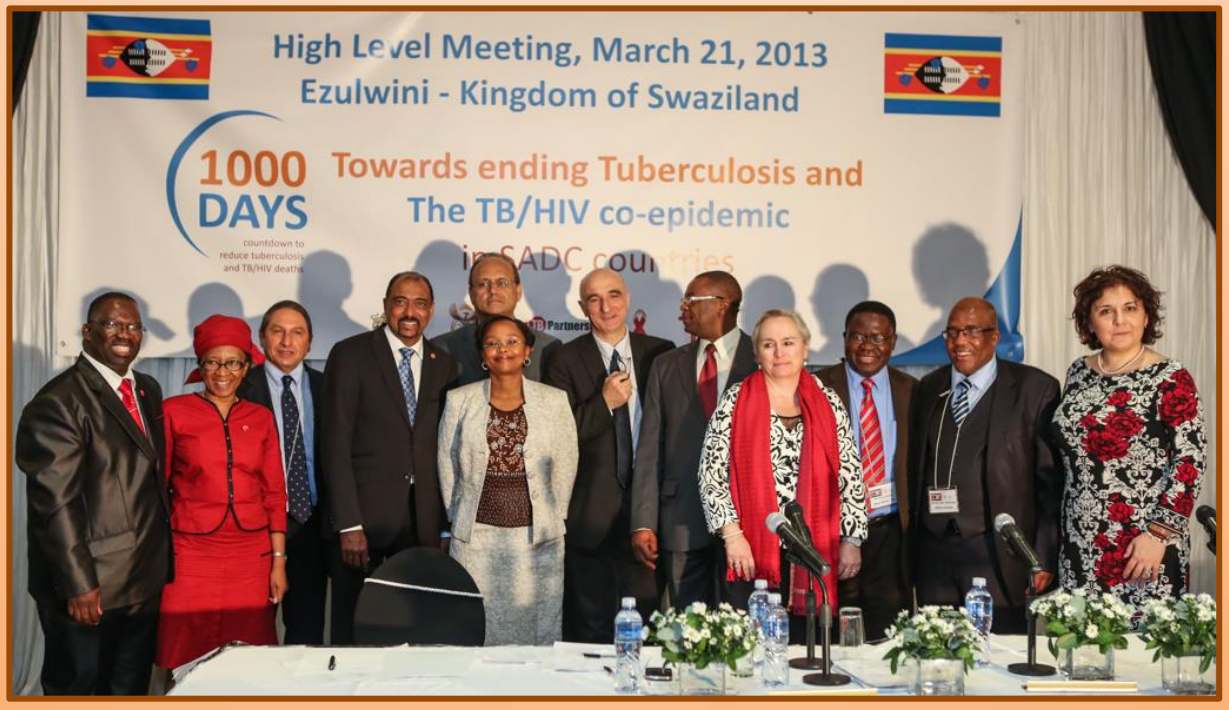
The Kingdom of Swaziland



SWAZILAND GLOBAL AIDS RESPONSE PROGRESS REPORTING 2014

NERCHA

UNAIDS

Foreword

The Kingdom of Swaziland is proud to present the country report for the 2014 Global AIDS Response Progress Reporting (GARP) to the United Nations as an expression of the will to halt the spread of HIV, mitigate its effects on Swazi society and reverse the trends. The report represents the continuous efforts made by multi-sectoral partners in turning the tide.

The country's National Multi-sectoral Strategic Framework on HIV and AIDS has been revised to support the 2011 UN Political Declaration on HIV/AIDS in ensuring that all related national targets are in line with the Global Targets outlined in the Declaration. The development of the extended National Strategic Framework for HIV and AIDS (eNSF), which becomes operational on 01 April 2014, builds on the results based management approach and suggests a more effective and efficient response. Local institutional capacities are being strengthened to offer integrated and mainstreamed HIV programmes.

In March 2013, the country was joined by UNAIDS Executive Director and co-chair of the Global Plan on Elimination of MTCT, Mr. Michel Sidibe and global health leaders to launch the "Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive Framework" and the "1000 days countdown towards an accelerated response to the TB and TB/HIV epidemics in Southern Africa". The plans are premised on the engagement of communities, infected and affected families, and partners in HIV prevention, treatment and support, and the need to strengthen health systems to sustain the response.

The GARP process not only allows us to take stock in the delivery on our commitments, but offers an opportunity to reflect on whether we could have done better. Swaziland is not complacent to the need to keep HIV as both a health and socioeconomic development issue. As a result, the impact of social, economic, political and environmental structural factors that that affect HIV risk and vulnerability are being assessed together with issues of fear, myths and misconceptions including HIV stigma and discrimination that hinder access and uptake of HIV services

I cannot over-emphasize that responding to the epidemic requires the concerted effort of global and regional leaders, bilateral and multilateral partners, all national stakeholders, communities and citizens. Indeed the beginning of the end of AIDS has begun, but we must remain vigilant to its devastating effects which will live with us for a longer future. For instance, about 20% of the population is living with HIV and will require lifelong treatment; and the country's population under the age of 18 is either orphaned or vulnerable and in need of sufficient social welfare systems. The Swazi domestic economy which currently contributes 40% of total HIV expenditure cannot be in a position to take on the full cost of the reversing the epidemic.

On behalf of His Majesty's Government, let met thank all partners, implementers and civil society actors who continue to support the HIV and AIDS response in Swaziland. Swaziland, together with countries in the sub-Saharan African region, looks forward to the new Millennium Development Goals in 2015 that look at HIV as a critical factor for the sustainable social and economic development of African countries.

Dr. Barnabas Sibusiso Dlamini
Prime Minister, Kingdom of Swaziland
28th March 2014

Acknowledgement

The country report for the 2014 Global AIDS Response Progress Reporting (GARP) represents the continuous dedicated work of all HIV partners and stakeholders. The support from the government, multilateral and bilateral partners, communities, People Living with HIV and AIDS and the private sector is noted and appreciated.

NERCHA recognizes the continued dedication and innovation in formulation of robust national policies and guidelines for HIV programmes; the programmes technical working groups are applauded for their unfailing support. All this would not have been possible without the commendable commitment of the Government of Swaziland which provides leadership and guidance.

I acknowledge the commitment of HIV partnership fora between NERCHA and Civil Society including Development Partners who work tirelessly to ensure that all interests are represented.

Finally, NERCHA would like to extend its appreciation to the National consultant, national stakeholders and key informants for their individual and collective contributions to the national report.

Mr. Khanya Mabuza
Executive Director- National Emergency Response Council on HIV/AIDS (NERCHA)

1 Contents

List of Figures

List of Tables

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CANGO	Coordinating Assembly of non-Governmental Organisations
CSO	Civil Society Organisations
DPM	Deputy Prime Minister
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
MC	Male Circumcision
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MTCT	Mother To Child Transmission
NASA	National AIDS Spending Assessment
NCP	Neighbourhood Care Points
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Government Organisations
NSF	National Strategic Framework
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan for HIV and AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PSHACC	Public Sector HIV and AIDS Coordinating Committee
SBCC	Social and Behavioural Change Communication Strategy
SDHS	Swaziland Demographic and Health Survey
SNAP	Swaziland National AIDS Program
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund

VCT	Voluntary Testing and Counselling
WHO	World Health Organisation

2 Status at a Glance

The 2014 Global AIDS Response Progress Reporting in Swaziland was based on broad stakeholder consultation. The process was guided by a core team led by the National Emergency Response Council on HIV and AIDS (NERCHA), with a national consultant leading the consultations. Amongst stakeholders consulted were government ministries, civil society organisations, private sector and development partners including the UN. The process started in February, and was concluded end of March 2014, with production of validated Country Progress Report (Narrative), Indicator Data, National Policy and Commitment Index (NCPI) and National Funding Matrix.

Swaziland has one of the highest HIV prevalence in the world with 26 per cent of the 15–49 year olds living with HIV (Swaziland Demographic and Health Survey, 2007). Women are disproportionally affected, with prevalence as high as 31 per cent compared to 20 per cent in men (SDHS, 2007). According to the 2011 Swaziland HIV Incidence Measurement Survey (SHIMS), it is estimated that HIV prevalence among adults aged 18-49 was 31% (SHIMS 2011). The SHIMS findings show that peak in HIV prevalence has shifted to older ages for both sexes to 30 - 34 year olds for women and 35 – 39 year olds for men whereas in the 2007 DHS, peaks were amongst 25 – 29 year olds for women and 30 – 34 year olds for men. HIV prevalence among Men having sex with Men (MSM) is 17.7% and high among sex workers at 70.3% (BSS MARPS, 2011). HIV prevalence is evenly distributed across the four regions in the country.

According to SHIMS, incidence is 2.38% in the age group 18 – 49 year olds, for men it is 1.7% and 3.1% for women. Incidence peaks at 3.12% amongst men aged 30-34 and there are three peaks for women at 3.8% in 18-19 year olds, 4.2% in 20-24 year olds and 4.1% in 30-35 year olds. HIV estimates further confirm that HIV incidence was 2.45% in 2011, and decreased to 1.79% in 2013 (Preliminary HIV Estimates, 2013). Heterosexual sex remains the main mode of transmission of HIV in Swaziland, accounting for 94% of all new HIV infections (MOT, 2009). Risk factors include but are not limited to, multiple and concurrent sexual partnerships, intergenerational and transactional sex, gender inequalities and gender based violence, low and inconsistent condom use and low uptake of male circumcision.

The HIV response in Swaziland is led and coordinated by NERCHA, working with other Ministries including the Ministry of Health. A number of policies have been reviewed and/or put in place to support the national response in 2013, and these include the HIV prevention policy. In the reporting period, the country has registered a significant increase in its ART and PMTCT programmes. By December 2013, 100,138 of the 122,185 people in need of treatment (82%) were receiving ART and 9,522 of the 11,307 HIV positive pregnant women (84%) were receiving PMTCT services. The country continues to show commitment and leadership in the national response, with Government financing and procuring all ARVs and TB drugs. Though HIV incidence has decreased since 2011, it is still relatively high and prevention remains a priority. Coverage of male circumcision is still low, with just over 20% of adult males circumcised with consistent and correct condom use at 73.1% amongst sexually active adults with more than one sexual partner (MICS, 2010).

The country has shown its commitment to HIV prevention in its new Extended National Strategic Framework (2014 – 2018), with a focus on high impact interventions and targeting of populations and geographic areas where most of the infections are coming from, and continuing to reduce the overall HIV costs.

Table 1: Summary Progress by Indicator

Target	#	Indicator	2011	2013
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015 General Population	1.1	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	Overall: 56% Women: 58.2% Men: 53.6%	No new data
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15	Overall: 3.2% Women: 3.8% Men: 2.6%	No new data
	1.3	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Overall 8.6% Women: 2.7% Men:15.7%	No new data
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	Overall 71.5% Women: 73.6% Men: 71.0%	No new data
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Overall:40.1%; Women: 47.3% Men: 31.3%	No new data
	1.6	Percentage of young people aged 15-24 who are living with HIV	ANC: 34.0% SDHS; Overall: 14.4% Women: 22.9% Men 5.9%	No new data
Sex Workers	1.7	Percentage of sex-workers reached with HIV prevention programmes	86%	No new data
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	87.4%	No new data
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	74.6%	No new data
	1.10	Percentage of sex workers who are living with HIV	70.4%	No new data
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	82.2%	No new data
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data	No data available
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	No data	No data available
	1.14	Percentage of men who have sex with men who are living with HIV	17.7%	No new data
Target 2: Reduce transmission of HIV among people who inject drugs by 50% in 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No data	No data available
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No data	No data available
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	No data	No data available
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No data	No data available

	2.5	Percentage of people who inject drugs who are living with HIV	No data	No data available
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	94.5%	84%
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	68.9%	68.0%
	3.3	Mother-to-child transmission of HIV (modeled)	15.4%	10.1%
Target 4: Have 15 million people living with HIV on ART by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	Overall: 80.0% Children: 53.2% Adults: 84.3%	No new data
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Overall: 87.2% Children: 87.6% Adults: 87.1%	Overall: 90.5% Children: 90.1% Adults: 90.5%
Target 5: Reduce TB deaths among PLHIV by 50% by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	9.7%	73.0%
Target 6: Close the global AIDS resource gap	6.1	Domestic and international AIDS spending by categories and financing sources	No data	
Critical enablers and synergies with development partners (NCPI)	7.1 Gov't	Overall, how would you rate strategic planning efforts in the country's HIV programmes	8	8
		Overall, how would you rate political support for the country's HIV programmes	8	8
		Overall, how would you rate policy efforts in support for HIV prevention	6	8
		Overall, how would you rate the efforts in implementation of HIV prevention programmes	7	7
		Overall, how would you rate the efforts in the implementation of treatment, care an support programmes	9	8
		Overall, how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children	7	9
		Overall, how would you rate the HIV related monitoring and evaluation	7	7
	Civil Society	Overall, how would you rate the efforts to increase civil society participation	6	4
		Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV	5	5
		Overall, how would you rate the effort to implement human rights related policies, laws and regulations	4	5
		Overall, how would you rate the efforts in the implementation of HIV prevention programmes	5	7
		Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes	6	8

	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	7.7%	No new data
	7.3	Current school attendance among orphans and non-orphans aged 10–14	Orphans: 97.2% Non orphans: 98.6%	No new data
	7.4	Proportion of the poorest households who received external economic support in the past 3 months	No data	No data available

3 Overview of the AIDS epidemic

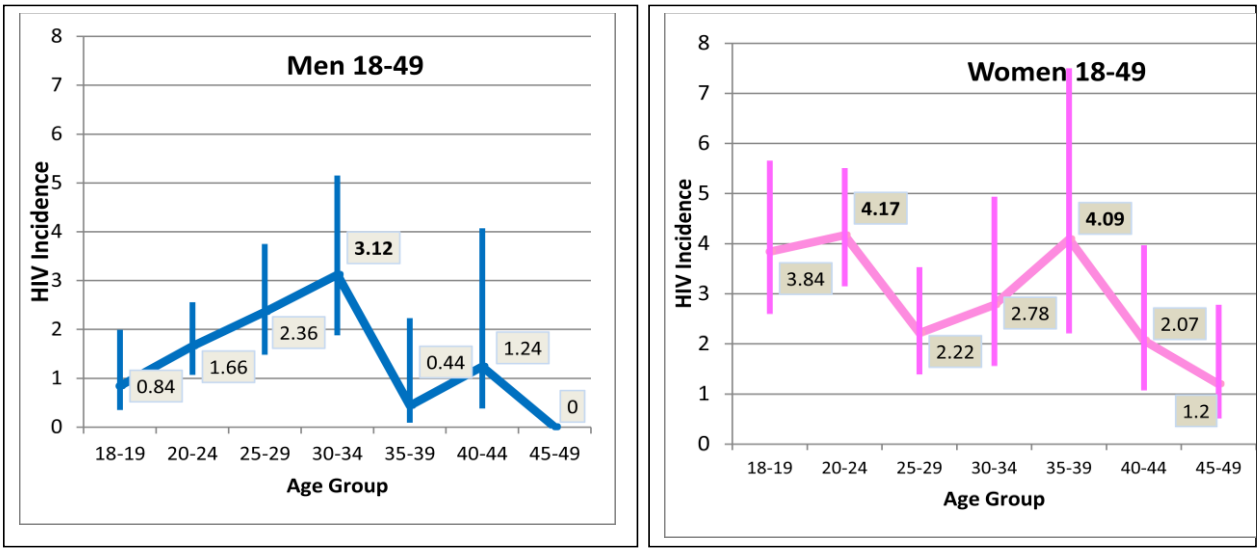
The following HIV epidemiological analysis incorporates new evidence from a variety of studies and surveys conducted since the last Global AIDS Report Progress in 2012/13.

Swaziland has one of the highest HIV prevalence in the world with 26 per cent of the population aged 15–49 years living with HIV (Swaziland Demographic and Health Survey, 2007) coupled with the highest tuberculosis (TB) incidence rate of 1,380 TB cases per 100,000 per year (Ministry of Health Annual TB Report, 2012). The SDHS of 2007 showed that women aged 15–49 have a higher prevalence than men (31 per cent and 20 per cent respectively), with prevalence peaking earlier among women (25–29 years) than men (30 – 34 years).

According to the 2011 Swaziland HIV Incidence Measurement Survey (SHIMS) it is estimated that the HIV prevalence among adults aged 18-49 was 31% (SHIMS 2011). This finding confirms that the HIV epidemic is stabilizing. In the SHIMS, peak in HIV prevalence has shifted to older ages for both sexes to 30 - 34 year olds for women and 35 – 39 year olds for men. HIV prevalence among Men having sex with Men (MSM) is 17.7% and high among sex workers at 70.3% (BSS MARPS, 2011). HIV prevalence is evenly distributed across the regions in the country.

According to SHIMS, incidence is 2.38% in the age group 18 – 49 year olds, for men it is 1.7% and 3.1% for women. Incidence peaks at 3.12% amongst men aged 30-34 and there are three peaks for women at 3.8% in 18-19 year olds, 4.2% in 20-24 year olds and 4.1% in 30-35 year olds as shown in figure 1 below:

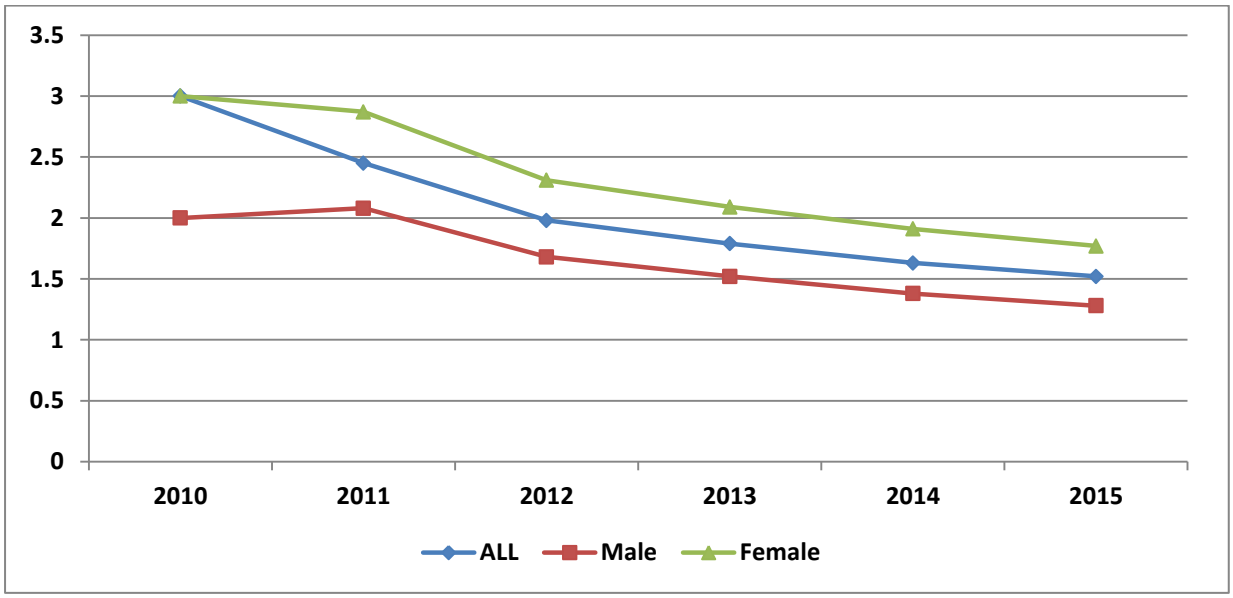
Figure 1: HIV Incidence Among Men and Women aged 18-49 years



Source: SHIMS 2012

The Preliminary results of Spectrum HIV Estimates and Projection model (2013) show that HIV incidence for people aged 15-49 was 2.45 % in 2011 and 1.79% in 2013, and is projected to further decrease to 1.52% in 2015.

Figure 2: HIV Incidence by sex among 15 - 49 year olds (2010 – 2015)



Source: Spectrum HIV Estimates & Projections 2013 (Preliminary Results)

Again both SHIMS and Estimates and Projections support the evidence of a downward trend of annual HIV infections. However, analysis show that SHIMS value for HIV incidence in 2011 is lower than the estimated value of 2.45%, but remains within its confidence intervals.

According to the MOH annual report for 2012-13, the percentage of HIV infected infants born to HIV positive mothers decreased from 12% in 2011 to 3% at age 6-8 weeks by end of 2012. This is promising trend towards the elimination of MTCT.

By December 2013, approximately 100,138 adults and children in need of ART were receiving. 92% of TB clients were tested for HIV by 2012 (NTBP). 73% of TB patients received treatment for HIV and TB (HMIS, 2013). The risk of developing TB is between 20 and 37 times greater in PLHIV than among those who do not have HIV infection. The emergence of MDR-TB continues to be a global challenge and Swaziland is no exception.

The devastation of the AIDS epidemic is evident from the rising number of orphaned and vulnerable children as well as other devastating social and economic impacts of the AIDS epidemic.

3.1 Epidemic Drivers and Factors influencing the Spread of HIV

A number of studies and surveys conducted recently including Hearsay Ethnography Research Study (2012) provided new insights on the epidemic drivers and other factors fuelling the spread of HIV. The following are the key drivers and factors that influence the spread of HIV in Swaziland:

i. ***Multiple and Concurrent Sexual Partners (MCP):*** Women who have more than one sexual partner within a year was 2.7% in 2010 and for men who it was 16% among those aged 15-49 (MICS, 2010). The Hearsay Ethnography Research Study (2012) identified 12 distinct sexual relationship types existing in Swaziland, ranging from monogamous, to couples with

sexual partners outside the main relationships, couples with more than one steady partner, to men who are regular clients of with sex workers.

ii. ***Sex work:*** According to the BSS MARPS (2010), 70% of women aged 15-49 who consider themselves as sex workers and had participated in paid sex were HIV positive, which is more than double (31%) that of the general population in the same age. While there is no data on transactional sex, the line between commercial sex and transactional sex remains unclear.

iii. ***HIV Stigma & discrimination:*** The Stigma and Discrimination Index (2011) conducted among PLHIV noted that self-stigma was higher than externally expressed stigma. All forms of stigma remain critical barriers to HIV prevention and treatment service uptake.

iv. ***Gender inequality and gender based violence (GBV):*** Gender inequality is prevalent in the Swazi society due to social-cultural, economic and political factors. Gender-Based Violence (GBV) and sexual abuse remain a daunting challenge for Swaziland. In a patriarchal Swazi society cultural values and norms uphold men's privileges and tend to constrain women's decision-making on their sexuality and reproductive health.

v. ***Early sexual debut:*** Although the median age of sexual debut in Swaziland remains low, it has increased from 16 (SDHS, 2006/7) to 17 years for girls and 19 years for boys (MICS 2010). According to the MICS, 3.8% of young women and 2.6% of young men reported having had sex before the age of 15.

vi. ***Intergenerational sex:*** The rate of women aged 15-24 who had high risk sex with men who are 10 or more years older than them has doubled from 7% (2006/7) to 14% in 2010. Less than 1% of men aged 15-24 had high risk sex with women 10 or more years older than them. Young women do not consider relationships with older or wealthy men as risky. Coupled with this, condom use in young women is lower than young men and increases for women as they grow older and decreases in men.

vii. ***Men who have sex with men:*** HIV prevalence among men who have sex with men aged 16-44 years is at 17%, with the percentage increasing with age (BSS MARPS). The prevalence is lower than that of men in the general population aged 15-49 (20%). Condom use among MSM was estimated at 66% with non-regular partners. Self and external stigma prevents bi-MSM from disclosing their sexual orientation or HIV status to their female partners. Given the nature of the population group only 27.1% had been reached with targeted HIV prevention programmes.

4 The National Response

Swaziland's national response to HIV has grown in scope, due to harsh realities on the ground and lessons learned over the past two decades of both successes and challenges. Since the first case of HIV were reported in the early 80s, up to the point that HIV and AIDS was recognised as a national disaster by His Majesty King Mswati III in 1999, the government in collaboration with non-state actors, has passed through phases of the response that demonstrate sustained levels of commitment to reverse the effects of the epidemic in the country.

The National Emergency Response Council for HIV and AIDS (NERCHA) continues to coordinate the national response. Established in 2003 through an Act of Parliament, in part as a result of the global recognition of the multi-sectoral nature of HIV and AIDS and the call for one coordinating authority, NERCHA has presided over the development of three national HIV and AIDS strategic plans (2000 – 2005, 2006 – 2008 & 2009 – 2014). NERCHA has led in the development of a new Extended NSF covering the period 2014 – 2018. Decentralised coordination has been strengthened through the establishment of regional and community structures. These structures are the Regional Multisectoral HIV and AIDS Coordinating Committee (REMCHACC), Tinkhundla Multisectoral HIV and AIDS Coordinating Committee (TIMSHACC) and Multisectoral HIV and AIDS Coordinating Committee (CHIMSHACC). These work closely with the Ministry of Tinkhundla Administration and Development which is also responsible for regional and community level responses. Public Sector Coordination involves all public ministries and departments, directorates and units and is led by Public Sector HIV and AIDS Coordination Committee (PSHACC). Through PSHACC a public sector coordinating strategy has been developed and is being implemented.

The HIV response amongst civil society is coordinated through the Swaziland HIV and AIDS Consortium (SHACO) an arm of the Coordinating Assembly of Non-Governmental Organisations (CANGO), which includes civil society and private sector umbrella bodies that have been created to provide sector leadership in their respective areas. Private sector response is led by Swaziland Business Coalition on HIV and AIDS (SWABCHA). Development Partners are facilitated through the Donors' Forum and the Swaziland Partnership Forum.

In its current scope, the national response has been guided by the soon-to-end 2009 – 2014 National Strategic Framework (NSF). Set out across four thematic areas of prevention, care & treatment, and impact mitigation. In recognition of the importance of coordinating resources and stakeholders, the framework included a fourth category of response management. A hallmark of this framework was a well-articulated results framework, based on evidence and setting baselines against which targets were set to facilitate monitoring and evaluation of the national response. The results framework also mapped out resources required by the national response against the results aimed to be achieved.

Prevention of new HIV infections remains the priority for the NSF. Since the adoption of the 2011 Political Declaration, the country released a National HIV Prevention Policy in 2012 in recognition of the challenges that have been experienced and the gaps that have been identified in prevention programming. As the policy notes, "Preventing new HIV infections in the Kingdom of Swaziland is vital to reverse the epidemic and achieve treatment, care and impact mitigation targets." The

national prevention policy demonstrates a renewed emphasis on evidence-informed prevention programming.

During the NSF implementation, the mid-term review of the NSF and new developments at global level including the 2011 Political Declaration to which the country signed up to, called for a renewed commitment to the national HIV response. These developments have had a contributory and streamlining effect on the national response as a whole and are discussed in the relevant sub-sections of this chapter.

The year 2014 is largely a transition year for the recently developed eNSF (2014 – 2018). Although not formally launched at the time of preparing this report, the framework has largely been adopted in the national narrative and has become the focus of discussions and plans for the next phase of the national response. This fact is highlighted to avoid confusion that may result from readers who have embraced the new dispensation.

4.1 Target 1. Reduce sexual transmission of HIV by 50% by 2015

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

Heterosexual sex remains the main mode of transmission of HIV in Swaziland, accounting for 94% of all new HIV infections (MOT, 2009). Risk factors include but are not limited to multiple and concurrent sexual partnerships, intergenerational and transactional sex, gender inequalities and gender based violence, low and inconsistent condom use and low uptake of male circumcision.

4.1.1 Young people: Knowledge about HIV prevention

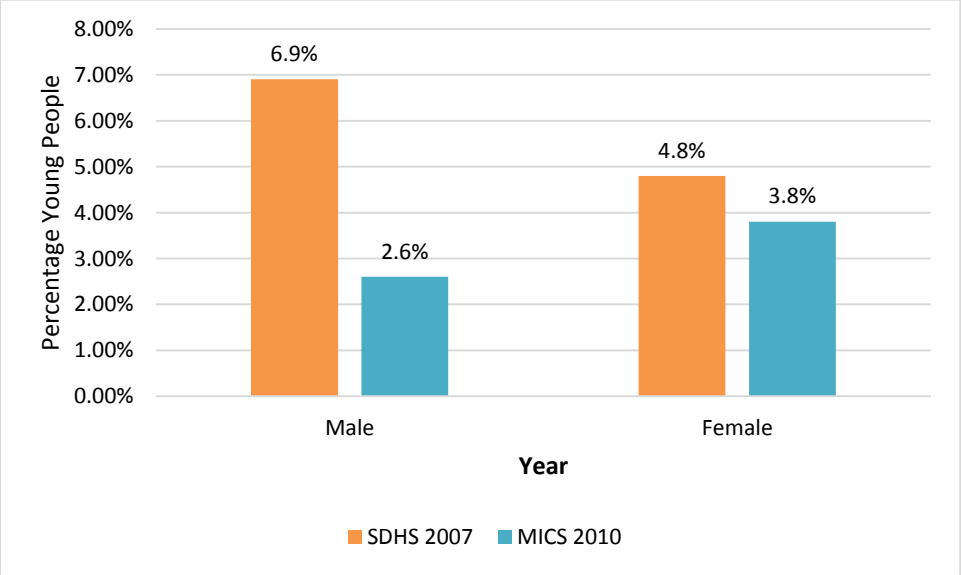
Young people's knowledge of HIV prevention has been documented as a predictor of the adoption of safer sexual behaviours although not a sufficient condition in itself. Like many other countries in Sub-Saharan Africa, Swaziland's opportunity to influence attitudes and directly affect the knowledge on HIV and AIDS for young people is largely through education and communication campaigns. The country launched the Social Behaviour Change Communication (SBSS) strategy (2009 – 2014), a framework for programming on social and behaviour change for HIV and Sexual Health. Young people have been targeted and within this context, toolkits to support implementation of SBCC interventions have been developed and rolled-out, including the HIV Prevention Toolkit - an age-appropriate information guide to facilitate peer and family life skills - for in and out-of school youth. The HIV toolkit has been adopted as a standard reference material for peer education in the country by all stakeholders implementing HIV-focussed peer education in Swaziland.

Over and above the toolkit, stakeholders including UN agencies, CSOs and government through the Ministries of Education (MoE) and Health have galvanised resources and support to develop a Comprehensive Lifeskills Education (CLSE) Programme for in-school youth, CLSE is offered in all secondary schools in the country. Through the Ministry of Sports Culture and Youth Affairs (MoSCYA) and its partners, the CLSE concept has been adapted at community level, leading to greater involvement and reach for out-of-school youths. As part of this intervention, HIV prevention and

GBV messages were disseminated during traditional events that bring young girls and boys before the King (Umhlanga and Incwala).

4.1.2 Sexual activity among young people - Sex before the age of 15

Figure 3: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

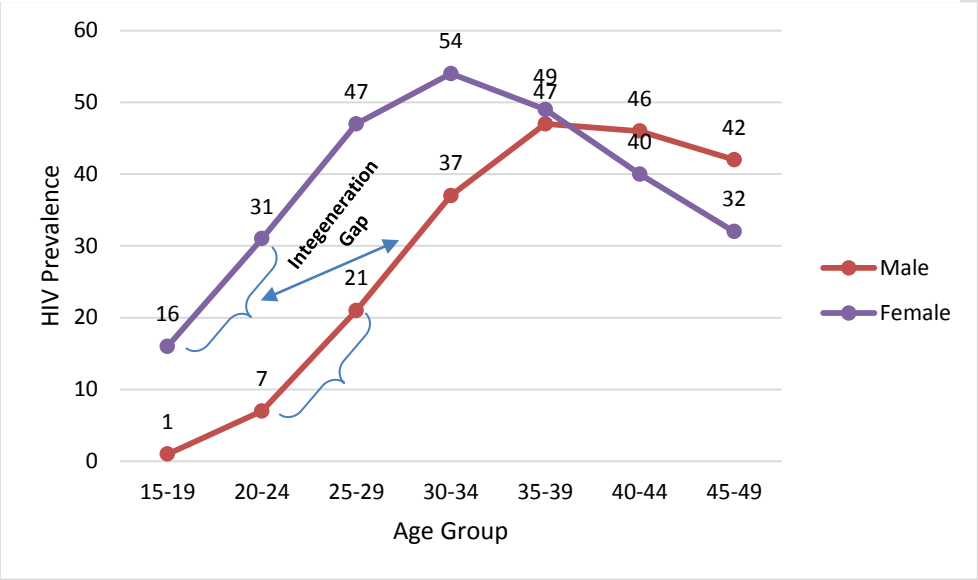


The onset of sexual activity presents increased risk of pregnancy and in the era of HIV and AIDS, greater risk for HIV transmission.

The median age of sexual debut in Swaziland has slightly increased from 16 (SDHS, 2006/7) to 17 years for girls and 19 years for boys (MICS 2010). This increase is largely attributed to concerted IEC/BCC efforts that are assumed to have helped increase knowledge about sexual and reproductive health including transmission of HIV and its relationship with early sexual debut. Other potentially contributory factors to this include the protective effects of education, with the MICS (2010) reporting over 80% of children completed primary school and the transition into secondary school was over 80%.

With a ten year gap between the two age ranges, young people characteristically engage in pre-marital sex, often with more than one partner. For both men and women, first sexual intercourse is in the age range 15–19, but according to MICS, this tends to occur earlier in rural females and urban males. Data from SHIMS 2011 shows that there is a dramatic increase in HIV prevalence between the ages 15–19 and 20–24 for females. Taking into consideration observations around intergenerational sex in Swaziland, these sharp increases in HIV prevalence for younger women can be attributed to the fact that HIV prevalence in men in the age ranges 30 – 34 and 35 - 39 is at its highest. These are men assumed to be engaging in sex with younger, sexually inexperienced women.

Figure 4: HIV Prevalence for Men and Women Aged 15 - 49 years

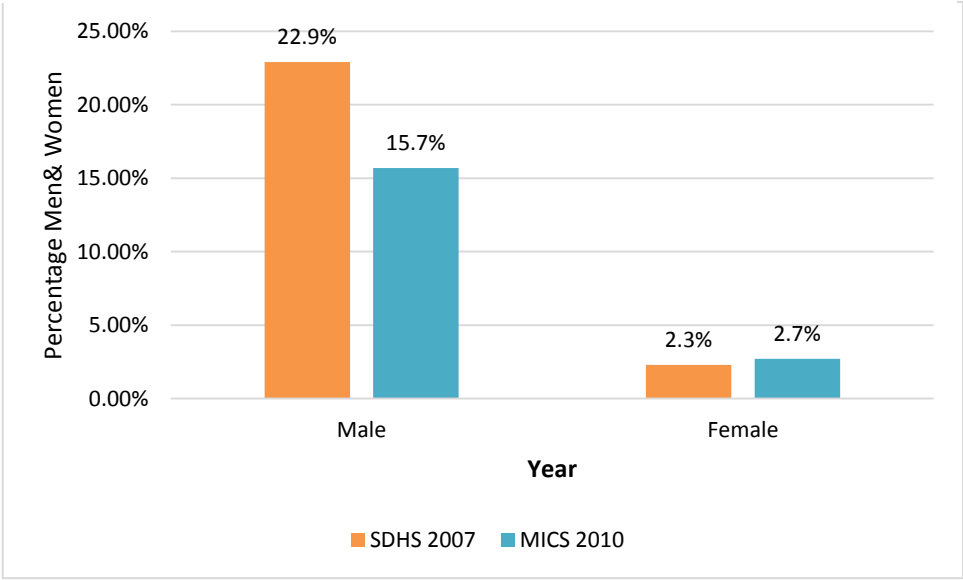


Source: SHIMS 2011

4.1.3 Multiple Sexual Partnerships

Multiple and Concurrent Sexual Partnerships (MCP) have been identified as a key driver that fuels the epidemic in Swaziland (MOT 2008). The National Prevention Policy (2010) outlines strategies for addressing this driver of the epidemic including priorities for communication campaigns and messaging, targeting populations and combination prevention strategies. Since 2011, communication campaigns to address MCP include the 'One Love' Campaign. The national SBCC strategy has been highlighted in the eNSF for intensified implementation, building on past communication campaigns.

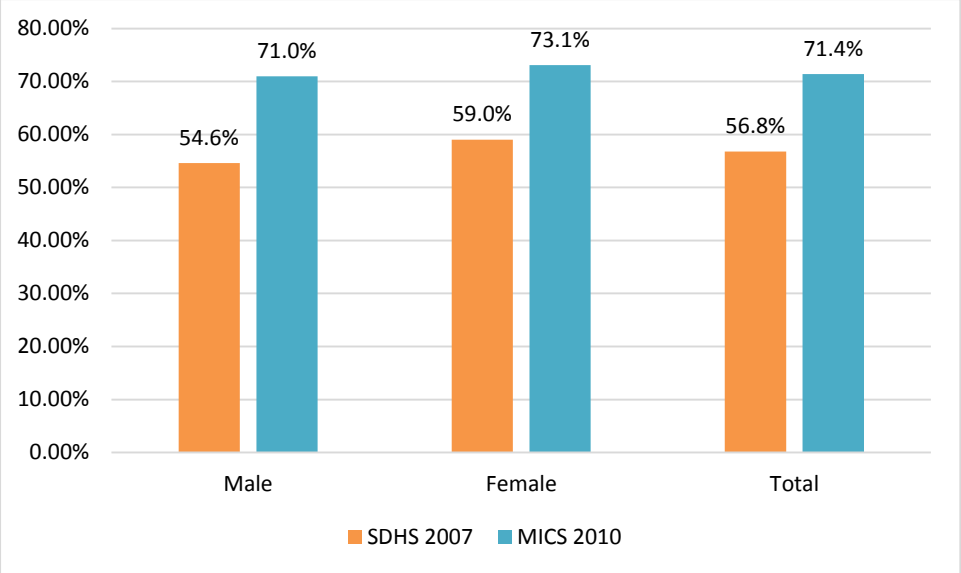
Figure 5: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months.



4.1.4 Condom use at last sex among people with multiple sexual partnerships

The national response in the area of HIV prevention is largely characterised by three areas of focus – abstinence, faithfulness to one partner and correct and consistent condom use. Since 2010, the national response has been aided by the development of critical programme frameworks that have contextualised condom programming. Condoms as a HIV prevention strategy have been successfully implemented in other countries. This observation coupled with their documented efficacy has made them a key choice of prevention strategy given the high HIV prevalence and incidence in Swaziland. Condom use in high risk sexual contexts has increased from 56.8% in 2007 to 73.1% in 2010.

Figure 6: Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse.



The 2010 – 2015 National Condom Strategy sets out targets for procurement, identifies bottle-necks for distribution together with proposals for overcoming these and highlights complimentary efforts of other guidance documents. The National Prevention Policy, together with the National SBCC Strategy offer programming coherence around the issue of communication campaigns, target groups and overall combination prevention. Condom procurement is centralised through the central medical stores, a quasi-governmental entity with the responsibility of managing condom procurement. In 2010, over 10million condoms were distributed nationally. According to the National Condom Strategy, all health facilities are required to have a regular supply of condoms. The 2013 Service Availability Mapping (SAM) study states that a total of 224 health facilities had provided condoms in the year preceding the survey. Of these only four experienced stock-outs in the month preceding the survey.

4.1.5 HIV testing in the general population

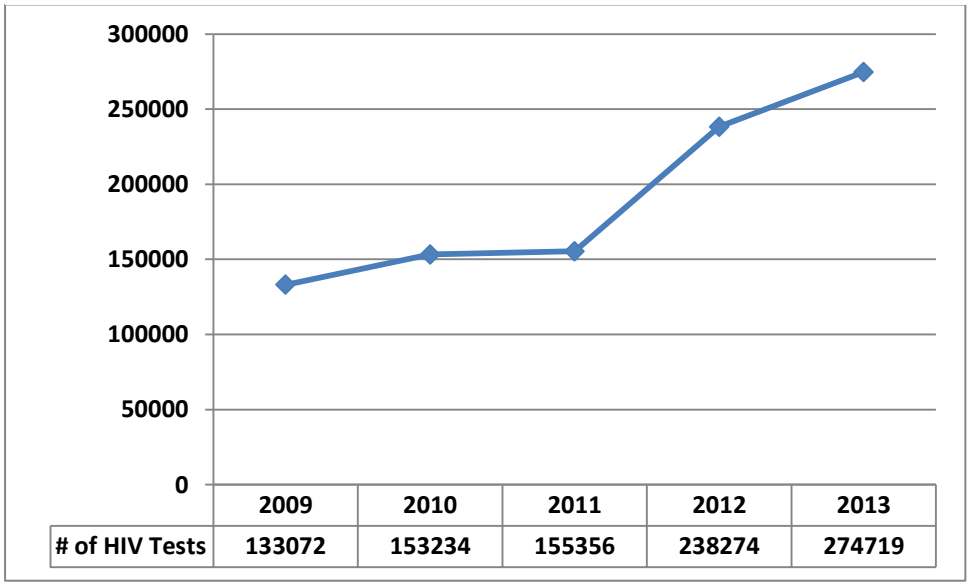
Over the past 15 years, HIV counselling and testing initiatives have grown in scope and innovativeness, a reflection of lessons learned. With a national HTC programme in place, under the auspices of the MoH, HTC programme achievements are categorised in two areas, as reflected in the two major strategies adopted national – the Provider and community Initiated HTC Strategies.

Under PITC, testing has greatly benefitted from the introduction of Standard Operating Procedures that helped in enforcing quality requirements and in the overall roll-out of the service in all health facilities. It is now standard for health workers in Swaziland to offer HTC for any health service accessed at public health facilities in the country.

HTC Programme Achievements

- A dramatic increase in overall testing: In a total of **252 678 and 274, 719 HIV tests** were performed in 2012 and 2013 respectively.
- Testing in outpatient units increased by almost **150%**, from **24 184 to 59 477 tests**.
- Testing in family planning settings increased from **1 067 to 6 031** tests
- Innovative strategies to reach men and adolescents have improved access to services and increased the number of HIV tests provided for men and adolescents (men increased from **56 839** in 2011 **to 74 194** in 2012 and adolescents from **62 166** in 2011 to **85 461** in 2012).
- Over **99.8%** people tested received their test results.

Figure 7: Number of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.



	2009	2010	2011	2012	2013
# of HIV Tests	133072	153234	155356	238274	274719

Source: National HTC Programme, 2013

Overall, since 2009 HTC has more than doubled with close to 280,000 tests performed in the country in 2013.

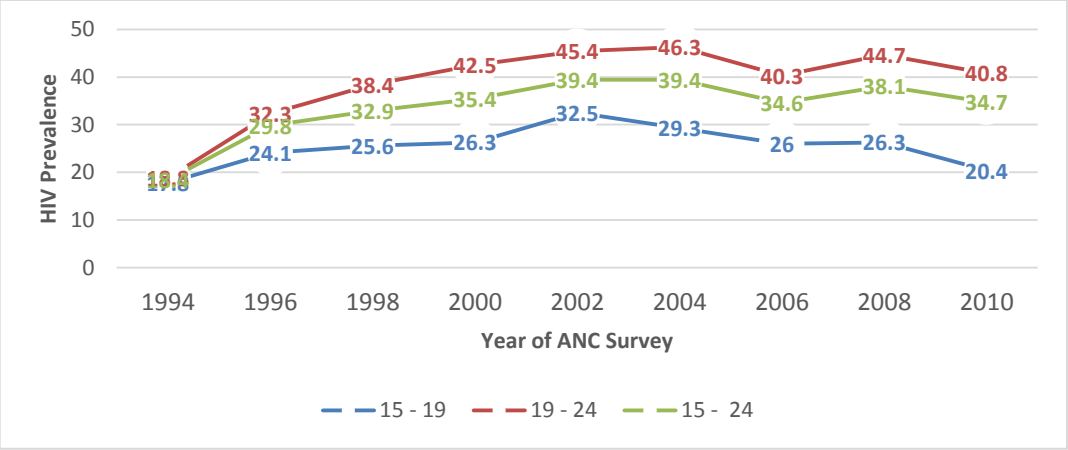
Though in its infancy, 'Couples Testing' has been initiated, with a 'Love Test' Campaign introduced to contribute to efforts to increase the number of couples that test for HIV.

For the CITC strategy, continued efforts were made in the area of innovative community mobilisation techniques including the use of spatial approaches in mapping out coverage and linking HTC data with other HIV services such as MC to explore inter-relationships that help provide insights on challenges and gaps. A key achievement in this area has been the finalisation of the National Referrals and Linkages Strategy – an effort that helps address the gap between testing and concomitant HIV services. The strategy includes a scientifically tested protocol helps mitigate the attrition that is experienced in linking individuals who test positive to associated care and treatment services as well as offering alternative pathways to other health and lifestyle information and services for those that test negative.

4.1.6 HIV prevalence in young people

HIV prevalence in Swaziland peaked in the first half of the past decade and started to decline towards the end of the decade. This downward trend is shown in the figure below:

Figure 8: HIV Prevalence among youth 15 – 24 years



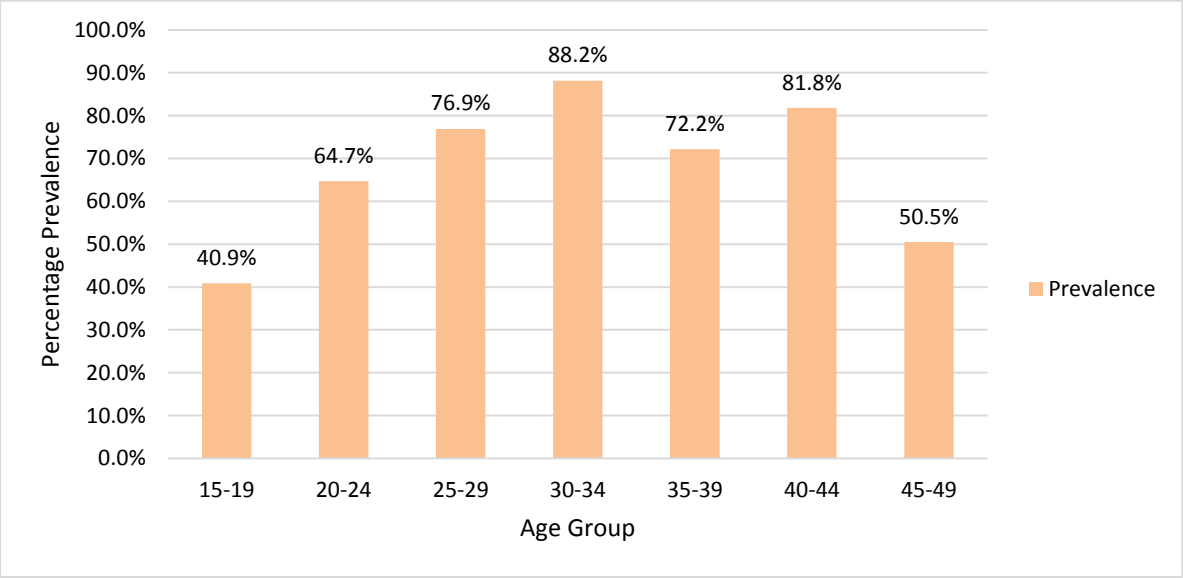
Source: ANC Sentinel Surveillance Reports

In 2011, the MoH, in collaboration with implementing partners embarked on the alternative of using routine PMTCT data to estimate prevalence based on successful trials of this method of estimating prevalence from other countries in the regions such as Botswana and South Africa. This study is scheduled for implementation in 2014.

4.1.7 Sex Workers

Legislation around sex work creates barriers for full-fledged development and implementation of HIV programmes in Swaziland. With a generalized epidemic, the impact of sex work is hard to determine. Transactional sex is commonplace among the sexually active population rendering the definition of sex work problematic. The National Prevention Policy calls for more research in this area to provide a clearer sense of the extent of the issues. In 2011, a Behavioural Surveillance Survey (BSS) was conducted and targeted sex workers. While informative and providing insights into the issues of sex work and men who have sex with men, the BSS had a non-representative and small sample size rendering the findings not compliant with reporting requirements for the GARP.

Figure 9: Percentage of sex workers living with HIV by age group



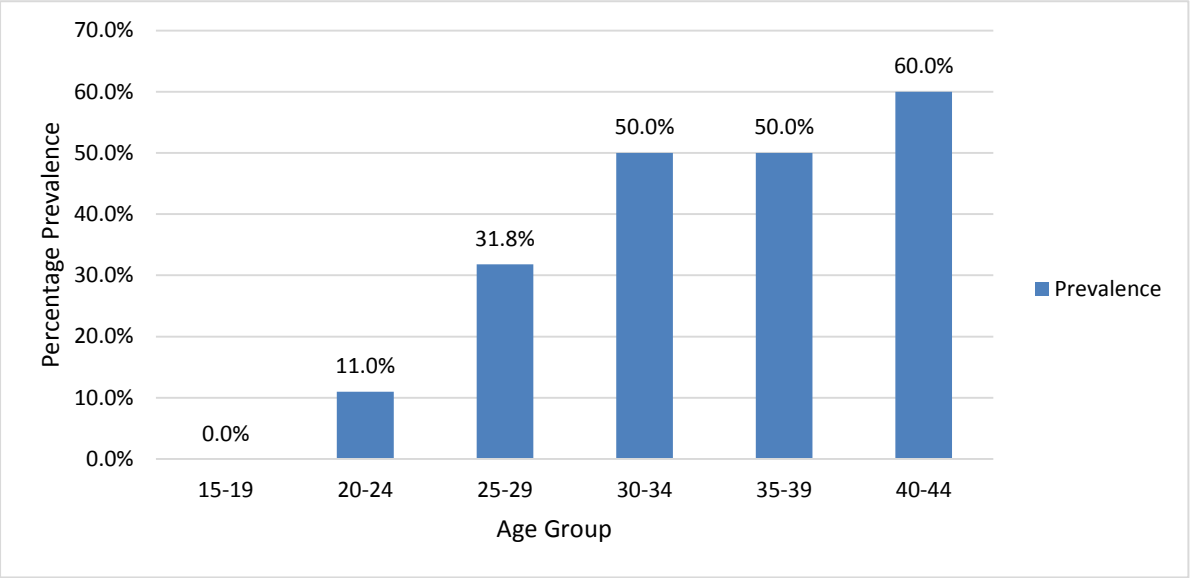
Source: BSS 2011

From the BSS, HIV prevalence among sex workers was found to be higher (70.3% - BSS MARPS 2011) than the general population. There is no data on the extent of transactional sex generally across the population although anecdotal evidence suggests that it may be widespread. The distinction between "sex workers" and persons engaged in transactional sex is currently not available.

4.1.8 Men who have sex with men: prevention programmes

Similarly, work around MSM is hindered by the legislative environment. While there are organisations addressing HIV among LGBT communities, this work is largely undocumented and where records exist, they are not consistently kept, rendering meaningful programmatic analysis difficult. As part of the 2011 BSS, HIV prevalence amongst MSM was noted to increase with age. No clear reasons for this trend are offered. Anecdotal information points to a potentially problematic challenge of MSM staying in heterosexual relationships for fear of reprisals from family and community members if their sexual orientation was revealed. Research in this area is required to help paint a clearer picture of the scope of this phenomenon.

Figure 10: Percentage of men who have sex with men risk who are living with HIV



Source: BSS 2011

4.2 Target 3. Eliminate New HIV Infections among Children by 2015 and Substantially Reduce AIDS-Related Maternal Deaths

The prevention of mother-to-child transmission of HIV (PMTCT) has been given high priority by the Government of the Kingdom of Swaziland and according to the latest data, significant progress has been made in delivering PMTCT services in Swaziland. In 2010, Swaziland committed to the elimination of new infections in children and keeping their mothers alive through comprehensive scale up of PMTCT. Scientific and program evidence points out that PMTCT interventions, including primary prevention, reducing unintended pregnancy, antiretroviral (ARV) prophylaxis and care and treatment for mothers living with HIV and new-borns exposed to HIV, can reduce the risk of HIV transmission from mother to child to less than 5% in countries where mothers predominantly breastfeed and to as low as 2% in non-breastfeeding countries. Although there has been a dramatic increase in commitment, resource mobilization and programming, especially around ARV prophylaxis, significant efforts are still required to realize the MTCT elimination goal of above 95% reduction of mother-to-child transmission by 2015. This will only be achieved if Swaziland continues to accelerate its commitment to making available comprehensive and effective PMTCT programs.

The PMTCT program and its supporting partners have implemented many actions to scale up PMTCT interventions and focus areas, and these include expanded targeted mentoring on PMTCT at health facilities, improved coordination at national, regional, and facility level, strengthened and expanded PMTCT service provision to community level, implementation of innovative program interventions for the involvement of male partner and strengthened tracing and follow up of antenatal care clients and HIV exposed infants.

Some of the key results due implementation of the above include an increase in overall HIV testing rates, with 89% of pregnant women tested for HIV, a decrease in HIV prevalence among pregnant women (37%) and a significant decrease of sero-conversion among PMTCT clients from 10% in 2010 to 2.8% in 2012. Enhanced efforts have been made during this period to educate and retest pregnant women during antenatal care and labour and delivery.

The proportion of all HIV positive pregnant women who receive ARV prophylaxis has significantly increased, reaching 84% in 2013, with slight improvement in CD4 testing during pregnancy from 66% in 2011 to 68% in 2012 and 2013.

4.2.1 Prevention of mother-to-child transmission

PMTCT is fully integrated into ANC services in Swaziland. The 2010 Essential Health Care Package lists a range of services that can be accessed for each tier of health facility. National PMTCT guidelines provide for all HIV infected pregnant women to be assessed for ART eligibility through clinical staging and CD4 testing.

The 2013 SAM report states that a total of 162 facilities offered PMTCT services out of a total of 252 public health facilities in the country. HIV Estimates and projections show that there were 11,307 pregnant women living with HIV in 2013. Of these, 9,522 were provided with ARV prophylaxis to reduce MTCT. Based on these estimates, a total of 84% of all HIV positive pregnant women received ARV prophylaxis to reduce MTCT by the end of 2013 (HMIS 2013). For women who were assessed using WHO CD4 staging, the percentage increased from 64% in 2011 to 68% in 2012 and remained constant in 2013 at 68%.

4.2.2 Early Infant Diagnosis

National guidelines stipulate that infants should be tested through DNA-PCR from as early as two months of birth to facilitate early interventions and reduce infant mortality. Since its launch in 2007, the early infant diagnosis (EID) program has achieved a significant increase in coverage. By the end of 2011, 82% (127) of 154 health facilities offering child-welfare services offered DBS for DNA PCR.

Table 2: Number of children born to HIV-positive women receiving a virological test for HIV.

Infant	Q1-2012	Q2-2012	Q3-2012	Q4-2012
<8 weeks	3826	2153	2148	1940
2 - 6 months	1003	521	504	426
6 - 12 months	625	256	308	314
12 - 18 months	176	43	57	62
> 18 months	53	22	17	19
Unknown	202	97	123	92
Total	5885	3092	3157	2853

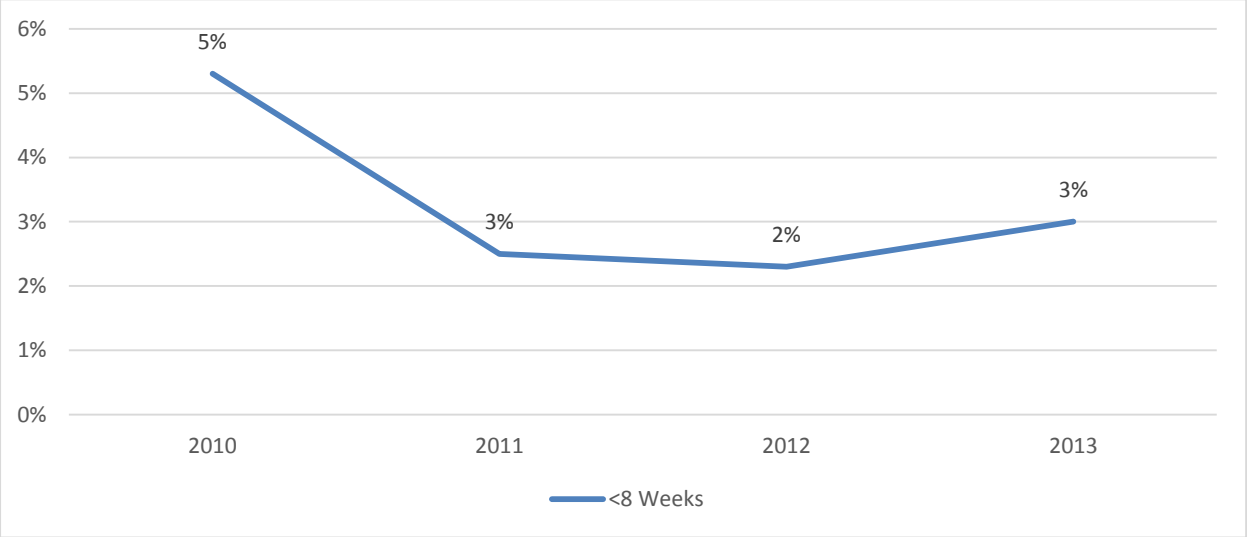
Source: HMIS 2012

With virological testing becoming an established component of PMTCT services for all HIV exposed infants at 6-8 weeks, EID and ART uptake for young children in the country has increased. According to the MoH HMIS database, a total of 9 084 HIV exposed infants age 6-8 weeks had been tested for HIV through DNA PCR. Less than 3% percent of these infants tested HIV positive.

4.2.3 Mother-to-child transmission of HIV

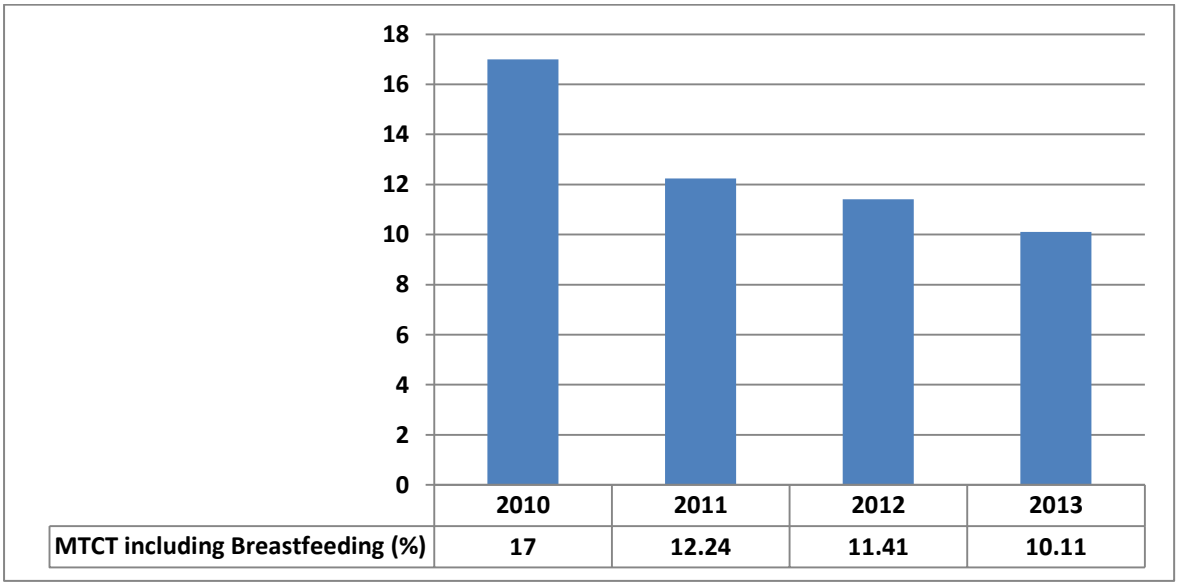
Data from the MoH shows that there is a declining trend for infants testing HIV positive over the years. In 2013, 3% of infants tested HIV positive at age 6 – 8 weeks. The average for the past three years has been 2.5%. Figure 14 below shows the average percentage of infants who tested positive from women delivering in the past 12 months for the periods 2010 – 2013. This decline is largely attributable to the successful roll-out of the EID initiative.

Figure 11: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months.



Source: HMIS 2012

Figure 12: Percent of new HIV infections in children including breastfeeding



	2010	2011	2012	2013
MTCT including Breastfeeding (%)	17	12.24	11.41	10.11

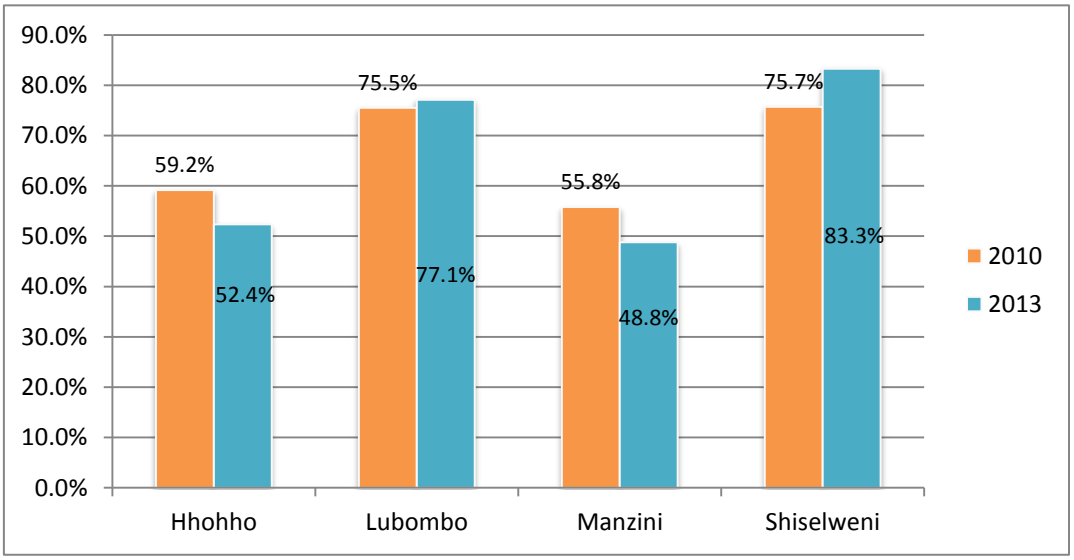
Source: Preliminary SPECTRUM Estimates and Projections (2013)

4.3 Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Since the 2011 Political Declaration, Swaziland has made impressive strides in the provision of HIV treatment services. Swaziland introduced the ART programme in 2003 to improve morbidity and mortality among people living with HIV. ART is provided for free to patients based on current national eligibility criteria of CD4<350. The country has limited options for second and third line therapy and the programme tries to ensure that there is greater adherence to the first line regimen. Data from the SAM shows a growth in the provision of ART services. In 2008, only 70 facilities provided ART services. The number increased to 114 in 2010 and 133 in 2013. Over and above the increase in the number of facilities offering ART services, decentralisation has been prioritised to contribute to the goal of ensuring services are accessible to closest possible location

Making ART services more comprehensive has resulted in the provision of Pre-ART services. With pre-ART, the goal is to ensure People Living with HIV (PLHIV) are kept in care and constantly monitored and initiated on ART when eligible. The 2013 SAM reports that out of the 252 health facilities in the country, 186 provided active management of HIV and AIDS (Pre-ART, ART and OIs). Of the 186, 90.9% (169) and 94.1% (175) provided pre-ART and clinical staging respectively. A critical part of ensuring comprehensive and high quality ART services are provided is ensuring a robust information system to capture programme data. In this regard, Pre-ART services have been strengthened through the development and dissemination of Pre-ART tools for data capturing. By the end of 2012, there were 38,164 Pre-ART patients enrolled, which is an improvement from a previous situation where there was no record of people on pre-ART services.

Figure 13: Availability of Pre-ART Services in facilities by Region, 2010 and 2013



Source: SAM 2013

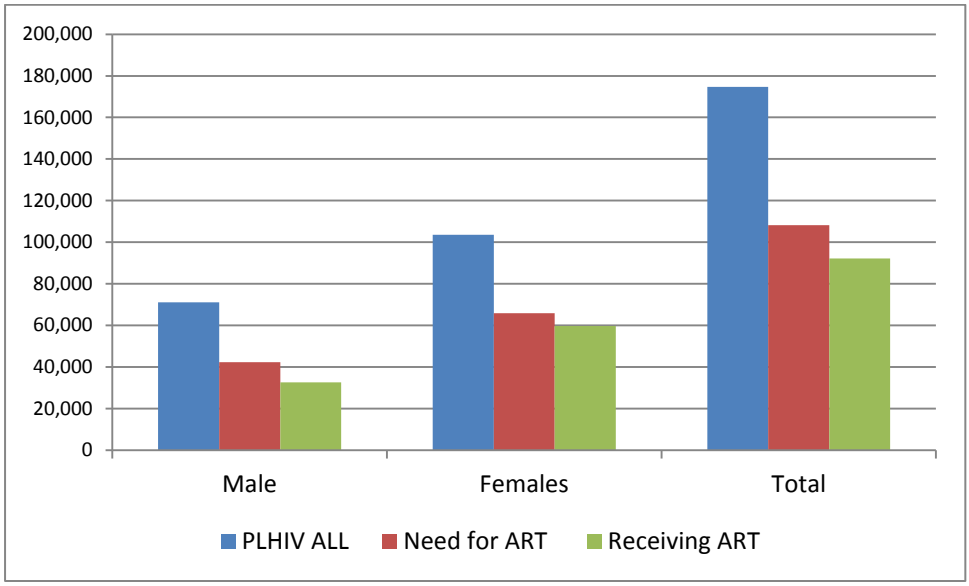
The decentralisation strategy for ART services is characterised by two features. Firstly, it includes increasing access to services by designating non-core treatment sites as re-fill points. The number of facilities providing ART initiation, and refill services increased by 16.8% from 107 in 2011 to 124 in 2012. By 2013, the SAM study estimates that 134 facilities offer these ART services. This represents a 20% increase from 2011. Secondly, it leverages the role of service providers through the nurse-led initiative, bringing more health care personnel into the role of initiating ART. According to the MoH 2012 ART Report, there were 15,438 clients newly enrolled on ART.

4.3.1 HIV treatment: antiretroviral therapy

Swaziland has adopted the 2013 WHO HIV Treatment Guidelines for ART initiation and clinical staging (500 cells/mm^3). The full roll-out of these guidelines is anticipated to commence in July 2014. For this reporting period, previous guidelines for clinical staging (350 cells/mm^3) are used. In 2008, the median baseline CD4 count at initiation was 90 cells/mm^3, while in 2012, this number increased to 200 cells/mm^3. This increase could be attributed to increased knowledge and less stigma associated with ART and overall, an increase in services making them more accessible. Data from the ART Programme shows that there were 100,138 people alive and on ART at the end of December 2013. Of the 92,249 adults on ART, 36,600 and 59,620 were males and females respectively. Using the 2013 Spectrum Estimates, this represents ART coverage of 85% for adults and 57% for children in need.

ART regimen distribution for Swaziland follows the WHO 2010 guidelines. Relatively, 1,213 adults were on 2nd line ART regimen in 2012 compared to 1,502 in 2011 representing 1.6% and 2% of all adults on ART respectively. The reduction in second line regime over the two periods is probably indicative of a reduced tendency to switch regimens. The exact reasons have not been researched and reported.

Figure 14: Percentage of adults currently receiving antiretroviral therapy among all adults living with HIV and in need of ART.



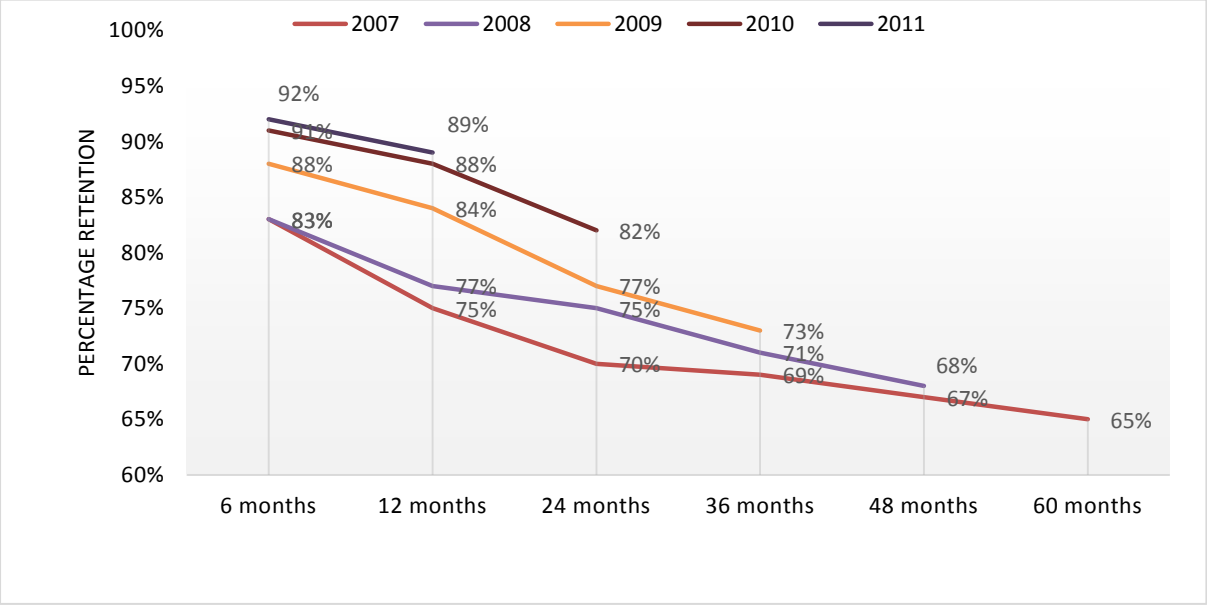
Source: Preliminary SPECTRUM Estimates and Projections (2013) and HMIS

4.3.2 Twelve-month retention on antiretroviral therapy

Patient retention is an important component of the ART service continuum. Part of the programme initiatives included the use of PLHIV as expert clients providing adherence and psychosocial support, augmenting tracing and defaulter efforts by facilities. Retention overall, provides a broad perspective of the quality of ART services.

In Figure 15 below, retention has improved from 83% in 2007 to 92% in 2012 in the first six months. Overall, the ART programme reports retention rate of 65% at 60 months. This is beyond the average of 60% retention at 12 months for Sub-Saharan Africa. The 2011 and 2012 cohorts exhibit a lower reduction in retention compared to the 2007 – 2009 cohorts that had a slightly higher reduction in retention rates. This is probably indicative of the changes made to the national treatment guidelines in 2010.

Figure 15: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy



4.4 Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

The Government's strong commitment to reducing TB-related mortality and morbidity is evidenced by the substantial investment in TB medicines and infrastructure. GeneXpert machines have also been placed in high volume clinics. Government has ensured procurement of equipment and human resources remain a priority as a safeguard against interruptions in the delivery of TB services.

The groundswell to prevent TB/HIV co-infection commenced in earnest in 2007 with the development of the National TB/HIV Co-infection Policy guidelines. The guidelines have provided clarity on the integration of services contributing to improved adherence to both treatments and synchronization in the drug pick up appointment for patients with co-infection.

The National TB report states that improved uptake of ART (66%) in TB clinics has contributed to a reduction of mortality from 18% to 9% (TB Annual Report, 2012). The report also highlights a sustained degree of high CTX provision among TB/HIV co-infected patients of between 95% and 98%.

4.4.1 Co-management of Tuberculosis and HIV treatment

Approximately 5,184 patients with TB were also co-infected with HIV in 2013. Of these 3,806 were placed on both TB treatment and ART, giving coverage of 73%.

4.5 Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries.

Reversing the AIDS epidemic is generally acknowledged as an effort that will require significant resources to be mobilised by both government and international partners. AIDS spending has long been recognised, as a marker of commitment, political will and support towards the HIV response.

Table 4 below shows trends in adjusted AIDS spending by categories for the period 2010 – 2013. Government spending has been on the increase in each successive year with the exception of the financial year 2011/12. Considering the dip experienced during that period, the recovery in the following years is remarkable – surpassing the 2010/2011 financial year. The bulk of government funding was on care and treatment. As alluded to earlier on in this report, one of the significant actions by the Government of Swaziland was the decision taken to finance the procurement of all ARVs – a huge undertaking on its own and a significant contribution to the overall costs reflected under the care and treatment line item.

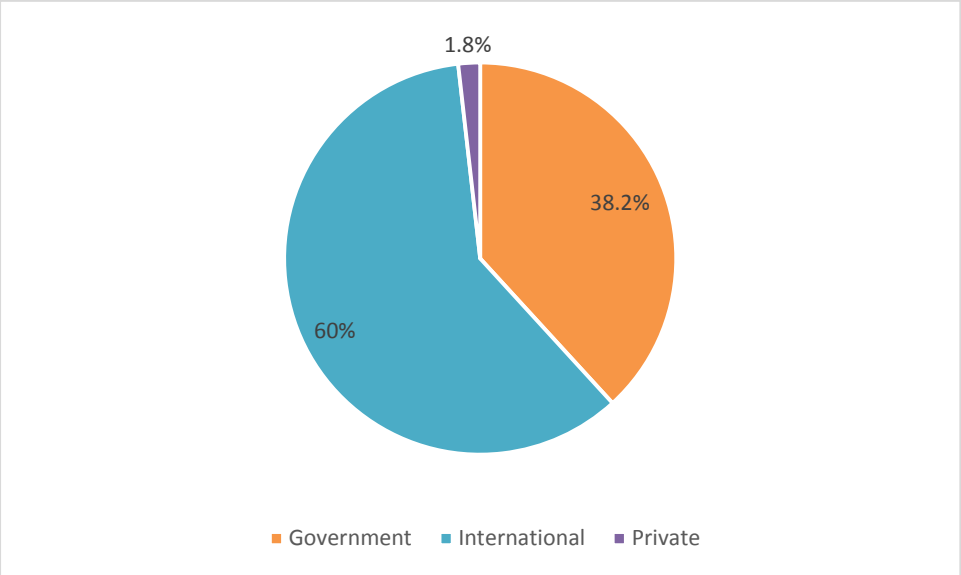
Table 3: Source of Funds and AIDS Spending Category (in '000 US$)

	Adj. FY 2010/11	Adj. FY 2011/12	Adj. FY 2012/13
Public	**30,878**	**26,453**	**33,155**
Prevention	**1,680**	**1,350**	**1,352**
Care and treatment	**22,365**	**20,102**	**26,023**
Programme management and administration	**6,833**	**5,001**	**5,780**
International	**55,864**	**56,116**	**63,776**
Prevention	**12,500**	**15,725**	**18,981**
Care and treatment	**25,358**	**20,322**	**25,340**
Orphans and vulnerable children (OVC)	**2,015**	**2,170,**	**2,555**
Programme management and administration	**12,725**	**14,892**	**13,773**
Human resources	**3,173**	**2,902**	**2,802**
Enabling environment	**33**	**15**	**49**
HIV-related research (excluding operations research)	**60**	**91**	**276**
Grand Total	**86,741**	**82,568**	**97,932**

Source: Resource Mapping Data 2013 (MoH)

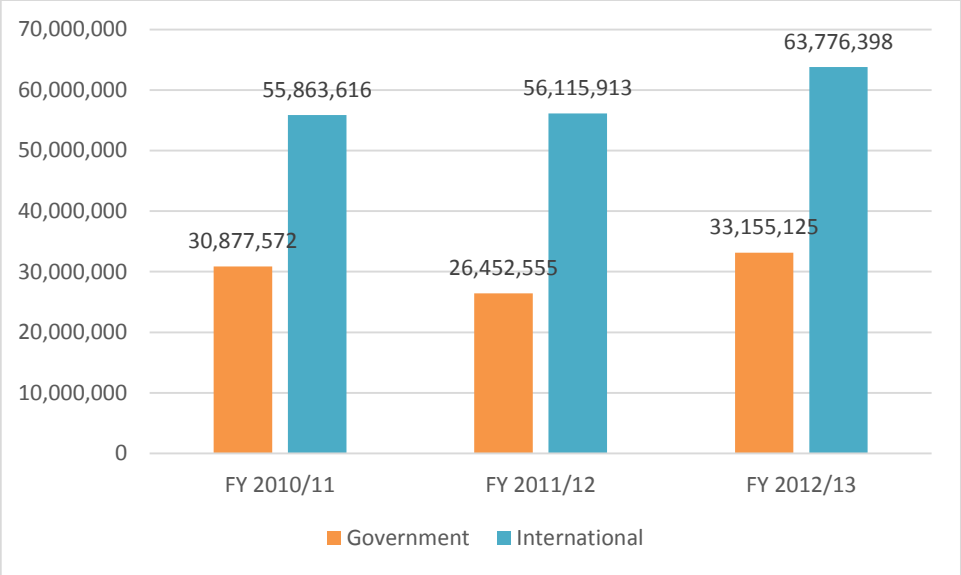
International funding closely follows government spending on care and treatment and supplements shortfalls in other areas. Overall, international spending has remained relatively constant even in the face of urgent calls for increased domestic financing and amidst flat lining of resources.

Figure 16: AIDS Spending Source of Funds (in US$)



Source: Resource Mapping Data 2013 (MoH)

Figure 17: Total AIDS Spending 2011 – 2013 (in US$)



Source: Resource Mapping Data 2013

The 2013 Mid-Term review of 'Ten Targets' of the 2011 UN Political Declaration on HIV and AIDS shows that Government has maintained resources committed for HIV and AIDS programmes, specifically highlighting programme areas such as procurement of ARVs, provision of HIV and AIDS services especially access to impact mitigation through education, food security and psychosocial support. These commitments happened amidst the fiscal crisis that the country experienced in the past four to five years.

4.6 Target 7: Eliminating gender inequalities

Swaziland has yet to conduct a nationally representative survey on Gender and related dynamics including gender-based violence. There are no data for this indicator for the reporting period.

Notwithstanding, the country has advanced the gender programme implementation platform in a number of ways. Political will to address gender and related issues is evidenced by the development and adoption of the National Gender Policy (2010). The Deputy Prime Minister's office houses a Gender and Family Affairs Unit, tasked with responsibility of coordinating and facilitating non-state actors' role in addressing gender. Between 2012 and 2013, Swaziland passed the Sexual Offences and Domestic Violence Bill and this has become law. On the GBV front, decentralization of social welfare services and development of the National Violence Surveillance System underpins continued efforts at strengthening systems and structures that facilitate programme efforts in addressing gender issues.

4.7 Target 8: Eliminating stigma and discrimination

The 2011 Stigma Index Report offers the most current data on stigma in Swaziland. In that report, internal stigma amongst PLHIV is relatively high, with 26% of sampled individuals citing feelings of guilt associated with being HIV positive, close to half (45%) not wanting to bear children as a result of their status and 22% stopping having sex.

4.8 Target 10: Strengthening HIV integration

4.8.1 Current school attendance among orphans and non-orphans aged 10‑14*

The figure below presents school attendance by OVC status. Compared to the 2007 DHS, the percentage of OVCs attending school has increased close to universal coverage (97.2%). While the proportion of non-OVCs attending school was lower in 2007, this proportion surpassed OVCs in 2010. Notwithstanding this, the high level of OVCs attending school is indicative of impressive levels of success of mitigation strategies in this area.

Figure 18: Current school attendance among orphans aged 10–14

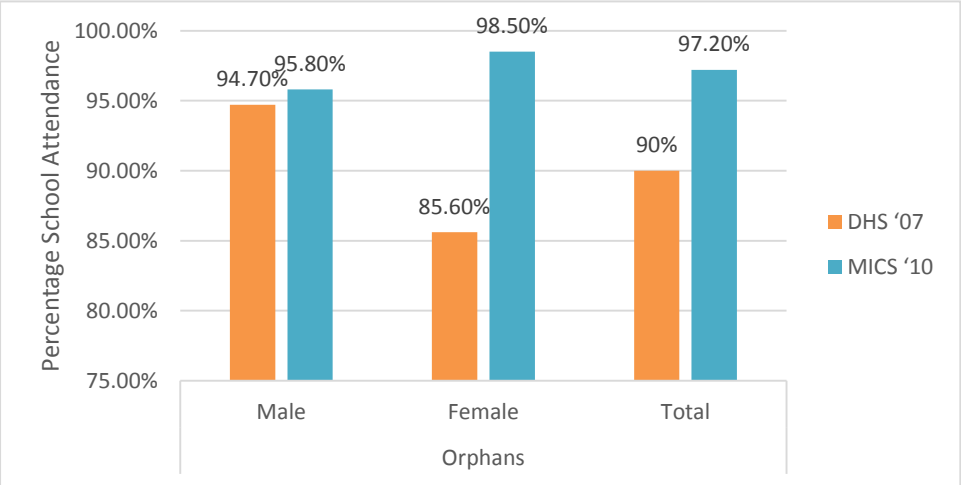
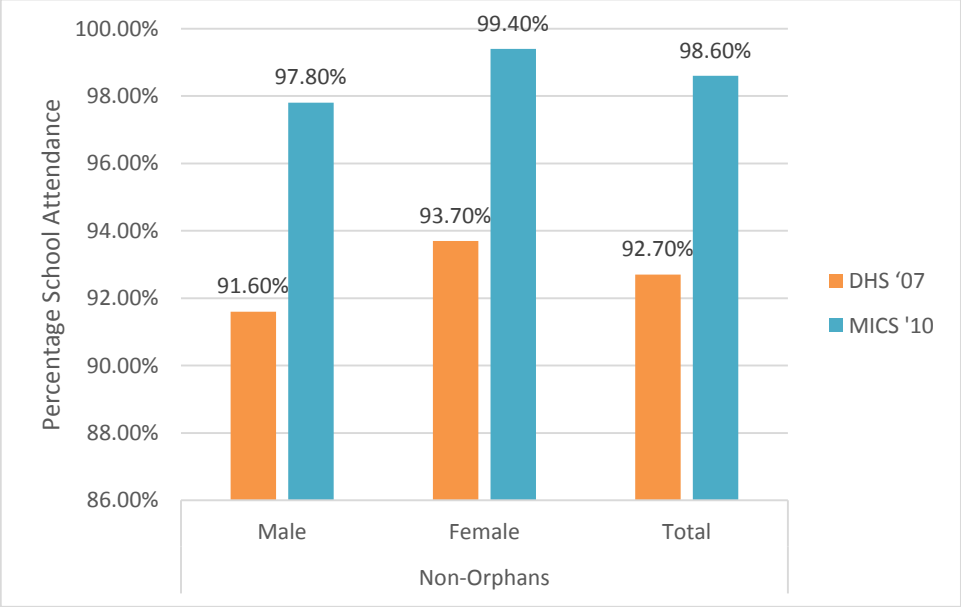


Figure 19: Current school attendance among non-orphans aged 10–14



5 Best Practices

The Kingdom of Swaziland remains committed to strengthening its response to the HIV and AIDS epidemic. This is demonstrated by a continuous development of innovative interventions at policy and programmatic levels, which have been initiated and further replicated at grassroots level.

The programs below have been identified as national best practices that reflect consolidated and innovative effort towards meeting national goals in HIV prevention, treatment, care and support and management of the response.

5.1 Leadership and political commitment

As part of the AU Roadmap on 'Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012–2015)' 's Pillar 3 on Leadership, governance and oversight for sustainability, the Government of Swaziland has continued to show commitment and leadership in the national HIV response. This has been shown through financing and procurement of all ARVs in the country despite the fiscal crisis the country experienced in recent years. Since the financial year 2009/10, the Government has financially supported the procurement of all ARVs in the country, and this continued commitment has been demonstrated in a recent budget speech for the fiscal year 2014/15 presented by the Minister of Finance to the House of Assembly, where an increase in the drugs budget was given. The country has endorsed the 2013 WHO HIV Treatment Guidelines, with ART eligibility threshold moved from CD4 ≤ 350 to ≤ 500 cells/mm³ with priority given to pregnant and breastfeeding women, children <5 years (regardless of CD4 count), TB/HIV co-infected and HIV/Hep B co-infected.

5.2 Adoption of the Investment Approach in HIV response planning

The development of the Extended National Strategic Framework (eNSF) adopted the new investment approach. This was critical as previous assessments of the national response that though the National Strategic Framework (NSF) adopted the results based planning approach; there were a number of structural and programmatic inefficiencies that could be minimized by adopting the investment approach. For example, the National AIDS Spending Assessment (NASA, 2011) revealed that 41% of total AIDS expenditure was spent on managing the response, with only 8% spent on HIV prevention. In terms of beneficiaries, the NASA revealed that 30% was spent on orphaned and vulnerable children. Adopting the investment approach in HIV programming will lead to better results for the HIV response, with a reduction in new infections and AIDS related mortality, as well as efficient use of available resources.

5.3 Strengthened TB/HIV co-infection programme

The country faces a dual epidemic of TB and HIV, wherein 80% of people who have TB are also co-infected with HIV. The collaboration of the TB and HIV programmes started in 2007. By 2012, over 90% of newly diagnosed TB patients are tested for HIV, over 60% of co-infected TB patients receive treatment for both and the death rate has been halved from 18% to 9%. The programme has been able to achieve this through *TB/HIV services that have been decentralized and integrated* in both programmes to provide a 'one stop shop' approach for TB screening, HIV testing and synchronized drug pick up. There is also improved diagnostic capacity for MDR TB with the roll out of XpertMTB/RIF (GeneXpert) and Line Probe Assay technology.

5.4 Task shifting/sharing

Since its inception in January 2010, Swaziland has implemented a task sharing/shifting strategy, where nurses have been trained to also initiate patients on ART. The nurse led ART initiation has seen a tremendous reduction on the patient load faced by doctors. The continuous capacity building of health care workers in various areas of PMTCT and paediatric HIV and improved management of labour and delivery at the primary health care clinics as part of its decentralization of health services has been enhanced .As a result, more patients are initiated on treatment and 110/265 health facilities are now accredited to provide treatment, from 31 facilities in 2009. This has also improved service delivery integration at all levels. According to the MoH ART 2012 report, there were 15 438 clients newly enrolled on ART reflecting an 8.1% reduction in ART initiations compared to 2011 (16 695). This increase is attributed to such initiatives.

6 Major Challenges and Remedial Action

6.1 Progress made on the challenges reported in the 2012 Country Progress Report and the Mid-Term Stocktaking Report 2013

Table 4: Progress made on challenges reported in the 2012 GARP Report

Challenge reported during last reporting period	Remedial action proposed during reporting	Progress to date
1. Government Fiscal Crisis Threat	An extensive resource mobilisation campaign for the national HIV strategy to be undertaken.	-beginning FY2013/14 Government has increased the allocation for the health sector and in particular for the purchase of antiretroviral therapy (ART). -An HIV response financial sustainability strategy is being developed. - The eNSF has been costed and programme efficiency analyses will be undertaken to make programmes less costly. -an HIV fiscal sustainability paper has been developed which reflected that the response in Swaziland cannot be sustained without external support.
3. Limited condom availability at rural communities	Condom distribution to be expanded through community-based institutions and condom management systems strengthened.	In progress. Condom management systems are being strengthened. Through funding from UNFPA, an M&E officer has been employed to streamline reporting and data management for condoms and reproductive health commodities.
4. Limited capacity to undertake research and absence of National HIV Research Agenda	Develop an HIV research agenda and develop research capacity	A National Research Agenda has been developed and adopted with the official launch scheduled early 2014. In the Strategic Information department of the MOH, the research unit has a full-time position of national research manager for the MoH.

6.2 Challenges reporting in the current reporting period

6.2.1 HIV response does not address structural drivers of the epidemic

Issues of high unemployment, especially among the youth and women, poverty alleviation and stigma and discrimination do not have mitigation plans within the HIV response. The effects of these are seen in the increasing number of young women aged 15-24 who engage in intergenerational sex and the suspected increases in transactional sex to supplement low incomes. Issues of Stigma and discrimination reduction are discussed but not prioritised

Remedial Action

Strengthen HIV response programmes to address structural issues that have bearing on HIV and health outcomes.

6.2.2 Weak mainstreaming of HIV and AIDS in corporate and Government sector operations

Although all government ministries have been oriented to mainstream HIV and AIDS within their sectoral mandate, only the Ministry of Health, Education, Agriculture and Deputy Prime Ministers Office have been able to mainstream HIV into their sectoral plan and budget.

Remedial Action

Develop a mainstreaming programme and build capacity for mainstreaming in the development sector.

6.2.3 Lack of an Integrated Database for HIV Programmes

Even though the SHAPMoS is widely known, there is need to create an integrated database with the Health Management Information System managed by the Ministry of Health and, tracking clients' referrals across the health sector remains weak. As a result, clients are often lost in the health system.

Remedial Action

Create an integrated HMIS database to track clients' referrals and programme managers in the health sector should commit to making the patient tracking system a success.

6.2.4 Inadequate policy environment for improving nutrition for all vulnerable children and PLHIV

Emphasis is placed on food distribution as opposed to food security to enable vulnerable persons to generate own food. There is weak coordination of the many leaders in the programme 1) The Ministry of Health coordinates national nutrition standards as prescribed in the National Guidelines on the Integrated Management of acute malnutrition. 2) Ministry of Education coordinates the distribution of food to schools, 3) the DPM's Office coordinates food distribution at communities and 4) Ministry of Agriculture coordinates the distribution of agricultural inputs. Non-governmental organisations manage the distribution of food to Neighbourhood Care Points (NCPs) and Swaziland Network of People Living with HIV and AIDS (SWANNEPHA) distributes food to PLHIV.

Remedial Action

Strengthen the coordination of food security and nutrition programmes.

6.2.5 Poor programme coordination and low capacity for programme development

This leads to poor quality of some services, inadequate coordination and sustainability concerns.

Remedial Action

Build capacity for programme development.

7 Support from the Country Development Partners

7.1 Key Support Received from Development Partners (DPs)

Development partners supporting the Swaziland HIV response have continued to show commitment, with close to 60% of all funding coming from external sources. The major sources of this external funding during 2012 and 2013 were the United States Government through the President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund, UN Agencies, other bilateral partners including the European Union, World Bank, Netherlands, United Kingdom and Japan and International NGOs (Clinton Health Access Initiative (CHAI), World vision, MSF) as shown in the commitments in the table below:

Table 5: International Sources of HIV Funding

Partner (Figures in $'000)	2012	2013	Total reporting period
Global Fund	5,640	7,072	12,712
PEPFAR	40,995	32,700	73,695
UN Agencies	2,437	1,584	4,021
Bilateral	2,247	2,724	4,971
International NGO	15,544	15,911	31,455
Loans	2	203	205
Total International HIV Funding	**66,865**	**60,194**	**127,059**

Source: Swaziland HIV Resource Mapping and PEPFAR Expenditure Analysis

Development partners in Swaziland subscribe to the five principles outlined in '*The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*'. Development of the National HIV and AIDS Strategic Framework (NSF) is led by NERCHA, with involvement and participation by other government departments, civil society organisations and development partners. This is the guiding document for all HIV responses in the country, with development partners aligning their own strategic documents to the NSF. The UN for example, ensures that the UNDAF is fully aligned to the NSF when it comes to the UN's support to the HIV response.

Harmonisation of development partners' efforts is an on-going process, with different approaches bring used to enhance this. Through the national AIDS spending assessments for example, NERCHA has been able to use these findings to engage development partners on the gaps in financing for the national response. The National M&E systems are the authoritative systems used by all partners in the response, with partners aligning their indicators and tools to these systems. The National M&E Systems used for tracking progress in the HIV response are the HMIS and SHAPmos.

7.2 Actions for development partners to ensure achievement of HIV response targets

Development partners need to continue to;

- Align their support with the objectives of the eNSF and work with NERCHA to identify funding gaps in the eNSF.
- Undertake coordinated resource mobilization for the eNSF in collaboration with the Government of Swaziland and NERCHA and share information to avoid duplication.
- Make themselves accountable to their commitments/pledges and support the country to improve its absorption and efficient use of funds.
- Align their monitoring systems to the National HIV M&E System managed at NERCHA and the HMIS managed at the Ministry of Health and report on their financial expenditure through the National AIDS Spending Assessment (NASA) every second year.
- Build capacity of the country to develop innovative domestic financing mechanisms.

8 Monitoring and Evaluation Environment

The national HIV and AIDS Response Monitoring and Evaluation System is based on the principle of the "Three Ones", one coordinating body, one national strategic framework and one monitoring and evaluation system. The national M&E system is designed to provide policy makers and planners with up-to-date reliable data on HIV interventions in the country.

The Swaziland HIV/AIDS Program Monitoring System (SHAPMoS), a recurrent data collection system, is in place to collect and report timely, reliable, quality assured data on HIV activities that are being carried out by all health and non-health HIV implementers. The HMIS from the Ministry of Health also provides useful information on the HIV response, feeding into SHAPMoS. The system was reviewed in 2012/3, and is being revised to account findings from the review.

The geographic information system (GIS) is in place to show spatial coverage of service demand and supply. The country is able to undertake national surveys on episodic basis. The most recent survey is the Swaziland HIV Incidence Measurement Survey which reported HIV incidence by gender and age. It also revealed the average viral load among people living with HIV as very high.

The country is in the process of developing the HIV research function at NERCHA. A draft HIV research agenda has been developed. The M&E Technical Working Group (M&E TWG) coordinates the implementation of the M&E system.

Challenges faced in implementation of system and their proposed remedial actions are shown in table 7 below.

Table 6: M&E System challenges and remedial action

No#	Challenge	Remedial Action	Responsible entity
1	**Absence of M&E function and personnel** in sectors and implementers: reliance on volunteers or staff with another core function	-develop and fill in M&E positions for all HIV implementers, Sectors and development partners	-HIV implementers -Sectors -Development Partners
2	**Low reporting to SHAPMoS**: Despite numerous training of implementers on M&E, existence of an agreed upon M&E framework, a culture of reporting still needs to be inculcated. Reporting by partners is not at the expected level of 100%.	-develop reporting compliance requirement in operation instruments (MoUs) -devise innovative methods of retrieving data from implementers.	-NERCHA -Development Partners -MoH -CANGO

3	**Low quality of routine data and management**:- Some implementing partners do not keep registers, there are quality issues among those that do and in most instances routine data is not fed back for timely decision making.	-Build capacity for M&E from the national office at NERCHA, sector level and at community level. -undertaken regular data audits. - implement M&E Advocacy sessions with Senior managers.	-Technical Assistance -NERCHA -MoH -HIV Sectors
4	**M&E system does not inform all indicators in the NSF and eNSF results Framework**	-review M&E system to incorporate all indicators that are required to track progress towards meeting NSF and eNSF objectives.	-Technical Assistance -NERCHA -MoH -CANGO
4	**Weak programme evaluation**: during the reporting period only the PMTCT programme has been evaluated.	-Build capacity for programme evaluation.	Technical Assistance -NERCHA -MoH -HIV implementers
5	**Uncoordinated researches:** In the absence of an operational research agenda, researches conducted are not coordinated and their findings not used in policy and planning.	-Build capacity for research coordination	-Technical Assistance -NERCHA -MoH