

US Government Rapid Appraisal for HIV/AIDS Program Expansion

Swaziland

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United State Agency for International Development (USAID)
and Centers for Disease Control and Prevention (CDC)



“We will need to take risks and learn from our mistakes rather than stay paralyzed by the scale of the situation, so that a real difference can be felt in people’s lives.” (Dr Alan Brody, UNICEF 2004)

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ABBREVIATIONS

ABC	“Abstain, Be faithful, or use Condoms” Approach
BCC	Behavioral Change Communication
BSS	Behavioral Surveillance Survey
CANGO	Coordinating Assembly of Non-Governmental Organizations
CDC	Centers for Disease Control and Prevention
CHBC	Community and Home Based Care
CMTC	Crisis Management and Technical Committee
COH	Corridors of Hope
DHS	Demographic Health Survey
DOD	Department of Defense
FBO	Faith Based Organizations
FLAS	Family Life Association of Swaziland
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
MOHSW	Ministry of Health and Social Welfare
NERCHA	National Emergency Council on HIV/AIDS
NGO	Non-Governmental Organization
PMTCT	Prevention of Mother to Child Transmission
OI	Opportunistic Infections
PEPFAR	President’s Emergency Plan for AIDS Relief
PLWHA	People Living with HIV or AIDS
PPP	Public Private Partnerships
RHM	Rural Health Motivators
RSSC	Royal Swaziland Sugar Corporation
SASO	Swaziland AIDS Support Organization
SHAPE	School Health HIV/AIDS and Population Education
SFL	Swaziland Federation of Labor
SFTU	Swaziland Federation of Trade Unions
SI	Strategic Information
SIPAA	Support to International Partnership against AIDS in Africa
SNAP	Swaziland National AIDS Program
SNALA	Swaziland National Association of Local Authorities
STI	Sexually Transmitted Infection
SWANASO	Swaziland National AIDS Support Organization
SWAPOL	Swaziland Women Association for Positive Living
TA	Technical Assistance
TASC	The AIDS Information and Support Center
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government

Executive Summary

Background: Swaziland currently does not have either a USAID or CDC office and is a non-focus country for the President's Emergency Plan for AIDS Relief (PEPFAR). In recent years, through the Corridors of Hope Initiative (COH), the Ambassador's initiative on HIV/AIDS and other support to non-government organizations (NGOs) and to the National Emergency Response Committee on HIV/AIDS (NERCHA), the United States Government (USG), primarily through the regional offices of CDC and USAID, has emphasized prevention of HIV/AIDS among high risk groups such as truck drivers, taxi drivers, seasonal agricultural workers and commercial sex workers. In addition, PMTCT, VCT and BCC projects have been supported. Anticipating increased funding for Swaziland for fiscal year 2005, a rapid appraisal of the USG strategy was conducted from August 22nd to August 30th with a team comprising USAID, CDC and FHI technical staff from both Washington and the regional offices of the respective agencies. The major objectives of the rapid appraisal were to plan a joint USG strategy for Swaziland and make recommendations to reorient USG programs within a generalized epidemic. In addition, although Swaziland is not a focus country for PEPFAR, the program can clearly contribute to and benefit from aligning itself with the Emergency Plan goals of treating 2 million PLWHAs, preventing 7 million HIV infections and caring for 10 million PLWHA and orphans and vulnerable children (OVC) by 2008. The rapid appraisal was not designed to be a formal evaluation of interventions previously or currently supported by the USG or other donors.

Findings: The findings of the rapid appraisal team are presented in detail below. Substantial opportunities for rapid expansion of HIV/AIDS activities were noted by the team. First, Swaziland is a small country with relatively good transport and health care infrastructure. A cadre of community-based health workers, known as Rural Health Motivators (RHMs) was established with support from USAID in the 1980s and remains in place. Second, Swaziland is a country with a relatively homogenous population comprising of one major ethnic group and the common language of Siswati. Literacy rates are relatively high. Third, the establishment of NERCHA has clearly assisted in building momentum for a coherent response to the epidemic. NERCHA has attracted substantial funding from the Global Fund for AIDS, TB and Malaria (GFATM) and is the principal recipient for those funds. It has the potential to develop into a very effective coordination body for a multi-sectoral response to HIV/AIDS. Fourth, the government, led by the Ministry of Health and Social Welfare (MOHSW) and, as outlined in its 7 point plan, has recently demonstrated a commitment to roll out clinical and community-based programs to PLWHA; VCT and PMTCT access is expanding and more than 3,000 PLWHA are now receiving ART. Fifth, the United Nations agencies, through the UN theme group and activities such as WHO's 3 by 5 initiative, UNICEF's support to neighborhood care points for orphans and vulnerable children (NCPs), and World Food Program's support for food for patients receiving DOTs and ART, are contributing to the response. Finally, and perhaps most importantly, several important indigenous networks, with the potential to mobilize communities, educate the population and deliver a comprehensive package of services for infected people and affected communities are beginning to coalesce. These networks include those of the Faith-Based Organizations (FBOs), PLWHA and youth. For example, there are some 3,000 churches in the country and more than 75 percent of people are estimated to attend church services regularly. The five major churches are beginning to work together under the auspices of the Church Forum. An active media (radio, print and TV) also exists that has the potential to contribute to the response.

However, significant challenges also remain. Despite the ubiquitous nature of the epidemic in Swaziland, HIV/AIDS is still heavily stigmatized; few PLWHA, particularly prominent people, such as parliamentarians, religious and traditional leaders or media/sports personalities, have come out publicly and revealed their status. This stigma hinders the flow of information to communities, hampers prevention efforts and reduces utilization of services. The delivery mechanisms for HIV/AIDS services appear to be vertical in nature and planning is sub-optimal. Monitoring and evaluation needs to be strengthened and service utilization and coverage data are not systematically collected. Prevention messages are not entirely consistent and frequently not conveyed in Siswati. Such messages have either focused on condom use through social marketing and targeting of high risk groups or, more recently, on a predominately abstinence-based message for youth. Behavioral disinhibition following large scale ART introduction may pose a real risk in the future unless accompanied by strong communication messages that HIV treatment is not a cure for AIDS. Until recently, OVC programming appears to have been mainly focused on raising awareness about child abuse and on access to food; future efforts could increase support for OVC to access an increasingly full range of basic social services including health and education and integrating child protection into such activities. Finally, the human resources capacity of the MOHSW, both to manage the response and to deliver services, is stretched to critical levels by a combination of increasing demands on the health system due to illness and death of staff, inadequate enrollment of new cohorts of health workers, and the emigration of qualified staff.

Recommendations: The following represent a summary of recommendations for USG assistance to HIV/AIDS activities in Swaziland. Such assistance needs to be placed in the context of current or planned assistance by other major donors, be consistent with the 7 point plan of the MOHSW, and be coordinated through NERCHA. The GFATM has committed more than 100 million US Dollars over five years through two separate grants to Swaziland (the second is approved but awaiting signature). Major areas of focus for GFATM funds include: ART, STI treatment, VCT expansion, home-based care, behavior change among youth, support to the education sector and monitoring and evaluation of HIV/AIDS programs. Other major donors include the European Union (NCPs), DFID/British High Commission (capacity development), the World Bank (support for M and E) and the Italian Cooperation (WHO and laboratory/research support). Bristol Myers Squibb is also supporting a small ART site in Mbabane offering family-centered services.

In making its recommendations, the USG team sought to identify a balance between support for filling critical gaps in technical capacity and for expanding service delivery in a well-coordinated manner. Furthermore, a substantial proportion of fiscal year 2004 funds are already committed in broad terms to specific partners. Wherever possible these activities will need to be reoriented to support the approach outlined below. Funds for fiscal year 2005 and beyond will then follow the strategy outlined in this document.

The team considers the following guiding principles to be essential:

- A) Project support will contribute to national-level policy development;
- B) MOHSW capacity can be strengthened particularly at the national and district levels;
- C) The UNAIDS “Three Ones” principle (one national plan for HIV/AIDS, one coordination mechanism, and one M&E plan) will be followed closely;
- D) USG assistance will be consistent with President Bush’s Emergency Plan policies and contribute to its goals; and
- E) USG support will be designed to utilize most effectively the comparative advantage of CDC, USAID and other USG agencies including DOD and the Peace Corps.

SUMMARY

The USG, in the short and long term, will support:

- Development of HIV/AIDS advocacy strategies including involvement of the Royal Family, traditional leadership, traditional healers and other key opinion leaders.
- Development an integrated prevention, care and treatment project to be used as a model for national scale up if funds become available
- Development of a strategic prevention program using the ABC model with a focus on the B element- (Be faithful, partner reduction and partner selection) and utilizing the A element, particularly for out of school youth and as an entry point for other messages.
- Development of a national communications strategy through technical assistance to NERCHA and/or MOHSW.
- FBO, PLWHA, Business Coalition, NGO and journalist networks by facilitating linkages with regional networks in southern Africa and with each other.
- Scaling-up VCT using existing USG partners and considering new delivery mechanisms such as mobile VCT and new counseling approaches such as opt-out and family-based or couple counseling where appropriate.
- Scaling up PMTCT+ where possible.
- Strengthening the links between the DOTS infrastructure and the ART referral system at the hospital, clinic and community levels following the network model of the Emergency Plan.
- Strengthening key technical areas including palliative care, care and treatment for children living with HIV/AIDS, nutrition and infant feeding, and community-based programs for OVC. Home-based care, utilizing RHMs and perhaps a possible new cadre of workers known as lay counselors may provide the most appropriate mechanism for delivery of services.
- Strengthening of the laboratory system.
- National monitoring and evaluation where possible.
- Development of a detailed human resources (HR) plan for the health sector.
- The involvement of PLWHA networks in all aspects of the program, particularly prevention, working with youth, FBOs and churches and in supporting care and treatment literacy.

The Following SHORT TERM Recommendations are Suggested.

Prevention

- A) Support FBOs and CBOs in promoting abstinence and delay of debut to youth.
- B) Support specific behavior change outreach to sexually active males, who play a primary role in sustaining the epidemic.
- C) Provide support to mobilize churches, traditional leaders, business and other professionals, traditional story tellers, PLWHA, the media and other local sectors to openly discuss sexuality and social and cultural norms around sexual behavior.

Care, Support and Treatment

Voluntary Counseling and Testing

- A) Conduct a more detailed VCT planning visit primarily to develop consensus on increasing number of VCT sites and identifying potential partners for new fixed and mobile sites as well as expansion of existing sites
- B) Assist MOHSW and NGO partners to develop a plan for securing high quality training of counselors (including lay counselors) and lab personnel.
- C) Support the training of additional lay counselors working at the community level.

Palliative Care

- A) Include Swaziland in the Office of the Global AIDS Coordinator (OGAC) palliative care assessments.
- B) Support the formation of a National Palliative Care Association

Community and HOME Based Care (CHBC)

- A) Support a national mapping exercise to identify current CHBC coverage and efforts, levels of CHBC being provided, gaps (geographic and provision of services), and future funding and technical assistance needs.
- B) Support the participatory rapid assessment of the quality of CHBC and identify strategies to rapidly scale up CHBC.

Antiretroviral Therapy (ART) and Prevention of Mother to Child Transmission (PMTCT)

- B) In conjunction with EGPAF, UNICEF and WHO conduct a training needs assessment for PMTCT and ART.
- C) Provide funding for NGO service personnel (especially doctors, pharmacists, lab staff) until more Swazis can be trained.
- D) Support funding and technical assistance to conduct a laboratory assessment.

Orphans and Vulnerable Children (OVC)

- A) Support a review of services providing HIV/AIDS care and support to identify gaps and opportunities to strengthen the integration of children within these services and move towards a family centered approach.
- B) Provide technical and programmatic support for community based programs for OVC further expanding the NCPs and Ka Gogo initiatives and increasing their capacity to mobilize communities, strengthen community level coordination, and to provide essential care and support services for OVC including children with HIV within a family centered approach.

Human Capacity Development and Resource Management

- A) Support a one year secondment of an HR expert to the MOSHW to assist with the HR strategy with a clear mentorship role and exit plan.
- B) Provide programmatic and technical assistance, as appropriate, for pre- and in-service training of General Practitioners, Nurses, and Social Workers in the clinical management of HIV/AIDS.

- C) Provide programmatic and technical support for the development of short and long term training systems including training key trainers to increase the cadre of health and social welfare workers to support current and future prevention, care and treatment activities.

People Living with HIV/AIDS (PLWHA) Networks

- A) Provide support to the national network of PLWHA to develop a strategy and implementation plan based on the rapid appraisal findings with possible additional funding for carrying out select key activities.
- B) Provide support for the first National PLWHA consultation whereby the constitution, strategy and resource guide can be validated and launched.

Social Mobilization

- A) Provide technical assistance to lift and strengthen advocates for change such as the PLWHA Network, FBOs, National Palliative Care Association, Business Coalition Against Aids, Traditional healers and others including possible assistance to develop strategies for increasing the visibility and enhancing the leadership of national associations and other national organizations.
- B) Support forums for the exchange of lessons and ideas.

NOTE: Broadly, and over time, the USG would like to provide support both at the national as well as at the district and community levels. In FY 2005 the USG might focus support in a specific underserved district in order to build a comprehensive continuum of care from the community into the formal health system and back into the community. Alternatively, USG support might focus in particular technical areas across all ten districts.

Recommendations for the medium and long-term are described in the full report. The amount of funding in FY 2005 and beyond will dictate which recommendations can be supported. In addition, a number of detailed assessments not-yet-completed might also shift priorities.

BACKGROUND

1.1 Country Context

Swaziland, with a population of 1.08 million people and an estimated HIV prevalence of 38.8 percent in the adult population (UNAIDS, 2004), is at the epicenter of the global HIV pandemic. Swaziland has now overtaken Botswana as the country with the highest HIV prevalence in the world. Median HIV prevalence among women attending antenatal clinics increased dramatically from 3.9 percent in 1992 to 38.6 percent in 2002. The epidemic now uniformly affects urban and rural areas across the four major regions of Hhohho, Manzini, Shiselweni and Lubombo (prevalence range: 36.6 percent-41.2 percent). An estimated 220,000 people are living with HIV/AIDS (PLWHA) including around 16,000 children between the ages of 0-15 years. In 2003, there were an estimated 17,000 people who died of AIDS. In addition, the very high prevalence rates of HIV reported among both young women and young men indicate that incidence rates remain high; as many as 20,000 to 30,000 new infections may occur each year. The number of orphans in Swaziland is estimated to be 100,000 or 18 percent of all children in the country; around 65,000 or 63 percent of these are orphaned by HIV/AIDS. Some 29,000 children are double orphans. The main factor driving the epidemic in Swaziland is multiple, concurrent sexual partnerships. Inter-generational and transactional sex are likely to be contributing significantly to transmission. Young age of sexual debut, especially among women, is also contributing. According to a recent Behavioral Surveillance Survey (BSS), condom use with last non-regular sexual partner is relatively high. Out of school youth demonstrate significantly more risky behaviors than in-school youth; although age of sexual debut is higher, condom use is much lower and the mean age of sexual partner higher.

Swaziland is divided into four regions and further divided into 55 political constituencies. Each constituency is made up of several chiefdoms and headed by an elected individual known as Indvuna. The chiefdoms are made up of clusters of homesteads forming communities. These are headed by the chiefs who are appointed by His Majesty the King, who delegates authority to them based on heritage.

Health care services in Swaziland are offered through modern/western methods and traditional medicine is practiced through traditional healers/herbalists, etc. The modern/western health care system in Swaziland is decentralized into the four administrative regions. Each region coordinates its activities, however all the regional activities are coordinated at the central level. The country has both private and public health facilities throughout the country. The country's health care delivery system is divided into three main levels namely the clinic as the first level of contact and a primary health care unit, the health center/Public Health Unit is the second level of contact and the hospital is the last level. Approximately 80 percent of the total population resides within 8 km radius of a health facility.

Substantial opportunities for rapid expansion of HIV/AIDS activities exist. First, Swaziland is a small country with relatively good transport and health care infrastructure. A cadre of community-based health workers, known as Rural Health Motivators (RHMs) was established with support from USAID in the 1980s and remains in place. Second, Swaziland is a country with a relatively homogenous population comprising of one major ethnic group and the common language of Siswati. Literacy rates are relatively high. Third, the establishment of NERCHA has clearly assisted in building momentum for a coherent response to the epidemic. NERCHA has attracted substantial

funding from the Global Fund for AIDS, TB and Malaria (GFATM) and is the principal recipient for those funds. It has the potential to develop into a very effective coordination body for a multi-sectoral response to HIV/AIDS. Fourth, the government, led by the Ministry of Health and Social Welfare (MOHSW) and, as outlined in its 7 point plan, has recently demonstrated a commitment to roll out clinical and community-based programs to PLWHA; VCT and PMTCT access is expanding and more than 3,000 PLWHA are now receiving ART. Fifth, the United Nations agencies, through the UN theme group and activities such as WHO's 3 by 5 initiative, UNICEF's support to neighborhood care points for orphans and vulnerable children (NCPs), and WFP's support for food for patients receiving DOTs and ART, are contributing to the response. Finally, and perhaps most importantly, several important indigenous networks, with the potential to mobilize communities, educate the population and deliver a comprehensive package of services for infected people and affected communities are beginning to coalesce. For example, there are some 3,000 churches in the country and more than 75 percent of people are estimated to attend church services regularly. The five major churches are beginning to work together under the auspices of the Church Forum. These networks include those of the Faith-based Organizations (FBOs), PLWHA and youth. An active media (radio, print and TV) also exists that has the potential to contribute to the response.

However, significant challenges also remain. Despite the ubiquitous nature of the epidemic in Swaziland, HIV/AIDS is still heavily stigmatized; few PLWHA, particularly prominent people, such as parliamentarians, religious or traditional leaders or media/sports personalities, have come out publicly and revealed their status. This stigma hinders the flow of information to communities, hampers prevention efforts and reduces utilization of services. Finally, the human resources capacity of the MOHSW, both to manage the response and to deliver services, is stretched to critical levels by a combination of increasing demands on the health system due to the epidemic, illness and death of staff, inadequate enrollment of new cohorts of health workers, and the simultaneous emigration of qualified staff.

1.2 Previous USG Support

Swaziland currently does not have either a USAID or CDC office and is a non-focus country for the President's Emergency Plan for AIDS Relief (PEPFAR). Since 2000, through the Corridors of Hope Initiative, the Ambassador's initiative on HIV/AIDS and other support to non-government organizations and to the National Emergency Response Committee on HIV/AIDS (NERCHA), the United States Government, primarily through the regional offices of CDC and USAID and in partnership with the Family Life Association (FLAS), has emphasized prevention of HIV/AIDS among high risk groups such as truck drivers, taxi drivers, seasonal agricultural workers and commercial sex workers. FLAS has promoted condom use, distributed and sold condoms, and referred clients to clinics for diagnosis and treatment of sexually transmitted infections. Most banners, billboards, buttons, pamphlets, posters, and T-shirts that promote anti-HIV/AIDS messages throughout Swaziland have been and continue to be purchased and distributed with funds from the U.S. Government.

In addition, since 2003, PMTCT has been supported through the partnership with the Elizabeth Glaser Pediatric HIV/AIDS Foundation (EGPAF). Implementation priorities have included integration of PMTCT with antenatal care, training for staff in PMTCT and VCT and linking the services to community and support. VCT projects have been supported in partnership with PSI.

Anticipating increased funding for Swaziland for fiscal year 2005, a rapid appraisal of the USG strategy was conducted from August 22nd to August 30th with a team comprising USAID, CDC and FHI technical staff from both Washington and the regional offices of the respective agencies. The major objectives of the rapid appraisal were to plan a joint USG strategy for Swaziland and make recommendations to reorient USG programs within a generalized epidemic. In addition, although Swaziland is not a focus country for PEPFAR, the program can clearly contribute to and benefit from aligning itself with the Emergency Plan goals of treating 2 million PLWHAs, preventing 7 million HIV infections and caring for 10 million PLWHA and orphans and vulnerable children (OVC) by 2008. The rapid appraisal was not designed to be a formal evaluation of interventions previously or currently supported by the USG or other donors.

Prevention

2.1 Background and Current Status

Swaziland suffers from the world's highest estimated adult HIV prevalence, at 39 percent which is just above Botswana's rate. The most recent antenatal surveillance was conducted in 2002 (a 2004 round is scheduled), and a full behavioral and biological DHS ("DHS+") survey is planned for the near future. With regard to the primacy of building a strong prevention response, it is important to note that even in this severely affected nation, some 80 percent of the country's population is uninfected with HIV.

The most recent and complete source of behavioral data is the 2002 BSS survey, which found that in general knowledge of HIV, including modes of transmission, is relatively high; however, a high level of reported risky sexual behavior persists. For example, the mean age of sexual debut among in-school youth was 16.3 years, and from 29% to 58% of the surveyed adult population groups (factory workers, long distance drivers, kombi drivers and assistants, military, police, night watchmen, seasonal workers, and tertiary students) reported having a non-married/non-cohabitating sexual partner during the last 12 months. Given that marriage rates are relatively high, this suggests that a considerable degree of multiple concurrent partnerships is fueling the epidemic. Higher levels of multiple sexual relationships were also common among both the adult and youth populations surveyed in the BSS. For example, from 34-64% of those men reporting non-regular partnerships reported having two or more non-regular partners in previous year.

From 3-12% of men in the respondent groups reported having a "lishende," meaning a regular, non-married/non-cohabitating partnership of more than one year's duration. In contrast, only 0.8%, 0.6%, 0.4%, and 0.0% of military, night watchmen, seasonal workers and police, respectively, reported having a commercial sex work (CSW) partner in previous year. Among long distance drivers and kombi drivers/assistants, 5% and 2% reported a CSW in past year, respectively. (The long distance drivers reported having from 2-3 different CSW partners in previous year.) While reported condom use at last sex was relatively high, especially among female sex workers (90% with paying clients), in-school youth (86% at last sex with non-regular partner) and police (73% last sex with non-regular partner), the level of consistent use in the general population remains fairly low, as in most regions. Such low rates of condom use appear mainly due to the level of trust that people attach to their ongoing relationships -- in which it has been rare to achieve high levels of consistent condom use globally.

The majority of the adult male populations surveyed, with the exception of kombi drivers and assistants, reported ever having married. Of those currently married, the majority reported being in single unions, with a minority, ranging from 6-18 percent, being in polygamous unions. The mean age at first marriage was similar across the surveyed adult male populations, ranging from 24.6 years among seasonal workers to 27.4 years among long distance drivers. The gap between mean age of sexual debut and age of marriage, a factor identified by UNAIDS and others as an important risk factor for population-level HIV transmission, is quite large. A recent unpublished, population-based, prevalence and behavioral study by UNICEF in one rural region suggests there may be relatively low HIV prevalence (<6 percent), and correspondingly low risk behaviors, in youth under age 19. Although it is possible that antenatal surveillance data considerably over-estimate actual HIV prevalence in youth if youth are abstaining, the very wide disparity between these reported prevalence rates and those found among young women in the 2002 ANC surveillance and surveys of sugar industry employees, requires confirmation by a national population-based survey.

Approximately 5 million male condoms were distributed or sold in the country last year, or roughly 20 condoms per adult male. Although quite high by African standards, about three times this number were available in Botswana in 2003. In contrast to other southern African countries, such as Zimbabwe, South Africa and Botswana, the contraceptive prevalence rate is relatively low in Swaziland, and fertility remains relatively high. The (self) reported prevalence of STIs during the last 12 months was relatively high, from 4-12% in the surveyed populations (suggesting that consistent condom use is not particularly high), and the proportion who had ever had an HIV test was fairly low, ranging from 6-28%.

Swaziland is a very religious, predominately Christian country, with the Zionists forming the largest denomination. In this survey, 65% of seasonal workers reported being Zionists and 18% reporting being Protestants; 54% of night watchmen and 42% of Kombi drivers were Zionists, whereas 37% of truck drivers were Protestants and 33% were Zionists, and among military men 47% were Protestants and 39% were Zionists. There are no quantitative data available on the prevalence of male circumcision, although it appears the practice is rare in Swaziland. (A large number of epidemiological and biological studies have identified lack of male circumcision as a significant risk factor for heterosexual HIV infection.) Recently there appears to be growing interest on the part of NERCHA, UNICEF and some other stakeholders in expanding access to safe, voluntary male circumcision/male RH services in the country.

Most people reported hearing about HIV/AIDS via radio, followed by newspapers (80% of Swazis are literate), and only a minority via television. As in other African societies, significant proportions of the population reported that HIV can be spread through casual contact such as from sharing food. (In the BSS, 56% would not share food with a PLWHA, and 46% would not buy food from a shopkeeper with HIV.) Almost 3% of people reported that having sex with a virgin cures HIV.

It appears there has been to date relatively little integration of prevention with care/support programs and approaches. Evidence from Uganda and elsewhere suggests that the direct and intensive involvement in prevention activities by care givers, PLWHA and others can significantly strengthen behavior change efforts, at the population level. In addition, several informants, including PLWHA, reported that a growing misperception by some people in the community that ARVs are a cure for AIDS may make behavior change efforts more challenging. With regard to one of the central aspects of PMTCT, breast feeding is the norm in Swaziland; however, exclusive breast

feeding (EBF) appears to be relatively rare. Rather, mixed feeding (with formula, cow's milk and other liquids or solids, etc.) is probably the practice for the large majority of infants and young children. Recent research from Zimbabwe appears to confirm previous findings from South Africa that mixed feeding carries much greater risk for MTCT transmission than does EBF.

Previous USG Prevention Approach: The USG has primarily supported the Corridors of Hope focus on “high-risk populations” (CSW, truckers, etc.). It is increasingly clear that this approach will not be very effective in one of the world's most generalized epidemics. Even if all such “high-risk” transmission were completely stopped (and already the proportion of men reporting commercial sex is very low, and reported condom use is very high for CSW), this would be unlikely to have a significant impact on the overall epidemic in Swaziland, which is primarily driven by multiple concurrent partnerships in the general population. Furthermore, the previous USG approach focused on condom social marketing and STI treatment and there is growing consensus (including by NERCHA, MOHSW, USG, UNICEF, UNAIDS, etc.) that a comprehensive “ABC” approach would be more effective. Such an approach emphasizes delay among youth and partner reduction, as well as correct and consistent condom use, among the sexually active population, where the majority of new infections are occurring.

In addition, the emerging scientific evidence on the impact of STI treatment suggests that while activities such as syphilis control remain an important public health intervention, the population-level impact of STI treatment on HIV transmission is increasingly less certain. (Also, a recent Swaziland study found that the most common type of syndromic management was for vaginal discharge, which USAID, CDC and others have identified as ineffective, at best.) Furthermore, the increasing need to involve important local stakeholders such as FBOs and traditional community leaders underscores the need for a considerable shift toward a more comprehensive behavior change approach; i.e., one that may include but does not overly emphasize activities such as condom social marketing.

Current Status: While a national consensus appears to be emerging around the strong need for a comprehensive “ABC” national prevention and communication approach, it is somewhat unclear whether the most crucial/strategic behavioral objective(s) for the country's response to the epidemic have been clearly specified. Evidence and analysis from other countries, including Uganda, Zambia, Ethiopia and Kenya, increasingly points to the crucial epidemiological importance of “B” (mutual fidelity, partner reduction and partner selection issues) for reducing HIV prevalence at the population level, especially in a generalized epidemic. Similarly to other countries in Africa and in the Southern African region, “B” appears to have been somewhat of a “neglected middle child of ABC” in Swaziland, where “C” and other technical areas like STI treatment have previously been emphasized. In addition there has been a recent interest in “A” for youth.

Partner reduction was recognized by several key informants and stakeholders as a potentially important new area for the country's behavior change focus; i.e. to build on the growing momentum to promote abstinence/delay among youth and expand this to a partner reduction/be faithful behavior change focus for the sexually active population. (The example of Botswana, where the age of debut is relatively late and HIV prevalence is much lower among youth, illustrates that “A” will only have a limited impact on the overall epidemic -- if once people begin sexual activity they typically engage in multiple concurrent partnerships).

Experience from several countries suggests that gender is also critical; women's empowerment and the involvement of women's groups was a major part of the Uganda success, as was promotion of partner reduction and other behavior change among older men. Areas that could fruitfully be explored in Swaziland might include involving the traditional male regiments in HIV prevention/behavior change activities, greater male involvement in PMTCT activities, and expansion of male-focused RH services for STI treatment, VCT, BCC and perhaps access to safe and affordable voluntary circumcision services, if warranted within the local cultural context.

Above all, as MOH, NERCHA and other local stakeholders have recognized, it is vital to establish and invigorate a coherent, unified communications strategy for the country. Such a strategy could include a strong focus on sexual behavior change in addition to other important areas such as treatment literacy, OVC and PMTCT (including promotion of family planning and EBF to reduce MTCT). Several informants reported that previous BCC approaches and messages have often been too sporadic or heterogeneous, sometimes even working at cross purposes, and that insufficient attention has been paid to agreeing upon the overall prioritization of key messages, target groups and of evidence-based, endogenously-developed behavioral change objectives for mounting an effective response to the epidemic.

2.2 New Directions and Recommendations for Prevention

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Support FBOs and CBOs in promoting abstinence and delay of debut to youth. (For youth who have begun sexual activity, returning to abstinence or being mutually faithful with a seroconcordant partner can be encouraged, as well as correct and consistent condom use).
- B) Support specific behavior change outreach to sexually active males -- who play a primary role in sustaining the epidemic -- needs to be scaled-up, involving the male "regiments" and other traditional organizational structures, as well as workplace settings, church groups, military and police institutions, sports clubs, traditional healers, PLWHA and, perhaps, support for safe, voluntary male circumcision services within the context of male prevention/RH services generally. There clearly appears to be a dearth of positive role models for males in particular to emulate, and identifying of such positive models within the Swazi culture and local society would be very useful toward fostering new and healthier norms of behavior.
- C) For adults/the sexually active population, support could be provided to expand behavior change activities beyond "A" to focus significantly on "B"/partner reduction objectives. Churches, FBO networks, traditional leaders, business and other professionals, traditional story tellers, PLWHA, the media and other local sectors could be supported in mobilizing much more open discussion of sexuality, social and cultural norms around sexual behavior (including issues of transactional and cross-generational sex; the possibility of establishing new group norms of behavior, etc.)

MEDIUM AND LONG TERM

- A) Support for the secondment of a BCC specialist with a mentorship role and exit strategy.

B) Development of a communication strategy and the development of a national BCC strategy.

Care, Support and Treatment

A comprehensive package of care, support and treatment activities are essential for addressing the HIV and AIDS epidemic in Swaziland. Such activities include: Voluntary counseling and testing (VCT); Palliative Care; Community and Home-Based Care (CHBC); Clinical Management including PMTCT and ART, Children and Family Psychosocial Support (particularly in the area of supporting children who have been abused, are dealing with life threatening illnesses, and issues involving anticipated grief and grief) and support to Orphans and other Vulnerable Children (OVC). When these essential elements are implemented in a mutually reinforcing manner they meet many of the needs of children, adults, and families thus contributing to comprehensive HIV/AIDS programming.

3.1 Voluntary Counseling and Testing

3.1.1 Background and Current Status

In the Health Sector Response to HIV/AIDS (2003 – 2005), the MOHSW highlights the importance of VCT. It is recommended that VCT services be provided free of charge, especially in low income communities. The long term plan is to provide 20 VCT centers and outreach to approximately 51 rural communities. Monitoring and Evaluation are seen as a priority; and VCT will be included in the country-wide computerized data management system. The goal is to have all hospitals and health centers providing VCT by the end of 2005.

There are several types of HIV Counseling and Testing sites; 1) Integrated within government medical facilities; 2) Integrated – not within regular medical facilities; 3) Free Standing; and 4) Mobile Units with outreach to rural communities and private companies.

Integrated in Hospitals	Integrated Not in Hospitals	Free Standing Sites
Mbabane Government Hospital	Hospice at Home - Matsapha	The AIDS Information and Support Center (TASC) Manzini
Mankayane	Umbutfo Defense Force - Matsapha	TASC AMICAAL Consortium Piggs Peak
Piggs Peak	Shewula	PSI Siteki
Good Shepherd Hospital – Siteki		Mhlume – Royal Swaziland Sugar Corporation (private)
Raleigh Fitkin Memorial – Manzini		Simunye –Royal Swaziland Sugar Corporation (private)
Manstanjeni – Lavumisa		Salvation Army – Mbabane
Hlatikhulu Clinic		FLAS – Mbabane

National Guidelines for VCT were developed by MOHSW in 2002. VCT training is conducted primarily by TASC over 10 days and includes theoretical and rapid test training, plus 6 weeks hands on training. Lay counselors are used by NGOs in their VCT centers but, numbers are small and this cadre is not allowed to perform tests unless they undergo phlebotomist training. All sites use a serial rapid HIV testing algorithm on a venipuncture specimen with Determine and Unigold test kits. Ten percent of samples are submitted for quality assurance ELISA testing at the HIV Reference Laboratory at Mbabane Government Hospital (MGH). The MOHSW has a national VCT Coordinator in the Swaziland National AIDS program (SNAP). USG support to VCT has been primarily through RHAP supported partners such as Population Services International (PSI), TASC, and others.

The National VCT Guidelines (2002) serve to bridge the gap between HIV and AIDS prevention and early access to care. The framework provides a strategic opportunity not only to consolidate the gains made with regards to HIV prevention, but to maximize the impact of interventions related to TB control, PMTCT, STI management, Home-based Care, and the clinical management of people living with HIV.

The National HIV policy recognizes and advocates for increasing access to VCT services. There is a need to expand access to quality VCT services at all levels in the country and to develop protocols for specific HIV/AIDS program contexts such as PMTCT, post exposure prophylaxis and child sexual abuse.

USG support for VCT will be consistent with and contribute to the national goals. Specific objectives would include improving the quality of HIV counseling and testing country wide, increasing access to services, integrating VCT into HIV/AIDS care services, improving and expanding the MIS and data management capacity of VCT sites, and increasing the number of couples counseled.

Linkages to HIV prevention activities can be strengthened; risk reduction through counseling and testing is best accomplished by targeting communities. Communications messages for VCT should be consistent with the ABC approach with a particular emphasis on partner reduction and partner selection. Limited funding has been made available for community mobilization; approaches might include couples-based and family-based approaches and social marketing campaigns.

Encouraging people to seek testing early in the course of their disease (before they become symptomatic), and assuring that they use HIV care and treatment services are important components of effective counseling and testing services. It is highly recommended by the MOHSW that testing of minors under 18 years of age, especially those less than 15, should be done with the knowledge and participation of their parents or guardians in order to determine that the reasons for testing are valid and to ensure appropriate access to follow-up services and support. The best interests of the child should be the primary concern when considering testing a minor. Counselors and organizations providing services to children, particularly OVC, should receive additional training on the unique ethical issues relating to HIV testing and counseling in this age group.

3.1.2 New Directions and Recommendations for VCT

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Conduct a more detailed VCT planning visit primarily to develop consensus on increasing number of VCT sites through projects, such as New Start, and identification of potential partners for new fixed and mobile sites as well as expansion of existing sites (USAID and CDC Regional programs in conjunction with PSI – October 2004). Information on program effectiveness of interventions currently supported might also be gathered.

Based on the rapid appraisal findings it is expected that support will be needed for the establishment of more free standing VCT centers, expansion of mobile teams and sites to reach the large rural populations and introduction of routine provider initiated counseling and testing e.g. for patients with TB or STIs.

- B) Assist MOHSW and NGO partners to develop a plan for securing high quality training of counselors (including lay counselors) and lab personnel.
- C) Support the training of additional lay counselors working at the community level.

MEDIUM AND LONG TERM

- A) Through discussions with the MOHSW and other VCT partners create a national network of standardized VCT Centers which are franchised (e.g. New Start) to local NGOs in collaboration with AMICAAL (for the towns) under the technical guidance of the USG (through RHAP and CDC regional with advocacy and liaison support from the Embassy). A consensus building meeting of relevant stakeholders might first be conducted.
- B) Assist in the strengthening of a monitoring and evaluation system for VCT in order to have national level data on coverage and uptake. Support the establishment of a standardized information system to monitor uptake and referral linkages to treatment and ongoing care.
- C) Develop capacity to support HIV diagnosis and capacity for lab monitoring of HIV care and treatment in infants/children.
- D) Provide technical assistance for the inclusion of a strong “know your status” message especially for couples, within the new communications strategy for the country.
- E) Provide technical assistance the National Reference Laboratories and to select local laboratories. Assist the Office of the Director of Medical Services and the National Referral Laboratory for HIV/AIDS and Quality Assurance (MOHSW) to support the introduction of finger prick testing on capillary samples (versus venipuncture testing).

3.2 Palliative Care

Palliative Care is defined as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.¹ The terms palliative care and care of the dying (end of life care) are often confused. End of life care is only one component of palliative care because palliative care addresses need across the spectrum of care.

3.2.1 Background and Current Status

The MOHSW and NERCHA have both identified palliative care as a priority for increasing care and support for PLWHA in Swaziland. The first national care strategy implemented in 2000 included palliative care education for health professionals. Palliative care providers have played a key role in training care givers (mainly Rural Health Motivators) and in raising awareness among civil society, churches and schools, of palliative care. According to recent data, a total of 4316 people have been trained; trainees represent a broad range of groups including civic groups, professional health workers and community carers. Students from the schools of nursing (105) also received training from hospice providers in home-based palliative care including the following topics; palliative care concept, symptom management, death, grief and bereavement, pain management, home-based palliative care, and spiritual care. Since these initiatives commenced, demand for palliative care has reportedly increased in Swaziland.

Funding for palliative care programs was requested for the first time from the Global Fund as part of the round four application specifically for the provision of training, drugs and materials. Swaziland Hospice at Home is the major palliative care NGO partner that will receive support from the GFATM.

The first national palliative care strategy has been drafted by the Swaziland National AIDS Program (SNAP) under the leadership of the clinical coordinator of the national HIV referral center in Mbabane and is expected to be reviewed with the next few weeks. SNAP is currently seeking assistance with the review of the draft strategy and implementation support. There are currently no national standards or protocols for palliative care, training guidelines or systematic palliative care training for pre- and in-service professional health care workers (including pharmacists) or for informal community health workers.

An important milestone for Swaziland was its representation at the African Palliative Care Association (APCA) inaugural meeting held in Arusha, Tanzania, June, 2004 where agreement was reached on definitions and goals, and palliative care priorities were identified. A critical next step identified for Swaziland from this meeting includes the establishment of a national palliative care committee responsible for coordination and advocacy for palliative care activities including access to pain control for adults and children living with HIV/AIDS. However, the committee has yet to be formed.

¹ World Health Organization definition of palliative care.

The goal is to offer effective palliative care in the home, community and facility (hospitals, hospices, etc) across Swaziland. However, current palliative care initiatives are fragmented and are not reaching the vast majority of people in need. Implementation is expected to be rolled out through NGOs, FBOs and CBOs. However, very few NGOs or service providers have expertise in palliative care. In addition to Swaziland Hospice at Home, only three other NGOs were identified as being recognized palliative care NGOs: Hope House (the only inpatient facility); Parish Nursing; and the Salvation Army. The primary focus of these NGOs is on community and home based palliative care where the need is greatest. Several community based church organizations also provide supportive care to terminally ill patients yet the coverage and quality of work is unknown.

Table 1 Palliative Care Provision in Swaziland 2003

	Freestanding Hospice Unit	Home Care	Day Care	Clinic Drop-In Center
Hope House	X			
Parish Nursing		X		
Swaziland Hospice at Home		X		X
Salvation Army		X		X

All the palliative care services, with the exception of Swaziland Hospice at Home, are charities that rely heavily on donations and small grants for their income. Funds come from a variety of sources including Catholic Bishop’s Forum, Rotary Club of Mbabane and Bristol Myers-Squibb Company. Very few organizations or individuals in Swaziland have the necessary skills to provide clinic or community based palliative care for children.

While pain management, specifically access to opioids including morphine, is clearly a priority for quality palliative care in Swaziland, comprehensive programs are also essential and should address a wide-range of needs including non-pharmaceutical pain management skills, management of chronic diarrhea, cough and skin disorders, oral health, ability to carry out activities of daily living, spiritual and emotional support and palliative care for infants and children.

The current provision of pain management at the household level relies heavily on the use of aspirin and paracetamol (panado). Paracetamol may mask underlying issues including allowing for appropriate investigation of emotional pain, mental illness or physical ailments such as neuropathic pain.² At the other end of the spectrum, the limited availability of morphine, especially morphine syrup, may hinder effective management of severe pain especially at or near the end of life. Morphine is not stocked in large volumes. According to the home based care manual, Hospice³ is the custodian of morphine for Swaziland. Morphine is prescribed with the assistance of a visiting doctor after the patient has gone through the pain management protocol and morphine is indicated. Other drugs are prescribed by nurses after they have made a physical assessment and come up with a nursing diagnosis. All prescribed medication is supplied to patients by hospice nurses. Parish nurses use analgesics such as Stilpayne, Painagon and Tylenol; they do not give morphine.

² The heavy reliance on aspirin increases the risk of gastric irritation (especially for people who are unable to eat). Misuse of paracetamol (panado) can lead to liver failure.

³ Swaziland Hospice at Home

The following key priorities for palliative care development in Swaziland were previously identified by the four primary Palliative Care NGOs in the country and appear to be consistent with those outlined by the MOHSW.

- Funding for palliative care programs, training, medications, staffing and administrative costs;
- Increased drug availability;
- Education and training;
- Capacity building for a palliative care workforce;
- Support for palliative care providers;
- Development of national palliative care guidelines (in process); and
- Development of a Swaziland Parish Nurse Education and Resource Center.

Although the provision of palliative care is very limited in Swaziland it is clear that palliative care is considered critical to the care and support of PLWHA and their families. Given the high level of determination, commitment and the important role that palliative care plays in effective care, the provision of support for rapidly scaling up palliative care in Swaziland is timely.

3.2.2 New Directions and Recommendations for Palliative Care

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Include Swaziland in the Office of the Global AIDS Coordinator (OGAC) palliative care assessments. It is recommended that this be done in collaboration with APCA and that the team is comprised of local stakeholders including PLWHA and traditional healers as a first step in mobilizing the response for palliative care.

B) Support the formation of a National Palliative Care Association

MEDIUM AND LONG TERM

A) Assistance with the review, finalization and implementation of the national palliative care strategy.

B) Technical assistance for the development of standards and protocols for palliative care, and national training guidelines.

C) Technical and programmatic assistance for the training of pre- and in-service health professionals and community health workers. The first step will be a workshop with key stakeholders including other donors to identify who is currently conducting training in home and community based care and palliative care and the development of a detailed training strategy from which USG will provide support. Key people working in palliative care will be identified and trained as master trainers for further training of those working in palliative care including within home care, community care and facility based settings.

- D) Technical assistance for the development of a national monitoring and evaluation system for palliative care.
- E) Support to strengthen and advocate for community level palliative care for children with HIV and other life threatening illnesses (using a family centered approach). This support can include the adaptation of the up-coming southern Africa Palliative Care Training Guide for Children Living with HIV and other Life Threatening Illnesses.
- F) Programmatic and technical palliative care support to NGOs, CBOs, and FBOs including those working in CHBC to increase their palliative care skills and reach.

3.3 Community and Home Based Care

Community and home based care is a “the provision of care and support that endeavors to meet the nursing and psychosocial needs of persons with chronic illnesses and their family members in their home environment”⁴. The fundamental distinction between home based care and palliative care is that home based care is a delivery system adapted to the home environment and palliative care is a specific type of care that is offered wherever it is applicable – in the home, community and in facilities (hospitals, hospices, etc.)

3.3.1 Background and Current Status

Swaziland has developed a strong foundation and made progress in beginning to implement CHBC. CHBC guidelines were developed in November 2002 by the MOHSW which include clear guidance on the purpose, implementation and monitoring of CHBC. A national CBHC training manual and handbook for community home based caregivers and training system has also been developed. The training manual and handbook are reportedly used throughout the country but the extent and availability of RHM training is unclear. There is no readily available information on the national coverage, status, and quality of CHBC activities. For instance, through a CHBC database, resource guide, or quality review. National level coordination for CHBC appears to be strong with the exception of limited involvement from PLWHA and the department of social welfare.

CHBC services are provided through the government CHBC system, NGOs and FBOs. The CHBC system in Swaziland includes caregivers who provide respite care and emotional support to clients and household members, RHMs who provide basic care and referral (to clinical services and VCT and PMTCT) and clinical nurses who are the link between CHBC and clinical service. The delineation of responsibility for each level of CHBC workers has not been mainstreamed and the referral system from the household to clinical services for symptom management and early treatment remains weak. A number of factors contribute to these challenges including a lack of community level mobilization and coordination, transport, the frequent rotation of nurses, and the ratio of RHM to clients, and nurses to RHMs.

The severe shortage of nurses and nearly non-existence of social workers in the county is of critical concern. While the RHMs are able to provide support at the home, the current government CHBC

⁴ Family Health International, Comprehensive Care and Support Framework

estimated ratio of RHMs to clients is 1:40 and the ratio of nurses to RHMs is unknown but reportedly high.

Discrepancies in the system of payment exist whereby RHMs receive financial incentives on a monthly basis but most NGOs are not able to provide the same incentive to their CHBC givers. Each constituency (55) has a CHBC supply point from which very basic materials are provided to the RHMs and CHBC workers. The number of supply points for RHMs will be increased to include neighborhood care distribution points located with specific NGOs, CBOs and FBOs. Only basic materials, such as bleach, gloves, aspirin and paracetamol (panado), ORS, gauze, and soap, are provided at the supply points. However, maintaining an uninterrupted supply of materials has been a challenge. Other essential supplies for use in the provision of CHBC are reportedly only available from a limited number of CHBC partners such as NGOs and mission hospitals.

Access to clinical services at the community level is considered critical to effective scale up of care and support services including VCT, PMTCT, clinical management and ART. However, the technical capacity of RHMs is limited and there is a great deal of concern regarding the availability of required human resources and technical skills at the community level. The recent introduction of ART will require access to cadres of CHBC workers who can provide much needed support for care and treatment literacy campaigns and adherence monitoring.

While pain was clearly recognized by CHBC workers and other stakeholders in CHBC it appears that there is no systematic way of assessing pain or addressing pain management (including access to medication).

CHBC workers and stakeholders also reported that they are faced with many issues related to OVC within the context of CHBC including children who are suspected to be HIV+. However, a review of the training material and key informant interviews, indicates that specific training or skills building in this area is weak. Although the primary focus of the CHBC workers is their client, it appears that their ability to provide care and support is sometimes compromised by complicated family and household issues of their clients such as communication around illness and the early identification of other family members who may be ill especially children.

There are an increasing number of PLWHA support groups (46) and PLWHA who are becoming publicly open about their sero-status in the country. However the involvement of PLWHA directly or indirectly in CHBC was consistently stated by stakeholders to be limited.

One promising CHBC program visited in terms of both scale and implementation was that of the Good Shepard Hospital. Clear lines of responsibility exist for each level of care in the referral system and access to clinical care, and monitoring exists at all levels. Several strong NGOs, primarily run by retired nurses, work with Good Shepard to support the system.

Funding for the national CHBC program is provided both through the Global Fund and the EU to the MOHSW. Services are also provided by individual NGOs, FBOs and mission hospitals. However, EU funding which provides the majority of support for the CHBC training materials will end in June 2005 and no additional funding has been identified.

Swaziland has created a strong foundation for CHBC and has accelerated its provision in recent years. With increased programmatic and technical support, CHBC in Swaziland has the potential to become a model of care from which others can learn.

3.3.2 New Directions and Recommendations for CHBC

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) National mapping exercise to identify current CHBC coverage and efforts, levels of CHBC being provided, gaps (geographic and provision of services), and future funding and technical assistance needs.
- B) Participatory rapid assessment of the quality of CHBC and identification of strategies to rapidly scale up CHBC coupled with immediate support for improving the quality of CHBC in the assessment site. This could be done in collaboration with existing CHBC programs such as those of the Good Shepherd Hospital and its partners in their geographic catchment area. The results would automatically feed into strengthening the reach and quality of CHBC and the model could be used for replication in other geographic areas. Examples of areas for exploration include:
 - Community level coordination and involvement of key stakeholders such as PLWHA, social workers and traditional leaders.
 - Review of the effectiveness of CHBC for increasing clients' ability to perform activities of daily and identification of skills needed to improve provision of care.
 - Communication skills on dealing with difficult issues such as eliciting clients' concerns, physical condition of client, emotional and mental distress and illness, differing concerns of household members, physical limitations due to illness, anticipatory grief, and impending death.
 - Strengthening the role of CHBC within ART treatment for adults and children and strengthen home care support for those on treatment including care and treatment literacy, side effects and adherence monitoring and support.
 - Making use of CHBC as an entry point for prevention by ensuring that any communication strategy developed at the national level includes CHBC as a mechanism to deliver clear and consistent messages and advice.

MEDIUM AND LONG TERM

- A) Development of a national CHBC database and resource guide for increasing access.
- B) Identification of the possible need for and development of a national accreditation process for CHBC workers and organizations.
- C) Provide support for the review and up-grade of the content of CHBC kits and supplies. There are several model CHBC kits in the region that could be drawn upon such as those used by National Department of Health in South Africa. A study on feasibility and effectiveness of CHBC kits has been recently completed in South Africa and findings may be beneficial.

- D) Support the provision of essential elements of palliative care including pain and symptom control within CHBC. See Palliative Care Section.
- E) Assistance for the development of low-literacy client- provider materials to facilitate the provision of CHBC. The first priority would be the collection of existing materials from the region that could be quickly adapted and used in Swaziland.
- F) Strengthening on-going education in particular technical areas such as pain management, palliative care, children with HIV, psychological and emotion support, dealing with mental health issues, and OVC within CHBC. These might be prioritized within a strategy for providing ongoing education and support to each level of CHBC worker coupled with the development of specific training modules in technical gap areas. See palliative care for training strategy.

3.4 Prevention of Mother to Child Transmission (PMTCT)

3.4.2 Background and Current Status of PMTCT

The MOHSW launched the PMTCT program in March 2003. At present there are 8 PMTCT sites:

1. Good Shepherd Hospital in Siteki
2. Mbabane Government Hospital
3. Raleigh Fitkin Memorial Hospital (RFMH) in Manzini
4. King Sobhuza II Clinic in Manzini,
5. 3 clinics under RFMH in Manzini Region
6. Mankayane Hospital.

The PMTCT Program is based in the Reproductive Health Unit, MOHSW under one focal person. There is 1 nutritionist and 2 staff in the Health Education Unit. A rollout plan, PMTCT guidelines, training curriculum (10 days), and an implementation guide have been developed by the MOHSW.

The first training of trainers has been completed and training is to be decentralized to the regions, but the cost of training was reported as being very high since hotels must be used in the absence of a government training center.

While this visit did not constitute a program review, the guidelines state that isoniazid (INH) should only be given to symptomatic HIV-positive women - INH is actually contraindicated in anyone with signs and symptoms suggestive of TB. This error should be corrected if not already done. Single-dose nevirapine is the cornerstone of the program. Exclusive breastfeeding for 4-6 months is recommended unless formula feeding is feasible – most mothers reportedly opt for breastfeeding because of the cost implications. Mixed feeding, however, is more common than exclusive breastfeeding and is likely to be increasing rates of HIV transmission. Eligible women can only access ART through one of the existing ART sites. The development of stronger linkages between PMTCT and ART was identified as a need.

US-funded support through the Elizabeth Glazer Pediatric AIDS Foundation (EGPAF) to the Manzini Region started in January 2004 and includes training, provision of a national-level

coordinator, additional nurses at 3 sites, renovation, nevirapine through the Boeringher-Ingelheim Company donation program, equipment, and project monitoring and evaluation. An EGPAF-funded baseline KABP survey has also recently been conducted through AED and AMICAAL in the Mankayane sub-district. Preliminary findings suggest that 90 percent of pregnant women receive formal ANC care, 70 percent deliver in a health facility, PMTCT knowledge in the community is low, misconceptions about HIV remain common, and community involvement is low. The same rapid testing procedures are used with PMTCT as with VCT. All PMTCT counseling and testing is dependent on nurse counselors. No national PMTCT information system has yet been developed and the lack of data on national program performance was reported as a priority need. EGPAF has recently development a monitoring system for their 3 project sites. EGPAF has also assisted with revision of the ANC and maternity registers to include PMTCT information.

The proportion of pregnant women receiving testing was anecdotally reported by 2 ANC units as approximately 50-80 percent of new visits. However, the maternity register at RFMH (>7300 births per annum) showed that ~90 percent of the women who delivered in July 2004 had unknown HIV status. The MOHSW rollout must now reach a total of 159 clinics, 5 health centers, and 3 more hospitals since ANC is well-decentralized and integrated into routine services at all clinics. The primary constraint of the MOHSW is lack of human capacity to manage, monitor, and implement the services that are needed.

Swaziland has greatly accelerated its response over the past year and with support is poised to take PMTCT and treatment services to scale. Timely and targeted USG support primarily to MOHSW and local NGOs is highly recommended in this regard. The large GFATM commitment provides an excellent opportunity of leveraging USG resources and technical assistance. Direct program support is probably of secondary importance compared to the need for developing local human capacity at all levels.

3.4.3 New Directions and Recommendations for PMTCT

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) In conjunction with EGPAF, UNICEF and WHO consider training needs assessment for PMTCT.
- B) Funding for NGO service personnel (especially doctors, pharmacists, lab staff) until more Swazis can be trained.

MEDIUM AND LONG TERM

- A) Assistance to the MOHSW to develop a comprehensive Human Resource Development Plan.
- B) The MOHSW has requested the assignment of a USG medical epidemiologist to help build local capacity. Short-term TA from RHAP, CDC Regional, and other USG supported staff from countries in the region might be provided in the meantime to establish and maintain momentum.

- C) Design and implementation of simpler service delivery models (e.g. adding lay counselors to the health system, allowing trained nurses to prescribe the first-line regimen when criteria are met).
- D) Support to pre-service and in-service training.
- C) Assist/support MOHSW in the development of the PMTCT monitoring and evaluation system; in collaboration with NERCHA, further explore how proposed USG funded activities for PMTCT could be incorporated into the planned computerized management system for the National ARV Program, and development of a national database and associated accountability framework.
- D) A number of steps could be taken to specifically increase coverage with PMTCT services through programmatic and technical support, these include:
- Adoption of an opt-out consent approach for HIV testing in ANC
 - Greater community sensitization to the importance of HIV testing in pregnancy along with other laboratory tests e.g. syphilis
 - Addition of lay-counselors to busy ANC sites
 - Addition of rapid HIV testing to labor and maternity wards for untested women
 - Establishment of a national information system for PMTCT to monitor uptake by site
 - Development and implementation of a strong communication strategy to include involvement of PLWHA who have strong communication skills and are supportive of PMTCT services
 - Revitalization of the training and support programs for Rural Health Motivators and Traditional Birth Attendants to address the high percentage of home deliveries
- E) Provide support for the integration of appropriate elements of the Emergency Plan basic care package for adults and children into ART, PMTCT and CHBC.

3.5 Orphans and Other Vulnerable Children

3.5.1 Background and Current Status

Swaziland defines a child as a person between 0 to 18 years of age; *orphans* are defined as children less than 18 years old who have lost one or both biological/and or adoptive parents. *Vulnerable children* are defined as children less than 18 years of age whose parents or guardians are incapable of caring for them, who are physically challenged, living alone, living with poor elderly grandparents, living in a poor sibling-headed households and/or have no stable place to live. Vulnerable children are also those children who “lack access to healthcare, education, food, clothing, psychological care, and shelter and hence are exposed to all forms of abuse, including child labor”.⁵

Despite the complex challenges faced by Swazis, due to the combined impact of HIV/AIDS and poverty, families and communities remain at the forefront of responding to the needs of OVC. Promising community-based initiatives have recently commenced, such as the system of the current

⁵ Draft National Policy on Orphans and Vulnerable Children, 2003

4000 neighborhood care points and the Ka Gogo (at grandma's place) initiative (MOSWH) whereby local women are provided a stipend to look after OVC in their communities.

External support has primarily consisted of material and training support with a heavy focus on provision of food and the prevention and identification of child abuse. Few programs have been able to comprehensively address the major needs of children infected and affected by HIV/AIDS including psychological support and ensuring access to basic, government-run health and education services as well as specific services for HIV exposed and/or positive children. For instance, NERCHA OVC programs focus mainly on food relief, economic empowerment followed by socialization, and limited psychosocial support. Children have not been adequately addressed within the context of the continuum of comprehensive HIV/AIDS prevention, care and treatment. During this rapid appraisal process the team was unable to identify a comprehensive program (implemented by either one or several organizations) providing for all of the needs of a child.

The GFATM and UN organizations, including UNICEF, UNAIDS, and the World Bank, are the primary OVC donors in Swaziland. The Government Education Fund and BMS also contribute, but expenditures from these programs were unclear to the team. An effective government-led coordination mechanism with a dedicated budget line to address the OVC crisis in Swaziland does not yet exist.

Swaziland has participated in key OVC consultations and a draft national action plan has been developed.⁶ During the 2002 Regional Workshop on Orphans and Vulnerable Children the following actions were identified by the Swazi delegation:

1. To ensure that all school age OVC are attending school by 2005;
2. To protect OVC rights, prevent discrimination, exploitation, and abuse, and reduce stigma;
3. To ensure adequate psychosocial support for OVC; and
4. To ensure access to health and nutrition for OVC.

However upon completion of this rapid appraisal it was unclear how widely the draft action plan has been shared with the entire OVC community.

Swaziland's response remains fragmented and severely constrained by the lack of a multisectoral OVC coordinating structure. Of critical concern is that the department of social welfare, the structure responsible for the welfare of children and families, does not seem to be adequately engaged in or sufficiently included in the response to OVC. Furthermore, Swaziland has yet to complete a national situation analysis or mapping of services and the identification of specific geographic and service needs nor is there a national monitoring and evaluation mechanism comparing access of OVC to basic social services with that of other children.

Despite these challenges the National Policy on Children including Vulnerable Children has been drafted and recently submitted to Cabinet for approval. The National Policy was validated at the National Stakeholders' Conference on Orphans and Vulnerable Children in November 2003⁷. Once

⁶ Key consultations include the first and second Southern and East Africa Regional OVC Consultations (2000 and 2002) and the Strengthening National Responses: Southern Africa Workshop on Orphans and other Vulnerable Children (November 2003).

⁷ Convened by the Ministry of Health and Social Welfare

approved, the National Policy will guide appropriate government and civil society responses in support of the long-term protection and well being of children, including OVC.

Although there are many small NGOs, FBOs, and community initiatives, a critical need exists for technical assistance to increase their capacity to mobilize communities, to provide essential care and support services for OVC and provide family centered care. Of concern is the very loose use of the term OVC program and some of the ethical issues raised by their expansion to other service areas. For instance, upon closer review of an FBO program providing “OVC care and support,” it appeared that the program was actually an informal feeding point. The program did not have access to adequate technical expertise for addressing complex issues such as informed consent of guardian and/or OVC when conducting HIV testing of OVC, while adhering to ethical principles and a family-centered approach. A similar issue also seems to be emerging in relation to psycho-social support (PSS) whereby the term is sometimes used to describe a program that is simply bringing children together in a common place to eat without an additional PSS component. Similarly, it appears that there has been an increase in the recognition, reporting and possibly in the incidence of sexual abuse. However, the team was unable to identify any clear ethical guidelines for the collection of such sensitive information from children or protocols for the provision of physical and emotional support to children suspected of being abused.

Given the increase in funding for OVC, recognition of the plight of these children, the increasing community mobilization in support of these children and their families, and the emerging response to HIV/AIDS, Swaziland has the potential to dramatically increase its OVC response.

3.5.2 New Directions and Recommendations for OVC

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Review of services providing HIV/AIDS care and support to identify gaps and opportunities to strengthen the integration of children within these services and move towards a family centered approach. This could be done through a consultative process with key stakeholder whereby a review of current services and materials would be conducted and up-graded to focus on family centered care.
- B) Technical and programmatic support for community based programs for OVC further expanding the NCPs and Ka Gogo initiatives and increasing their capacity to mobilize communities, strengthen community level coordination, and to provide essential care and support services for OVC including children with HIV within a family centered approach.

MEDIUM AND LONG TERM

- A) National level support for strengthening and implementing the national plan of action, national coordination, and national monitoring and evaluation plan in line with UNGASS commitments.
- B) Mapping of services to identify coverage and gaps that can feed into a national monitoring and evaluation mechanism.

- C) The integration of child protection activities within more comprehensive OVC programs that aim to increase access to regular social services focusing on the best interest of the child. A starting point for this could be the adaptation and implementation of the newly developed ethical guidelines for information gathering from children (USAID, FHI, Futures Group and UNICEF).

3.6 Treatment (Antiretroviral Therapy – ART)

3.6.1 Background and Current Status of ART

ART involves the provision of a comprehensive evidence-based package of services through a network of linked providers in the public and/or private sector. Such services should include the provision of ARV drugs, treatment counseling, laboratory support, PMTCT, TB Control, STI management and overall clinical care of these infected with HIV/AIDS.

Through the WHO-led 3 by 5 initiative, a global target of three million people receiving antiretroviral treatment (ART) by 2005 has been set. Swaziland's target is 13,000 people on treatment by 2005. Over the past few months, MOHSW has begun to roll out ART at all regional hospitals and to date more than 3,000 people are receiving treatment. Rapid appraisal team also had the opportunity to briefly discuss the provision of TB treatment and follow-up to TB patients at the Good Shepherd Hospital. The TB program works very closely with the community (i.e. rural health motivators, community carers and family members) to ensure the completion of TB treatment according to DOTS protocol.

ART first started at the HIV/AIDS referral clinic in Mbabane General Hospital (MGH) in late 2001 but it was not until November 2003 that ART was offered free of charge to the public. To date MGH has registered approximately 6,000 HIV-positive patients and approximately 3,000 have been started on ART (these numbers could not be confirmed). All 6 hospitals have started ART except Mankayane, which will start later this month. No national reports on ART uptake were available and there is a need to introduce cohort analysis into a national reporting system.

Several large private estate ART programs, including Simunye Sugar Mill and Usuthu Pulp are being incorporated into the government program as free ART is made available. ART guidelines have been developed. ART training was previously being conducted outside of the country in South Africa, but WHO is now supporting the development of a new 10-day comprehensive HIV/AIDS care training which includes ART. Their target is to train 80 percent of health workers by the end of 2005 taking services down to the clinic level.

Through NERCHA, a drug procurement policy and strategy has been developed which will serve as a guide for the overall procurement process. Funding has been provided by the Italian Cooperation to assist in the establishment of operating policies and procedures for drug procurement and other health products. The drug supply has been secured through the government tendering process, mostly for generics, and is largely paid for through the GFATM by NERCHA. Eligibility includes CD4<200 or Stage III or IV disease. Bristol Myers Squibb is conducting a research project at MGH on ART for 200 pregnant women, partners, and children as part of a family model for care.

All CD4 testing is performed on 2 Beckman-Coulter machines in the Mbabane laboratory using the PLG method. At present, approximately 200 tests are being run per day. Viral load testing has not yet been started. A new National Reference Laboratory is being constructed and will open in 2006. Italian Cooperation is also providing support to the national reference laboratory. Plans are underway to decentralize CD4 testing to at least Manzini in the near future where there is a high volume of patients. Human capacity in the laboratory setting was reported as a major constraint and the development of a quality assurance program for HIV/AIDS, STI/HIV, and TB/HIV-related laboratory services was reported as an urgent need.

Since March 2004, an elaborate, web-based electronic information system has been undergoing pilot-testing by a Case Management Team using computer terminals in NERCHA. The paper report form for the system is ~25 pages long. With financing from the GFATM, the software has been supplied by the Innovir Institute, a private HIV/AIDS practice and consulting service in Johannesburg. The database is maintained in Johannesburg and the hardware and internet communications systems are maintained by Netsite, a private computer company. The system provides an interactive web-based interface between clinical, laboratory, and Central Medical Stores information on individual patients based on a bar-coding system. CMS is also prompted by the system to pre-package ARVs for distribution to individual patients on a specified date and time. The system is currently on-line only with MGH and does not yet include laboratory information. The Innovir system raises some concerns over sustainability and feasibility for MOHSW to be able to implement, afford, and maintain such a complex design. Monitoring systems are a useful tool to improve service delivery when they are based within the program rather than with an outside entity. The role of the USG with monitoring of ART can only be clarified when the future of this system is finalized. Clarification on the role of the MOHSW in monitoring ART rollout is needed, as is the need for a more practical, simplified paper and computerized system in the meantime.

The primary constraints to ART rollout are human capacity at all levels, inadequate outpatient infrastructure, lack of local training capacity, and inadequate capacity within laboratory service and pharmaceutical management, particularly with inventory control beyond CMS.

3.6.2 New Directions and Recommendations for ART

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- F) In conjunction with EGPAF, UNICEF and WHO consider training needs assessment for ART.
- G) Funding for NGO service personnel (especially doctors, pharmacists, lab staff) until more Swazis can be trained.
- H) Support funding and technical assistance to conduct a laboratory assessment.

MEDIUM AND LONG TERM

- E) Assistance to the MOHSW to develop a comprehensive Human Resource Development Plan.

- F) The MOHSW has requested the assignment of a USG medical epidemiologist to help build local capacity. Short-term TA from RHAP, CDC Regional, and other USG supported staff from countries in the region might be provided in the meantime to establish and maintain momentum.
- G) Design and implementation of simpler service delivery models (e.g. adding lay counselors to the health system, allowing trained nurses to prescribe the first-line regimen when criteria are met).
- H) Support to pre-service and in-service training.
- I) Assist/support MOHSW in the development of the ART monitoring and evaluation system; in collaboration with NERCHA, further explore how proposed USG funded activities for ART could be incorporated into the planned computerized management system for the National ARV Program, and development of a national database and associated accountability framework.
- J) Encourage the development of model programs to address HIV diagnosis, care and treatment of HIV infected infants and children, including co-trimoxazole (building on the example of the Good Shepard Hospital).
- K) Provide support for the integration of appropriate elements of the Emergency Plan basic care package for adults and children into ART, PMTCT and CHBC.

Nutrition

4.1 Background and Current Status

HIV/AIDS compromises the nutritional status of infected individuals, increases energy requirements and causes symptoms that constrain dietary intake and reduce nutrient absorption. In addition, HIV exposure and infection exacerbates problems of child malnutrition. Swaziland is rolling out ARVs. ARV therapy improves nutritional status, but it may also have side effects and metabolic complications. Communities, policy-makers and PLWHAs, need to have accurate information regarding nutrition and HIV/AIDS.

4.2 New Directions and Recommendations in Nutrition

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Intensify efforts to implement essential nutrition actions (ENA) within existing USG- funded PMTCT and MCH programs, recognizing the special needs of HIV-positive mothers and children.
- B) Identify areas of opportunity with key networks and organizations such as the PLWHA network, Swaziland Nutrition Network, Alliance of Mayors and Municipal Leaders on HIV/AIDS in

Africa (AMICAAL), Elisabeth Glazer Pediatric AIDS Foundation (EGPAF), Academy for Education Development (AED) and others.

MEDIUM AND LONG TERM

- A) Provide financial and/or technical support to existing advocacy groups to increase awareness, knowledge and understanding among policymakers and stakeholders about the relationships among nutrition, food insecurity and HIV/AIDS.
- B) Provide financial and/or technical support to scale up nutritional education and counseling as part of a preventive care package to maintain body weight, prevent food and waterborne infections, manage dietary complications of HIV-related symptoms and secondary infections, manage side effects from ART and OI medications and assure safe infant-feeding practices in health facility, community, and home-base care programs.
- C) Provide financial and/or technical support to plan targeted evaluation activities on nutrition interventions in HIV/AIDS programs.
- D) Since there is no Title 11 program in country, work with the WFP to analyze the determinants of HIV/AIDS and food insecurity using data from the mapping of malnutrition, food insecurity, HIV/AIDS prevalence/impact and community capacity. Determine the geographic coverage of HIV/AIDS, nutrition and food security programs in order to identify the highest-risk areas, gaps in services and appropriate strategies for linking existing programs.
- E) Assist with the development, adaptation or revision (as appropriate) guidelines for nutrition care and support for HIV-positive adults and children.
- F) Provide technical support for the revision and finalization (as appropriate) of the national nutrition policy to include considerations for HIV-positive adults and children and HIV-affected families.
- G) Support the development, adaptation or revision (as appropriate) of SOPs to integrate nutrition interventions into HIV/AIDS prevention, care and treatment (particularly PMTCT, ART, HBC and OVC) programs.
- H) Provide programmatic and technical assistance for the development of job aids and education/counseling tools (based on formative research) for use within HIV/AIDS prevention, care and treatment programs.
- I) Assist with the training of clinic, community and home-based providers in the nutrition SOPs and on how to use the job aids/tools.
- J) Provide technical review of local regulations related to product safety and marketing of foods, medicinal herbs and nutrition supplements and strengthen enforcement capacity (as needed) to protect PLWHAs from dangerous and/or ineffective products.

Human Capacity Development and Resource Management

5.1 Background and Current Status

The Swaziland health and social welfare sectors play a paramount role in the provision of care and support to the spectrum of the population from infant to adult. Swazi health and social welfare professionals are clearly committed to delivering quality care but are working in an extremely challenging environment. The increasing demand for comprehensive HIV/AIDS services and continued poverty are causing unprecedented pressure on health and social welfare structures to deliver quality and coordinated services within an already overwhelmed system. The impact of HIV, lack of human, financial and technical support and coordination has resulted in a critical shortage of capacity within the health and social services sectors.

Despite efforts made by the MOHSW such as the formation of the human resource mobilization technical subcommittee, there are still serious gaps in human resource management and lack of an information system to track coverage (geographic, human, and educational). For instance, the MOHSW is responsible for delivering services, the Ministry of Public Services is responsible for employing the workforce and the Ministry of Works is responsible for the repair and maintenance of buildings and equipment. Additionally, the MOE is responsible for the pre-service preparation of professional health workers and the department of social welfare is responsible for the training and employment of social workers.

Human resource budgets have been reduced over the past decade. The percentage of the national budget allocated to health and social welfare sectors is among the lowest in SADC and less than half of what was stated in Swaziland's international statements of commitment. According to the UN donor community the country has reached a point where institutions are severely stressed and capacity is insufficient to even seize opportunities of external assistance.

To gain a better understanding of the situation the MOSHW (with WHO support) recently developed a detailed report of key issues specifically focused on human capacity facing the health sector. The ratio of doctors to people is reportedly 1; 5,953 and one professional nurse per 356 people. There are even fewer pharmacists and laboratory technicians and only 12 social workers for the entire country. Four pediatricians have been requested in the fourth GF application. Swaziland has no medical schools or training facilities for laboratory technicians or social workers.

Like other developing countries nurses account for the vast majority of the professional health care work force, are caring for ill family members, depended on by their community for support and some themselves are living with HIV. While Swazi nurses have received basic HIV training, there is a clear need to increase their: clinical HIV knowledge and skills; access to information; ability to advocate for nurses living with HIV; and provision of quality care through the availability of essential basic materials. These deficiencies have resulted in an annual nursing attrition rate of 11 percent - losing approximately 330 each year while only producing 90.⁸ Likewise social workers are carrying caseloads of approximately 1,500 but are only able to follow up on very few cases due to

⁸ MOHSW and WHO, 2004

the shortage of staff and lack of support. *“When we finally reach some of our client’s homes we find that they have passed away. This makes it hard for us to stay motivated.”*⁹

The above conditions have resulted in high absenteeism and burnout, “brain drain”¹⁰ and a profound effect on the delivery of services. During this appraisal it was clear that professional health care workers in Swaziland are deeply passionate and concerned for the future of their people. There is also an impressive network of community based health workers (volunteers and RHMs) who are being increasingly called upon to provide support in the community. Retired nurses, PLWHA, and unemployed young people with university degrees are eager to become more engaged in the provision of services and are a pool of skilled workers that can be better utilized.

Recognizing these challenges the MOHSW held a national forum on human resources for health in June 2004. The forum focused on three key areas: retention of health care workers, employment of new health care workers, and strategies to increase nursing school enrollments. A memorandum of understanding to improve compensation packages, provide special allowances for rural health post workers, and provide HIV care for health care workers is reported to be signed with health associations by the end of September.

5.2 New Directions and Recommendation for HCD and Resource Management

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) A one year secondment of an HR expert to the MOSHW to assist with the HR strategy with a clear mentorship role and exit plan.
- B) Provide programmatic and technical assistance, as appropriate, for pre- and in-service training of General Practitioners, Nurses, and Social Workers in the clinical management of HIV/AIDS.
- C) Provide programmatic and technical support for the development of short and long term training systems including training key trainers to increase the cadre of health and social welfare workers to support current and future prevention, care and treatment activities. Key actors include lay counselors, RHMs, PLWHA, retired nurses and social workers, unemployed youth with university degrees, and auxiliary workers/volunteers working in communities and at neighborhood care points.

MEDIUM AND LONG TERM

- A) Assistance to develop a health and social HR sector strategy including resource mapping, planning, management, the development of pre- and in-service training for all levels of the health and social welfare workforce and appropriate strategies for integrated workforce planning and improved communication across ministries.

⁹ Key informant interview, Swazi social worker August, 2004

¹⁰ Brain Drain is defined as the exodus of health care workers from developing nations to the wealthier countries of the North. (PHR, 2004, p.1)

- B) Since there is no medical school in the country and nursing schools are overtaxed, in partnership with Peace Corps, consider twinning arrangements with American based tertiary institutions to support training capacity locally or within the region.
- C) Explore possibilities of utilizing and strengthening regional networks supporting health workers such as the as the SADC AIDS Network of Nurses and Midwives (SANNAM) of which Swaziland is an active member. SANNAM provides cross fertilization and technical assistance from regional nursing experts in HIV/AIDS. Requesting countries can access national technical assistance and psycho-social care and support activities for nurses infected and affected by HIV/AIDS. Another important network to consider is the SADC Human Resource Development Sector of which Swaziland is the host country.
- D) Assist with the development of care and support for caregivers. This could be easily done through the adaptation of the Caring For Carers Handbook developed by the Nursing Association of Botswana and possible twinning with the association.
- E) Investigate models for engaging private sector health workers, NGOs, FBOs and capacity building of local training institutions.

People Living with HIV/AIDS (PLWHA) Networks

6.1 Background and Current Status

The first known Swaziland PLWHA organization was formed in 1993 through the AIDS information and Support Center (TASC). The support group grew and developed into a registered organization of PLWHA in the country known as the Swaziland AIDS Support Organization (SASO). SASO operates at a national level with two regional offices in Lumbobo and Shiselweni. Since SASO three other primary PLWHA support groups have emerged – Swaziland Positive Living, Women Together, and Endless Hope. Since their inception these groups have focused much of their attention on advocating for PLWHA rights, their inclusion in key decision making arenas at the national and regional levels, and coordinating their efforts.

In February 2003, Skillshare International completed a needs assessment of organizations, associations and networks working with PLWHA in Botswana, Lesotho, Namibia and Swaziland. The SADC-DFID funded assessment confirmed that PLWHA networks, organizations and support groups made some progress in meeting the social challenges posed by HIV/AIDS but that their responses did not match the scale of the problem. This study provided the impetus for an in-country rapid assessment of groups, associations and organizations of PLWHA.

Through support from UNAIDS, NERCHA, and SIPAA the rapid appraisal was carried out in May 2004 by SASO, Swaziland Positive Living, Women Together. Both the process and findings of the rapid appraisal have resulted in not only key information needed to strengthen PLWHA groups in Swaziland but also the creation of a national network of PLWHA.

Key to the findings was the identification of 46 groups of PLWHA ranging in size from a membership of three (3) to 1,445 with more than three quarters of the groups having between 3 and

50 members. Approximately 90 percent of the groups have been formed in the past four years. Generally, the proportion of people who are public about their HIV status is relatively small and this is attributed to the perceived stigma, discrimination felt by PLWHA and fear of revealing a positive HIV status. The primary activities reportedly carried out by PLWHA groups include information, education, and communication on HIV/AIDS, peer support and counseling, community mobilization and income generation. However, PLWHA groups throughout Swaziland are reportedly faced with a number of challenges including lack of leadership structures and management skills, low self-esteem, stigma, and low levels of education. Among the most important areas identified for capacity building are HIV/AIDS literacy specifically related to treatment, CHBC, leadership management, household economic strengthening, and nutritional support for PLWHA.

The new national network of PLWHA has completed a draft constitution and is starting to use the rapid appraisal findings to advocate for increased strategic support for PLWHA. This includes advocating for inclusion of PLWHA group representatives on local and national HIV/AIDS activities and key working groups and the development of a national data base containing key information on each group. SASO is a partner on both the 2002 and 2004 GFATM proposals. But much more assistance is needed to assist the network in achieving its goals and to help build the capacity and reach of local PLWHA groups.

6.2 New Directions and Recommendations for PLWHA network support

The achievements and motivation of the PLWHA network, identified status of local PLWHA groups and the critical role of PLWHA in HIV/AIDS prevention, care and support cannot be understated.

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Support to the national network of PLWHA to develop a strategy and implementation plan based on the rapid appraisal findings with possible additional funding for carrying out select key activities.
- B) Support for the first National PLWHA consultation whereby the constitution, strategy and resource guide can be validated and launched.

MEDIUM AND LONG TERM

- A) Assistance to the national network of PLWHA to develop a resource reference guide (based on the national data base) for national distribution. The resource reference guide will enable PLWHA to find support groups in their areas and can be used as a referral guide for those working with PLWHA.
- B) PLWHA training to increase leadership, management and HIV/AIDS skills and knowledge. There are several emerging PLWHA training groups throughout Southern Africa (South Africa in particular) who can be called upon for assistance. This may also be an opportunity for PLWHA twinning activities.

- C) Support for forums which build linkages between community-based support systems and national and regional networks for PLWHA.
- D) Assess the number of key PLWHA policies yet to be implemented, government commitment and available resources for implementation. Identify the role of the PLWHA network in implementation.
- E) Programmatic and technical support to key local PLWHA groups including in the Good Shepard catchment area as part of the Good Shepard comprehensive prevention, care and treatment model.

Social Mobilization for Advocacy and Policy Change

7.1 Background and Current Status

The challenges faced by children, families, communities, and the government in addressing the impact of HIV/AIDS are enormous. Therefore, comprehensive and cost-effective approaches, coupled with coordinated partnerships, effective policies, and social and community mobilization, are needed. There is wide consensus in Swaziland that broad multisectoral participation is needed to achieve goals in HIV/AIDS prevention, care and treatment. To build political commitment and catalyze a social movement it is critical to increase the involvement of women, youth, PLWHA, the private sector, media representatives, human rights activists, the faith community, and traditional leaders. The NCP and Ka Gogo models at the community level provide a strong foundation for community mobilization.

Experience¹¹ has confirmed the importance of advocacy to formulate, implement and monitor effective policies that address the needs of those they are intended to serve. Increased active involvement of Swazi key stakeholders will help to ensure that needs are accurately addressed and resources are allocated to meet these needs. Through increased coordination and involvement knowledgeable advocates will play an important role as watchdogs, facilitating political commitment and making sure that governments carry out their promises.

While there appears to be an understanding that multi-sector approaches to health issues often proven more effective than purely health-sector approaches and that many issues affecting health (e.g. stigma, cultural practices, women's lack of resources or decision-making authority) can not be solved by the health sector alone. However, it is also evident that this is an area in need of greater attention and support in order to increase the wider involvement of all sectors.

¹¹ Experience from three decades of USAID support for policy work in family planning and reproductive health.

7.2 New Directions and Recommendations for Social Mobilization

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

- A) Provide technical assistance to lift and strengthen advocates for change such as the PLWHA Network, FBOs, National Palliative Care Association, Business Coalition Against Aids, Traditional healers and others including possible assistance to develop strategies for increasing the visibility and enhancing the leadership of national associations and other national organizations.
- B) Offer forums for the exchange of lessons and ideas.

MEDIUM AND LONG TERM

- A) In collaboration with key stakeholders identify the most effective mechanisms for compiling, analyzing and using and country-specific and global data for policy analysis, dialogue and formulation coupled with the development of a mechanism to measuring changes in the policy environment.
- B) Provide financial and/or technical support for disseminating relevant data and information to policy makers, program planners, and community-based advocates. This might include groups such as the media, Parliamentarians, community aids action committees and others.
- C) Conduct gap analysis of existing national associations and networks including, but not limited to, the following areas: (a) organizational capacity; (b) collaboration and communication; (c) advocacy skills; and (d) resource mobilization.
- D) Provide assistance to develop an inventory of existing and needed key policies including those that have yet to be implemented, government commitment and available resources for implementation

NEXT STEPS

- 1) By September 27, draft report to be shared for comment with U.S. Ambassador, CDC and USAID Regional and Headquarters (HQ) Offices, HHS and OGAC and in-country partners. Comments are to be returned by October 8th and the Report Finalized by October 15th.
- 2) By October 15, US Ambassador, appraisal team members and CDC/USAID regional directors to provide a formal briefing to the US Office of the Global AIDS Coordinator.
- 3) By October 22nd, representatives of CDC and USAID regional offices to review budget for Swaziland and determine which activities can be initiated immediately and which will need to wait for confirmation of additional FY funding.
- 4) By the end of November, US Ambassador and CDC/USAID Regional Staff to meet with GoS in order to confirm USG FY 2004 support and discuss potential FY 2005 activities.
- 5) By the end of November, the CDC/USAID Regional offices to develop a joint USG plan of action in response to the recommendations including planning of short-term TA and identification of country technical back-stops at regional and HQ levels.
- 6) By November, meet with the UN Expanded Theme Group on HIV/AIDS to brief them on appraisal findings and recommendations.

***Note on implementation:** The U.S. Ambassador and U.S. Embassy HIV/AIDS support staff will play a pivotal role in moving the USG team effort forward. This will be achieved through on-going dialogue and close communication with the MOHSW, NERCHA, other USG agencies (such as the Peace Corps and the Department of Defense (DOD) and community partners such as the FBOs, NGOs, PLWHA networks, and Public-Private Partnerships (PPPs).

An umbrella grant mechanism through Pact will allow activities to be expanded immediately. The CDC and USAID Regional Offices need to develop additional funding mechanisms for working with the U.S. Embassy, MOHSW and other key stakeholders that are implementing HIV/AIDS programs. Certain HR and procurement policies for non-presence countries may need clarification as programs are scaled up. Furthermore, TA could be provided predominantly through the CDC and USAID regional offices; ideally, there can be designated focal persons to provide continuity in their specific technical areas of expertise.

REFERENCES

- Academy for Educational Development. (2004) Nutrition and HIV/AIDS: Evidence, gaps and priority actions. Technical brief prepared for the U.S. Agency for International Development, April, 2004.
- Bailey RC, Plummer FA, Moses S. Male circumcision and HIV prevention: current knowledge and future research directions. *Lancet Inf Dis* 2001;1:223-31.
- Carael M. Sexual behavior. In *Sexual Behavior and AIDS in the Developing World*. JG Cleland, B Ferry eds. Taylor and Francis, 1995.
- Cross AR, Rutstein SO, Otieno F, Cheluget B. [Sociodemographic and behavioral correlates of HIV prevalence in Kenya](#). The XV International AIDS Conference, July 12, 2004, Bangkok. Abstract no. MoPeC3641.
- Drain PK, Smith JS, Hughes JP, Halperin DT, Holmes KK. Correlates of national HIV seroprevalence rates: an ecologic analysis of 122 developing countries. *J Acquired Immunodef Syndr* 2004;35:407-20.
- Epstein H. The fidelity fix. *The New York Times Magazine*. June 13, 2004.
- Flood M. Lust, trust and latex: why young heterosexual men do not use condoms. *Culture, Health & Sexuality* 2003;5:353-69.
- Grémy I, Beltzer N. HIV risk and condom use in the adult heterosexual population in France between 1992 and 2001: return to the starting point?
- Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention, www.thelancet.com, Volume 364, July 3, 2004.
- Desmond, C., King J., Tomlinson, J., Sithungo, C., Veenstra, N., and Whiteside, A. (In Press). Changing patterns of mortality and their consequences in Swaziland.
- Family Health International and U.S. Agency for International Development. (2001). Lesotho, Swaziland and Mozambique, HIV/AIDS risk assessments at cross-border and migrant sites in Southern Africa, April 2001.
- Famine Early Warning Systems Network (FEWSNET) (2004). Southern Africa food security brief. July, 2004.
- Formative research (behavioral assessment) on PMTCT, maternal nutrition, infant and young child feeding, care and support in the context of HIV and AIDS. In collaboration with AED/LINKAGES/AMICAALL and EGPAF, 2004.
- Halperin D, Bailey RC. Male circumcision and HIV infection: ten years and counting. *Lancet* 1999;354:1813-15.
- Halperin D, Epstein H. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *Lancet* 2004;363:4-6.
- Hearst N, Chen S. Condom promotion for AIDS prevention in the developing world: is it working? *Studies in Family Planning* 2004;35:39-47.
- Kingdom of Swaziland. (2002). Application for global fund for AIDS, TB, and malaria funding: Round 2. Submitted September 2002.
- Kingdom of Swaziland. (2004). Application for global fund for AIDS, TB, and malaria funding, Round 4. Submitted DATE.
- Leclerc-Madlala S. Transactional sex and the pursuit of modernity. *Social Dynamics* 2003;29:1-21.

Ministry of Health and Social Welfare. (2003). The health sector response to HIV/AIDS in Swaziland, 2003-2005. July, 2003.

MOHSW, HIV/AIDS Crisis Management and Technical Committee. (2000). Swaziland National Strategic HIV/AIDS Plan for 2002-2005.

MOHSW and World Health Organization. (2004). A situation analysis of the health workforce in Swaziland. April, 2004.

MOHSW, Family Life Association of Swaziland, USAID, FHI. (2004). Swaziland Behavioural Surveillance Survey 2002.

MOHSW, USAID, FHI, UNICEF, UNPF, and WHO. (2003). Eighth HIV Sentinel Serosurveillance Report: Kingdom of Swaziland, 2002.

Morris M. and Kretzschmar M. Concurrent partnerships and the spread of HIV. *AIDS* 1997; 11:681-83.

Ministry of Health and Social Welfare. July 2003 The Health Sector Response to HIV/AIDS Plan for Swaziland, 2003-2005.

Ministry of Health and Social Welfare – 2002 National Guidelines for Voluntary Counseling and Testing.

Ministry of Health and Social Welfare (November 2002) Guidelines for Prevention of Mother to Child Transmission of HIV

Ministry of Health and Social Welfare Improving Access to HIV/AIDS Care in the Kingdom of Swaziland End of Project Report July 2001-December 2003

NERCHA Annual Report 2004

NERCHA – 2004 A National Multi-Sectoral Response to HIV/AIDS – A Synopsis of Selected Interventions.

Physicians for Human Rights. (2004). An action plan to prevent brain drain: Building equitable health systems in Africa. June, 2004.

Pilcher CD, Tien HC, Eron JJ, et al. Brief but efficient: acute HIV infection and the sexual transmission of HIV. *J Infect Diseases* 2004;189:1785-92.

Regional HIV/AIDS Program Southern Africa, Quarterly Report DATE, 2004. FHI, 2004.

Regional HIV/AIDS Program Southern Africa, Quarterly Report DATE, 2004. Population Services International, 2004.

Regional HIV/AIDS Program Southern Africa, Quarterly Report DATE, 2004. Futures Group, Policy Project, 2004.

Report Back on Swaziland, Notes for Press Briefing, Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa, March 31, 2004
www.sarpn.org.za/documents/d0000774/P879-Swaziland_Lewis_31032004.pdf

Shelton J, Halperin DT, Nantulya V, Potts M, Gayle HD, Holmes KK. Partner reduction is crucial for balanced "ABC" approach to HIV prevention. *BMJ* 2004;328:891-93.

Skillshare International, SADC Health Coordinating Unit, and DFID. (2003). An assessment of the needs and gaps of PLWHA networks, organizations and support groups in Botswana, Namibia, Lesotho and Swaziland. December, 2003.

Status of palliative care in Swaziland: http://www.eolc-observatory.net/global_analysis/pdf/swaziland_country_report.pdf

Stoneburner R, Low-Beer D. Population-level HIV declines and behavioral risk avoidance in Uganda. *Science* 2004;304:714-18.

Swaziland Palliative Care Country Profile. Received Draft version from APCA conference organizers.

Swaziland: Seven point plan to fight HIV/AIDS, March 2004. (IRIN).

Swaziland tightens its grip, March 2004. (IRIN).

Swaziland Vulnerability Assessment Committee (2004). A study to determine the links between HIV/AIDS, current demographic status, and livelihoods in rural Swaziland, April 2004.

www.sarpn.org.za/documents/d0000784/P904-Swaziland_VAC_April2004.pdf

Trip Report: Heckert, K. and Selvaggio, M. - Swaziland 27-28 April 2004, Elizabeth Glaser Pediatric AIDS Foundation and USAID.

United Nations. (2004). Mission report: Malawi, Mozambique, Namibia and Swaziland, June 14-22, 2004. Mr. James T. Morris, Special Envoy of the Secretary-General for Humanitarian Needs in Southern Africa.

UNAIDS and WHO (2004). Swaziland epidemiological fact sheet on HIV/AIDS and Sexually Transmitted Infections, 2004 Update.

UN Theme group on HIV and AIDS (2004). Statement by Dr. Alan Brody at the Annual General Meeting of the National Emergency Response Council on HIV/AIDS (NERCHA), July 30, 2004.

Weiss HA, Quigley MA, Hayes RJ. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 2000;14:2361-70.

W.K. Kellogg Foundation and the Human Sciences Research Council (HSRC). (2004). An audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe.

Whiteside, A., Desmond, C., King J., Tomlinson, and Sithungo, C. (2002). Evidence of AIDS mortality from an alternative source: A Swaziland case study. *African Journal of AIDS Research*, 2002, 1:1-4.

Whiteside, A., Hickey, A., Ngcobo, N., and Tomlinson, J. (2003). What is driving the HIV/AIDS epidemic in Swaziland, and what more can we do about it? Report prepared for National Emergency Response Committee on HIV/AIDS, UN Program on HIV/AIDS and Health Economics and HIV/AIDS Research Division.

Wilson D. Partner reduction and the prevention of HIV/AIDS: the most effective strategies come from within communities. *British Medical Journal* 2004;328, 848-49.

ANNEX 1: SCOPE OF WORK

LESOTHO AND SWAZILAND HIV/AIDS PREVENTION, CARE, SUPPORT AND TREATMENT, RAPID APPRAISAL

**United States Agency for International Development (USAID)
U.S. Center for Disease Control and Prevention (CDC)**

August 10, 2004

Purpose: To inform the design of USAID and CDC - supported HIV/AIDS prevention, care, support and treatment programs in Lesotho and Swaziland and to improve performance and greater program/resource integration in addressing the HIV/AIDS pandemic.

Objectives:

- Rapid appraisal to identify the current status of HIV/AIDS prevention, care, support and treatment including strategies, available resources, and the coverage and effectiveness of ongoing and current activities undertaken by Lesotho and Swaziland government, UN supporting agencies, local and international NGOs and other private sector organizations and donors.
- Identify linkages (between national and community programs; between supporting government institutions and other sectors, non-government and private organizations) that are required for HIV/AIDS prevention, care and support, and treatment approaches for the spectrum of the population including infants to elderly to succeed.
- Identify strengths and weaknesses (policy, resources, technology) of current efforts (what is working and what is not working including geographical targeting of resources, coordinating mechanisms, and activities).
- Identify potential constraints to and opportunities for scaling up successful interventions and strategies to address constraints. Opportunities might build on and complement on-going activities in HIV/AIDS prevention, care, support, and treatment.
- Make recommendations for greater program and resource integration to support improved performance in addressing the HIV/AIDS pandemic including assistance needs. This will include the identification of technical assistance needs and resources for scaling up prevention, care, support, and treatment programs in Lesotho and Swaziland (individuals, organizations, training institutions).
- Identify the potential role that RHAP and the CDC regional office can play in support of USAID and USG's larger efforts to confront and support HIV/AIDS comprehensive prevention, care, support, and treatment based on outcomes of the rapid appraisal and existing evidence of key interventions. This will include the identification of key strategic interventions and partnerships for RHAP to consider.

- Identify potential in-country key stakeholders to play a future role in guiding USAID and CDC implementation support.
- Identify potential stakeholders and technical expertise in the region to play a future role in strengthening program.
- Provide feedback to in-country stakeholders

The appraisal will specifically look at the following aspects and linkages related to HIV/AIDS prevention, care, support, and treatment for the spectrum of the population from infants to elderly (see appendix A for details):

- HIV prevention programs and activities
- Prevention of Mother to Child Transmission of HIV/AIDS
- Care including palliative care for people living with HIV/AIDS across the spectrum of the infant and elderly population across the disease continuum¹²
- Clinical HIV Management including OI, ART, STI, etc
- HIV counseling and testing
- Referral systems and linkages for clients and families for care, treatment and prevention needs
- Orphans and other vulnerable children
- Nutrition and food security
- Traditional structures, services, and practices
- Community involvement and participation
- PLWHA involvement in prevention, care, and treatment
- Human resources and capacity
- Coordinating structures and policies
- Organizational capacity

Appraisal Team Tasks

1. Refine and approve SOW. Develop appraisal tools and process. This will also include agreement on the roles and responsibilities of each team member.
2. Review literature (e.g., research, strategies and program documents) on HIV/AIDS programming (per above focus areas) in Lesotho and Swaziland. Some documents will be available for review before in country fieldwork others will only be available in country hence reviewed in country. See Appendix A for list of key documents.
3. Conduct appraisal/field work per SOW.
4. Draft document including documentation of existing strategies, coordinating mechanisms, and programmatic responses to address comprehensive HIV/AIDS prevention, care, support, and treatment per technical focal areas outlined. The review might cover programs supported by government, USAID, UN organizations and other donors or development agencies as well as

¹² Looking at providing the key services, strengthening systems and building the policies that enable quality, holistic home-based, community-based and clinic based care across the disease continuum.

national HIV/AIDS strategic plans. Document the extent to which plans include comprehensive HIV/AIDS care, treatment and prevention programs and considerations.

5. Finalize Report.
6. Develop and participate in dissemination and debriefings (in-country and other) as planned by appraisal team.

Methods

The appraisal will be based on the review of available literature and data, key informant interviews, informal focus group discussions, stakeholder meetings and project site visits.

Team Composition

Ideally each team will have a combination of technical skills per the aspects and linkages related to HIV/AIDS prevention, care and support, and treatment outlined in the objective section of this SOW. The following specific technical expertise for the spectrum of the population including infants to elderly will be essential within each team:

- Clinical HIV/AIDS management and ART across disease continuum
- Prevention (including Behavior Change Communication)
- Orphans and other vulnerable children
- Palliative care
- Home based care
- Socio-economic support
- Monitoring and Evaluation
- Comprehensive HIV/AIDS strategic design
- Organizational Capacity
- PMTCT and maternal, neonatal and child health

Lesotho Team

Ms. Kendra Phillips, Director, USAID/RHAP

Ms. Celicia M. Serenata, CDC, Global AIDS Program Southern Africa

Dr. Cheryl Scott, CDC, Global AIDS Program Southern Africa

Dr. Michael Cassell, Prevention Technical Advisor, USAID/OHA

Dr. Kelello Lerotholi, Health Consultant

Ms. Sara Bowsky, Sr. Technical Officer, FHI (Team Leader)

Ms. Monica Fako, Logistical Assistance

Swaziland Team

Ms. Kendra Phillips, Director, USAID/RHAP

Dr. Melanie Duckworth, CDC, Global AIDS Program Southern Africa

Dr. Peter Salama, Principal Advisor HIV/AIDS, USAID/Africa Bureau (Team Leader)

Dr. Daniel Halperin, Prevention Technical Advisor, USAID/OHA

Ms. Julie Cory, HIV/AIDS Technical Advisor, US Embassy Swaziland

Ms. Sara Bowsky, Sr. Technical Officer, FHI

Mr. Dlamini, Logistical Assistance

Deliverables

1. Debriefings – one for local USAID/USG staff and other partners in Lesotho and Swaziland and one for USAID/Washington.
2. Final report documenting the findings. Describe how HIV/AIDS prevention, care, support, and treatment efforts are being implemented, the strengths and challenges, and recommendations for strengthening current efforts in each country. Appendices including SOW and tools used for the appraisal. The report will also identify appropriate local resources for strengthening the program and will be shared with local partners, USAID/Washington, CDC/Atlanta, USAID and CDC Southern Africa Programs and other key partners.
3. List of names, contact information and qualifications of potential in-country key stakeholders that might play a future role in guiding USAID and CDC implementation support.
4. Dissemination plan for findings/report.

Time Frame*

3 weeks in total for initial document review, travel, debriefings, drafting and finalization of the report.

August 13th: Key documents and draft tools sent to teams.

August 21-30th **Swaziland**: first day to review SOW and tools, 7 days to conduct rapid appraisal, 1-2 days for writing and in country debrief.

September 5 –14th **Lesotho**: first day to review SOW and tools, 7 days for conducting rapid appraisal, 1-2 days for writing and in country debrief.

September 24th: Final Reports disseminated.

Key Questions and Considerations

Care for positive adults and children across the disease continuum that looks at providing the key services, strengthening the systems and building the policies that enable quality, holistic home-based, community-based and clinic-based care across the disease continuum:

Services

1. Physical care for adults/children: OI prophylaxis and treatment; ART adherence support; STI treatment; pain and symptom assessment and management with non-opioids and opioids; nutrition assessment, counseling and supplementation interventions (as appropriate); linkages or access to appropriate child survival interventions for positive kids; access to clean water/hygiene; access to ITNs; process for identification and referral system for OVC programs within the care program; integration of appropriate prevention activities along the care continuum (e.g. strategies for caregivers working in the home, community, clinic – building prevention on a foundation of care); basic nursing care (including hygiene for client and home).
2. Psychological and emotional support services - including mental health care, spiritual support, substance abuse, bereavement counseling and end of life support for PLWHA, their families and caregivers (especially specific strategies for kids and caregivers)

3. Socio-economic support services: Legal support (will making, succession planning, property issues); stigma reduction; food security; economic strengthening activities e.g. IGA for PLWHA and caregivers, etc.

Systems

1. Human, financial resources and capacity to deliver family-centered, holistic care in the home, clinic and community – including support for caregivers.
2. Education and Training: pre-service, in-service and other training programs and curriculum on HIV/AIDS care for physicians, clinical officers, midwives, nurses and community health workers
3. Quality Standards in care

Policies

1. Drugs: access, regulation and prescribing privileges of nurses, midwives, clinical officers and physicians to provide and prescribe OI medications, ART and narcotic analgesics at tertiary, district and community settings.
2. Status of national policy on palliative care, hospice care or home based care (may be included in the national HIV/AIDS policy)

Palliative Care

1. National policies on palliative care
2. Status of national palliative care committee (coordination, advocacy and other palliative care activities, particularly on access to pain control for adults and children living with HIV/AIDS).
3. Status and future plans for providing and strengthening the care services, systems and policies as described above.
4. What are the activities, challenges and future plans for advancing the area of pain and symptom control in Swaziland and Lesotho?
5. Who are the country-specific leaders or champions in the area of palliative care? (and their contact information). What are their priorities? Who is assisting them?
6. Understand and address the status of Pain/symptom control, including ADL areas and opioid availability,
7. Pre and in-service training in palliative care,
8. Prescribing and dispensing privileges of all types of medications in HIV/AIDS care and treatment by physicians, nurses, nurse midwives, rural health motivators and community carers

Treatment

1. Public hospitals already doing ART if there are any. Otherwise those doing PMTCT only. Consider Mbabane Govt, Raleigh Fitkin in Manzini, and Good Shepherd in Siteki.
2. The laboratory, pharmacy, OPD, ANC, and maternity in each of those facilities
3. The central laboratory for HIV testing (which used to be in Manzini)
4. The central medical stores (which used to be in Matsapha)
5. The training institution, if any, which has done or would do ART training (? if the Institute of Health Sciences in Mbabane is involved)
6. The TB clinic or hospital (which used to be in Manzini)
7. The head of the local HIV clinicians society if there is one affiliated with the society in South Africa, or, a private practitioner (Dr. Zama Gama in Manzini is an old friend of mine and would be a good source of what is happening in the private sector if an appointment could be made)
8. Whomever in the national AIDS program is tasked to oversee PMTCT, ART

9. Potential partners for ART which those on the ground with the USG have identified to provide ART
10. It would be helpful to see any existing MOH plans, guidelines, curricula with respect to ART, PMTCT, and VCT; current support for ART, PMTCT, and ART from other donors; GFATM application if available; current Medium Term Plan, etc

ANNEX 2: ORGANIZATIONS AND INDIVIDUALS INTERVIEWED

Organization	Individuals Interviewed	Title/Position
National Emergency Response Committee HIV/AIDS (NERCHA)	Derrick Von Wissel Sibusiso Dlamini	Director Care & Support Nat'l Coordinator Monitoring and Evaluation Prevention Impact Mitigation
Ministry of Health & Social Welfare		Minister Permanent Secretary Director of Clinical Service
Key Government Officials Mbabane Government Hospital	Dr. Mahaliyana x Beatrice Dlamini x Thandi Dr. Sukati Albert Thwala x	Director, VCT Swaziland Nat'l Nutrition Council Dir., Swaziland Nat. AIDS Prog. Logistics Officer, SNAP Dir., Rural Health Motivator Prog. Univ. Swaziland, Nursing Dept. African Methodist Episcopal Church Health Education Unit
U.S. Peace Corps	Dr. Winnie Emoungu	Director Coordinator, SPA Grants Program
U.S. Embassy	Lewis Lucke Robert Dance	U.S. Ambassador Deputy Chief of Mission
UN Theme Group on HIV/AIDS	Dr. Alan Brody Mulu Tennagashaw Dr. Mauro Almaviva Rudolph Mazero Bernadette Nnabugwa Penny Dlamini Jabulane Tsabedze Chinwe Dike Sid Nirupam Sue Godt Wesly Jickling Vuli Simelane	UNICEF UNAIDS Country Coordinator Italian Cooperation AMICAAL WFP UNICEF, FBO DFID UNDP Country Representative UNICEF, Nutrition UNICEF, Lifeskills UNAIDS US Embassy
NGO Forum Meeting at Family Life Association of Swaziland	Thabana Masasgane Jabulani Gamedze Babazile N. Dlamini Lucy Aliband Dorah Dlamini Phindile Dlamini Tsembeni Magongo Bongani Phorswu Jerome Shongwe Janet Khumalo Cedric Musa Mgogo Thandiwe Dlamini Sarah Dlamini Linah Dlamini Linah Ntiwane Edith Ntiwane Janet Ongole	Hospice, Palliative Care Nurse Hospice, Palliative Care Nurse PSI, Program Manager PSI, Reg. Director PSI, Research Officer Correctional Svcs., HIV Committee Swaziland Defense Force Swaziland Defense Force FLAS, Corridors of Hope FLAS, Clinical Services Mgr. FLAS, Executive Director Coordinator, Parish Nurse Prog. Hope House, Coordinator Parish Nurse Program Parish Nurse Program Parish Nurse Program TASC Project Officer

Organization	Individuals Interviewed	Title/Position
Good Shepherd Hospital	Dr. Aby Phillip Sr. Andrew Jele	Hospital Administrator Director, HBC Program Nurse Supervisor TB Program Person HBC Nurse Pediatric Physician PSI VCT Center PMTCT Physician, Outpatient Clinic
Simunye Sugar Company		Coordinator, HIV Workplace Prog.
Children's Cup Orphan Feeding Program	Ben Rogers x	Director Primary School Teacher
Hope House	Sarah Dlamini x	Director Nurse
Media	Sazikazi Thabede Sihle Mavuso M. Nkambule Muzi Yende Nozipho Mamba Bonisile Dlamini Simangele Dlamini	Times Times Observer Observer Observer SBIS (Radio) SBIS (Radio)
Meeting with Faith-Based Network Mountain Inn Conference Room	Mandla Mazibuko Thandiwe Dlamini K. Olamini Kevin Ward Don Smith	Save the Children UK Church Forum Scriptur Union Lighthouse International Church
TB and NCP		
Meeting with PLWHA groups	Fikile Dlamini Vusi Matsebula Esther Diekmann M. Mkhonte	MAHPI LDS LDS SASO
Swaziland Action Group Against Abuse	Mandla Lumphondo	
Department of Social Welfare	Sibongile Matsebula Ellen Mabuna	Director, Social Welfare TITLE