



The Kingdom of Swaziland

SWAZILAND COUNTRY REPORT ON MONITORING THE POLITICAL DECLARATION ON HIV AND AIDS

MARCH 2012



FOREWORD

In June 2011, Swaziland joined the international community to sign the 2011 Political Declaration on HIV and AIDS; reconfirming its previous commitments made in 2001 and 2006. The Political Declaration motivates and compels countries to work towards achieving the Millennium Development Goal Six to halt and reverse the spread of HIV epidemic by 2015. The 2011 Political Declaration demonstrates the spirit of planning for results through setting time bound targets that countries should achieve by 2015.

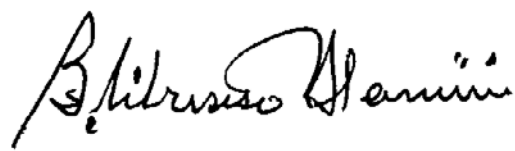
I am pleased to announce achievements made in responding to the epidemic. In HIV prevention, we are on the verge of virtual elimination of mother-to child-transmission and appropriate behavioural change is observed particularly among the youth whose HIV prevalence has reduced. People Living with HIV and AIDS are accessing treatment and we expect that this will translate into improvements in life expectancy and correspondingly, we anticipate the number of AIDS orphans to subdue. A majority of our children are attending school and communities have been mobilized to take meaningful role in the response to HIV and AIDS.

The country is going through a fiscal crisis that calls for budget shifts towards priority interventions. I am honoured that allocations for HIV and AIDS activities have been sustained and in particular resources for the procurement of drugs and the education of children including Orphaned and Vulnerable Children (OVC). The Government has recognized the contribution of community care givers, in particular grandparents, and makes provision for elderly grants. The National AIDS Spending Assessment (NASA) 2011 uncovered that the Government contribution to HIV is on the rise and spending priority is given to the education of children including those made vulnerable by the epidemic, whose spending accounted for 25% of total spending for HIV in 2009/10.

The country is not only committed but has demonstrated political support for the response. Such support will be sustained to ensure that we achieve the Universal Access targets. I am pleased that this report demonstrates our collective successes and the achievements are attributed to the people of Swaziland; the youth who begin their sexual lives having attuned to safer behaviours; the women who visit antenatal care clinics to protect their unborn children; the men who are getting circumcised; the support groups of PLHIV; the carers of OVC and chronically ill patients; the key populations who are coming out to become active partners in HIV prevention efforts and the households who participate in national surveys.

On behalf of His Majesty's Government, I would like to express gratitude to all multisectoral stakeholders. The collective efforts of the friends of Swaziland; the Civil Society, development partners, bilateral and multilateral donors, including business can never be overlooked. All this has been made possible by the commendable commitment of the Government of Swaziland in providing the leadership and guidance that is necessary to spur the country to meet MDGs.

Lastly, I still believe an HIV-free generation is possible; through continued engagement, participation and shared responsibility. For now let us carry this document with pride and the knowledge that significant milestones have been achieved by the country.



Dr. Barnabas Sibusiso Dlamini
Prime Minister
Kingdom of Swaziland
28th March 2012

ACKNOWLEDGEMENTS

The Government of Swaziland extends her sincere gratitude to all partners and stakeholders who contribute to the national response. Appreciation goes to the community based organisations, Non Governmental organisations (NGOs) including the network of people living with HIV, government ministries, the UN family and all donors partners

Special mention is extended to the UNGASS country core team comprising of technical officers from the Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA), the Deputy Prime Minister's Office, Ministries of Health; Education and Tinkhundla Administration and Development, the United Nations, Institute of Health Measurement and the National Emergency Response Council on HIV/AIDS (NERCHA). The contribution made by The National Steering Committee and the NERCHA Council provided invaluable insight into the process.

All this, would not have been possible without the commendable commitment of the Government of Swaziland which provided the leadership and guidance necessary to spur the country to meet MDG Six.

I would like to acknowledge the partnerships between NERCHA and Civil Society including Development Partners who have put the Swaziland HIV agenda on the table.

Finally, NERCHA extends its appreciation to the National and International consultants, national stakeholders and key informants for their individual and collective contributions to this national report.

NERCHA and UNAIDS are applauded for the provision of technical and financial support.



Derek von Wissell
Executive Director- National Emergency Response Council on HIV/AIDS (NERCHA)

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ACRONYMS

ABC	Abstinence, Be faithful and Condoms
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
AZT	Zidovudine
BCC	Behaviour Change Communication
CANGO	Coordinating Assembly of non Governmental Organisations
CBO	Community based organizations
CCM	Country Coordinating Mechanism
COP	Country Operational Plan
CSO	Central Statistical Office
CT	Counselling and Testing
DPM	Deputy Prime Minister
FLAS	Family Life Association of Swaziland
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, TB and Malaria
HBC	Home-based Care
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
MC	Male Circumcision
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MOAC	Ministry of Agriculture and Co-operatives
MOE	Ministry of Education
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
MTPI	First Medium Term Plan
MTPII	Second Medium Term Plan
NAP	National Action Plan
NASA	National AIDS Spending Assessment
NBTS	National Blood Transfusion Service
NCP	Neighbourhood Care Points
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Government Organisations
NSP	National Strategic Plan
NVP	Nevirapine
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan for HIV and AIDS Relief
PLWHA	People Living with HIV and AIDS

PLWHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSHACC	Public Sector HIV and AIDS Coordinating Committee
QMS	Quality Management System
RHMS	Rural Health Motivators
SSBCC	Swaziland Social and Behavioural Change Communication Strategy
SDHS	Swaziland Demographic and Health Survey
SMP	Strategic Management Plan
SNAP	Swaziland National AIDS Program
STIs	Sexually Transmitted Infections
SW	Sex Workers
SWAGAA	Swaziland Action Group Against Abuse
SWANNEPHA	Swaziland National Network for People Living With HIV and AIDS
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Children's Fund
VCT	Voluntary Testing and Counselling
WFP	World Food Program
WHO	World Health Organisation

1. STATUS AT A GLANCE

Introduction

This Section presents an overview of the methods and processes used in compiling the Country Progress Report for Swaziland; it provides a snapshot of the local epidemic status; the institutional arrangements for the coordination of HIV and AIDS; a summary brief of policy and programmatic improvements during the reporting period; and the UNGASS Indicator Summary Table.

1.1. The Report Writing Process

The overall coordination of compiling the Country Progress Report was provided by NERCHA together with UNAIDS. One International and a National Consultant were contracted to support the core country multisectoral report writing team composed of different specialists with diverse backgrounds to compile the report. The National consultant administered the National Commitment Policy Instrument (NCPI) and the international consultant assessed the process for inclusiveness and quality of data and information. The Country multisectoral team composed of 14 members drawn from Government, Development partners and CSOs across the HIV and AIDS thematic areas were engaged to collect and analyze both primary and secondary data, and compile the Report.

Data collection methods used were mainly qualitative in nature and included desk review, in-depth interviews with key informants, group discussions and consultative meetings. The multisectoral team reviewed literature, took notes during report update meetings and incorporated comments in the draft report. Key informant interviews were conducted with selected stakeholders from government, Bilateral, Multilateral and CSOs to have in-depth understanding of progress, challenges and the future direction of the national HIV and AIDS response.

The (NCPI) questionnaire was administered to government officials (Ministry of Health, Public Sector HIV and AIDS Coordination Committee (PSHACC), Parliament HIV and AIDS Portfolio Committee, Ministry of Justice and NERCHA), representatives of CSOs bilateral and UN organizations. The completed NCPI forms were synthesized by the National Consultant and vetted by the International consultant to ensure the results were consistent with national performance and reporting guidelines. Final NCPI Part A (for Government) and Part B (for CSOs (Swaziland Action Group Against Abuse (SWAGAA); Coordinating Assembly of Non Governmental Organisations (CANGO); Swaziland National Network of People living with HIV and AIDS (SWANNEPHA); Family Life Association of Swaziland (FLAS); Bilateral Agencies and UN Organizations (UNAIDS; United Nations Theme Group; and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)) are shown in Annex 2.

Reports used include: draft HIV Estimates and Projections Report 2012; WHO Global TB Report 2011; Ministry of Health Annual M&E Report (2011); National AIDS Spending Assessment report (NASA 2011); National Tuberculosis Control Programme Annual Report (2011); NERCHA Annual M&E Report (2011); Swaziland Behavioural Sentinel Surveillance for Most-at-risk-populations (preliminary BSS: MARPS 2011) Preliminary results on the Swaziland Behavioural Sentinel Surveillance (BSS 2011); Swaziland Multiple Indicator Cluster Survey (MICS 2010); HIV Sentinel Surveillance Report (2010); Service Availability Mapping Report (2010); TB Drug Resistance Survey (2010); Modes of Transmission report (2009); and Swaziland Demographic and Health Survey (SDHS 2007).

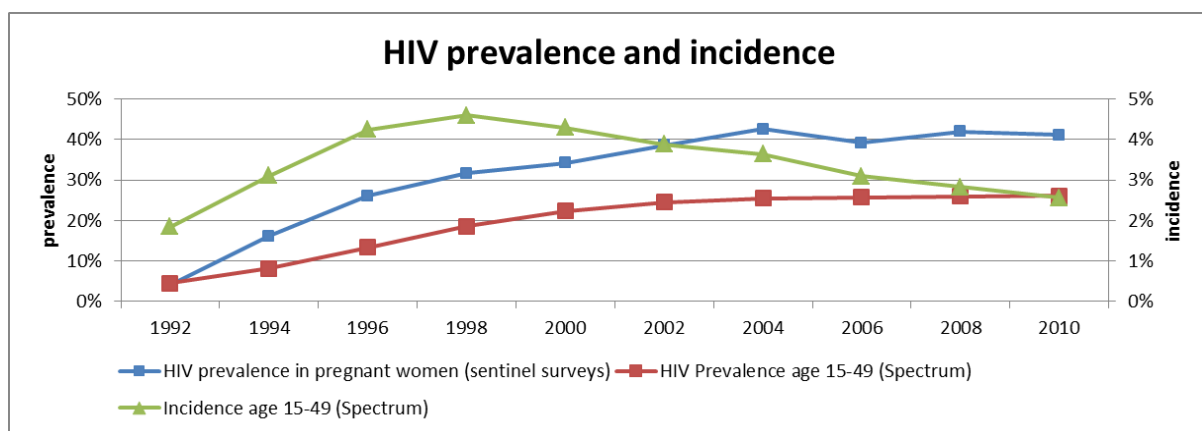
A validation and Consensus Building workshop was held on March 15th, 2012, See Annex 1 for the List of Participants. The final draft was presented to stakeholders for adoption and comments were included in the current Swaziland Report.

The final draft County report was presented to the NERCHA Council and Cabinet for Government consensus and approval.

1.2. The Status of the Epidemic

Epidemiology review indicates an increase in HIV prevalence among pregnant women, from 3.9% in 1992 to 41.1% in 2010¹. The 2010 ANC sentinel surveillance survey showed that prevalence has stabilised between 42% and 41% and that HIV prevalence is highest among those aged 30-34 years (53.8%) and lowest among those aged 15-19 years (20.4%).

Figure 1: HIV Prevalence and incidence



Source: ANC 2010, Spectrum HIV Estimates & Projections 2010

Current evidence suggest some stabilisation of prevalence in pregnant women. The stabilisation might be caused by the increase ART uptake and the strong PMTCT programme.

Preliminary HIV estimates and projection generated by the Spectrum model estimate HIV incidence for ages 15-49 to be on declining trend since 1998. The strong behaviour change program, male circumcision program and improved HIV treatment has attributed to the decline. According to preliminary data from HIV Estimates Report 2012, HIV incidence rate is projected to decline from 2.9% in 2009 to 2.4% in 2015. The number of people living with HIV in 2011 was estimated to be 173,619 adults and 21,780 children. Using the eligibility criteria of CD4 cell count <350/mm³, an estimated 78,127 adults and 12,353 children were in need of ART in 2011 and by the end of the year, 80% of all who were in need of ART were receiving, comprising of 84.3% and 53.2% for adults and 6,567 children, respectively.²

¹ MOH 2010, 12th National Serosurveillance among women attending antenatal care services in Swaziland

² HMIS

1.3. Policy Development and Implementation

1.3.1. Overall progress in policy development

The National Emergency Response Council on HIV and AIDS (NERCHA) was set up by Act of Parliament No 8 of 2003 in December 2001 and is mandated to facilitate and coordinate the implementation of the multisectoral response to HIV and AIDS. NERCHA's role includes mobilization of all line sectors to realize and respond to social challenges posed by HIV and AIDS.

HIV and AIDS service delivery actors include the Government, development partners, Private sectors, donors partners, networks of People Living with HIV and AIDS, faith based sector, Non Governmental Organisations, Community Based Organisations, traditional sector and communities, who were mobilized to engage and implement programmes in response to HIV and AIDS. This followed a realization that the response to the HIV and AIDS epidemic was not only a health issue but required a developmental approach and engagement of all sectors.

Coordination of the National Response: The 'Three Ones Principle'

The coordination of the response is managed using the three ones principle, where NERCHA is the one coordinating body, The National Strategic Framework for HIV and AIDS 2009-2014 the One strategy and One Monitoring and Evaluation system.

One Coordinating Agency

NERCHA is the national AIDS commission mandated to coordinate the multisectoral response. The management of the HIV response has been decentralized to lower levels in partnership with the Ministry of Tinkhundla Administration and Development (MTAD). Institutional mechanisms have been put in place and these include; Regional HIV and AIDS Coordination Committee (REMSHACC), Tinkhundla HIV and AIDS Coordination Committee (TIMSHACCC) and Community HIV and AIDS Coordination Committee (CHIMSHACC) to ensure equity in service delivery and institutionalization of the principle of the three ones at lower levels. In addition, 360 community centres (KaGogo Social Centres) have been built at the community level in both urban and rural areas to support coordination and HIV service delivery at grassroots levels.

The country also operates sectoral coordination of the response which bring together Government sector; United Nations (UN) and Bilateral; Non Governmental Organizations; Traditional sector; Private Sector and Academia. This arrangement has effectively ensured inter-sectoral coordination and monitoring implementation of the NSF.

One Strategic Framework

A third generation multisectoral National Strategic Framework on HIV and AIDS (NSF) 2009-2014 was developed following a four stage highly participatory process. The NSF introduced a paradigm shift in the planning landscape for HIV in the country by ushering a results and evidence based planning approach. An elaborate results framework has been developed that has concrete, evidence informed and time bound results at impact, outcome and output levels. The overall purpose of the NSF is to bring together stakeholders to work together towards achieving the common results.

The NSF has mainstreamed Universal Access and Millennium Development Goals targets allowing the country to monitor international commitments through the national M&E framework. The country is positioned positively to achieve universal access targets for HIV&AIDS prevention, care,

treatment and social support by 2015 through implementing the response using the comparative advantages of each sector. The impact results of the NSF are:

- Improve the Swaziland Human Development Index from 0.542 reported in 2008 to 0.55 in 2014
- Reducing Swaziland incidence rate of HIV from 2.9 in 2008 to 2.3% in 2014
- Increased life expectancy from 40.2 years in 2008 to 44 years in 2014,
- Increase the percentage of households with vulnerable individuals that are able to cope with the impact of HIV from 72% in 2008 to 80% in 2014
- Increase the percentage of vulnerable individuals that report that all the services they receive were relevant, timely, and comprehensive and of good quality to 70% in 2014.
- Increase the percentage of mid-term and end of NSF service coverage targets (output level) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increase to 80% by end of NSF in 2014.³

One Monitoring and Evaluation Framework

The National HIV and AIDS Monitoring and Evaluation Framework 2009-2014 was developed and aligned to the NSF. The M&E system monitors progress towards attaining the results set out in the NSF Results Framework.

HIV monitoring has been decentralised to be in line with the coordination structures. Routine reporting is generated from the source (community level) to the regional and sectoral structures and aggregated at the national level in NERCHA.

Strengthening the reporting of the HIV response using the Geographic Information System (GIS) to improve performance of national response

The GIS system was introduced in 2010 and is still at infancy stages of implementation. The system however has capability to report on all programmes in the national monitoring system. The use of maps in depicting service delivery is a very useful tool to disseminate user friendly information. It also allows for immediate decision making thus linking monitoring to planning.

Joint Review of the National Strategic Framework 2011

In 2011 the country undertook a joint review of the NSF, the review documented the success , challenges and proposed new strategies to all HIV and AIDS partners and implementers. The NSF provide guidance to all HIV implementers in their planning and programmatic response. Major findings were the need to further clarify the roles of different stakeholders contributing to the response in line with the newly adopted results-based planning approach and strengthening the application of the decentralisation of the 'Three One Principle' to lower levels. The need for mainstreaming gender in HIV programmes was reflected as well as improving the capacity of implementers and community level players in monitoring and evaluation. The review recommended the need to diversify donor support through an intensive donor resource mobilization process. Following the Joint Mid Term Review an HIV and AIDS, a National HIV Coordination Framework that will provide guidance and clarify roles and responsibilities is under development.

2009-2014 National multisectoral HIV and AIDS Framework

1.3.2. The Policy and Programmatic Response

The country has developed a number of policies, guidelines and plans that feed into the Poverty Reduction Strategy and Action Programme (PRSAP), National Development Strategy (NDS), Decentralization policy, including the National Gender Policy (2010). These policies include; national palliative Care policy and the HIV and AIDS Prevention Policy (in final stages of approval). There are several other guidelines such as HCT, ART, PMTCT, OVC, palliative care, MC and TB. There are a number of other national planning frameworks and policies that address the control of HIV&AIDS in general such as the, National Plan of Action for Orphans and Vulnerable Children among others. The national response to HIV&AIDS enjoys evident political commitment and support at the highest level, policy of openness enhancing better dialogue and communication, multisectoral interventions and co-ordination at various levels.

The following Laws, Policies and programmes have been put in place during the reporting period 2010-2011;

i. The People Trafficking and People Smuggling (Prohibition) Act 2009

The legislation seeks to prevent human trafficking and smuggling and enable the judicial system to prosecute perpetrators. The law is based on three principles of Prevention of trafficking, Protection of the victims/survivor and Prosecution of perpetrators. This legislation came into effect in March 2010.

ii. The Employment Act of 1980 (as amended)

The Act was recently amended and in Section 29 makes provision for non discrimination between employees in any contract of employment based on sex, race, colour, religion, marital status, national origin, tribal or clan extraction, political affiliation or social status. Under this law persons living with HIV are protected from any form of discrimination at workplace. Part X (sections 95 to 109) makes provision for the protection of women, children and young persons in the workplace.

iii. Sexual Offences and Domestic Violence Bill (2010)

The bill was enacted to address the increasing rates of domestic violence in the country and also the deaths of women the hands of their partners. The bill has been passed by the House of Assembly and is awaiting finalization in Parliament.

iv. Children's Bill (2011)

This bill is a comprehensive collection of all laws that address issues of children including Orphaned and Vulnerable children. The bill has been passed by the House of Assembly and is waiting to be debated in House of Senate.

v. Education Sector Policy (2010)

The Education Sector Policy integrated HIV and AIDS under the schools as Centres of Care and Support Programme (Inqaba). This culminated in the creation of a formal guidance and counselling syllabus which focuses on age specific sensitivity in handling health promotion at secondary and high schools. This approach is also working at reviving traditional practice of 'liguma' and 'lisango' (gender specific huts) where girls and boys would be provided with age-specific sexuality education from generation to generation.

vi. Parliament Strategy on HIV and AIDS (2011)

The Parliament of Swaziland has developed a strategy that outlines how the parliament will engage with constituencies in response to HIV and AIDS. The Strategy will assist in supporting members of parliament to provide leadership in matters related to HIV and AIDS.

vii. National HIV Prevention Policy (2011)

This Policy seeks to strengthen efforts in prevention and create an enabling environment for the prevention response. The policy has been discussed extensively with stakeholders and has been presented to Government for approval.

viii. Stigma and Discrimination Index (2011)

The Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) spearheaded the development of the first Stigma and discrimination Index. This index is an international tool rollout in countries to gauge the attitudes of people towards People Living with HIV and AIDS and also how positive living has been rolled out amongst PLHIV. The strategy shows that the country has made notable progress in managing stigma and discrimination amongst the general population but however that self stigma or internal stigma is still rife.

ix. National Palliative Care Policy (2011)

The policy aims in the quality and affordability of palliative care services in Swaziland. It facilitates integration of regulated palliative care service delivery and provides guidance for use in developing standards.

x. The revision of the National PMTCT Guidelines (2010)

Aligned with the virtual Elimination of Mother to Child Transmission of HIV Strategy the PMTCT guidelines were reviewed. The new changes include the following:

1. Under prong 1 - Primary prevention of HIV infection among women of child bearing age: Emphasis will be given to keeping HIV-negative pregnant women and partners of pregnant women HIV-negative. This new approach is based on recent research in Swaziland that showed high levels of new HIV infections occurring during the last trimester of pregnancy.
2. Under prong 2 – Prevention of unintended pregnancies among HIV positive women; -, continued capacity building for health care workers to provide the sexual reproductive health services and ensuring availability of SRH commodities that are easily accessible to all who need. This approach is based on recent findings in the ANC surveillance report that over 60% of pregnancies were unplanned.
3. Regular HIV retesting during pregnancy: HIV testing among pregnant women performed on discovery of pregnancy, 8 weeks after the first HIV negative test, during the last trimester, at delivery and at 6 weeks postpartum in order to identify new HIV infections and provide ARV prophylaxis immediately. This also strengthens the linkages between the PMTCT and ART programmes. This approach was initiated in response to a realization that the number of women that seroconvert during the last trimester of pregnancy was increasing.

xi. The revision of National Antiretroviral Treatment (ART) Guidelines (2010)

In 2010 the National ART guidelines for adults and children were reviewed to be in line with World Health Organization (WHO) recommendation of early enrolment into care. Prior to the review enrolment into ART was at a CD4 threshold of <200 which has been increased to a CD4 threshold of <350.

xii. Public Sector Workplace Policy and Wellness Programme (2011)

Coordinated by the Public Sector HIV and AIDS Coordinating Committee (PSHACC) the Wellness Programme for the public Sector was launched by the Honourable Prime Minister. This is one programme that evidences the implementation of the Public Sector policy.

1.4. Global Reporting Swaziland Indicator Summary Data

Data in the Country Report indicator table was collected from official Government documents, bilateral and UN agencies documents and studies conducted in Swaziland in last two years.

Table 1: Swaziland Summary Indicator Table

Target	Indicator #	Indicator	2009	2011
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: 52.2% Women: 52.1% Men: 52.3%	Overall: 56% Women: 58.2% Men: 53.6%
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15	Overall: 5.9% Women: 6.9% Men: 4.8%	Overall: 3.2% Women: 3.8% Men: 2.6%
	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: 13.1% women: 1.8% Men: 14.8%	Overall 8.6% Women: 2.7% Men: 15.7%
	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	Women: no data Men: 56.2%	Overall 71.5% Women: 73.6% Men: 71.0%
	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: 16% Women: 22% Men: 9%	Overall: 40.1%; Women: 47.3% Men: 31.3%
	1.6	Percentage of young people aged 15-24 who are living with HIV	ANC 38.1% SDHS; Overall: 14.4% Women: 22.9% Men 5.9%	ANC: 34.0% 15-19-(20.4%) 20-24-(40.8%) SDHS; Overall: 14.4% Women: 22.9% Men 5.9%
Sex Workers	1.7	Percentage of sex-workers reached with HIV prevention programmes	No data	No data

	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	87.4%	No data
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data	No data
	1.10	Percentage of sex workers who are living with HIV	No data	69.7%
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No data	No 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
	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
	1.14	Percentage of men who have sex with men who are living with HIV	No data	16.7%
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
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No data	No data
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	No data	No data
	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
	2.5	Percentage of people who inject drugs who are living with HIV	No data	No data
Target 3: Eliminate mother-to-child	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	69%	94.5%

transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	No data	68.9%
	3.3	Mother-to-child transmission of HIV (modeled)	16.9%	15.4%
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: 59.2% Children: 66.1% Adults: 58.5%	Overall: 80.0% Children: 53.2% Adults: 84.3%
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Overall: 77.3% Children: 78.2% Adults: 77.1%	Overall: 87.2% Children: 87.7% Adults: 87.1%
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	No data a	9.7%
Target 6: Reach a significant level of annual global expenditure in low and middle income countries	6.1	Domestic and international AIDS spending by categories and financing sources	Overall: SZL582,670,706 Domestic: SZL251,106,819 International: SZL331,563,887	No data
Target 7: Critical enablers and synergies with development partners	7.1 Government	Overall, how would you rate strategic planning efforts in the country's HIV programmes	6	8
		Overall, how would you rate political support for the country's HIV programmes	7	8
		Overall, how would you rate policy efforts in support for HIV prevention	No data	6
		Overall, how would you rate the efforts in implementation of HIV prevention programmes	6.5	7

		Overall, how would you rate the efforts in the implementation of treatment, care and support programmes	No data	9
		Overall, how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children	7	7
		Overall, how would you rate the HIV related monitoring and evaluation	6	7
	Civil Society	Overall, how would you rate the efforts to increase civil society participation in 2007, 2009 & 2011	6	6
		Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2007, 2009 & 2011?	6	5
		Overall, how would you rate the effort to implement human rights related policies, laws and regulations in 2007, 2009 & 2011	3	4
		Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007, 2009 & 2011?	7	5
		Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007, 2009 & 2011?	6	6
	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	No data	7.7%
	7.3	Current school attendance among orphans and non-orphans aged 10-14	Orphans: 91.4% Non-orphans: 92.6%	Orphans: 97.2% Non orphans: 98.6%

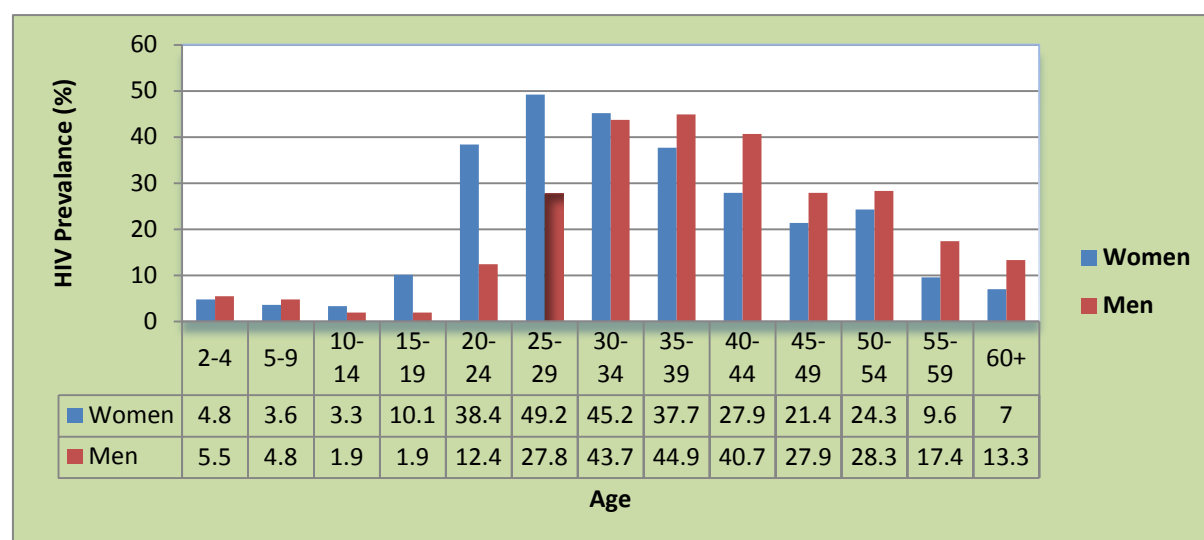
	7.4	Proportion of the poorest households who received external economic support in the past 3 months	No data	No data
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2. OVERVIEW OF THE EPIDEMIC

The last national survey that included HIV biological testing among the general population was conducted in 2007. The survey revealed that the country has generalized hyper-endemic HIV; the national prevalence among the population aged 2 and older was 19% (22% females and 15% male) and 26% (31% women and 20% men) for the reproductive population aged 15-49 years.⁴

Women continue to be more affected compared to their male counterparts and significant variations exist by sex and age. For instance, highest prevalence rates are observed among the 25-29 year age group for women and 35-39 years for men at 49% and 45%, respectively. Prevalence in adults aged 50 and older is 14% while among young children aged 2 – 14 years was reported at 4%.

Figure 2: HIV Prevalence, women and men, 2007



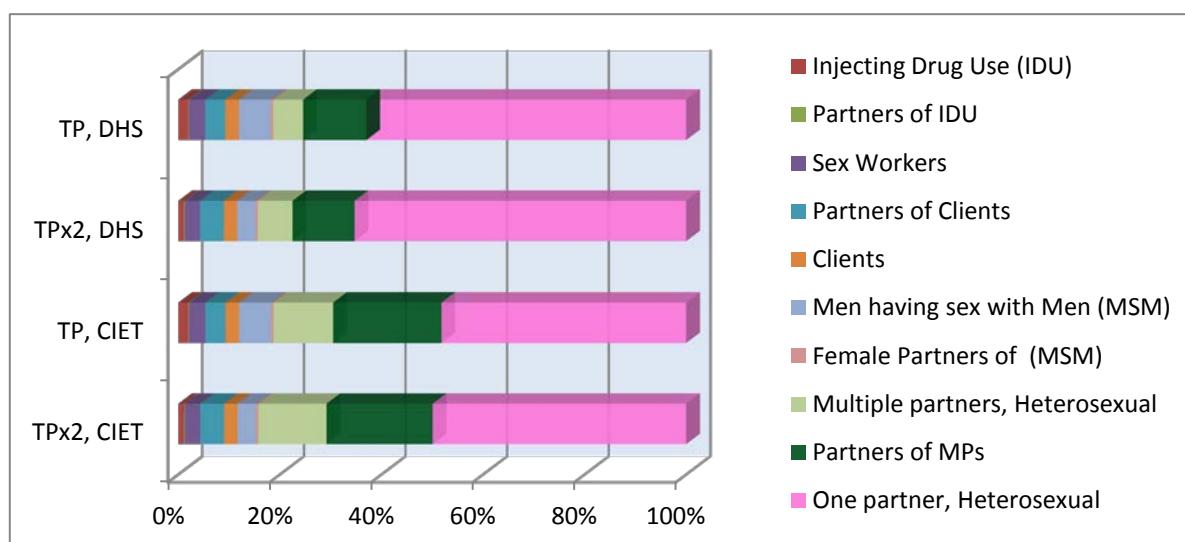
Source: adapted from the Swaziland Demographic and Health Survey (2007)

The HIV prevalence among pregnant women attending ANC aged 15-49 years is 41.1% (confidence intervals 38.7- 43.4), with variations in age groups: 15 – 19 years is 20.4%; 20 – 24 years is 41%; 25-29 years 51%; and 30-34 years, 54% (source: ANC Sentinel Surveillance 2010).

The HIV Modes of Transmission Study (2009) established that heterosexual contact among persons with one sexual partner is the main mode of HIV transmission in Swaziland. It indicated that, 62% of new infections occur among women and that almost two thirds (65%) of 100 new infections in Swaziland occur among those aged 25 years and older, many of whom one would expect to be married or cohabiting with a steady partner.

⁴ Swaziland Demographic and Health Survey (SDHS) 2007

Figure 3: Sensitivity Analysis; Distribution of projected new infections in four scenarios (2008)



Source: UNAIDS incidence model, Swaziland 2008. 100%= total number of new infections projected for 2008.

Legend of Abbreviations used in figure 3:

- TP, DHS- TP gene assessment using Swaziland Demographic and Health Survey data
- TPx2, DHS- TPx2 gene assessment using Swaziland Demographic and Health Survey data
- TP, CIET- TP gene assessment using Centre de Investigacion de Tropicales (Centre of Tropical Disease Research) data
- TPx2, CIET- TPx2 gene assessment using Centre de Investigacion de Tropicales data
- MP- Multiple Partners

Figure 3 shows the distribution of projected new infections using the UNAIDS HIV incidence Model using Swaziland data. All four scenarios show a similar pattern of sources of new infections, predicted that most new infections occur in the group reporting one heterosexual partner during the last 12 months confirming the MOT conducted in 2009. It is deduced therefore that new infections arise because of HIV discordance in couples, low levels of disclosure, lack of condom use in steady couples and possibility of secret sexual partners which were not declared (direct citation from the MOT, 2009).

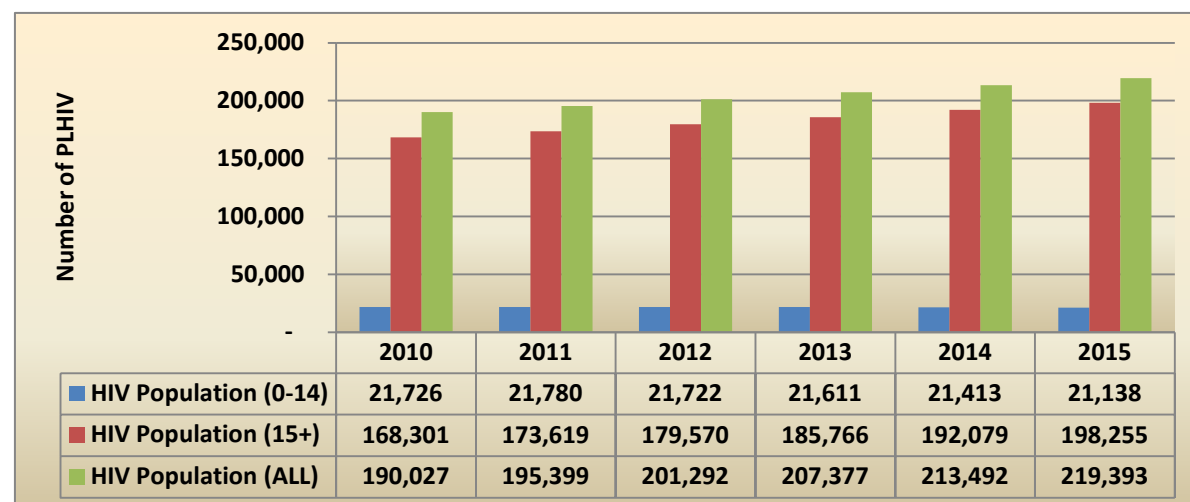
Early sexual initiation coupled with inter- generational sex and late marriage present a risk of contracting HIV. The median age of sexual debut is 16 and 17 for women and men, respectively and 48% of women and 34% of men aged 18-24 begun their sexual relations by the age of 18. The median age of marriage is 26 years for women and 29 years for men aged 30-34. This increases the likelihood of a higher average number of individual lifetime sexual partners (SDHS, 2007). The SDHS established that 43% of women and 49% men aged 15-24 used a condom the first time they had sex and 54% of women and 70% of men of the same age group (15-24) used a condom at last sex.

The Multiple Cluster Indicator Survey undertaken in 2010 and revealed a reduction in the number of youth whose sexual debut was before the age of 15. Condom use was reported to have increased, especially among people with non-regular partners. The same survey indicates, national testing rate among people aged 15-49 improved 40% (47% women and 32% men) compared to 16% in 2007. Male circumcision among males aged 15-49 increased from 7% in 2007 to 19% in 2010.

In 2010 the country undertook the first national behavioural sentinel surveillance for key populations, comprising of sex workers and men having sex with men (MSM) including bio-markers. Preliminary findings from the BSS MARPS study revealed that, HIV prevalence among sex workers is high (70%) and lower among men who have sex with men (17%).

The Preliminary findings from HIV Estimates and Projections (2012) show a total of 168,301 adults and 21,726 children were living with HIV People Living with HIV (PLHIV) in 2010. The PLHIV population is expected to increase to 219,393 by 2015, as shown in *Figure 4* below. Adults constitute a greater number of PLHIV and there are more women than men who are living with HIV. This trend will continue over the years.

Figure 4: Number of People Living with HIV and AIDS, age groups, 2010-2015



Source: Spectrum HIV Estimates & Projections, 2012 (Preliminary)

The HIV incidence rate, of adults aged 15-49, is projected to decline from 2.74% in 2010 to 2.35% in 2015. Although the rate seems to be declining the actual number of new annual HIV infections among the general population are expected to increase from 13, 885 to 14,444 during the same period.

The intensification of the Prevention of Mother to child programme, which began in 2003 and reprogrammed towards the virtual elimination of mother to child transmission in 2010 is showing signs of success. Preliminary HIV Estimates and Projections (2012) show that in 2011, the percentage of HIV positive infants born to HIV infected mothers lowered to 15%, from 17% in 2009.

In accordance with World Health Organisation recommendations, the country revised the national antiretroviral treatment guidelines in 2010. This resulted into a change of treatment eligibility criterion from a CD4 count threshold of <200 to CD4 count threshold of <350 thus a direct effect to increased need for ART. The country has been able to meet the demand by exceeding universal access target as the current treatment service coverage is 80%.

The MICS 2010 demonstrated that, vulnerability among children increased to 45% from 31% in 2007⁵ of children under the age of 18 are classified as either orphaned or vulnerable (OVC), with more children being vulnerable than orphaned. . Preliminary HIV and AIDS Estimates (2012) project the number of AIDS orphans will reduce from 104, 026 in 2010 to 97,293 in 2015.

The number people expressing accepting attitudes towards PLHIV⁶ has increased from 44% in 2007 to 46%, this shows a decline in stigma and discrimination towards people living with HIV and AIDS. In 2011 the Swaziland Network of People Living with HIV/AIDS (SWANNEPHA) conducted a stigma assessment among people living with HIV and produced the Stigma Index Report 2011. The

⁵ SDHS 2007

⁶ SDHS 2007 and MICS 2010

report reflected that 20% of PLHIV have experienced situations where their partner and member of their household were discriminated because of the respondents HIV positive status. Internal stigma seemed to be the most common type of stigma; 45% of PLHIV reported to having made the decision not to have any more children; 22% decided not to have sex and 18% decided not to get married because of their HIV status. The stigma report supported the notion of non-discriminatory service provision in Swaziland as 95% of PLHIV reported that their children had never been dismissed, suspended or prevented from attending an educational institution and only 2.8% ever experienced being refused employment or work opportunity because of their HIV positive status.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1. Target 1: Reduce Sexual Transmission of HIV by 50% by 2015

HIV Prevention remains critical to the national response to HIV and AIDS. Effective prevention interventions are selected on the basis of empirical evidence of their efficacy in preventing new infections. This includes interventions that are designed to reduce exposure to HIV, reduce the probability of transmission when exposed, and influence change in societal norms, values and practices that tend to impact on peoples' ability to adopt key prevention behaviours.

The NSF (2009-2014) includes the following specific targeted areas to address change in societal norms, values and practices. The specific interventions include improving comprehensive knowledge on HIV, addressing sexuality and reproductive health needs, multiple concurrent partners and empowerment of women and girls. Reduced exposure to HIV infection interventions will discourage early sexual debut, multiple concurrent partners, and inter-generational sex. To reduce the probability of infection, the NSF aims to scale up prevention of infection to unborn babies through PMTCT, male circumcision and promote condom use. In 2010, the country developed the male circumcision Accelerated Saturation Initiative (ASI) that sought to circumcise 110,000 men aged 14-49 in a period of two years.

While prevention focuses on priority interventions, there are other interventions that need to continue because of their importance in sustaining the gains already achieved in prevention. HIV Testing and Counselling is one of those interventions. The HTC component is a critical entry point to HIV treatment, care and support services. For a long time in Swaziland, access to knowledge of one's HIV status has been through the client initiated approach (VCT) and to a limited extent the provider-initiated approach. With the need to reach more people in 2006, the country adopted provider initiated HTC approach and integrated HIV counselling and testing into the existing general health care system.

Indicator 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%, 58.2% women and 53.6% men)

MICS 2010 shows that the level of comprehensive knowledge stands at 58.2% and 53.6% for women and men respectively. In comparing with the with the SDHS 2007 results it is noteworthy that there has been an improvement.

In support of the NSF recommendation to adopt SBCC strategies that will influence change in social norms and values, in 2010 the country launched the Swaziland National Strategy for Social and Behaviour Change Communication (NSSSBCC) 2009-2014 with its guidelines and implementation

tools. The strategy seeks to guide the implementation of evidence based, integrated and community focused SBCC interventions. Accordingly, capacity building for civil society organizations which spearhead SBCC initiatives at community level was initiated to improve targeted behaviour change messages. The HIV prevention toolkit was developed and trainings have been undertaken with civil society organizations and government sectors. Dialogues at individual and community level have been conducted targeting youth, uniformed forces, church and other groups.

Other activities include male targeted programs in tertiary institutions, workplace, dipping tanks and in communities to encourage interpersonal communication and HIV testing.

Indicator 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%)

Findings from the MICS report (2010) revealed a significant decline in the proportion of young women and men aged 15-24 that begun sexual relations before age 15. Four percent (3.8%) of women and 2.6% of men aged 15-24 began having sex before the age of 15. This is a reduction from the 6.9% and 4.8% of young women and men aged 15-24 respectively, that reported to having had sexual intercourse before 15 years in the SDHS 2007.

The country has registered positive changes in delay of sexual debut over time largely owing to concerted IEC/BCC strategies targeting adolescents, youths and unmarried people both in school and out school. Early sexual debut presents numerous SRH and HIV risk factors for young people calling for specific interventions that focus on addressing this vulnerable group. In 2010, The Education Sector Policy integrated HIV and AIDS under schools sector care and support programme, through the formal Guidance and Counselling Syllabus, it emphasizes on age and sex specific health promotion at both secondary and high schools. Participation of civil society organizations in community mobilization, dialogues to reach out of school youth at community level and support re-enrolment of OVC back into school provide protection to young people against the acquisition of HIV.

Indicator 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%- 2.7% women and 15.7% men)

Multiple and concurrent sexual partnerships are identified as one of the key drivers of the HIV epidemic in country. Swaziland HIV response focuses on two ways to prevent HIV infection among its population; consistent condom use and promotion of single sexual partner. In 2007, the SDHS reported 22.9% of men aged 15-49 had sex with more than one partner and 2.3% was among women in same age category. The Multiple Indicator Cluster Survey (MICS) 2010 shows that among men and women aged 15-49 years, 15.7% and 2.7% respectively reported to have had sex with more than one partner in the 12 months preceding the survey.

The country has developed national gender targeted campaigns that are implemented by civil society organizations which incorporate both mass media and interpersonal communication at community level. These include the 'One love' and the 'Choose One' campaigns addressing MCP in the country. A change in behaviour among this age group will be especially important to reduce new infections

Indicator 1.4: Percentage of women and men aged 15-49 who had more than one partner in the last 12 months who used a condom during their last sexual intercourse (Overall 71.4%, women 73.1% and 71.0% men)

The MICS (2010) showed that condom use at last sex among men with more than one partner, has improved to 73.1% and at 71.0% among women and men respectively, when compared to the SDHS 2007.

The condom sub thematic area developed a condom Strategy for the period 2010-2015 which is aligned to the NSF. The strategy has been costed and currently awaiting adoption by the WHO and Swaziland Standards Authority approval. Local distribution of condoms at community level is carried out at health facilities, community social centres and key population hot spots. The promotion of consistent condom use is regarded as the cornerstone for HIV prevention responses especially among men and women who have multiple sexual partners. The country has intensified integrated SBCC dialogues with condom promotion and distribution at community level among youth, uniformed forces, and the general public to contribute reduced HIV incidences.

Indicator 1.5: Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results [Overall: 40.1%, Women: 47.3% & Men: 31.3%]

HIV Testing and Counselling (HTC) is the critical entry point to HIV treatment, care and support services. Swaziland started testing patients for HIV based on clinical presentation in 1986 that is when the first HIV case was identified. On discovery of the first HIV case in Swaziland, HIV testing was conducted done in few isolated hospitals. In 1994 the country conducted its first National Sero – surveillance among pregnant women and began screening donated blood for. At that time test results would be obtained after 2 to 3 weeks.

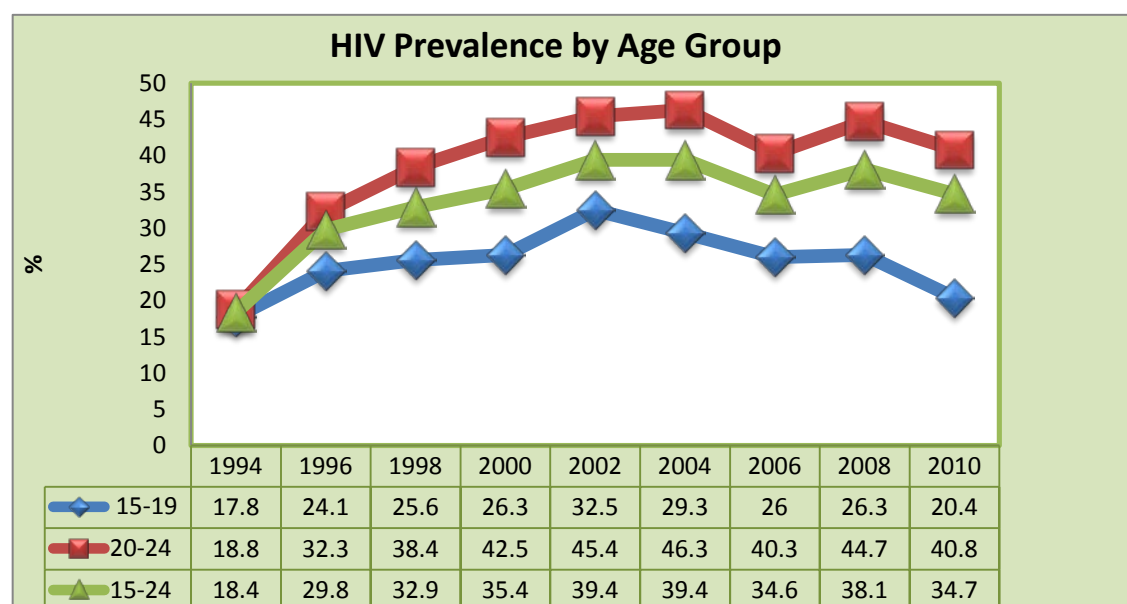
The HTC programme was formally introduced in 2002 as the client initiated testing, known as the Voluntary Counselling Testing. Seeing the need to reach more people, in 2006, there was the paradigm shift from VCT to provider initiated HTC approach and integration of HIV counselling and testing into the existing general health care system. Currently there are three HTC models and these include free standing centres - offering client initiated or VCT services, integrated HTC services, and outreach HTC services. According to the 2010 Service Availability Mapping (SAM) report, there are 201 out of the total 265 (76%) health facilities offering HTC services and 40 outreach sites.

The findings from the MICS 2010 reflect a significant increase in the level of testing in the 3 years since the last survey. The testing rate among men has increased almost three fold and doubled among women. For 40.1% of the survey respondents (47.3% women and 32.2% men) reported having been tested and received their results in the 12 months preceding the survey. The same study further showed that 73.3% and 45.5% of women and men respectively, had ever had an HIV test. The improvement could be contributed to by national promotion activities like HIV testing in the male circumcision campaign, the ‘Man knows’ campaign, door-to-door testing, couple testing and male involvement in the PMTCT program. The efforts have seen community health workers (CHWs) trained to carry out testing in communities, hard to reach areas although data in regard to their intervention has not been captured.

Indicator 1.6: Percentage of young people aged 15 – 24 who are HIV infected (34.0%)

HIV prevalence among the age group 15-24 is used to estimate the recent trends in HIV incidence and behaviour. The HIV Sentinel Surveillance Survey conducted in 2010 by the MOH show that prevalence within the age group 15-24 is at 34.0% overall; age groups 15-19 and 20-24 the HIV prevalence is 20.4% and 40.8% respectively. HIV prevalence among the 15-24 age groups is on a downward trend compared to 38.9% in 2008 as illustrated in *Figure 5*. Shows that the current prevalence rate as comparable to prevalence rates in 2006;

Figure 5: HIV Prevalence by Age Group 15-19, 20-24, 15-24 in 1994-2010



Source: ANC, 2010

In 2007, the SDHS (2007) reported that 15.9% (21.8% women and 8.9% men) of the population had reported having had an HIV test and received their results in the 12 month preceding the study.

Most at Risk Populations

The NSF classifies most at risk populations in Swaziland as sex workers, migrant or mobile populations and prisoners. The country has a generalized epidemic which makes it difficult to discover the extent to which sex work, men who have sex with men (MSM), intravenous drug users (IDU) and prisoners contribute to the spread of HIV in Swaziland. In 2011, His Majesty's Correctional Services conducted an assessment that revealed the prevalence of HIV to be 34.9% among prisoners, from a total of 473 prisoners'. The preliminary results of the BSS 2011 revealed that the HIV prevalence amongst mobile or migrant population revealed that it is 30.4%.

Although there have been attempts to define and measure the extent of sex work; MSM and IDU there is still little information. Reasons for this could be that sex work; MSM and IDU are considered illegal and are therefore concealed. The legal environment around these issues present barriers to the provision of targeted prevention, treatment and care; and support services that the MARPs need. As a result there are fewer programmes specifically targeting these internationally defined key populations. Service provision in Swaziland is on a human rights equitable basis that is open to all who need.

According to the MOT 2009, the contribution of most practices by MARPs in fuelling the epidemic remains unknown due to limited data. In this regard, MARPs practices are considered not to be a major factor in the Swaziland's epidemic. The NSF 2009- 2014 recognizes that while controlling HIV infections among the MARPs may not have a significant impact in reducing HIV infection in a generalized epidemic, there is need to target these groups as a human rights issue. It is important to note that what is shared by MARPs universally is their high vulnerability to HIV infection and low access to targeted HIV services.

The Ministry of Health in collaboration with civil society developed an operational framework to address HIV amongst MARPS. The framework seeks to strengthen leadership, management,

coordination and the implementation of programs targeting MARPS guided by MARPs technical guidelines, community advisory committees (CAC) and MARPs TWG. In addition, the framework advocates for an enabling policy, social and legal environment for programmes targeting MARPs. The framework builds on activities that the civil society organizations are already implementing with MARPS. Interventions in place include: peer education program, access to services using the coupon system whereby coupons are distributed on demand by the different peer educators for use when accessing health care services which enable MARPs to access the health services free of charge and condom provision at hot spots. The use of the coupon system has played a major role in motivating the health worker to provide MARPs specific interventions, training of Health care providers on MARPS friendly services.

In 2010/11 the country undertook a Behavioural Surveillance Survey: MARPs 2011 (BSS: MARPS 2011) specifically targeting sex workers and men having sex with men. The Respondent Driven Sampling (RDS) technique was used to identify respondents who consider themselves as sex workers and MSM. The BSS MARPs 2011 was able to map and collect data from 323 female sex workers aged 15-49 and 326 MSM aged 16-44. The survey was enriched by the assessment of the respondents' HIV sero-status.

Indicator 1.7: Percentage of sex workers reached with HIV prevention programmes [Women no data]

Swaziland has a generalized epidemic which makes the definition of sex work difficult. This is due to the element of money exchange and sex being prevalent in most relationships. As a result there is informal transactional sex that is may be difficult to classify as commercial sex. The country has made attempts to define and measure the extent of the phenomenon in the country but there is still little information. The legal environment around these issues restricts efforts to implement programmes to counter the spread of HIV this sub population.

Despite the limited access to these population groups; some organizations implement programmes within the country but the size of the population remains largely unknown and services provided to them as well. The BSS: MARPS 2011 mapped out and collect data from 323 female sex workers. Preliminary findings from survey show that 81% of sex workers have received information on HIV in the 12 months preceding the study.

Indicator 1.8: Percentage of sex workers reporting the use of a condom with their most recent client [No data]

Data relevant to this indicator that is in compliance with the reporting guidelines is not available in the country. Previously the proportion of female sex workers reporting use of condoms with clients was reported at 90% with 74% using it consistently (BSS, 2001). According to the same survey, not all sex workers are particular about condom use; some women reported they would agree to have sex without a condom for a higher fee.

Preliminary findings from the BSS MARP's 2011 indicate that 82.3% of female sex workers report to have used a condom at last sex with their regular client and 87.7% reported having used a condom at last sex with a new client. The findings however do not specify usage of a condom with the most recent client. The high numbers of female sex workers reporting condom usage with both regular and new client at last sex can be attributable to the strategy of condom distribution at 'hot spots' thereby increasing the accessibility of condoms.

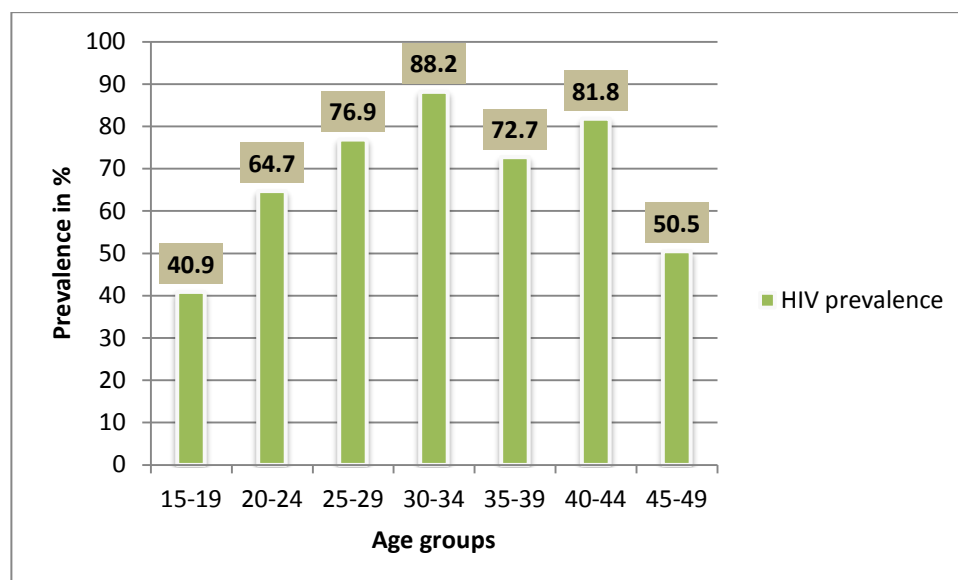
Indicator 1.9: Percentage of sex workers who received an HIV test in the past 12 months and know their result (No data)

The purpose of this indicator is to provide a direct measure of how well sex workers are covered by HIV Testing Counseling (HTC) services and utilization of these services by sex workers. Reaching high coverage figures for these populations often suggest that services are trusted, friendly to priority populations and easily accessible. Though the country has no data available for this indicator, the preliminary data obtained from the BSS MARP's 2011 reveals that 74.6% of sex workers reported having received an HIV test in the 12 months preceding the survey. However, respondents were not asked whether they had received their test results.

Indicator 1.10: Percentage of sex workers who are living with HIV (69.7%, N=326)

Prevalence data among MARPs in the country has previously not been available. The BSS MARPs 2011 presented an opportunity for the country to know the extent of the spread of the epidemic within these groups. Preliminary results of the study, which included testing for HIV, show that 69.7% of female sex workers are living with HIV. This finding is consistent with UNGASS 2009, in which 68% sex workers who were interviewed self reported that they knew their HIV status to be positive.

Figure 6: HIV Prevalence among female sex workers aged 15-49, by age group, 2011



Source: Preliminary data from the BSS MARPS 2011

As shown, in figure 6, HIV prevalence is highest among sex workers aged 30-34 years and lowest among those aged 15-19. Caution must be exercised in interpreting the results for those aged 40 and above because of the small sample size for that age group.

HIV prevalence findings are consistent with the 2010 Ante Natal Care prevalence results that show a higher disease burden among those aged 30-34 and lowest among the 15-19 age group at 53.5% and 20.4%, respectively.

Indicator 1.11: Percentage of men who have sex with men reached with HIV prevention programmes (no data)

Data relevant to this indicator that is in compliance with the reporting guidelines is not available in the country. Provisional results from the BSS MARPs 2011 show that 69.8% of the 326 surveyed MSM's have access to and have been given condoms in the 12 months leading to the survey. However, only 27.1% reported to have received information about prevention of HIV with specific focus on men who have sex with men within the same period.

Currently there are two implementing organizations providing services to MSM's. However, it is suspected that a bigger proportion of the MSMs are not members of the two organizations but participate in activities targeting the sub-population. On another note, the bigger challenge is reaching MSMs who are may be in heterosexual relationships due to issues of disclosure.

Indicator 1.12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (No data)

Data relevant to this indicator that is in compliance with the reporting guidelines is not available in the country. Even though the country has no data available for this indicator, preliminary data obtained from the BSS MARPs 2011 shows that 70.7% and 66.2% of MSM reported to have used a condom the last time they had sex with regular and non- regular male partner, respectively. The high condom use among MSM is supported by the easy access to condoms, as reported by 69.8% of MSM.

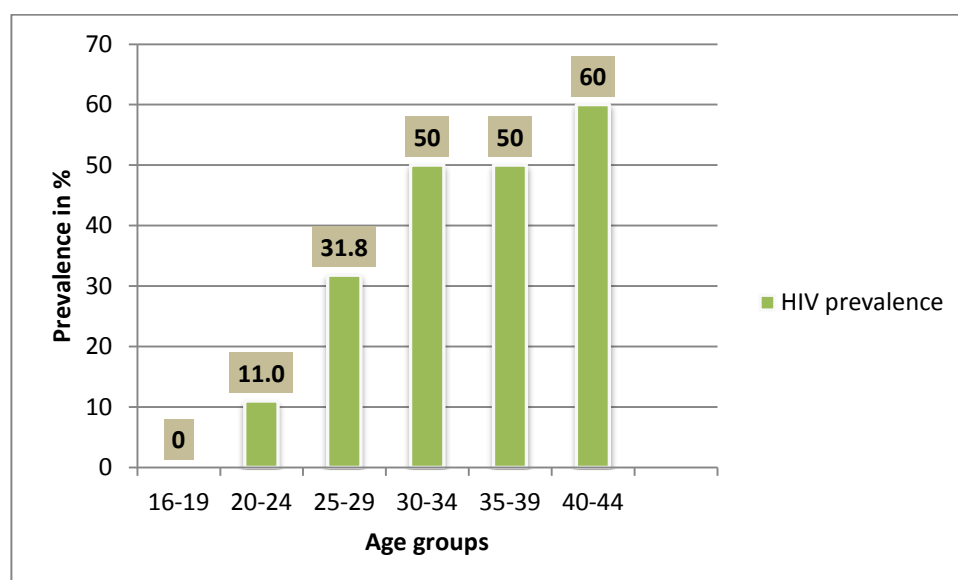
Indicator 1.13: Percentage of men who have sex with men who have received an HIV test in the past 12 months and know their results (No data)

Data relevant to this indicator that is in compliance with the reporting guidelines is not available in the country. According to the preliminary BSS MARPs 2011, testing for HIV among the sub population in the 12 months was recorded as 30.4%; however the survey did not solicit information in regards to receipt of test results. It is noted that the proportion of the testing rate is consistent with the HTC rate of 31% among men aged 15-49 as reported by the MICS, 2010.

Indicator 1.14: Percentage of men who have sex with men who are living with HIV (16.7%, N=324)

The country has never collected data on HIV prevalence among MSM as a sub-population. The BSS MARPS 2011 provided the opportunity to gain insight on HIV prevalence among this group as survey respondents were tested for HIV during the assessment. Preliminary findings from the BSS MARPs (2011) reveals that HIV prevalence amongst the MSM aged 16-44 who were interviewed is at 16.7%.

Figure 7: HIV Prevalence among MSM, by age group, 2011



Source: Preliminary data from the BSS MARPS 2011

As shown in figure 7 above, HIV prevalence among MSM increases with age as higher prevalence rates are observed in the older ages and the highest being among those aged 40-44. None of the younger respondents aged 16-19 were found to be HIV positive.

3.2. Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

The NSF 2009-2014 and the Health Sector Strategic Plan 2008-2013 highlight the need for interventions targeting injecting drug users as a key population. The Operational Framework for MARPS includes interventions targeting IDUs that range from prevention of entry into drug use, counselling for those who are willing to quit the practice, managing the withdrawal symptoms and complications resulting from drug use. However, there is still a gap in the provision of harm reduction strategies and the provision of Opioid substitution therapy. In an effort to bridge the gap, MoH and NERCHA have launched a task team to drive issues relating to drug use.

The MOT (2009) indicated that injecting drug use was not a major driver of HIV in Swaziland. This assertion cannot be corroborated to date because there are no recent studies which have been carried out to determine the population size of IDUs including their knowledge, attitudes and practices around HIV issues. Information obtained from a mini assessment which included 40 drug users conducted by the MOH with partners in 2011 revealed that, 62.5% of those surveyed used injectable drugs and 92% self-reported to ever sharing injecting devices

Indicator 2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

Swaziland is not reporting on this indicator as there are no data available.

Indicator 2.2: Percentage of people who inject drugs who report the use of a condom at last sexual intercourse (39.4%, N=25)

Though the country does not have data on this indicator, information obtained from a mini assessment conducted by the MOH with partners revealed that 39.4% of IDUs used a condom consistently.

Indicator 2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

Swaziland is not reporting on this indicator as there are no data available

Indicator 2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results (52.5%, N=25)

The mini assessment conducted reveals that 60% of IDU respondents (N=25) had ever tested for HIV and of those, 52.5% knew their status.

Indicator 2.5: Percentage of people who inject drugs who are living with HIV

Swaziland is not reporting on this indicator as there are no data available.

3.3. Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

The PMTCT programme was officially launched in 2003 and implemented within the maternal, newborn and child health (MNCH) services. Since then, there has been notable progress in PMTCT service coverage. HIV prevalence among pregnant women is 41.1%, is highest among the older age group 30-34 and lowest among the 15-19 age group⁷.

The PMTCT services begin with the routine offer of HIV testing as an integral part of ANC services. HIV testing is an entry point to: primary prevention of HIV among young women of reproductive age, prevention of HIV from HIV infected mother to the child and treatment and care services for HIV infected mothers, families and children to access treatment and care services.

Strategically, PMTCT is implemented through a four pronged approach:

- Prong 1: Primary prevention of HIV infection among women of child bearing age
- Prong 2: Prevention of unintended pregnancies among HIV positive women
- Prong 3: Reduction of MTCT from HIV positive woman during pregnancy, labour and breastfeeding periods.
- Prong 4: Care, treatment and support for HIV positive women and their families⁸

At the programme inception, Swaziland had only 3 health facilities offering PMTCT services and this has gradually increased to a total of 154 (88%)⁹ health facilities by 2010. The country has high antenatal care (ANC) attendance of 97% which puts the provision of PMTCT services at an advantage. As HIV testing is part of the essential ANC package, Swaziland has witnessed a tremendous increase in the proportions women tested for HIV during pregnancy. By the end of 2010, over 80% of pregnant women were tested for HIV. The country has also applauded itself on the

⁷ Swaziland 12 Round HIV sentinel Surveillance Report, 2010

⁸ National PMTCT Guidelines

⁹ Service Availability Mapping, 2010

increase in ARV uptake among pregnant women, either for PMTCT or for their own health, from 4% in 2004 to about 85% by end of 2010¹⁰.

Indicator 3.1: Percentage of HIV- positive pregnant women who receive Antiretroviral to reduce the risk of mother-to-child transmission (94.5%)

The National PMTCT Guidelines 2010 provides direction on the initiation of positive pregnant mothers on prophylaxis and ART from as early as 14 weeks of pregnancy. The guidelines also provide direction while in labour, delivery and throughout the breastfeeding period. To ensure that there are no losses due to sero-conversion after the initial test, the country re-tests HIV negative pregnant women every 8 weeks, at 36 weeks and throughout the breastfeeding period to identify transmission risk as soon as possible and the practice has resulted into tremendous gains in the reduction of mother to child infection.

In 2011 a total of 10,641 HIV pregnant women were provided with antiretroviral prophylaxis to reduce MTCT. Based on service demand denominator from the HIV Estimates and Projections¹¹ (2010) for 2011, 94.5% of all HIV positive pregnant women received antiretroviral prophylaxis to reduce mother to child transmission by the end of 2011. This shows substantial improvement from the 69% reported at the end of 2009 and 77% at the end of 2010.

Table 2: Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT 2010-2011

Indicator	2010	2011
Number of HIV positive pregnant women	13,454	13,245
Number of women needing PMTCT	11,436	11,258
Number receiving ARVs for PMTCT	8752	10641
Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT (%)	76.5%	94.5%

Source: Preliminary HIV Estimates and Projections 2012 and HMIS

Actual data for health facilities show that 12,156 HIV pregnant women were seen in ANC facilities in 2011. Using the actual number of women seen at facilities as a denominator (and not the Spectrum estimates), a total of 87.5% (10,641/12156) of all HIV positive pregnant women received antiretroviral prophylaxis to reduce mother to child transmission by the end of 2011. Table 3 depicts the ARV service coverage among pregnant women using health facility data.

¹⁰ Ministry of Health Routine HMIS Database

Table 3: Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT 2010-2011 (Actual health Facility Data)

Indicator	2010	2011
Actual number of Pregnant women attending Ante Natal Care	33,916	33,601
Actual number of Pregnant women attending Ante Natal Care who were tested for HIV and received results	29046	30812
Actual number of HIV positive women seen at ANC facilities	11,776	12,156
HIV prevalence among pregnant women attending ANC	40.5%	39.5%
Actual number of HIV pregnant women who received ARV	8752	10641
Percentage of HIV pregnant women who received ARV to reduce the risk of MTCT	74.3%	87.5%

Source: Ministry of Health Service Coverage Report 2010

The country has decentralized PMTCT and ART services to peripheral clinics as well as STI services in terms of coverage in service delivery, training of health care workers and availability of technical guidelines. There is an on-going decentralization of laboratory and other support services to ensure that positive health outcomes are realized timely.

Indicator 3.2: Percentage of infants born to HIV-positive women receiving a Virological test for HIV within 2 months of birth (68.9%)

The introduction of the virological testing for all exposed infants at 6-8 weeks has increased early infant diagnosis and ART uptake for young children in the country. Sixty-nine percent (68.9%) of HIV exposed infants received a virological test within 2 months as recommended in the PMTCT/Pediatric guidelines during 2011. This is a major milestone for the country where the testing of Dried Blood Spots (DBS) uptake has increased significantly in comparison to previous years.

The SAM 2010 reported that, 82% of health care facilities have capacity to collect DBS for DNA PCR and offer child welfare services. All Regional hospitals, hospitals, public health units and government clinics and other clinic have Pediatric ART guidelines and are utilized to deliver ART services to clients. It is also worth noting that these facilities have trained staff and there is on-going capacity building.

Table 4: Percentage of Infants born to HIV positive women receiving a virological test for HIV within 2 months of birth

Indicator	2010	2011
Estimated Number of births	33,030	33,425
Number of exposed ¹² infants	13,580	13,740
Number of infants born to HIV positive women who received a virological test at 6-8 weeks	5,713	9,470
Percentage of infants born to HIV positive women who received a virological test at 6-8 weeks	42.1%	68.9%

Source: Population Projections 2007-2030 and HMIS

¹² Exposed infants are calculated as all births * 41.1% HIV prevalence at ANC 2010.

Indicator 3.3: Mother to child transmission of HIV (modeled) 15.4%

A majority of HIV infections in children in Swaziland are due to mother to child transmission during pregnancy, childbirth and breastfeeding. New infant infections are influenced by the number of HIV positive women who access PMTCT services, who receive an appropriate ARV regimen and who adopt the recommended infant feeding option. It is assumed that fewer children who are born from HIV positive mothers can be infected as the coverage of PMTCT interventions increases as well as use of more effective regimens.

These variables were factored into the Spectrum¹³ model software and yielded the data in *Table 5* below. Through the use of modelling data, the value for mother to child transmission is 18.4% and 15.4% in 2010 and 2011, respectively. This implies that in 2011, fifteen percent of children born to HIV infected mothers were infected through MTCT.

Table 5: Percentage of Children born to HIV infected mothers who are infected, 2010-2011

Indicator	2010	2011
Estimated number of HIV positive pregnant women	13,454	13,245
Estimated number of HIV positive pregnant women who are in need of PMTCT	11,436	11,258
Number of HIV + pregnant women receiving ARVs for PMTCT ¹⁴	8752	10641
Number of new infections 0-14 years	2,106	1,739
Percentage of child HIV infections from HIV –positive women	18.4%	15.4% ¹⁵

Source: Preliminary Spectrum outputs 2012

The modelling assumed that, children aged 0-14 can only be infected through mother to child transmission and thus representing the estimated number of newly infected children with HIV. Other assumptions included in the model were; no ARV coverage during breastfeeding. The national programme however, supports the provision of ARV prophylaxis throughout the breast-feeding period and guided by the national PMTCT programme. At the beginning of 2010 the country stopped provision of single dose niverapine. Currently all HIV positive pregnant women are given more efficacious regimens of either dual or triple ARV therapy.

The country has generated data for the PMTCT programme from immunisation sites on the actual numbers of women and child that visits these sites. The national coverage of immunisation is high and, according to the MICS 2010, over 90% of children under 1 year have been given a basic immunisation package. The country collects dry blood spots from infants who are born to HIV positive mothers during the first routine immunisation visit and a test for HIV using DNA PCR is performed. Testing is again done at 1 week after cessation of breastfeeding. During 2011, a total of 2,884 infants aged 6-8 weeks were tested for HIV. From those 190 tested HIV positive. As a result the Mother to child HIV transmission rate amongst infants aged 6-8 weeks is 6.6% in 2011.

¹³ Spectrum is a software package can be used to project the impact of the HIV epidemic. Spectrum is developed by Futures Group Institute and can be downloaded from <http://www.futuresinstitute.org/pages/Spectrum.aspx>

¹⁴ Values obtained from National programme through HMIS

¹⁵ Routine data from immunizations sites gives 6.6%.

3.4. Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

The provision of antiretroviral therapy (ART) in Swaziland started in late 2003 as a pilot project at the Mbabane Government National Referral Hospital. Over the years the service has been decentralized to other regional (district) hospitals, Health Centres and clinics, which include Government, NGOs and private sector, in an effort to make this essential service accessible to all and especially in the rural areas. To date 110/265 (42%) health care facilities offer comprehensive ART services either as an initiating site or refills point. ART is provided free of charge to all patients in need of ART at public centres, outreach sites and NGOs. Some private health facilities are also supported by the Ministry of Health to provide free ART services. In 2010, the country adopted WHO ART guidelines that expanded treatment eligibility to a CD4 <350 threshold for children above 5 years and adults. Children under 2 years are automatically enrolled and those between 2-5 when their CD4 count is less than 25%¹⁶.

The national HIV programme has a structured Pre-ART programme, where clients are automatically enrolled into HIV pre-ART care upon receiving a positive HIV result. Pre-ART services include TB screening, Prophylaxis cotrimoxazole & isoniazid, Health education and routine monitoring of CD4 count, screening and management of opportunistic infections. This helps to keep clients in HIV care and enables early enrolment in ART as soon as they are eligible for the best treatment outcome.

Indicator 4.1: Percentage of eligible adults & children currently receiving Anti- retroviral therapy (Overall: 80.0%; adults: 84.3% & children 53.2 %)

Based on the estimated need threshold of CD4 <350 for adults, a total of 90,480 (78,127 adults and 12,353 children) were in need of ART in 2011. By end of December 2011, a total of 72,402 people were actively on Anti-retroviral treatment constituting 65,835 (84.3%) adults and 6,567 (53.2%) children, shown in figure 8 and table 6. This translates to a treatment service coverage rate of 80.0%. This indicates a good performance for the programme in adult enrolment as the programme had targeted to reach 80%¹⁷ in 2011.

In order to support patients on treatment, a family approach is encouraged. However, a shortfall of 22% is realised among children in need of ART as only 53.2% has been achieved against the target of 75% by the end of the 2011. This could be attributable to the current investments being more focussed on PMTCT and Expanded Programme on Immunisation (EPI) . Children under 2 years are better recruited and enrolled into care as a continuity of PMTCT care and the expanded programme on immunization (EPI- a program ensures all children complete their immunization schedule), the widest gap is with the children above 2 years until adulthood, 16 years and older.

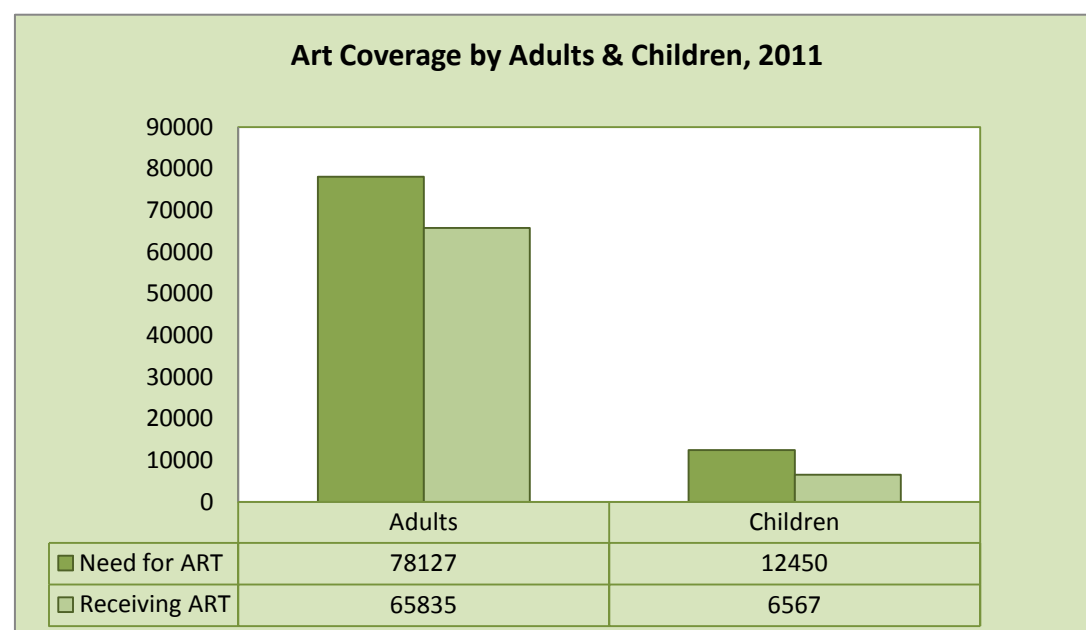
Factors that contribute to the service gap are the national HTC legal age for consent of 16. Additionally, even though Swaziland has a strong immunisation programme and coverage, majority of children exit the immunization programme they are only brought back to health facilities when they suffer from ailments; and they are normally brought back to the health facility by a caregiver and , in most cases these cannot consent for the child to have an HIV test.

The national ART programme has developed some strategies to improve paediatric ART care and is currently under discussion with relevant line ministries, to ensure that more children are tested for HIV and the eligible to be enrolled into care.

¹⁶ National ART Pediatric Guidelines 2010

¹⁷ NSF result for 80% of Adults and 75% of children who are eligible to receive ART in 2011.

Figure 8: ART Coverage by Adults & Children, 2011



Source: Preliminary data from HIV Estimates and Projection 2012 and HMIS 2011

As shown in table 6 below, more women than men are receiving ART in Swaziland. This is more common among adults. This is partially explained by the positive health seeking behaviour among women. In 2011, over 90% of women who were in need were receiving ART and 71% of men who were in need received. Gender differentials in accessing care among children are minimal owing to the strong care programme targeting children at immunisation sites irrespective of gender.

Table 6: Children and Adults receiving ART, by sex, 2010 and 2011

		Children 0-14 years			Adults 15+			TOTAL
		Female	Male	Total	Female	Male	Total	
2010	Need	6,191	6,259	12,450	41,939	30,000	71,939	84,389
	Receive	2,889	2,764	5,653	35,814	19,290	55,104	60,757
	Coverage (%)	46.7%	44.2%	45.4%	85.4%	64.3%	76.6%	72.0%
2011	Need	6,145	6,208	12,353	45,615	32,512	78,127	90,480
	Receive	3,400	3,167	6567	42,741	23,094	65,835	72,402
	Coverage (%)	55.3%	51.0%	53.2%	93.7%	71.0%	84.3%	80.0%

Source: Preliminary HIV Estimates and Projections 2012 and HMIS

Indicator 4.2: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (Overall: 87.2%; Adults 87.1% & Children 87.7%)

Adherence to ARVs is a major determinant of the quality and length of life for HIV patients. Recognizing the importance of keeping patients on treatment, the program has put in place stringent mechanisms to limit the number of defaults and loss of follow up clients. This includes engagement

of community based expert clients and treatment supporters that encourage patients to adhere to treatment and track defaulters. On the other hand health facilities offering ART services have in place appointment cards and registers to ensure that appointments honoured by patients. This is complemented by a system of defaulter tracing that is implemented in conjunction with local networks of people living with HIV and AIDS.

As a result of those efforts, data from the ART patient management system as shown in Table 3 below demonstrates that 87.4% of adults and children with HIV known to be treatment were alive 12 months after initiation of ART. This constitutes of 87.1% among adults and 88% among children.

As a result of these efforts, data from the ART patient management system as shown in Table 7 below demonstrates that 87.4% of adults and children with HIV known to be treatment were alive 12 months after initiation of ART. This constitutes of 87.1% among adults and 88% among children.

Table 7: Cohort of Patients starting ART in December 2010

	Original Cohort	Net Cohort	Proportion alive (%)
Adults	14114	12299	87.1
Children	1546	1355	87.7
Total	15660	13654	87.2

Source: HMIS

Programme data shows that 4% of the people that are no longer on treatment are deceased and the 9% are lost to follow up¹⁸. In 2010, the Ministry of Health commissioned a study to understand who and where the patients that were recorded as lost in the system could be found. The results of the study found that of the total patients that were recorded as lost to follow up 12% of patients had restarted at other sites, 37% had died and 51% were untraceable.

3.5. Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

HIV is strong risk factor for developing the tuberculosis (TB) disease in those with latent or new Mycobacterium tuberculosis infection. The risk of developing TB is between 20 and 37 times greater in people living with HIV than among those who do not have HIV infection. TB is responsible for more than a quarter of deaths in people living with HIV. In response to the dual epidemics of HIV and TB, the World Health Organization (WHO) has recommended collaborative TB/HIV activities as part of core HIV and TB prevention, care and treatment services. They include interventions that reduce the morbidity and mortality from TB in people living with HIV, such as the provision of antiretroviral therapy (ART) and the Three I's for HIV/TB: intensified case-finding of TB (ICF), Isoniazid preventive therapy (IPT), and infection control for TB. All have been adopted and are being implemented by the country.

New guidelines have been developed whose recommendations are for the use of a simplified screening algorithm that relies on five clinical symptoms to identify those eligible for either IPT or further diagnostic work-up for TB and other conditions.

¹⁸ When an ART patient has not attended two consecutive visits, the ART patient monitoring system automatically records them as lost to follow up.

Indicator 5.1: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (9.7%)

Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. Collaborative efforts to curb the dual co infection of HIV and TB are relatively new in the country. The country put in place the TB/HIV National Coordinating Committee (NCC) to coordinate the national response to the intersecting epidemics of TB and HIV since 2007. One of the main goals of the TB/HIV NCC is to have integrated services for both TB and HIV that entails infection control, intensifying case finding, isoniazid preventive therapy to mention a few. Through the committee the country has developed National TB/HIV Policy Guidelines to guide the implementation of the collaborative programs. As a result, TB services are now offered in ART sites and initiation of both TB and HIV treatment. The country has also adopted WHO guidelines and subsequently all TB cases that are HIV positive are initiated- on ART regardless of CD4 cell count.

According to the national TB programme report for June 2010, 84% of TB clients were tested for HIV and 85% of those who were tested for HIV were found co infected with HIV TB but these only 32% received treatment for both HIV and TB. According to WHO guidelines, all co-infected patients should be started on ART as soon as they can tolerate TB treatment. Data from the ART routine system show that in 2011 a total of 1,259 people with advanced HIV infection who received antiretroviral were also started on TB treatment. Annual estimates of TB cases among people living with HIV are high and the TB burden for Swaziland is 13,000, as calculated by the WHO. This gives a 9.7% of estimated positive incident TB cases that received treatment for both TB and HIV. The country strategies focus on integrating the coordination of TB and HIV programmes in order to optimize the use of resources and access to care for patients who are co-infected. The M&E systems for both programmes are being strengthened through the integration both programmes' collection systems.

3.6. Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low and middle income countries

Funding for the HIV and AIDS response is provided by two main sources the Government of Swaziland and international partners. Swaziland has two major international partners contributing to the national response the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM/Global Fund) and the Presidents Emergency Relief Plan (PEPFAR), through the Global Health Programme. The Clintons Health Initiative (CHAI) assists greatly in technical support and mentoring of local agencies. The United Nations also provides additional support and other bilateral partners including the European Union and international Non Governmental Organisations. The private sector contribution to the response is also on the increase.

Support provided by bilateral and multilateral partners is mobilised through the Swaziland Partnership Forum against AIDS and the Donor Forum/s. These forums provide strategic direction to international partners that are willing to support the response. Funding from international partners forms about 60% of the total funding for HIV in the country and is channelled through government and civil society organizations for specific programmes predominantly, prevention and care and treatment. The support has created enabling environment to implement HIV and AIDS interventions as result has improved service delivery, strengthened local capacities and policy reform.

Indicator 6.1 Domestic and international AIDS spending by categories and financing sources

The country does have current data that responds to the reporting period for this indicator. Swaziland conducted the second round of the National AIDS Spending Assessment in 2011 covering the 2007/8, 2008/9 and 2009/10 financial years. The assessment covered expenditure from the public, nongovernmental and private sectors. Total expenditure in 2009 was SZL 435,374,505 (US\$ 49,362,188)¹⁹ rising to SZL 582, 670,706 (US\$75,280,453)²⁰ in 2010.

Table 8 below reveals that between the two years covered by the NASA 2011, the proportion of funding from external partners ranged from 54.79 % (SZL 238, 542, 436) in 2009 to 59.6% (SZL331,563,887) in 2010. On the other hand the contribution from the public purse decreased from 42.01% (SZL182, 905,780) in 2009 to 39.74% (SZL231, 521,283) in 2010. In addition, the private sector contributed 3.2% (SZL13, 926,289) in 2009 and 3.36% (SZL19, 585,536) in 2010.

Table 8: Sources of Funds in 2009 and 2010

Source	2008/09	(%)	2009/10	(%)
Public Funds	182,905,780	42.01	231,521,283	39.73
Private Funds	13,926,289	3.2	19,585,536	3.36
International Funds	238,542,436	54.79	331,563,887	56.9
Grand Total	435,374,505	100	582,670,706	100

Source: NASA, 2011

Overall, domestic sources contributed 45.21% in 2009 and 43.1% in 2010 whilst international sources contributed 54.79% in 2009 and 59.6% in 2010.

3.7. Target 7: Critical Enablers and Synergies with Development Sectors

The NSF states clearly that the country's response to HIV is designed to maximise the synergies of HIV programmes with the development sectors. Guided by the Goal to improve the country's Human Development Index (HDI), the NSF includes a wide range of actions aimed at improving the overall management of the response and socio-economic status of the Swazi populace in general. These include; community mobilisation, reduction of abuse, support to vulnerable households and OVC, greater involvement of people living with HIV and creating an enabling environment for implementation of the HIV response, including monitoring and evaluation.

Indicator 7.1 National Commitments and Policy Instrument (NCPI)

The National Commitments and Policy Instrument (NCPI) measures progress in the development and implementation of national level HIV and AIDS policies, strategies and relevant legal requirements for HIV effective response. The NCPI data collection tool, a questionnaire, was administered to leaders of strategic organisations in Government and civil society to gain insight on local successes and challenges in the areas of strategic planning, political support and leadership, human rights, civil society involvement, prevention, treatment, care and support; and monitoring and

¹⁹ In 2009 the exchange rate was US\$1= SZL 8.82

²⁰ An exchange rate of US\$1= SZL 7.74 was used in 2010

evaluation. A total of 12 questionnaires (5 from Government and 7 from civil society) were administered using face to face interviews, thereafter data was coded and analyzed along the themes provided in the questionnaire. The summary of findings for each sector are presented in the section and annexed.

3.7.1.PART A: Government perspective

Key informants for Part A of the NCPI targeted senior government officials and policy makers included officials from the Ministries of Health and Justice and Constitutional Affairs, National Emergency Response Council on HIV/AIDS (NERCHA), Public Sector HIV and AIDS Coordinating Committee (PSHACC) and Parliament of Swaziland.

The following are the summarized responses gathered from the government sector.

3.7.1.1. Strategic Planning

The country has developed 3 National HIV strategies. The first national multisectoral strategy for the period 2000-2005, the second strategic plan covered the period 2006-2008 and the current National Multisectoral Strategic Framework 2009-2014. The NSF is results based with formal impact and outcome level results. The NSF has clear baseline data and targets which were agreed upon through a highly participatory process involving a wide range of stakeholders including the civil society. Key strategies in the plan include working in collaboration with sectors in areas such as education, health, Labour, military/ police transportation, women and young people to achieve the desired strategic results.

The current NSF recognizes most at risk populations such as migrants/mobile populations, orphans and vulnerable children, people with disabilities, sex workers, women and girls. Other settings like prisons, schools and workplaces are particularly targeted with HIV prevention programs and services include HIV testing and counselling and ART.

The respondents noted that the key achievements for the period 2010-2011 included the launch of the National Strategic Framework in 2009 by the Prime Minister, development of the NSF and programmes action plans and budget provision for the scale up of programmes. The Government sector recognised the promotion of participation of all stakeholders in government, engagement of Non Governmental Organisations, civil society organizations and the private sector in the implementation of national HIV programmes and strategies. These include the decentralization strategy, SBCC strategy and PMCTC, ART and OVC support programmes.

However the respondents imitated challenges such as low capacity for planning and costing, inadequate financial resources and human resources as those that affect the implementation of NSF priorities.

3.7.1.2. Political Support and Leadership

Respondents pointed out that Swaziland enjoys political support and leadership for the response from the highest office of His Majesty King Mswati III, the Prime Minister and senior government officials who often speak about HIV and actively participate in most HIV country organized programs. The participation of the King and Members of Parliament in number of HIV program launches for example in male circumcision, ART and TB campaigns and implementation is a good indicator of political support. The increase in the Government contribution to the response was lauded, including that ART is fully funded by the Government of Swaziland.

The establishment of NERCHA as a multisectoral HIV coordination body to strategic leadership and management of national response and coordinate the combined efforts of civil society, organized networks of people living with HIV and the private sector was highlighted extensively. Respondents reflected that NERCHA had a clear mandate that includes roles and responsibilities. NERCHA, among others jointly works with donors to minimize parallel funding and duplication of efforts in the resource constrained country.

In terms of legislation, respondents highlighted the amendment of the Marriages Act, passing of the Children's Act 2010 and Sexual Offences Bill as part of the pertinent laws that will support the successful implementation of HIV response. Supportive environment prevails within development partners, CSOs, Smart partnerships and the availability of forums to discuss progress including concerns on the overall response were discussed. Despite the achievements, the country's institutions lack capacity to implement the laws and policies and coupled with declining financial revenues this will affect the implementation of policies and plan.

3.7.1.3. Human Rights

Respondents reflected that The Constitution of the Kingdom of Swaziland provides the preamble for human rights in Swaziland and contains the Bill of Rights for all people. Institutions such as Ministry of Justice, Human Rights Commission and police were recognised as a part of the mechanisms that are in place to ensure that laws and regulations protect and promote the rights of citizens'.

While progress has been made in ensuring zero discrimination, respondents noted that, indeed some laws and regulations promoted discrimination for key populations such as MSM, commercial sex workers and IDUs, however, to a limited degree. It was highlighted that some laws, regulations and policies presented obstacles to effective prevention, treatment, care and support for some key populations and vulnerable groups.

3.7.1.4. Prevention

Respondents agreed that HIV prevention remains critical in the response to HIV and AIDS and is prioritised as articulated in the NSF. Prevention programmes cited included male circumcision, condom distribution, social and behaviour change communication and PMTCT as key areas that are implemented in order to lower HIV incidence in the country.

The structural environment around HIV prevention has seen positive changes in the past 2 years. The development of the HIV prevention policy and SBCC strategy was recognised and noted that the strategy needs to be rolled out. HIV prevention successes included the over 90% PMTCT services coverage that enables almost all expectant mothers have access to ARV prophylaxis to reduce mother to child transmission. Programmes targeting young people including sex education related issues through the development of a life skills based education curriculum and is being implemented targeting schools at 3 levels (primary, secondary and teacher training). Others include the interventions offered by CSOs at the community level.

Despite of progress made, respondents pointed out the low levels of appropriate individual behavioural change to take up the responsibility to use available HIV services as a major prevention challenge. Other challenges included a weak funding base including budget for prevention and weak programme coordination mechanisms to maximize the use of scarce resources.

3.7.1.5. Treatment, Care and Support

Government respondents reported that the country's treatment, care and support programme is three pronged; HIV Testing and Counselling; Pre-ART services and provision of ART services. The country adopted the WHO 2010 guidelines and more recently the country's ART guidelines were revised to fit into the national context. The decentralization of ART services including laboratory services and nurse initiated ART services in remote areas were pointed out as successes in overall AIDS management. However the country still experiences shortage of skilled staff in laboratory supplier's management and financial resources has continued to decline.

Respondents reflected that even though the country has developed an Orphans and other vulnerable children strategy, the operational definition of OVC remains unclear and particularly vulnerability. More positively, the strategy has facilitated the implementation of programmes like OVC education, social protection grants and neighbourhood care points were OVC access food.

3.7.1.6. Monitoring and Evaluation

Respondents agreed that Swaziland operates a comprehensive monitoring and evaluation system that is aligned to the NSF 2009-2014. The development process of M&E system was highly participatory and that HIV implementing partners have aligned their programme monitoring and evaluation to the requirements to the national M&E framework. The alignment is envisaged to improve data collection, analysis, reporting and dissemination of results for planning and decision making at all levels.

The M&E framework outlines clear data collection strategy including routine monitoring, evaluation studies, behavioural surveys and surveillance. Components like data analysis, dissemination and use, standardized indicators and data capture tools are well articulated to provide an in-depth understanding to the user. Respondents estimated that about 5-8% of the total HIV programme funding facilitates M&E activities. M&E is coordinated by the national M&E Technical Working Group which has been in existence since 2006 and the main purpose of the TWG is to provide strategic and technical guidance to partners on M&E.

Respondents recognised that there was fully functional M&E Unit at NERCHA, the national HIV and AIDS coordinating body, with total of 9 staff. This included the National Coordinator, 4 officers, and 4 regional officers. The unit is responsible for compiling national strategic reports annually and quarterly in regard to national HIV and AIDS service delivery in collaboration with other relevant ministries. The M&E unit is mandated to build capacity of system user at all levels and regularly backstop regional and community data system users.

The key achievements in M&E include the revision of indicators and alignment of the M&E framework to the NSF and development of new reporting tools. In addition, the unit has been able to build capacity among implementing partners on elements of the new M&E framework and M&E in general. However, despite the trainings, statistics indicate there is a low reporting rate, low capacity for M&E still exist and lack of data collection tools among implementing partners.

3.7.2.PART B: Civil Society Perspective

Key informants for Part B of the NCPI included 7 civil society organizations, namely; PEPFAR, Coordinating Assembly of NGOs (CANGO), Swaziland Action Group Against Abuse (SWAGAA), Family Life Association of Swaziland (FLAS), UNAIDS, UN Theme Group on HIV and Swaziland Network of People Living with HIV and AIDS (SWANNEPHA).

The following are the summarized responses gathered from the government sector.

3.7.2.1. Civil Society Involvement

Civil Society respondents lauded the management of the civil society in HIV and AIDS national planning, programming and management and that this has supported their own planning and coordination approaches for service delivery in rural communities including hard to reach areas. For example, the appointment of CANGO as a sub recipient of the Global Fund for CSO was appreciated as well as the representation of CSOs in national HIV committees including the critical Country Coordinating Mechanism for the Global Fund. CSO respondents reflected that Person living with HIV have been brought on board as active partners in the HIC response and were active in both the development and implementation of national HIV and AIDS programmes. The revival of the Swaziland HIV and AIDS Consortium (SHACO) in 2011 is yet another platform which has provided an opportunity for CSOs to work together, participate, coordinate and manage to contribute to the Successes were pointed out in areas of CSO participation in the use of data for decision making, financial support to implement HIV activities and participation in M&E committee is limited. However, CSO urged that there still fragmentation and disconnect between coordinating bodies at their constituencies, limited funding and disharmony between civil society organizations and government

3.7.2.2. Human Rights

In terms of human rights, CSO respondents reported to the existence of laws that protect populations from discrimination especially those living with HIV, orphaned and vulnerable children, people with disabilities, women and girls and young women and men. However some laws and cultural prejudice were seen to work against men who have sex with men, people who inject drugs, sex workers and transgendered people. Persons imprisoned were also cited as deprived of the liberty to access certain services but acknowledged that this was the legal requirement and change would have to be done through changes in certain laws. Respondents reflected that mechanisms and institutions are in place to ensure non-discriminatory laws are implemented and these include the Human Rights Commission, Human Trafficking Office and NERCHA among others.

Respondents reported that the design of some Laws and programme has gaps in terms of prevention, care and support service provision to MSMs, sex workers and IDUs who have the potential to accelerate the rate of HIV incidence. For example the HIV prevalent rate among sex worker is estimated at about 70% according to BSS MARPS study 2012. At policy level, formulation and approval of the Gender Policy, Enactment of the Children's Bill in 2010, Domestic and Sexual Violence Bill and the Marriage and Deeds Acts in 2011 were cited as great achievement in terms of contributing to overall HIV response programming in the country. Also noted was the need to legislate on and operationalize Human Rights Commission and increase civil education on human rights.

3.7.2.3. Prevention

CSO respondents reflected that, by and large, HIV prevention services are accessible to all persons with exception of specialized MSMs and IDUs services. Respondents applauded that studies such as the modes of transmission, programme reviews, SBCC and SDHS have been conducted to determine the needs of the groups. The impressive uptake of PMTCT service scale up of male circumcision, education of stigma and discrimination and prevention programmes for out of school young people among others were reported as major gains in prevention. However the challenge of low uptake of prevention services among men yet evidence informs that over 15% are involved in sex with more than one partner, and low individual behaviour change among the population are critical to be looked

into, including access to prevention services. Weak coordination mechanisms of prevention intervention efforts among all stakeholders, delayed approval of the HIV Prevention Policy, lack of HIV research agenda, and lack of a clearing house of HIV information have remain challenges that have the potential to affect the effective implementation of the HIV prevention response.

3.7.2.4. Treatment, Care and Support

CSO respondents reflected that the country has identified essential elements of a comprehensive package for HIV treatment, care and support services. The majority of people who are in need of treatment services have access. Services include ART, post -delivery care, HTC, TB screening for people living with HIV and STI services among others. These interventions have been implemented through Rollout of decentralization strategy, operationalization of the regional of ART and clinical mentorship teams. Issues that were cited as challenges for the treatment, care and support programme include stigma and discrimination, lack sustainable finances for programmes, limited nutrition support for people on ART and ART patient defaulting.

Indicator 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male partner in the past 12 months (7.7%)

Gender based violence has been identified as a factor that has the potential to fuel the spread of HIV in Swaziland and Sub Saharan Africa in general. Despite programmes and laws aimed at curbing gender based violence recent studies indicate that physical and sexual violence on women is still prevalent in the country and there is some supporting attitude towards its prevalent in certain instances amongst both males and females.

A study commissioned in 2007 to describe the epidemiological patterns of sexual and physical violence against children and young women revealed that one in three (33%) women had suffered some form of sexual violence as a child and that 5% had experienced physical violence (UNICEF, 2007).

According to MICS (2010) 7.7% of women aged between 15 and 49 years had been beaten by their husband or partner in the 12 months preceding the study. Research on attitudes of both men and women towards domestic violence has shown that 33% and 39% of men and women respectively believe there are some circumstances when a man is justified in hitting their partner (MICS, 2010). This reflects an increase the proportion of women who have an accepting attitude to domestic violence in female attitudes, from the SDHS 2007 findings that lesser 37.9% of women believe that men are justified to hit their partner.

On the other hand, a slight reduction is observed among men from 40.6% who believe that men are justified to hit their partner in 2007. Some of the reasons highlighted by women as justification for beating include unfaithfulness, arguing with male partner and child neglect. Common reasons cited by men include unfaithfulness by female partner, arguing, going out without informing the partner and child neglect.

Indicator 7.3: Current School Attendance among orphans and among non- orphans aged 10-14 (Overall: 97.9%, orphans-97.2% & non –orphans-98.6%)

Swaziland has done considerably well in ensuring that orphaned and vulnerable children get access to education despite their vulnerability status, through Government and Civil Society efforts school attendance by children including orphaned and vulnerable children in particular has greatly improved.

In 2007, the SDHS reported school attendance at 92.3% for all (90.0% orphans; 92.7% non orphans) among children aged 10-14 years. The MICS 2010 found that there is minimal difference in school attendance between orphans and non-orphaned children. It reported that 97.2% of orphans are attending schools compared to the 98.6% amongst non -orphans. The ratio of orphans to non -orphans of 0.99 indicates similar attendance rates between the groups.

Interventions contributing to the improvement include the OVC schools bursary scheme from which 87,720 children benefitted from in 2011. The scheme is complemented by support from civil society organizations. Another notable intervention is the Free Primary Education programme introduced in 2010 that eliminated the payment of school fees by parents at government schools for all primary school attending children. The programme currently caters for grades 1 to 3.

Indicator 7.4: Proportion of the poorest households who received external economic support in the last 3 months (no data)

HIV has permeated every aspect of Swazi society; this has given rise to the number of vulnerable households and individuals. The elderly have become primary caregivers to vulnerable children and some households are child-headed. According to SHIES (2011) 63% of the population in Swaziland is considered to be poor. Although poverty prevalence remains very high, it has dropped marginally from the levels previously reported in the early 2000s (69%). In spite of this, the welfare of the poorest continues to plummet owing to the adverse situation. This subsequently necessitates the need for external support to the poor and vulnerable households. The country is currently implementing a number of strategies in addressing poverty, which include external support for poor and vulnerable households which is primarily food and education support. External support can be either directed to individuals or the households. The target unit is households with orphaned and vulnerable children. Other strategies in place are the disbursements of quarterly social grants to the elderly and the disabled people.

There is an elderly grants programme that is non-exclusive and all persons (male and female) aged above 60 years are eligible to benefit. Programme data from the Deputy Prime Minister's office indicate that 47,275 elderly people received the grant in 2011 (DPM's Office, 2011). A total of 55,000 received food support in 2010 (VAC, 2011).

4. BEST PRACTICES

The national response to HIV has grown tremendously over the last few years. The growth is attributed to some spirited and innovative interventions in both the policy and programmatic functions of the response. The effects of these efforts are realized in the form of improvements in some of the indicators that are covered in this report.

The following programmes are presented as national best practice that have shown success, are sustainable and can be replicated elsewhere;

4.1. The National Antiretroviral Therapy Programme

The National ART programme has shown an improved service coverage rate as 80% of PLHIV who need ARV are also receiving treatment. In 2009 the percentage of people with advanced HIV infection receiving ART at the <350 CD4 eligibility criteria was about 59%. The retention rate of PLHIV 12 months after initiation of treatment has improved from 77% in 2009 to 87% in 2011.

The following practices are attributed to the success of the programme;

- i) Task shifting from solely doctor-led to include nurse-led ART

As of January 2010, local nurses were capacitated to initiate patients into ART, a responsibility that was exclusively for doctors. Local nurses are able to initiate the first line of ARV thereby reducing the patient load faced by doctors. As a result, more patients are initiated on treatment and more (110/265) health facilities are now accredited to provide treatment, from 31 facilities in 2009. This ensures that the service is available daily in the clinics or health facilities in the absence of a doctor.

- ii) Strong pre-ART service and regular CD4 count assessment

Upon discovery of a positive HIV status, patients are enrolled on the pre-ART programme. The programme includes regular monitoring of the patients' CD4 count for enrolment into treatment when found to be eligible. CD4 count monitoring is extended to patients on ART and administered every 8 weeks to assess changes in order to make decisions on appropriate line of treatment required by the patient.

- iii) Decentralisation of Services

Access-In addition to the 110/265 health facilities (NGOs, Government & Private) that have the capacity to initiate ART, some have the capacity to do outreach services provided.

Laboratory services- In 2010, the country established a national sample transportation system to the peripheral facilities to those with established laboratory systems. This has improved the turnaround time between testing and getting results from an average of 14 to 5 days. Lab services have decentralised in a phased approach, with the priority being the high volume clinics, point of care CD4 machine have been placed.

- iv) Strong linkages with the national PMTCT programme

Prong IV²¹ of the PMTCT four-pronged approach creates direct linkages of the programme with the ART programme. During ANC, HIV positive pregnant women are assessed for ART eligibility through clinical staging and CD4 count assessment. Patients found to have TB are also enrolled on treatment.

- v) Government funding of ARV

As of 2009/10 financial year²², the Government of Swaziland has taken up the responsibility to fund the total requirement of ARV drugs. Even though the country is having fiscal challenges this commitment has been upheld and there have not been any stock shortages. Greater Involvement of PLHIV

An expert client program was also introduced to ensure the retention of patients through defaulter tracing and creating linkages between the Pre-ART service and ART programme. As a result of the expert client programme and other efforts, the number of patients who are lost to follow up has reduced to 6%, from over 10% in 2009.

4.2. Prevention of Mother to Child Transmission

There are exceptional strides made by the national PMTCT programme since inception less than 10 years ago. The programme started in 2003 with less than 3% of health facilities offering the service. By the end of 2011 about 88% (150/171) ANC facilities are actively offering the service. As a result, the HIV prevalence rate of infants born to HIV positive mothers currently stands at 6.6% at 6-8 weeks.

Practices that have contributed to the success of the programme include;

- i) High level of HIV testing and knowledge of status during ANC

Although the country has an opt-in and opt-out to HTC during ANC, in 2010 and 2011, a total of 86% (29,046/ 33,916) and 92% (30,812/33,601) pregnant women, respectively, tested and received their HIV results. This has resulted in more women in need of PMTCT accessing ARV prophylaxis to reduce MTCT. This is supported by client-initiated HTC approach and the mothers-to-mothers programme where HIV positive mothers encourage other pregnant women to know their status.

- ii) Regular HTC at different intervals

HIV testing during pregnancy is conducted upon discovery of pregnancy; during follow-up visits; at delivery and post-delivery for breastfeeding mothers until weaning. This was started after the programme observed high rates of sero-conversion of pregnant women during different visits.

4.3. Strengthening of local community systems

The KaGogo Social Centres (KSCs) have demonstrated the effectiveness of community leadership, participation, and ownership of AIDS programmes for high impact at low cost.

KSCs were created in 2003 to decentralize implementation the national HIV response. They have restored traditional methods which local communities' understand and prefer. Built by community

²¹Prong IV is the continuum care for HIV positive mothers, their infants and families.

²² Financial year an April-March calendar

members themselves, KSCs have been placed in all 360 communities and situated within royal Umphakatsi (chiefdoms). The structure empowers the community to look after their vulnerable populations and serve as meeting venue to discuss how to mitigate the epidemics impact in the local area.

KSCs have evolved to become strong monitoring and evaluation actors, providing information on community vulnerability and service provision. This data has helped shape national policies and responses to HIV/AIDS. As a result, KaGogo centres have demonstrated the opportunity to decentralize the management of HIV response to the community level.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Introduction

This section examines the major challenges during the reporting and remedial actions being undertaken. Following the guidelines, the section starts with highlight on the previous challenges identified in the last UNGASS and the progress achieved.

5.1. Challenges in Last UNGASS Report and Remedial Actions

Three key challenges were identified in the last UNGASS Report, namely, low levels of community reporting, weak coordination and management system, inadequate human and structural capacity.

The remedial actions for the challenges that were identified in the last report are as follows:

5.1.1. Low level of Community Reporting

NERCHA and partners are implementing a community reporting system aligned to the national M&E system. The system requires community based service providers to avail data to community based clerks routinely. The service providers and clerks have been trained on tool development, data collection and management. The current reporting rate of has improved to over 50% of HIV implementers reporting in December 2011.

5.1.2. Weak Coordination and Management Systems

The National Strategic Framework (NSF) is viewed as a national multisectoral framework with all partners and stakeholders working towards achieving the goals articulated within. A draft coordination framework is under development that will clarify roles and responsibilities.

5.1.3. Inadequate Human and Organizational Capacity

With support from partners, the country has put in place an HIV technical support function to regularly conduct organizational needs assessment among partners to establish technical capacity gaps. The results were used to inform national capacity building plan, this is being implemented to improve among others management systems. In addition, the country has put together a United Nations Volunteer system to build capacity amongst partners in the areas of financial management, monitoring and evaluation and planning.

5.2. Challenges faced in 2010-2011

5.2.1. Government Fiscal Crisis Threat to programs

The fiscal crisis facing the country has not been witnessed in the country before. The main source of revenue is the Southern African Customs Union (SACU) whose receipts represent over half of all revenue. These receipts decreased from 20% of GDP (SWZ 5.2 billion) in 2009 to 9.3% of GDP (SWZ 2.6 billion) in 2010. Although a peak of 23.4% of GDP (SWZ 7.1 billion) is expected in the current financial year caution has been given that this peak could be a result of delayed benefits and gains from the recent international event held in the region. It is expected that revenue will revert to a lower level around 12% of GDP until 2016 (MoF, 2012). As a result expenditure on programmes has been kept at a minimal and is likely to negatively impact on HIV programme delivery.

Remedial action

NERCHA and partners will begin an extensive resource mobilisation campaign for the national HIV strategy. Current efforts include applying to the Global Fund for AIDS, TB and Malaria (GFATM) and collaboration with PEPFAR and plans for donor's conference are underway. The costing of the NSF and development of annual national Action Plans will assist in identifying those areas that need resource mobilisation.

5.2.2. Low capacity for RBM

The newly adopted approach of using Results Based Management in the HIV and AIDS response has not been decentralised to all HIV Implementers, sectors and the regions thus compromising synergies and accountability towards achieving the results.

Remedial action

The country has developed a technical support plan that includes capacity development in RBM. The country is finalizing the coordination framework document that sets out guidelines for coordination of the response at programme level, sectors level, and geographical level and also for development partners

5.2.3. Limited condom availability at rural communities

The availability of condoms at the most rural community structures is a challenge in the country. Condoms, so far have been made available only in health facilities.

Remedial action

The country aims to expand community distribution through community-based institutions such as kaGogo Centres as well as strengthening condom management systems, distribution logistics, monitoring and reporting at all levels and in particular at community level. A condom promotion campaign that will include development of new partnerships for condom distribution is underway.

5.2.4. Limited capacity to undertake research and absence of National HIV Research Agenda

HIV research is designed to complement existing M&E information by providing detailed information that routine data and surveys cannot capture. Currently, there are some researches that are undertaken in -country but these are not coordinated and undertaken at an ad-hoc basis. This is exacerbated by the absence of a national research agenda. Local capacity to perform research is underdeveloped and reliant on external support.

Remedial action

The Central Statistical Office, NERCHA and the Ministry of Health and other community level partners need to be capacitated to perform HIV research. The country will develop an HIV research agenda that will include a HIV research priority list.

6. SUPPORT FROM THE COUNTRY DEVELOPMENT PARTNERS

Introduction

This Section focuses on the support from Development Partners (DPs) during the reporting period, challenges and gaps as well as actions required.

6.1. Key Support Received from DPs

The country benefits from technical and financial support provided by development partners. Over 50% of the total funding for HIV is from international partners channelled through government and civil society organizations for specific programmes in prevention and care and treatment. Forums have been set up to mobilise resources for HIV, these include the Swaziland Partnership Forum against AIDS, donors' forum and a planned Donors' Conference. These forums are used to provide strategic direction to international partners in an effort to harmonize support to the response. The Coordination Framework, under development, proposes the expansion of the role of the CCM to become more active in resource mobilisation for the entire NSF as opposed to only concentrating on the Global Fund financed programmes.

Funding for the HIV response is provided by two major international, the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM/Global Fund) and the Presidents Emergency Relief Plan (PEPFAR), through the Global Health Programme. The Clintons Health Initiative (CHAI) assists in technical support and mentoring of local agencies. The United Nations also provides additional support and other bilateral partners including the European Union and international Non Governmental Organisations. The United Nations provides additional support as well as other bilateral partners including the European Union and international Non Governmental Organisations. The country has taken significant strides in the effort to harmonize Development Partners contribution. This was mainly guided by the technical support planning process that was concluded in September 2010. This exercise sought to enhance the efficiency and efficacy of technical support by all development partners in the country. The product was The Swaziland Technical Support Plan 2010 – 2014 document which prioritized key areas for technical support in the country. This document is now guiding the sourcing and implementation of technical support to be prioritized, targeted and aligned to the national strategic framework.

In further support of the harmonized approach to programme support, Development Partners have supported the country to develop key documents to guide the implementation of the response. In the prevention programme, the partners supported the development of the SBCC Strategy rolling it out as well as its implementation. Others include the development of the HIV Prevention Policy. Under treatment and care, development partners are currently assisting with human resource, infrastructure and capacity building in terms of training and mentorships. Partners also assisted in the printing of Pediatric guidelines and Comprehensive Package of Care guidelines in (2010-2011). In some instances, they also assist in the management of TB and HIV patients. In impact mitigation support was given to the development of early learning standards of Early Childhood Care & Development were over 50,000 children at NCPs benefitted. Under response management the country is finalizing the coordination framework document that sets out guidelines for coordination of the response at programme level, sectors level, and geographical level and also for development partners. This document will also identify the various forums for coordination activities.

7. MONITORING AND EVALUATION ENVIRONMENT

7.1. Introduction

Swaziland has put in place a national monitoring and evaluation system managed by NERCHA by virtue of the mandate to coordinate the national response to HIV and AIDS. While led by NERCHA, the management of the system is done in conjunction with other partners who collect and provide data at various levels. As a result the national M&E system is reliant on sources data from other partners to feed back into the broader response.

NERCHA has put in place a monitoring and evaluation unit with 6 officers, comprising of the national coordinator, Swaziland HIV/AIDS Programme Monitoring System (SHAPMoS) manager, Research manager (vacant), and 3 monitoring and evaluation officers. Plans are underway to develop a post for financial monitoring under the unit. In addition to the national level office, NERCHA with support from the Ministry of Tinkhundla Administration and Development (MTAD) has put in place 4 regional M&E officers to support the regions and communities.

Regional HIV M&E officers are mainly in charge of implementing the non clinical part of the national programme monitoring system; the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS). SHAPMoS incorporates the routine monitoring of service demand and supply as well as financial monitoring. Demand for service is tracked by the KaGogo Centre Managers (GCMs) who are based at placed in the communities as part of the coordination structures at that level. Other sources of non clinical data include the Education Management Information System, National Children's Coordination Unit and coordination sectors.

The provision of data about clinical services is tracked by the Monitoring and Evaluation Unit of the Ministry of Health's Strategic Information Department through the Health Management Information System (HMIS) and Research Units. Headed by the health M&E coordinator, the health M&E unit has 8 officers in place as well as data clerks in all four regions of the country. Information on clinical services is sourced from health facilities through the 4regions to the national office.

In addition to programme monitoring, the national M&E system collectes episodic data through surveys, surveillance, assessments and modeling. Examples of episodic data sources include the Demographic and Health Survey, Quality of Impact Mitigation Services (QIMS), Vulnerability Assessments, Service Availability Mapping (SAM) and the Ante Natal Sentinel Surveillance Surveys. Other surveys include the Multiple Indicator Cluster Surveys (MICS), National AIDS Spending Assessment (NASA), Behavioral Sentinel Survey (BSS), Condom Availability Survey, Workplace Survey and the NERCHA Client Satisfaction Survey.

The HIV research function is still underdeveloped. Whilst there are research activities that are happening there is no coordination structure in place and no research agenda. Plans are afoot to develop the agenda in the coming year and financial resources tracking. The research agenda will also be used to mobilise resources for research in Swaziland.

Coordination of the implementation and maintenance of the M&E system is through the M&E Technical Working Group (M&E TWG), multisectoral grouping of experts. The TWG plays a leading role in assisting NERCHA with the development of national M&E strategies, systems, and tools, with developing M&E capacity among partners, and in disseminating critical results.

Challenges faced in implementation of system

- Poor data quality and management

- Underutilised M&E Technical Working Group
- Low coordination of HIV research and absence of national HIV research agenda

Remedial actions planned

Low quality of routine data and management: NERCHA, MoH and Regional M&E officers conduct regular data auditing and verification exercises to HIV implementers at community and facility levels to assess the quality of data provided. This is complemented by ongoing capacity building efforts targeting HIV implementers, KaGogo Social Centre Managers and data clerks in health facilities. NERCHA has engaged an officer to manage the data auditing and verification programme for SHAPMoS data. However, there is still more work that needs to be done.

Underutilised M&E Technical Working Group: The M&E TWG has not regular sitting and attendance to meetings is low. An assessment into the function of the TWG was conducted in 2011 and as a result, the terms of reference and membership are being revised.

Low coordination of HIV research and absence of national HIV research agenda: Partially due to the unavailability of a national HIV research agenda, ad hoc researches are being conducted in the country, but these are not coordinated and assessed for the development of synergies between them. Local capacity to undertake research is underdeveloped and current efforts rely on expatriate technical advice which has not benefitted from yielded significant skill transfer.

Need for M&E technical assistance

The country's M&E system is stronger in monitoring and weaker in evaluation and research. Technical assistance is required to build capacity for Evaluation and Research in the country. As noted, the research and programme evaluation function of the system is still underdeveloped and there is need for assistance in building capacity in both carrying out evaluation and research studies and in the coordination of the function.

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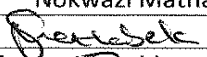
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ANNEX 1: CONSULTATION PROCESS

ANNEX 1

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

	YES	NO
1. Which institutions/entities were responsible for filling out the indicator forms:		
a) NAC- NERCHA	Yes	
b) NAP (NSF 2009-2014)	Yes	
c) Other (please specify)		No
2. With inputs from		
Ministries of:		
Education	Yes	
Health	Yes	
Labour (PSHACC)	Yes	
Foreign Affairs		No
Prime Minister's Office	Yes	
Others (Deputy Prime Minister's Office, Tinkhundla Administration and Development)	Yes	
Civil Society Organisations		
People living with HIV	Yes	
Private Sector	Yes	
United Nations Organisations	Yes	
Bilateral	Yes	
International NGOs	Yes	
Others (please specify)		No
3. Was the report discussed in a large forum?	Yes	
4. Are the survey results stored centrally?	Yes	
5. Are data available for public consultation?	Yes	

6. Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report? NERCHA and UNAIDS	
Name/Title: Nokwazi Mathabela	National M&E Coordinator
Signature: 	Date: 28 March 2012
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ANNEX 2: NATIONAL COMMITTEMENTS AND POLICY INSTRUMENT

PART A GOVERNMENT OFFICIALS

STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV? (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No	Not Applicable (N/A)
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Period covered: 2009-2012

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why:

- The National strategic framework is results based with clear baselines data and targets
- Brought on board all stakeholders in the development and implementation process

1.1 Which government ministries or agencies have overall responsibility for the development and implementation of the national multisectoral strategy to respond to HIV?

- NERCHA,
- Ministry of Health,
- Prime Minister's Office,
- Ministry of Tinkhundla, Administration and Development (MTAD)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
	Yes	No	Yes	No
1. Health	Yes	No	Yes	No
2. Education	Yes	No	Yes	No
3. Labour at workplace	Yes	No	Yes	No
4. Transportation	Yes	No	Yes	No
5. Military/Police	Yes	No	Yes	No
6. Women not specific	Yes	No	Yes	No
7. Young people	Yes	No	Yes	No
8. Other*: [write in]	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations

a. Men who have sex with men	Yes	No
b. Migrant Populations	Yes	No
c. Orphans and Vulnerable Children	Yes	No
d. People with disabilities	Yes	No
e. People who inject drugs	Yes	No
f. Sex workers	Yes	No
g. Transgendered people	Yes	No
h. Women and girls	Yes	No
i. Young women/ young men	Yes	No
j. Other specific vulnerable populations		
Settings		
h. Prisons	Yes	No
i. Schools	Yes	No
j. Workplace	Yes	No
Cross-cutting issues		
k. Addressing stigma and discrimination	Yes	No
l. Gender empowerment and/or gender equality	Yes	No
m. HIV and poverty	Yes	No
n. Human rights protection	Yes	No
o. Involvement of people living with HIV	Yes	No

IF NO, explain how were target populations identified?

1.4 What are the identified target populations for HIV programmes in the country?

- Migrant population
- Youth girls and women
- Disabled people
- People Living with AIDS
- Pregnant women

1.5 Does the multisectoral strategy include an operational plan?

Yes	No
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1.6 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes	No
b. Clear targets or milestones?	Yes	No
c. Detailed costs for each programmatic area?	Yes	No
d. An indication of funding sources to support programme implementation?	Yes	No
e. A monitoring and evaluation framework?	Yes	No

1.7 Has the country ensured “full involvement and participation” of civil society* in the development of the multisectoral strategy?

a. Active involvement	b. Moderate involvement	c. No involvement
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IF active involvement, briefly explain how this was organised:

- Participation and involvement of civil society in planning, policy formulation processes and coordination mechanisms and being sub recipient of GFATM
- Highly represented on national committees e.g. National HIV and AIDS Council and Country Coordinating Mechanism (CCM)
- Regular participation national organized reviews, forums and capacity building interventions

IF NO or MODERATE involvement, briefly explain why this was the case:

1.8 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No
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1.9 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners
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IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and Why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A
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2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	a. Yes	b. No	c. N/A
b. Common Country Assessment / UN Development Assistance Framework	a. Yes	b. No	c. N/A
c. Poverty Reduction Strategy	a. Yes	b. No	c. N/A
d. Sector-wide approach	a. Yes	b. No	c. N/A
e. Other:	a. Yes	b. No	c. N/A

2.2 IF YES, are the following specific HIV related areas included in one or more of the development plans?

1. Treatment, care and support (including social security or other schemes)	Yes	No
2. HIV impact alleviation	Yes	No
3. Reduction of gender inequalities as they relate to HIV prevention/ treatment, care and/or support	Yes	No
4. Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No
5. Reduction of stigma and discrimination	Yes	No
6. Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
7. Other:	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A
-----	----	-----

3.1 IF YES, to what extent has it informed resource allocation decisions?

Low						High
0	1	2	3	4	5	

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)? Yes

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?

Yes	No
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5.1. Have the national strategy and national HIV budget been revised accordingly? Yes

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy? Estimates of Current and Future Needs

5.3. Is HIV programme coverage being monitored?: Yes

- a. If yes, is coverage monitored by sex (male, female)? Yes
- b. If YES, is coverage monitored by population groups? Yes
 - If YES, for which population groups
 - People aged 15- 24, 15- 49 and children below 15 years
 - Commercial sex workers
 - Orphans and other vulnerable children

- Married people
- Pregnant women

Briefly explain how this information is used:

- Information is used for planning, budgeting, implementation and determining HIV incidence and prevalence rates.
- To create awareness on HIV related issues e.g. male circumcision, condom use

c. Is coverage monitored by geographical area?: Yes

If YES, at which geographical levels (provincial, district, other)?

- National, regional, community level

Briefly explain how this information is used:

- Planning
- Allocation of resources
- Determining need and distribution of services
- Monitoring of programmes

5.4 Has the country developed a plan to strengthen health systems? Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

- Supported structural development for example, expansion of health facilities; ART, PMTCT and laboratory services through the implementation of decentralization strategy
- Increased human resource capacity e.g. deployment of pharmacists at regional level and engagement of more doctors and nurses
- Procurement of medical supplies, in 2011 the country never experienced drug stock outs
- Strengthened data collection processes

6. Overall, on a scale of 0-10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in the HIV programmes in 2011?: 8

Since 2009, what have been key achievements in this area?:

- Scaling up national interventions in ART, PMTCT, male circumcision, TB, laboratory and HTC services
- Expansion of health infrastructural including laboratory facilities
- Operationalizing National Strategic Framework and its M&E framework
- Identification of human resource needs and conducting capacity building initiatives to improve service delivery
- Increase human resources for health

What challenges remain in this area:

- Inadequate capacity of the human resources in planning and costing
- Limited funding for programmes as a result of national and international economic crisis
- Unreliable human resources, the skilled human resources are donor funded and provide short term services
- Government policy of zero growth prohibiting human resource recruitment leading to shortage of employee

II. POLITICAL SUPPORT & LEADERSHIP

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

Government Ministers	Yes	No
Other high officials at sub national level	Yes	No

1.1 In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV? Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

- Launching of the national male circumcision campaign and openly encouraging people to go for HIV testing and adherence to ART by His Majesty King Mswati III
- Declaration of TB as a national emergency by the PM
- Official opening of TB and HIV wing at Nhlanguano Health Centre by His Majesty King Mswati III

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	No
-----	----

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 IF YES, does the national multisectoral HIV coordination body

Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person IF YES, what is his/her name and position title?: Chief Ndabankulu Simelane, Chairperson	Yes	No
Have a defined membership? IF YES, how many members? 17	Yes	No
Include civil society representatives? IF YES, how many? 8	Yes	No
Include people living with HIV? IF YES, how many? 1	Yes	No
Include the private sector?	Yes	No

Have an action plan?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A
-----	----	-----

IF YES, briefly describe the main achievements:

The government, civil society and private sector interact regularly through the Swaziland HIV/AIDS Partnership Forum. HIV was part of the agenda in the National Smart Partnership dialogues.

Briefly describe the main challenges:

- Limited Funding
- Weak coordination among the stakeholders and duty bearers, these result into limited participation of other actors.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year? No data

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of drugs or other supplies	Yes	No
Technical guidance	Yes	No
Other:	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No
-----	----

6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	No
-----	----

Being amended

IF YES, name and describe how the policies / laws were amended:

- Employment Act added a clause on non-discrimination at workplace.
- Public workplace policy
- HIV prevention policy
- Stigma and discrimination policy

- Sexual abuse and domestic violence Bill was passed in Parliament

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Grey areas in criminalization of transmission of infection e.g. people who rape children especially by people who are HIV positive.

7. Overall, how would you rate the political support for the HIV programme in 2011?

2011 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2009, what have been key achievements in this area:

- Allocation of government resources to finance all national ART program activities
- High level involvement of national leaders in the HIV response activities

What are remaining challenges in this area:

- Inadequate knowledge about HIV impact among politicians makes them fail to give it the priority it deserves.
- Inadequate laws and regulations to criminalize rape and incest in case there HIV transmission
- Financial crisis leading to reduced budget allocations leading to shortage of skilled human resources in specialized medical professionals e.g. laboratory pharmacy technician.

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/ mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and Girls	Yes	No
Young women/ young men	Yes	No
Other specific vulnerable sub populations		

1.2 Does the country have a general (i.e. not specific to HIV related discrimination) law on non discrimination?: Yes

If YES, TO Question 1.1 or 1.2 briefly describe the contents of the laws

- Constitution of the Kingdom of Swaziland provides rights for all people.
- Girls and women's Acts protect girls and women from sexual abuse

Briefly explain what mechanisms are in place to ensure these laws are implemented:

- Social Welfare Department
- Human rights commission
- Police Service and Prosecutors' Office
- Ministry of Youth and Culture
- Gender desk in the Deputy Prime Minister's Office

Briefly comment on the degree to which they are currently implemented:

There has been some progress but some of the mechanisms are relatively new and are still experiencing teething problems i.e. Human Rights Commission and the Gender Desk

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/ mobile populations	Yes	No

Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and Girls	Yes	No
Young women/ young men	Yes	No
Other specific vulnerable sub populations		

Briefly describe the content of these laws, regulations or policies:

- Laws that criminalize activities practiced by the key populations i.e. sex workers, men who have sex with men and injecting drug users.

Briefly comment on how they pose barriers:

- These groups cannot access specialized services as a result of the criminalization of their activities. HIV service providers cannot openly provide their services to them.
- Sex workers are not protected and they are abused by their customers because industry is illegal and if found they are arrested.
- Current laws prevent access of these groups to preventive services.

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No	N/A
-----	----	-----

IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted

a. Abstain from injecting drugs	✓
b. Avoid commercial sex	✓
c. Avoid intergenerational sex	✓
d. Be sexually abstinent	✓
e. Delay sexual debut	✓
f. Engage in safe(r) sex	✓
g. Fight against violence women	✓
h. Greater acceptance and involvement of people living with HIV	✓
i. Greater involvement of men in reproductive health programmes	✓
j. Know your HIV status	✓
k. Males to get circumcised under medical supervision	✓
l. Prevent mother-to-child transmission of HIV	✓
m. Promote greater equality between men and women	✓
n. Reduce the number of sexual partners	✓
o. Use clean needles and syringes	✓
p. Use condoms consistently	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No
-----	----

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	No	N/A
-----	----	-----

2.1 Is HIV education part of the curriculum in:

Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No
-----	----

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No
-----	----

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes	No
-----	----

IF NO, briefly explain:

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other populations
Condom Promotion			✓	✓		
Drug substitution therapy						
HIV testing and counseling			✓	✓		✓
Needle & syringe exchange	✓					
Reproductive health, including sexually transmitted infections prevention and treatment			✓		✓	
Stigma and discrimination reduction				✓	✓	
Targeted information on risk reduction and HIV education			✓	✓	✓	
Vulnerability reduction (e.g. income generation)		N/A	N/A	N/A	N/A	N/A

3.2 Overall, how would you rate policy efforts in support of HIV prevention in 2011?

2011
Excellent

Very

poor

0 1 2 3 4 5 **6** 7 8 9 10

6

Since 2009, what have been key achievements in this area:

- PMTCT scale up and increased service up take to more than 90% in 2010
- Developed and implemented Youth, inmates prevention programmes
- Scale up TB and HIV co infection services
- Development of HIV prevention policy due for approval by cabinet
- The development and implementation of the SBCC strategy.
- Establishment of national HIV Information Centre

What are remaining challenges in this area:

- Limited individual responsibility to take up available HIV prevention services . The

- preventive strategies have not yielded intended results wanted
- Delayed approval of the HIV prevention policy
- Insufficient budget for prevention programs
- Weak coordination of donors and civil society leading to duplication of efforts and poor utilization of scarce resources HIV testing

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No
-----	----

IF YES, how were these specific needs determined?

- Surveys
- Service availability through mapping by region to identify needs on yearly basis
- Sentinel surveillance studies
- Special research studies

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access				
	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Condom Promotion	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Harm Reduction for people who inject drugs	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Harm Reduction for out of school young people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV prevention in the workplace	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV testing and counselling	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
IEC on risk reduction	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
IEC on stigma and discrimination reduction	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Prevention of mother to child transmission of HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Prevention for people living with HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Risk reduction for intimate	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

partners of key populations	Disagree			Agree	
Risk reduction for men who have sex with men	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Risk reduction for sex workers	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
School-based HIV education for young people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Universal precautions in health care settings	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Other: [write in]	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

5. Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2011?											
2011 Very poor										Excellent	
	0	1	2	3	4	5	6	7	8	9	10
7											

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:

Yes	No
-----	----

IF YES, Briefly identify the elements and what has been prioritized:

<ul style="list-style-type: none"> - PMTCT - HCT - Pre ART and ART - Economic and Social support to people affected by HIV - Procurement of drugs and equipment - Recruitment of human resources. - Support for PLWA support groups
--

Briefly identify how HIV treatment, care and support services are being scaled-up?:

<ul style="list-style-type: none"> - Use of WHO revised guidelines e.g. provision of ART to patients with <350 CD4 cell count instead of <200 - Roll out of the decentralization strategy i.e. provision of services by lower level facilities (Health centres and clinics in addition to hospitals) - Roll out of nurse initiated ART which previously was initiated by doctors.
--

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access				
Antiretroviral therapy	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
ART for TB	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Early Infant diagnosis	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV testing and counselling for TB patients	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Nutritional Care	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Paediatric AIDS treatment	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post delivery ART provision to women	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post exposure prophylaxis for non	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

occupational exposure (e.g. sexual assault)	Disagree			Agree	
Post exposure prophylaxis for occupational exposures to HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Psychosocial support for people living with HIV and their families	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Sexually transmitted infection management	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
TB infection control in HIV treatment and care facilities	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
TB preventive therapy for people living with HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Treatment of common HIV related infections	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:

Yes	No
-----	----

Please clarify which social and economic support is provided:

- Provision social protection grants to the elderly and OVC
- National school feeding program.
- Distribution of food donations to PLWA with special needs.

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	No
-----	----

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes	No
-----	----

IF YES, for which commodities?:

- All health products including ARVs and condoms

5. Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

2011	Very poor											Excellent
	0	1	2	3	4	5	6	7	8	9	10	
										9		

Since 2009, what have been key achievements in this area:

- Decentralization of ART services
- Consistence in ARVs supplies as result no drug stock outs were reported in 2011
- Support has been encouraged by government.
- Decentralization of ART including improved laboratory test or services

What are remaining challenges in this area:

- Weak supply chain management system to effectively determine the distribution schedules of ARVs
- Shortage of human resource like doctors nurses , pharmacist and lab technicians
- Inaccessibility to HIV services to people living far from health centres

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	NO	N/A
-----	----	-----

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No
-----	----

6.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No
-----	----

6.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No
-----	----

6.4 IF YES, what percentage of orphans and vulnerable children is being reached?
65%

7. Overall, how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children in 2011?

2011											Very	poor	
Excellent	0	1	2	3	4	5	6	7	8	9	10		
	7												

Since 2009, what have been key achievements in this area:

- Free primary education
- Expansion of neighborhood care point (NCPs) to meet nutritional and educational needs of OVC

What are remaining challenges in this area:

- Lack of a holistic program that address OVC concerns/needs
- Limited funding for the school feeding and other education needs (uniforms, books)

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes	In progress	No
-----	-------------	----

Briefly describe any challenges in development or implementation:

- Inadequate integration of M&E activities into the planning cycle
- Low levels of reporting
- Lack of appreciation of M&E benefits
- Inadequate capacity and skills of the Human Resources in M&E

1.1 IF YES, years covered: 2009-2014

1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No
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Briefly describe what the issues are:

- Lack of the appreciation of M&E in the overall designing and programming
- Difficulty in aligning funder M&E requirements with national requirements

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes	No
IF YES , does it address: routine programme monitoring behavioural surveys	Yes	No
HIV surveillance	Yes	No
Evaluation / research studies	Yes	No
a well-defined standardised set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing data quality (i.e., validity, reliability)	Yes	No
a data analysis strategy	Yes	No
a data dissemination and use strategy	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No
-----	-------------	----

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? 5%

4. Is there a functional national M&E Unit?

Yes	In progress	No
-----	-------------	----

Please describe any obstacles

- Lack of technical Capacity at all levels among human resources to analyze and use data
- Inadequate funding for M& E activities

4.1 Where is the national M&E Unit based?

in the National AIDS Commission (or equivalent)?	Yes	No
in the Ministry of Health? M & E Health	Yes	No
Elsewhere?	Yes	No

4.2 IF YES, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: 4		
Position: M & E coordinator	Full time / Part time?	Since when?: August 2009
Position: SHAPMoS Manager	Full time / Part time?	Since when?: March 2009
Position: M&E officer 1	Full time / Part time?	Since when?: January 2009
Position: M&E officer 2	Full time / Part time?	Since when?: January 2011
Number of temporary staff: 0		
Position:	Full time / Part time?	Since when?:
Position:	Full time / Part time?	Since when?:

4.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No
-----	----

IF YES, briefly describe the data-sharing mechanisms:

SHAPMoS, through which all implementing partners report to the national system on a quarterly basis

What are the major challenges in this area?

- Human Resources
- Financing
- Low reporting rate of implementing partners

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No
-----	----

6. Is there a central national database with HIV- related data?

Yes	No
-----	----

IF YES, briefly describe the national database and who manages it
CRIS database, managed by Nercha IT

6.1 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

- a. **Yes, all of the above**
- b. Yes, but only some of the above:
- c. No, none of the above

6.2 Is there a functional Health Information System?

At national level	Yes	No
At subnational level IF YES , at what level(s)?	Yes	No

7. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No
-----	----

8. How are the M&E data used?

For programme improvement	Yes	No
In developing/ revising the national response	Yes	No
Resource allocation	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

- Used to inform the development of NSF
- Used to scale up HIV services and adaption of the decentralization approach
- Used for budgeting, decision making and programming

Challenges:

- Inadequate data validation
- Limited feedback to partners

9. In the last year, was training in M&E conducted

At national level?	Yes
IF YES, Number trained:	
At sub national level?	Yes
IF YES, Number trained:	
At service delivery level including civil society?	
IF YES, Number trained:	

9.1 Were other M&E capacity-building activities conducted other than training?

Yes	No
-----	----

IF YES, describe what types of activities:

-On going mentorship sessions after the trainings

10. Overall, how would you rate the M&E efforts of the HIV programme in 2011?

2011 Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10
7

Since 2009, what have been key achievements in this area:

- Capacity building
- Revision of the indicators and alignment with NSF and new reporting tools were developed

What are remaining challenges in this area:

- Low reporting rates from implementing partners and lack of trained M&E experts
- Unreliable supply of data collection tools to different stakeholders who collect data

PART B: CIVIL SOCIETY, BILATERAL AGENCIES, UN ORGANISATIONS

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations? 2

Comments and Examples:

-There is politically supportive environment for civil society engagement with government in policy and plan formulation but this is negated by the tendency of civil society not to speak as a unit but present organizational views in these forums.
- PLHIV are most vocal and actively participate in these forums.

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)? 5

Comments and Examples:

-There is active involvement of civil society in national planning, policy formulation and technical working committees along the HIV thematic areas for example NGOs, FBOs and the private sector have representation in the committees coordinating the response.
-The development of the National Strategic Framework was highly consultative with civil society playing a leading role.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

National HIV Strategy	4
National HIV Budget	3
National HIV Reports	4

Comments and Examples:

The national strategy recognizes all parties providing services but the work of the civil society at community level is not captured. This leads to the national reports missing information on the work conducted at the community level because the monitoring and evaluation system is aligned to the national strategic framework. There is inclination of the report towards showing clinical based services which are mainly provided by the government.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?

Developing the national M&E plan	3
Participating in the national M&E committee / working group responsible for coordination of M&E activities	3
Participate in using data for decision-making	3

Comments and Examples:

- Highly participative in national M&E plan and strategy development processes
- Civil Society are part of the national M&E TWG
- Participate in data collection processes and use for planning and decision making but there is need for capacity building to improve on the utilization of M&E.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?: 4

Comments and Examples:

Civil Society representation on the national committees is broad based including Faith Based Organization and PLWHA. There is however minimal representation of key populations i.e. sex workers, men who have sex with men and injecting drug users (as a result of the legal environment)

6. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access

Adequate financial support to implement its HIV activities 2

Adequate technical support to implement its HIV activities 1

Comments and Examples:

Support for HIV services has gone down. The country is undergoing a fiscal crisis that has limited the amount of resources dedicated to responding to HIV. Fewer organizations are able to access funds from the government and this is further exacerbated by dwindling levels of external support in recent times. Global Fund resources reach only a few organizations.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations	None	<25%	25-50%	51-75%	>75%
People living with HIV:	None	<25%	25-50%	51-75%	>75%
Men who have sex with men:	None	<25%	25-50%	51-75%	>75%
People who inject drugs:	None	<25%	25-50%	51-75%	>75%
Sex workers:	None	<25%	25-50%	51-75%	>75%
Transgendered people:	None	<25%	25-50%	51-75%	>75%
Testing and Counselling:	None	<25%	25-50%	51-75%	>75%
Reduction of Stigma and Discrimination:	None	<25%	25-50%	51-75%	>75%
Clinical services (ART/OI)	None	<25%	25-50%	51-75%	>75%
Home Based Care	None	<25%	25-50%	51-75%	>75%
Programmes for OVC	None	<25%	25-50%	51-75%	>75%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?: 6

Since 2009, what have been the major achievements in this area?

- Representation of Civil Society at national committees for example CCM, national council and national technical working groups for HIV across the thematic areas
 - Capacity building in HIV management, monitoring and evaluation among others
 - Created a policy and supportive environment to provide information, care for vulnerable groups
 - Enhance participation in national strategic planning and policy formulation

What challenges remain in this area:

- Competition among civil society organizations
- Resource constraints
- Poor legislative environment
- Poor relationship between civil society and government

II. POLITICAL SUPPORT & LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:

Yes	No
-----	----

IF YES, describe some examples of when and how this has happened:

- National strategic framework and M&E development processes
- Resource mobilization e.g. GFATM proposal development process
- Financial and technical support to networks of PLHIV by the Ministry of Health and NERCHA
- Involvement of network of PLHIV in ART to ensure drug adherence

III. HUMAN RIGHTS

1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations?

People living with HIV:	YES	NO
Men who have sex with men:	YES	NO
Migrants/mobile populations:	YES	NO
Orphans and other vulnerable children:	YES	NO
People with disabilities:	YES	NO
People who inject drugs:	YES	NO
Prison inmates:	YES	NO
Sex workers:	YES	NO
Transgendered people:	YES	NO
Women and girls:	YES	NO
Young women/young men:	YES	NO
Other specific vulnerable subpopulations [write in]:	YES	NO

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:

Yes	No
-----	----

If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

- There various laws and acts, the constitution has clauses prohibiting
- Human trafficking
 - Sexual abuse

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Institutions like the Human Rights Commission, Ministry of Justice, DPM's Office, police and prosecutors are mandated to ensure the laws are implemented accordingly.

Briefly comment on the degree to which they are currently implemented:
Some are well advanced but there are some like the Human Rights Commission that are still new and need to be strengthened.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:

Yes	No
-----	----

2.1. IF YES, for which sub-populations?

People living with HIV:	Yes	NO
Men who have sex with men:	YES	NO
Migrants/mobile populations:	YES	NO
Orphans and other vulnerable children:	YES	NO
People with disabilities:	YES	NO
People who inject drugs:	YES	NO
Prison inmates:	YES	NO
Sex workers:	YES	NO
Transgendered people:	YES	NO
Women and girls:	YES	NO
Young women/young men:	YES	NO

Briefly comment on how they pose barriers:
Overall the existing laws criminalize sexual workers, IDUs and MSM activities as such prevent these populations from access to preventive services.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:

Yes	No
-----	----

Briefly describe the content of the policy, law or regulation and the populations included:
 The policy exist but its outdated, the Domestic and Sexual Offences Bill has been passed in Parliament but now waiting for the King's accent to make it to a law. The Gender Policy also safeguards against such.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:

Yes	No
-----	----

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
 The human rights based approaches to service provision are articulated in the HIV policy

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:

Yes	No
-----	----

IF YES, briefly describe this mechanism:
 Institutions such as the Human Rights Commission and WLSA are well placed to address such issues.

6. Does the country have a policy or strategy of free services for the following?

	Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Antiretroviral treatment	YES	NONE	NONE
HIV prevention services	YES	NONE	NONE
HIV-related care and support interventions	YES	NONE	NONE

If applicable, which populations have been identified as priority, and for which services?:

- Young people for prevention services
- PLWA for ART services and home based care
- People in steady couples for Prevention services
- OVC for social protection and education support

- Pregnant women for PMTCT services.
- Elderly and people with disability access to care and support

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:

Yes	No
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7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:

Yes	No
-----	----

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:

Yes	No
-----	----

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:

Yes	No
-----	----

IF YES, briefly describe the content of the policy or law:
 -Employment Act
 - HIV Policy
 - ILO Labour laws

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:

Yes	No
-----	----

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:

Yes	No
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IF YES on any of the above questions, describe some examples:
 - Human Rights Commission

11. In the last 2 years, have there been the following training and/or capacity-building activities

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:

Yes	No
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b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:

Yes	No
-----	----

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework:

Yes	No
-----	----

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:

Yes	No
-----	----

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:

Yes	No
-----	----

IF YES, what types of programmes?

Programmes for health care workers:	YES	NO
Programmes for the media:	YES	NO
Programmes in the work place:	YES	NO

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?: **5**

Since 2009, what have been key achievements in this area:

- Passing of Gender policy in 2010 and Children’s Act In 2010
- Domestic violence and Sexual Offences Bill

What challenges remain in this area:

- Slow operationalization of the laws and policies
- Government delayed domestication of international protocols, guidelines and frameworks

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:

Since 2009, what have been key achievements in this area:

- Establishment of Gender, disability and children units in government ministries
- Increased advocacy campaigns for male circumcision including involvement of political leaders
- Increase HIV service delivery using the decentralization strategy

What challenges remain in this area:

- Lack understanding of human rights
- Absence of legislation that will fully operationalise the Human Rights Commission
- Legal status of women

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No
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IF YES, how were these specific needs determined?

- Mode of transmission study
- Through research, programme reviews and during development of National Strategic Framework, Social and Behavior Change Communication Strategy

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access				
	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Condom Promotion	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Harm Reduction for people who inject drugs	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Harm Reduction for out of school young people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV prevention in the workplace	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV testing and counselling	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
IEC on risk reduction	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
IEC on stigma and discrimination reduction	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Prevention of mother to child transmission of HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Prevention for people living with HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Risk reduction for intimate partners of key populations	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Risk reduction for men who have sex with men	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Risk reduction for sex workers	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
School-based HIV education for young people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Universal precautions in health care settings	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

2. Overall, how would you rate the effort in the implementation of HIV prevention programmes in 2011? **5**

Since 2009, what have been key achievements in this area:

- SBCC Campaigns increase coverage and increase in condom distribution
- Implementation of national male circumcision campaign
- Scale up of PMTCT services to over 80% coverage
- Scale up VCT services
- Reduction of HIV infection among 15-19 year old by 20%
- Reduction of new infection among newborn babies from 17% to below 5%

What are remaining challenges in this area:

- Key populations do not have access to specialized services
- Demand for male circumcision remain low despite concerted efforts to encourage take up of services
- Poor mother follow-up for mother-baby pairs for early infant diagnosis
- Limited uptake of services by males

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:

Yes	No
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IF YES, Briefly identify the elements and what has been prioritized:

- HIV testing
- ART
- TB and HIV co-infection

Briefly identify how HIV treatment, care and support services are being scaled-up?:

- Decentralization of services and having outreach to clinics
- Task shifting of service provision from exclusively doctors to include nurses. Nurses can now initiate ART.

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access				
Antiretroviral therapy	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
ART for TB	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Early Infant diagnosis	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV testing and counselling for TB patients	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Nutritional Care	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Paediatric AIDS treatment	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post delivery ART provision to women	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post exposure prophylaxis for non occupational exposure (e.g. sexual assault)	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post exposure prophylaxis for occupational exposures to HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Psychosocial support for people living with HIV and their families	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

Sexually transmitted infection management	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
TB infection control in HIV treatment and care facilities	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
TB preventive therapy for people living with HIV	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Treatment of common HIV related infections	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

1.2 Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011? 6

Since 2009, what have been key achievements in this area:

- Decentralization of services
- Task shifting of ART initiatives
- Establishment of Ministry of Health Regional clinical mentor teams
- Sample transport system
- Roll out of ART programme using CD4 count <350 from <200

What challenges remain in this area:

- Quality assurance
- Medication and laboratory chain
- Follow up of cases as patients get lost to treatment and cannot be traced
- Distance to health facility to get services
- Stigma attached to taking ARVs
- Insufficient nutritional support for ART patients

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N/A
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2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No
-----	----

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No
-----	----

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No
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2.4 IF YES, what percentage of orphans and vulnerable children is being reached? 90%

3. Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011? 8

Since 2009, what have been key achievements in this area:

- Increase in coverage of neighbourhood care points
- Free education Programme

What are remaining challenges in this area:

- Duplication of services and competition among organizations for scarce resources
- Sustainability of interventions