

PROGRAMME COORDINATING BOARD FIELD VISIT | 14-16 November 2017

UNAIDS PCB Field Visit to Swaziland

I) Summary:

A delegation from the UNAIDS Programme Coordinating Board (PCB) undertook a field visit to Swaziland on 14-16 November 2017.

The delegation included members from Belarus, Ecuador, Ghana, Madagascar, United Kingdom, and the United States, as well as the PCB NGO Delegation and UNAIDS Cosponsors, participating from the global, regional and national levels. The Ambassador of Swaziland to the United Nations in Geneva, H.E. Mr Zwelethu Mnisi, also participated in the visit. The delegation met with a range of stakeholders engaged in the response to HIV in Swaziland.

The delegation met with the Deputy Prime Minister, the Minister of Health and the Minister for Economic Development as well as senior officials from the Ministry of Health, National Emergency Response Council on HIV and AIDS (NERCHA), as well as development partners, the UN country team, civil society with a focus on youth and affected populations and the private sector, including private sector companies engaged in the response in Africa.

The visit was a valuable opportunity for Board representatives to observe the AIDS epidemic and the HIV response of a country with a very important epidemic and an adult HIV prevalence rate of some 27 percent.

The visit also served to demonstrate the value of the integrated multisectoral support provided by the Joint Programme through the Joint Team to the national AIDS response, in the context of support for overall development efforts from the UN Country Team (UNCT) led by the UN Resident Coordinator.

Key issues addressed during the visit:

- Swaziland has a unique HIV response as it builds on cultural strengths and draws on these for an effective response;
- There is political support at highest level, ever since the King's announcement of HIV as an emergency situation. This highlights the importance of leadership of HIV coordination driven from the Prime Minister's Office, as well as the leadership from the Ministry of Health and other ministries;
- Scale-up of treatment and early adoption of 90-90-90 target have been a game changer in the response – and have been key to considerably diminishing HIV

incidence by an impressive 44 percent since 2011 despite indication of decreasing knowledge of HIV amongst young people and increasing stigma around HIV;

- HIV Incidence is equal across age groups – but gender disparity is marked amongst the younger age groups with young women up to 6 times more likely to be HIV positive than their male peers;
- Sustainability of the response with a high number of people on treatment remains an issue and a sustainability transition plan is required with a strategy for reducing dependence on external financing;
- The disproportionate impact on young women and girls needs address:
 - Inter-generational sex
 - Decreasing knowledge of HIV
 - Lack of female-controlled prevention technologies
 - Disclosure of HIV status highly sensitive despite a 27 percent adult prevalence rate
 - Condomize – many young people do not use condoms, as only condoms with flavour are of interest. Those provided stay unused and there are no condoms for the age group of 11-13 years old
- Funding of community programmes, in particular for prevention is quite limited, and these will be critical for the next phase of the response with more focus on bringing down HIV incidence by primary prevention, including condom use;
- Programmes that ensure that a positive HIV test leads to treatment initiation and adherence, as well as consistent condom use to protect partners, are critical, but these can only be successful if the sensitivity on disclosure of HIV status is addressed – champions as chiefs and vocal positive youth leaders in each community are key;
- The contribution of the private sector in terms of service delivery has been important, in particular the corporate social responsibility demonstrated by some of the major companies has been key for the roll out of treatment for staff, as well as the surrounding communities. This must be built upon for scaling up HIV prevention;
- Getting men to test and into care, as well as staying in care still represents a challenge;
- Sexual and gender-based violence remains an issue that has very little coverage in the public space and needs to be brought out.

II) Background

The PCB field visit to Swaziland provided a valuable opportunity to understand the particular challenges of the AIDS response in the country with the highest adult HIV prevalence rate at some 27 percent.

The Kingdom of Swaziland is a landlocked country in Southern Africa with a land area of approximately 17,000 square kilometres. The climate favours the cultivation of both subsistence and cash crops. The majority (79%) of the population lives in rural areas and is dependent on subsistence farming. Swaziland has an estimated population of 1,287,000 people. Approximately 44 percent of the population is under 15 years of age. Declining fertility levels, coupled with a rising rate of mortality, have been responsible for the low annual rates of population growth.

Swaziland has a monarchical system of government with His Majesty King Mswati III as Head of State and a Prime Minister as the Head of Government. The government is made up of the Cabinet and Parliament whose members are elected and appointed. The administrative system is made up of a combination of a traditional Tinkhundla system and western-based administrative organization. The administrative structure consists of various sectoral Ministries headed by Ministers while the Tinkhundla system is built on chiefs and chiefdoms and provides a foundation on which government anchors and decentralizes implementation of its policies and strategies.

Swaziland is classified among the lower middle-income category of countries. The country exports particularly sugar, textiles, soft drink concentrates, canned fruit and citrus fruits. However, the global economic crisis, incidences of depression of prices in the agricultural sector, persistent drought, climate change, and the impact of HIV on human capital over the past two decades have compromised the country's ability to implement policies in the social sector of health, education, water and sanitation and rural development. The economic growth rate declined from an average of 10 percent in the 1990s to 3 percent in the last ten years.

III) Objectives of the Programme Coordinating Board visit to Swaziland

The goals and objectives for this field visit were to:

- Observe the realities of the epidemic and response in a highly generalized epidemic of a high impact country;
- Demonstrate the value of an integrated, multi-sectoral response and the role of UNAIDS-led UN Joint Team in support of the nationally-owned response;
- Demonstrate successful approaches in the AIDS response, including the critical importance of strong political leadership at the highest level, global solidarity in the response, a strong service delivery role of the private sector; and the unique role of the Joint Programme in bringing together government, development partners and civil society around the same national priorities; and
- Enable delegates to report back to the PCB on the work of the Joint Programme at country level.

IV) The HIV epidemic in Swaziland

HIV and TB have imposed by far the largest burden of disease on the population. HIV prevalence among 15-49 year olds is currently estimated at 27.2%. The rate is higher among women (35%) than men (20%) and prevalence in women peaks at 58% among women aged 35-39 years. However, the disparity in HIV prevalence by sex is most pronounced among young adults: HIV prevalence among 20- to 24-year-olds is six times higher among females than males.

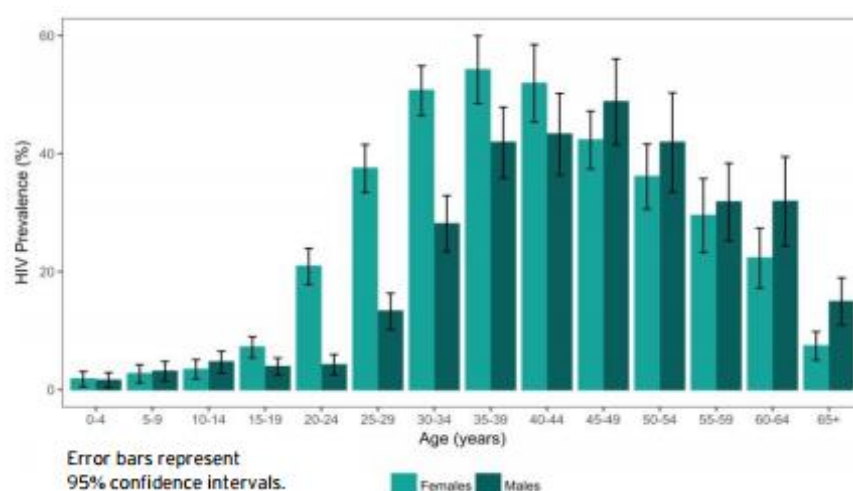
Unsafe sex practices, inter-generational sex, multiple concurrent partners and misconceptions about HIV transmission account for high levels of HIV prevalence among young persons, pregnant women and other population groups. The high prevalence of HIV and recent projections showing continuing new infections are most likely influenced by misconceptions of HIV among young people (only 54% have comprehensive knowledge).

These facts underline the importance of reaching out more effectively to young people with correct information and better methods of engaging them. Counselling, testing and receiving results is lowest among the youngest age group (age 15-19 years). Current data indicates that there is still a significant proportion (about 30%) of those who had sex with more than one partner who did not use a condom.

Annual incidence of HIV among adults ages 15 years and older in Swaziland is estimated at 1.52 percent: 1.82 percent among females and 1.24 percent among males. This corresponds to approximately 8,100 new HIV infections annually.

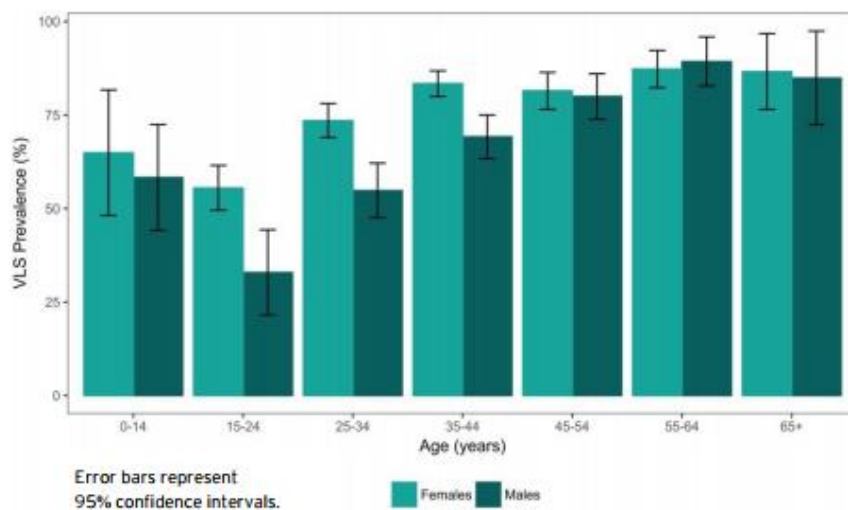
However, the latest survey data from the Swaziland HIV Incidence Measurement Survey (SHIMS, July 2017) revealed remarkable progress. Since the first survey in 2011, new infections fell by nearly half (44 percent), and viral load suppression among people living with HIV more than doubled.

The SHIMS survey also estimated the prevalence rate of viral load suppression (VLS) among HIV-positive adults ages 15 years and older in Swaziland to be 73.1 percent: 76.0 percent among females and 67.6 percent among males.



Viral load suppression (VLS) among HIV-positive people, by age and sex

The SHIMS also provided data on viral load suppression (VLS). While VLS is generally quite high, young people (under 24 years old) are significantly less likely to be virally suppressed. Prevalence of VLS among HIV-positive people in Swaziland is highest among older adults: 87.3 percent among HIV-positive females and 89.3 percent among HIV-positive males ages 55 to 64 years. In contrast, prevalence of VLS is lowest among younger adults: 55.5 percent among HIV-positive females and 32.9 percent among HIV-positive males ages 15 to 24 years.



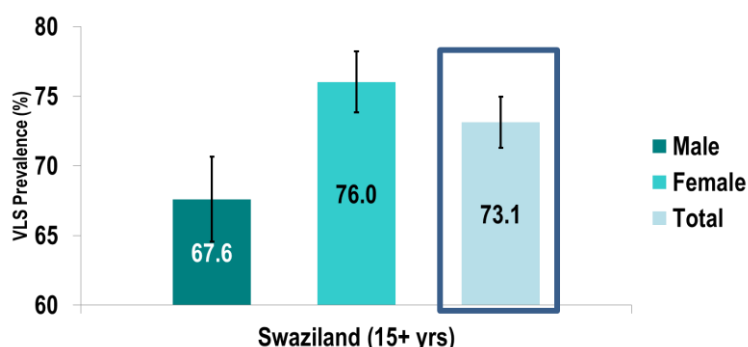
Achievement of the 90-90-90 Goals among HIV-positive adults, by sex

Data suggest that significant gaps remain in treatment cascades for men, youth and key populations.

Diagnosed: In Swaziland, 84.7 percent of PLHIV ages 15 and older report knowing their HIV status: 88.6 percent of HIV-positive females and 77.5 percent of HIV-positive males know their HIV status (SHIMS2, 2016).

On Treatment: Among PLHIV ages 15 and older 80 percent were receiving ART at the end of 2016: 85 percent of HIV-positive women and 72 percent of HIV-positive men were receiving ART. (UNAIDS 2017)

Virally Suppressed: Among PLHIV ages 15 and older who selfreport current use of ART, 73 percent of people living with HIV are virally suppressed: 76 percent of HIV-positive women and 68 percent of HIV-positive men are virally suppressed.

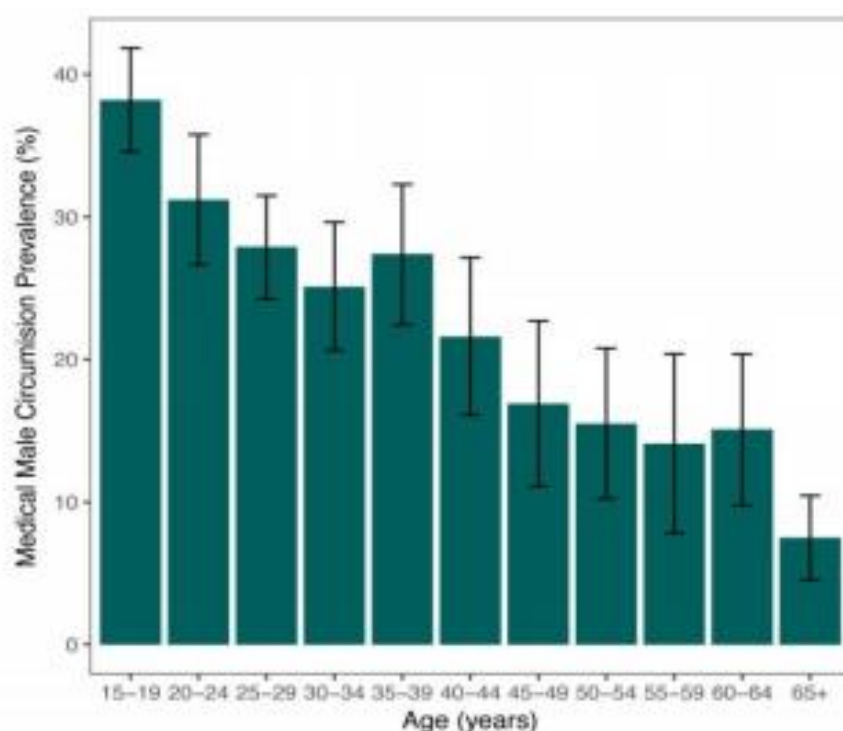


* Denominator is all PLHIV with viral load results (irrespective of awareness of HIV-positive status and ART status)

Source: SHIMS

Voluntary medical male circumcision and HIV prevalence among adults males by sex

Among males 15 years and older, prevalence of medical circumcision is 26.7 percent. Prevalence of medical circumcision decreases with age, from 38.2 percent among 15- to 19-year olds to 7.5 percent among males 65 and older. One out of three 15- to 24-year old males is circumcised (34.8 percent), compared with one out of five males ages 25 years and older (21.9 percent).



Prevention of Mother to Child Transmission (PMTCT)

Modelled estimates suggest an HIV prevalence rate of 33% among pregnant women. Over time, the PMTCT programme has been providing near universal HIV testing among pregnant women in Swaziland. According to the 2013 Service Availability Mapping, more than 80% of health facilities are providing PMTCT services. Yet, there are 13 antenatal care sites which do not offer ART.

In the absence of intervention, mother to child transmission of HIV (MTCT) significantly contributes to the number of new HIV infections in a population. In a national survey conducted in 2013 in which about 2,000 women participated, 724 known HIV-exposed children 18-24 months old were identified and HIV transmission rate was determined to be 3.6% (95% CI: 2.3-5.25). This programmatic transmission rate is an underestimate of the true transmission rate as about half of all children infected with HIV at birth will die before their second birthday. Those children who passed away would not have been captured in

this estimated transmission rate. Modelled estimates suggest the vertical transmission rate in 2016 was 6%.

Data from the PMTCT program show that 8,730 infants were exposed to HIV in 2015 and of those 8498 had DNA PCR test at 6 weeks, and 122 were found to be HIV infected (about 1.44%). Available data show that the programme-level MTCT rate at 6-8 weeks increased from 2.0% in 2013 to 3.0% in 2014 and has since remained the same. Models estimate that the final transmission rate after breastfeeding was 6% in 2016. This increase among many other causes may be suggesting problems with adherence. There are reports elsewhere that pregnant women still in good health may not adhere to treatment after delivery of the baby. This may increase the risk for postnatal HIV transmission through breastfeeding as well as transmission among women who seroconvert during breastfeeding.

The priority strategies for PMTCT in the health sector as articulated in the “Health Sector Response for PMTCT” and the “2011-2015 Elimination Framework” are aligned to the four-pronged approach defined by the World Health Organisation. These are:

- Prong 1: Keeping HIV-negative women from acquiring HIV infection in the first place;
- Prong 2: Integrating Family Planning (FP) into ART and labour and delivery sites to reduce the unmet FP need among HIV-positive women;
- Prong 3: Improving the quality of care especially during Labour and Delivery; and,
- Prong 4: Standardising comprehensive care for HIV positive mothers and their HIV-exposed infants.

The PMTCT programme, now referred to as the programme for “Elimination of New HIV Infections among Children and Keeping their Mothers Alive”, is one of the priority programmes outlined in the Swaziland 5-year Health Sector Response to HIV and AIDS Plan (2014-2018). The PMTCT programme transitioned from short course ARVs (Option A) for HIV-positive pregnant women to Lifelong ART for Pregnant and Lactating women (Option B+) upon adoption of the 2015 WHO guidelines.

V) PCB Field Visit activities

Meeting with the Resident Coordinator and the UN Country Team



The 'Joint UN Team on AIDS' in Swaziland is composed of technical members of specific UN agencies participating in the AIDS response and convened by the UNAIDS Country Director. Currently, there are ten agencies in the team, which are UNICEF, UNDP, UNFPA, UNESCO, UNODC, WFP, WHO, FAO and UNAIDS Secretariat. The World Bank and UN Women engage from their offices in South Africa and the ILO has been supporting private sector programmes from their office in Zimbabwe. The UN Joint Team works under the guidance and overall leadership of the Resident Coordinator.

Key issues discussed with the country team included:

- The challenges of keeping AIDS high on the political agenda and ensuring sustainability of the financing of the response;
- The key role of the UN in supporting the development of a new focused, multi-stakeholder national AIDS strategy;
- The UN's particular role to play in ensuring sensitive political issues and the multisectoral dimension of the response are addressed through its strategic policy advice and working across pillars;
- Technical and policy support of the UN is an essential part to the AIDS response in Swaziland.;
- The challenge to ensure Comprehensive Sexuality Education in and out of school;
- Gender-based violence has been largely invisible but reporting of cases is now picking up;

- Health systems are weak in terms of human resources;
- Joint UN Team on AIDS has moved things forward –Prioritization is set through a consultative process – keeping in line with government plans – then the allocation of country envelopes by priority area and subsequently dividing tasks depending on comparative advantage within the Joint Team;
- There are high levels of teenage pregnancy – being addressed by programmes to keep adolescent girls in school;
- Key populations in Swaziland: the ‘health for all’ perspective can be understood by all - police and health workers have been targeted for training – but there is still a need to destigmatize the issue of key populations (size estimates are done for MSM and sex-workers)
- How to support PLHIV not to be stigmatized? It is important to understand and respect culture before – building trust and respect to be able to address sensitive issues;
- The Minister of Health is very strategic – using the ‘health for all’ angle and labelling Comprehensive Sexuality Education as “life skills” while keeping the full content.

Meeting with the Minister of Health, Senator Sibongile Ndlela-Simelane



The meeting of the PCB delegation with the Minister of Health of Swaziland was an opportunity for the delegation to discuss with the Minister the importance of political leadership in the response, cross-ministerial engagement, collaboration with the Joint Programme to ensure ongoing political commitment, as well as collaboration with civil society partners and the private sector.

It was also an opportunity to understand the history of the response in Swaziland since their Majesties declared HIV an emergency. This was the point when the response took off and chiefdoms, government, religious and cultural groups had to engage in it. HIV Programme coordination was placed in the office of the Prime Minister, which is where all coordination now takes place, including the financial aspects.

During the discussion the following issues were underlined:

- The importance of His Majesty consistently addressing HIV in his annual speech to parliament;
- The use of culture in the response to ensure a dialogue with young girls on when to start sexual activity – it is not attempting to change initiation of sexual activity but support them in making sound choices;
- The use of culture also means finding a way of protecting people from HIV in a polygamic setting rather than making value statements about polygamy;
- The chiefs of the country's 366 chiefdoms are required to report on people knowing their status in the chiefdom;
- It is important that political will is made practical to achieve Swaziland's ambition of eliminating new infections by 2022 and a reporting tool is in place to measure progress;
- The Ministry is partnering with civil society and has given an additional space to civil society service delivery. It is not about "task shifting" – but rather "task sharing";
- The Ministry is looking at how the model for HIV can be used for NCDs, for instance ongoing work on tasks that doctors can share with nurses on diabetes;
- Investing in adolescent young women and boys is key – and looking at all individuals as clients;
- Size estimates of key populations have been essential to communicate to the Swazis that key populations do exist in Swaziland and that even sex work is quite frequent. But a two-pronged approach is needed with advocacy and services for all, subsequently looking at policy and legal issues;
- Constitutionally, every Swazi has the right to services.

Meeting with Deputy Prime Minister Dr Paul Dlamini



The meeting of the PCB delegation with the Acting Prime Minister was an opportunity to understand what it has meant for the response in Swaziland to be coordinated at the highest political level and how central the AIDS epidemic and the response to it has been to all aspects of development of the country in the past decades.

The Acting Prime Minister declared his gratitude to the PCB and UNAIDS for the visibility provided to some of the best practices that Swaziland has demonstrated in the HIV response. He stressed the importance of the King's decisive action since 1999 as the real game changer in the response, when Swaziland was known globally as the country with the highest HIV prevalence and AIDS still the leading cause of morbidity and mortality – known as a nation on the edge of extinction.

Issues that came up during the meeting and at the following meeting with the Press included:

- Coordination in the office of the Prime Minister rather than the Ministry of Health has been key to fostering the multisectorality of the response;
- The King called upon the Prime Minister to establish the coordination mechanism in the office, which became NERCHA;
- Swaziland is celebrating remarkable results, in particular in terms of rolling out access to HIV treatment, attaining viral suppression of 90% of people on treatment and will soon celebrate the achievement of the 90-90-90 targets;
- The nation remains committed, but it is important to stress that success would not have been possible without global solidarity of loyal partners;
- UNAIDS has been setting course for ending AIDS – thanks to the vision of the Executive Director and the UNAIDS Office in Swaziland is one of the Government's strongest allies in the response.

Meeting with civil society and networks of people living with HIV



The delegation's meeting with a broad set of civil society actors ranging from youth networks to faith communities and religious leaders, was an opportunity to see the broad engagement of civil society in the response in Swaziland and to discuss platforms for coordination of civil society interventions, champions in HIV prevention in and out of school and how civil society sees culture used in HIV prevention.

The civil society organizations participating included: The Alliance of Mayors' initiative for community action on AIDS, Church Forum, Family Life Association Swaziland, Swaziland Network of People Living with HIV, Super Buddies Club, World Vision, youth networks, as well as the CANGO Secretariat, which facilitates coordination of the NGO sector in Swaziland with a specific consortium on HIV and AIDS.

Issues that were brought up during the discussion, included:

- The curriculum of “life-skills” training that the Ministry of Education is rolling out has NGOs and the Ministry of Health cooperating on different sessions, including a stepping stone manual for out-of-school children – the pilot phase has been running for two years now;
- The objectives are to increase knowledge, knowing risks, facilitate decision-making, getting tested and if positive enrolled in treatment;
- Within the education settings there are a number of barriers as condoms and sexual and reproductive health services are not easy to access for young people even if students are sexually active;
- DREAMS also include services outside school systems which children can access;
- Peer to peer programs are essential, where youth and teen clubs exist and include peer facilitators with training. They are making an impact;
- Disclosure of HIV status is still an issue, and stigma around HIV positive status means that many engage in sex without using prevention, as condoms are associated with being HIV positive;
- Programming this far has not targeted young people and 20,000 young people are living with HIV – in particular young people in rural areas;
- Resources are lacking for prevention as significant budgets are spent on treatment
- The recent Global Fund proposal only contains USD 4.5 million for prevention out of a USD 49 million grant;
- STI trends continue to show increasing numbers as young people are taking condoms but not using them;
- The types of condoms available is also a major issue – young people only want to use flavoured condoms meaning a lot of the standard condoms are unused;
- The organizational work of networks of PLHIV are largely not funded in Swaziland – aside from a few grants from external sources;
- There is an urban/rural divide and within the Manzini and Mbabane perimeter: the “90-90-90” concept is understood inside – but not outside;

- The Prep agenda requires PLHIV involvement. Pilots are ongoing but only with tokenistic involvement of civil society;
- Of importance is how civil society works together and speaks with one voice when speaking to government and development partners;
- Civil society partners appreciate the political lobbying of UNAIDS – with the King and the Prime Minister – this has been critical for the HIV response in Swaziland;
- Mobile men and young women and girls has been largely unaddressed – there are a few cross broader initiatives to target executives and young women;
- The use of culture in prevention is important. Swaziland has a traditional event for all young ladies – the “red dance” – this was previously used for messages to avoid early pregnancy but is now used for broader SRHR messages; For young men there is a tradition to cut in a tree to pass messages on delaying sexual debut, but this is now combined with messages on condom use and distribution;
- Another issue that needs to be further addressed is the gap in adherence to treatment of adolescents living with HIV;
- Community representatives feel that that Global Fund grants are skewed towards clinical initiatives – moreover clinics are not equipped to target young people, so they are left behind;
- Test and start has been rolled out with limited information on issues as viral load suppression etc. – it is left for communities to do treatment literacy to reach 90-90-90, but no funding is allocated for this role;
- The prevention agenda needs to be placed with communities – if people do not have information they will not access services: condoms, Prep, testing or treatment – the bridges between programmers do not exist and funding is not allocated for it;
- Young people are still at highest risk: they use drugs – parents do not know – boyfriends do not know. After circumcision, young men think sexual relationships are without risk of HIV;
- The composition of the Country Coordinating Mechanism (CCM) is critical. The CCM has a strategic role and the need for focus on prevention led by communities needs to be brought to that forum – much prevention work could be done by the 30 million returned from Global Fund grants.

Site visit to Matsapha Correctional Services, including the health clinic



The visit to His Majesty's Correctional Services was the fourth field visit for a PCB delegation since the 2013 Zambia field visit. UNODC is leading the Joint Programme support to governments' policy and service delivery work in prison and other closed settings and also led this part of the PCB field visit in Swaziland. The latest available data show that 35 percent of offenders are HIV positive compared to the national prevalence of 27 percent in the general population.

The clinic within the Correctional Services in Matsapha started in 2009 focused on HIV, TB, syphilis and hepatitis. Until UNODC started the support, many of the correctional services were not very suited for human habitation.

The Joint Programme's support, implemented by UNODC, has had many elements, including training of ambulance personal and putting ambulances at the disposal of the clinics. This was necessary as the hospital facilities has considerable stigma against inmates. The programme is implemented as part of UNODC's wider prison support programme in Eastern Southern Africa where prevalence amongst inmates is very high. The programme has also contributed with generation of strategic information from prisons, which started in 2010.

The Swaziland coordination of prison services is in many ways a best practice involving NGOs and the Ministry of Health and Ministry of Justice. Putting clinic services in closed settings under the Ministry of Health facilitates transition to the broader health services when inmates leave, and also allows for links to services of family and sexual partners.

Issues discussed during the visit, included:

- HIV is part of the prison commissioner's curriculum training, which has changed its prioritization;
- Inmates are offered HIV tests on arrival – it is voluntary so far in this prison, there have not been cases of prisoners entering HIV negative and testing positive later;
- 300 HIV tests have been conducted during the past 12 months – (30 positive cases from April 2016 to March 2017). This is significantly lower than the country prevalence for adults;
- If an inmate tests TB positive, the system will go back to family to ensure they are tested – this is not the case for HIV for reasons of confidentiality, but it is offered with the inmate's agreement - partner notification is a new policy (call family for testing);
- Sex in prison remains a taboo – Prep is not offered and there is no distribution of condoms or lubricants – these would require law to change.

Site visit to Matsapha Comprehensive Care Clinic



The visit to the Matsapho Comprehensive Care Clinic was a possibility for the delegation to see the facilities, as well as engage with doctors and nurses providing a broad area of health services. The visit was also a showcase of the advantage and efficacy of service integration, and in particular HIV and TB.

The clinic is part of a network of five clinics supported by AIDS Healthcare Foundation which services over 25,000 patients on ARVs annually. The Matsapho clinic alone services 7,000

people living with HIV and some 150-200 outpatients per day. All arriving patients are treated, including cross-border patients arriving from Mozambique with services provided free of charge.

Issues discussed during the visit included:

- Systematic linkage between testing for HIV, TB, testing and treatment and HIV, cervical cancer screening;
- Service provision for key populations, in particular sex workers;
- Service provision for cross-border workers and patients from Mozambique and South Africa;
- Non-discrimination training of staff;
- Sustainability of resourcing the clinic;
- Options for patient payment for services.

Site visit to the Central Medical Stores



The visit to the Central Medical Stores (CMS) was an opportunity to see a state of the art central medical storage which stores and distributes medicines and medical products to almost 400 facilities in Swaziland. The Assistant Director of the CMS is also the Chair of the Supply Chain Technical Working Group of the Ministry of Health.

The CMS was initiated following an assessment of warehousing and distribution of health products and the shortcomings that existed in terms of management and delivery to health facilities. The funding of the CMS has been partly Government, partly Global Fund. With the

move of warehousing essential medicines, ART, vaccines and laboratory equipment, there is now full integration of warehousing and distribution.

Issues discussed during the visit included:

- Time table for rollout to connect to facilities through 2018;
- Timing of move to full bar-code electronic system;
- Payment of suppliers is happening from the Ministry of Health, which can pose problems for deliveries to the CMS due to cash flow issues;
- Cost of procurement of medicines are less costly than the supply chain management;
- Support from PEPFAR to manage supply chain at time of transition;
- Challenge for small country to buy certain medicines because of lack of volume – obligation to pool with larger countries.

Meeting with United States partners – PEPFAR, USAID and CDC



The Delegation also met with the PEPFAR, USAID and CDC. The United States has been a key partner for the Government of Swaziland in the response to HIV and continues to be supporting all aspects of the response across sectors. The presentation of the PEPFAR programme demonstrated how the UNAIDS Country Director is an integral part of PEPFAR planning and helps forming the programme in the country.

Issues discussed during the meeting included:

- Disparity in 90-90-90 progress – more than 84 percent of women living with HIV on treatment - men 63 percent;
- Increase of community outreach is essential to further progress on 90-90-90;

- The biggest gap in awareness of HIV status is among men – improve after hour access is key;
- Focus women 15-29 men 20-39 – testing and improve link to treatment – community engagement key to progress – uptake in clinics very good but next phase is to improve through community services;
- Viral load testing is expensive – reduction is key for government to continue;
- Stable patients should not need to go to clinics every 3 months;
- For prevention and access to treatment for adolescents, teen clubs are key to access – need to increase numbers – as their value added is clearly demonstrated;
- Despite decrease in HIV incidence there is a decrease in knowledge of HIV, an increase in stigma – incidence decrease essentially stems from viral load suppression;
- There is a need to look at nuanced plans for communication – to resonate with different age groups, sexes, rural/urban;
- Swaziland has a unique community leadership – governmental and traditional – chieftdom structures have responsibility for development of their communities – they are key to understand the resources that are in the community, such as retired nurses, and make these resources support the response;
- Prep has only recently begun – what will be the potential in a high prevalence setting as Swaziland – three ongoing demonstration projects (PEPFAR, CHAI, MSF);
- UNAIDS, PEPFAR and USAID are supporting Government to produce key populations size estimate;
- Male circumcision is progressing but needs acceleration;
- Financial sustainability of the response is an issue: Donor funding is stabilizing at best;
- Strategic information generation and data collection is an important contribution of PEPFAR and close collaboration with UNAIDS on analysis;
- In 20-24 years old there is the greatest disparity – prevalence 5 times higher for women – 3 times higher in 24-29 – and amongst women 30-44, 1 in 2 are HIV positive;
- PEPFAR's cooperation on analysis and data with UNAIDS is key to the understanding of epidemic. Submission of data to the King happens through UNAIDS;
- Despite Swaziland 44% decrease in HIV incidence, the epidemic is still one of highest in the region and needs to reduce by 50% over the next 5 years;
- There is a significant prevention potential with the current youth bulge;
- The recent reinvigoration of HIV prevention with the UNAIDS roadmap for prevention and the Prevention Coalition is an opportunity for Swaziland;

- Prevention programmes are coordinated by UNAIDS, which brings Global Fund partners and the Cosponsors together – this brings harmonization of interventions through the collaboration between UNAIDS and NERCHA;
- It will be key to get “sexiness” back into condom programming but it has been challenging to expand flavoured condoms despite ask from youth - getting them in through civil society may be an option as it has failed to do so through the private sector;
- The focus on teen clubs and the very sexually active populations needs further expansion as does addressing the issue of stigma around disclosure of HIV status.

Meeting with Development Partners



The meeting with the development partners was also an engagement with the CCM Executive Committee members and included the European Union, the Clinton Health and AIDS Initiative and other major supporters of the HIV response in Swaziland. It was an opportunity for the delegation to engage on the sustainability of the financing of the response, as well as the opportunities for scaling up financing for prevention.

Issues brought up during the meeting included:

- Swaziland has a challenge on prevention of new infections in young women and girls;
- The HIV grant is coming to expiry next year but there has been an issue of absorption capacity and an acceleration plan for all three grants was developed – the absorption rate is now close to 80 percent for the HIV grant but some USD 30 million still were returned. This was a missed opportunity;

- Medical aspects have been at the centre of HIV interventions, but the EU has pushed for more resources for prevention, in particular for behaviour change and impact mitigation (social protection);
- The Ministry of health has been doing well on Global Fund resources including with the prospect of the availability of the generic, single-pill HIV treatment regimen containing dolutegravir as first line at a price ceiling of USD 75 for a better drug with faster viral load suppression and better tolerability;
- This will be key for pregnant women as it has an impact on transmission of HIV to baby
- HIV drug resistance is low in Swaziland – less than 1 percent
- There is agreement that empowerment of regions in Swaziland is important but the resources do not always follow;
- Viral load monitoring is high – but how to maintain at current cost? The response is expensive and still quite medicalized;
- Supporting networks of PLHIV is critical to keep a vibrant response;
- There are high levels of sexual violence but not much focus on this in the HIV response;
- DREAMS has been a catalyst for awareness on sexual and gender-based violence – resources to training of health facility providers and police – and there has been an increase in notification of cases;
- PEPFAR is supporting the Deputy Prime Minister's office and the Minister of Justice with a child-friendly court and police on violence reduction also for key populations – one stop centres with justice, medical, social services and lawyers together;
- Sexual violence is also addressed by UNICEF with the police and they have a new campaign in the workplace – using some of the celebrities in country.

Visit to Baylor Children's Foundation Clinic in Mbabane

The PCB delegation visited the Baylor Clinic in Mbabane to see child and youth friendly services for HIV treatment and prevention. The Teen Clubs run by the clinic, as well as the U-Report supported by the Joint Programme, through UNICEF, are an important part of high impact prevention programmes that specifically target youth populations.



The clinic provides children and family-oriented HIV prevention, care and treatment services, tuberculosis screening, control and treatment for other diseases affecting children in Swaziland. The centre also offers services such as cervical cancer screening, Mother-baby pair and family planning services. In collaboration with UNAIDS, the clinic runs a specific index to find adolescents living HIV in part through adults testing positive.

Issues discussed during the visit included:

- Swaziland has done well on incidence of adults but struggling with adolescents;
- Testing of adolescents is low despite age of consent of 12 years old;
- How to expand initiatives as U-report and Teen Clubs to be run in all villages?
- Disclosure of HIV status remains a major issue and in particular for very young people living with HIV – even disclosing status to friends is difficult;
- U-report has been successful as a reactive service – how can it become more outreaching and pro-active?
- The peer training in the Teen-Clubs and the youth leadership in them is key to reaching other adolescents – how can it be scaled up and how do champions get identified?
- Condoms available are not appropriate for use by very young people – in the Swaziland context, sexual relationships are not uncommon amongst 12-13 years old and standard condoms are not rightsized for this age-group;
- How to get to messages from Teen-Clubs to form part of national planning?

- Prevention messages need to be highly segmented and tailor-made to different age groups – 12-13 years old need different messages from 14-15 years old and different again for 16-17 years old – granularity in messaging is key.

Site visit to the private sector AIDS response at the Simunye Sugar Company



The Royal Swaziland Sugar Company in Simunye is one of the largest companies in Swaziland producing 2/3 of the country's sugar and a significant quantity of ethanol. The company employs more than 3,500 employees. The HIV prevalence rate of the employees at 34 percent exceeds the nation average prevalence.

The company has been supported by ILO from its office in Zimbabwe to develop its workplace policies on HIV, which are in accordance with ILO guidelines. The company provides, free of charge, the full services of its health clinics to permanent and temporary staff and their families as well as the surrounding communities. The clinics are run and paid for by the company but commodities as testing and medicines are provided to the clinics by the government.

Key issues discussed during the visit included:

- This represents a real model of corporate social responsibility;
- Important private-public partnership, which is key for the financial sustainability of response;
- Importance of providing same treatment to temporary and permanent staff;

- Importance of extending services of the clinic to surrounding communities including key populations and, in particular sex workers;
- Importance of linking positive tests with offer of Voluntary Testing and Counselling for family members and sexual partners;
- Consideration of work-place based health insurance scheme in the future;
- How can the excellent treatment services offered, condom distribution and prevention information programmes run at the company be expanded to also constitute prevention programmes for young people in the surrounding communities?



VI) Conclusions from the Field Visit

The PCB Delegation concluded its visit with a debriefing with the Minister of Health and NERCHA colleagues on the key take away messages and lessons learned:

- Swaziland has a unique HIV response as it builds on cultural strengths and draws on these for an effective response;
- There is political support at the highest level, since the King's announcement of HIV as an emergency situation – this shows the importance of leadership of HIV coordination driven from the Prime Minister's Office, as well as the leadership from the Ministry of Health and other ministries;
- Scale-up of treatment and early adoption of the 90-90-90 target have been a game changer in the response – and have been key to bringing down HIV incidence by an impressive 44 percent since 2011 despite indication of decreasing knowledge amongst young people and increasing stigma around HIV;
- HIV Incidence is equal across age groups – but gender disparity is marked amongst the younger age groups with young women up to 6 times more likely to be HIV positive than their male peers;
- Financial sustainability of the response with a high number of people on treatment remains an issue and a sustainability transition plan is required with a strategy for reducing dependence on external financing;
- The disproportionate impact of HIV on young women and girls needs to be addressed, in particular:
 - Inter-generational sex
 - Decreasing knowledge of HIV
 - Lack of female-controlled prevention technologies
 - Disclosure of HIV status is highly sensitive despite a 27 per cent adult prevalence rate
 - Condomize – many young people do not use condoms, as only condoms with flavour are of interest. Those provided stay unused and there are no condoms for the age group of 11-13 years old
- Funding of community programmes, in particular for prevention is quite limited, and these will be critical for the next phase of the response with more focus on bringing down HIV incidence by primary prevention including condom use.
- Programmes ensuring that a positive HIV test leads to treatment initiation and adherence, as well as consistent condom use to protect partners, are critical, but these

can only be successful if the sensitivity around disclosure of one's HIV status is addressed – thus champions as chiefs and vocal positive youth leaders in each community are key;

- The contribution of the private sector in terms of service delivery has been important, in particular the corporate social responsibility demonstrated by some of the major companies has been key for the roll out of treatment. This must be built upon for scaling up HIV prevention;
- Getting men to test and into care as well as staying in care still represents a challenge;
- Sexual and gender-based violence remains an issue that has very little coverage in the public arena and needs to be brought out.

[End of document]