of TB are more common among HIV positive people. The national TB/HIV co-infection policy guidelines were developed in 2007 and since then TB/HIV collaboration and integration has been scaled up. TB patients are screened for HIV and those testing positive are put on treatment and care while HIV patients are also screened for TB and those positive are put on treatment.

Challenges the eNSF set out to address include low TB/HIV treatment rate with 66% (2012 programme data) of TB patients with HIV receiving treatment for both HIV and TB; weak HIV and TB services coordination; lack of isolation facilities for effective infection control; and incomplete of IPT data due inadequate integration of electronic systems hence only initiation is captured and not the follow up for completion of the drug course.

Results achieved

Outcome: There is no data on the indicator used to measure eNSF TB/HIV co-infection outcome – percentage of incident TB cases among PLHIV who have successfully completed their TB treatment. Available data shows mortality rate among TB/HIV co-infected patients at 14% in 2017 up from a baseline of 10% in 2015 and a rate of TB/HIV co-infection declining from 80% in 2012 to 70% in 2016. Thus, HIV is still the key driver of TB in the country.

Outputs: Most of the TB/HIV programme output targets have been met while others have been surpassed. Over 90% of the HIV patients with TB are initiated on ART while about 99% are initiated on CPT. It is observed that although the HIV/TB response has performed optimally, co-infection rates remain high.

Achievements/ progress

Integration of HIV and TB services has been scaled across all TB and HIV service points in the country

National and regional HIV/TB technical working committees have been established with membership from both SNAP and NTCP to coordinate HIV/TB integration. These committees meet quarterly to review programme progress and make decisions to improve performance. Implementation of TB/HIV collaborative activities are guided by a joint TB/HIV work plan. There is a high level of awareness of the need for integration among health practitioners and programme implementers.
HIV services are integrated in all BMU sites. The TB programme has integrated HIV services in their sites where all patients are tested for HIV and if positive they are initiated on ART. 100% of TB facilities are providing ART. In HIV facilities patients are screened for TB and if positive referred to TB facilities. TB Screening is also implemented in nearly all HFs at HIV service points across the country. TB/HIV integration policies and Guidelines have been disseminated and health workers are being trained or capacitated with HIV information including those supporting TB programmes. However training on TB is still not widely available to all nurses.

At community level, community partners support TB/HIV screening and the 5-questions screening tool is widely used. They also conduct active TB and HIV case finding through door-to-door campaigns. These services are often combined with other programme activities such as home-based care, index client contact tracing and community awareness programmes.

There is wide coverage in the provision of 3Is for HIV/TB: TB screening is widely implemented at different levels including clinical and non-clinical settings using the 5-questions screening questionnaire. Persons suspected as potential TB clients undergo diagnostic tests including sputum testing. 99% of health facilities currently conduct active TB screening for HIV patients. IPT is widely available at HFs and prescribed for HIV positive clients. Infection control is also implemented in all health facilities.

Gaps and challenges

(i) High TB/HIV co-infection remains a major issue for both TB and HIV programmes. The TB burden among PLHIV is still high with mortality being at 14%. People have a high knowledge of HIV compared to TB

(ii) Low uptake of IPT among TB negative PLHIV as well as frequent stock out of IPT

(iii) Lack of reliable data on IPT provision in HFs due to inadequate documentation

(iv) Sub-optimal documentation of TB screening among PLHIV attending ART clinics

(v) Training for health care providers on TB is lagging behind training on HIV

Priorities

(i) Develop and implement one TB/HIV plan by SNAP and the NTCP in order to address data gaps and improve cost efficiencies in implementation especially in rolling out support to HFs. A joint research agenda for SNAP and NTCP would address some of the research gaps which apply to both programmes.

(ii) Strengthen Regional Coordination of the two programmes TB/HIV and improve implementation of plans at site levels.

(iii) Strengthen M&E for TB/HIV to effectively track TB screening among PLHIV and other high risk groups and as well as effectively monitor provision of IPT

(iv) Review local data on implementation model and documentation of IPT to inform policy with a view to improving IPT uptake

(v) Strengthening screening and testing among HIV clients especially use of diagnostic tests in patients that may not be able to produce sputum

(vi) Improve laboratory transport and coordination to ensure that sputum samples are routinely collected from health facilities

(vii) Strengthen data collection on TB case finding among HIV positive clients
5.3 Care and support for Orphaned and Vulnerable Children

5.3.1 Family strengthening

The increasing number of Orphans and Vulnerable Children (OVC) is one of the most visible effects of HIV in Swaziland. Children classified as Orphans and Vulnerable Children (OVC) increased from 45% in 2010 to 71% in 2014 with Lubombo and Shiselweni regions presenting the highest rates – 75% and 73% respectively. During the same period, orphan-hood decreased from 24% to 20% with 41% of adolescents aged 15-17 having lost at least one parent and 54% of children having a chronic ill parent. Estimates of the number of orphans based on patterns of mortality and fertility show a declining trend from 82,991 in 2013 to 67,820 in 2020. Total orphans represent about 19% of the total child population. The number of AIDS orphans is almost double the number of non-AIDS orphans. The projected trend for OVCs is shown below.

The eNSF aimed at strengthening the capacity of families to effectively provide comprehensive care and support for OVC. The key issues eNSF had to address are lack of focus on strengthening the family system; weak linkage of OVC initiatives with social welfare programmes, lack of programmes to mitigate the economic drivers of HIV for vulnerable children, inconsistency and lack of definition of psychosocial support interventions, inadequate protection of widows and children’s property rights and inadequate monitoring, enforcement and compliance to standards for residential and alternative care facilities for children.

Results achieved

Outcomes: The proportion of the poorest households who received external economic support in the past 3 months was 27% against a midterm target of 50%. The eNSF end-term target of 70% is not likely to be achieved. Data for OVCs receiving basic material need and those malnourished (underweight) was not available.

Outputs: Data was not available for three programme output indicators: percentage of orphans receiving psychosocial support, those accessing ECD and those receiving food support, and the number of households with vulnerable individuals reached with sustainable livelihood support. With regard to the fourth output, 2,540 households with vulnerable individuals were reached with

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13 MICS 2014
14 The denominator and the data source for this indicator is not provided
sustainable livelihood support in 2015 against a mid-term target of 10,000. The trend shows that the end-term target of 15,000 is not likely to be achieved.

**Achievements/ progress**

The limited data for both outcomes and outputs indicators makes it difficult to determine the level of success for the support to OVCs. It also demonstrates the weakness in the M&E systems for OVC programmes. However, there are several on-going interventions providing various support to OVCs in the country.

**Provision of economic and psychosocial social support to OVCs was sustained during the eNSF period:** During the eNSF period, the government and other partners continued providing financial and non-financial support to OVCs to improve their livelihoods. Interventions implemented include:

(i) **Social transfers and other safety nets:** The country has continued to provide social transfers and other types of support to the OVC. It is noted that most of these initiatives were in place to prior to the eNSF and have been sustained over the eNSF period.

(ii) **Old Age Grants to people aged 60 years and above:** This pension achieves a more widespread reduction in vulnerability not just for the older people but also for orphans and vulnerable children the old people are caring for as some of the elderly receiving the Old Age Grants are also caring for the OVCs. Thus, pension income mitigates the plight of such OVC. The table below shows the number of the elderly provided with these grants from 2012 to 2016.

<table>
<thead>
<tr>
<th>Table 7: Number of the elderly receiving Old Age Grants quarterly</th>
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<tbody>
<tr>
<td>Quarter</td>
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<tr>
<td>------------------</td>
</tr>
<tr>
<td>Quarter 1</td>
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<td>Quarter 2</td>
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<td>Quarter 3</td>
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<td>Quarter 4</td>
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<td></td>
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<td>Data source: Programme data</td>
</tr>
</tbody>
</table>

(iii) **School feeding:** The School Feeding Programme which has contributed to increased school enrolment for OVCs and also addresses food insecurity in poor households some of which care for OVCs. This is a holistic interventions supporting all children in schools including OVCs. It is, therefore, a social protection programme that has wide benefits including for OVCs.

(iv) **Free Primary School programme for primary school level:** This is a programme that has removed cost, as a key barrier to “education for all”. “Free” primary education couples with the school feeding programme has seen enrolment in primary school increase to over 90% as shown in the figure below.

![Figure 23: Net enrolment rates primary: 1999-2012](image)

![Figure 24: Survival rates primary level-2012](image)
(v) **School fee grant for OVCs:** OVCS proceeding to secondary school are provided school fees and examination fee grants. This grant play a key role in ensuring OVCs complete their secondary school education. It contributes to keeping OVCs in school, thus reducing their vulnerability to HIV infection and improves employability. The number of OVCs supported are shown in the table below.

<table>
<thead>
<tr>
<th>Period</th>
<th>No. of OVC</th>
<th>Total grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>89,706</td>
<td>98,968,193</td>
</tr>
<tr>
<td>2010/11</td>
<td>118,219</td>
<td>125,341,432</td>
</tr>
<tr>
<td>2011/12</td>
<td>87,713</td>
<td>143,804,994</td>
</tr>
<tr>
<td>2012/13</td>
<td>87,551</td>
<td>136,173,224</td>
</tr>
<tr>
<td>2013/14</td>
<td>77,014</td>
<td>141,834,174</td>
</tr>
<tr>
<td>2014/15</td>
<td>61,998</td>
<td>139,167,221</td>
</tr>
<tr>
<td>2015/16</td>
<td>53,564</td>
<td>135,791,597</td>
</tr>
<tr>
<td>2016/17</td>
<td>52,632</td>
<td>137,320,260</td>
</tr>
</tbody>
</table>

*Data source: Programme data*

(vi) **Cash transfers targeting OVCs:** This is a World Bank supported pilot project that commenced in 2010 but actual cash transfers started in 2016. So far, 7,063 OVCs were reached by December 2016 while project targets 8,000 OVCs by 2018. Lessons from this programme will inform a policy decision on cash transfers for OVCs.

(vii) **Holistic livelihoods and social protection for OVCS:** Adolescents OVC girls are provided with support which includes secondary school grants, mentoring and safe spaces, HIV risk assessment and referral for HTS, ASRH, Family Planning and condoms; employability skills, parenting skills and household economic strengthening for care givers as well as GBV prevention and post-abuse care.

(viii) **Social support for OVCs:** Neighbourhood Care Centres (NCPs) as well as other social centres are being used as points of care for OVCs. Civil society, faith based organizations and communities provide food, clothing, psychosocial support and Early Child Care and Development (ECCD) education at these points. With free primary education in place, these points catering for OVCs in pre-schools years as well as all children during weekends and holidays. The support of non-state actors is mainly provided by volunteers who make meals for the children and also provide ECCD at the NCPs.

(ix) **Access to food and ECCD:** Government in collaboration with agencies such as WFP, faith based, civil society and private sector organisations have been supplies food to the NCPs and to households caring for OVCs. Secondly, NERCHA working with the Ministry of Agriculture have been providing communities with farm inputs and technical expertise to cultivate community farms and supply food to the NCPs and selected households although this support has come to an end.

**Family/community systems to improve socialization and protection and ECCD for OVC have now been strengthened:** Intervention focusing on family units as centres of socialization and protection were limited. Stakeholders observed that there was lack of clarity on the concept of family strengthening and how this could translate into specific interventions and activities. However, Alternative Care
Centres (ACCs), as structures supporting OVCs with no family support have continued to provide services. These are child residential facilities providing a package of defined services and supervised by social development workers under the Department of Social Welfare (DSW). The DSW has started promoting foster to improve the quality of care for OVCs and as a sustainability strategy.

**Limited advocacy for policies, legislation and regulations to meet the needs and uphold the rights of most vulnerable and excluded:** There was limited effort to advocate for policies, legislation and regulations relevant to OVCs. Policies and legislations to be advocated for was also not identified/defined. The evaluation, however, noted that the country has several policies and legislation protecting children and women that, if implemented effectively, could promote and protect the rights of OVCs.

**Process of harmonising existing social protection services and strengthening administration and monitoring of child outcomes has been initiated:** The DSW is in the process of developing a Charitable Organizations Bill to improve coordination and harmonization of services provided to OVCs. Overall mechanisms for coordination and harmonization of OVC support remains weak.

**Gaps and challenges**

(i) **Coordination:** Whereas a wide range of social safety nets are provided to OVCs by various government ministries and civil society organisations, a mechanism to coordinate this support not been put in place, resulting in weak planning, targeting, monitoring and reporting on OVC services. The DSW coordination and oversight role is also not being carried effectively due to lack of the coordination platform, inadequate information on who is funding what and who is doing what and where. The DWS is currently developing a Charitable Organizations Bill which will give it authority to coordinate organizations to ensure they share plans and reports and align their interventions.

(ii) **Planning:** The strategic plan for family strengthening programme has not developed due to lack of funds. The national Plan of Action also ended in 2015 and has not been reviewed. Further, the DSW is developing regulations to guide operations and service provision to children but these are not yet complete.

(iii) **Monitoring:** An M&E system that collects and consolidates data from the wide range of institutions providing support to OVCs (Governments ministries, civil society, faith based organizations and private sector) is inadequate. Therefore, DSW does not have comprehensive data on OVC support and, as a result, data for eNSF indicators for the family strengthening program is also not available.

(iv) **Access to education:** Similar success in net enrolment in primary education has not been registered in secondary and tertiary levels. The net enrolment rate for secondary-school aged youth is only 27%. Though this data is not disaggregated by OVC, it indicates huge proportion of children not transitioning to secondary. OVCs are likely to be more affected given their lack of access to educational support.
(v) **Family strengthening interventions:** There was no specific initiative to strengthen families and communities to improve socialisation and protection, and ECCD for OVC beyond the social protection programmes outlined above. The concept of family strengthening and the related interventions were not defined. Secondly, there were no specific interventions for HIV positive children and adolescents, children who dropped out of school, child and elderly headed families, families with under OVC, although these families were categorized as most vulnerable.

(vi) **Supervisory and compliance capacity:** The DSW as a focal coordination point lack adequate financial and human resources. It lacks adequate social development officers to effectively supervise services provided to OVCs and also undertake all other activities of the department. The capacity to supervise and ensure compliance with the standards for Alternative Care Centres as well as Foster Care are weak. The number Social Development Officers tasked with supervision and compliance are not adequate and those in place have a huge work load.

(vii) **Consistency and sustainability of support to OVCs through community centres:** Support for OVCs provided by civil society and faith based organizations is sporadic as it depends on resources from volunteers, small donors and the community. The support they provide to OVCs through NCPs, churches and to OVC households is, therefore, not regular and sustainable. These organisations provide the support when the resources available. The support to communities to produce food provided by NERCHA and Ministry of Agriculture ended in 2015 due to lack of resources.

**Priorities**

(i) Establish a robust coordination mechanism for OVC/social protection programme and build the capacity of the DSW to effective coordinate this sector.

(ii) Strengthen monitoring and evaluation of OVC/social protection programme

(iii) Finalise the national action plan for OVC support

(iv) Undertake a mapping of all implementers and services provided to OVCs to firm a basis for effective coordination and targeting

(v) Harmonise social protection services to minimise duplications and enhance synergies

(vi) Strengthen the DSW through capacity building, increased funding and additional staff to effectively monitor support provided to OVCS, PLHIV, the elderly and other vulnerable populations

(vii) Integrate human rights approaches to promote and protect rights of OVCs
5.4.1 Gender based violence

Whilst the HIV prevalence in Swaziland is high, estimated at 26% among 15-49 year olds, prevalence is higher among women (31%) compared to men (20%); and girls and young women (15-24 years) account for about 46% of new infections. A number of social-cultural and economic factors account for the increasing vulnerability of girls and women to HIV infection. These include gender based violence, inter-generational sex, school attrition and limited participation in employment and the economy. Gender based Violence (GBV) undermines the health, dignity and security of its survivors and makes them susceptible to forced and unwanted pregnancies, sexually transmitted diseases including HIV, limited sexual and reproductive health rights and even death. Among women 15-49 years, 1 in 5 is beaten by her husband or partner; 24% of women who have been married for 5-10 years and 15.1% of those who have been married for less than 5 years have experienced gender based violence15.

The eNFS identified the following gaps in addressing GBV: limited understanding of the drivers of GBV; inadequate social work services to support survivors of GBV; reliance on volunteerism to sensitise communities and report GBV; weak reporting, case management and referral system; lack of specialized facilities to shelter survivors; and limited outcomes from social and economic empowerment of women.

Results achieved

*eNSF outcomes*: Data for the four outcome indicators measuring GBV outcomes is not available and therefore outcome level results cannot be determined.

*eNSF outputs*: performance against the indicator measuring the eNSF output shows that 38% of abuse cases have been reported to a service providers compared to 2015 (mid-term) target of 62%. The denominator for this indicator is not defined and it is not possible to make a determination of the level of success especially in the context of weak monitoring and under-reporting of GBV.

Achievements/progress

*Structures and systems for coordination of GBV interventions has been set up*: Several government ministries and departments as well as civil society and faith based organizations have roles to play in addressing GBV. Effective coordination of such a multi-sectoral programme is key for success. In this respect, coordination mechanisms have been established. The Gender Unit was elevated to Department of Gender and Family Issues (DGFI) in 2014; High Level Task Team on Violence with membership comprising principal secretaries has been established to steering the multisectoral response; a Multi-sectoral Technical Team on Violence has also been set up to support the high level team and provide technical leadership to the response; and each Government Ministries, Private Sector and Civil Society organizations has established a gender focal person. The task team and technical team have been meeting quarterly.

*Strong enabling environment for GBV exists but capacity to enforce the legislations and policies varies across institutions*: Despite Sexual Offences Bill not being enacted, various other laws are in place to protect and promote rights of women and children – Crimes Act, Girls and Women Protection Act, Protection of People Trafficking and People Smuggling Prohibition; Children’s Protection and Welfare Act; and a National Gender Policy 2009. The challenge has been the effectiveness in the enforcement of these laws. The National Strategy and Action Plan to End Violence in Swaziland 2017-2022 has been

developed to guide the response against GBV and other forms of violence but implementation has not commenced.

**GBV prevention interventions are being implemented by a wide range of institutions:** Several initiatives are being implemented to address the root causes of GBV, raise awareness of communities (leaders, men and women) on GBV and advocacy focusing on protecting women rights and reporting GBV. These initiatives include:

- 16 days of activism against GBV marked by several activities including community mobilization, marches, dialogue, awareness raising events
- Commemoration of other important days including – international Women’s Day; International Day of the Child, World Population Day
- Community awareness sessions and meetings and community mobilization against GBV carried out by several organisations including DGFI dissemination of GBV information through the Tinkhundla; support for GBV and women rights promotion by the UN Gender Theme Group, GBV awareness campaign, raising awareness and encouraging reporting undertaken by the Gender Consortium, SWAGAA, GEMSW and Gender Links among others.
- Dissemination of information on GBV and HIV during key events and forums such as umhlanga (women/girls national gathering), lusekwane and emabutfo.
- Faith Based Organizations (FBO) “end it now” month long advocacy on GBV. Churches have integrated awareness sessions for men and women focusing on how to win over the community to address cultural power structure by addressing cultural norms that propagate the imbalanced power structure.
- Urban HIV programme established child protection committee and deployed volunteers conducting door to door to visit families to sensitize them on child protection, and identify and report child abuse cases.
- Inqapa programme implemented by the Ministry of Education and Training in schools focusing on 7 pillars prevention, services and referral, advocacy and capacity building, dialogue, awareness using mass media and mainstreaming GBV in curriculum. This programme aims at transforming schools into centres of child care and development.
- Prevention, mitigation, research and advocacy on sexual harassment at the work place. Most companies have established gender policies and are engaging men on GBV.
- Establishment and training of community led child protectors called Lihlombe Lekukhalela (Should to cry on) which is part of the formal referral network system. The initiative focuses on awareness and education and provides a mechanism for reporting GBV and child abuse cases at community level.

Response to GBV cases and access to justice by GBV survivors has been improved over time, although reporting of cases at community level and case management and referral across systems and institutions remains weak: The interventions implemented to strengthen response to GBV cases are as follows:

(i) Police officers have been trained on effective handling of GBV cases and providing child friendly approaches; the Domestic Violence, Child Protection and Sexual Offences units have been decentralized thus improving access to services by survivors of GBV and child violence; and the police (in collaboration with other organizations) are participating in sensitizing communities on GBV and child protection and the system for reporting GBV cases. The Domestic Violence, Child
Protection and Sexual Offences units have been set up 24 police stations established in all 4 regions and police officers trained. These units are partnering with CSOs and community leaders to create awareness and also to respond to GBV cases, investigate cases and link them to prosecution.

(ii) The MoH undertook an exercise to revise the health sector GBV guidelines and also sensitize RHMTs and health care workers in the four regions. About 300 health professional have been sensitized. The MoH is also providing Post Exposure Prophylaxis, post rape care and support for survivors of GBV. However, sexual related GBV cases cannot be routinely reported due to data collection constraints.

(iii) The Directorate of Public Prosecution under MoJCA establishment an integrated One Stop Shop Centre in Mbabane providing comprehensive victim-centred services to GBV survivors; Sexual Offences Unit whose objectives include development and enhancement of skills and professionalism to ensure efficiency, expediency in dealing with sexual offences. The Judiciary has also set up three child-friendly courts set up at the high court, Siteki Magistrate court and Nhlangano Magistrate court to better address violence cases.

(iv) The MoET is reviewing the system (procedures) for case management and reporting of GBV; has started sensitizing education officials on corporal punishment and encouraging the adoption of positive punishment. The ministry has set up a crisis response team based at regional level to address violence in schools.

(v) The Prime Minister’s Office has established a system for documentation of sexual offences cases tried in the High Court and the Supreme Court to be used as precedence in prosecuting other cases in relation to sexual offences. A legal aid bill is also being drafted by the Ministry of Justice to improve access to justice for GBV survivors by providing professional legal services.

Initiatives to support recovery of GBV survivors are being implemented but they limited in geographical coverage and timeframe: These initiatives include psychosocial support and training of survivors on entrepreneurship to improve their livelihoods and empower them economically as a measure for reducing vulnerability to violence.

Gaps and challenges

(i) Coordination structures have been recently established and need capacity building: Challenges include (i) Weak capacity of DGFI to effectively coordinate stakeholders and development partners supporting programmes to end violence. The unit needs appropriate authority and support as well as resources. (2) Gender focal points have not been institutionalized. The role of Gender Focal Person in the ministries and other non-state organizations is assigned to officers with other full time responsibilities. This role is seen as an add-on and not prioritized.

(ii) Inadequate funding: Implementation of the National Strategy and Action Plan to End Violence in Swaziland 2017-2022 is hampered by lack inadequate funding.

(iii) Weak monitoring and evaluation system: The monitoring and evaluation system to capture data, document and report on GBV as well as support GBV case management across institutions is inadequate. Several institutions are managing and reporting on different aspects of GBV data (police, Central Statistics Office, NGOs, DSW etc.). This has resulted in inadequate data on GBV cases in the country and hindered continuity of service across institutions.

(iv) Inadequate evidence on GBV and its root causes and other vulnerability factors to support effective programming
(v) Poor legislation and policy implementation: Institutional capacity to effectively implement the legislation and policies in place to address GBV is inadequate. Therefore, legislation and policies in place are not effectively implemented.

(vi) Weak referral: Response, documentation, reporting and referral of cases by government and non-state actors is not well coordinated leading to loss to follow up of cases. Weaknesses include unclear guidelines and data management as well as support to survivors through the referral chain. (3) Inadequate counselling and lack of facilities for shelter for survivors to support recovery

(vii) Inadequate programming: Inadequate research into drivers of the violence, lack of capacities/expertise needed for the response and programmes being implemented are not comprehensive. For example, some interventions on awareness raising do not have a component of follow up to address GBV cases; and survivors are provided with treatment and care services but have limitations in accessing psychosocial support and justice.

(viii) Low reporting rates: Several GBV cases go unreported due to close relationship between the survivors and perpetrators, and other community dynamics. This also contributes to withdrawal of reported cases.

**Priorities**

(i) Strengthen coordination mechanisms through institutionalizing focal persons and resourcing the coordination secretariat as well as setting up planning, M&E and reporting systems

(ii) Strengthening various monitoring systems that report on GBV and establishing a common dashboard to provide timely data

(iii) Mapping of existing interventions to establish who is doing what and where

(iv) Development of a referral system across all institutions in line with the mandates for GBV

(v) Generating evidence to inform programming

(vi) Scaling up community awareness and case reporting through a community led paralegal system

(vii) Integrating GBV screening in health and non-health services

(viii) Establishing shelters/protection centres for survivors and scaling up recovery interventions
6.0 Management and coordination of the HIV and AIDS response

Coordination and management of the HIV response is premised on the “three ones” principles (one coordinating authority, one national strategic framework and one monitoring and evaluation framework) and the multisectoral nature of the response. The national HIV and AIDS Response coordination framework was revised in 2011 to strengthen the coordination and management of the response. The framework lays out the roles and responsibilities of various institutional structures and the systems expected to be in place to effectively coordinate the response.

The overall coordination of the response is vested in NERCHA as per NERCHA Act of 2003. Primary responsibilities of NERCHA include strategic leadership and advocacy, planning, monitoring & evaluation, resource mobilisation and ensuring proper implementation of programs. NERCHA is made up of a Council and a Secretariat reporting to Prime Minister’s Office. The secretariat is responsible for day to day coordination and management of the response. Other structures include sector coordinating bodies, regional/decentralised level coordinating institutions and technical working groups coordinating programmes.

Performance of the coordination and management of the response

The eNSF objective was to improve the efficiency, effectiveness, gender equality and ownership and accountability of coordinating structures by realigning them to their mandates and heightening the Three Ones principals at all levels. The evaluation findings with regard to overall coordination and management of the response are as follows:

(i) There has been sustained high level political and policy level support for the HIV response. The Prime Minister’s Office has continued to provide leadership in multi-sectoral coordination of the response and in ensuring HIV is integrated into the Government budget.

(ii) Government leadership was also demonstrated through the King’s vision for ending AIDS by 2022 and the launch of the Umgubudla fast track programme. This vision galvanised all sectors to work towards achievement of the 2030 targets. Further government leadership in the response was also demonstrated through the Queen Mother’s initiative mobilising adolescents and young women for HIV prevention.

(iii) With regard to the three ones, the country has consistently developed the “one strategic framework” for the response to guide all stakeholders. The one coordinating authority (a role played by NERCHA) focused on upstream coordination while it scaled down its support for downstream (sector and regional level) coordination over time. The “one M&E system” has not been efficient largely because the systems, processes and capacity to implement this system remained weak. Each sector was left on its own to develop their M&E system and to report periodically to NERCHA. However, these systems have varied capacities which impacted in overall reporting.

(iv) Coordination activities have been scaled down due to limited funding. Most sector coordinating bodies have challenges convening planning meetings, conducting periodic reviews and monitoring the activities of their member organisations while decentralised structures are either no longer operating (such as the REMSHACCs) or are not fully constituted (i.e. TIMSHACCs and CHIMSHACCs). The capacity of the coordinating structures also varies depending on funding levels. In addition, the national level TWGs expected to be convened by NERCHA to provide strategic guidance and support accountability are also not in place.
The current coordination architecture has been in place perhaps since the multisectoral HIV response was established and has not changed in tandem with the transformation of the response and declining funding for the HIV response.

The multi-sectoral focus of the response has weakened over time. In its place, a dichotomy between bio-medical and non-biomedical response has emerged and overshadowed the multi-sectorality of the response. Stakeholders categorise their interventions as either being bio-medical or non-biomedical.

Coordination between community and public health response is also weak. Although the two systems serve the same populations, there are no clear mechanisms for communication and data sharing between the two systems. This affects the continuity of care from the community to health facility level and vice versa.

The following is an assessment of each coordination structure.

6.1.1 National Emergency Response Council on HIV and AIDS (NERCHA)

NERCHA has sustained political and policy level leadership but less so in leading implementation of the response: NERCHA has sustained the political and policy level leadership and support for the response. The support from the highest political office with a clear vision to end AIDS by 2022 has been a major development. Continued commitment by government to invest substantial resources in the response including funding all first line ARVs as well as other ancillary needs, mainstreaming of HIV in the workplace/wellness employee programs and the development of the Parliamentary HIV and AIDS Strategic Plan shows government leadership to the response.

Strategic level planning has been consistent while processes for operational planning has largely been lacking impacting in coordinated implementation and accountability: NERCHA has successfully led the development of 5-year cycles of national strategic frameworks for HIV and AIDS since 2003, the latest one being the extended NSF 2014-2018. These frameworks provide a basis for alignment of all HIV programmes towards national priorities and form a basis for periodic reviews of progress of the response. However, there are limitations in the planning process. The National Operational Plan (NOP) to guide implementation of the response was not implemented and guidelines on how the eNSF could be cascaded to or inform programme, regional, or sectoral HIV plans were not put in place. The decision for NERCHA to focus on upstream coordination leaving sectoral and regional coordination bodies to lead downstream coordination contributed the weakening or scaling down of coordination activities. A coordination plan defining systems and processes for planning, implementation, funding, monitoring and progress review among others is not in place. Technical working groups envisaged under the 2011 coordination framework are not operational. Period progress reviews of the eNSF is not carried out. There are no mechanisms in place to ensure accountability in implementation of the response. NERCHA does convene a Directors Forum which brings together directors of the sector coordinating structures but this forum is not pre-planned, regularly held and issues discussed are not adequately followed up. At regional level, NERCHA relies on meetings convened by other organisations to provide feedback and information on HIV issues.

Communication is inadequate and ad hoc: A communication plan for the response was not developed. Given the wide range of stakeholders and the different levels of implementation, it is imperative that a robust communication plan is developed and implemented. As a result, stakeholders observed that communication is ad-hoc and event based; stakeholders have little information on what NERCHA does while NERCHA also has limited information on activity implementation. Stakeholders further observed
that NERHCA is detached from coordinating structures and implementers, and implementers work in silos.

**Limited capacity to regulate the response:** Coordination of the response is, to some extent, hindered by the poor sharing of reports, low reporting rates, delays in reporting and lack of up to date information on who is doing what and where. NERCHA does not have the legal capacity to enforce coordination.

**No mechanism for donor coordination but such as system may not add much value:** NERCHA has not established a system for coordinating donor funding or external support to the country for HIV and AIDS. However, given the small number of donors currently supporting the response, the focus should rather be on resource coordination and management in order to capture funding from all sources (donors, government, private sector and communities). Secondly, given the likelihood that funding for the response has flat-lined, NERCHA should also prioritise increasing efficiency in use of resources through resource tracking, improved coordination and development of cost effective strategies.

**Limited funding for NERCHA Field offices:** The field offices have staff but they are largely underfunded to be able to carry out their responsibilities. They largely rely on meetings and events convened by other organisations. This has also impacted on the functioning of the regional coordinating mechanisms.

**Stakeholder perspective/ expectations:** The visibility of NERCHA as the “One Coordinating Authority” has reduced partly due to declining funding for coordination activities, inadequate communication, and non-functioning of the technical working groups and other coordination forums. Stakeholders observed that “funding from NERCHA has declined; NERCHA is longer visible; its officers are not supporting/visiting sectors and regions regularly. NERCHA is not providing direction on what needs to be done and its voice is generally absent”.

### 6.1.2 Sector coordination

Structures coordinating various sectors include Co-ordinating Assembly of Non-Governmental Organisations (CANGO), Public Sector HIV and AIDS Coordinating Committee (PSHACC), Swaziland Network of People Living with HIV and AIDS (SWANNEPHA), the Church Forum, Alliance of Mayors’ Initiative for Community Action on AIDS at the Local Level (AMICAALL), and Swaziland Business Coalition on HIV and AIDS (SWABCHA). The following are the findings of the evaluation of the sector coordinating structures.

**CANGO (Civil society response coordination)**

CANGO coordinates the civil society HIV response through the Swaziland HIV and AIDS Consortium (SHACO).

**Coordination mechanisms are in place and regularly implemented:** CANGO has in place a mechanism and forums for coordinating the civil society response to HIV. A directors’ forum is held periodically, which serve as a policy decision mechanism that guides policy direction for implementers and decides on civil society position on legislative and policy issues related to HIV. A technical coordination meeting for SHACO members is held quarterly to review progress and develop solutions for emerging issues. SHACCO regional coordination meetings are also held for CSOs in each region to strengthen monitoring and evaluation and share information. The regional coordination meetings have created linkages and networking among CSOs, improved information flow, raised advocacy issues and also strengthened partnership with NERCHA.
Platform for facilitating coordinated planning is in place: CANGO convenes SHACO meetings where members share their plans and consolidates the civil society response. This planning process has improved synergy and collaboration among CSOs and minimized duplication.

Monitoring and reporting inadequate: CSOs report on their activities through SHAPMOS and share reports during the SHACO quarterly meetings and regional meetings. NERCHA also provides feedback based on the data it received from CSOs during SHACO Meetings. However, it was noted that reporting is not always up to date and timely and CSOs give priority in reporting to their donors.

SHACCO providing opportunities for capacity building: CANGO has been instrumental in developing the capacity of SHACO members in advocacy and organisational development in order to improve their effectiveness. Some of the advocacy issues addressed include access to healthcare by sexual minorities and Sexual Offences and Domestic Violence Bill. The major challenge for coordination of CSOs is the frequent staff movement where the forum has to frequently retrain new staff.

Church Forum (Faith Based Response Coordination)

The Church Forum coordinates the Faith Based Organizations (FBOs) response to HIV. Members of the Forum include Swaziland Conference of Churches, League of Africa Churches, Council of Swaziland Churches and individual churches not affiliated to any group – Seventh Day Adventist and International Tabernacle Ministries.

Coordination has weakened over time due to declining funding: Previously, the Church Forum held meetings for its members to share annual plans, and identify synergies and areas for collaboration. This ensured that FBOs plans were well aligned to the eNSF. Currently, the CF is not convening such meeting due to funding constraints. Instead, each member develops an annual work plan individually and submit it to the CF for review and advice. The Forum is also no longer able to fund the churches plans which has impacted on the churches commitment to report to the forum. The Forum also has limited staffing capacity to support planning, conduct reviews, track and monitor interventions of their members.

Decentralisation approaches have been adopted to improve communication and information flow: The CF is working with umbrella organisations to collect information on FBOs activities. Information flows from the local churches to branches in the regions and to the national umbrella body. The Forum has encouraged umbrella bodies to constitute regional committees to get closer to churches. The Forum is also using these structures to reach out to churches to collect information and build capacity.

Capacity building has been sustained but sustainability is challenged due to limited funding: The Forum, with support from various partners, is building the capacity of church bodies by focusing on the capacity needs common to all churches. These include provision of new HIV information, raising awareness on HIV among church leaders, training on HIV stigma and discrimination, project management training, and advocacy to enable church leaders to speak with one voice as well as advocacy targeting internal structures of the church to take their role in the HIV response as well as external advocacy to mainstream HIV in the church programmes.

Church Forum’s role in resource mobilization has become minimal: There is no one programme for FBOs to support common resource mobilization. Each member does its resource mobilization. However, the Church Forum is developing a resource mobilization strategy to be used by churches at all levels, focusing on approaches the church can adopt to implement HIV activities without needing funding such as awareness and demand creation, home visits, psychosocial support using church programmes and caring for OVCs.
**Value addition of Church Forum as a coordinating body:** Members still value the existence of the Church Forum as a body that amplifies the voice of the Church in the HIV response, coordinates programmes by bringing members together, training members, sharing information in new development in HIV response and coordinating the messaging of the FBOs work. Thus, while members continue to value the coordination, the resources and capacity of the Church Forum to meet these expectations is continuing to decline.

**AMICAALL (Coordination of the urban response)**

AMICAAL was set up to enable Mayors as local leaders to provide leadership in the HIV response in urban areas. The Alliance covers 12 town and all the mayors constitute the board of AMICAAL. Overall, coordination of the urban response has evolved over time. At the initial stages, AMICAAL coordinated the development of one urban response plan, mobilised funding based on this plan and coordinated implementation, monitoring and reporting by all town implementing the programme. The funding sources have reduced over time and funding for one urban response is no longer taking place. This has weakened coordinated planning, implementation and monitoring of the urban response.

**Weakening of coordination over time:** Taking the approach of “3 ones”, AMICAAL supported the creation of coordination mechanism (Municipality Health Team) at town level where partners (NGOs, Government Ministries and other partners) periodically come together to plan, share their plans, review progress and report. This coordination is taking place mutually as there is no policy framework supporting this structure. It is important to note that coordination or reviews were conducted monthly in the past, but currently, 2 meetings are held per year due to resource constraints.

**Planning and resource mobilisation role has become minimal with time:** AMICAAL facilitate a planning process to develop a common plan for the urban program which was used to mobilise resources. This reduced transaction costs and improved efficiency by having partner deal with one office on behalf of all towns for all programme planning, implementation, monitoring and programmatic and financial reporting. However, it has become difficult for AMICAAL to convene planning meetings and to develop one common plan because funding from AMICAAL has declined. Each town develops its plan and shares it with AMICAAL. Partners have also started to fund municipalities directly further weakening coordination.

**Capacity building and advocacy has been sustained but faces funding constraints:** AMICAAL conducts training for the towns on a wide range of HIV issues. It also leads policy advocacy at national level focusing on disaggregation of data by urban and rural divide and by towns in order to inform prioritisation, and generating knowledge/evidence to inform programming. In addition, through capacity building and advocacy by AMICAAL, the management of municipalities has integrated health and HIV into their programmes. They have established positions for health managers and budgets include a budget line for health. A few towns have also established clinics to provide primary health services including HIV services.

**Monitoring and reporting systems are in place but the impetus to report faces sustainability challenges:** There are two channels of reporting – Towns reporting to AMICAAL who generates one report to the Board and also to the funding partners; and towns also reporting to NERCHA through the regions. With the declining role of AMICAALL in resource mobilisation, the motivation to report by municipalities is also declining.

**Building partnerships:** AMICAAL is involved in building partnerships with Government Ministries such as Education and Health to avoid each municipality engaging each ministry on its own.
SWABCHA (Private sector response)

SWABCHA leads the coordination of the private sector response to HIV. This is a body constituted and owned by the private sector. Members contribute a subscription fee to meet the operational cost for SWABCHA.

**Coordination sustained by support from members:** SWABCHA coordinates private sector organizations in planning by convening meetings of focal point persons where they share their annual plans for peer review. The meetings also serve as avenues of providing private sector firms with any new information on HIV strategies that can be included in their plans. HIV has been falling as a priority in the private sector because the HIV cases have reduced, treatment and care offered to HIV positive workers has also improved their productivity while the incidence diseases – particularly non communicable diseases – have increased. Thus, continuous advocacy is needed to ensure HIV remains priority.

**Monitoring and review carried out adequately:** SWABCHA monitors the HIV interventions in the private sector. It makes regular monitoring visits to the companies and received reports regularly. It also holds review meetings to assess progress of the private sector response.

**Capacity building ensuring members remain up to date on the response:** SWABCHA has continued to build the capacity of private sector to provide HIV services. This includes bringing together peer educators to share information and also provide them with new information on HIV; conduct training on topical issues such as how to engage and increase service uptake among men, Gender based violence and treatment adherence.

**Supporting and coordination of partners to reach the business community:** On recent, several partners (mainly NGOs) have shown interest in reaching men in work places in the private sector. SWABCHA is assisting these partners to have an entry into the private sector firms by introducing the organizations and their interventions to the focal persons in the targeted firms. However, the NGOs have limited experience in working with private sector and build trust with the private sector; their programmes are not yet aligned with the private sector perceptions and interest; and they tend to implement their activities for a short period. The exit from the private firms is not well managed.

PSHACC (Coordination of the public sector response)

**Coordination is on-going but impacted by limited funding and staffing:** PSHACC secretariat based on the Public Service ministry is in place to coordinate the public sector response. However, the secretariat is thinly staffed to deliver its mandate effectively. A focal point person is appointed in each ministry to coordinate the work place HIV response targeting employees. These persons have their core duties and coordination of the HIV response is an added on responsibility. Irrespective of this, the focal persons have shown commitment to coordinating the response. These focal point persons are not in the department of human resources which has the responsibility of ensuring employee welfare.

**Measures have been taken to improve planning but common planning framework not yet in place:** Overall, the HIV response in the public sector has shifted from focusing in HIV as a stand-alone issue to focusing on employee wellness where HIV is one of the issues to be addressed. Other issues being non-communicable diseases, stress management and employee counselling. A strategic plan for employee wellness for 2016-2021 has been developed but it is yet to be endorsed and implemented. This strategic plan offers an opportunity to improve coordination and effectiveness of the public sector response. Secondly, each ministry develops its own annual work plan for HIV response and submits this to PSHACC. However, PSHACC has not established a planning format or guidelines to ensure uniform planning across ministries.
Capacity in monitoring and reporting quality of reports needs improvement: PSHACC monitors the implementation of the response by ministries. It receives reports from the ministries and uses these to follow up on emerging issues. The reports are also shared with NERCHA. The challenge is the delays in reporting and poor quality of reports with some having incomplete data. Attempts have been made to improve capacity of ministries in monitoring and reporting but time reporting and the data quality is still a concern.

Provision of Capacity building of ministries but not able to meet demand: PSHACC has made efforts to build the capacity of ministries in planning, monitoring and reporting. It has also sensitised the leadership on HIV response and overall wellness of employees to generate support from the ministry leadership. The demand for capacity building is higher than the capacity of PSHACC to respond.

Challenges facing coordination of public sector response include (i) leadership – implementation to a large extent depends on the leadership commitment and support for the programme. Hence there are variations in implementation of the programme across ministries. (ii) limited funding for the HIV activities. There is no dedicated budget but activities are undertaken as and when there are funds for specific events; and (iii) focal persons are not full time employees and give priority to their core duties.

SWANNEPHA (Coordination of PLHIV involvement in the HIV response)

SWANNEPHA has undergone restructuring to improve its organisational governance, management capacity and systems to effectively coordinate the involvement of PLHIV in the HIV response. Membership of the organisation are networks of PLHIV from the regions. The networks themselves coordinate PLHIV support groups and PLHIV led organisations. The evaluation found out that to a large extent, coordination of PLHIV response is weak, they lack funding, PLHIV support groups at community level are not supported and most of them have stopped functioning.

Weakened coordination due to funding constraints and organisational governance: SWANNEPHA facilitating the planning process for the networks of the PLHIV. It has a strategic plan in place to provide overall guidance. In the past, the umbrella body convened annual planning meetings for the networks to harmonise their plans and aligned them to the SWANNEPHA strategic plan. Due to limited funding, currently each network develops its plan which is reviewed by the umbrella body.

Declining funding has affected PLHIV involvement in the report: SWANNEPHA has been playing a key resource mobilisation for the PLHIV networks and provided funds to support implementation. Funding has declined and support provided to the networks is limited. As a result, implementation of activities by the network organisations is largely ad hoc and in some cases have stalled. The network organisations also have challenges mobilising resources as most funding organisations request for strategic or programme plans which they do not have.

Monitoring and reporting: SWANNEPHA members submit reports directly to NERCHA through SHAPMOS. Feedback on the data submitted from NERCHA to SWANNEPHA and to the members is limited.
There is a need for role clarity: Members observed that SWANNEPHA, in some cases, bypasses them to implement activities directly at the community level. This is seen as a conflict of interest. The view of members is to have SWANNEPHA focus on coordination and they focus on implementation.

Communication: Members are not updated or provided information on policy and strategy issues. Feedback on the data they shared is also not forthcoming. Meetings are also not regularly convened. Poor communication is related to the funding constraints at SWANNEPHA level.

6.1.3 Regional Coordination of the HIV response

The regional coordination structure comprises of the Regional Multi-Sectoral HIV and AIDS Coordinating Committees (REMSHACCs); Tinkhundla Multi-Sectoral HIV and AIDS Coordinating Committees (TIMSHACCs) and Chiefdom Multi-Sectoral HIV and AIDS Coordinating Committees (CHIMSHACCs).

REMSHACCs

REMSHACCs memberships is expected to include the Regional Secretary as the chair, representation from civil society organisations, private sector, the Regional Health Sector Management Team (RHMTs), Government representation through PSHACC and traditional representatives among others. REMSHACCs are expected to play a key role in coordinating the regional response by facilitating development of regional HIV and AIDS plans, coordinating implementation, reviewing reports and review progress periodically, ensuring coordination of interventions and geographical coverage of the response. Other responsibilities outlined in the 2011 coordination framework include evidence generation and strategic partnerships.

Engagement of Regional Secretaries: The REMSHACC’s discussions and reports are expected to be reported to the Regional Development Committees chaired by Regional Secretaries as well as to NERCHA. Regional Secretaries have high commitment as well as expectations to be involved in the coordination. They rely on the NERCHA regional coordinators for updates on the response and are also involved in some key events taking place in the region such as World AIDS Days events. However, the communications tends to be between NERCHA and the coordinator with limited engagement of the Regional Secretaries. It was also observed that regional secretariat were engaged during the dissemination of the eNSF but there has been no follow up to provide guidance and resources.

REMSHACCs not operational and there not playing their coordination role: REMSHACCs are expected to meet periodically to review progress, share information, address emerging issues and ensure the regional response is on track. Most of the REMSHACCs have not met for over three years due to funding constraints. Implementers do attend regional meetings convened by other players where NERCHA provides feedback on the national response. However, REMSHACC meetings bringing together REMSHACC members to focus on their role are not taking place. Most REMSHACC members met for the first time in about 3 years during the consultations held as part of this evaluation.

No platform for regional level planning: In the absence of REMSHACC meetings, there are no regional plan developed. Implementers develop their plans individually and share them with the NERCHA coordinator. This makes it difficult to coordinate the targeting of interventions and avoid duplication.

Limited monitoring of the response: Due to funding constraints, REMSHACCs are not involved in monitoring and reporting. The NERCHA regional staff also rely on partners to visit project sites for monitoring. The absence of REHSHACCs also means that there is no platform to present monitoring reports. Given organisations submit reports to NERCHA using an on-line SHAPMOS tool, the coordinator also get feedback from NERCHA.
Sectoral coordination at regional level: Sector coordinators such as CANGO, SWABCHA and RHMTS for the health sector do convene coordination meetings for their members in the regions. Through these meetings, implementers get to receive feedback and also to share information as well as address emerging issues. As indicated earlier, NERCHA uses these platforms to also provide feedback on the response. These meetings have assisted to some extent on enhancing coordination although they are sector focused.

**HIV Interventions in the regions:** REMSHACC members observed that HIV prevention, treatment, care and support and impact mitigation activities are being undertaken in the regions. These include social and behaviour change targeting men, women, adolescents and young people; HTS, condom promotion and distribution, male circumcision, home based care, ART, TB screening, support for treatment adherence, support for OVCS through NCPs and household support among others. Notably, interventions are implemented in an integrated manner with most interventions providing several services. There is also collaboration among organisations especially those convened by CANGO and those meetings in various forums.

**TIMSHACCs**

Most of the TIMSHACCs consulted (7 out of 9) are constituted as a typical Inkundla council and do not refer to themselves as TIMSHACCs. These councils deal with all development issues including HIV and they do not dedicate themselves to coordinating the HIV response as a separate issue. HIV is included in the agenda of the Council meetings if necessary, and is discussed alongside other development issues.

The organisational set up and all procedures for establishing and operating TIMSHACCs have not been designed and put in place. Members of the Council have not been capacitated in the management and coordination of HIV services. The councils do not have a plan for coordinating the HIV response and are not aware that they should be involved in the planning process. They deal with several development issues and do not have adequate time to dedicate to HIV issues.

Organisations implementing HIV activities share their plans with the councils as an entry point to the community. The councils do not have a system in place to track the activities of these organisations, the organisations do not provide feedback to them and often they are not aware as and when the organisations exist the constituency. However, because the council members are also involved in community activities, they have a good awareness of the type of HIV interventions implemented at constituency level.

Overall, the Inkundla council is the structure operating or being referred to as a TIMSHACC. The councils are playing a facilitative role in supporting implementers to access communities and also in mobilising communities for HIV interventions. Therefore, the TIMSHACC structure as envisaged in the coordination framework, with its full complement of coordination roles, has to a large extent not been realised.

**CHIMSHACCs**

CHIMSHACC membership include bandlacane, bucopho, Government extension workers, representatives of key groups such as teachers, and health motivators among others. There was also variation in the composition of these committees from chiefdom to chiefdom.

The councils or committees do not have knowledge of the role of CHIMSHACCs and have not been trained as CHIMSHACCs. They have limited influence on the HIV services as implementing organisations come to the community with a pre-determined plan. Consequently, coverage of services is not uniform across all areas.
These committees play a key role in ensuring ownership of HIV services by the community. All implementing organisations share their plans with them before implementation commences. These groups also target the committees for sensitisation and to assist in community mobilisation. As a result, the members are aware of all interventions and implementers in the chiefdom.

Overall the committees operating as CHIMSHACCs play a facilitative role in supporting implementation of HIV interventions by mobilising communities. They do not, in essence, coordinate the implementing organisations; they have limitations in determining what services should be provided and where they should be provided. There is minimal communication between the committees and those at constituency and regional level. They also receive minimal or no support from the national or regional level.

**Priorities going forward**

Detailed recommendations the future of coordination of the response are provided in the “recommendations” section. Here below, priorities on areas that should be addressed are outlined.

(i) Strengthen NERCHA to play an effective coordination role for the HIV response. This will include developing a coordination plan and establishing planning, implementation, monitoring and accountability guidelines and capacity building for the organisation

(ii) Establish coordination mechanisms such as technical working groups and policy level coordination platforms

(iii) Build the capacity of sector coordinating bodies including rationalising the funding provided to these organisations.

(iv) Develop and implement clear communication plan for the response

(v) Re-establish REMSHACCs given the key role they play at regional level

(vi) Integrate TIMSHACCs and CHIMSHACCs into the relevant traditional structures to improve sustainability of these bodies
7.0 Mainstreaming in development sectors

Mainstreaming of HIV into development sectors is a strategy for ensuring a multi-sectoral response. Internal mainstreaming involves organizations providing HIV services to their employees and families while external mainstreaming involves an organization using its comparative advantage to provide services that impact on HIV prevention; treatment, care and support or mitigation of HIV socio-economic impact. The eNSF identifies comparative advantage of each sector in mainstreaming HIV. The eNSF sought to address the weak leadership and commitment necessary to drive the mainstreaming agenda in particular to ensure the commitment for resources for HIV synergies; limited understanding of and capacity for mainstreaming and a lack of HIV accountability framework within the development sector.

The priority strategies set out to address these challenges include (i) strengthening sector capacity to mainstream HIV within their core mandate; (ii) strengthening leadership and ensuring commitment to support the mainstreaming agenda; and (iii) defining an HIV mainstreaming accountability framework for the sectors.

7.1.1 Internal mainstreaming

Internal mainstreaming constitutes the focus on improving access to HIV prevention, treatment, care and support as well as impact mitigation among the employees in the public and private sectors.

Public sector internal mainstreaming

In the public sector, internal mainstreaming is coordinated by the Public Sector HIV/AIDS Coordinating Committee (PSHACC) established in 2004 under the Ministry of Public Service to put in place measures on the prevention, mitigation and control of HIV/AIDS infection amongst public sector workers. Initially, the focus of PSHACC was on facilitating the access to HIV treatment and increasing productivity. With the establishment of PSHACC several benefits were realized including the coordination of access to treatment, care and support for public servants, increased awareness of HIV/AIDS, reduction of stigma in the workplace and establishment of support groups, amongst other key milestones achieved. PSHACC has widened the range of its services in tandem with evolving priorities and demand of its clients (employees). Services offered no long just focus on HIV but include screening and testing for other illnesses such as TB, diabetes, hypertension, treatment of minor ailments and psychological counseling. It also offers services on stress management, team building, financial wellbeing and psychological counselling.

Coordination: PSHACC holds work planning and progress review meetings with wellness coordinators where wellness coordinators from the ministries present their plan for review. Planning sessions have also been held with Under-Secretaries, Deputy Commissioners and Staff Association representatives to review and develop public sector work place wellness policy and strategic plan. Quarterly review meetings are also held in the regions to review progress in implementation of HIV and wellness activities. PSHACC also holds meetings with the support group committee to review and develop ways of strengthening employee support groups.

Information and education: Interventions include training of planners, Accountants, Principal Human Resource Officers, Wellness Coordinators, Under-Secretaries and Inspectorate Department of MoET as well as teachers on their roles in scaling up external mainstreaming of HIV and Wellness within the Public sector and beyond; financial and financial and stress management training and counselling. Information and debriefing is also provided to employees on NCDs including Diabetes Mellitus, HIV, Male Circumcision, Gender Based Violence, Sexuality and Family Dynamics, Human Trafficking, Cancer, Kidney importance and Hypertension.
Counselling and support: Provision of psychosocial support to public sector work force; strengthening ministerial/regional support groups for PLHIV and other chronic illnesses and developing an EAP model that speaks to psychosocial aspects. PHSHACC has recruited psychologists who are providing psychosocial support and counselling to employees on issues that range of issues (work stress, financial problems, depression, trauma and burnout, relationship problems, substance abuse and bereavement); held regional trainings and education sessions for support groups and developed psychosocial assessment tools.

Screening and testing for HIV, TB and non-communicable diseases to government employees: HIV testing is being offered to employees and those testing positive are referred for treatment and care. Employees are offered an integrated service that includes HIV testing, TB screening and screening for NCDs during outreach campaigns to ministries and walk in clients.

Care and treatment – providing clinical services to public sector work force: PSHACC is using a holistic approach in providing treatment and care to include HIV, TB, NCDs and minor ailments. This approach is aimed at reducing HIV stigma and increasing uptake of HIV services.

Referral of employees to treatment and care services: PHSACC has established partnership with the Ministry of Health for public sector employees to access care and the MoH wellness Clinic which serves healthcare workers. However, access of employees to this clinic has been out on hold. Employees are also referred to the National Psychiatric Centre as well as other health facilities. Referrals are made on several illnesses beyond HIV. These include cancer, upper and lower respiratory track infections, Musculo Skeletal Problems, Asthma, Eye Problems, Abdominal Pains, Allergies, Toothache, Hypertension and Diabetes Complications.

Monitoring and reporting: The capacity of all government ministries focal persons for HIV in the workplace have been trained on data analysis and report writing to produce complete and timely reports. This training was also extended to Wellness Coordinators and Wellness nurses from different health facilities to strengthen the reporting system.

Gaps and Challenges

(i) Coverage of the HIV and employee wellness programme is not comprehensive. The programme is implemented by 50% of the government and mainly concentrated in Mbabane and Manzini areas.

(ii) The public sector employee wellness strategic plan has not been finalized. Due to lack of a common planning framework, each ministry develops its HIV and Wellness Plan. These plans are mainly a set of activities/ events to be held during the year.

(iii) Wellness coordinator are not dedicated on this programme fulltime. They have their core duties and the wellness programme is an add-on.

(iv) PSHACC Secretariat has limited capacity to effectively coordinate the public sector mainstreaming of HIV. It has inadequate number of staff, funding and physical facilities.

(v) Linkage between the wellness programme and the human resources department is weak. The wellness programme coordinators are not located within the human resources management departments.

(vi) Despite the training in M&E, most of the government ministries, including those trained during the M&E course, do not provide complete reports and also reports are not submitted on time. Quality of reports received is poor. Data presented is incomplete and most numbers do not tally.
There either exists over reporting or underreporting. Also, the absence of staff complements from the submitted reports further impacts negatively on data analysis and report presentation.

(vii) PSHACC secretariat has limited capacity in terms of number of staff, funding and transport to meet the demand for HIV and wellness services from employees. Thus, the education sessions and information provided creates demand but PSHACC does not have sufficient personnel to meet the demand.

(viii) Employee support groups are disrupted due to movement of staff through transfers and promotions

(ix) There is no system in place to follow up on clients referred to various services

**Private sector internal mainstreaming**

As is the case with public sector, the private sector has also made strides in shifting from HIV stand-alone interventions to integrating HIV in the employee wellness programme in order to sustain the momentum and support for HIV interventions. The private sector has seen the falling cases of HIV positive employees and decreased absenteeism due to more employees LHIV being in treatment and care.

**Key HIV interventions in the private sector:** The private sector, with overall coordination and technical support from SWABCHA, is undertaking (1) HTS and referral of positive clients to treatment and care; (2) psychosocial support for employees and their families; (3) support for treatment (ART, OIs, PMTCT and STIs); (4) promoting adherence to treatment through employee support groups and treatment literacy; (5) HIV education and awareness through holding discussion sessions, visiting departments, e-mailing electronic fliers and commemorating special days such as World AIDS Day; (6) condom distribution in offices; (7) physical wellness through sports events and exercising; and (8) supporting backyard gardens for food production and provision of food to OVCs.

**Integration of HIV in employee wellness activities:** Private sector firms have integrated HIV activities in company policies and programmes as well as plans. This includes mainstreaming of HIV in the human resources management policies; incorporating staff wellbeing aspirations in company organizational strategy and implemented through the human resources department. All departments are also required to report on their HIV activities. The integration ensures that HIV activities are incorporated in performance management systems of the firms.

**Sustained funding of HIV response:** Private sector companies are funding HIV activities from their own resources. HIV activities are included in the organizational budget including free medication and condoms. Other funding sources are medical contributions of employee clinic revenue (for those companies with clinics). The companies are also paying subscription fee to SWABCHA to sustain the coordinating body.

**Coordination of the private sector response has been sustained:** stakeholders observed that SWABCHA has sustained the coordination of the response. Critical coordination activities include regular meetings bringing focal persons together to review and plan the response, training of private sector firms on HIV issues, HTS camps and services, provision of condom, holding awareness sessions and mentorship and monitoring the private sector response.

**Gains made by private sector response:** Private sector stakeholders observed that over the years, the private response has contributed to the reduction in AIDS related deaths among employees, increased the number of people enrolled on ART, reduced absenteeism and burden of illness, increased awareness in most wellness issues including HIV and NCDs.
Challenges: Challenges facing the HIV response in the private sector include (i) Funding constraints as companies face competing priorities, (ii) Lack of management support for the HIV response, partly due to apathy in the HIV response, (iii) Fear and self-stigma among employees hindering access to services, (iv) Resistance from the management staff in targeting them for HIV, (v) Due to declining funding base, the support from SWABCHA has also dropped; meetings are not convened as frequently and they lack resource to make follow ups and also provide reports/feedback.

Priorities going forward: Though progress has been made, there is a need to focus on the following aspects of the response going forward – HIV testing and counselling to reach men; training and education on HIV and other illnesses, advocacy to ensure more involvement of management staff, continued awareness campaigns and provision of condom.

Swaziland Uniformed Services Association on HIV (SUSAH)

SUSAH was established to coordinate workplace HIV programmes among the uniformed services personnel. These include the Royal Swazi Police, Fire Department, USDF, His Majesty Correctional Services, Customs and SFES. It was observed that all these institutions have workplace HIV programme targeting their employees. The services are coordinated and implemented through focal points established in each institutions.

A summary of HIV services offered are listed below:

<table>
<thead>
<tr>
<th>Royal Swazi Police</th>
<th>USDF</th>
<th>Fire department</th>
<th>Correctional services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social behaviour change communication</td>
<td>• Male circumcision</td>
<td>• HIV prevention education sessions (GBV, stigma, condom use)</td>
<td>• Appropriate admission of offenders – data collection, HIV testing, TB screening within 7 days</td>
</tr>
<tr>
<td>• Peer education</td>
<td>• Outreach to all units on GBV</td>
<td>• Home visits for PLHIV</td>
<td>• OMTCT, education, palliative care and support</td>
</tr>
<tr>
<td>• Psychosocial support</td>
<td>• HIV care and support</td>
<td>• Spiritual support through chaplaincy</td>
<td>• ART</td>
</tr>
<tr>
<td>• HIV testing</td>
<td>• Condom provision</td>
<td>• Sporting activities</td>
<td>• OI and NCD screening and treatment</td>
</tr>
<tr>
<td>• Pre-ARTm ART and PMTCT</td>
<td></td>
<td></td>
<td>• Linkage to public health facilities based on agreed SOPs</td>
</tr>
<tr>
<td>• TB screening and treatment</td>
<td></td>
<td></td>
<td>• Transition from prisons to community with support of welfare officers and chaplaincy</td>
</tr>
<tr>
<td>• Sensitisation of police on key populations (FSWs and MSM)</td>
<td></td>
<td></td>
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</tbody>
</table>

Achievements: The uniformed services institutions have seen a change in health seeking behaviour resulting in increased uptake of HTS, increased disclosure of HIV status partly due to reduced stigma; early diagnosis and early start of treatment; and improved positive living among PLHIV due to use of
expert clients and peer educators. These gains has contributed to reduced absenteeism among employees.

**Challenges:** Each SUSAH institution faces specific challenges as follows:

(i) **RSP:** Partner testing is not yet well accepted, coverage of HIV services is low because the RSP has few medical officers and only 2 health facilities service the entire force; police cells are also not well ventilated raising potential of TB spread.

(ii) **USDF:** Constraints in funding especially for the drama groups used for HIV education and awareness, peer education and medical staff; coordination is also impacted by movement/transfers of focal point persons and the mobility of the drama group members.

(iii) **Fire Department:** Due to funding and other capacity constraints, the Fire Department does not implement HIV activities on its own. Activities are implemented in collaboration with other agencies such as PSHACC, PSI, WHO, EGPAF, UNAIDS etc. they do not have protective clothing hence personnel are exposed to HIV and other infections; they have no clinic for their personnel and they refer employees to clinics of other uniformed services.

(iv) **HMCS:** Infection control strategies are not adequately implemented; there is no secure or isolation ward for MDR-TB, emergency care is provided at national level and therefore clients have to be transported from the all regions; there are challenges in managing opportunistic infections (screening and provision of treatment).

**Priorities:** NSF should have a specific objective to address uniformed personnel needs for HIV/TB. Currently there is no objective specific to uniformed services. There are specific activities SUSAH can implement to contribute to the NSF and such an objective will capture the contribution.

- Provision of protective gear and regular condom supply given that the nature of the uniformed work makes personnel vulnerable
- There is need for a referral hospital for uniformed services to improve healthcare
- Continuous training of the focal persons and personnel on HIV and provision of IEC materials
- There is a need for in-house psychologist for the Fire Department and other services needed given the nature of work the personnel do
- Improve infection control in the correction services and police cells as well as establishing an isolation cells to manage MDR-TB
- SUSAH institutions should shift from vertical HIV response to integrating HIV in the wellness programme for comprehensive care
- NERCHA to hold review meetings regularly involving SUSAH and other stakeholders
- Conduct knowledge exchange visits to learn from other countries
- Prioritise male circumcision given that the services are male dominated

7.1.2 **External mainstreaming**

External mainstreaming varies from ministry to ministry depending on capacity, resources and leaderships support. The evaluation found out that all ministries have to some extent mainstreamed HIV in line with their core mandates. The following are examples of external HIV mainstreaming among the institutions consulted:

**Ministry of Education and Training:**

MoET is implementing the SADC Framework for Care and Support for Teaching and Learning to provide a full package of services. This framework seeks to establish “child friendly” schools along 7 pillars-
quality teaching, positive discipline, safety and protection, psychosocial support and Guidance lifeskills and HIV and AIDS education. The MoET has mainstreamed HIV using this framework. Key interventions includes life-skills education, creating demand for SRSH through awareness and education; provision of dignity pack for girls recently launched to mitigate girls dropping out of schools and engaging in transactional sex; and schools feeding programme to address food insecurity that contributes to low enrollment.

**Ministry of agriculture:** The ministry has been partnering with NERCHA to provide technical support/agricultural extension services to farmers producing food for OVCs. However, this initiative has ended due to lack of funding.

**Ministry of Justice:** protection of the rights of PLHIV, women and children including prosecution of GBV cases. Children friendly courts have been established and the prosecution department has also taken measures to manage GBV cases.

**Royal Swazi Police:** protection of rights of key populations, children and women and investigation of GBV cases. Domestic violence, children protection and sexual offices units have been set up in 24 police stations. Police have also been sensitized to support healthcare provision to key populations.

**Parliament**

Parliamentary HIV Programmes has mainstreamed HIV internally and externally. Internal mainstreaming targets members of parliament for awareness and education on HIV and in accessing HIV services themselves. HIV is integrated into the wellness programme for MPs. However, the wellness programme has not taken off due to funding and time constraints from the MPs. External mainstreaming has been more success compared to internal mainstreaming, MPs have been successful in mobilizing communities and engaging them in regional consultations to raise awareness on HIV, address stigma and discrimination and listen to their concerns on the HIV response. Issues raised form the basis for advocacy by the MPs to have government find solutions.

However, parliament has made limited effort in playing its role in oversight and financing of the HIV response partly due to competing tasks and capacity limitations. MPs have a high turnover every five years and it takes time to sensitize and train a new cohort of MPs. Secondly, the programme faces funding constraints. Implementation of the parliamentary HIV and AIDS strategic plan has not commenced partly due to funds limitations.

To strengthen the parliamentary programme, there is a need to cascade the regional consultations to constituency level to engage more directly with communities; build the capacity of parliamentarians in oversight, financing and advocacy for the HIV response through strategies such as benchmarking; establish a wellness programme.

**Coordination:** There is no coordination mechanism for external mainstreaming. Each ministry working on their own. Leadership and commitment therefore varies from ministry to ministry. Coordination of the players providing HIV within each sector also varies. MOET has identified one organisation to coordinate all external players targeting in-school youth; mechanism for coordinating GBV and other forms of violence have also been set up. Mechanism for coordination of social protection programs including OVC support are in conceptual stage. Therefore, there is a need to establish the status of coordination of external mainstreaming within each ministry and establish a mechanism to coordination external mainstreaming across all ministries.
Accountability framework has not been developed. Hence, indicators and targets for external mainstreaming not set up; no system for ministries to develop or share plans, report on external mainstreaming, review progress and also to plan.

**Contribution of mainstreaming to national development**

Stakeholders observed that HIV mainstreaming has contributed to national development as follows (although data is not available to show the extent of this contribution).

(i) Absenteeism both in the public and private sector has reduced and worker productivity increased. This is partly due to employees adopting HIV prevention methods and those who are positive being put on treatment and care. Human resources policies have also been adjusted to address the needs of PLHIV.

(ii) Contribution to HIV prevention among communities: The sectors have programmes on HIV prevention among all key populations and vulnerable groups. These programmes have contributed to reduction of new infections.

(iii) Socio-economic impact mitigation: various sectors have contributed to support for OVCs and in promoting and protecting the rights of people infected and affected by HIV. Policies put in place by various sectors have improved access to education, protection of women, and improved livelihoods.
8.0 Inclusiveness, human rights and gender

Inclusiveness

The eNSF identified all key groups – key populations (MSM and FSWs) and vulnerable groups (Adolescents and young women, prisoners and mobile populations and migrants. The HIV response reaches out to most of the key populations and vulnerable groups. Programs for MSM and FSWs have been scaled up. The response is also prioritizing adolescents, youth, young women and men.

However, the following groups are not sufficiently reached: (i) Persons with disability where by programmes tailored to the needs of this groups are insufficient. (ii) Boy-child – there is more emphasis on adolescents girls and young women compared to boys. (iii) Mobile populations and migrants – focus has so far been on the transport sector targeting long distance buses and trucks and also reaching out to the transport hotspots. These interventions started recently and there is a need to be sustained and expanded to provide a comprehensive package of services. (iv) People Who Inject with Drug. There is insufficient data to support HIV programming for PWID.

Gender mainstreaming: There are some efforts taken to mainstream gender in the HIV response. Interventions targeting gender issues such as gender based violence, male engagement, addressing vulnerability factors for adolescent girls and young women among others are being implemented. Mainstreaming to ensure programmes are gender responsive is an on-going process and tends to depend on programming policies of individual institutions. Most institutions have taken deliberate steps to mainstream gender in their programmes.

Human rights mainstreaming: Guidelines for mainstreaming human rights into HIV programmes have not been developed and human rights mainstreaming has been slow. There are specific interventions addressing human rights issues such as sensitization of law enforcement agencies on key populations’ access to health care; training of health workers on needs of key populations and adolescents/young people; sensitization of service providers and communities on stigma and discrimination among others.

Gaps and Challenges

(i) Perceptions on human rights among key players in the country differs. This has to some extent been a bottleneck in implementing a human rights approach to HIV response.

(ii) Data on gender and human rights related indicators is limited. Most of the indicators are not being reported on regularly.

(iii) An assessment of the legal environment for HIV has been conducted but ownership of the report is a challenge

(iv) Human rights approach to HIV programming has not been systematic. There are no deliberate actions undertaken to mainstream gender and human rights approaches in the HIV response.

(v) Human rights issues in “test and start” approach have not been addressed. There are no guidelines and training on human rights has not been undertaken.

(vi) Negative attitude and beliefs of communities and service providers toward key populations, lack of a conducive and enabling environment for KPs (policies and legal framework), and stigma are hindering access to services.
9.0 Funding of the HIV response

The assessment of the funding of the HIV response focuses on the total spending over the eNSF period, the trend in spending over time, sources of funding and the absorption rate. This assessment shows the extent to which funding has been increasing over time and the rate of absorption of the funds. The analysis does not take into account community resources, private sector contributions and spending by other government ministries on mainstreaming of HIV. However, it does show an approximate trend in the funding for HIV from major funding sources in the country.

10.1 Funding for the HIV response

(i) Funding of the response during eNSF period

The figure below shows that annual funding for the eNSF ranged from US$103 to US$ 127. The peak in funding was in 2016.

![Figure 26: Annual Funding for HIV Response, 2014-2017 (US$)](image)

Data source: Global Fund Funding Landscape, 2015

(ii) Trend in HIV funding 2008 and 2017

Figure 27 below shows the trend in HIV spending between 2007/8 and 2011/12 based on the NASA assessment. This data includes funding from all sources – government, external and private funds. During this period, the funding increased by 63%. Figure 28 shows a trend in funding between 2012 and 2017 based on Global Fund funding landscape analysis which does not private funds. During this period the funding increased marginally by 7%. A comparison between these two periods depicts the general trend in funding for the HIV response internally. There was an increase in development funding including for HIV pandemic internationally between 2000 and 2010, whereas the funding has remained at the same level since 2010 partly due to the financial crisis and also due to Swaziland status as a middle income country. It is unlikely that new funding sources or current funding sources will substantially increase resources for the response. It is, therefore, important to shift focus to in-depth prioritisation of interventions and development of strategies to gain efficiencies.
(iii) Source of funding

Since 2012, both external and government funding for the HIV response has to a large extent flat-lined. There is a marginal increase or decrease from year to year. Overall donor funding remains higher than government funding. This underscores the issues that additional funding sources are becoming limited.

(iv) Major development partners supporting the response

Three development partners are contributing about 90% of the external funding. It is unlikely that new major development partners will come on the scene in the short term.
(v) Allocation of government funding

Major items to which government funding is allocated are ARVs (first line drugs) and laboratory reagents; administration and operational costs and personnel. Funding for drugs has been on an upward trend since 2012, which is a reflection of the increasing demand as number of PLHIV enrolled on ART increases. In order to achieve the 90-90-90 targets, an increase in funding for drugs and other pharmaceutical commodities will be required.

Data source: Global Fund Funding Landscape Analysis

10.2 Funding absorption

(i) Fund absorption rate for the Global Fund Programme

Absorption rate for the Global Fund grant managed by NERCHA as Principal Recipient shows a sharp increase over time; from 8% in 2015 to 90% by March 2017. This is a reflection of improved management and timely implementation of the programme. (See figure 32 below)
The absorption rate for the global Fund grant managed by CANGO was at 84% in March 2017. The figure below shows absorption by programme areas with highest absorption recorded for prevention programmes for adolescents and youth and lowest absorption for prevention programmes for FSWs and their clients.

Data source: Programme data

(ii) Fund absorption rate: Ministry of Health HIV Programme

Expenditure rate for three programmes – SNAP, SRHU and Laboratory – which implement HIV interventions. Expenditure rate ranges between 76% and 89%.

Table 9: Expenditure rate for Ministry of Health HIV Programme (Amounts in SZL)

<table>
<thead>
<tr>
<th>Programme</th>
<th>2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme</td>
<td>2014/2015</td>
</tr>
<tr>
<td>SNAP</td>
<td>8,623,061.00 8,369,593.20 97%</td>
</tr>
<tr>
<td>SRHU</td>
<td>9,546,645.00 657,726.86 7%</td>
</tr>
<tr>
<td>LAB</td>
<td>46,927,748.00 40,491,270.70 86%</td>
</tr>
<tr>
<td>Average</td>
<td>65,097,454.00 49,518,590.76 76%</td>
</tr>
<tr>
<td>Year</td>
<td>2015/2016</td>
</tr>
</tbody>
</table>
### Programme

<table>
<thead>
<tr>
<th>Programme</th>
<th>Estimate released</th>
<th>Actual Amount</th>
<th>Proportion spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNAP</td>
<td>12,015,513.00</td>
<td>9,495,966.68</td>
<td>79%</td>
</tr>
<tr>
<td>SRHU</td>
<td>2,680,376.00</td>
<td>4,061,736.47</td>
<td>152%</td>
</tr>
<tr>
<td>LAB</td>
<td>85,960,472.00</td>
<td>39,216,827.51</td>
<td>46%</td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
<td>89%</td>
</tr>
</tbody>
</table>

### Year

<table>
<thead>
<tr>
<th>Programme</th>
<th>Estimate released</th>
<th>Actual Amount</th>
<th>Proportion spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNAP</td>
<td>10,932,626.00</td>
<td>10,770,915.60</td>
<td>99%</td>
</tr>
<tr>
<td>SRHU</td>
<td>2,187,132.00</td>
<td>6,454,717.51</td>
<td>295%</td>
</tr>
<tr>
<td>LAB</td>
<td>52,695,297.00</td>
<td>33,197,932.77</td>
<td>63%</td>
</tr>
<tr>
<td>Average</td>
<td>87,384,746.00</td>
<td></td>
<td>132%</td>
</tr>
</tbody>
</table>

Source: MoH Expenditure data

Key factors determining absorption rates include:

- Timeliness in the release of funds by government to the Ministry of Health. Delays in fund release have contributed to low absorption.

- Achievement of targets and timely expenditure of funds of the Global Fund funds. Global Funds operates a performance based funding system where by principal recipients have to demonstrate expenditure of funds and achievement of results in order to receive further disbursement. Fund absorption is therefore determined by timely implementation which itself depends on the efficiency of the implementation arrangements and strategies.

- Data for absorption of USG funds was not available. However, implementation of programmes supported by USG is through selected partners implementing through public and community systems. Implementing partners are selected based on their capacity and experience and their performance is closely monitored and assessed based on achievement of targets.

### 10.3: Challenges

The major challenge facing Swaziland is that funding for the response has flat-lined while fund absorption rate (especially for donor funding) has been in upward trend. This implies that the space to achieve efficiencies based on the current implementation arrangements and strategies may be narrow.

The number of donors for HIV have declined and/or changed focus. The impact of declining resources has been more profound among CSOs. Some are closing while other are phasing down their activities. On the other hand, the need for additional resources is likely to increase because the rate of reduction of new HIV infections is gradual, the number of PLHIV on ART is expected to continue increasing and the decrease of number of AIDS related OVCs is also on a gradual downward trend. There is therefore a need to focus on both domestic and international resource mobilisation and also improve efficiency of available resources.
10.0 Strategic Information and Knowledge Management

The objective of the strategic information and knowledge management component of the eNSF was to generate, analyse and use strategic information for decision making in HIV response planning, implementation and accountability. This is a critical element of the “three one” which aims at ensuring coordinated M&E for the response and effective data use. Key findings of the evaluation are as follows:

The “One M&E system” is not working efficiently

NERCHA is housing the “one M&E system for the HIV response. Stakeholders report to this system to enable NERCHA developed a consolidated report. About 51% of the eNSF indicators have data while 49% do not have data. This reporting rate shows that more work is needed to enhance the one M&E system.

A results framework is in place but the national M&E plan is not finalized and operational guidelines for M&E have not been developed

The country has an eNSF results framework which list national indicators for tracking progress in eNSF implementation and the targets to be achieved over time. This framework forms a good basis for the One M&E framework for HIV. Most of the indicators confirm to a large extent to internationally agreed indicators. Most of these indicators have also been adopted by programmes to facilitate the link between programmes M&E and the national M&E for the HIV response.

However, the national M&E plan for the HIV response is in draft form and operational guidelines or SOPs for M&E support stakeholders in data collection and reporting on HIV indicators have not been developed. This has limited the operationalization of the results framework.

A mechanism for M&E coordination is not in place

The technical working group for M&E is currently not functional but plans are underway to revive it. In the absence of the TWG, there is no forum to bring M&E experts from all sectors together to review data, identify M&E weaknesses and seek solutions and contribute to the improvement of the one M&E system for HIV.

M&E systems expected to report to the one M&E system for HIV are aligned but reporting has limitations

Various M&E systems linked to the HIV M&E system are providing reports. For instance, SHAPMOS receives data on community based interventions from CSOs, FBOs, Private Sector and Ministries. The health sector response data is submitted through the Health Management Information System. Other systems in the health sector providing data are the Client Management Information System which is in pilot phase and the Community Based Management Information System (CBMIS). The public sector data on internal and external mainstreaming as well as private sector response is also reported to NERCHA.

On the other hand, not all systems are providing data to the One M&E system for HIV as expected. Reporting rate to SHAPMOS is not optimal because some organisations do not report, not the same organisations report every quarter and not all organisations have access to internet to use the online SHAPMOS tool; not all government ministries report on internal and external mainstreaming; and data for impact mitigation interventions (OVC and GBV) is limited.

In the health sector, data is not available in one place and has to be collated and consolidated from various units to have a holistic report. Reporting on community interventions is inadequate and the
indicators have not evolved with the transformation of the response. Data on key populations, OVC support and GBV is also inadequate.

**Measures are being taken to ensure data quality but challenges remain**

SHAPMOS and HMIS have data protocols that are aimed at ensuring data quality. Data verification is conducted by NERCHA and MoH to review completeness and accuracy and develop ways to address gaps identified. However, there are challenges with data quality (completeness and accuracy). Denominators for some of the indicators are difficult to determine as they require surveys or other size estimation methods; and data for community based interventions is difficult to verify given the nature of the interventions.

**Platforms for data use are in place for specific programmes but overall use of data for accountability and tracking eNSF implementation is limited**

Each programme is also using its data to improve the HIV response. For example, the health sector undertakes national and regional semi-annual review of the data to inform programming; Civil society, FBOs, urban response, public and private sectors also convene their members (when funds are available) to review progress based on monitoring reports. Data is being used to report to international systems such as the Global AIDS Response Progress Report (GARPR) and SADC. At the national level, data use is limited due to the non-existence of the key coordination TWGs and other platforms where data can be used for accountability and to review progress in implementation of the entire eNSF. Secondly, at regional level, the absence of REMSHACCs means there is no platform for comprehensive use of data to inform regional interventions.

**Information products produced are mainly reports and there is need for innovation**

Common information products are quarterly and annual reports produced by individual sectors and by NERCHA, Prime Ministers Reports and the Reports produced for the Directors’ Forum. The health sector also produces visualized information products. There is need for innovation on development of information products for various audiences and for different purposes.

**HIV research agenda has not been finalized, a coordination mechanism is not place and several research gaps have not been addressed**

The research agenda for HIV is in draft form. There are also several data gaps for outcome eNSF indicators, some of which will be addressed by the 2017 SHIMS evaluations and others need different surveys. Secondly, efforts to generate evidence to inform specific areas of programming (male circumcision, stigma, key populations, and men and adolescents health seeking behaviour among others) have been limited.

**Knowledge management platform has not been established.**

This is a major gap in strategic information management. A strategy and platform for knowledge management had not been developed to facilitate availability and use of M&E products and research.

**Priorities**

(i) Strengthen M&E coordination by reviving the M&E TWG and improving communication and provision of feedback

(ii) Develop an M&E plan for the national HIV framework and corresponding operational guidelines

(iii) Strengthen M&E for non-health sectors to ensure data for internal and external mainstreaming of HIV, HIV impact mitigation and community based interventions is available
(iv) Establish an M&E system for key populations data linking it to other appropriate systems

(v) Establish multisectoral platforms for data use at national and regional level including reviving the M&E TWG

(vi) Finalise the HIV research agenda

(vii) Commission surveys to address data gaps and generate evidence to support programming

(viii) Establish and operationalise a robust knowledge management platform
12.0 Recommendations

One of the objectives of this evaluation was to inform the development of the next strategic framework for HIV and AIDS for the period 2018-2022. Under each programme, priorities to be addressed going forward have been identified and will not be repeated in this section. The recommendations outlined in this section focus on the overall HIV response.

a. Overall focus of the next strategic framework

The next strategic framework should aim at achieving the country’s vision to end AIDS by 2022. It should be designed to ensure urgency in implementation of the response, galvanise all effort towards sustaining the momentum created under the eNSF and also serve as a blue print to significantly reverse the HIV epidemic in Swaziland. The framework should incorporate the Umgubudla while extending the targets to 2022 and also including other core programmes beyond those prioritised under Umgubudla.

b. Increase efficiency of the HIV response by adopting cost efficient and cost effective strategies to maximise impact

In the context of flat-lined funding and the unlikely substantial increase of funding for HIV in the future, the focus of the next NSF should be in increasing efficiency of the HIV response and establishing innovative domestic resource mobilisation strategies. The next strategic framework (2018-2022) should therefore combine prioritisation of core programmes with proven effectiveness and strategies that accrue efficiency gains. That is, strategies for delivering the prioritised programmes should be selected based on value for money (economy, efficiency and effectiveness) criteria.

Some of the approaches for increasing efficiencies that can be adopted include:

- Resource tracking – establishing a system for tracking resources to various programmes and flow of resources from national to service delivery points and efficiency in utilisation of resources to achieve outputs. Public expenditure tracking and quantitative service delivery surveys can be utilised to identify bottlenecks and inform the development of a resource tracking system.

- Service integration – Service integration should also be used as an approach for minimising the vertical nature of the HIV response. HIV should be integrated with. Priority could be given to strengthening and expanding HIV/TB/RMCNAH integration to the lowest primary health care and at community level as well as integration of HIV with NCDs.

- Improving coordination of implementers and establishing collaborative/joint implementation of interventions to minimise duplications and gain from synergies. This approach calls for coordination approaches that facilitate joint planning and implementation especially among community level implementers.

- Conducting value for money assessments prioritising high cost/budget programmes to identify strategies for efficiency gains

- Implementing proven cost efficiency approaches such as differentiated care models, micro-targeting based on granular data analysis, and delivery of training through mentorship during support supervision, video-conferencing and on-line training platforms among others.
c. Develop and implement a financing strategy for the HIV response

Globally, countries are working towards ending AIDS by 2030 but within a resource constraints environment. To achieve this goal, an increasing number of PLHIV will have to be sustained on ART for a long period of time while new infections have to be reduced substantially. Swaziland is in a similar environment. There is a need for a comprehensive analysis of the level of financing needed, taking into account maximising of programme efficiencies, to inform the development of a financing strategy for the HIV response. Given the limited international financing options, a financing strategies for the HIV response should establish domestic financings strategies while leveraging on available external resources. The focus of such a financing strategy should be on “sustainability of results achieved so far and further scale up to end AIDS”. Swaziland can learn lessons from other countries, such as Uganda, that are already embarking on a similar process.

d. Restructure the coordination architecture to address redundancies, inadequate capacities, funding constraints and to be in tandem with improvements made in the HIV response

Coordination has been scaled down due to limited funding; some key activities such as planning and monitoring implementation are not adequately being carried out, some of the structures such as REMSHACCs are not operating while TIMSHACCs and CHIMSHACCs are not fully constituted. As a result, the on-going scale up of the response is taking place in an environment of weak coordination.

The purpose of restructuring of the coordination architecture is to align coordination to the current state of the HIV response and establish the role coordination should serve at this stage. It will bring synergy between sectoral, programmatic and regional coordination to reduce costs and enhance collaboration. The architecture should bring to the centre the multisectorality of the response by bridging the gap between community and health sector response. This should be a lean but efficient architecture that enables the response to achieve efficiency gains.

Proposals that can be considered in updated coordination framework (which are not exhaustive) include:

- Having sector coordinating bodies cascade approaches for gaining efficiencies such as collaborative or joint planning and implementation; data driven micro targeting and establishing linkages to other sectors; capacity building of members to improve programme quality, efficiency and effectiveness such as training members in data use for programming; engaging in assessments of sector specific contributions to overall HIV response, identifying bottlenecks and seeking solutions. Thus, the role of the sector coordinating bodies should not be more of the same – planning, monitoring, reporting and advocacy.

- Establish TWGs at the national level: these should be TWGs for Prevention, Treatment, Care and Support, Social-Economic Impact Mitigation; Planning, Resource tracking and accountability; and Strategic Information and Research.

- Reconstituting or reviving REMCHACCs to serve as a platform for coordination of all interventions in the region. However, to avoid duplication and also to reduce costs, all sectors should be represented in the REMSHACC and sector specific meetings should be minimised. I.e, all players at national level could coalesce at the REMSHACC so that this becomes a single platform where all regional HIV interventions and issues are discussed.

- Establish annual stakeholder fora at the regional level feeding into a national annual stakeholder forum to review progress and identify priorities going forward. Holding the regional forum will limit the number of people attending the national forum hence making it cost-efficient.
• Integrate TIMSHACCs and CHIMSHACCs into the existing traditional structures at the two levels. The role of these structures should primarily be entry points for implementers into the community, facilitating community mobilisation; tasking implementers to share information with these structures to enable them be aware of the work being done and as avenues for raising community concerns on the HIV response. HIV will continue being one of the development issues on the agenda of these institutions. The evaluation found out that these structures capacity to play traditional coordination roles – planning, monitoring, and reporting among others - is limited and even not feasible. They should therefore play roles that are in line with their overall mandate.

e. **Conduct NERCHA organisational review**
NERCHA being at the centre of the coordination needs to be reviewed to bring its organisational architecture in line with the current demands of the response. The purpose of the review is to update NERCHA organisational structure to be fit for purpose. Some of the issues this review will address include:

• Reconfiguring NERCHA organisational structure to be in line with the revised coordination roles spelt out in the reviewed coordination framework
• Ensuring the organisation has relevant capacities and competencies needed for emerging demands of the response such as resource tracking, value for money programming, granular data analysis, micro targeting, and collaborative implementation among others.
• Improving internal organisational accountability
• Strengthening internal management systems
• Improving internal and external communication and stakeholder management

f. **Strengthen strategic information and knowledge management**
Strategic information, research and knowledge management is central to an effective response. This component should be strengthened to improve effectiveness and efficiency of the response. Recommended actions include:

• Finalising the M&E plan and operational guidelines for the national M&E for HIV
• Building the capacity of sector monitoring and evaluation systems giving priority to those where data is missing or inadequate
• Setting up a coordination mechanism for M&RE. This may require reviving or setting up a new M&E TWG
• Finalise the research agenda and establish a knowledge management platform tailored towards improving programming
• Establish a national depository for HIV data, mechanisms for data dissemination and build capacity for data use

g. **Establish a regulatory mechanism to enforce coordination**
Through this mechanism, it should be clear who is doing what and where. In will also ensure that implementers’ reports are received by NERCHA. Such a mechanism can be supported by a form of GIS based ‘situation room” system that tracks implementers, programme results and resources on one platform and allows access to the information for decision making.
h. **Conduct research and generate evidence and knowledge to improve programming**

There are data gaps for most of the programmes. Different types of research should be commissioned to fill data gaps and also to generate information that informs better programming. Immediate need for evidence and knowledge include factors barring men from accessing HIV services including male circumcision; factors facilitating translation of knowledge and awareness to behaviour change among the youth; the disconnect between condom scale up and condom use; and HIV vulnerability factors for adolescents and young people.

i. **Develop a comprehensive HIV prevention strategy aligned to the overall NSF**

Prevention still remains a cornerstone for reversing the HIV epidemic. New infections are still significantly high though gradually declining. About 45% of the infections are among adolescents and young people. Prevention interventions, however, are implemented by a wide range of multi-sector institutions and do not have one lead institution. There is, therefore, a need for a comprehensive HIV prevention strategy that will guide all implementers, tailor interventions to each specific population and ensure effectively coordination. This strategy should prioritise adolescents and young people and men. It should utilise combined prevention strategies that offer a comprehensive package of services, and it should be evidence based.

j. **Ensure a balanced HIV response between prevention, and treatment, care and support**

Strengthen linkages and synergies between prevention, treatment, care and support services to ensure continuity of care by addressing critical system areas such as referral, data sharing, cross programme communication, task shifting and multi-tasking and cross training.

k. **Strengthening community health systems and response**

Investments in the health sector/public health systems have had huge success in scaling up HIV services. The community health systems and response has had limited investment. CSOs, FBOs, peer educators and PLHIV support groups are poorly resourced, depend on volunteerism and their activities are in most cases short term and ad-hoc. There is a need to build the capacity of the community response to support HIV service delivery especially given the trend of having services offered at community level. The link between the community and facility services should also be strengthened to improve continuity of care.
Annex 1: Terms of Reference


1. BACKGROUND
Swaziland is severely affected by the HIV and AIDS epidemic wherein an estimated 28% of the adult population is living with HIV. New infections are still unacceptably high at an annual rate of 1.9% every year, with rates as high as 4% in young women making HIV the leading cause of morbidity in urban and rural areas. The epidemic necessitates concerted multisectoral action and an elaboration of National Multisectoral Plans.

In 2014, the Extended National Multisectoral HIV and AIDS Strategic Framework (eNSF) 2014-2018 was developed through participatory processes to operationalize commitments in the National Development Strategy (NDS, 1999), Health Sector Strategy (HSS, 2015), Millennium Development Goals (MDGs, 2000), UN Political declaration on HIV/AIDS (2011), Paris Declaration of AID effectiveness, Abuja Declaration, SADC Declaration on HIV and AIDS; and Universal Access targets, amongst others. The goal of the eNSF is to halt the spread of HIV and reverse its impact on Swazi society. It guides HIV and AIDS interventions that should result in significant progress towards halving new infections and averting AIDS-related deaths, through efficient and effective delivery mechanisms. Following the vision of His Majesty King Mswati III of an AIDS-free Swaziland by 2022, the Umgubudla Fast-Track Programme towards an AIDS-Free Swaziland was developed and launched in July 2016. Umgubudla builds on eNSF by recommending game changing action in 5 eNSF strategic areas to drastically reduce new infections and averting AIDS deaths by targeting population groups that are vulnerable and at higher risk of HIV acquisition. The country has a HIV/TB coinfection programme to respond to the high rate of co-infection between the two diseases. The National Operational Plan has been developed to implement these.

The eNSF is coming to an end in 2018 necessitating the development of a new strategy that takes into account recent realities of the HIV epidemic in Swaziland and embraces emerging evidence for controlling the spread of HIV while recognizing ongoing global and local financial constraints. To effectively fulfill the mandate to coordinate the national multisectoral response, NERCHA wishes to engage a short-term consultancy to evaluate progress in meeting mid and end-of term targets committed in the eNSF and the country’s trajectory for Umgubudla impact targets. The findings of the evaluation will be used to recommend the strategic direction for a new strategy for 2018-2022.

2. OBJECTIVES OF THE ASSIGNMENT
The overall objective of this consultancy is to obtain a critical assessment of Swaziland HIV responses’ overall performance in implementing the eNSF and Umgubudla and draw any significant lessons. Information gathered from this review will be used to design and implement an appropriate HIV response agenda for the period 2018-2022.

Taking cognizant of ongoing evaluations in HIV Prevention and Treatment, the evaluation will specifically focus on the following areas;

2.1. Performance of the Swaziland HIV and AIDS response
2.2. Contribution to national development efforts, in particular mainstreaming HIV in the development sector and Ending AIDS by 2022
2.3. Inclusiveness of the HIV response
2.4. Resources for the HIV response
2.5. Strength of the ‘Three Ones’ Principles including coordination and implementation arrangements

3. ROLES AND RESPONSIBILITIES
The consultant will work under the daily supervision of NERCHA. The consultant will undertake a majority of tasks in collaboration with a National Steering Committee and National Task Team. The consultancy is also expected to liaise with programmes Technical Working Groups, HIV coordinating partners, implementing partners, development partners, donor partners, service beneficiaries and other stakeholders.

4. SCOPE OF WORK
Specifically, the Consultant working closely with the NERCHA Response Leadership Department will;

4.1. Evaluate the national HIV and AIDS response with a focus on its impact, effectiveness, relevance, value addition, efficiency, and sustainability as implemented since 2014
4.2. Evaluate the national HIV and AIDS response’s contribution to national development efforts and in particular the mainstreaming of HIV in the development sector and pathway towards Ending AIDS by 2022
4.3. Evaluate the inclusiveness, equity and human rights considerations of the HIV response
4.4. Evaluate the extent of resources available, their utilization and the country’s absorptive capacity
4.5. Evaluate existing coordination and institutional arrangements at all levels with a view to improve their efficiencies in view of a global flat lined resource base
4.6. Develop an evaluation report that outlines implementation successes, challenges, resource management and emerging opportunities, and recommend a strategic direction for the National Multisectoral HIV and AIDS Strategic Framework for 2018-2022

5. METHODOLOGY
The consultant is expected to draw from ongoing programme evaluations in HIV prevention, treatment and impact mitigation, conduct interviews with policy makers in government, programmes Technical Working Groups, HIV coordinating partners, implementing partners, development partners, donor partners, and service beneficiaries and other stakeholders. Conduct desk reviews, and analyses and other relevant evaluation techniques as required by the scope of work.

6. DELIVERABLES
A) An evaluation report of the Multisectoral HIV and AIDS Response in Swaziland (2016)