



**Implementation of  
regional and  
international HIV  
prevention, treatment,  
care and support  
Conventions and  
Declarations in  
Swaziland and  
Zambia**

Prepared by



with support from







# ACKNOWLEDGEMENTS

This research was commissioned by the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) in October, 2008 with funding support from the Open Society Initiative for Southern Africa (OSISA). SAfAIDS acknowledges the generous funding support from OSISA.

The assessment would not have been possible without the generous contribution from a number of people. We are grateful to informants from Swaziland, including Rejoice Nxumale-Nkambule (Public Health Services), Khanya Mabuza (NERCHA), Dr Velepi Okolo (SNAP), Thembile Dlamini (UNAIDS), Anson Zwane (WHO), Nonhlanhla Hleta-Nkabule, Celiwe Seyama, Zodwa Dlamini (UNCF) and Dudu Simelane (FLAS). Russell Dlamini, Bagezile Dube, Cliff Dlamini and Chipo Karoro-Nyamayaro all from World Vision, Dumisani Msibi and Thamary Silindza (Save the Children), Gcebile Ndlovu (ICW), Emmanuel Ndlangamanhla, Wandile Nkosi, Sizakele Hlatshayo and Bongiwwe Zwane (CANGO), Siphwe Hlope (SWAPOL), Nonhlanhla Dlamini (CEDAW), Vusi Matsebula and Madzabudzabu (SASO), Jabulani Tsabedze (WILSA), Rachel Masuku (Central Statistical Office) and Khosi Hlatshwayo (Business Coalition).

We are also grateful to the stakeholders' meeting and focus group discussion participants: the youth, men and women who spared their valuable time to participate in this assessment.

The Swaziland research was conducted by Tendayi Kureya, with substantial input from Wandile Nkosi from CANGO and Unity Chipfupa from Development Data.

The research Team is indebted to OSISA for choosing Zambia to be one of the fortunate countries where the domestication of international treaties and conventions that have a bearing on HIV and human rights, is being assessed. The research team would like to express its profound gratitude to the Government of the Republic of Zambia through the Human Rights Commission, Ministry of Health, and ZARAN, for allowing this research to proceed in an uninterrupted manner through their constant availability when they were needed. Valued thanks are due to the Anti Corruption Commission, the Drug Enforcement and the Zambia Police Service Victims Support Unit.

We are grateful to Zambians from the Zambian Network of People Living with HIV and AIDS (NZP+), Treatment Advocacy Literacy Campaign (TALC), and many NGOs who agreed to participate in this extremely important project. We are grateful for the leadership of the SAfAIDS Zambian office for their technical and strategic leadership throughout the course of this research.

Dr Michael Mulimansenga Chanda and Dr Patrick Mamimine (Research Consultants). Editing and review by Sara Page and Rouzeh Eghtessadi with assistance from Petronella Mugoni. Design and Layout by Fikile Gotami.

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# ACRONYMS AND ABBREVIATIONS

AAA	Accra Agenda for Action
ACC	Anti-Corruption Commission
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ART	Antiretroviral Therapy
ARV	Antiretroviral
CANGO	Co-ordinating Assembly of Non-Governmental organisations
CBO	Community-Based Organisation
CCM	Country Co-ordinating Mechanism
CDC	Centre for Disease Control and Prevention
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CHAZ	Churches Health Association of Zambia
CMTC	Crisis Management and Technical Committee
CSO	Civil Society Organisations
DATFs	District AIDS Task Force
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMIS	Education Management Information System
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
FYO	Forum of Youth Organisations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoS	Government of Swaziland
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information Education and Communication
JASZ	Joint Assistance Strategy for Zambia
JFA	Joint Financing Arrangement
M&E	Monitoring and Evaluation
MDG	Millenium Development Goal
MISA	Media Institute of Southern Africa
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NAC	National HIV/AIDS/STI/TB Council
NARFs	National AIDS Reporting Form
NASF	National AIDS Strategic Framework
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-Governmental Organisation
NRC	National Research Council
NSP	National Strategic Planning Process
OSISA	Open Society Initiative for Southern Africa
OVC	Orphans and Vulnerable Children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PSI	Population Services International

SAFAIDS	Southern Africa HIV & AIDS Information Dissemination Service
SAI	Supreme Audit Institution
SHAPMoS	Swaziland HIV/AIDS Programme Monitoring System
SHARe	Support for the HIV/AIDS Response Project (USAID/ JSI)
SNAP	Swaziland National AIDS Programme
STI	Sexually Transmitted Infection
SWANNEPHA	Swaziland National Network of People living with HIV and AIDS
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Emergency Fund
UNISWA	University of Swaziland
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey
ZNAN	Zambia National AIDS Network
ZNBT	Zambia National Blood Transfusion Services
ZSBS	Zambia Sexual Behaviour Survey
ZWAP	Zambia Workplace AIDS Partnership

## EXECUTIVE SUMMARY

HIV is an epidemic of catastrophic proportions. It has mostly affected the world's poorest nations, especially those in Africa, and sub-Saharan Africa is by far the worst-affected by the virus. Although the region has just over 10% of the world's population, it is home to 67% of all people living with HIV (PLHIV).

Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), with support from the Open Society Initiative for Southern Africa (OSISA), commissioned country studies in Zambia and the Kingdom of Swaziland in 2008. Similar studies had been conducted in 2006 in Lesotho, Malawi and Mozambique. The aim of the study was to examine the extent to which these countries were implementing HIV and AIDS prevention, treatment, care and support (impact mitigation) strategies and services, in line with major international commitments and declarations to which they are signatories.

This report highlights SAfAIDS' findings on the implementation of regional and international HIV prevention, treatment, care and support conventions and declarations in Swaziland and Zambia. The assessment, which used qualitative methods to collect data on various HIV and AIDS services, used literature review and consultative meetings and key informant interviews with key stakeholders and focus group discussions with users of services and their representative organisations. SAfAIDS put together technical teams in the two countries comprised of an independent researcher, SAfAIDS staff and an in-country partner organisation identified to conduct the assessment.

Swaziland is one of the southern African countries worst affected by the HIV and AIDS epidemic. Out of an estimated population of just over one million people, the HIV prevalence for the population aged between 15 and 49 years is 26%. Official reports also show that women (31%) are more likely to be HIV positive than men (20%)<sup>1</sup>. This, as reported by the Government of Swaziland, is attributed to the unwillingness of the Swazi population to change their sexual behaviour.

Swaziland has, however, made considerable efforts in prevention, care and support. The percentage of donated blood screened for HIV with an external quality assurance scheme is 100%. The country also developed prevention of mother-to-child (PMTCT) guidelines in 2002. As a result, HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. Finally 35% of adults and children with advanced HIV infection are receiving antiretroviral therapy.

Like Swaziland, Zambia is one of the countries in sub-Saharan Africa worst affected by the HIV epidemic. HIV prevalence according to the 2008 Demographic Health Survey report, is currently 14.3% among the 15-49 years age group. Zambia has, however, made strides in scaling up its response to the HIV epidemic in the areas of prevention, treatment, care and support and mitigation. Despite a number of challenges, Zambia remains an enviable model in the region in the rapid roll out of the HIV and AIDS response from the centre to the periphery, using a multi-sectoral approach. It is commendable that the HIV and AIDS Strategic Framework was formulated in a highly participatory manner, using a bottom-up approach.

1 UNGASS Report, 2008

Generally, survey findings show that Swaziland and Zambia have, to some extent demonstrated their commitment to be guided by regional and international commitments made with respect to HIV. The two countries are signatories to the Millennium Development Goals (MDGs) and UNGASS Declarations, as well as the Maputo Plan of Action, among others. Both Governments have put in place policies and frameworks for domestication of these international conventions and protocols.

According to the WHO, Swaziland's response enjoyed high level political commitment, although this has not correlated to reduced rates of HIV infection (Avert.org, 2008). The same can be said of the response in Zambia. Although progress has been documented, it still falls far short of actual needs on the ground. However, Zambia has not yet made a deliberate attempt to put in place a legal framework that specifically addresses the various protocols to which the country is signatory. The need for a rights-based approach is also identified as an essential element for Swaziland.

A multi-sectoral approach in planning and resource mobilisation was adopted in both Swaziland and Zambia. There are systems that allow for the participation of beneficiaries and communities in the development of sectoral operational programmes that go through the government planning and budgeting procedures. Priorities related to HIV and AIDS prevention, care and treatment are set based on a needs analysis and rational policy choices. The priorities seek to address the needs of different segments of the population through clearly outlined strategies. This is critical, as it ensures community ownership of interventions, which in turn not only improves the implementation of international conventions and declarations, but also results in rational prioritisation of interventions, thereby allowing for efficiency and effectiveness in achieving set targets and goals in the national HIV response.

A number of key stakeholders from the UN, civil society and practitioners agree that there is high level political commitment to the fight against HIV and AIDS in southern Africa.

In line with this agreement, findings of the study have shown that there are general improvements in co-ordination of the response, with co-ordinating authorities significantly resourced to fulfill their responsibilities. For instance, national level monitoring and evaluation (M&E) information is more available, with data showing some improvements in general reporting, especially through the UNGASS and DHS processes. Although this is the case, current figures do not show a rapid impact of responses. Prevalence, although indicating a possible decline, is still very high, and the full impact of the epidemic is yet to be realised.

The provision of HIV prevention, care and support services in both countries is also guided by the country commitment to international instruments, particularly UNGASS, the MDGs, the Abuja Declaration and the WHO HIV and AIDS Plan 2004-2005. UNGASS makes provision for the development and implementation of multi-sectoral national strategies for combating HIV and AIDS, which includes addressing risk, vulnerability, prevention, care, treatment and support for those affected by the HIV epidemic. The MDG goal number six seeks to combat HIV and AIDS and other diseases through increased use of condoms and behavioural change. The goal also sets a target for the universal access to treatment for HIV and AIDS for all those who need it through the use of ARVs.

The survey findings show that the commitments of Swaziland and Zambia to regional and international declarations on HIV and AIDS have yielded notable improvements in HIV prevention, treatment, care and support strategies and services.

Swaziland's UNGASS report for 2008 shows that the country has made considerable efforts in prevention, care and support. The report states that Swaziland undertook a number of HIV prevention strategies, among them voluntary counselling and testing (VCT), condom promotion, information, education and communication (IEC), PMTCT and blood safety. Achievements under prevention include development of a national policy on blood safety in 2000 and adoption of national guidelines by 2001. The percentage of donated blood screened for HIV with an external quality assurance scheme is 100%.

HIV prevalence among Swazi people aged 15-49 years has stabilised, but at a high rate of about 26.1% from 2000 to date. The period of stabilisation coincides with the period in which Swaziland signed a number of declarations and conventions relating to HIV. One would therefore deduce that the conventions and declaration might have to some extent helped in stabilising the high HIV prevalence rates in Swaziland.

Having developed its first PMTCT guidelines in 2002, HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. The percentage of HIV positive pregnant mothers under PMTCT programme was 62% in 2006 and 64.8% in 2007. The country is thus on course to reach its committed target of 80% by 2010. (Universal Roads Access to Prevention Treatment and Care and Support in Swaziland, November 2007).

In relation to care and support, the UNGASS report for 2008 states that the GoS focused on treatment, care and support by highlighting the need for increased access and proper utilisation of ART; clinical management of opportunistic infections; diagnostic testing and counselling; institutional and home-based care; and palliative care. Achievements under care and support include rolling-out of ART. Swaziland achieved the WHO '3 by 5' targets of 13,000 patients on ART by 2005. Currently, 35% of adults and 31% of children with advanced HIV infection are receiving ART. The country's target, by end of 2008, is 50%. Free ART was introduced in 2003 with 3,200 accessing it in 2004 and 25,000 in 2007. More healthcare workers have been trained since 2005 and there has been a scaling up of voluntary testing and counselling and supplying free Nevirapine for HIV positive pregnant women.

Zambia, like Swaziland has scored positive results in implementing HIV prevention, treatment, care and support in line with several regional and international declarations to which the country is a signatory.

Recent studies, including the ZDHS 2008 and UNAIDS update 2008, have shown that adult (15-49 years) prevalence has been declining from 1995. Current statistics indicate that the HIV prevalence rate among the adult population (15-49 years) has declined from about 16% in 2005 to about 14.3% in 2007. These declines coincide with periods in which the Zambian Government, like Swaziland has committed itself to various declarations and conventions, including the implementation of free ART policy.

The national HIV prevention, treatment and care strategy is focused on prevention of HIV transmission through blood, provision of ART services, including prevention of mother-to-child transmission (PMTCT), voluntary counselling and testing and prevention of HIV transmission through health care and other care settings, including support for children affected by HIV and AIDS.

Since the last reporting period and based on the core national programme indicators outlined in the 2008 UNGASS reporting guidelines, Zambia maintained 100% screening for HIV of all blood units collected in a quality assured manner for both 2006 and 2007, with the procedures and results endorsed by an external quality assurance team from the Royal College of Pathologists of Australia. This has been achieved despite increases in blood units collected from 61,584 in 2005 to 68,265 in 2007.

The number of persons with advanced HIV infection receiving ART has increased from 39,351 in 2005 to 149,199 in 2007. In 2006, a total of 80,030, or 32.9% of all adults and children with advanced HIV infection were receiving ART, while the 149,199 accounted for 50.6% in 2007. The scaling-up of free ART was continued in 2008, resulting in a significant increase in the number of centres providing both ARVs for PMTCT and ART nationwide, from 62 in 2005 to 146 in 2006, and 320 at the end of 2007.

### Conclusions for the specific objectives include the following:

- While the two countries have demonstrated their commitment to be guided by interventional principles and are signatories to major international conventions that guide HIV responses, budgetary allocations to key Ministries, including Health, do not match the work that needs to be done. The two countries budgets fall short of the agreed health sector budget allocation of 15% set under the Abuja Declaration (Swaziland-10%; Zambia-12%), indicating that more commitment is still required from the two Governments.
- While there are credible efforts to enhance transparency and participation in processes for strategic planning and resource mobilisation for HIV and AIDS interventions, the same cannot be said about the use of acquired resources. This survey highlights that for both countries, not all stakeholders are happy with the way in which resources, especially those from State coffers, are accounted for.
- To a very large extent, both countries have processes and systems in place to promote effective collection and analysis of HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes. Systematic data collection and reporting has also been enhanced by the need to report routinely against the MDGs.
- There are, however, a number of serious gaps in the data collected. For example, data collected indicate a high level of HIV awareness of most-at-risk populations. Although this figure is high, new discussions based on evidence from southern Africa (SADC, 2006) indicate that the most-at-risk populations are young girls between 15 and 24 years, and this population is not included in collected statistics. Then there is the increasing number of orphans. It is certain that the actual numbers are not well known; let alone the current and future needs of orphans. Planning processes are therefore continuing to be reactive, where pro-active actions are required to establish the exact magnitude of the problem.

- The available legal frameworks in the two countries have not addressed existing negative practices which have impacted on HIV transmission in a negative way. Men dominate women in all aspects of life and culture. Women are not equals to men in society, and therefore, they are not empowered to stand up for their rights. They were, and still are, socialised to be subservient to men, so much that even family laws tend to work against them. In Swaziland, women have limited property rights, they are home-makers and caregivers to the sick, leaving them exposed and most at risk of accidental infection with HIV. Moreover, polygamy, inheritance and beliefs that having sex with a virgin cures HIV all make women, especially young women and girls, vulnerable to infection. Swaziland is thus in a state of emergency, albeit, not well known by many.
- It is evident from the survey that both countries have adopted a multi-sectoral approach in planning and resource mobilisation. Systems have been put in place to allow for the participation of beneficiaries and communities in the development of sectoral operational programmes that go through the government planning and budgeting procedures. Priorities related to HIV and AIDS prevention, care and treatment are set, based on a needs analysis and rational policy choices. The priorities seek to address the needs of different segments of the population through clearly outlined strategies. This is critical, as it ensures community ownership of interventions, which in turn not only improves the implementation of international conventions and declarations, but also results in rational prioritisation of interventions, thereby allowing for efficiency and effectiveness in achieving set targets and goals in a national HIV response.

## Recommendations

### Swaziland-specific recommendations

- a) Government should provide a platform for experts in the fields of poverty, HIV and AIDS, climatic and economic crises to establish the interrelatedness of the crises and thereafter ensure that stakeholders from these sectors fully understand the magnitude of the problems facing the country. Specifically, the triple threat of food insecurity, HIV and AIDS and weakening government's capacity to respond to needs to be debated at all levels. Resources within different sectors - including civil society organisations (CSOs), private companies and international technical assistance organisations need to be managed prudently.
- b) Swaziland National Network of People Living With HIV and AIDS (SWANNEPHA) should develop a profile of CSOs addressing HIV and AIDS and the nature of their work. Such a profile could help quantify their input, relevance and resource base.

### Zambia-specific recommendations

- a) The Ministry of Health and the NAC should consider updating the HIV and AIDS policy frame-work to enable it to accommodate new challenges and opportunities, for instance in pursuing circumcision.
- b) The Ministry of Health and the NAC should consider translating both the HIV and AIDS Policy and Strategic Framework into the vernacular in order to make it more accessible to non-English speakers.
- c) The Government of Zambia, through the Ministry of Health and the NAC, should spearhead the national response.
- d) The Government of Zambia should consider elevating the institutional positioning of the NAC into an autonomous body, with a chief executive who has powers of a controlling officer.
- e) Now that an adjunct to the National AIDS Strategic Framework (NASF) 2006-2010, which has taken into consideration emerging issues of men who have sex with men (MSM), medical male circumcision and mainstreaming issues, has been developed, approved and launched, there is need to revisit the M&E plan with a view to including indicators for the new items.
- f) Given that there are more people appointed to deal with information and data management at the NAC and MOH and their decentralised structures, there is need to have a continuing education programme for key personnel.

## General recommendations

### Governments and national AIDS co-ordinating bodies should:

- a) Create an enabling environment for rights-based approaches to service provision. The Government should consider drafting and passing HIV and AIDS specific legislation to guarantee the rights of health service users in the national response.
- b) Consider a formal feedback mechanism from users of health services. Activation of the office of the ombudsman, or in the least case, suggestion boxes at health delivery centres is imperative.
- c) Continue to encourage integration of responses, especially those that are clinical and those based in the community.
- d) Provide the required leadership in meeting and reporting against commitments, including the Abuja and Maseru declarations, and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC), at least at the same level of commitment expressed within the United Nations General Assembly Special Sessions (UNGASS) process.
- e) Strengthen monitoring and evaluation systems of key departments such as those addressing vulnerable children and abuse of women, including linking with stakeholders who are willing to share skills in these areas. There is need to consider placing M&E officers at lower levels.
- f) Pro-actively share information on successes and challenges with implementers at all levels. Establish a mailing list or e-forum where information can be shared regularly.
- g) Provide additional funding to national HIV and AIDS co-ordinating bodies and other players to ensure that their monitoring and evaluation capacity is strengthened and rolled out at all levels.
- h) Provide frameworks for pro-active national level discussions on Accra Agendas for Action (AAA) and the Paris Declaration.
- i) Honour budgetary obligations in the HIV and AIDS intervention processes. Meet the Abuja Declaration regarding the 15% governments agreed to allocate to their Health Sectors, and specifically increase actual spending on HIV and AIDS.
- j) The Government should create adequate frameworks for the protection of the rights of vulnerable groups. All relevant international instruments like CEDAW and the CRC should be translated into national laws and policies.
- k) Government should encourage positive utilisation of the media so that it can be used as a vehicle for education and dissemination of information on HIV and AIDS. HIV and AIDS programmes should be aired during prime time.
- l) Government needs to come up with attractive remuneration packages that will be competitive enough to retain staff. In the long term it would be prudent for government to develop a career progression plan with each new essential health worker recruited to the Public Service.

## Civil Society Organisations

- a) Co-ordinating bodies of CSOs should work closely with co-ordinating partners to ensure that the organisations are using the approved M&E frameworks for reporting.
- b) CSOs should develop the capacities of users of health services and their organisations so that they are better able to defend or demand their rights.
- c) As part of the AAA process, CSOs should seek to improve co-ordination and alignment of their efforts with government programmes. They should also work with Government to create an enabling environment that maximises their contribution to development efforts.
- d) There is need to enlighten society about the importance of changing cultural beliefs and attitudes about sex. People need to change their sexual behaviour and avoid multiple casual sexual partners and use condoms consistently.
- e) There is need for media monitoring and training on reporting issues of gender and HIV and AIDS.

## Funding and technical partners

- a) Continue to provide technical capacity and other resources to ensure that the national response to HIV is informed by evidence, and observes people's rights. New research, for instance that on male circumcision, transmission rates during window periods, etc., should be adapted to local settings, and resources made available to test their applicability.
- b) It is clear that additional resources have to be solicited from external development partners. Notwithstanding the Paris Declaration, there is need to ascertain the number of emergencies the countries are dealing with, and ensure that development assistance takes cognisance of these.
- c) There is need to improve the implementing and national co-ordinating entity's capacity to mobilise resources. While most implementing partners have finance and accounting departments, they do not have resource mobilisation components or units.
- d) Funding partners should consider funding a retention and capacity building strategy for professional health care personnel. The retention strategy should include competitive remuneration packages and sufficient protective materials and equipment for health care personnel. The working and living conditions for all health workers especially those in rural areas should be improved and another deliberate measure should be to recruit health care professionals from abroad.
- e) It should be the responsibility of SADC or international bodies to find the means and ways to implement these agreements after being clearly articulated. It is not enough to talk. There must be action on the ground that produces desired results. Implementing agencies should come up with realistic funding proposals and receive adequate funding. Drugs must be supplied constantly, and always be in excess of the required quantities. Workshops should not be confined to urban areas but must reach even the remotest areas. Food must be made available to all, despite geographical locations, as even urbanites can be economically disadvantaged.



# 1.0 INTRODUCTION

## 1.1 Background

HIV is an epidemic of catastrophic proportions. It mostly affects the world's poorest nations, especially those in Africa, and sub-Saharan Africa is by far the worst affected.

Although the Sub-Saharan region has just over 10% of the world's population, it is home to 67% of all people living with HIV (UNAIDS, 2008). During 2007 an estimated 1.9 million adults contracted HIV. This brought the total number of people living with HIV in the region to 22 million by the end of the year. HIV prevalence varies considerably across this region - ranging from less than 1% in Madagascar to over 25% in Swaziland.

The effects of the HIV epidemic will be experienced for a long time. Although HIV prevalence appears to have declined slightly in this region over recent years, the total number of people living with HIV is still rising because of overall population growth. In sub-Saharan Africa, deaths resulting from AIDS-related illnesses were approximately 1.5 million in 2007. Average survival in the absence of treatment is around 10 years after infection. ARV medicines that dramatically extend survival, allowing many years of healthy life, remain unavailable to most Africans.

The Governments of Swaziland and Zambia are signatories to a number of international conventions and declarations that seek to respond to the epidemic. These declarations include the Maseru Declaration, the Abuja Declaration and the United Nations Special Assembly on HIV and AIDS (UNGASS). An assessment of the progress made by the two Governments in implementing these agreements, i.e., the transformation of the declarations into actions on the ground, is not only timely, but also an important source of information for future actions.

## 1.2 Problem statement

HIV and AIDS have made it more difficult for African Governments to escape the poverty trap. Most African countries already struggle to address poverty and the provision of basic needs to their people, and in southern Africa in particular, HIV and AIDS have added pressure to struggling economies that are characterised by weak public health systems and poor citizens. Recognising that the world in general, and the region in particular, has a severe HIV and AIDS crisis, Governments have committed themselves to addressing this through actions that are guided by local and international instruments and declarations. However, there is a significant disconnect between the commitments made through these international conventions and action on the ground. Various factors have been noted for this situation. Some of the factors include limited capacity; inadequate resources; poor translation of international commitments into local policies; and in some cases, dysfunctional governance systems.

Have the international conventions, declarations and other instruments on HIV and AIDS clearly defined the means and ways that Governments could put in place to achieve the desired goals? The Millennium Declaration adopted at the fifth session of the UNGASS in 2000, lists targets with limited specific tactics and capacity for implementation, especially for developing countries (UNAIDS, 2000). Some important international HIV interventions, such as WHO's '3 by 5' initiative also achieved limited success. Well-intended instruments, that could indeed transform the lives of the economically disadvantaged, do not seem to achieve much, and it is important to expose some of the major pitfalls.

Another key factor is the country-specific settings that make it impossible to identify peculiar requirements that are essential for the success of the initiative or implementation of the declarations. The socio-political, economic and cultural environments of each country are unique in their own way. As a result, a number of factors- such as available financial resources or future political landscapes- unforeseen during the signing of the declarations hinder the achievement of set goals and targets. Also, failure is attributed to failure by Governments and other key players to facilitate the implementation of actions required to realise the goals and targets of the declarations and other international instruments.

In a small but significant way, this assessment contrasts Swaziland and Zambia's commitment to both local and international instruments against deliverables recorded to date. The report attempts to assess the commitments these countries have made, how far they have gone in honouring these, and identify the challenges that exist.

### 1.3 Goal and objectives of the assessment

The key objective was to analyse the extent to which the governments of Swaziland and Zambia have implemented HIV prevention, treatment, care and support strategies and services, in line with current international and regional conventions and declarations to which they are signatories. The report analyses four key areas where improvements are likely to indicate impact the of activities. These are governance of interventions; country strategies and processes; policy and legal frameworks; and human and financial resources management. The analysis is pegged against provisions made in international conventions.

The specific objectives were:

1. To explore how legal and policy frameworks guarantee that HIV and AIDS interventions are in compliance with international human rights requirements to which the countries are signatories.
2. To analyse how processes and systems in place promote the effective collection and analysis of HIV and AIDS information and knowledge required for planning, monitoring, evaluation and effective management of prevention, care and treatment programmes.
3. To explore how transparent and participatory processes such as strategic planning and resource mobilisation for HIV and AIDS interventions are.
4. To assess how accountable and integral systems for delivery of health service are.

### 1.4 Structure of the report

This report is divided into 12 sections. The first section presents the background, the problem statement and the objectives of the study. The second section outlines the methodology used in the study. Research findings are described in section 3 to 11. Section 12 presents an analysis and discussion of the results as well, and then summarises the conclusions and recommendations.



## 2.0 METHODOLOGY

This assessment primarily used qualitative methods to obtain information. Three main approaches were used for data collection: literature review; consultative meetings or key informant interviews with key stakeholders and focus group discussions with users of services and their representative organisations. Technical teams comprising an independent researcher, SAfAIDS staff and an identified country partner were set up in the two countries to conduct the assessments. Country stakeholders were consulted at all stages of the study i.e. at the inception, data collection and reviewing and finalisation of country reports. A range of stakeholders participated in the study, including policy makers, government representatives, civil society opinion leaders, beneficiaries of State and non-State HIV and AIDS interventions and individuals responsible for health service delivery.

### 2.1 Data collection

#### Literature review

In order to get an in-depth understanding of the progress that the Governments of Swaziland and Zambia have made in implementing their HIV and AIDS commitments, a detailed literature review of relevant documents was conducted. Key literature included HIV and AIDS national policies, HIV and AIDS strategic plans, National Multi-sectoral AIDS Programme Work Plans, UNAIDS reports, UNGASS country reports, and web resources on the MDGs. Literature was collected mainly from government agencies responsible for co-ordinating country HIV and AIDS responses, such as Ministry of Health and Social Welfare, other government departments, Central Statistical Office; and the internet. Internet sources such as government official websites and UN portals were used as sources of background information.

#### Key informant/ consultative interviews

The review teams held consultative meetings with key stakeholders in the HIV and AIDS sector. A key informant interview guide was developed and used to guide discussions. Stakeholders that participated included professionals from relevant government departments, civil society, UN agencies, donors, labour unions and users of services. These meetings provided an in-depth understanding of the country's response to the HIV epidemic, as well as queried some of the general observations from literature.

#### Focus group discussions

Focus group discussions (FGDs) were set up and held with youths, women and men. Participants of the FGDs comprised PLHIV and users of HIV and AIDS services selected from across the country.

### 2.2 Data analysis

Most of the data collected were qualitative in nature. It was therefore deemed necessary to use qualitative data-compatible analysis methods. This meant categorising data according to main themes and sub-themes, and then analysing thematically to identify common trends and processes.

## 3.0 OVERVIEW OF THE HIV AND AIDS SITUATION

This section sheds light on the extent of the HIV and AIDS crisis in the two countries. Swaziland and Zambia may be geographically relatively close, yet the social, political and cultural settings indicate differences that determine how the epidemic may have been managed.

### 3.1 Overview of the HIV and AIDS situation in Swaziland

#### 3.1.1 Context

Demographic information shows that Swaziland is one of the southern African countries with a low population of just about 1,141,000 in 2007. The annual growth rate is about negative four, indicating that the country has not been growing or that the population is decreasing, partly due to deaths that are mainly caused by AIDS. Life expectancy at birth is estimated at 42 years while in every 100,000 births 112 children die. See the fact sheet below:

**Table 1: Demographic Facts for Swaziland**

Demographic Data	Year	Estimate
Total Population	2007	1,141,000
Population aged 15 - 49	2007	582,000
Female population aged 15-24	2007	143,000
Annual population growth	2005 - 2010	-0.4
Maternal mortality ratio (100,000 live births)	2005	390
Life expectancy at birth	2006	42
Under 5 mortality rate (100,000 live births)	2006	164
Infant mortality ratio (100,000 live births)	2006	42
Infant mortality (100,000 live births)	2006	112
Under 5 mortality rate (100,000 live births)	2006	164

*Source: WHO/UNAIDS/UNICEF Epidemiological Fact Sheet on HIV and AIDS Swaziland update Report 2008*

UNGASS and DHS reports also show that women (31%) are more likely to be HIV positive than men (20%). The HIV and AIDS situation has worsened over the years since the first reported AIDS case in 1986. This, as reported by the GoS, is attributed to the unwillingness of the Swazi population to change their sexual behaviour (National Multi-sectoral HIV and AIDS Policy Document, 2006).

The practice of multiple concurrent casual heterosexual partners which is predominant in Swaziland is mainly responsible for the spread of HIV<sup>2</sup>. Between 1992 and 2004, an increase (3.9% to 42.9%) in the percentage of women who tested HIV positive was registered. Although results from the Sentinel Surveillance Report 2004 showed that this figure had slightly reduced to 39.2%, it is still one of the highest prevalences among women in the world, and researchers concurred that this did not mean a decline in prevalence, but merely increased accuracy in estimation.

Table 2 below shows HIV and AIDS estimates for Swaziland as reported in the UNAIDS 2008 Report on the Global AIDS Epidemic. The number of adults (15 years +) living with HIV increased by approximately 13% since 2001, whilst the prevalence rate among young women (15-24 years) increased approximately four-fold from 5.8% to 22.6% since 2001.

**Table 2: Swaziland HIV and AIDS estimates**

Indicator	2001	2007
<b>Estimate number of PLHIV</b>		
No. of adults (15+) living with HIV	150,000	170,000
Adults (15 - 49) prevalence %	26.3%	26.1%
Women (15+)	91,000	100,000
Children (0 - 14)	10,000	15,000
Young women (15 - 24) prevalence %	5.8%	22.6%
AIDS deaths		
Estimated number of deaths	7,700	10,000
Orphans due to HIV		
Orphans (0 - 17)	19,000	56,000

*Source: UNAIDS Global AIDS Report 2008*

### 3.1.2 Evolution of the national response to HIV and AIDS

Swaziland has had a number of national response plans since the first HIV case was reported in the country in 1986. The country has developed systems to drive and manage the national response to HIV and AIDS. The initial strategies were introduced under the Swaziland National AIDS Plan (SNAP) that was formulated in 1986. Under SNAP, a Short-Term Plan covered the period between 1986 and 1988 whilst the First Medium-Term Plan covered 1989 to 1992. These two focused primarily on prevention: that is, providing information and education on HIV and AIDS; promoting condom use; managing the spread of STIs and screening all donated blood. SNAP was reviewed in 1993, resulting in the development of the National Strategic Plans of 1994-1997 and 1998-2006, commonly referred to as the Second Medium -Term Plan and then the Pre-Multi-Sectoral plan respectively.

In 1999, AIDS was declared a 'national disaster.' In response, the Crisis Management and Technical Committee (CMTc) was formed to lead the development of national responses. The CMTc developed the First National Multi-sectoral HIV and AIDS Strategic Plan 2000-2005. This focused on behaviour change communication (BCC) through national media, schools and workplaces. This also involved improving health services and minimising the future impact of the epidemic, especially on vulnerable groups.

In 2001, the National Emergency Response Council on HIV and AIDS (NERCHA) replaced the CMTC. NERCHA was established as a statutory council mandated to co-ordinate and facilitate the national multi-sectoral response to HIV and AIDS, and tasked to mobilise for an expanded response to the epidemic in line with the Second National Multi-sectoral HIV and AIDS Strategic Plan of 2006 to 2008.

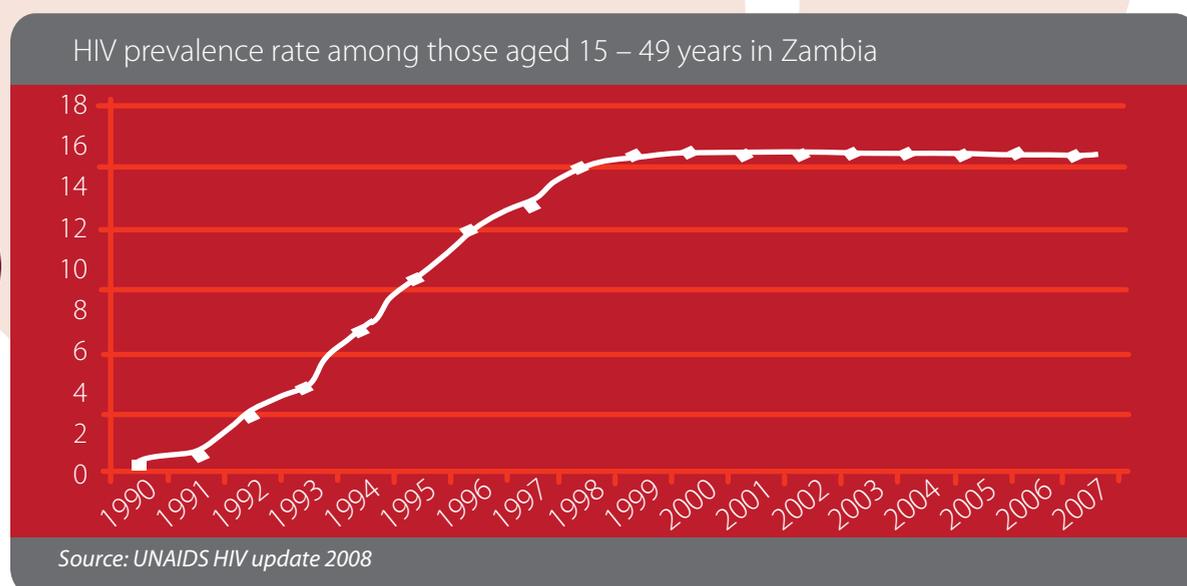
The Second National Multi-sectoral Plan also signalled the intention of the Kingdom of Swaziland to extend the national response to the HIV epidemic beyond 2005 by providing a framework for resource mobilisation and co-ordination of all HIV and AIDS activities in the country. Its existence was formed based on the findings of a joint review of the 2000-2005 National HIV and AIDS Strategic Plan as well as countrywide consultations on the drivers of the epidemic: how the epidemic was affecting individuals, communities and the country at large as well as what could be done differently. Consequently, all HIV programme implementers were obliged to act within the parameters of this plan and in support of the principle of the "three ones," that is, one national co-ordinating body; one national strategic plan and one national monitoring and evaluation framework.

### 3.1.3 Progress on managing HIV

Swaziland's UNGASS report for 2008 shows that the country has made considerable efforts in prevention, care and support. The report states that Swaziland undertook a number of HIV prevention efforts, such as voluntary counselling and testing (VCT), condom promotion, information, education and communication (IEC), PMTCT and blood safety. Achievements under prevention include development of a national policy on blood safety in 2000 and adoption of national guidelines by 2001. The percentage of donated blood screened for HIV with an external quality assurance scheme is 100%.

The HIV prevalence for Swaziland showed an increase until 1999/2000 where it stabilised. As depicted in the graph below, the HIV prevalence among people aged 15-49 years has stabilised but at a high rate of about 26.1%. The period of stabilisation coincided with the period in which Swaziland signed a number of declarations and conventions relating to HIV. One would therefore deduce that the conventions and declaration might, to some extent have helped in stabilising HIV prevalence. A lot more effort is needed to bring down the high HIV prevalence in the country.

**Figure 1: HIV prevalence among adults aged 15 – 49 years since 1990**



Having developed its first PMTCT guidelines in 2002, HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. The percentage of HIV positive pregnant women accessing PMTCT programmes was 62% in 2006 and 64.8% in 2007. The country is thus on course to reach its target of 80% by 2010. (Universal Roads Access to Prevention Treatment, Care and Support in Swaziland, November 2007).

The percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results was 94%. Condom use was high among sex workers who reported using a condom with their most recent client [All: 98%; Aged 15-24years: 100%; 25+ year old: 92.9%]. However, the Demographic and Health Survey (DHS 2006/7) indicates that less than 60% of women and men aged 15-49 who had more than one sexual partner in the past 12 months reported using a condom during their last sexual intercourse. Thus, although condom use is high among commercial sex workers, it is not as high among the most vulnerable age groups in the country; especially young girls aged 15-24.

**Table 3: Indicators**

Indicators	Years			
	2004	2005	2006	2007
Number of sites providing ART		17		22
Estimated Number of people needing ART	44,000	48,000	53,000	59,000
Estimated Number of people receiving ART	6,000	13,000	18,000	25,000
% of ART coverage	14	27	35	42

*WHO/UNAIDS/UNICEF Epidemiological Fact Sheet on HIV and AIDS Swaziland update report 2008*

In relation to care and support, the UNGASS report for 2008 states that the GoS focused on treatment, care and support by highlighting the need for increased access and proper utilisation of ART; clinical management of opportunistic infections; diagnostic testing and counselling; institutional and home-based care; and palliative care. Achievements under care and support include rolling-out of ART. Swaziland achieved the WHO '3 by 5' targets of 13,000 patients on ART by 2005. Currently, 35% adults and 31% children with advanced HIV infection are receiving ART. The country's target by the end of 2008 is 50%. According to NERCHA, free ART was introduced in 2003 with 3,200 people accessing it in 2004 and 25,000 in 2007. PMTCT funding from the Elizabeth Glaser Paediatric AIDS Foundation in 2004 provided training for health-care workers, scaling up voluntary testing and counselling and supplying free Nevirapine for HIV positive pregnant women.

Statistics reveal that AIDS-related deaths have resulted in increased numbers of orphans, from 19,000 in 2001 to 57,000 by 2007. According to Moya Centre, a local care centre for orphaned children, there were more than 70,000 orphans due to the HIV epidemic at the end of 2007, and by 2010, it is estimated that 120,000 will be orphans. Some 15,000 households will be child-headed (Moya, 2006). NERCHA had higher estimates and indicated that by the beginning of

2007, 25% of the population were already orphans. Anecdotal evidence from the focus group discussions indicates that the social protection capacity is failing to respond to the increased demand put on it by people impoverished by HIV and AIDS. This has a serious implication on the social protection policies and systems of the country.

Swaziland data in the UNGASS report also show that there are a number of areas that still require action. More work is still required in information, education and communications. The percentage of most-at-risk populations reached with HIV prevention programmes was 76.9%; (<25 years was 75.7%; 25+ years was 80%). The percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 46.2%; (<25 years was 48.6%; 25+ years was 40%).

The percentage of young women and men aged 15-24 years who correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 52.2%; (women: 52.1%, men: 52.3%). These results are alarming given the high prevalence levels in the country, indicating that work is still required in achieving positive behaviour change. The country still needs to do more to provide adequate information and advocacy. Without positive behavioural change no meaningful achievement will be realised as a result of the initiatives being implemented by the government.

### 3.2 Overview of the HIV and AIDS situation in Zambia

Zambia had an estimated population of 11,922 million by the end of 2007 according to information in the WHO/UNAIDS/UNICEF Epidemiological Fact Sheet on HIV and AIDS Zambia update report of 2008. The annual population growth is estimated at 1.7 for the period 2005-2010. Like Swaziland, Zambia's life expectancy at birth is as low as 43 years. Among every 100,000 children born in Zambia, 102 die of various illnesses, including HIV.

**Figure 2: Demographic facts for Zambia**

Demographic facts for Zambia		
Demographic Data	Year	Estimate
Total Population	2007	11,922,000
Population aged 15 - 49	2007	5,459,000
Female population aged 15-24	2007	1,269,000
Annual population growth	2005 - 2010	1.7
Maternal mortality ratio (100,000 live births)	2005	830
Life expectancy at birth	2006	43
Infant mortality (100,000 live births)	2006	102
Under 5 mortality rate (100,000 live births)	2006	182

*Source: WHO/UNAIDS/UNICEF Epidemiological fact sheet on HIV and AIDS Zambia update report 2008*

Zambia is one of the Sub-Sahara African countries worst affected by the HIV epidemic. During the period from the year 2001, HIV prevalence has decreased from about 16% to 14.3% among those aged 15-49 years according to the recent Zambia Demographic Health Survey report of 2008. However, this prevalence is too high for a country which has an estimated highest dependency ratio in the world which was reported as 0.9 for 2008 compared to 0.4 for 2001. Unemployment is high and presents a serious social problem. A combination of high dependency ratio and high unemployment presents a significant challenge for HIV and AIDS for Zambia.

### 3.2.1 Multi-sectoral response to HIV and AIDS

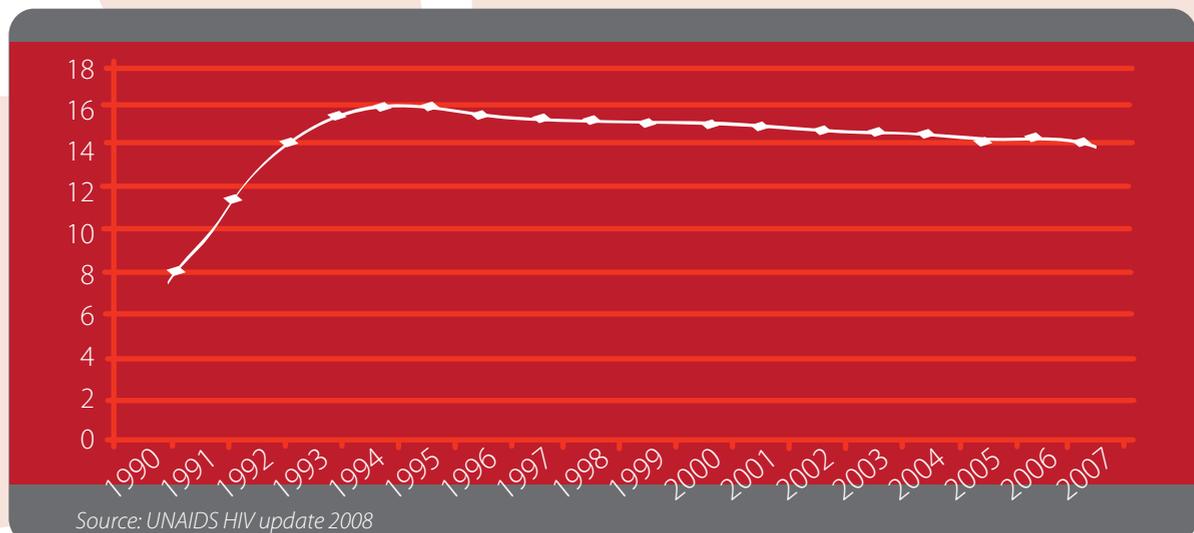
A multi-sectoral response has been adopted throughout the implementation of the programme, with partnerships established both at national and sub-national levels. At the national level, partners involved in the response are organised using self-co-ordinating groups, theme groups, sector advisory groups, partnership forums, co-operating partner groups, and the UN Joint Team. At sub-national level, partnerships are organised through the District AIDS Task Forces (DATFs) and the Community AIDS Task Forces (CATFs).

### 3.2.2 Progress in the HIV and AIDS national response

The national HIV prevention, treatment and care strategy is focused on prevention of HIV transmission through blood, provision of ART services, including prevention of mother-to-child transmission, voluntary counselling and testing and prevention of HIV transmission through health care and other care settings including support for children affected by HIV and AIDS.

Since the last reporting period and based on the core national programme indicators outlined in the 2008 UNGASS reporting guidelines, Zambia maintained 100% screening for HIV of all blood units collected in a quality assured manner for both 2006 and 2007 with the procedures and results endorsed by an external quality assurance team from the Royal college of Pathologists of Australia. This has been achieved despite increases in blood units collected from 61,584 in 2005 to 68,265 in 2007. Recent studies, including the latest ZDHS 2008 and UNAIDS update 2008 have shown that adult (15-49 years) prevalence rates have been declining from 1995. Current statistics indicate that the HIV prevalence rate among the adult population (15-49 years) has declined from about 16% in 2005 to about 14.3% in 2007. These declines coincide with periods in which the Zambian government, like the GoS has committed itself to various declarations and conventions, including the implementation of a free ART policy.

**Figure 3: HIV prevalence rate among those aged 15-49 years in Zambia**



The number of persons with advanced HIV infection receiving ART has increased from 39,351 in 2005 to 149,199 in 2007. In 2006, a total of 80,030 or 32.9% of all with advanced HIV infection were receiving ART while the 149,199 accounted for 50.6% in 2007. However, in terms of the programme implementation performance according to set targets of 90,000 for 2006 was 88.9%, while in 2007 a 115% result was attained based on reaching 80% of the estimated need of 130,000. The scaling-up of free ART was continued in 2006, resulting in a significant increase in the numbers of centres providing both ARVs for PMTCT and ART nationwide, from 62 in 2005 to 146 in 2006 and 320 at the end of 2007. The HIV treatment figures reported in the UNGASS report slightly differ from those collected on the UNAIDS site, given below:

**Table 4: Indicators**

Indicators	Years			
	2004	2005	2006	2007
Number of sites providing ART		110		322
Number of people needing ART	290,000	300,000	310,000	330,000
Number of people receiving ART	20,000	49,000	82,000	151,000
% of ART coverage	7	16	26	46

*WHO/UNAIDS/UNICEF Epidemiological Fact Sheet on HIV and AIDS Zambia update Report 2008*

The total number of HIV infected pregnant women who received ARVs to reduce mother-to-child transmission increased from 14,071 in 2005 to 25,578 in 2006 and by the end of 2007, the number had increased to 35,314. Based on an estimated need of 86,232 for 2006, the percentage of HIV positive pregnant women who received ARVs was 29.7%, while in 2007 Zambia increased this proportion to 39.1% based on an estimated need of 90,252.

The percentage of estimated HIV-positive and TB coinfection cases that received treatment for both TB and HIV was 34.8% out of a total need of 60,723, while in 2007 of the 12, 835 (or 66%) TB patients who tested positive for HIV, a total of 5,017 (or 39%) individuals were started on ART.

Vulnerability to HIV among the youth remains high, with only 10.2% of young women and men aged 15-19 years taking an HIV test in the last twelve months and knowing their results in 2007. This situation was further compounded by the fact that only 33.6% of the youths of the same age group were able to correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission. Youth vulnerability to HIV also increased; the proportion of 15 to 24 year olds who reported having sexual intercourse before the age of 15 years rose from 10.3% in 2005 to 14.6% in 2007.

Similarly, the percentage of most-at-risk populations, classified as sex workers, who received an HIV test in the last twelve months and knew their results remained low at 17.3% for all sex workers, with the under 25 year olds scoring 17.9% while those 25 years and above scored slightly less at 16.5%.

During the reporting period it was established that 15.7% or 578 of the 3,671 orphans and vulnerable children (OVC) surveyed reported that their households had received free basic external support. Zambia has an estimated 1.2 million orphans of which 75% were orphaned by HIV and AIDS. Service delivery data in 2006 showed that for the age group 15 to 24 years, 454,069 received life-skills-based HIV and AIDS education, out of which 234,058 were male and 220,010 were females. However, the UNGASS indicator revealed that 60% of schools provided life skills-based HIV education in the 2006 academic year.

### 3.3 Brief analysis of the HIV and AIDS situation in Swaziland and Zambia

According to the WHO, Swaziland's response enjoyed high level political commitment, although this did not correlate to observed HIV prevalence (Avert.org, 2008). The same can be said of the response in Zambia. Although there is registered progress, this still falls far short of actual needs on the ground.

Culture has played and continues to play an important role in the fight against HIV. Both country's populations religiously cling to their culture. This is mostly so in Swaziland. Cultural beliefs are strongly linked to the undesirable increases in incidence of HIV among young girls<sup>3</sup>. Incidence increased in Swaziland by four times since 2001.

There are a number of serious gaps in data collected. For example, data collected indicate a high level of HIV awareness of most-at-risk populations. Although this figure is high, new discussions based on evidence from southern Africa (SADC, 2006) indicate that the most-at-risk population are young girls between 15 and 24 years, and these are not included in the collected statistics. Then there is the increasing number of orphans. It is certain that the actual numbers are not well known; let alone the current and future needs of orphans. Planning processes are therefore continuing to be re-active where pro-active actions are required to establish the exact magnitude of the problem.

3 The prevalence rates for young women aged 15-24 years is often used as an indicator for incidence among girls because most young people will be becoming sexually active for the first time.

## 4.0 COMPLIANCE WITH LOCAL, REGIONAL AND INTERNATIONAL LEGAL AND POLICY FRAMEWORKS

### 4.1 National provisions for HIV and AIDS prevention, care and support

Over the years the Governments of Swaziland and Zambia have put in place legislative policies and frameworks to guide the implementation of HIV and AIDS responses in accordance with the international conventions and declarations the countries are signatory to. Fundamentally, the crafting of these legislative policies and frameworks in the two countries was guided by a number of principles which included political leadership and commitment; a multi-sectoral approach and partnership; co-ordinated approach; greater involvement of PLHIV; decentralisation and promotion and protection of human rights, among others.

Swaziland has indirect constitutional provisions for HIV prevention, care and support, such as the right to affordable and accessible social services, including health, protection of the right to life, rights to freedoms of women and rights of children. The national response to HIV and AIDS prevention, care and support is guided by the National Multi-sectoral HIV and AIDS Policy of 2006, and before it, the Health Sector Policy on HIV and AIDS and STD Prevention and Control of 1998. Other policy and legislative provisions that guide HIV and AIDS prevention, care and support responses in Swaziland include the National Policy on Children (2003), the Health Sector Response to HIV/AIDS Plan in Swaziland 2003-2005; the Draft National Policy on Children Including Orphans and Vulnerable Children, the National HIV/AIDS Communication Strategy for Swaziland (2004) and the Public Sector HIV/AIDS Strategic Plan 2006-2008. Swaziland's National Multi-sectoral HIV and AIDS Policy (2006) document provides a framework for undertaking prevention, care and support in responding to the epidemic. The emphasis on comprehensive prevention for a heterosexually-transmitted epidemic is highlighted. This is intended to respond to evidence from the region that multiple concurrent sexual relationships in the absence of medical male circumcision and consistent condom use are the key drivers of the epidemic.

Regarding care and support, the policy places emphasis on the use of antiretroviral therapy as a way of treating and managing AIDS. The policy addresses increased access and proper utilisation of ART, clinical management of opportunistic infections, diagnostic testing and counselling, institutional and home-based care, and palliative care. Of importance is the recognition of the importance of traditional remedies in the fight against HIV and, the provision of nutrition and mental health services.

In Zambia the HIV and AIDS response is guided by the 2005 National HIV/AIDS/STI/TB policy and National HIV and AIDS Strategic Framework 2006-2010, whose vision is to have a nation free from the threat of HIV and AIDS by 2030. The policy and strategic framework were formulated in accordance with the National HIV/AIDS/STI/TB Council Act of 2002. The policy prioritises prevention and control of the spread of HIV/STIs/TB, promotes care for those infected and affected and seeks to reduce the personal and social impact of the epidemic. Zambia's Constitution is silent on, or does not have adequate provisions to support a number of issues pertinent to HIV and AIDS. An overarching criticism of the legal framework is that no deliberate attempt has been made to date, to come up with clear and specific legal instruments focusing on the HIV and AIDS national response in compliance with the numerous declarations and conventions to which Zambia is a signatory.

The prevalence rates for young women aged 15-24 years is often used as an indicator for incidence among girls because most young people will be becoming sexually active for the first time.

## 4.2 Regional and international provisions for HIV and AIDS prevention, care and support

The appropriateness of legislative and policy frameworks to steering an effective HIV national response depends on the extent to which that country complies with various regional and international declarations and conventions to which it is signatory, and also the extent to which policies and frameworks take into account the diverse interests of different stakeholders. Table 3 highlights the regional and international conventions that were signed by the Governments of Swaziland and Zambia.

**Table 5: Conventions and Declarations to which Swaziland and Zambia are signatory**

<b>Convention or Declaration</b>	<b>Date</b>	<b>Swaziland</b>	<b>Zambia</b>
Convention on the Rights of the Child (CRC).	<b>1989</b>	<b>X</b>	<b>X</b>
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).	<b>1979</b>	<b>X</b>	<b>X</b>
Political Declaration and further action on Beijing Declaration and Platform for Action.	<b>1995</b>	<b>X</b>	<b>X</b>
Millennium Development Goals (MDGs)	<b>2000</b>	<b>X</b>	<b>X</b>
Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS/TB and other related infectious diseases in Africa.	<b>2000</b>	<b>X</b>	<b>X</b>
United Nations General Assembly Special Session on HIV/AIDS (UNGASS)	<b>2001</b>	<b>X*</b>	<b>X</b>
SADC Declaration on HIV and AIDS.	<b>2003</b>	<b>X</b>	<b>X</b>
Protocol on the Rights of Women in Africa (PRWA) - African Protocol.	<b>2003</b>		<b>X</b>
Political Declaration on further action to implement the World Summit for Development.	<b>2002</b>		
African Region call for action to fight HIV and AIDS, and Vienna Human Rights Declaration.	<b>1993</b>	<b>X*</b>	
Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010.	<b>2006</b>	<b>X*</b>	
Maputo Resolution on Acceleration of HIV Prevention in Africa.	<b>2005</b>	<b>X</b>	<b>X</b>

<b>Convention or Declaration</b>	<b>Date</b>	<b>Swaziland</b>	<b>Zambia</b>
Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment, Care and Support.	<b>2005</b>	<b>X</b>	<b>X</b>
OAU Assembly Declaration on AIDS Epidemic in Africa.	<b>2000</b>	<b>X</b>	<b>X</b>
Paris AIDS Summit.	<b>1994</b>		
SADC Declaration on Gender.	<b>1997</b>	<b>X</b>	<b>X</b>
United Nations Declaration on the Elimination of Violence against Women.	<b>1993</b>	<b>X*</b>	
WHO/UNAIDS 3x5.	<b>2003</b>	<b>X</b>	<b>X</b>
UN 2006 High Level Meeting on HIV/AIDS, Uniting the world Against AIDS.	<b>2006</b>	<b>X*</b>	
Abuja Call For Accelerated Action Towards Universal Access to HIV and AIDS Tuberculosis and Malaria Services in Africa.	<b>2006</b>	<b>X</b>	<b>X</b>
New Partnership for Africa's Development (NEPAD)	<b>2001</b>	<b>X</b>	<b>X</b>

X - Signed; X\*- Represented

Adoption of a multi-sectoral response in the two countries to ensure that all sectors of society are actively involved in the design, implementation, review, monitoring and evaluation of the national response to HIV/AIDS is in line with UNGASS (2001), the Abuja Declaration (2001) and the Maseru Declaration (2003). Article 37 of UNGASS calls for governments to ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS. Abuja Declaration article 26, calls for Governments to “make available the necessary resources for the improvement of the comprehensive multi-sectoral response” and articles 1(a) and 3 (e) of the Maseru Declaration also exhort SADC countries to implement multi-sectoralism in their HIV and AIDS national response.

The provision of HIV prevention, care and support services in both countries is also guided by their commitment to international instruments, particularly UNGASS, the Millennium Development Goals (MDGs), the Abuja Declaration and the WHO HIV and AIDS Plan 2004-2005. UNGASS makes provisions for the development and implementation of multi-sectoral national strategies for combating HIV and AIDS, which includes addressing risk, vulnerability, prevention, care, treatment and support for those affected by the HIV epidemic. The MDG goal number six seeks to combat HIV and AIDS and other diseases through increased use of condoms and behavioural change. The goal also sets a target for the universal access to treatment for HIV and AIDS for all those who need it through the use of ARVs.

The two countries have adopted UNAIDS’s three ones principle (one strategy, co-ordinating authority, and monitoring and evaluation framework) evidenced by their countries’ commitment to having one agreed upon AIDS action framework (NSP), one national co-ordinating authority (NERCHA for Swaziland and NAC for Zambia) and one monitoring and evaluation framework (SHAPMoS for Swaziland and NARF for Zambia).

### 4.3 Analysis of legislative and policy environment

On paper, Swaziland and Zambia’s HIV and AIDS policies tend to comply with the various international and regional declarations on a number of issues such as elimination of stigma and discrimination against PLHIV; gender equality and elimination of all forms of discrimination against women; greater involvement of PLHIV; PMTCT; prevention of HIV infection and respect for human rights of PLHIV. HIV and AIDS responses in the two countries also seem to recognise the conventions and declarations they are signatory to.

Certainly, the two countries’ national responses are in line with the Maseru Declaration on HIV and AIDS adopted by the SADC Summit in 2003 and the New Partnership for Africa’s Development (NEPAD) adopted in July 2001. The Maseru Declaration reaffirms SADC governments’ commitment to promote HIV prevention, care and support. The Declaration particularly makes provisions for reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values, positive behavioural change and promoting responsible sexual behaviour. The Declaration also makes provisions for improving care, access to counselling and testing services, treatment and support by focusing on strengthening health-care systems, family and community-based care; expansion of workplace programmes, expanding access to voluntary counselling and testing and increasing access to affordable essential medicines, including ARVs and related technologies. The NEPAD framework identifies HIV and AIDS as one of the major impediments facing African development. The framework makes provisions for strengthening Africa’s participation in processes aimed at procuring affordable medicines and mobilising resources required to build effective disease interventions and secure health systems.

However, serious gaps exist. The two countries' budgets fall short of the agreed Health sector budget allocation of 15% set in the Abuja Declaration (Swaziland-10%; Zambia-12%), indicating that more commitment is required from the two Governments. In southern Africa, Mozambique is currently the only country meeting this requirement (Guthrie, 2008). However, Swaziland's 2008 national budget speech recognises the need to scale up allocation to the health sector to at least meet the 15% needs.

Zambia's HIV and AIDS policy has some gaps on prevention. According to the mid-term review of the National HIV/AIDS/STI/TB Strategic Framework (NAC, 2008), the prevention aspect of policy does not address the issue of men who have sex with men (MSM) and male circumcision. It is also justifiably argued that there is little attention paid to intravenous drug users, a relatively small problem for the country. Then the issue of MSM is a sensitive one in Zambia because of observed cultural values of Zambian society which do not recognise the practice of MSM. However, MSM is now a reality in the country. A snap survey of the website: [www.adultfriends.com](http://www.adultfriends.com) on June 10, 2009 for Zambia, in a small sample of 100 people who were seeking for friends, 81 indicated they were looking for a person of the opposite sex, 5 men were looking for men, 3 women were looking for fellow women and 4 men and 3 women were looking for both men and women for sexual relationships. Such is the complexity of issues which have either emerged or were not considered at the time of developing the policy.

Both Swaziland and Zambia are not reporting on sexual minorities in their UNGASS reporting. This is blamed on the unavailability of data. Both Governments could put in place systems that ensure that information on sexual minorities is deliberately captured in the national statistics. There is also a need to initiate HIV and AIDS interventions that specifically cater for sexual minorities.

Legislation on HIV and AIDS is either 'hidden' or implied in other statutes not directly related to HIV and AIDS which do not exist at all. One researcher, Mr Kaumbu Mwendela, with the Public Health Watch in Zambia and a board member of the Zambia AIDS Law Research and Advocacy Network (ZARAN) stated that:

***"It is important to keep legislation as generic as possible to accommodate unforeseen eventualities but specific enough to avoid arbitrariness and abuse. If the law is so broad and sweeping then the enforcer is a law unto themselves. In this case the adage 'absolute power corrupts absolutely' applies."***

## 5.0 HIV/AIDS INFORMATION COLLECTION, PUBLICATION AND MANAGEMENT

In order to achieve effective prevention of HIV and AIDS, it is essential that governments have accurate and up-to-date information about the populations that will need to access the different services. Collection and publication of this data is thus an important issue. This section examines:

1. The extent to which good quality national statistics are available and relevant for the planning and monitoring of HIV and AIDS prevention programmes;
2. Whether statistics are disaggregated into useful socio-economic and regional categories in order to enable monitoring of the effect of policies on different groups, especially the most vulnerable; and
3. The extent to which NACs have functional records management systems on the national HIV and AIDS response and how these records are analysed and reports made available and kept.

### 5.1 Availability of good quality national statistics for planning and monitoring of HIV and prevention programmes

Availability of credible data and statistics has improved dramatically within the last five years. Recent data collection and dissemination exercises within the countries include the UNGASS reporting (2008) and the Demographic and Health Surveys (conducted 2006-2007) which, for Swaziland, used population-based testing<sup>4</sup> to determine HIV prevalence (Demographic and Health Survey, 2007). The DHS included samples of blood collected from a nationally representative sample of the population in their homes. This method provided direct information on HIV infection among men, women and children. Previously, HIV prevalence estimates were based on sentinel surveillance.

In Zambia there exist other media for ensuring availability of reliable quality statistics or data essential for planning. The Central Statistical Office, MoH and NAC are authentic sources of national statistics. The country has an efficient system of collecting HIV and AIDS information. Data collected is made public through targeted publications by the Central Statistical Office via census of population and households, the Zambia Demographic Health Survey (ZDHS), Zambia Sexual Behavioural Survey (ZSBS) among others. The MOH makes its data public through the Health Management Information System (HMIS). At NAC, the National AIDS Council Management Information System (NACMIS) is fast becoming a source of valuable consolidated data.

Other co-ordinated publications common to both Swaziland and Zambia include the Joint Programme Reviews, Annual M&E Reports, the UNGASS report and the mid-term reviews for the national strategies.

4 Chin, who heads the WHO Statistics Office in Geneva said statistics on Africa were overblown in their estimations but the population surveys were reliable. For example, Ethiopia was recently estimated at 5-6% prevalence rate but was later found to be only rated at 1.5%. (MmegiOnline, Vol. 24 No. 162, page 12007)

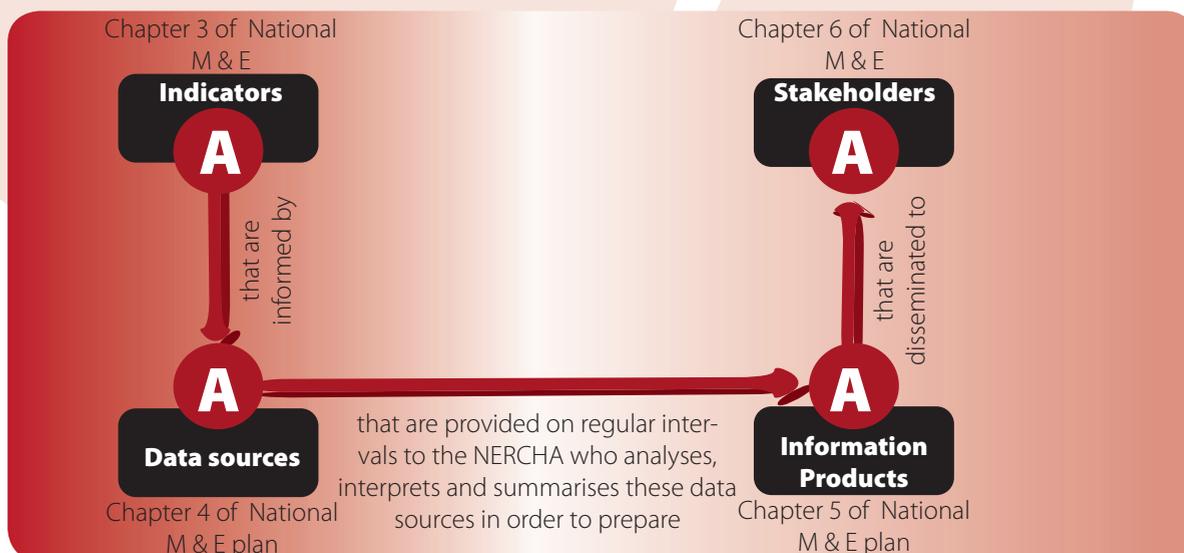
Generally, HIV and AIDS data in both countries is disaggregated by socio-economic sector and region in order to enable monitoring of the effect of policies on different groups. Nevertheless, in the majority of cases, HIV and AIDS-related statistics do not adequately capture information on orphans, refugees, gays and lesbians, disabled persons, children, language minorities, internally displaced people and others.

## 5.2 HIV/AIDS information management system

Information packaging and dissemination are important components of any response. NERCHA in Swaziland co-ordinates the packaging, publication and dissemination of HIV and AIDS information. Information and publications are available at NERCHA's resource centre and on their websites. Government line ministries' offices and websites are also reliable sources of HIV and AIDS information. In Zambia, information on HIV and AIDS can be obtained from the Central Statistical Office, MoH and NAC. NAC plays a critical role in the dissemination of information. NAC has launched a resource centre and website. However, there is need to strengthen national feedback mechanism to ensure that the communities are aware of the available information and how they can utilise it to improve their health.

Focus group discussions pointed out limited usefulness and timeliness of information published on NERCHA's website. NERCHA co-ordinates the monitoring and evaluation system which has a paper-based data collection form (SHAPMoS) designed for non-health sector players. Both NERCHA and implementers, especially from the NGO sector, acknowledged limited compliance with the system. The M&E system however was constructed on four pillars:

**Figure 4: Operational Framework for the National M&E System for HIV and AIDS**



In Zambia NAC co-ordinates monitoring and evaluation systems in the HIV sector. NAC uses the NACMIS to consolidate and report on information that is collected through the National AIDS Reporting Form (NARF). NARF has got 21 indicators which are collected and collated at district, provincial, and finally, at national level. Recognising that there are many errors in the manually-managed NARF, NAC is piloting a computerised version of the NARF. This is aimed at improving the quality of collected data. Staffing levels for M&E are close to 100% and what remains is to create a programme for continuous learning for members of staff in the unit. NAC also offers technical assistance to DATFs, PATFs and some line ministries in aspects of M&E which include data collection, cleaning, collating, storage, retrieval and data use.

## 6.0 HIV AND AIDS STRATEGIC PLANNING, MONITORING AND EVALUATION

The existence of a policy complying with regional and international declarations and conventions is not enough to guarantee an effective HIV and AIDS national response. Developing a strategic plan and a framework for monitoring and evaluating it are critical elements in scaling up an HIV and AIDS national response. This chapter, therefore, critically examines the two Governments' existing HIV and AIDS strategic and M&E plans and their appropriateness for the HIV and AIDS national response.

### 6.1 National Strategic Plan (NSP) for the prevention, care and support of HIV and AIDS

#### 6.1.1 Development and updating of the NSPs

In Swaziland, the findings of the Joint Review of the First NSP were taken into consideration during the development of the Second NSP. The Joint Review was commissioned with the objective to review the national response, document achievements, gaps, lessons learnt, constraints, challenges, and opportunities and to make recommendations. Lessons learnt from the previous interventions were instrumental in developing the current strategic plan. Before the development of the Second National Multi-sectoral Plan, Swaziland did not have a monitoring and evaluation plan for the national responses to HIV and AIDS. Consequently, there was no systematic way for collecting output and outcomes data related to the national HIV and AIDS responses. This had a negative impact on the generation of information implying that little information on challenges and successes was generated. Furthermore, there was no systematic way of disseminating information generated from the national responses.

In the case of Zambia, joint planning plays a critical role in the development and reviews of the NASF. Since 2002, NAC has made it a policy matter to engage all key stakeholders in strategic planning and operational planning. The first strategic plan which was developed by NAC covered the period 2002-2005. This was in line with the medium-term expenditure framework (MTEF). Building on the strengths of the first NASF, the second NASF was developed to cover the period 2006-2010. The 2006-2010 NASF was developed through a multi-staged participatory, bottom up approach. In June 2008, a nationwide exercise to conduct a mid-term evaluation of the NASF 2006-2010 was conducted. This exercise led to the production of the NASF supplement which has additional objectives and strategies, taking into consideration emerging issues including MSM and the development of resistant strains of both TB and HIV. NAC also takes advantage of the Joint Annual Programme Reviews (JAPR) to disseminate and get feedback on the NASF.

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#### 6.1.2 Extent of stakeholder consultation in formulation of NSPs

In both countries stakeholders were widely consulted in the development of the current national strategic plans for HIV and AIDS multi-sectoral response.

The Swaziland NSP was based on findings of the joint review report of the First National Multi-sectoral Strategic Plan produced by NERCHA and literature review. Primary data was gathered through a consultative process involving a wide array of stakeholders. Data was gathered

through focus group discussions involving communities and interviews with stakeholders and key informants. Focus group discussions were held in all chiefdoms. Stakeholder interviews were held with different groups, such as interest groups, business communities, NGOs and the Government. Key Informant Interviews were held with national leadership, opinion leaders and policy makers among others. Additional consultations with members of the public were held through radio and television call-in programmes. Draft documents were reviewed at different levels and by different groups and their comments were incorporated in the final draft.

In Zambia, the NASF is a product of wide consultations locally, regionally and internationally. The process involved the World Bank and UNAIDS which sent in consultants. Regionally, UNAIDS supported the process through the Southern Regional Technical Support Facility (TSF) in Johannesburg. Locally, there was involvement of the public sector through HIV/AIDS focal point persons and Ministry AIDS Co-ordination Advisors (MACAs), the private sector through the unions and the Zambia Workplace AIDS Programme Partners (ZWAPP) and civil society through self-co-ordinating organisations such as the Network of People Living with HIV and AIDS (NZP+), the Zambia Interfaith Networking Group on HIV and AIDS (ZINGO), Forum for Youth Organisations in Zambia (FYOZ) and Zambia Alliance of People with Disabilities (ZAPD). A bottom-up approach was adopted in the formulation of the current NASF in Zambia. Initially, there was formation of a multi-sectoral steering committee at national level, then engagement of consultants with support from the World Bank and UNAIDS to facilitate the process. A National Facilitation Team (NFT) composed of key stakeholders in the HIV and AIDS sector was assembled. After orientation of the NFT, it was divided into nine (three members each) with a team assigned to each province. The NFT served to build the capacity of provincial trainers (PACA, Provincial Planner and Provincial Accountant) to form PAFT, followed by capacity building of DAFT. The DAFT built the capacity of district stakeholders to go to communities to initiate the process of a bottom-up approach, using participatory action for learning and participatory rural appraisal. DAFT consolidated community submissions and the process continued until district strategic plans were completed. These were then used to feed into a national document which gave birth to the National Strategic Framework (NASF).

### 6.1.3 Plan objectives, needs analysis and rational policy choices

The NSP in Swaziland sets out credible strategies for the achievement of set objectives. On all issues that form Swaziland's national response, the NSP identifies strategic issues that include challenges that the country, i.e., the Government, civil society and private sector, are facing under that particular issue. It then goes on to set objectives and strategies for achieving those objectives, while recognising challenges. It also highlights indicators for measuring achievement of those objectives. However, the NSP does not show the cost implications of achieving set objectives. Cost calculations are made when the document is translated into the national programme of action and when the annual workplan is drawn. Similarly, the NASF in Zambia presents key challenges that the country will face in the 2006-2010 planning horizon. In light of these challenges, strategic objectives are crafted to address key issues in the HIV and AIDS response. Unlike the NSP for Swaziland, the plan is accompanied with costs. Sources of funds are clearly spelt out and so are the committed funds and gaps. The gaps are used for further resource mobilisation. The NASF recognises the fact that human resources are key to successful implementation of the plan. The NASF has clearly outlined how to access operational capacity, and identifies the strengthening of skills in the prevention and management of opportunistic infections at all levels of health care as key. The plan spells out clear strategies for training and retaining adequate skilled human resources while developing viable sustainable rural retention schemes.

The national strategic plans for the two countries also set out clear policy objectives and priorities based on a needs analysis and rational policy choices. The NSP in Swaziland addresses the needs of different segments of the population through the various strategies that are clearly outlined in the NSP. The country has an implied prevention strategy which prioritises behavior change around sexual activity and partnerships, condom logistics, promotion and management, prevention of mother-to-child HIV transmission of HIV, prevention and management (early diagnosis and treatment) of STIs, post exposure prophylaxis, prevention of HIV and AIDS at the workplace, and HIV and AIDS counselling and testing. Prevention strategies target the population groups that have been identified as high risk groups. These groups include in- and –out of school youths, commercial sex workers, seasonal and factory workers, long distance truck drivers, the armed forces and employees of the public transport sector.

The NASF in Zambia is also informed by needs on the ground, and priority areas are identified in the national HIV and AIDS policy by stakeholders. NASF operationalises the HIV and AIDS policy. The HIV and AIDS policy outlines sectoral responsibilities which are neither goals, objectives nor strategies. It is simply a responsibility. For this reason, it needs to be operationalised. This is done through the NASF. Priorities with the NASF were also set by way of the Three Point Criteria, which was used to qualify each issue into a strategic issue. This criterion assessed three aspects of an issue, i.e., is the issue fundamentally complex; is there anything which NAC can do about this issue within the provisions of its mandates and if NAC does not do anything about this issue, are there grave negative consequences which will ensue as a result of this failure? Through this criterion, strategic issues were identified and included in the NASF. The NASF also identifies within its guiding principles that HIV and AIDS interventions should be pro-poor, with HIV and AIDS mainstreamed in the national development agenda, sector policies, plans and budgets of the country in order to ensure sustainability. However NASF does not have a deliberate objective specifically developed for the poor. Nonetheless, this principle is invoked in a different theme group, other than prevention, where it should have been prominent.

In theme group three of mitigating the socio-economic impact of HIV and AIDS, all the three strategic (14, 15 and 16) objectives are pro-poor. All three strategies outlined in that section aim at protecting and providing support for OVC, PLHIV and promoting the programme of food security and income/livelihood generation for PLHIV and their caregivers/families. Indeed, stakeholders agree that the documentation of objectives and strategies for PLHIV in both the policy and the NASF are clearly provided for and straight forward. The problem has been lack of concrete operationalisation of what is provided for. Besides being informed by needs on the ground and priority areas co-identified with partners, the Strategic Plans for both Governments also serve as vehicles for translating the numerous regional and international declarations and conventions to which they are signatory into programmes of action, by aligning themselves with most of them. There is a strong realisation that HIV and AIDS are very much inter-linked with poverty, social and economic inequities between men and women and long-standing cultural behaviours and beliefs, and that the epidemic seriously undermines, the countries' commitment to achieving set targets from the different international declarations and conventions which they signed.

#### 6.1.4 Mechanisms for co-ordination and co-operation in prevention of HIV

The Swazi and Zambian national strategic plans make provisions for the co-ordination of a multi-sectoral response to HIV and AIDS. Clause 8 of the Second National Multi-sectoral HIV and AIDS Strategic Plan 2006-2008 in Swaziland spells out that NERCHA is "mandated to

co-ordinate the national response and further provide support in the form of funding and logistics to a wide variety of implementing partners which include government, private sector and civil society organisations." Clause 9 of the strategy details the mechanisms through which NERCHA co-ordinates actors in the HIV and AIDS sector. It mandates NERCHA to disseminate the policy to all implementing and supporting agencies. It is responsible for the formulation and implementation of sectoral and constituency plans. It also has budgetary oversight i.e., translation of the national strategy plan into annual sectoral operational work programmes, resource mobilisation and funding aspects regarding implementation of the plan. However, the strategy falls short of detailing mechanisms to ensure co-operation of multiple actors in HIV and AIDS. It actually admits that linkages of NERCHA to existing partners and stakeholders within the broader co-ordination framework are not defined. This has led to it being viewed with suspicion and perceived as competing with implementing agencies.

In Zambia, the NASF make provisions for the NAC to co-ordinate the multi-sectoral response to HIV and AIDS. Through the NASF, NAC should work to strengthen the institutional legal framework as part of co-ordination. NASF emphasises co-ordination through decentralised structures, including policy reform, joint planning and formation of synergies between and among stakeholders. However, there are many opportunities and mechanisms that exist in Zambia which foster co-ordination in ways that are not described in the NASF. For example, at district level, most DATFs hold stakeholder forums on a quarterly basis (SHARE, 2008). The purpose of the stakeholders' forum at that level is to share experiences, and lessons learnt, and to create linkages and synergies and reinforce practical co-ordination. Civil society is composed of self-co-ordinating bodies including the civil society forum itself, and the OVC forum. FBOs are co-ordinated through the Zambia Interfaith Non-Governmental Organisation on HIV/AIDS, the youth are co-ordinated through the Forum for Youth Organisations in Zambia, traditional leaders through the National Royal Foundation, PLHIV through NZP+ and Treatment Advocacy and Literacy Campaign, while the disabled are co-ordinated by the Zambia Alliance of People with Disabilities.

NAC in Zambia is also working with the Department of Manpower Development (PSMD) to come up with a public sector strategy aimed at enhancing co-ordination of a public sector HIV and AIDS response. Co-ordination of private sector response ideally should be done through the Tripartite Advisory Council and Decent Country Workplace Programme agenda. With support from ILO the tripartite arrangement did carry out a detailed study in 2007 which led to the establishment or declaration of the three pillars which ILO Zambia is using as the basis to support the world of work. Of these three pillars, pillar two is all about HIV and AIDS in the world of work.

Unfortunately, even the NASF supplement did not consider funding the Tripartite Advisory Council the main co-ordinating body of all activities in the world of work, yet the private sector contributes 58.5% of funding to the NASF. Zambia Workplace AIDS Partnership which comprises four private sector NGOs, falls outside the jurisdiction of the tripartite arrangement. Strictly speaking, ZWAP members are civil society organisations or agencies working in the private sector. In their quest to facilitate co-ordination and raise awareness in the informal sector where some members may not even be unionised, ILO did conduct yet another study in 2007 which concluded that the Zambia Chamber of Small and Medium Business Associations (ZCSMBA) is better placed to have units within its district offices through which HIV and AIDS may be co-ordinated in the informal sector. The NASF should have highlighted these factors, considering there was an opportunity during the mid-term review of the NASF, but it did not.

## 6.2 Monitoring and evaluation

### 6.2.1 National capacity to monitor and evaluate effectiveness of HIV and AIDS strategies

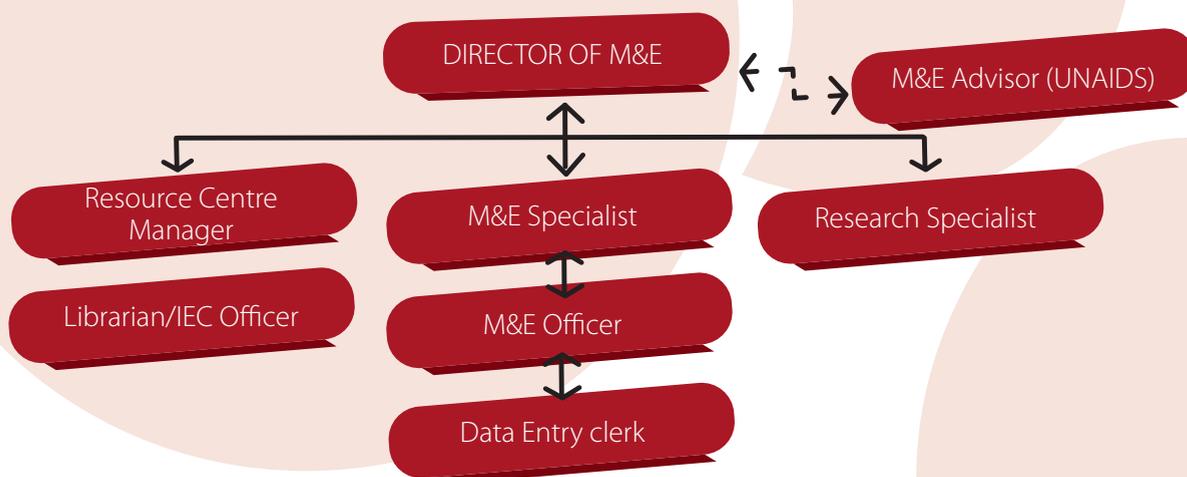
HIV and AIDS co-ordinating bodies in Swaziland and Zambia have strong M&E units backed by their central statistical offices with a capacity to monitor the HIV and AIDS national responses. However there are various challenges specific to each country that needs strengthening in order to ensure that this capacity is realised.

In Swaziland, although NERCHA has a strong M&E unit, monitoring and evaluation systems of implementing agencies of HIV and AIDS interventions are not homogenous and, in most cases, weak. A recent assessment of M&E capacity of HIV and AIDS organisations in Swaziland identified M&E technical skills as a common gap. There was lack of experience in advanced areas of research methodology, design, data management and use of qualitative data analysis software. This translated to a limited capacity for adequate management of M&E processes at organisational level.

Government agencies' capacity to monitor and evaluate were found to be generally weaker than that of NGOs'. Further, there was less support for M&E activities for departments not dealing with traditional health and welfare issues, compared to those operating under MoHSW. Funding for M&E is generally low. However, a comprehensive picture has not been developed since NERCHA's financial system is only able to track projects that it funds directly, and thus leaving out projects funded by or through other sources. Even though the plan does not specifically state the targeted annual funding resources for HIV and AIDS interventions that is to be earmarked for M&E, the realisation of the need to dedicate resources to the component is evidenced by its inclusion as one of the core indicators. Human resource capacity has also been a major challenge to the implementation, monitoring and evaluation of the nation's responses to HIV and AIDS.

For Zambia, the capacity of the M&E unit at NAC has grown in recent years into a reasonably well-staffed unit with some levels of specialisation. The current establishment and staffing levels of the Unit are outlined below:

#### Organisational structure of the NAC M&E unit in Zambia<sup>5</sup>



All these positions are filled. UNAIDS has seconded an Advisor, who advises the Director. The unit is supported by a team of experts, the M&E theme group, which is one of the six theme groups tasked to support different functions of NAC in line with the strategic plan.

The existence of several M&E systems used by different partners presents opportunities for a strengthened national capacity to monitor and evaluate the national response in Zambia. Some examples include the NACMIS, Health Information Management System (HIMS) for the MoH, Education Information Management System (EIMS) for the MoE and M&E systems for PEPFAR, CDC, Churches Health Association of Zambia (CHAZ) and Zambia National AIDS Network (ZKAN). There is a system in place to facilitate all the M&E systems to contribute directly to national statistics through the NACMIS. NAC notes that reporting by these partners has not been problematic. However, the multiplicity of M&E systems means that there is usually pressure on implementers to respond to these multiple systems. Apart from the potential of double reporting, it is not cost-effective. These systems are yet to develop to levels where they are in full synchronicity with the NACMIS, which promotes one monitoring system in line with the principle of “three ones”. The challenge is that most systems are older and more established than the NACMIS, highlighting a missed opportunity to build on these.

## 6.2.2 Dissemination and use of HIV/AIDS monitoring and evaluation information

In both countries the HIV and AIDS co-ordinating bodies, i.e., NERCHA for Swaziland and NAC for Zambia, are mandated to publish and disseminate information on all output indicators reflected within their HIV and AIDS Strategic Plans. These co-ordinating bodies also publish annual reports on all indicators in the strategic plans. The M&E units within the co-ordinating bodies lead the mid-term and end-of-term review of the HIV and AIDS strategic plans. Such reviews consist not only of the analysis of indicator scores, but also other consultative processes, using qualitative research techniques to determine the challenges, implementation impediments and achievements. The two countries are signatory to the UNGASS and thus produce and present the bi-annual UNGASS report.

Swaziland NSP states that tracking the national response to HIV and AIDS should be done through ongoing tracking of core indicators and, mid-term and end-of-term reviews of the National Strategic Plan for HIV and AIDS. Core indicators for every sub-thematic area should be tracked on a regular basis. Indicator scores are then calculated on a quarterly basis for all output-level indicators, and on an annual or biennial basis for all outcome-level and impact-level indicators. The national M&E core data sources are defined. These core data sources consist of both independent serological and behavioural surveillance, as well as the mandatory collection of HIV service coverage data from all implementers of HIV and AIDS interventions. Such mandatory data collection on the nature and extent of HIV and AIDS service coverage is done using the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS). This system is well-developed in terms of literature and support materials, but most NGO partners have not been adhering to its requirement. NERCHA also has the mandate and financial support to develop quarterly reports for all output indicators in the NSP, and an annual report for all indicators in the NSP. The M&E Unit at NERCHA is responsible for facilitating dissemination of information. Different and appropriate dissemination channels, including publication on its website, are used to achieve this objective. However, the utilisation of data collected during M & E in informing policy has been a challenge.

In Zambia NAC has developed a National HIV and AIDS M&E System to allow the country to track its progress towards the goals and objectives as stated in the NASF. In order to establish a national M&E system, NAC operationalised the NAC activity reporting systems using NAC NARFs as a means of capturing HIV and AIDS programme monitoring data from provincial and district levels. Data sources for M&E of the national HIV and AIDS response in Zambia consist of the following: the NARF, Cohort Studies; Education Management Information System (EMIS); Special Education Surveys that feed into the EMIS; HMIS; National Composite Police Index (NDPCI) and Sentinel Surveys. Others include: UNAIDS Financial Resource Flows Survey; Workplace Survey; Zambia Demographic Health Survey (ZDHS) which is conducted every 4-5 years, and Zambia Sexual Behaviour Survey (ZSBH). The M&E Unit at NAC produces quarterly reports upon consolidating what is submitted by the PATFs and other partners. These reports are shared with partners. Members of the general public are free to access them. In order to increase the coverage from disseminating these results to members of the general public, the public relations manager at NAC authors a weekly column in the Daily Mail (one of the Government tabloids). In this column, the public relations manager highlights critical aspects of the quarterly report that could be of interest to members of the general public. In future, quarterly and annual reports will be posted on the newly launched NAC web site.



## 7.0 FUNDING MECHANISMS FOR HIV AND AIDS PROGRAMMES

Funding mechanisms and expenditure management are essential to the delivery of HIV and AIDS responses. One of the most important mechanisms for ensuring efficiency and equity is to demand that budget processes be transparent. In this section we examine the budget process, procurement and financial reporting.

### 7.1 Funding and budgeting processes for HIV and AIDS programming

In Swaziland NERCHA receives all funding for supporting co-ordination and implementation of activities that target members of the public, while the MoHSW gets direct allocation for the health sector response. Other direct allocations are made to respective government Ministries like the Public Sector for the public sector HIV workplace programme. The situation is slightly different in Zambia. In Zambia NAC has separate mechanisms for funding programmes being run by sectoral stakeholders and resources for co-ordinating the response by NAC. NAC receives funds that are specifically for co-ordination in line with its work plan. Funds for service delivery are managed by stakeholders identified and recommended by NAC. In both countries, Government has the obligation to fund HIV and AIDS responses. As indicated earlier in section 4.2, the budget allocations for the health sector in the two countries still fall short of the expectation of the Abuja Declaration of 15% of the national budget, the bulk of HIV and AIDS interventions are still donor funded. Both countries are also recipients of the Global Fund.

In Zambia NAC has managed to work with donors to create what is known as a Joint Financing Agreement. This is a practice where donors pool their resources in the same basket to support the national response through NAC. Due to lack of control while disbursing these funds, some donors are reluctant to contribute to the basket. Given that the government budget for NAC is very limited and unable to meet demand, NAC does prepare its own budget, which takes into consideration all other non-traditional sources of funds, including the JFA, Global Fund and any other direct contributions. There seem to be problems related to transparency regarding the manner in which funds are handled between the Principal Recipients and the beneficiaries. In the public sector, for example, funds allocated to some line ministries do not flow to district level. They end up being utilised at the headquarters in Lusaka. Similarly, some respondents felt that both ZNAN and CHAZ are not transparent because they work through the District AIDS Task Force.

In Swaziland NERCHA provides the overall facilitation to the HIV and AIDS national response budgeting process. The process is conducted simultaneously with the annual planning process. Annual plans form the framework for budgeting, resource mobilisation and funding. The budgeting process is decentralised and community-driven, in line with the planning process. NERCHA develops the annual budgeting framework, which is then used by different constituencies to develop budget estimates. The budgets are then approved by a national budgeting committee constituted by representatives from various stakeholders (government, civil society and the UN).

## 7.2 Procurement processes

Procurement is a very pivotal aspect of the operationalisation of any plan or programme. In this sub-section we assess whether the HIV and AIDS co-ordinating bodies and Ministries of Health in the two countries have published any binding procedures setting out transparent and equitable rules for procurement of goods and services from private suppliers and also assess whether in practice there are mechanisms in place to ensure that these rules are enforced.

In Swaziland NERCHA oversees procurement of ARVs, making use of funds from the Government and the Global Fund to Fight Aids, Tuberculosis and Malaria. To reduce the possibility of abuse and misuse or misallocation of resources, NERCHA will not pay or transfer money to banking accounts of implementing agencies, but it pays directly to suppliers in accordance with approved projects. As the national co-ordinator for all activities related to HIV and AIDS, NERCHA is also responsible for sourcing funding and disbursing it to affected and infected people.

In Zambia procurement is an important function of both the MoH and NAC. Being public service institutions, they are both bound and guided by the Zambia National Tender Board Act (Cap 394. MoH procurement is further guided by the Ministry of Health Procurement Management System (MoH, 2006-2010 Strategic Plan). The purpose of the procurement management system is to provide a well co-ordinated, efficient, cost-effective, transparent and accountable procurement service to all levels of health care delivery. With the establishment of the Central Board of Health (CBoH) the central procurement functions of MoH were split into two. MoH is responsible for the development of policies and guidelines in line with the ZNTB Act while CBoH was subcontracted by the MoH to deal with the procurement of public health goods and services financed by both the government or a donor. In order to further enhance transparency, efficiency and effectiveness MoH developed procurement plans in 2004, in consultation with co-operating partners, leading to a draft procurement plan. NAC has its own procurement guidelines which are in keeping with the provisions of the ZNTB Act. Like the MoH, NAC has procurement systems and guidelines which guide all procurements. These guidelines are provided for in the NASF. However, there seem to be apparent challenges related to misappropriation of funds within the MoH due to loopholes in the system and a weak legal framework that has structural inadequacies.

## 8.0 HUMAN RESOURCE MANAGEMENT

Human resource management is key to the success of HIV and AIDS response. In this section, we review recruitment, retention and promotion and conditions of work in the health sector in Swaziland and Zambia.

### 8.1 Recruitment, retention and promotion of health personnel

The health sector in both countries faces a severe human resources shortage at all levels of the health system, which is significantly undermining the capacity to provide even the basic health care services to the people. This is even acknowledged in the HIV and AIDS policies and strategic frameworks of both countries. The already inadequate health systems have also suffered further deteriorations due to high staff attrition rates attributed to the migration of health professions and HIV/AIDS-related deaths. In Swaziland, the doctor to patient ratio is 1 per 100,000 and the nurse to patient is 56 per 100,000<sup>6</sup>. The situation is slightly better in Zambia but still does not meet the required minimum standards. The doctor to patient ratio is 1 per 17,589 and the nurse to patient ratio is 53 per 100,000 (MoH HRS Database). The WHO has recommended the Staff/Population ratios for Africa of 1:5,000 and 1:700 for doctors and nurses respectively. Based on the figures above, it is apparent that the doctors and nurses in both countries are significantly overworked. Generally, the current health sector human resource capacity in the two countries does not exceed 50% of the recommended establishment. Furthermore, the distribution of health care staff is skewed across provinces and districts in the two countries. In Swaziland over 50% of the health workforce is deployed in hospitals mainly located in urban areas where only 20% of the population lives, leaving the majority of 80% under-served (MoHSW, 2006).

In both countries inadequacy of human resources emanates partly from the countries' limited ability to develop and supply adequate human resources for the health sector. In Swaziland, there are three local training institutions for health professionals: the Faculty of Health Sciences at the University of Swaziland, which trains almost 70% of the professional nursing cadres in community and medical and surgical nursing; the Nazarene College of Nursing; and The Good Shepherd Nursing School, which trains 40 Nursing Assistants per year. There are no training facilities for medical doctors, rehabilitation therapists, biomedical engineering technicians, laboratory technicians or radiographers. Currently, all these professionals are sent to other countries for training. Once qualified, they often never return (NHSSP, 2008-2013, 2008). Furthermore, Swaziland has a policy which prohibits the recruitment of foreign nurses. The Faculty of Health is trying to re-establish training for clinical officers, pharmacy technicians and dental therapists. The MoH has requested the Ministry of Public Service to lift a ban on the recruitment of foreign nurses<sup>7</sup>. The nurses would be paid by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In Zambia, the rate of producing health workers by training institutions is outpaced by demand for these workers, especially with the ever-increasing burden of disease brought about by HIV and AIDS, resurgent epidemics and inadequate funding of training institutions.

6 MoHSW 2006 Selected Health Services Indicators by Region (2006)

7 Swaziland: Nurses Fleeing the HIV/AIDS frontline" (ReutersAlertNet : <http://www.alertnet.org>)

What was also observed was that training priorities and curricula for nurses and some undergraduate medical professional courses are not consistent with needs, and require updating to ensure their relevance to local conditions and demands. Also, the fact that in-service training is not properly integrated and co-ordinated leads to significant numbers of front line staff spending more time attending in-service programmes than providing the service.

## 8.2 Conditions of work for health staff

Swaziland and Zambia's investment in the Health sector has not been commensurate with the increasing demand for health services due to HIV and AIDS and other re-emerging epidemics like TB. In Swaziland the exodus of skilled health workers from the public sector is mainly attributed to lack of career progression, unattractive terms and conditions of service, poor working environment and lack of incentives. The remaining staff are succumbing to attrition emanating from increased disease burden mainly HIV and having to work with inadequate materials and medicines. They are further not protected from occupational exposure to HIV. In Zambia, the conditions of work in the health sector are not considered attractive enough to keep staff in their positions. Factors contributing to limited health staff and mal-distribution of health workers in Zambia include the following:

- Highly qualified staff feel intellectually and socially isolated in rural communities and hence are reluctant to work in rural areas;
- Poor standards of accommodation;
- Amenities, such as electricity and phones, that staff have been accustomed to elsewhere, are absent in rural areas;
- Transport and communication to maintain contact with family and colleagues is limited;
- Professional support and staff development is lacking in rural areas;
- Educational facilities for children are below standard; and
- The range of professional skills required may not be matched by prior training.

According to the World Bank<sup>8</sup>, Governments of the region have set up the Africa Health Workforce team to build an evidence base to determine what type of incentives motivate health workers to stay in their country. Among other things, the World Bank recognises that Governments need to provide improved equipment, safe housing and access to training, apart from improved remuneration.

## 9.0 EXTERNAL OVERSIGHT MECHANISMS

There is increasing consensus that external and independent audit and oversight of the executive is essential to improving government performance in service delivery and other areas. The AU Convention on Preventing and Combating Corruption, among other things, requires States to “establish, maintain and strengthen independent national anti-corruption authorities or agencies”. In pursuance of these normative standards, we examine in the two countries the existence and efficacy of action against corruption and misconduct, protection of whistle-blowers, the Supreme Audit Institution, existence of any anti-corruption agencies, independent investigation of public complaints and monitoring of performance by media and civil society. The section also examines if there is any linkage between HIV and AIDS co-ordinating bodies and health ministries’ activities on HIV and AIDS and the national assemblies.

### 9.1 National assembly

Swaziland’s National Assembly is generally regarded as inaccessible or not independent on any issue, including HIV and AIDS. Swaziland is an absolute traditional monarch, headed by a king (King Mswati III since 25 April 1986). Government is headed by a prime minister appointed by the king. The most recent general election in October 2008 was the first under a new constitution agreed in 2006. International election observers were invited for the first time ever, although some pro-democracy protestors were arrested. Generally, when a public outcry is made, it takes time for the central government to react and sometimes there is no action at all.

Unlike in Swaziland, there exists a clear link between NAC, MoH and the National Assembly in Zambia, through the Cabinet Committee of Ministers on HIV and AIDS. The Committee is comprised of, Ministers of Health, Finance and National Planning, Sport, Youth and Child Development, Education, Labour and Social Security, Mines and Mineral Development, Communications and Transport and Information and Broadcasting Services. It provides policy direction and, supervises and monitors the implementation of HIV and AIDS programmes. In addition, the Public Accounts Committee in the National Assembly also has a legislative oversight on all public expenditure accounts, which include money allocated for the HIV and AIDS national response.

### 9.2 Action against corruption and misconduct

Currently, Swaziland does not have an office of the ombudsman through which public complaints can be investigated. The public can only have their complaints heard through section 35 of the Constitution which gives the High Court the jurisdiction to hear and determine claims against breach of any of the protective provisions of the constitution. Unlike Swaziland, Zambia has two principal instruments providing the public with avenues for redress when concerned about service standards, corruption or misconduct by public servants. These are the institution of the Ombudsperson (Commission for Investigations) established under section 90(1) of the Constitution and the Anti-Corruption Legislation (see Section 9.6). The ombudsperson is a public office, that is charged with representing the interests of the public by investigating complaints reported by citizens and addressing them, usually through mediating a settlement. The office of the ombudsperson may initiate action on its own or respond to issues referred by others. Absence of an ombudsperson office prejudices citizens by depriving them of a formal complaint mechanism.

### 9.3 Whistle-blower-protection

The two countries do not have laws to protect whistle-blowers. If one blows the whistle one does it at one's own risk. This has created a situation where people fear to report alleged corruption cases for fear of victimisation. However, in Zambia the ACC has put a provision in the draft National Corruption Prevention Policy. The idea eventually is to come up with a whistle blowers bill, which can then be enacted into law.

### 9.4 Supreme audit institution

The Supreme Audit Institution has the onerous responsibility of auditing not only governmental but also quasi-governmental institutions and reporting on the audit to the Supreme Authority, whatever form it may take, depending on the prevailing political system. However, Krishnamachari (undated) indicated that unless Supreme Audit Initiators are assigned appropriate status and given adequate authority, they cannot function effectively.

The Auditor's-General in both countries has the mandate to inspect accounts of the Ministries of Health, and in Swaziland, this has been happening annually. The Zambia Constitution has adequate provisions spelling out the work of the Auditors-General. However there is need to ensure independence of the functions of the Auditors General from the executive in the two countries.

### 9.5 Oversight from media and civil society organisations

The success of the fight against HIV and AIDS is dependent on the fundamental role of the media. The ability to reach a wider population makes the media a superior weapon to fight the spread of HIV and AIDS. However in Swaziland, there is considerable weakness in media coverage of gender violence stories. According to responses from FGDs, gender violence stories lack context, are not gender-balanced, ignore gender issues, and are normally reported from a male perspective and negatively portray abused women. In 2007 the Media Institute of Southern Africa (MISA) reported Swaziland to have been amongst the four most oppressive and media-unfriendly countries in the region. The other three were Zimbabwe, Lesotho and Angola. Government has tight control over the media. According to one local newsletter, citizens rarely get the opportunity to air their views to a minister, government official, community leader or journalist (ASICHUMANE, April-June 2006). In an article by Reuters AlertNet<sup>9</sup> the Alliance of Mayors and Municipality Leaders on HIV/AIDS in Africa (AMICAAL) an NGO co-ordinating the response of urban leaders to their towns, felt that the response to HIV and AIDS by the Press was poor. The organisation proposed that reporters become involved, and attend conferences held on the epidemic. CANGO and MISA regularly try to meet this need by calling for workshops for the media and NGOs to discuss issues of HIV and AIDS (CANGO, 2007).

In Zambia the media is part of the five broad groupings of partners of the multi-sectoral HIV and AIDS response. In addition, the media is a member of the National AIDS Council. The media in Zambia is perceived to be relatively robust and a true watch-dog of society. Criticism of Government at times even emanates from State-owned media. The Press is free to publish anything critical of the establishment without any fear of reprisals.

Nevertheless, the media in Zambia still faces harassment and criticism from individuals in government and politicians. Indeed, stakeholders agree that the *Zambian Press* had reached 'fatigue levels' in its contribution to the HIV and AIDS response. If this is true, then Zambia is losing a very important ally in the fight against HIV. There is no substitute for the media's ability to reach a wider population', which is key to the prevention drive. There seems to be a need for an investigation into why the *Zambian media* is becoming indifferent to the HIV and AIDS response, at a time when prevention efforts are deemed to be a key weapon in ensuring that the gains of treatment are neither trivialised nor reversed by an increase in HIV infection in the country.

Part of external oversight mechanisms in both countries is also implemented by CSOs, notably SWAGA on women's rights, and Save the Children on child rights in Swaziland, and Zambia National Women's Lobby Group (ZNWLG) in Zambia, among others.

### 9.6 Anti-corruption agencies

Both countries have shown their commitment to combat corruption in both the public and private sector by putting in place policies to establish anti corruption agencies. In Swaziland, the Anti-Corruption Commission is a creature of statute, the Prevention of Corruption Order No. 19 of 1993 as amended. In Zambia, the government enacted the Corrupt Practices Act No. 46 of 1980 established the Anti-Corruption Commission. For the first time, corrupt acts were to be investigated and prosecuted by an independent body separate from the Zambia Police. This Act was later repealed by the Anti-Corruption Commission Act No. 42 of 1996 which, among other things, gave operational autonomy to the ACC. In both countries the mission of the ACC is to fight and prevent corruption in both the public and private sectors, by utilising investigation, prevention and public education strategies; and thereby creating a corruption-free society leading to investor confidence and good governance.

However, despite the existence of ACC in both countries corruption remains high although some slight gains were reported in Swaziland by the Transparency International, due to the introduction of anti-corruption measures. Swaziland is now ranked 72nd, from 84th, in the world according to the 2008 rankings by Transparency International Corruption Perception Index<sup>10</sup>. According to the same ranking Zambia is ranked 115 in the world. The issue of autonomy of the ACC in the two countries affects their operations and hence their effectiveness.

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10 <http://ourdevelopment.blogspot.com/2008/09/world-corruption-ranking-23-september.html>

## 10.0 LESSONS LEARNT IN IMPLEMENTATION OF AGREED CONVENTIONS

### 10.1 Positive lessons learnt

Swaziland and Zambia have demonstrated their commitment to be guided by major international conventions that guide HIV and AIDS responses. The two countries are signatories to the following conventions, declarations and protocols: the Abuja Call For Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, TB and other related Infectious Diseases in Africa; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Gaborone Declaration on a Roadmap Towards Universal Access to Prevention.

The two countries are also signatory to the Maputo Resolution on Acceleration of HIV Prevention in Africa, the Millennium Development Goals (MDG); the New Partnership for Africa's Development (NEPAD); OAU Assembly Declaration on AIDS Epidemic in Africa; the Political Declaration and Further Action on Beijing Declaration and Platform for Action; the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), and the SADC Declaration on HIV and AIDS.

Both Governments have put in place policies and frameworks for domestication of these international conventions and protocols. However, Zambia has not made any deliberate attempt to put in place a legal framework that specifically addresses the various protocols to which the country is signatory. The following are some of the key achievements and challenges faced by the two countries in the implementation of conventions, declarations and protocols.

#### 10.1.1 Specific lessons from Swaziland

Swaziland's UNGASS report for 2008 shows that the country has made considerable efforts in prevention, care and support. Swaziland undertook a number of HIV prevention efforts, such as VCT, condom promotion, IEC, PMTCT and blood safety. Achievements under prevention include development of a national policy on blood safety in 2000 and the adoption of national guidelines by 2001. The percentage of donated blood screened for HIV with an external quality assurance scheme is 100%.

Having developed its first PMTCT guidelines in 2002, HIV testing among pregnant women increased from 15% in 2004 to 66% in 2006. The percentage of HIV positive pregnant women under the PMTCT programme was 62% in 2006 and 64.8% in 2007. The country is on course to reach its committed target of 80% by 2010. (Universal Roads Access to Prevention, Treatment and Care and Support in Swaziland, November 2007).

Swaziland achieved the WHO '3 by 5' target of 13,000 patients on ART by 2005. Currently, 35% of persons with advanced HIV infection are receiving ART (children: 31%; adults: 35.1%). The country's target by end of 2008 was 50%. According to NERCHA, free ART was introduced in 2003, with 3,200 accessing it in 2004 and 25,000 in 2007. PMTCT funding from the Elizabeth Glaser Paediatric AIDS Foundation in 2004 provided training for healthcare workers, scaling up voluntary testing and counselling and supplying free Nevirapine for HIV positive pregnant mothers.

### 10.1.2 Specific lessons from Zambia

In Zambia, 15.7% or 578 of the 3,671 OVC have reported that their households had received free basic external support. Zambia has an estimated 1.2 million orphans, of which 75% were orphaned by HIV and AIDS. Service delivery data in 2006 showed that, for the age group 15 to 24, 454,069 received life-skills-based HIV and AIDS education, of which 234,058 were males while 220,010 were females.

## 10.2 Challenges faced in the implementation of the conventions, declarations and protocols

Various factors have been noted for the failure by the countries to meet their obligations under the various conventions, declarations and protocols. Some of the factors include limited capacity; inadequate resources; poor translation of international commitments into local policies and in some cases, dysfunctional governance systems.

Another key factor is the country-specific settings that make it impossible to identify peculiar requirements that are essential for the success of the initiative or implementation of the declarations. The socio-political, economic and cultural environments of each country are unique in their own way. As a result, a number of factors, unforeseen during the signing of declarations and the international instruments hinder the achievement of set goals and targets. Also, failure is attributed to sheer failure by Governments and other key players to facilitate the implementation of actions required to realise the goals and targets of the declarations and other international instruments.

There is a strong realisation that HIV and AIDS are very much inter-linked with poverty, social and economic inequities between men and women and long-standing cultural behaviours and beliefs, and that the epidemic seriously undermines the countries' commitments to achieving set targets.

Also, the two countries' budgets fall short of the agreed Health Sector budget allocation of 15% set in the Abuja Declaration (Swaziland-10%; Zambia-12%), indicating that more commitment is still required from the two Governments. In southern Africa, Mozambique is currently the only country meeting this requirement (Guthrie, 2008). However, Swaziland's 2008 national budget speech recognises the need to scale up allocation to the Health Sector to at least meet the 15% Abuja requirement.

Another factor could be the failure by the international conventions, declarations and other instruments on HIV and AIDS to clearly define ways and means that governments could put in place to achieve the desired goals. For example, the Millennium Declaration adopted in the fifth session of the UNGASS in 2000 lists targets with limited specific tactics and capacity for implementation, especially for developing countries (UNAIDS, 2000). Others, such as WHO's '3 by 5' initiative also achieved limited success. It is also worth noting that both Swaziland and Zambia are not reporting on sexual minorities in their UNGASS reporting.

### 10.2.1 Challenges faced by Swaziland

Budgetary allocations to key ministries, including health, do not match the work that needs to be done. HIV is still a politically and socially-sensitive issue. As noted in the Joint Review of 2005, the Swazi government has admitted lack of seriousness in dealing with the AIDS crisis. The allocation to Health, at 10.6%, still fails short of agreed commitments, especially the Abuja Call For Accelerated Action Towards Universal Access to HIV and AIDS Tuberculosis and Malaria Services in Africa.

Although NERCHA has a strong M&E unit, monitoring and evaluation systems of implementing agencies of HIV and AIDS interventions are not homogenous and in most cases, weak. A recent assessment of M&E Capacity of HIV and AIDS Organisations in Swaziland identified M&E technical skills as a common gap. This is a major challenge especially in measuring how the country is performing in its bid to fulfil its obligations under various conventions, declarations and protocols.

Swaziland data in the UNGASS report also show that the percentage of young people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 52.2%; (Women: 52.1%, Men: 52.3%). These results are alarming given the high prevalence levels in the country, indicating that work is still required in achieving positive behaviour change. The country needs to do more to provide adequate information and advocacy. Without positive behavioural change, no meaningful achievement will be realised through initiatives being implemented by the Government.

### 10.2.2 Challenges faced by Zambia

Zambia has not yet made a deliberate attempt to put in place a legal framework that specifically addresses the various conventions, declarations and protocols to which the country is signatory. Many issues which are core to the declarations are said to be accommodated in some clauses in other legal sources such as the Constitution and statutory law. Their accommodation may take the form of them being implied as opposed to being expressed. An overarching criticism of the legal framework is that no deliberate attempt has been made to date to come up with clear and specific legal instruments focusing on the HIV and AIDS national response in compliance with the numerous declarations and conventions to which Zambia is a signatory.

Zambia's HIV and AIDS policy has some gaps on prevention. According to the mid-term review of the National HIV/AIDS/STI/TB Strategic Framework (NAC, 2008), the prevention aspect of policy does not address the issue of men who have sex with men (MSM) and male circumcision. It is also justifiably argued that there is not much attention paid by the policy to intravenous drug users (IDUs). Regarding UNGASS, an indicator revealed that only 60% of schools provided life skills-based HIV education in the 2006 academic year.

## 11.0 MECHANISMS FOR CO-ORDINATION OF DEVELOPMENT ASSISTANCE

Most African countries receive bilateral or multilateral development assistance that contributes towards the realisation of public HIV and AIDS service delivery objectives. There is a consensus that, though such assistance can make a major contribution to achieving universal realisation of economic and social rights, there is a need for the quality of assistance to improve. This has been recognised by the Paris Declaration on Aid Effectiveness<sup>11</sup> of March 2005. The Paris Declaration expresses the global commitment for donors and recipient countries to support the direction for reforming aid delivery and management to achieve improved effectiveness and results. Also relevant are the Guiding Principles on Civil Service Reform<sup>12</sup>, adopted in 1995 by the Special Programme of Assistance for Africa (SPA), a group of aid agencies co-ordinated by the World Bank.

Both countries are signatory to the Paris Declaration on AID Effectiveness. The two countries have over the years expressed their willingness to support effective delivery and management of development assistance. They both endorsed the Accra Agenda for Action (AAA) on the acceleration and intensification of the implementation of the Paris Declaration on Aid and Effectiveness. The Accra Agenda for Action also acknowledges the role of civil organisations in advancing aid effectiveness. Thus they are important as development actors, and also have an important role in promoting accountability and in demanding results. Clause 16 specifies the intention of donors and Governments to building more effective and inclusive partnerships for developments. They acknowledge that partnerships are most effective when they fully harness the energy, skill and experience of all development actors - bilateral donors, global funds, CSOs and the private sector.

A comprehensive donor harmonisation framework that operates at national level was developed in Zambia in 2004. The framework is articulated in the Harmonisation in Practice Initiative (HIP), which involves a Memorandum of Understanding that was signed in April 2004, initially by the Government with 15 development partners operating in the country. The MoU provides the platform for developing the harmonisation of cooperation by development partners and alignment to Government procedures and processes. The harmonisation framework addresses issues of common procurement and disbursement guidelines, pooled funding, common monitoring and evaluation indicators of programmes, timely disbursement of donor commitments and reduction of bank accounts used to manage donor funds, among other things. It is within the context of the harmonisation framework that the development partners have agreed to prepare a Joint Assistance Strategy for Zambia (JASZ) covering the period 2006 to 2010, instead of independent planning instruments. The Bank Group, as a signatory to the Rome and Paris Declaration on Donor Harmonisation, actively participated in the JASZ process between 2005 and 2007.

11 The Paris Declaration on Aid Effectiveness 2005 expresses the international community's consensus on the direction for reforming aid delivery and management to achieve improved effectiveness and results. The Declaration is grounded on five mutually reinforcing principles: Ownership-Partner countries exercise effective leadership over their development policies and strategies, and co-ordinate development actions; Alignment-Donors base their overall support on partner countries' national development strategies, institutions, and procedures; Harmonization-Donors' actions are more harmonized, transparent, and collectively effective; Managing for results-Managing resources and improving decision making for development results; Mutual accountability: Donors and partners are accountable for development results.

12 <http://unpan1.un.org/intradoc/groups/public/documents/CAFRAD/UNPAN010830.pdf>

## 12.0 CONCLUSIONS AND RECOMMENDATIONS

### 12.1 Conclusions

Swaziland and Zambia have demonstrated their commitment to be guided by interventional principles by virtue of being signatory to major international conventions that guide HIV responses. Both governments have put in place policies and frameworks for domestication of these international conventions and protocols. However, Zambia has not yet made a deliberate attempt to put in place a legal framework that specifically addresses the various protocols to which the country is a signatory. Many issues core to the declarations are said to be accommodated in some clauses in other legal sources such as the Constitution and statutory law. Their accommodation may take the form of them being implied as opposed to being express. Putting in place legislation specifically addressing the protocols engenders a rights-based approach to the entire response framework. The need for a rights-based approach was identified as an essential element in Swaziland.

Zambia has made strides in scaling up its response to the HIV and AIDS epidemic in the areas of prevention, treatment, care and support and mitigation. Despite the weaknesses already identified in the system, Zambia remains an enviable model for the region in the rapid roll out of the HIV and AIDS response from the centre to the periphery, using a multi-sectoral approach. It is commendable that the HIV and AIDS Strategic Framework was produced in a highly participatory manner, using a bottom-up approach. In other words, there was a broad buy-in from stakeholders. However, one noteworthy element is that the Plan (2006-2010) does not take most of its remit from the National HIV and AIDS Policy. It ushers in some new courses, obviously to compensate for the gaps in the HIV and AIDS Policy, and is an admission by planners that the current policy is outdated. Furthermore, there are many current issues impacting on the HIV and AIDS national response that are not addressed such as provision of second line medicine when the first regimen of ARVs has failed and tracking the impact of circumcision on the incidence of HIV.

A multi-sectoral approach in planning and resource mobilisation was also adopted in Swaziland. Strategic planning and resource mobilisation of HIV and AIDS interventions are participatory in nature. There are systems that allow for the participation of the beneficiaries and communities in the development of sectoral operational programmes that go through the government planning and budgeting processes. Priorities related to HIV and AIDS prevention, care and treatment are set based on a needs analysis and rational policy choices that address the needs of different segments of populations through clearly-outlined strategies. This is critical in that not only does community ownership of interventions improve implementation of international conventions and declarations but rational prioritisation of interventions allows for efficiency and effectiveness in achieving set targets and goals in the national HIV response.

In Swaziland, information dissemination is subdued, despite this being critical for a rights-based response. For example, stakeholders lamented the inadequate dissemination of NERCHA's reports, especially at levels lower than national level. Although some reports are available on NERCHA's website, most stakeholders want NERCHA to be pro-active with information dissemination. There is huge potential for harmonising interventions and increasing co-ordination with the consortia of stakeholders working on gender, HIV and AIDS and food security established by CANGO. The starting point will be to develop credible registers of stakeholders with their response profiles, and to link this to the monitoring and evaluation efforts of SHAPMoS.

### 12.1.1 Swaziland

A number of key stakeholders from the UN, civil society and practitioners agree that there is high level political commitment to the fight against HIV and AIDS in Swaziland. There are general improvements in co-ordination of the response, with NERCHA significantly resourced to meet its co-ordination task. National level M&E information is more available, with data showing some improvements in general reporting, especially through the UNGASS and DHS processes. Yet the figures do not show a rapid impact of responses. HIV prevalence, although indicating a possible decline, is still very high, and the full impact of the epidemic is still to be realised.

The country has also demonstrated its commitment to be guided by interventional principles, by virtue of being a signatory to major international conventions that guide HIV responses. However, budgetary allocations to key Ministries, including health, do not match the work that still needs to be done. HIV is still a politically and socially sensitive issue. As noted in the Joint Review of 2005, the Swazi Government has admitted a lack of seriousness in dealing with the AIDS crisis. The allocation to Health, at 10.6%, still fails short of agreed commitments.

The Swaziland national HIV and AIDS policy assumes that the provision of HIV and AIDS services will entail a continuum of care where prevention, care and support co-exists, and are implemented in such a way that users are able to access required services as and when necessary. In reality, there are clear differences between these three key categories, and within each category. Prevention, for example, has two distinct components, including clinical-related, such as PMTCT, and community-based interventions, such as behaviour change communications. A number of practitioners lament lost opportunities in merging these components.

Culture has impacted HIV transmission in a negative way. Men dominate women in all aspects of life in Swaziland's culture. Women are not equals to men in this nation's society and therefore, are not empowered to stand up for their rights. They were and still are socialised to be subservient to men, so much that even the family law works against them. Women have no property rights. They are the home makers and care-givers to the sick, thereby leaving them exposed and most at risk to be infected with HIV accidentally. Moreover, polygamy, inheritance and beliefs that having sex with a virgin cures HIV makes women, especially young women and girls, vulnerable. Swaziland is thus in a state of emergency, albeit, not well conceived by many.

Socio-economic data show a declining quality of life and increasing poverty in Swaziland. Users of health services talk about a more glorious past. A rights-based approach to programming is therefore required. Essentially, such a human rights-based approach would integrate culture and norms, standards and principles of the international human rights system into the plans, policies and processes of programme development. Basic principles of equity, empowerment, participation and accountability demand that the national HIV response shifts its paradigm.

For example, more efforts will be required to ensure that the Swazi society recognises that women need to have increased ability to protect themselves from HIV infection, by initiating condom use and deciding when to have sex and with whom. Society would need re-education on the need to stick to one sexual partner and the Government and traditionalists would have to realise that. These people should be able to lead by example. Under clause 20 of the AAA, the government of Swaziland shows its intention to deepen engagement with civil society organisations. The Government and donors undertook to invite CSOs to reflect on how they can apply the Paris principals of aid from a CSO perspective; and engage with them in a CSO-led multi-stakeholder process to promote effectiveness of development initiatives. This contradicts available evidence that points to Government's inclination to control information flow.

## 12.2 Recommendations

### 12.2.1 Specific to Swaziland

- a) Provide a platform to link poverty, HIV and AIDS, climatic and economic crises and ensure that stakeholders from these areas fully understand the extent of hardships that the country is faced with. Specifically, the triple threat of food security, HIV and AIDS and declining Government capacity to react needs debate at all levels. Resources within different sectors - including CSOs, private companies and international technical assistance organisations need to be managed cleverly.
- b) SWANNEPA should develop a profile of CSOs and their work in different areas. Such a profile could help quantify their input, relevance and resource base.

### 12.2.2 Specific to Zambia

- a) The MoH and NAC should consider updating the HIV and AIDS policy framework to accommodate new challenges.
- b) The MoH and NAC should consider translating both the HIV and AIDS Policy and Strategic Framework into vernacular languages to make it accessible to non-English speakers.
- c) The Government through the Ministry of Health and NAC, should enhance the publicity of new HIV and AIDS policies and legal instruments. This is important for making people aware of their rights and obligations in the HIV and AIDS national response.
- d) The government should elevate the status of NAC so that it becomes an autonomous body with chief executive powers.
- e) Now that an adjunct to the NASF 2006-2010, which has taken into consideration emerging issues of MSM, male circumcision and mainstreaming issues has been developed, approved and launched, there is need to revisit the M&E plan with a view to including indicators for new inclusions in the supplement.
- f) With more people appointed to deal with information and data management at NAC and MoH and the decentralisation of their structures, there is need to have a continuing education programme at the two institutions.

### 12.2.3 General recommendations

#### Governments and national AIDS co-ordinating bodies

- a) Create an environment for rights-based approaches to service provision. Government should consider drafting and passing HIV and AIDS-specific legislation to guarantee the rights of people in the national response.
- b) Consider a formal feedback mechanism from users of health services. Activation of the office of the ombudsperson or at least place suggestion boxes at health delivery centres.
- c) Encourage integration of responses, especially those that are clinical and those based in the community.
- d) Provide the required leadership in meeting and reporting against commitments, including the Abuja and Maseru Declarations, CEDAW and the CRC, at least at the same level of commitment expressed regarding the UNGASS process.

- e) Strengthen M&E systems of key departments such as those on vulnerable children and abuse of women, including linking with stakeholders that are willing to share skills in these areas. There is need to consider placing M&E officers at district level.
- f) Pro-actively share information on successes and challenges with implementers at all levels. Establish a mailing list or e-forum where information can be shared regularly.
- g) Provide additional funding to National HIV and AIDS Co-ordinating Institutions and other players to ensure that M&E capacity is strengthened and rolled out at all levels.
- h) Provide frameworks for pro-active national level discussions on AAA and the Paris Declaration.
- i) Increase monetary allocation in the HIV and AIDS intervention processes. Meet the Abuja Declaration 15% agreed allocation for Health, and increase actual spending on HIV and AIDS.
- j) The Government should create a framework to safeguard the rights of vulnerable groups. All relevant international instruments like CEDAW and the CRC should be translated into national laws and policies.
- k) Governments should encourage positive utilisation of the media so that it can be used as a channel for education and dissemination of information on HIV and AIDS. Programmes on HIV and AIDS should be aired during prime time.
- l) Government remuneration packages should be competitive enough so as to retain staff. In the long term it will be prudent for Government to develop a career progression plan with each new essential health worker recruited to the public service

## Civil Society Organisations

- a) NGO co-ordinating bodies should work closely with co-ordinating partners to ensure that CSOs are using the agreed M&E framework for reporting.
- b) CSOs should develop the capacity of users of health services and their organisations so that they are better able to defend and demand their rights.
- c) As part of the AAA process, CSOs should seek to improve the co-ordination of CSO efforts with government programmes, enhance CSO accountability for results, and improve information on their activities; and work with Government to provide an enabling environment that maximises their collaboration with Government.
- d) There is an urgent need to enlighten society about the need to change cultural beliefs and attitudes about sex. People need to change their sexual behaviour and avoid multiple casual sexual partners and use condoms consistently.
- e) There is need for media monitoring and training on reporting issues of gender and HIV and AIDS.

## Funding and technical partners

- a) Continue to provide technical capacity and other resources to ensure that the national response to HIV is informed by evidence, and observes people's rights. New research on male circumcision, transmission rates during window periods, etc should be adapted to local settings, and resources made available to test their applicability.
- b) It is clear that additional resources have to be solicited from external development partners. Notwithstanding the Paris Agenda, there is need to sum-up the number of emergencies the countries are dealing with, and ensure that development assistance takes cognisance of these.

- c) There is need to improve the implementing and the national co-ordinating entity's capacity at resource mobilisation. While most implementing partners have finance and accounting departments, they do not have resource mobilisation components or units.
- d) Funding partners should take steps to fund a retention and capacity building strategy for professional health care personnel. The retention strategy should include issues such as competitive remuneration packages, availability of sufficient protective materials and equipment for health care personnel. The working and living conditions for all health workers, especially those in rural areas should be improved, including recruitment of health care professionals from abroad and neighbouring countries.
- j) For SADC and international bodies, it is recommended that ways and means to implement these agreements should be clearly outlined and executed. It is not enough to talk. It is only action on the ground that will produce desired results. Finances allocated for HIV and AIDS interventions should be realistic. Medicines must be kept in constant supply and always be in excess of the required amounts. Workshops must not be confined to urban areas but should reach even the remotest of areas. Food must be made available to all despite geographical locations, as even urbanites are poor. There is need for awareness-creation on the pandemic through education. Also, awareness should be created about conventions, declarations and other instruments governing the implementation of HIV and AIDS-related interventions and translated into the local legislation. This is necessary to enlighten citizens to be able to participate and also understand their rights.

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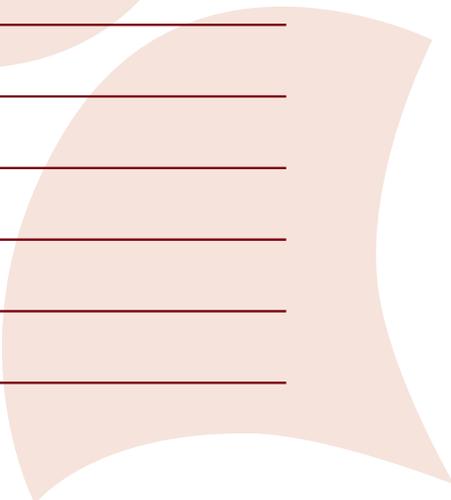
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Prepared by



ISBN: 978-0-7974-4030-2

with support from

