ESWATINI NATIONAL MULTISECTORAL HIV AND AIDS STRATEGIC FRAMEWORK 2024-2028

National Multisectoral HIV and AIDS Strategic Framework 2024-2028

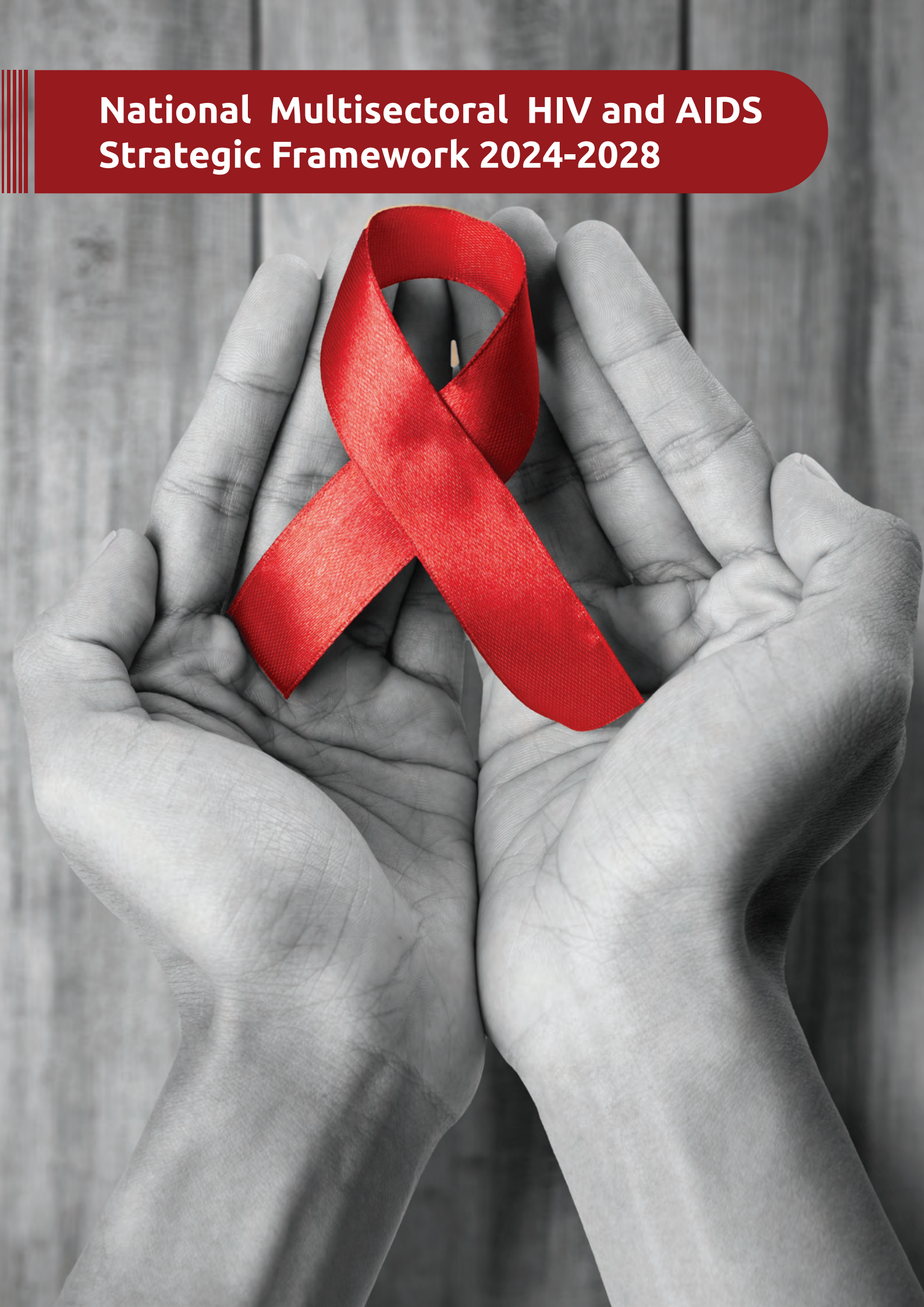
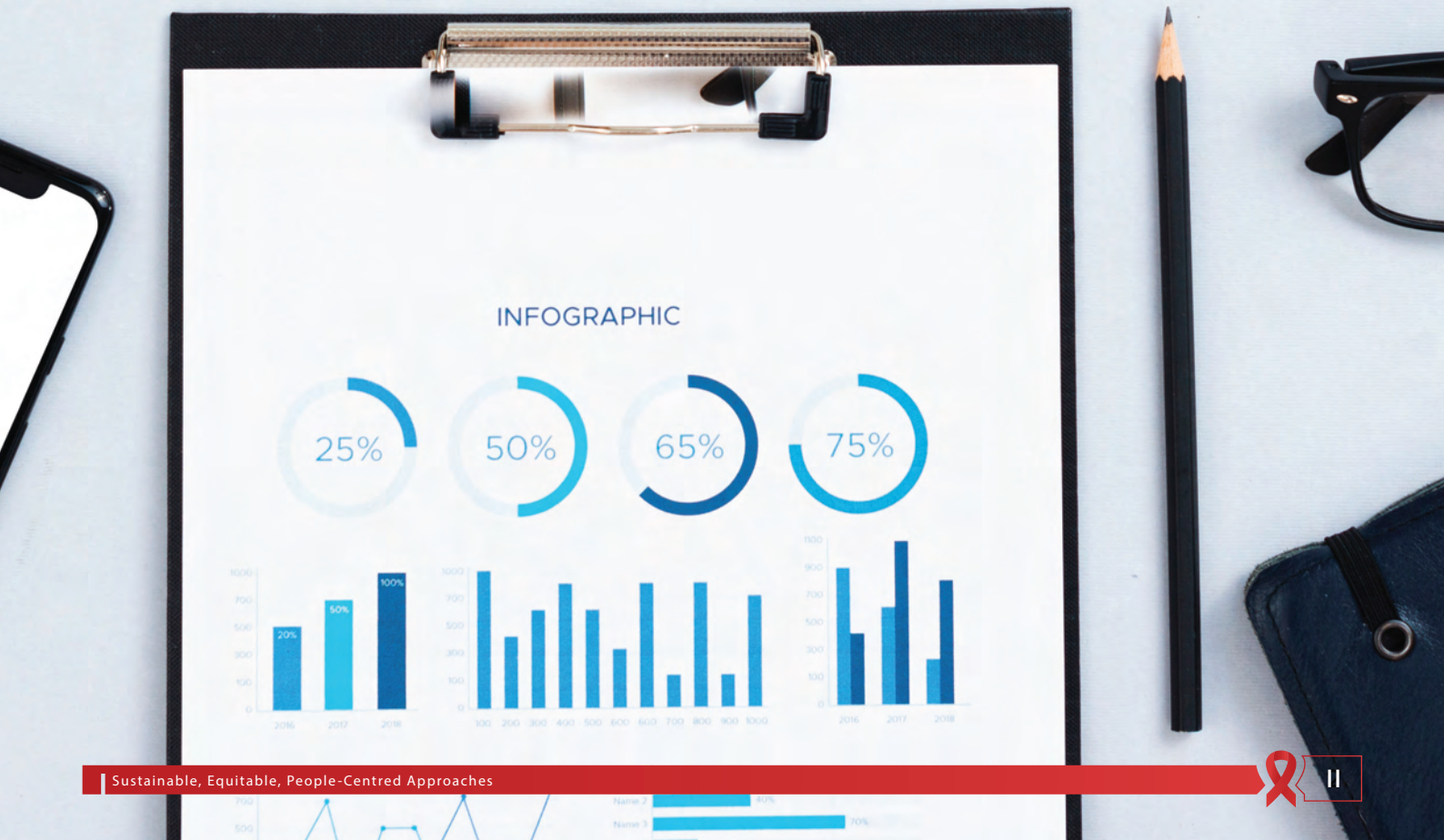


TABLE OF CONTENTS

List of Tables

List of Figures



ABBREVIATIONS AND ACRONYMS

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
ASPIRE	Attain & Sustain 95-95-95, Prevent New Infections and Reach All Populations for Epidemic Control
AYP	Adolescents and Young People
CBO	Community-based Organization
CLHIV	Children living with HIV
CLO	Community-led Organization
CMIS	Client Management Information Systems
COVID-19	Coronavirus disease 2019
CSTL	Care and Support for Teaching and Learning
DREAMS	Determined, Resilient, =Empowered, AIDS-free, Mentored, and Safe
DSD	Differentiated Service Delivery
EMIS	Educational Management Information Systems
EMTCT	Elimination of mother-to-child transmission
FSWs	Female Sex Workers
GBV	Gender Based Violence
GC7	Grant Cycle 7
GHS	Global Health Security
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HTS	HIV Testing Services
IBBSS	Integrated Biological-Behavioural Surveillance Survey
IMF	International Monetary Fund
KPs	Key Populations
LSE	Life Skills Education
M&E	Monitoring and evaluation
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MSM	Men having sex with men
MTCT	Mother-to-Child Transmission of HIV
NCDs	Non-Communicable Diseases
NERCHA	National Emergency Response Council on HIV and AIDS
NSF	National Multisectoral HIV and AIDS Strategic Framework
NSP	National HIV and AIDS Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PPP	Public-Private Partnerships
PrEP	Pre-Exposure Prophylaxis
PWD	Persons with disabilities
PWIDs	People who inject drugs
SGBV	Sexual and gender-based violence
SHAPMoS	Swaziland HIV and AIDS Monitoring System
SHIMS	Swaziland HIV Incidence Measurement Survey

SI	Strategic Information
SRH	Sexual and Reproductive Health
STIs	Sexually transmitted infections
TB	Tuberculosis
TG	Transgender
TPT	TB preventive treatment
UNAIDS	Joint United Nations Programme on HIV and AIDS
VLS	Viral load suppression
VMMC	Voluntary Medical Male Circumcision
WLHIV	Women living with HIV
YPLHIV	Young People living with HIV

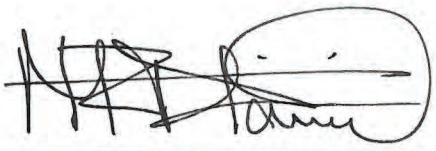
FOREWORD

The country remains proud of the national multisectoral HIV and AIDS response for the landmark of altering a crisis into a milestone. This has been achieved through guidance provided by the National Multisectoral HIV and AIDS Strategic Frameworks (NSFs) developed by the country from time to time. These NSFs provide strategic direction and highlight the areas to be addressed by all sectors for an effective response. The frameworks cover a period of five years and are reviewed at mid-point and endpoint. The mid-point evaluation assesses progress made by the country to achieve the aspirations of the NSF and the continued relevance of the strategies, given the dynamics of diseases and programs.

The end point evaluation, which happens immediately at the end of the five-year term of the NSF, assesses the country's performance against the five-year goals and targets aspired for in the NSF. The review of the NSF 2018 -2023 informed us of the great achievements accomplished by the Kingdom of Eswatini in the HIV response, and further indicated that Eswatini is on the right path to end AIDS by 2030. The latest Eswatini Population-based HIV Impact Assessment report, SHIMS III, confirms that Eswatini has reached the global 95-95-95 AIDS targets set for 2025, and reduced HIV infections and AIDS-related deaths as aspired for in the NSF 2018-2023. The NSF 2024-2028 sets a visionary course to combat HIV and AIDS, guided by ambitious yet attainable impact targets for the period 2024-2028. The NSF 2024-2028 focuses on three key areas: HIV response sustainability, reducing new HIV infections, and strengthening health systems. The NSF also calls for the intensification of investments in community-led and person centred multisectoral approaches, which will enable Eswatini to attain and sustain epidemic control in all sub populations and geographic locations. The end goal of the NSF is to sustain gains attained, and end AIDS as a public health threat by 2030. Further, the NSF is aligned with global AIDS strategies and Sustainable Development Goal 3.3. To achieve the goals of the NSF by 2028, the NSF highlights the importance of dedicated leadership, removing barriers to service access, developing resilient health systems, engaging communities effectively, dealing with structural barriers that increase risks to HIV acquisitions, and building strong partnerships with stakeholders.

Notwithstanding the competing demands on Government, development partners and the private sector, sustainable financing for the NSF remains key to achieving the NSF goals. The Government of the Kingdom of Eswatini appeals to its partners, including funding partners like PEFPAR and the Global Fund to continue supporting the country's HIV response. This by no means undermines the responsibility of Government to allocate sufficient funds to the response but merely recognizes that addressing all the areas articulated in the NSF requires more than what domestic resources can achieve.

The Goverment of the Kingdom of Eswatini believes that ending AIDS is within reach and is committed to a multisectoral approach in this effort. Eswatini will take bold and innovative actions to ensure that an HIV sustainability plan is developed and implemented. In this regard, Government has assigned the National Emergency Response Council on HIV and AIDS (NERCHA) to coordinate the implementation of the NSF 2024-2028, which is part of Government's broader vision that encompasses Universal Health Coverage and the overall development agenda, aiming to secure a prosperous future for all emaSwati.



His Excellency Russell Mmiso Dlamini

The Right Honourable Prime Minister
Kingdom of Eswatini

ACKNOWLEDGEMENTS

The Eswatini National HIV Strategic Framework (NSF) for 2024-2028 represents a significant milestone in the nation's efforts to combat HIV and AIDS. Its development is testament to the power of collaboration and shared commitment, involving a broad spectrum of stakeholders dedicated to eradicating this epidemic for the well-being of emaSwati and the country's sustainable development. The NERCHA Council extends heartfelt gratitude to all individuals, sectors, and partners who have generously contributed their time, expertise, and resources towards the development of this very important document.

Government Ministries, including the Ministry of Health, United Nations Agencies, the United States Government, through PEPFAR, Civil Society Organizations and others, have been instrumental in this process. The involvement of networks of people affected by HIV, implementing and civil society organizations, faith-based groups, and other vital contributors has been crucial in shaping this evidence-based framework.

Special appreciation is also given to expert reviewers whose insights and recommendations have significantly enhanced the quality and focus of the NSF.

We acknowledge Dr. Peter Memiah (Lead Consultant from the University of Maryland in Baltimore) and Dr. Nyasha Madzingira (M&E Expert) whose expertise and exceptional efforts in synthesizing inputs from various sectors has ensured that the Eswatini NSF 2024-2028 is a comprehensive and evidence-based plan, poised to substantially impact the fight against HIV and AIDS.

Finally, we express our profound gratitude to all stakeholders for their unwavering dedication to maintaining strong partnerships in implementing this national multi-sectoral strategic plan. The successful execution of the NSF relies on continued political commitment, sufficient resources, and effective implementation strategies.

This collective effort is crucial to achieving epidemic control and ultimately eliminating AIDS as a public health threat in Eswatini by 2030. Achieving the ambitious NSF targets will require a lot of resources, hence we appeal for increased support from our funders and development partners.

Ambassador Njabuliso Gwebu

NERCHA Chairperson

THE DEVELOPMENT OF THE NSF HAS BEEN MADE POSSIBLE BY THE CONTRIBUTION FROM THE FOLLOWING INSTITUTIONS:

Government Ministries (Public)

Prime Minister's Office
Deputy Prime Minister's Office
Ministry of Tinkhundla Administration and Development
Ministry of Health
Ministry of Sports, Culture and Youth Affairs
Ministry of Education and Training
Ministry of Housing and Urban Development
Minister of Finance
Ministry of Economic Planning and Development
Ministry of Justice and Constitutional Affairs

Steering Committee

National Emergency Response Council on HIV and AIDS (NERCHA)
Ministry of Health (MoH)
Eswatini Business Health and Wellness (EBH)
US President's Emergency Plan for AIDS Relief (PEPFAR)
Joint United Nations Programme on HIV and AIDS (UNAIDS)
Coordinating Assembly of Non-Governmental Organizations (CANGO)
People Living with HIV (PLHIV)
Prime Ministers' Office

HIV Implementing Partners

Georgetown University
ICAP
EGPAF
FHI360
Pact Eswatini
Kwakha Indvodza
Young Heroes
Cabrini Ministries
The Luke Commission
Bantwana
World Vision
Family Life Association of Eswatini
Country Coordinating Mechanism
Umhluma
Jhpiego
Baylor Clinic
University Research Council
Academia
AIDS Health Foundation
SAfAIDS
Eswatini Action Group Against Abuse

Sectors

Khulisa Umntfwana
Church Forum
PSHACC
EBH

UN Family

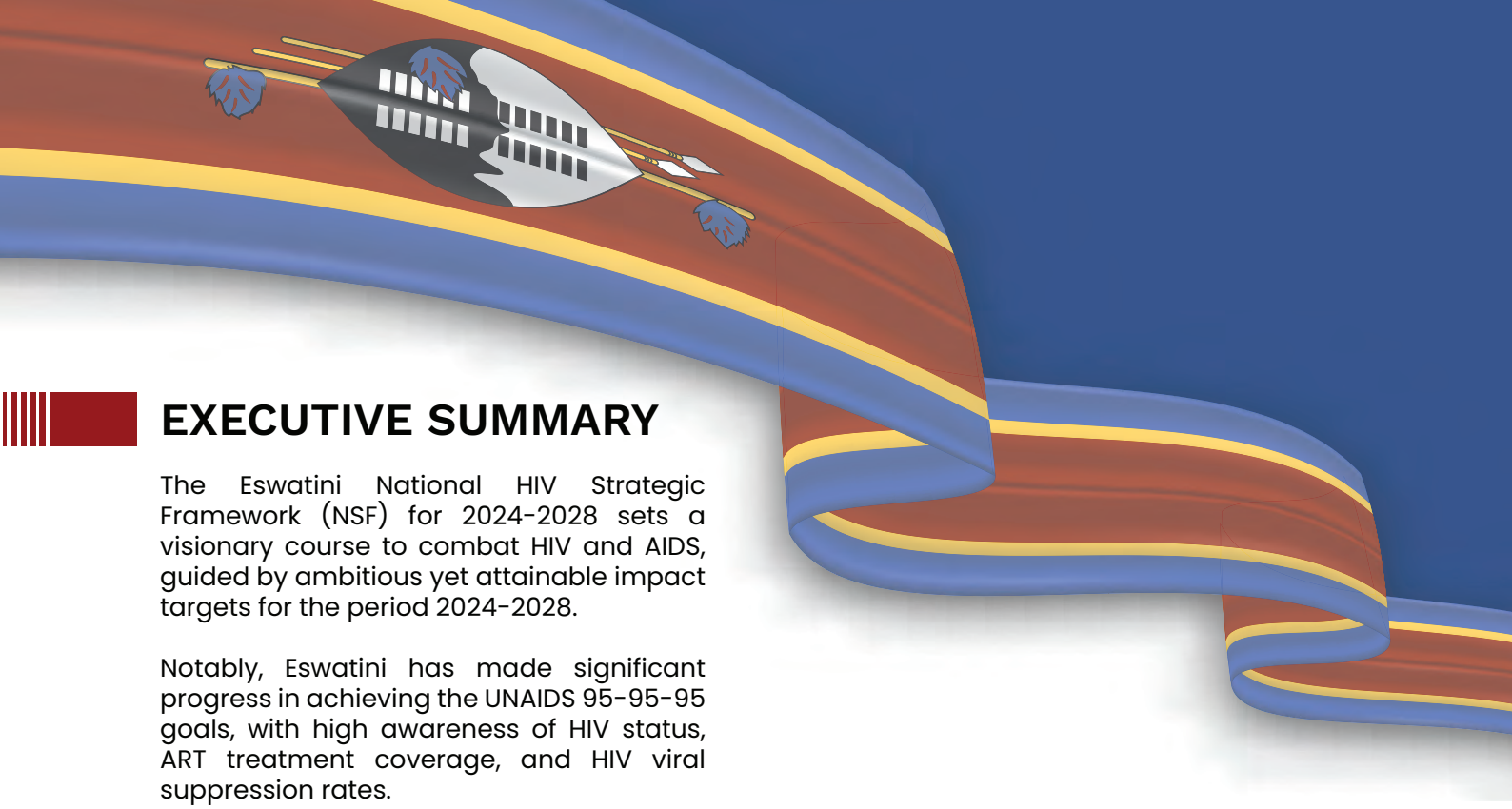
UNICEF
UNFPA
WHO
UNDP
UNRCO
World Bank
WFP
ILO
FAO
UNESCO
IOM

Key Programs and Departments

Eswatini National AIDS Program
National TB Control Program
Sexual Reproductive Health Unit
Non Communicable Diseases Program
Cancer Unit
Strategic Information
FODSWA
National Reference Laboratory
Central Medical Stores
PLHIV Groups

Writing Team

NERCHA
USAID
UNAIDS
MoH (ENAP)
SNYP+
WHO
CANGO
PSHACC (MoPS)
Kwakha Indvodza
FHI360



EXECUTIVE SUMMARY

The Eswatini National HIV Strategic Framework (NSF) for 2024-2028 sets a visionary course to combat HIV and AIDS, guided by ambitious yet attainable impact targets for the period 2024-2028.

Notably, Eswatini has made significant progress in achieving the UNAIDS 95-95-95 goals, with high awareness of HIV status, ART treatment coverage, and HIV viral suppression rates.

Lessons Learned: In the fight against HIV in Eswatini, critical lessons have emerged from the NSF 2018-2023. Ongoing awareness and education efforts are essential to reduce stigma and support those living with HIV. Early detection and prompt intervention have proven crucial for better health outcomes and reducing HIV transmission. Integrating health information systems has improved efficiency and coordination in the HIV response. Tailoring interventions to the specific needs of high-risk groups, ensuring sustainable funding, and active community involvement have been vital in the effectiveness of HIV initiatives. Continuous refinement of strategies is needed to address issues like gender disparities, and a data-driven approach is crucial for adaptive and evidence-based strategies. These lessons shape current and future strategies in Eswatini's fight against HIV.

Review of the NSF (2018-2023): The development of the 2024-2028 NSF involved a comprehensive review of the previous framework (2018-2023). This review was critical in identifying gaps, challenges, and gathering recommendations to shape the strategies of the new plan. It highlighted the need for precision prevention for those at high risk, equitable access to testing, care, and treatment for all PLHIV, the importance of removing structural barriers, promoting social enablers, and the necessity of resilient and sustainable approaches for long-term effectiveness.

Vision: The NSF 2024-2028 for HIV in Eswatini sets a transformative vision: ending AIDS as a public health threat by 2030. This vision aligns with global AIDS strategies and the Sustainable Development Goals.

Mission: The mission is to intensify investments in community-led and person-centred multisectoral approaches, enabling Eswatini to attain and sustain epidemic control in all subpopulations and geographic locations.

Impact Level Targets: To support the goal to end AIDS by 2030, the NSF has made achieving the following population level impact targets a priority:

1. Reduction of HIV incidence among persons aged 15+ years from 0.62 in 2021 to 0.31 in 2028.
2. Reduction of HIV incidence among females aged 15 – 49 from 1.45 in 2021 to 0.73 in 2028.
3. Reduction of MTCT from 1.34% in 2023 to less than 1% in 2028.
4. Reduction of AIDS-related deaths from 55% in 2023 to 70% in 2028.

Strategic Priorities: The NSF identifies 5 key priorities:

1. **Optimize HIV Testing and Linkage Services:** Addressing gaps in testing and linkage, especially among key and priority populations
2. **Precision Prevention of New HIV Infections:** Targeted and effective prevention strategies including tailored biomedical, behavioural, and structural interventions.
3. **Addressing Emerging Gaps in Care and Treatment:** Ensuring equitable access for all PLHIV. This involves equitable access to care and treatment.
4. **Eliminate Structural Barriers and Promoting Social Enablers:** Enhancing the environment for better HIV outcomes by eliminating barriers and promoting social enablers for optimal outcomes in the prevention and management of HIV, TB, and STIs.
5. **Promoting Resilient and Sustainable Systems:** Ensuring long-term effectiveness of the HIV response. This includes strengthening response systems, service delivery, sustainable financing, and resource mobilization.

NSF development process: The development of Eswatini's National HIV Strategic Framework (NSF) 2024-2028 for addressing HIV, TB, and STIs was a comprehensive and participatory process involving a wide range of stakeholders, coordinated by the National Emergency Response Council on HIV and AIDS (NERCHA). Key steps in the development included:

- **Review of Previous National HIV Strategic Framework (NSF 2018-2023):** A thorough assessment was conducted to evaluate progress, identify gaps, challenges, and gather recommendations to shape strategies for the new plan.
- **Epidemiological Analysis:** An analysis of Eswatini's HIV epidemiology was performed to understand the current epidemic status and prioritize interventions in the new strategic plan.
- **Progress Review of the HIV Program:** The existing HIV program was evaluated to assess progress against targets, identify program coverage gaps, and highlight challenges for the new plan.
- **Stakeholder Consultation:** Diverse stakeholders, including key populations, civil society and faith-based organizations, the private sector, government, academia, and development partners were involved in the development process to identify gaps and effective strategies for the new plan.

- **Review of the Draft Strategic Framework:** An extensive review of the draft strategic framework was conducted by technical teams, national stakeholders, and external experts, all inputs were incorporated, and a wide stakeholder engagement in the form of a validation meeting was held to finalize the document.
- **Target Setting and Costing:** Setting targets based on different coverage scenarios to reduce HIV incidence and deaths, using the Goals Model for prioritization, and conducting costing and investment analysis to estimate required resources and inform decision-making.

This structured and inclusive approach ensured that the NSF 2024 - 2028 is a well-rounded, evidence-based strategy to effectively tackle HIV, TB, and STIs in Eswatini.

Implementation and Coordination: To implement the NSF strategic priorities, NERCHA will support the development of a multi-faceted operational plan. This includes setting precise targets at the national, regional and inkhundla levels formulating corresponding work plans for each level. A critical component is our comprehensive monitoring and evaluation (M&E) plan, designed to track progress and impact meticulously. NERCHA will regularly review progress, at the national, regional, and inkhundla levels, to ensure alignment with this National Strategic Framework (NSF). These reviews will be collaborative, involving coordination teams from both national and regional tiers. To facilitate real-time monitoring and rapid response, NERCHA will manage an interactive dashboard. The dashboard will provide immediate feedback and allow for dynamic adjustments of strategies to ensure that the country remains on track.

This NSF also targets humanitarian and emergency situations i.e., it aims to guarantee uninterrupted access to essential services even in times of crisis. At the heart of this approach is NERCHA, who will play an indispensable role, providing leadership, advocacy, and coordination among a diverse range of sectors and stakeholders. The implementation of the Eswatini NSF for 2024-2028 will be centered on three fundamental pillars: efficient coordination, rigorous monitoring, and effective execution of our strategies collaboratively. This NSF reflects a collective resolve and a unified dedication to significantly improve HIV outcomes throughout the Kingdom of Eswatini.

CHAPTER 1: INTRODUCTION

1.1 Background

1.1.1 Population Context

Eswatini is a small landlocked country in Southern Africa, bordered by South Africa and Mozambique. It covers an area of 17,364 km and has a population of 1,093,238 (48.6% males, 51.4% females)(1). The life expectancy was 59.69 years in 2020, with a population growth rate of 1.0% (2). The country has a young population; 36% of which are children aged 0 to 14 years. Eswatini is divided into four administrative regions: Hhohho, Manzini, Shiselweni, and Lubombo. Manzini has the highest population at 33%, followed by Hhohho at 29%(1).

1.1.2. Economy

Eswatini is classified as a lower middle-income country with a gross domestic product (GDP) of US$ 3,962 per capita in 2021(IMF 2022). In addition, Eswatini is ranked 112 out of 190 countries in the "World Bank's Doing Business" ranking (3). The country exhibited a consumption per capita Gini index of 54.6 in 2017, reflecting high inequality. In Eswatini, poverty affects 59% of the population; 21% of young individuals live in extreme poverty, particularly in rural areas where the poverty incidence rate is as high as 70% (World Bank 2023 report). Approximately 32% of the population lived below the international poverty line of $2.15/day, while 55% were under the lower-middle-income country poverty line of $3.65/day (3).

Eswatini is currently recovering from COVID-19-induced challenges and the political civil unrest which took place in 2021 both of which threatened the prospects of economic growth. At the end of 2022, the International Monetary Fund (IMF) reported that Eswatini's economy was comparatively resilient through the COVID-19 pandemic following a strong rebound of 7.9 percent in 2021, and real GDP growth stagnated in 2022 by 0.4 percent. The IMF projected a 3.2% real GDP growth in 2023 and the rise in GDP was to be supported by agricultural production, manufacturing, and higher government capital spending.

1.2 Eswatini's HIV Epidemic Landscape

1.2.1 Overview of HIV and AIDS

The Kingdom of Eswatini has made strides in the HIV response through political commitment, intensified national efforts on treatment and prevention, reduction of stigma and discrimination, and equitable access to services for all. Access to antiretroviral therapy has increased by 76% (from 2010 – 2022), AIDS-related deaths have declined by over 67% (from 2010-2022), and new HIV infections declined by 71% (from 2010-2022)(4). Due to the significant strides made in the HIV response, Eswatini is one of the first countries to reach the 95-95-95 global targets.

1.2.2 HIV Epidemiological Context

The data for key HIV indicators (annual incidence, prevalence and viral load suppression (VLS)) obtained from the third Eswatini HIV Incidence Measurement Survey (SHIMS 3), an Eswatini Population-based HIV Impact Assessment (PHIA) are summarized in Table 1 (5).

Table 1: Eswatini HIV incidence

HIV Indicator	Women	95%	Men	95% CI	Total	95% CI
Annual incidence						
15-49 years	1.45	0.69-2.20	0.20	0.00-0.48	0.77	0.39-1.15
15 years and older	1.11	0.53-1.68	0.17	0.00-0.41	0.62	0.31-0.93

1.2.2.1 HIV incidence

Table 1 shows that Eswatini had an estimated HIV annual incidence of 0.62% among adults aged 15 years and older (~4,000 new HIV cases/year among adults). The incidence was seven times higher among women (1.11%) than men (0.17%). Among adults aged 15-49 years, the HIV incidence in women was almost twice this population's incidence at 1.45% (5).

The incidence declined from 1.13% in 2016 to 0.62 % in 2021 (Table 2). Similarly, HIV incidence among adolescents and young people aged 15 to 24 years decreased from 2.3% in 2010 to 1.0 % in 2020, and it was projected to further decline to 0.8% in 2023 (5).

Table 2: Eswatini HIV incidence

HIV Indicator	SHIMS 2 (%)	SHIMS 3 (%)
Annual percentage of new infections		
Adults aged 15 years and older	**1.13**	**0.62**
Females	1.41	1.11
Males	0.85	0.17
Adults aged 15 – 49 years	**1.28**	**0.77**
Females	1.73	1.45
Males	0.85	0.20

1.2.2.2 HIV Prevalence

The SHIMS 3 report revealed a national HIV prevalence of 24.8% (~185,000 adults living with HIV), which was higher among women aged 15 years and older (30.6%) compared to their male counterparts in the same age group (18.7%), as shown in Table 3 below.

Table 3: Eswatini's HIV prevalence

HIV Indicator	Women	95%	Men	95% CI	Total	95% CI
Prevalence (%)						
15-49 years	31.6	29.8-33.4	15.6	14.3-16.9	23.7	22.6-24.9
15 years and older	30.6	28.8-31.9	18.7	17.4-20.0	24.8	23.7-25.9

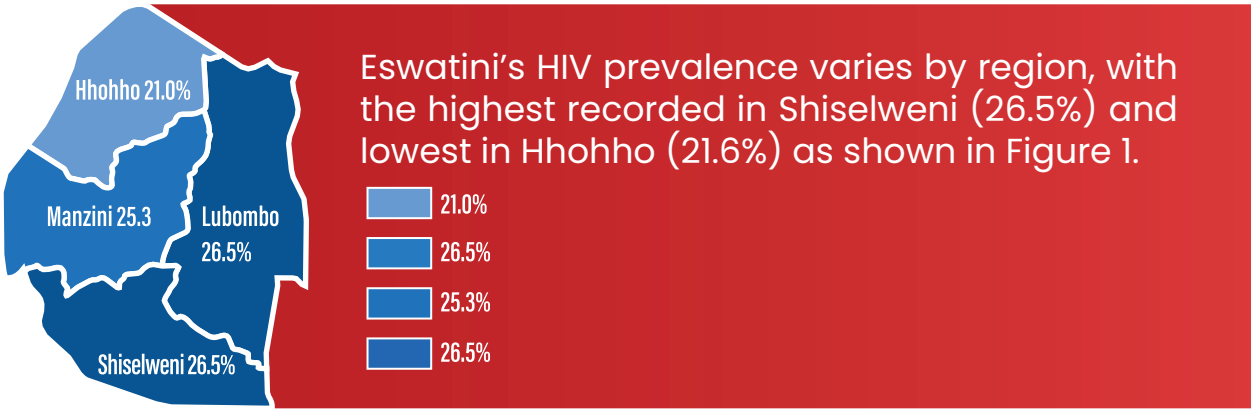
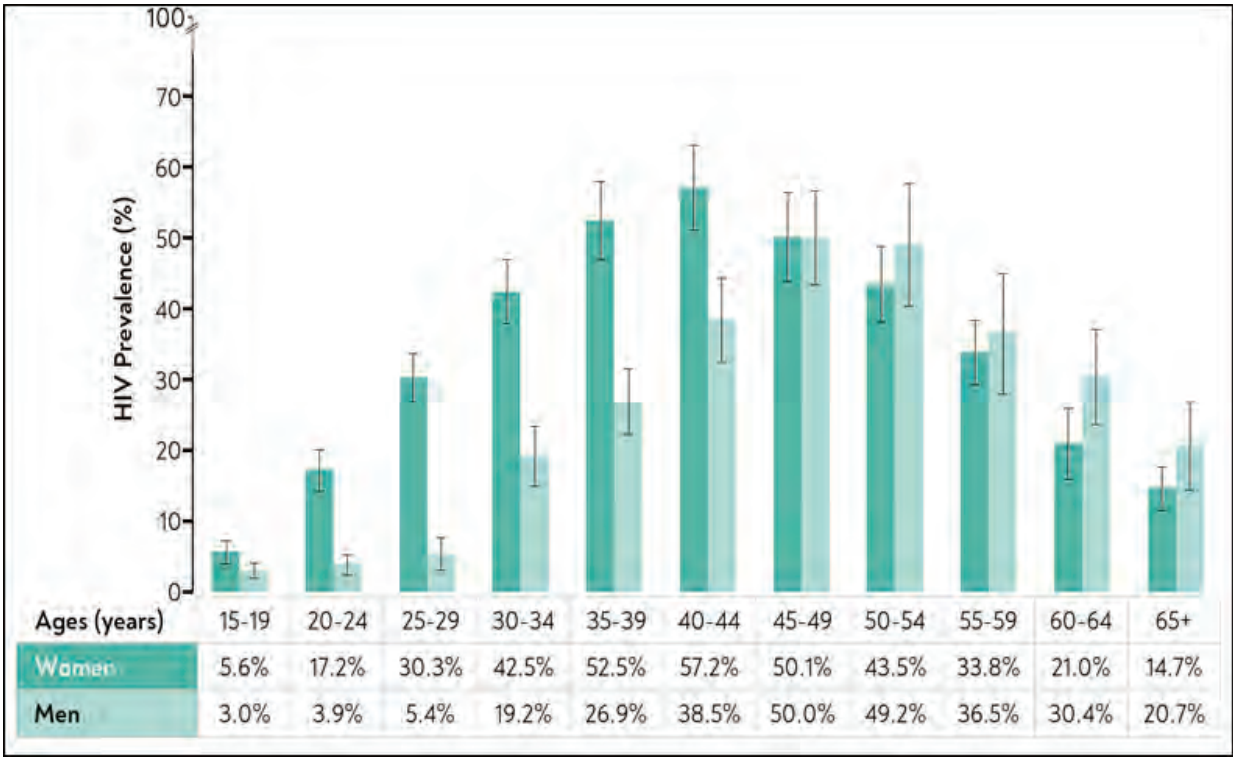


Figure 1: HIV Prevalence by Region

The population of people living with HIV (PLHIV) is aging. Figure 2 shows a 50% prevalence in the 45-49 year-old age category for both men and women. More than half the women in the age groups between 35-49 years are living with HIV. Among PLHIV aged 25-29 years, HIV prevalence was more than 5 times higher among women than men, however, HIV prevalence is higher among men aged above 50 than women. HIV prevalence is higher among men in their early 30s than among younger men (5).



Ages (years)	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Women	5.6%	17.2%	30.3%	42.5%	52.5%	57.2%	50.1%	43.5%	33.8%	21.0%	14.7%
Men	3.0%	3.9%	5.4%	19.2%	26.9%	38.5%	50.0%	49.2%	36.5%	30.4%	20.7%

Figure 2: HIV Prevalence by Age and Sex

HIV Prevalence Among Key and Vulnerable Populations
The Integrated Biological-Behavioural Surveillance Survey (IBBSS) conducted in 2021 indicates that MSM, FSWs, and Transgender (TG) people higher burden of HIV, with HIV prevalence rates of 21%, 58%, and 41.2%, respectively as shown in Figure 3 (6).

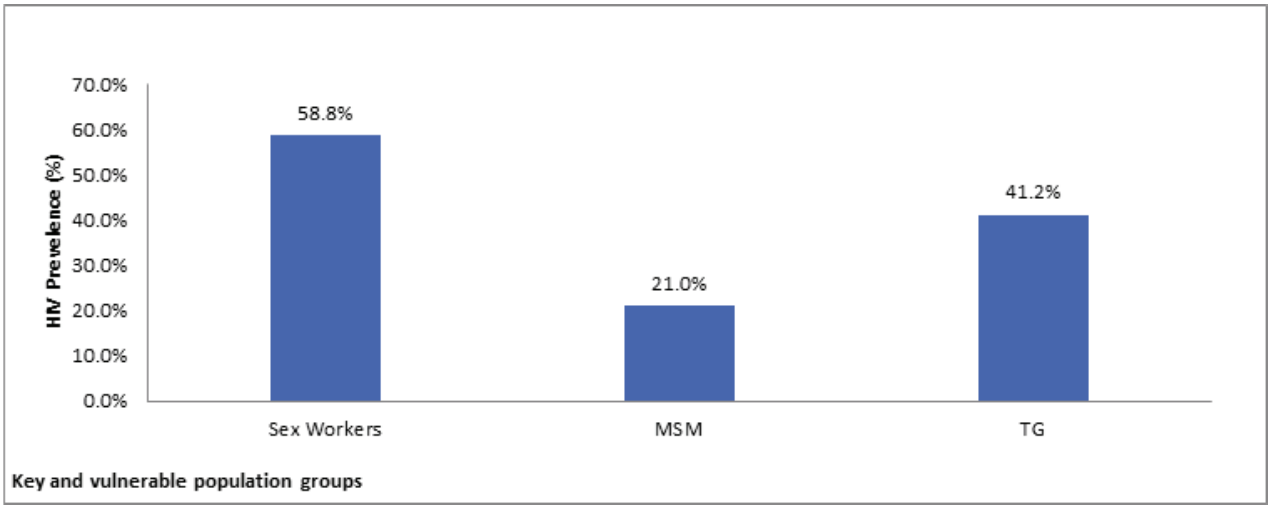


Figure 3: HIV Prevalence Among Key and Vulnerable Populations

Key populations in Eswatini are defined as groups of people at higher risk of contracting HIV. These include men who have sex with other men (MSM), sex workers (SWs), TG people, people who inject drugs (PWID) and people in correctional facilities. Vulnerable populations are identified as mobile populations, people living with disability (PWD) and young women (aged 15-24 years). Mobile populations include factory workers, cane cutters (seasonal workers), transport operators, construction workers, long-distance truck drivers and uniformed forces. These population groups are mainly vulnerable to HIV Infection in certain situations or contexts.

1.2.2.3 Viral load suppression

The overall viral load suppression (VLS) for PLHIV aged 15 years and older was 88.6% as shown in Table 4 .

Table 4 : Eswatini's Viral Load Suppression among adults

HIV Indicator	Women	95%	Men	95% CI	Total	95% CI
Viral Load Suppression (%)						
15-49 years	88.6	87.0-90.2	82.4	79.3-85.5	86.6	85.0-88.1
15 years and older	90.1	88.7-91.4	86.1	83.6-88.6	88.6	87.4-89.9
Viral load suppression is defined as HIV RNA <1000 copies per milliliter among all HIV-positive adults.						

Furthermore, Eswatini recorded a VLS of more than 90% among women living with HIV (WLHIV) aged 35 years and older, and men living with HIV (MLHIV) aged 45 years and older as shown in Figure 4.

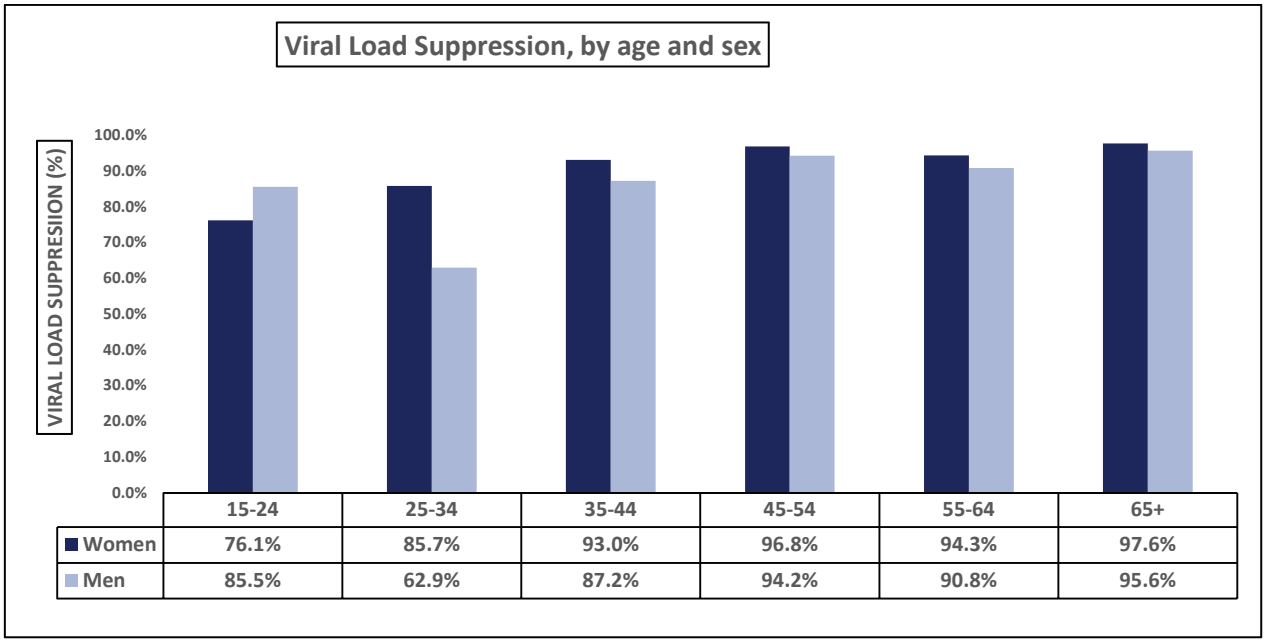


Figure 4: Eswatini's Viral Load Suppression, by age and sex (SHIMS 3; error bars represent 95% CIs)

The VLS prevalence increased to 97.6% (WLHIV) and 95.6% (MLHIV) among those aged 65 years and older. Viral load suppression was substantially lower among young women aged 15-24 years (76.1%), and among men aged 25-34 years (62.9%) as shown in Figure 3. Differences observed in VLS by region (87.7% in Manzini, 88.9% in Lubombo, 89.2% in Hhohho, and 89.6% in Shiselweni) were not statistically significant (5).

1.2.3 AIDS-Related Mortality

Between 2010 and 2021, AIDS-related deaths across all age groups declined by 57% (7). None the less, approximately 2,400 adults (aged ≥ 15 years) and about 200 children (aged ≤ 14 years) succumbed to AIDS in 2021 (Table (5).

Table 5: Trends in AIDS-related Deaths in Eswatini

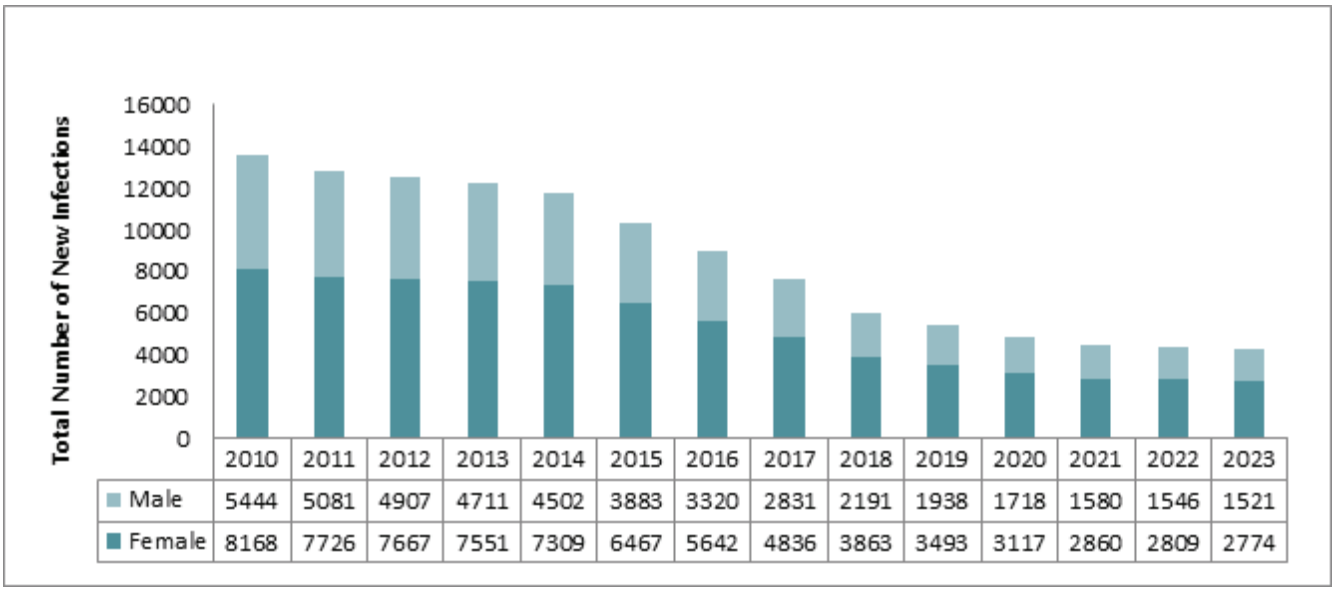
Indicator	2010	2015	2021
AIDS-related deaths (all ages)	6,000	3,500	2,600
AIDS-related deaths (0-14 years)	1,300	<500	<200
AIDS-related deaths (women, 15+)	2,600	1,800	1,400
AIDS-related deaths (men, 15+)	2,100	1,300	1,000

Children are disproportionately affected. HIV-related mortality continues to fall as ART treatment coverage and viral suppression improves. However, significant interruptions in treatment occur within the first year of treatment, particularly among females 20-29 and males 25-39 years of age, culminating in patient loss, especially among men (8). Eswatini needs to continue strengthening patient preparation for ART, extend psychosocial support through the first six months of treatment to address early disengagement from care, provide on-going psychosocial support to identify and address barriers to treatment, and continue to provide advanced HIV care to reduce mortality among older men. Another factor that can explain continued high mortality is poor health-seeking behaviour, especially among men, who seek treatment services when the disease is well advanced.

1.2.4 Social and Structural Drivers of New HIV Infection

New HIV infections are driven by various factors, including inequality and vulnerability. Income disparities, gender disparities, spatial inequalities, and policy barriers contribute to the transmission of HIV. Priority populations, such as AYP, women, persons with disabilities (PWD), KPs, and children are the most vulnerable. Among these population groups, economically disadvantaged AGYW residing in rural areas face heightened vulnerability(9).

Also, there are gaps in case finding among key and priority population groups, including AGYW, men aged 25-34, MSM, and SWs. Adolescent girls and young women aged 15-24 are disproportionately affected, experiencing higher rates of recent HIV infections (Figure 5).



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Male	5444	5081	4907	4711	4502	3883	3320	2831	2191	1938	1718	1580	1546	1521
Female	8168	7726	7667	7551	7309	6467	5642	4836	3863	3493	3117	2860	2809	2774

Figure 5: Estimated Total Number of New HIV infections, 2010-2023

Addressing the drivers of new HIV infections requires targeted interventions and strategies that address inequality, improve case finding, empower AGYW, and promote HIV testing and awareness among priority populations.

The MICS 2023 illustrates the drivers of new HIV infections in Eswatini (Table 6).

Table 6: Drivers of new HIV infection

Driver	Description
Low condom usage	• Condom usage at last sex among people with multiple sexual partnerships was 62.2% for females and 69.7 for men (10) • Condom use with nonregular partners is low for women (72%) compared to men at (87.3%) (10).
Low awareness of HIV-positive status	• Females 15-24 years (83.6%) and males 25-34 years (74.8%) have the lowest awareness of their HIV-positive status. • There are gaps in case finding among key and priority population groups, including AGYW, Pregnant and Breastfeeding Women (PBFW), men aged 25-34, TG, PWID, people in correctional facilities, mobile and migrant population, and PWD. • Percentage of sexually active men who have been tested for HIV in the last 12 months and know their HIV status is low (56.4%).
Low access to or take-up of pre-exposure prophylaxis (PrEP)	• Limited PrEP awareness. • Limited availability and accessibility of a variety of ARV-based prevention interventions, especially for key and other priority populations.

Driver	Description
Treatment interruption	• Adherence to ART among males 25-34 is low (86.8%) (SHIMS 3 report 2021). • Adherence to ART continues to be a significant challenge among individuals living with HIV. • The youth aged 15-24, both males (13.5%) and females (9.6%), are not virally suppressed (5).
Gender-based violence	• Women and girls are disproportionately affected by gender-based violence. • 48% of women have experienced Intimate Partner Violence (IPV). • 1 in 3 females experience sexual abuse by the age of 18 (11). • High occurrences of child sexual abuse and violence against children.
Poverty and unemployment	• Poverty and unemployment expose youth to risky relationships and hinder secure livelihoods for adolescents. • In 2022, about 32% of Eswatini lived below the $2.15/day international poverty line. • Unemployment rates peaked at 33.3% in 2021, with youth at 48% (12).
Inter-generational sex	• Intergenerational sex is notably high among females (31.8%) (13). • High HIV prevalence in females aged 20-29 (17.2%-30.3%) compared to their male peers (3.9%-4.9%) (5). • AGYW vulnerability due to socialization, culture, and gender norms. • Poor prevention knowledge and poverty hinder safe sex negotiation.
Low HIV knowledge among AYP	• Limited HIV prevention knowledge among youth. • Only 49% of young women (aged 15-24) and 51% of young men(aged 15-24) had sufficient knowledge(10).

1.3. Progress toward UNAIDS 95-95-95 targets

Despite having the highest HIV prevalence globally, Eswatini is on the verge of achieving epidemic control, with those 35 years and older having met the targets required for epidemic control. Eswatini has successfully met the ambitious 95-95-95 fast-track targets as shown in figure 6. According to SHIMS 3, in 2022, 93.7% people in Eswatini were aware of their HIV-positive status, 97.3% were on ART; and of these 96.2% were virally suppressed, as shown in Figure 4.

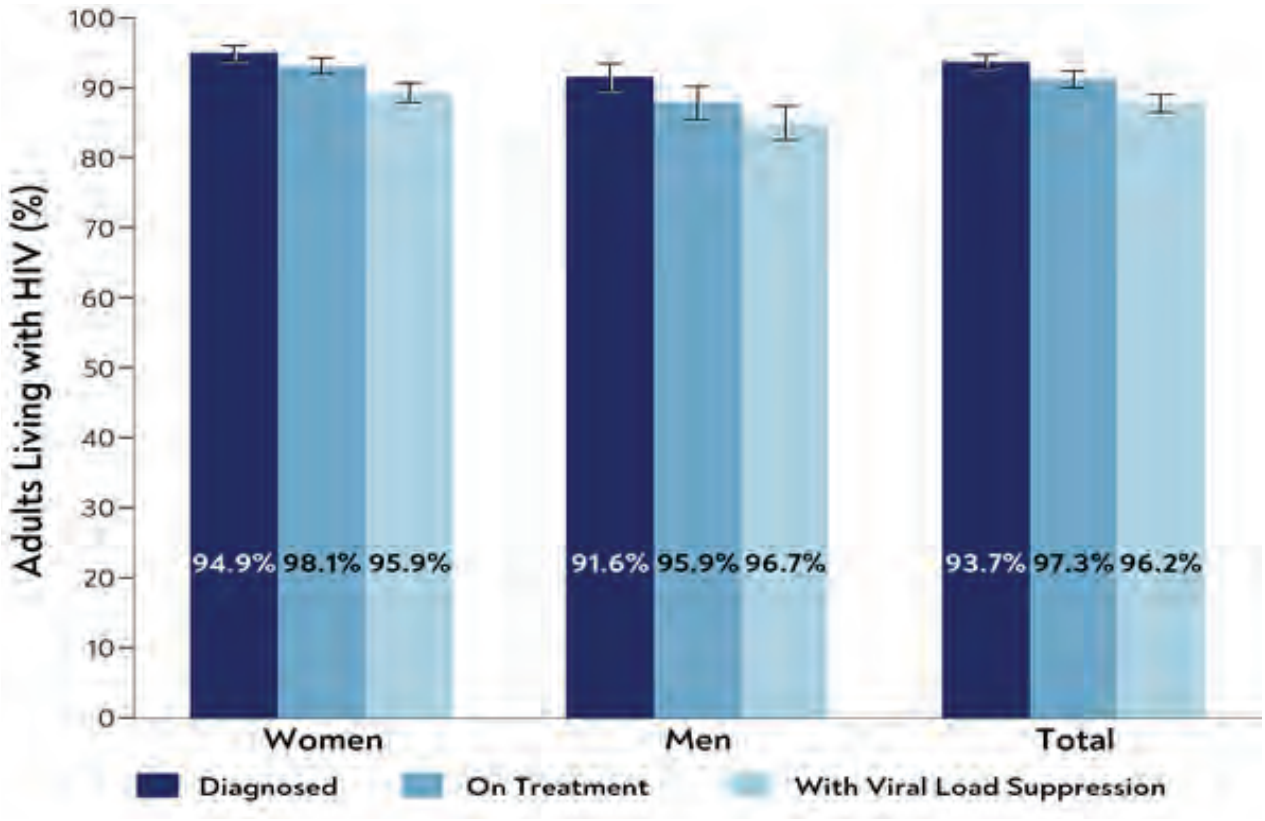


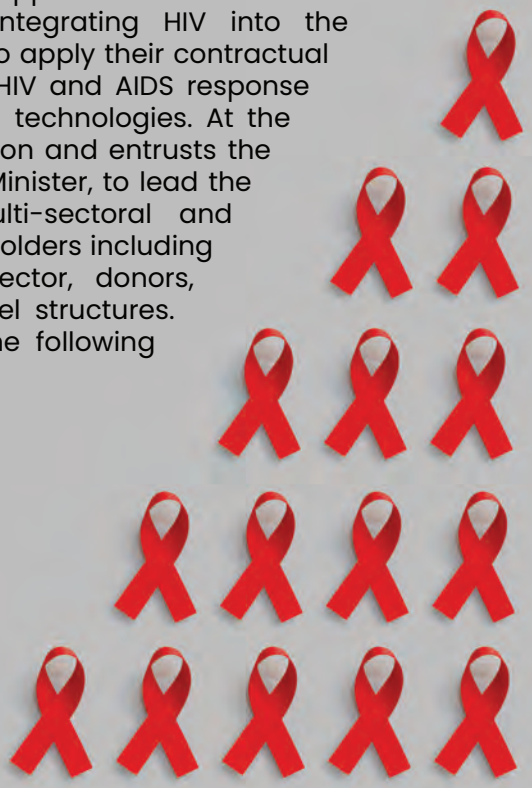
Figure 6: Eswatini's achievement of the 95-95-95 targets, by sex (Adapted from SHIMS 3)

More efforts are needed to reach marginalized and vulnerable populations, including children 15 years and below, AGYW (15-29), young men (25-34), and KPs, who face challenges in case finding and linkage to treatment.

Despite this key achievement, some subpopulations still lag and threaten to reverse these hard-earned gains. Some of the population groups lagging include key populations, adolescent girls and young women, men aged 15 to 34 years, and children below 14 years. Case-finding efforts are now focused on closing gaps in testing and treatment to address the remaining challenges.

1.4 Management and Coordination of the HIV Response

Eswatini has received sustained high-level political and policy support. The Prime Minister's Office provides leadership in multi-sectoral coordination, integrating HIV into the Government's agenda and calling upon government ministries to apply their contractual obligation. The Ministry of Health's (MoH's) contribution to the HIV and AIDS response focuses on improving access to HIV treatment and prevention technologies. At the national level, His Majesty King Mswati III calls the nation to action and entrusts the Head of Government, His Excellency the Right Honorable Prime Minister, to lead the response through NERCHA. Hence NERCHA leads the multi-sectoral and decentralised coordination and service delivery to various stakeholders including government, civil society, people living with HIV, private sector, donors, development partners, regional, inkhundla and community level structures. However, despite these existing management mechanisms, the following gaps and challenges have been noted:



- Lack of Integrated M&E system, with the NERCHA M&E system needing certain features for interoperability.
- Underutilized and suboptimal data quality to drive the response.
- Insufficiencies in sustainable funding mechanisms.
- Inadequate community engagement and participation in the response.
- Heavy dependence on external support and human resources for health.

1.5 Financing of the HIV Response

Eswatini, despite its classification as a lower-middle-income country, faces economic challenges more typical of a low-income country, including a weak business environment, low foreign investment, significant income disparity, and widespread poverty. Furthermore, funding for the HIV response in Eswatini heavily relies on external development partners, particularly the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund (GF). This external support is complemented by contributions from other partner initiatives in different geographical areas. National expenditure assessments, including the National AIDS Spending Assessment (NASA) and National Health Account (NHA), indicate that the HIV response funding is split between donors and the Government in a 60:40 ratio.

Despite these substantial investments, a significant funding gap exists due to minimal funding from the Government. To address this challenge, Eswatini needs to focus on enhancing domestic and international resource mobilization, building financial management capacity for Civil Society Organization (CSO) and improving the efficiency of the currently available resources.

1.6 Summary of Achievements, Gaps, Challenges and Recommendations

Under NERCHA's coordination, Eswatini has made significant progress in implementing the NSF 2018 - 2023. In the context of health, though there were social and economic disruptions and challenges associated with the COVID-19 era, Eswatini achieved the global UNAIDS targets of 95-95-95 in advance of the 2025 target date, providing clear evidence of the effectiveness of the country's HIV treatment programs. Furthermore, the observed decline in HIV incidence show the effects of expanding treatment coverage and adherence and the benefits of using the treatment as a prevention approach.

However, gaps remain in the HIV response. For example, women continue to bear a higher risk of contracting HIV than men, as more than half the Women Living with HIV (WLHIV) are aged between 35 and 49 years. There is a significant disparity in incidence between adult men (0.17%) and women (1.17%). Although Eswatini's overall VLS is high, men aged 25-34 years are lagging in achieving VLS (5). While the expansion of Voluntary Medical Male Circumcision (VMMC) provided additional prevention benefitsfor men, intensified evidence-based prevention interventions are needed to further reduce the risk of HIV acquisition among women, particularly young women.

Table 7 summarizes achievements across all the HIV response areas, the remaining gaps and challenges, and recommendations for the NSF 2024 – 2028 based on the review of the 2018 – 2023 NSF. These will form a basis of the focus areas to be addressed.

Table 7: Summary of achievements, gaps, challenges, and recommendations

Key issue	Description
Achievements of the NSF 2018-2023	• **Surpassing UNAIDS Targets**: Eswatini exceeded the UNAIDS treatment and viral suppression targets ahead of the 2025 target date; achieving 94-97-96 in 2021(5). • **Universal ART Initiation**: Adoption of the WHO "Treat All" recommendation, enabling universal antiretroviral therapy (ART) initiation for those diagnosed with HIV. • **Self-testing Africa (STAR) Initiative**: Participation in UNITAID's multi-country STAR initiative, promoting HIV self-testing. • **Transition to DTG-Based ART Regimen**: Switching all HIV-infected adults on ART to a Dolutegravir (DTG)-based regimen, enhancing treatment efficacy. • **DSD Models Implementation**: Implementation of differentiated service delivery (DSD) models, including multi-month dispensing of ARVs to reduce treatment interruptions. • **High PMTCT Coverage**: Achieving 95% coverage in the Prevention of Mother-To-Child Transmission (PMTCT) program; with a vertical transmission rate below 0.05 (14) • **Expansion of TPT**: Doubling the uptake of Tuberculosis Preventive Therapy (TPT) and increasing completion rates to 92%. • **Community ART Distribution during COVID-19**: Implementing community-based ART distribution to maintain treatment continuity during the pandemic. • **Low Annual HIV Incidence**: Achieving an overall annual HIV incidence of 0.62 in the general population. • **Significant Reduction in AIDS-Related Mortality**: Recording a 53% reduction in AIDS-related mortality. • **Introduction and scale-up of PrEP services**: More than 200 public health facilities are now offering various PrEP options

Lessons learned	• **Awareness and Education**: Ongoing campaigns and education reduce stigma and discrimination against people living with HIV (PLHIV).
	• **Early Detection and Swift Intervention**: Prompt action and early HIV detection are crucial for improving health outcomes and reducing transmission.
	• **Integrated Health Information Systems**: Centralizing health data improves intervention efficiency, service delivery, and healthcare coordination.
	• **Tailored Interventions**: Customizing approaches to address the specific needs of high-risk and vulnerable groups is essential.
	• **Sustainable Funding**: Establishing long-term funding mechanisms is vital, especially given the reliance on international donors.
	• **Community Engagement**: Active community involvement is crucial for successful health initiatives, as seen in ART distribution during COVID-19.
	• **Ongoing Strategy Refinement**: Meeting global HIV targets is just a step; continuous strategy improvement is needed to address persistent issues like gender and structural disparities.
	• **Global Health Security (GHS)**. GHS ensures that the country is ready and prepared to respond to any kind health emergencies. This must focus on:
	  ○ Integration of other disease programs such as NCDs with our PLHIV aging.
	  ○ Using a holistic approach to strengthen antimicrobial resistance (antivirals, antibiotics) surveillance and monitoring.
	  ○ Using a holistic approach to strengthen antimicrobial resistance

Key issue	Description
	(antivirals, antibiotics) surveillance and monitoring. o Pharmacovigilance for clients on ARVs
Recommendations for NSF 2024 – 2028	• ***Optimizing Primary Prevention:*** Focusing on primary prevention for Adolescent Girls and Young Women (AGYW), Adolescent Boys and Young Men (ABYM), and Key Populations (KP), including safe sex practices, contraception access, PrEP, and PMTCT for pregnant women living with HIV. • ***Tailored Case-Finding Strategies:*** Developing culturally sensitive and accessible outreach programs and testing services for diverse groups like AGYW, men aged 25-34, FSWs, MSM, uniformed services and children. • ***Closing Treatment Gaps:*** Identifying and addressing treatment gaps, particularly in specific populations such as men aged 25-34 and military personnel, by improving testing and treatment access, reducing stigma, and offering targeted interventions. • ***Institutionalizing Client-centred Approaches:*** Implementing client-centred healthcare to support treatment adherence, prevent attrition from care, ensuring continuity of treatment through personalized care plans, and patient involvement in decision-making. • ***Addressing Social and Structural Barriers:*** Addressing harmful gender norms and human rights barriers, involving men and boys in awareness campaigns and education to change attitudes, promoting health-seeking behaviors, and supporting gender equalities. • ***Addressing economic vulnerabilities:*** Lower economic status is one dimension of girls' and young women's vulnerability to HIV. As such, economic empowerment initiatives are necessary to reduce their vulnerability to HIV. Though "successful" economic approaches may not have a direct effect on HIV incidence, they may reduce conditions of vulnerability and improve the resilience of girls to manage risks in their environments. Economic approaches need to be developed carefully to consider the needs, aspirations, constraints, and capabilities of girls and young women in various settings. • ***Strengthening Community-Led Systems:*** Empower communities in the response to HIV through initiatives that bridge healthcare gaps, promote awareness, and support affected individuals. • ***Adopting Innovative Financing Approaches:*** Seeking sustainable domestic financing for HIV, TB, and STI responses, exploring new financing mechanisms like health insurance, public-private partnerships, and social impact bonds. • ***Enhancing Coordination:*** Ensuring effective coordination across sectors and organizations to comprehensively respond to HIV, TB, and STIs, building strategic alliances and partnerships for better resource use and broader intervention impact.

CHAPTER 2: THE STRATEGIC DIRECTION

The Eswatini National Multisectoral HIV and AIDS Strategic Framework (NSF) 2024-2028 is designed to align with and draw inspiration from various global, regional, and national policies and frameworks that guide the efforts to combat the HIV epidemic. The NSF 2024–2028 comprises a set of evidence-informed strategies focused on building resilient and sustainable health systems with a clear focus on a people-centred approach focused on community systems strengthening and a well-coordinated multi-sector response. The NSF 2024-2028 reflects the collective efforts of stakeholders and aims to effectively address the challenges and achieve the desired outcomes in the national response to HIV, TB, STIs, and other emerging public health threats in Eswatini. It shares a common vision, goal, and a set of targets with the Global AIDS Strategy 2021-2026 and the Sustainable Development Goals (SDGs), ensuring a cohesive and comprehensive approach on a global scale.

2.1 Vision:
To end AIDS as a public health threat by 2030 in Eswatini.

2.2 Mission:
To intensify investments in community-led and person-centred multisectoral approaches, enabling Eswatini to attain and sustain epidemic control in all subpopulations and geographic locations.

2.3 NSF impact targets:
To realize this vision, Eswatini aims to achieve the following impact targets by 2028:

1. Reduction of HIV incidence among persons aged 15+ years from 0.62 in 2021 to 0.31 in 2028.
2. Reduction of HIV incidence among females aged 15 – 49 from 1.45 in 2021 to 0.73 in 2028.
3. Reduction of MTCT from 1.34% in 2023 to less than 1% in 2028.
4. Reduction of AIDS-related deaths from 55% in 2023 to 70% in 2028.

2.4 Strategic Priorities

The NSF is a holistic and integrated framework that comprises various essential and interdependent components and strategic priorities. Each strategic priority complements and reinforces the others, aiming to establish a unified and effective approach to the AIDS vision. The strategic priorities are:

1) Optimize HIV testing and linkage services for key and priority populations to close the gaps in the HIV care continuum.
2) Precision prevention of new HIV infections among all Emaswati at high risk of HIV acquisition.
3) Address emerging gaps and ensure equitable access to care and treatment for all PLHIV.
4) Eliminate structural barriers and enhance social enablers to achieve HIV outcomes.
5) Promote resilient and sustainable approaches to ensure the long-term effectiveness of the HIV response.

2.5 Guiding Principles

The guiding principles align with the Global AIDS Strategy 2021-2026, the WHO Global Health sector strategy on HIV 2022-2030, and Eswatini's "HIV Prevention 2025 Road Map: Ending AIDS as a Public Health Threat by 2025". The guiding principles will shape the culture of the national HIV response, and ensure that all stakeholders (beneficiaries, PLHIV, key and vulnerable populations, service providers, communities, government, civil society, private sector, and development partners) understand the expectations in implementing the NSF. The following guiding principles are key to the implementation of NSF:

- **Accountability for HIV Prevention:** The NSF calls for accountability from all sectors i.e., service providers and beneficiaries, policymakers, and development partners that is anchored on the principles of shared and common interests, resources, risks, and benefits
- **Data-driven HIV response:** Comprehensive data collection and analysis are key for informed decision-making and adaptive HIV response strategies.
- **People-Centred Interventions:** The NSF will ensure meaningful engagement and participation of key and vulnerable populations at all levels of planning, capacity building, resource mobilization, implementation, service delivery, monitoring, review, and evaluation.
- **Protection, Respect, and Fulfilment of Human Rights:** The planning and delivery of all services will be anchored on promoting, protecting, and fulfilling key and vulnerable populations' human rights. Special attention will be paid to addressing stigma and discrimination and removing policy and legal barriers to accessing services.
- **Social and Economic Inequalities:** The strategic framework advocates for gender-sensitive and responsive interventions that address both social and economic inequalities.
- **Multi-sectoral and Decentralised Approach:** The NSF will expand the scope of the HIV response by strengthening and harmonising the multisectoral approach with emphasis on reaching out beyond the health sector, including community engagement.
- **Political Leadership and Commitment:** Strong political leadership and commitment, good governance, and accountability for the HIV response at all levels and sectors is critical.

CHAPTER 3: STRATEGIC PRIORITIES AND FOCUS AREAS

3.1 Conceptual Framework

The NSF 2024-2028 identifies five interlinked strategic priorities, each with focus areas and strategic recommendations as detailed in this chapter. The focus areas are designed to address emerging gaps to ensure equitable access to the nation's prevention, care, treatment, and support services. The priorities are centred around a renewed focus on a comprehensive combination of precision prevention strategies and continuity of care for key and vulnerable population groups.

The country acknowledges that person-centred precision prevention is about focusing the right intensity on people's needs. Precision prevention approach will contribute to the achievement of optimal prevention outcomes and reductions in HIV incidence. The NSF advocates for co-creation with communities, a mix of intensive prevention packages for populations with the highest HIV incidence (key populations and adolescent girls, boys, women, and men in communities). The NSF emphasizes equitable approaches involving removing gender and human rights barriers and promoting social enablers to ensure equal uptake of services across diverse populations.

Lastly, the NSF emphasizes resilience and sustainability as priorities. These include sustainable health financing to maintain the effectiveness of the response in the long term. Strengthening health systems through integration, efficiency, and technological innovation is a key priority. Emergency preparedness and empowering and engaging communities is vital, particularly during pandemics and public health emergencies, to foster community-led interventions and enhance resilience.

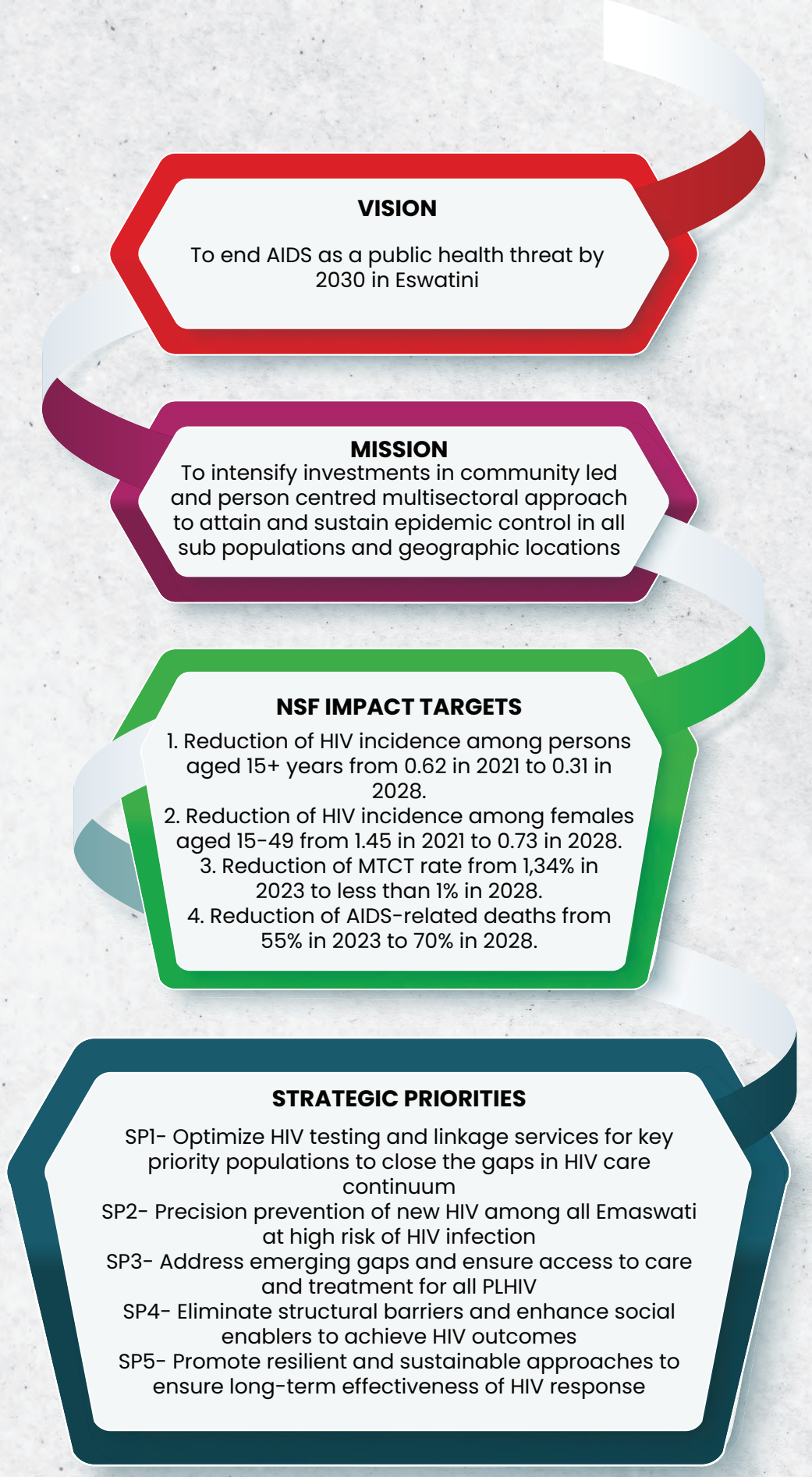


Figure 7: Eswatini NSF Conceptual Framework

3.2 Strategic Priorities

3.2.1 Strategic Priority 1: Optimize HIV testing and linkage services for key and priority populations to close the gaps in the HIV care continuum.

3.2.1.1 HIV Testing Services

Context

Eswatini has made substantial progress in its national HIV response, with a particular focus on HIV testing to improve awareness among populations like adolescent girls and young women (AGYW), adolescent boys and young men (ABYM), and key groups. According to the Swaziland HIV Incidence Measurement Survey (SHIMS3) in 2021, 94% of people living with HIV (PLHIV) are aware of their status, a result of enhanced testing strategies like facility testing, index testing, targeted community testing, and HIV self-testing (HIVST). However, there are age specific gaps, notably among AGYW aged 15-19 years, where about 16% are unaware of their HIV status. This gap is even larger among males aged 25-34 years and high risk groups like the female sex workers (FSW), and men who have sex with men (MSM).

To address these gaps, Eswatini has implemented a status neutral approach to HIV testing, prevention, and care, ensuring equitable access to services regardless of HIV status. Furthermore, the country has lowered the age of consent for HIV self-testing from 16 to 12 years to increase access and uptake of testing services among adolescents. Additionally, this NSF focuses on combination prevention services, furthering efforts to meet comprehensive health needs and prevention strategies which are:

- Targeted facility testing at each entry point
- Targeted community testing
- Heighten focus on HIV self-testing (HIVST)
- Optimization of index testing and social network testing
- Intensify linkages to HIV prevention services

Gaps and challenges

- Most key populations such as MSM, and FSW and priority populations such as AGYW, ABYM and older men are unaware of their status
- A high number (41%) of identified HIV positive cases are repeat testers
- Under-reporting of HIV testing services (HTS) data on the Client Management Information System (CMIS) due to frequent downtime.
- Inadequate system for follow-up and confirmatory testing at the community and facility level.
- Weak linkages to combination prevention services for HIV negative clients.
- HTS is not routinely offered and reported in private facilities.
- Erratic stock out of HIV testing commodities.

Strategic Objective

- To enhance innovative evidence-based HIV testing services for epidemic control.

Strategic Outcome

- 95% of people within subpopulations who live with HIV know their status.
- 95% coverage in all populations, age groups, and geographic areas of HIV testing services.

Target Populations

AGYW, ABYM, uniformed services, and key populations such as MSMs, FSWs, and clients of sex workers.

Priority Strategies

- Expand access to quality differentiated HIV testing services to leave no one behind especially AGYW, ABYM, uniformed services, key populations such as MSMs, FSWs, and clients of sex workers.
- Strengthen demand creation for HTS.
- Build the capacity of health workers in HTS case identification, referral, and HIV service provision.
- Implement a status-neutral testing approach to ensure linkages to combination HIV prevention services.
- Ensure standard implementation and adherence to national HIV management guidelines in both public and private sector health facilities.

3.2.2 Strategic Priority 2: Precision prevention of new HIV infection among all emaSwati at high risk of HIV acquisition.

No one HIV prevention strategy will stop the epidemic, hence there is a need to adopt and implement the combination prevention approach using packages of high-impact interventions. In addition to focusing on combination prevention, it is strategic for Eswatini to apply "precision prevention" where specific interventions and medical products target specific and well-defined problems and provide precision solutions. This approach is characterised by interventions that are right and evidence-based, people-centred, and are coupled with a mix of strategies that address biomedical, structural, and behavioural interventions. Comprehensive combination precision prevention is results-focused, and promotes, accountability, and strategic partnerships. The approach allows implementing partners not only to package interventions appropriately, but to move away from vertical programme implementation. This approach will facilitate the integration of biomedical, structural, and behavioural interventions, thereby increasing synergies and improving efficiencies and efficacy. The approach will reduce beneficiary fatigue and improve adherence and retention.

The NSF therefore places a renewed emphasis on comprehensive combination precision prevention strategies. This strategic framework will focus on implementing precision prevention, for all emaSwati at high risk of HIV infection. The interventions are guided by the five pillars of the Global HIV Prevention 2025 Road Map which are:

a) Comprehensive HIV prevention for key populations.
b) Combination prevention for AGYW.
c) HIV prevention services for adolescent boys and men.
d) Condom promotion and distribution.
e) ARV-based prevention (PrEP and treatment as prevention).

The NSF calls for the urgent strengthening and rapid scale-up of HIV combination prevention services that will have the greatest impact. The precision approach will be applied in the following prevention interventions.

- Risk Reduction Communication.
- Condom and Lubricants Programming.
- ARV – Based HIV Prevention (PrEP, PEP, and Treatment as prevention).
- Voluntary Medical Male Circumcision (VMMC).
- Prevention of Mother to Child Transmission (PMTCT).
- Harm reduction for HIV Prevention.
- STI screening and treatment.

Expected Results:

- 95% of people at risk of HIV infection use combination prevention options.
- Reduction of new infections from 0.62 to 0.31 by 2028.

3.2.2.1 Risk Reduction Communication

Context

Concerted HIV prevention and treatment efforts in Eswatini have significantly reduced adult HIV incidence by nearly 50% from 2016 to 2021, while also increasing viral suppression among those living with HIV (5). However, despite these substantial achievements, prevention gaps remain, and new infections continue to occur. A notable gender disparity exists in HIV incidence and prevalence, with women aged 15-49 years experiencing double the incidence rate of men in the same age group. Addressing treatment gaps is essential for reaching prevention goals. Furthermore, knowledge gaps leading to low-risk perception adversely impact the motivation for prevention. Comprehensive knowledge among young people aged 15-24 years remains low at 50.9% for females and 46.5% for males. While 96.3% of men aged 15-49 years know where to get tested for HIV, only 52.5% have reported having tested for HIV in the last 12 months and knew their results (10). As such enhancing outcomes for both behavioural and biomedical interventions necessitates a focus on risk reduction, which can be achieved by improving HIV risk perception, access to HIV information, HIV knowledge and support services for in-school youth.

Gaps and challenges

- Insufficient leadership, coordination, guidance, and quality verification including fragmented and siloed implementation of risk reduction and demand creation communication activities across sectors.
- Outdated HIV prevention materials, such as message briefs, risk reduction modules, and core packages.
- Poor referral and linkages for key and priority groups engaged via demand creation, and a lack of accountability across all target populations in the HIV service continuum.
- Inadequate knowledge of key and priority population estimates for evidence-based HIV programming.

Strategic Objective

- To enhance sexual autonomy, achieve a sustained reduction in HIV infections, and improve health outcomes through comprehensive, informed, and targeted approaches in Eswatini.

Strategic Outcomes

- 90% of at-risk and vulnerable key and priority populations take up combination prevention services.

Target Populations

Adolescent Girls and Boys; Young Men and Women; Adult Men and Women; KP; Young people living with HIV; Adults living with HIV; migrant and mobile populations.

Priority Strategies

- Re-establish and operationalize guidance documents for Government-led, coordinated, quality-assured risk reduction communication including capacity building of relevant stakeholders.
- Enhance the coordinated execution of risk reduction communication for national reach, customizing it for different segments of key and priority populations.
- Strengthen appropriately tailored linkages of vulnerable and at-risk key and priority populations to combination prevention interventions.
- Strengthen the capacity of the MOH (health promotion) and NERCHA to perform complementary roles to lead, coordinate, guide, and harmonize implementation, tracking, and monitoring of risk reduction communication interventions across sectors.
- Strengthen community-led HIV risk reduction communication.

3.2.2.2. Condom and Lubricants Programming

Context

Condoms and lubricant distribution and advocacy efforts have been supported through targeted mass media campaigns. The distribution of these commodities happens through health facilities and traditional outlets such as shops, public toilets, tinkhundla, and youth centres. According to the 2022 UNAIDS "Estimates and Projections Report", the distribution of male condoms decreased from 8.7 million in 2020 to 4.9 million in 2021 and picked up to 9.9 million in 2022. Although the uptake of female condoms is low in Eswatini, their distribution trends were similar to those of male condoms between 2020 and 2022 as shown in Table 8 below. The decline in the distribution of condoms in 2021 was associated with the socio-economic effects of COVID-19.

Table 8: Trends in condom distribution in Eswatini

Year	Male		Female		Total	
	Condoms distributed per year	% of annual target	Total condoms distributed	% of annual target	Total condoms distributed	% of annual target
2020	8,662,550	30	691,811	93	9,354,361	30
2021	4,912,139	16	280,317	36	5,192,456	16
2022	9,900,786	31	383,117	47	10,283,903	31

Source: Estimates and Projection Reports, UNAIDS 2022

Although correct and consistent use of condoms is a strategic triple prevention method for HIV, unplanned pregnancies, and other STIs, the uptake remains low. According to MICS (2023), condom use at last sex among women with multiple sexual partnerships is at 62.2% compared to men at 69.7%. Condom use with nonregular partners remains low for women (72%) aged 15-24 years when compared to men (87.3%) of the same age(10). Additionally, condom stock outs have been reported in different regions, and access has also been limited due to inadequate user-friendly outlets, including public community-based dispensers.

Gaps and challenges

- Sub-optimal condom programme coordination and Government leadership in community distribution of condoms.
- Inadequate demand creation activities including availability and coverage of condoms and lubricants in strategic points of access for key and priority populations.
- Weak monitoring and reporting of the distribution and coverage of condoms and lubricants.
- Insufficient condom social marketing and market analysis, resulting in low awareness and demand for condoms.
- Sub-optimal condom distribution aspect in National Condom Strategy.

Strategic Objective

- Improve knowledge, availability, accessibility, and consistent use of both male and female condoms.

Target Populations

AGYWs, Men, MSMs, FSWs, PWIDs, TG, and general population groups of childbearing age.

Strategic Outcomes

- Increase the availability of both male and female condoms by 50%.
- Increase correct and consistent use of condoms (male and female) by 50%.

Priority Strategies

- Strengthen comprehensive condom programming to include social marketing while accelerating last-mile community-level condom promotion and distribution.
- Strengthen the supply, warehousing, and distribution of condoms to improve the availability and consistent supply of male and female condoms at all distribution points.
- Conduct regular market research to assess condom demand and to identify new opportunities to promote condom use.
- Strengthen the capacity of the MOH to coordinate, plan, implement, monitor, and report on the condom program.
- Strengthen the condom distribution section in the national condom strategy.

3.2.2.3 ARV-Based Prevention

Context

Eswatini's implementation of Pre-Exposure Prophylaxis (PrEP) marks a major advancement in HIV prevention. PrEP, recommended by the World Health Organization since 2015, involves HIV negative individuals taking antiretroviral drugs to prevent infection. Eswatini began a PrEP study in 2016 and has since expanded its program. In 2021, Eswatini adopted WHO's new Event-Driven (ED) PrEP guidelines, targeting specific at-risk groups. The country's PrEP distribution includes health facilities and community outreaches, however, PrEP services face challenges like stigma and concerns about side effects, impacting service uptake and continuity.

Eswatini is exploring new PrEP technologies, such as the dapivirine ring and injectable cabotegravir, to address current challenges. It is crucial to define and differentiate between PrEP; which is the use of ARVs for prevention before exposure, while Post-Exposure Prophylaxis (PEP) is the use of ARVs to prevent HIV acquisition in persons who have been exposed to the virus. Despite progress in ARV-based prevention before exposure, Eswatini must continue to strengthen efforts to improve ARV uptake and client adherence to the medicines, and swiftly introduce advanced HIV prevention methods. Simplifying, differentiating, and digitizing services, alongside rapid adoption of innovative technologies, are key to expanding equitable access and effective use of PrEP and PEP.

Gaps and challenges

- Low uptake of PEP and PrEP among people at high risk of HIV acquisition.
- Sub-optimal PrEP uptake and adherence due to pill burden, side effects, and stigma and discrimination including PrEP packaging among others.
- Limited PrEP options that could address the challenges cited for sub-optimal uptake.
- Limited awareness of ARV-based prevention methods among key and priority populations.

Strategic Objective

- Scale up, intensify, and accelerate precision provision of PrEP and PEP for HIV prevention.

Strategic Outcome

- By 2028, >95% of all eligible clients receive PrEP and PEP for HIV prevention purposes.

Target Population

Adolescent Girls and Young Women (AGYW); Mature minors (age 12-15); Pregnant and Lactating Women (PLW); Sero-different Couples (SDC); KP; People with multiple sexual partners; Individuals with Sexually Transmitted infections (STIs); ABYM; migrant and mobile populations.

Priority Strategies

- Boost awareness, acceptance, effective use, and social support for PrEP and PEP as methods of HIV prevention.
- Expand differentiated and decentralized PrEP and PEP service delivery.
- Strengthen the integration of PrEP and PEP by improving access, educating the health workforce, and ensuring availability of PrEP and PEP services at all service points.
- Increase demand for ARV-based prevention and address barriers such as stigma, with a focus on innovative packaging, educational campaigns, collaborations with influencers, and tailored communication strategies.
- Enhance the monitoring and evaluation of PrEP and PEP implementation by establishing robust data collection, analysis systems, and regular feedback mechanisms for continuous improvement.

3.2.2.4 Voluntary Medical Male Circumcision (VMMC)

Context

The Voluntary Medical Male Circumcision (VMMC) program in Eswatini faces coverage challenges, which currently stand at a low 48% according to MoH annual report (2023). This report also revealed a notable decline in the number of circumcisions performed, dropping from 17,800 in 2019 to just 8,063 in 2020. This decrease may partly be attributed to the program's strategic shift towards targeting older men, a population traditionally less receptive to VMMC, to immediately impact the HIV epidemic. As a procedure, VMMC can be carried out at any age, including in early infancy, now described as Early Infant Male Circumcision (EIMC).

In response to these challenges, the VMMC program has implemented several strategic changes. A significant shift has been the transition from a doctor-led to a nurse-led model. This approach aims to integrate VMMC services into primary healthcare clinics, thereby improving access and client satisfaction. Additionally, all VMMC facilities have moved from paper-based systems to CMIS for real-time patient data tracking.

The VMMC program has adopted modern digital marketing strategies to enhance client engagement. These include using social media platforms like Facebook, a toll-free line, and WhatsApp to sensitize and mobilize potential VMMC clients. These technological advancements are expected to refine the national demand creation system, making it more effective for the older male population.

Gaps and challenges

- Inadequate VMMC service integration at all levels of the health system.
- Ineffective demand creation and contextualized identification of barriers to service uptake.
- Donor dependency leads to a lack of a national sustainability plan for the VMMC program.

Strategic Objective

- Increase the uptake of medical male circumcision among men.

Strategic Outcome

- Increase the VMMC coverage in men 15 - 49 years from 48% to 60% by the end of the strategy.

Target Populations

Neonates (0-2months) boys; Men aged 15 years and older.

Priority Strategies

- Scale up holistic person-centred VMMC services that meet and contextualize client needs.
- Expand VMMC services to high-risk groups and areas, prioritizing access in locations with less than 60% prevalence.
- Advocate for VMMC as a comprehensive health service encompassing Sexual and Reproductive Health (SRH), PrEP, condom use, Sexual and Gender-Based Violence (SGBV), and TB services.
- Enhance community engagement and innovative communication through existing structures to encourage VMMC among older males.

3.2.2.5 Elimination of Mother to Child Transmission (EMTCT)

Context

Eswatini has achieved significant milestones in the EMTCT program. Antiretroviral Therapy (ART) coverage among pregnant women has consistently been above 95% (14). This has resulted in high Early Infant Diagnosis (EID) coverage and maintaining low seroconversion rates among HIV-exposed infants. In addition, knowledge of mother-to-child transmission remains high among women (67.6%) 15-49 years compared to men (51.4%) (10).

The 2022 EMTCT Impact Evaluation Study shows that Eswatini reduced HIV mother-to-child transmission (MTCT) rate from 6.3% in 2017 to 1.2% in 2022. Additionally, the MTCT rate of HIV at 6-8 weeks postpartum has decreased from 2% in 2018 to less than 1% in 2022. Moreover, the rate of new pediatric HIV infections per 100,000 live births has halved, dropping from 1,093 in 2017 to 542 in 2022 (14).

Despite these remarkable achievements, challenges persist. The program still observes new HIV infections among infants, and there is a concern regarding poor adherence to treatment among pregnant and lactating women. These issues underscore the need for continued vigilance and enhanced strategies to ensure that Eswatini not only maintains but builds upon its current successes in the fight against HIV transmission from mother to child.

Gaps and challenges

- Limited EMTCT services in specialised service delivery points, such as Uniformed Forces clinics and psychiatric clinics.
- Insufficient linkage of HIV negative women to prevention services.
- Sub-optimal adherence to treatment and viral load coverage among Pregnant and Lactating Women on ART.

Strategic Objective

- To eliminate mother-to-child transmission of HIV 2028.

Strategic Outcome

- <1% MTCT rate between 18-24 months by 2028.

Target Population

Women of childbearing age, including AGYW.

Priority Strategies

- Expand the integration of EMTCT services into specialised service delivery points.
- Enhance the skills of healthcare providers to deliver unbiased and supportive antenatal care (ANC) and postnatal care (PNC) services to key and priority groups, while also strengthening the referral of HIV-negative women to HIV prevention services.
- Improve ART adherence, viral load testing, care engagement, and case management for pregnant and lactating adolescents and women.
- Develop the skills of healthcare workers to screen and manage Syphilis and Hepatitis B among pregnant women, including congenital syphilis in newborns.
- Enhance male participation in EMTCT services by increasing community awareness, reducing stigma, and improving partner testing and engagement.

3.2.2.6 Harm Reduction for HIV Prevention

Context

Harm reduction, as defined by the World Health Organization, is a comprehensive set of evidence-based public health interventions, aimed at people who inject psycho active substances for non-medical purposes. It focuses on reducing the major health harms, such as HIV, viral hepatitis, and overdose, without necessarily stopping drug use. This approach is grounded in public health and human rights principles and includes interventions like Needle and Syringe Programs (NSPs), Opioid Agonist Maintenance Treatment (OAMT), and naloxone for overdose management. People who inject drugs (PWIDs) face a plethora of health challenges and complications. These include a heightened risk of HIV infection, primarily due to shared contaminated injections and syringes. Statistically, about 1 in 8 PWIDs globally live with HIV, making them 35 times more likely to contract the virus compared to the general population (15). Beyond HIV, PWIDs are also vulnerable to mycobacterium tuberculosis and hepatitis C virus (15).

People who inject drugs often grapple with structural issues such as possible criminalization, marginalization, poverty, possible incarceration, and engagement in sex work. These factors not only compound their health risks but also significantly reduce their likelihood of adhering to HIV treatment or other medical treatments in the absence of a harm reduction program. In Eswatini, an assessment conducted by the Ministry of Health in 2020 estimated the presence of approximately 854 people who inject drugs. This local data underscores the urgent need for harm reduction strategies tailored to the specific context of Eswatini to effectively address the health challenges faced by this vulnerable population.

Gaps and challenges

- Limited interventions to reduce HIV transmission through needle sharing among PWID.
- Inadequate understanding of barriers influencing interruption of treatment among PWID and other PLHIV that use harmful products (including alcohol use).
- Insufficient harm reduction screening and inadequate referral processes.

Strategic Objective

- To scale up HIV services aimed at reducing harm among PWID.

Strategic Outcome

- 90% of PWID utilise appropriate HIV prevention and treatment services by 2028.

Target Populations

PWID: adolescents, men, and women 15 years and above.

Priority Strategy

- Introduce and scale up interventions to reduce HIV transmission among PWID, including Needle Syringe Program (NSP) and Opioid Substitution Therapy (OST).

3.2.3 Strategic Priority 3: Address emerging gaps and ensure equitable access to care and treatment for all PLHIV

Addressing the emerging gaps in HIV response is essential for providing equitable access and continuity of care for all people living with HIV (PLHIV). This approach focuses on identifying and overcoming barriers of access to essential services, aiming for comprehensive and equitable care to reduce disparities and improve health outcomes. The consistent decline in HIV incidence in Eswatini, from 14,000 cases in 2010 to 4,800 in 2021, with a projection of a further reduction to 4,300 in 2023, indicates significant progress towards the nation's goal of achieving zero new HIV infections by 2030(16). While women have achieved the 95-95-95 targets, challenges remain, particularly in reducing new infections among young women, men aged 25-34 years, MSM, and ensuring viral suppression in children. The NSF vision focuses on closing these gaps through tailored testing strategies, client-centred treatment approaches, and integrating HIV with other public health concerns such as antimicrobial resistance (AMR), non-communicable diseases (NCD) services, and Global Health Security (GHS), which is defined as the existence of strong and resilient public health systems that can prevent, detect, and respond to emerging infectious disease threats wherever they occur in the world. These efforts aim to strengthen health systems and achieve sustainable epidemic control in alignment with Eswatini's goals.

3.2.3.1 STIs and Viral Hepatitis Prevention and Treatment

Context

In Eswatini, recent program data and reviews have highlighted a significant challenge with sexually transmitted infections (STIs). The 2017 Joint Epidemiology Review reported a substantial increase in STIs, rising from 66,891 in 2014 to 190,872 in 2016, with a notable 25% of cases involving genital ulcers. The prevalence of syphilis among women was reported to be 2.0% (17). Further insights from a 2017 cross-sectional study involving 655 women, found a 19.4% diagnosis rate of curable STIs, including chlamydia, gonorrhoea, trichomonas, syphilis, and genital warts, with 6.3% of these women suffering from multiple infections. In 2019, it was observed that 51.6% of sex workers were tested for STIs, with 7.8% testing positive for syphilis (18). Among men who have sex with men (MSM), despite low testing rates, a significant 16.9% reported experiencing STI symptoms in Manzini. The 2019 ECHO trial further underscored the issue, revealing high prevalence rates of Chlamydia trachomatis (18%), Neisseria gonorrhoea (5%), and Herpes Simplex Virus 2 (38%) among women, alongside an increased HIV incidence in those with STIs, multiple partners, and particularly in women under 24 years of age(18).

The situation with viral hepatitis in Eswatini is also concerning, albeit less clear. While the overall burden in the general population is unknown, data from blood donor screenings indicates a rising trend, with hepatitis B surface antigen (HBsAg) prevalence at 3.7% in 2016 and hepatitis C virus (HCV) prevalence at 0.8%(19). A clinic study among people living with HIV for the period 2013-2016 indicated a high prevalence of HBsAg at 7.7% and HCV at 1.7%. These findings point to a significant and escalating public health challenge in Eswatini, necessitating comprehensive and targeted interventions to address the spread of STIs and viral hepatitis.

Gaps and challenges

- Absence of a standardised testing algorithm for syphilis in the general population and adhoc testing for other STIs.
- STI prevention efforts in schools are limited to awareness creation and screening services, without the provision of condoms.
- Absence of point of care (POC) testing to address asymptomatic STI and viral hepatitis.
- Minimal hepatitis B virus (HBV) and HCV prevention, screening, and management among high-risk groups.
- Lack of referral and linkage to care for blood donors who screen positive for HIV, HBV, HCV, and Syphilis.
- STI testing is limited to syphilis among pregnant women and at-risk populations are not routinely screened for HBV, except for antenatal screening, PLHIV, and specific cases.
- Suboptimal integration and reporting of STI services at delivery points and in the private sector, despite their availability in HIV, TB, NCD, VMMC, PrEP, and other SRH services.
- The limited variables and disease coding constraints in CMIS greatly hinder the ability of the electronic system to accurately estimate STI prevalence and incidence.
- Lack of a coordinated Antimicrobial Resistance (AMR) monitoring for bacterial STIs.

Strategic Objectives

- Strengthen national capacity to provide comprehensive STI services.
- Reduce Viral Hepatitis morbidity through scale-up of prevention, diagnostic testing, and treatment.
- Strengthen and coordinate AMR monitoring for bacterial STIs and other bacterial infections affecting PLHIV.

Strategic Outcome

- 95% of at-risk populations screened and treated for STI by 2028.

Target Population

All STI, HBV, and HCV at-risk populations.

Priority Strategies

- Create awareness on the prevention of STIs, HBV, and HCV.
- Strengthen the bidirectional integration of HIV, HBV, HCV, and STI services at all service delivery points and expand screening and management of STIs, HBV, and HCV including offering referral and linkage to care for all blood donors that test positive.
- Strengthen CMIS for comprehensive STI data collection, analysis, and utilization.
- Increase community awareness about STIs (including promotion of human papillomavirus (HPV) vaccination for those eligible).
- Enhance the engagement of the private sector (health facilities/pharmacies) in the STI syndromic case management approach.
- Reinvigorate STI surveillance and enhance AMR tracking for bacterial STIs and other infections.

3.2.3.2 HIV Care, Treatment and Quality of Life

Context

Eswatini has achieved remarkable progress towards the second of the 95 UNAIDS targets, which aims for 95% of diagnosed people living with HIV (PLHIV) to be on Antiretroviral Therapy (ART). From 89% in 2016, ART uptake among diagnosed PLHIV in Eswatini rose to an impressive 97% by 2021 (13). This includes 7,219 (88.4%) individuals aged 0-14 years and 192,728 (91.9%) adults aged 15 years and over, receiving ART in 2021 (20).

A key strategy in this success has been the implementation of Multi-Month Dispensing (MMD). By the end of 2020, 78% of patients were receiving three months' supply or more of medicines, significantly enhancing treatment continuity (21). Additionally, Differentiated ART Service Delivery and Care (DSD) has played a crucial role in not only improving adherence to treatment but also in reducing the stigmatization of patients at health facilities.

These strategic initiatives have led to a notable increase in viral load suppression among PLHIV on ART, from 91% in 2016 to 96% in 2021 (5). This significant improvement demonstrates Eswatini's commitment and effective approach to reaching epidemic control.

Strategic Objective

- To enhance early enrolment, retention in care, and sustained viral suppression to improve the health outcomes of all PLHIV.

Strategic Outcomes

- > 95% of all individuals and subpopulations diagnosed with HIV are on ART by 2028.
- > 95% viral suppression among all subpopulations of PLHIV on ART by 2028.
- 70% reduction in AIDS-related mortality by 2028.

Gaps and challenges

- Insufficient uptake of ART among HIV positive men aged 25-34 years.
- Sub-optimal viral load suppression among children, key populations, women, and men aged 15-24 years.
- Lack of continuity of care for migrant and mobile PLHIV.
- Sub-optimal transitioning package from children living with HIV (CLHIV) to young people living with (YPLHIV) care.
- Interruptions in the supply chain for diagnostics and therapeutics.
- Inadequate management of Advanced HIV Disease (AHD).

Target Populations

KPs, CLHIV, YPLHIV, and PLHIV (including migrant and mobile populations); 15-24 years (both women & men); and 25-34 years (men).

Priority Strategies

- Strengthen Advanced HIV Disease screening and management contextualized by sub-populations.
- Integrate TB, SRH, NCDs, AMR, and mental health into HIV services.
- Strengthen person and family-centred approaches targeting populations lagging on ART uptake and VL suppression.
- Enhance uninterrupted HIV service delivery for migrant and mobile populations via national and cross-border collaborations.
- Diversify platforms for psychosocial support tailored to PLHIV sub-populations including young people.
- Strengthen community-led approaches to improve treatment literacy among PLHIV including young people.
- Define and implement a transitional package for YPLHIV (prioritizing safe spaces).

3.2.3.3 Integrated service provision to address the HIV/TB syndemic

Context

Tuberculosis (TB) continues to be the leading cause of death among people living with HIV (PLHIV) globally. In 2022, a staggering 67% of newly diagnosed Eswatini TB patients were also found to be co-infected with HIV, highlighting the critical intersection of these two conditions (22). Given this high rate of co-infection, systematic TB screening and investigation within the PLHIV population is essential for effective TB case finding.

Despite significant strides in the provision of TB preventive treatment (TPT) to PLHIV, reaching 81% by March 2023, this effort still falls short of the national target of 90% (23). This gap underscores the need for enhanced TB prevention measures both in healthcare facilities and within communities to reduce TB morbidity and mortality among PLHIV.

Moreover, the mortality rate among TB/HIV co-infected patients remained alarmingly high at 13% in 2022, far exceeding the national target of less than 5% (22). This disparity indicates a critical need for strengthened interventions and strategies to address the dual burden of TB and HIV, aiming to significantly reduce mortality rates and improve overall health outcomes in this vulnerable population.

Gaps and challenges

- Inadequate TB case finding among PLHIV.
- Sub-optimal uptake of TB prevention among PLHIV.
- High mortality rate among notified TB/HIV cases.

Strategic Objective

- To enhance TB case finding, prevention, and access to quality and effective TB/HIV care and treatment services for all PLHIV.

Strategic Outcomes

- 100% of PLHIV are screened for TB.
- ≥95% TPT coverage amongst PLHIV.
- 100% TB/HIV co-infected people are started on ART.
- Reduce mortality among TB/HIV co-infected patients to < 5% by 2028.

Target Populations

PLHIV (including children, migrant, and mobile populations).

Priority Strategies

- Improve HIV-TB case identification, risk categorization, and linkage to treatment.
- Improve TB prevention services among PLHIV.
- Improve TB outcomes among PLHIV.

3.2.3.4 NCDs and Mental Health among PLHIV

Context

Eswatini is currently navigating a significant demographic shift, with an aging population of people living with HIV (PLHIV) who are at an increased risk of non-communicable diseases (NCDs). This issue mirrors a global trend where NCDs are a leading cause of death, particularly in low and middle-income countries. In Eswatini, the challenge is compounded by difficulties in screening for and managing NCDs, partly due to a lack of essential commodities.

To ensure continuity in care and to mitigate the risk of preventable deaths, it is vital to structurally integrate NCD care into existing HIV services. This integration is not just a health system optimization strategy but a crucial step towards safeguarding the health of PLHIV against the escalating threat of NCDs. As the country grapples with this dual burden, a coordinated approach in managing HIV and NCDs becomes increasingly essential to improve overall health outcomes and quality of life for this vulnerable population.

Gaps and challenges

- Insufficient screening for NCDs among PLHIV, and inadequate integration and treatment linkage between HIV and NCD services.
- Irregular treatment of PLHIV diagnosed with NCDs and other HIV-related malignancies.
- Frequent stock-outs of NCDs diagnostics and treatment commodities.
- Minimal engagement of communities in HIV and NCD prevention and management.
- Lack of structured/tailored mental health packages for PLHIV.

Strategic Objective

- To ensure that 90% of PLHIV are screened for NCDs and 95% of those diagnosed with NCDs receive appropriate treatment and support.

Strategic Outcomes

- 90% of all PLHIV are screened for all defined NCDs (diabetes mellitus, hypertension, cervical cancer) and mental health at least once a year.
- 95% of all PLHIV diagnosed with NCDs are treated for all conditions.

Target Populations

PLHIV (including migrant and mobile populations).

Priority Strategies

- Improve integrated systematic screening of NCDs for PLHIV.
- Strengthen capacity building for healthcare workers on NCD diagnosis and management.
- Strengthen the supply chain for NCDs diagnostics and treatment.
- Integrate and scale up mental health services for PLHIV.

3.2.4 Strategic Priority 4: Eliminate structural barriers and enhance social enablers to achieve HIV outcomes

Ensuring equal access to HIV prevention and care services hinges critically on promoting gender equality, protecting human rights, and dismantling barriers. This strategic priority addresses the entrenched social, cultural, and legal factors that hinder access to these vital services and perpetuate systemic inequalities. The strategy aims to empower individuals and communities by focusing on social enablers, enabling them to actively engage in their health and well-being. This approach is essential for cultivating an inclusive and equitable healthcare system. Through such measures, the country is not just tackling HIV but also fostering a health-care environment where every individual, irrespective of their gender or background, can access the care they need without facing discrimination or inequality.

Expected Results:

- <10% of PLHIV experience stigma and discrimination.
- <10% of KPs avoid seeking healthcare services due to stigma and discrimination.
- <10% of women, girls, PLHIV, and key and priority populations experience gender inequality and violence.
- 95% of orphaned and vulnerable children (OVC) receive a comprehensive package of HIV services.

Strategic Objective

- To address social, structural, and cultural barriers and promote enablers to achieve HIV outcomes.

3.2.4.1 Economic Strengthening Enabling HIV Prevention, Care, and Treatment

Context

The Government of Eswatini has implemented various economic strengthening programs to combat vulnerabilities linked to HIV infection. These include the Youth Enterprise Revolving Fund targeting youth aged 18-35 years, the DREAMS and Global Fund programs specifically for Adolescent Girls and Young Women (AGYW) at risk of HIV, the Regional Development Fund for the rural population, Junior Achievement for in-school and out-of-school youth, and Enactus for tertiary students with entrepreneurship programs. Supported by development partners, these initiatives are pivotal in addressing poverty-driven vulnerabilities such as transactional sex, intergenerational relationships, and multiple concurrent partners.

Economic development is crucial in altering inequitable power dynamics, be it economically, emotionally, gender-based, or otherwise within intimate relationships, enabling the disempowered to negotiate safe sex and effectively utilize HIV prevention services. Prioritizing economic strengthening is essential as a risk management strategy to sustain the progress made in the HIV response. Poverty and dependence, especially among youth and AGYW, continue to be significant challenges in reducing infections. These vulnerable groups must be equipped with the necessary tools to negotiate safe sex and access the HIV prevention services they need.

Gaps and challenges

- Minimal investments in economic empowerment initiatives.
- Poor coordination, ineffective monitoring, and reporting which hinder the progress of economic strengthening initiatives.
- Limited access to economic empowerment interventions by vulnerable key and priority populations.
- High failure rates of economic empowerment projects among key and priority populations.

Strategic Objective

- Increase access and utilization of economic development initiatives among economically vulnerable key and priority populations at risk of contracting HIV.

Strategic Outcome

- 95% of vulnerable key and priority populations at risk of contracting HIV start and sustain economic development interventions.

Target Populations

AGYW, FSW, PLHIV, Key populations, Women, Men, and boys; Persons with disabilities.

Priority Strategies

- Enhance access and effectiveness of economic development programs for key populations to mitigate their financial vulnerabilities.
- Strengthen the capacity of relevant government agencies to lead, coordinate, implement, monitor, and report on economic empowerment activities targeting key and priority populations.
- Strengthen capacity building of target and priority population to apply for economic development funds and successfully implement viable and sustainable economic empowerment initiatives.

3.2.4.2 Reduce gender inequities and Sexual and Gender-Based Violence (SGBV)

Context

Eswatini faces a persistent challenge of gender-based violence (GBV), with statistics showing that approximately 1 in 4 females experience some form of sexual abuse by age 18 years, and 28% of these women within the same age bracket have experienced either physical or sexual violence. About 7% of women aged 15-49 years have experienced sexual violence at some point and only 35% sought help. The VACS conducted in 2022 also showed that 12% of women aged 15-49 years believe that a man is justified for hitting or beating his wife for some reason.

Furthermore, about 6% of girls have experienced some form of sexual violence in their childhood, and only 2% among males. Physical violence among boys before the age of 18 years is as high as 14% compared to 5% among girls (11).

Despite these challenges, Eswatini has made significant strides in combating GBV through the implementation of the NSF 2018-2023. A notable achievement is the enactment of the Sexual Offences and Domestic Violence (SODV) Act, underscoring the country's commitment to addressing GBV (24). Additionally, Eswatini has implemented crucial measures such as referring SGBV cases to service providers, providing support services to abuse survivors, and offering Post-Exposure Prophylaxis (PEP) to victims of sexual assault. These efforts reflect the progress made in tackling GBV, though the escalating numbers of reported cases indicate that the challenge remains significant and requires continued and concerted efforts.

Gaps and challenges

- Lack of adequate prevention and response measures for incidents of sexual and gender-based violence (SGBV).
- Insufficient comprehensive support services for survivors of SGBV.
- Poor referral system and coordination among service providers in addressing SGBV.
- Limited coordination within the SGBV program.
- Harmful social norms and inadequate involvement of ABYM in preventing GBV and intimate partner violence, fuelling the spread of HIV.
- Insufficient engagement of ABYM on the prevention of GBV and intimate partner violence, and negative social and cultural norms and practices that fuel the transmission of HIV.
- Lack of prioritization of community awareness and social behaviour change communication (SBCC) regarding SGBV response.
- Inadequate monitoring and evaluation limiting the assessment and enhancement of effectiveness.
- Insufficient political will and commitment to enhance the response to SGBV.

Strategic Objectives

- Enhance prevention and early detection of SGBV, focus on raising awareness and addressing related social, cultural, traditional, religious, political, and economic factors.
- Improve the provision of effective, accessible, and responsive protection, care, and support services for individuals affected by SGBV.
- Advocate for efficient and effective management, coordination, and partnership building for the national response to violence, particularly SGBV.

Strategic Outcome

- <10% of women, girls, PLHIV, and key and priority populations experience gender inequality and violence.

Target Populations

Women, girls, PLHIV, key and priority populations, men and boys, asylum seekers, refugees, persons on the move, stateless persons, widows, and PWD.

Priority Strategies

- Develop a multisectoral GBV response strategy that targets all populations.
- Integrate SGBV response into sector plans and programs by enhancing the linkages between SGBV service providers and various sectors.
- Enhance the national coordination of efforts to prevent and respond to sexual and gender-based discrimination and violence.
- Strengthen SGBV prevention by incorporating gender transformative approaches across all programs.
- Assess the national legal and policy environment to align it with UNAIDS 10-10-10 targets, focusing on eliminating barriers to supportive legal and policy frameworks, ensuring access to justice, promoting gender equality, and creating a society free from stigma and discrimination that impedes access to or utilization of HIV services.
- Reinforce the legal and policy framework on HIV and AIDS to ensure that it is inclusive of all people living with HIV, people with a disability, key and priority populations, and other vulnerable populations.

3.2.4.3 Education enabling HIV Prevention, Care, and Treatment

Context

The Ministry of Education and Training (MoET) in Eswatini has adopted the Care and Support for Teaching and Learning (CSTL) known as the "Inqaba Framework" as a key measure to address the challenges faced by children affected by HIV and AIDS, aiming to provide inclusive and quality education. This framework plays a crucial role in harmonizing policy frameworks, ensuring that schools are safe and supportive spaces for all learners, particularly those facing vulnerabilities.

A significant milestone in these efforts was the launch of the Pregnancy Prevention and Management Policy (PPMP) in 2023, geared towards reducing new HIV infections, STIs, and early unintended pregnancies. This initiative aligns with the broader directives of the Education Plus Initiative (Strategy) and the Leave No One Behind Campaigns, underscoring a unified call for action. Additionally, MoET has implemented a Comprehensive Sexuality Education (CSE) curriculum, known as the Life Skills Education (LSE) program, which focuses on HIV. This curriculum is part of a holistic approach aimed at improving the well-being of all learners by ensuring their retention in school.

However, while these collective efforts mark significant progress, there are notable challenges in fully implementing these strategies. These limitations pose a barrier to effectively reducing and ultimately eliminating HIV incidences among learners, indicating a need for continuous evaluation and adaptation of these educational and health initiatives.

Gaps and challenges

- Limited comprehensive support that addresses the significant challenges for priority populations to enrol, retain, and complete education.
- Limited capacity in learning institutions to provide comprehensive services for vulnerable and at-risk priority populations including lack of case management and referral to other sectors for management.
- Increased dropouts due to pregnancy.
- Lack of dedicated LSE teachers responsible for case management and referral to prevention, care, and treatment services.
- Suboptimal HIV prevention services, including sexual reproductive health services.

Target Population

Learners in all learning institutions (primary, secondary, high schools, non-formal and tertiary institutions).

Strategic Objectives

- 100% of priority populations are enrolled, retained, and complete all levels of education
- 100% of priority populations are appropriately linked to relevant bio-medical and structural interventions.
- 100% of priority populations who drop out of the education system are linked to economic and social protection programmes.

Strategic Outcome

- To foster an education system that not only accommodates and protects learners, especially those affected by or vulnerable to HIV and AIDS but also actively contributes to the reduction of HIV incidences and related health issues through comprehensive education and supportive policies.

Priority Strategies

- Strengthen access to affordable, and quality HIV prevention services for learners.
- Enhance learner survival by mainstreaming the Care and Support for Teaching and Learning (CSTL) program in all learning institutions.
- Strengthen the rollout and operationalization of the Pregnancy Prevention Management Policy.
- Strengthen Life Skills Education (LSE) implementation for both in and out-of-school youth.
- Scale up skills development programs for young people Technical and Vocational Education and Training (TVET).

3.2.4.4 Stigma and Discrimination Reduction Enabling HIV Prevention, Care and Treatment

Context

The Eswatini Stigma Index (2023) reveals a substantial decrease in HIV-related stigma and discrimination among people living with HIV (25). Less than 10% of respondents reported experiencing such stigma in the past year, indicating a positive shift in societal attitudes towards HIV. Moreover, the high rate of HIV treatment uptake, with 98% of respondents receiving treatment and 42% starting immediately after diagnosis, underscores the effectiveness of strategies to facilitate access to HIV care (25) . However, challenges persist for key populations like female sex workers and men who have sex with men, who continue to face significant stigma and discrimination, often leading to their avoidance of healthcare services.

To combat this, the Government of Eswatini has implemented several initiatives, including HIV self-testing, community commodity distribution models, and ongoing awareness campaigns. These efforts have played a crucial role in reducing stigma and clinic-related barriers. Additionally, sensitization and training programs for healthcare workers and police aim to create a more inclusive and supportive environment. The empowerment of minority populations to confront internal stigma has also been a focus, enhancing their ability to access and adhere to HIV treatment and care. Collectively, these strategies contribute to a more supportive environment for PLHIV and key populations, leading to improved health outcomes and a reduction in HIV transmission rates, though targeted efforts for vulnerable groups remain essential.

Gaps and Challenges

- Internalised stigma including difficulty in disclosing HIV status perpetuated by the fear of being stigmatised and perceived as being promiscuous.
- Stigma associated with HIV services and treatment.
- Experienced and perceived stigma and discrimination from service providers, including, healthcare and social service providers.
- Lack of strong community-based monitoring (CBM) and community-led monitoring mechanisms to enable reporting of stigma and to improve health services and health outcomes.
- Limited interventions targeting stigma and discrimination, and biased understanding of stigma and discrimination.

Strategic Objectives

- <10% of PLHIV and KP experience stigma and discrimination.
- <10% of KPs and Priority Population (PP) avoid seeking HIV prevention and treatment services due to stigma and discrimination.

Strategic Outcomes

- <10% PLHIV and KP reporting experiences of stigma and discrimination.
- <10% of AGYW and boys and young men reporting fear of accessing HIV prevention services.
- >90% PLHIV and KP accessing health care services.
- ≥95% of PLHIV are taking HIV treatment consistently

Target Population

PLHIV (including YPLHIV, migrant and mobile populations), KP, AGYWs, ABYMs.

Priority Strategies

- Advocate for a friendly and conducive environment for all PLHIV including KP, AGYW, boys, and young men to access HIV services.
- Scale-up interventions aimed at eliminating Stigma and Discrimination among healthcare workers and social service providers.
- Empower all PLHIV especially Key and Priority populations against internalised stigma.
- Scale up community-led monitoring and utilise results to address stigma and discrimination challenges.
- Support the development and implementation of a comprehensive strategy to eliminate stigma and discrimination.

3.2.4.5 Social Protection Enabling HIV Prevention, Care and Treatment

Context

Eswatini's comprehensive OVC program is designed to cater to the specific needs of this population, aiming for positive outcomes in health, stability, safety, and education. The program provides a range of services tailored to the children and their families. These services include health referrals, psychosocial support, and individualized education assistance, which may come in the form of individual subsidies or school block grants. To further bolster family support systems, caregivers are offered training in parenting skills and the chance to join savings groups, enhancing their empowerment and economic resilience. Additionally, the program extends disability public assistance, incorporating monetary grants, as part of its elderly grants initiative, to address the needs of vulnerable groups within the community.

Gaps and challenges

- Limited availability of data on all eligible children, OVCs, and other vulnerable groups to monitor and evaluate gaps and disparities in service delivery.
- Inequitable and inadequate access to needs-based services for all eligible children, OVCs, and other vulnerable groups.
- Lack of sustainable positive outcomes for eligible children and other vulnerable groups in health, stability, safety, and education.
- Limited coordination, programming, and collaboration between the different sectors and stakeholders offering OVC services.
- Limited engagement of caregivers.

Strategic Objective

- ≥95% of OVCs receive a comprehensive package of HIV services.

Strategic Outcome

- Create a comprehensive support system that not only addresses the immediate needs of orphans and vulnerable children but also fosters an environment of empowerment and economic stability for their caregivers, thereby contributing to the long-term well-being and resilience of the entire community.

Target Populations

Eligible children and all vulnerable groups and OVCs.

Priority Strategies

- Strengthen intersectoral linkages for the provision of comprehensive services addressing risk and vulnerability to infection, non-HIV diagnosis, and disengagement from treatment.
- Strengthen social protection programmes to comprehensively address the needs of vulnerable key and priority populations and dissuade them from non-uptake of testing, prevention, and treatment services.
- Strengthen the prevention and response to child protection issues and violence against children.
- Enhance coordination of social protection programmes addressing the vulnerabilities to HIV infection, non-diagnosis, and disengagement from treatment.
- Optimize OVC programme management and implementation.
- Strengthen progress monitoring and the generation and utilisation of strategic information for social protection programmes to improve programming and coverage of vulnerable key and priority populations.
- Implement caregiver or parental sessions initiatives to support OVC program.

3.2.5 Strategic Priority 5: Promote resilient and sustainable approaches to ensure the long-term effectiveness of the HIV response.

The next phase of the HIV response is geared toward building a sustainable HIV response characterized by political, programmatic, and financial sustainability. The strategy will prioritize the development, implementation and monitoring of the country's HIV response sustainability roadmap that will ensure a systematic approach towards this goal.

Firstly, continuous political leadership and commitment shown by His Majesty King Mswati III, who mobilised the entire Nation to face HIV head-on as articulated in the 2022 Speech from the Throne: **"Sicondzene Ngco ne-AIDS!!! Asiyesabi"** is expected to result in an intensified response by the Government, Development Partners, Civil Society Organizations, Traditional Leadership, and the entire nation to strengthen delivery of critical HIV services. His Majesty further stimulated the nation to apply **"Nkwe!"** (2024 Speech from the Throne), a call for collective responsibility amongst all EmaSwati to transform Eswatini into a solution-based and proactive nation. This political commitment will ensure that the gains thus far are not reversed. Instead, response systems should be resilient and programmes must maintain epidemic control.

Secondly, the focus will be to ensure equitable service delivery for all key and priority populations to close the remaining gaps in HIV prevention, care, and treatment services to reach epidemic control. The strategy emphasizes integration including cross-sectoral linkages for optimization of services and efficient service delivery. The goal is to achieve better HIV and AIDS outcomes for both individuals and communities, ensuring they receive comprehensive HIV and AIDS services.

Thirdly, HIV response financial sustainability includes prioritizing domestic financing and strategic resource allocation to support the surge toward achieving and maintaining epidemic control. The strategy will focus on continuing to improve sustainable financing models and mainstream the response into normative programming including provision of budgets to specific appropriate areas of the HIV response in all sectors. HIV response funding coordination will be improved to ensure that the Government has visibility of what is supported by development and donor partners, including support going to civil society organizations. The goal is to facilitate a transition to domestic financing for the response.

Expected Results:

- Enhance community systems for sustainable and transformative HIV response focusing on the needs of vulnerable groups and addressing social and structural barriers.
- Strengthened supply chain of HIV commodities, products, and technologies.
- Improved governance and accountability for health products and technologies, including stronger regulatory systems and mechanisms for reporting and addressing shortages or stockouts.
- Increase in the number of skilled healthcare workers providing HIV and AIDS services to >90% by 2028.
- >75% of HIV expenditure is provided by domestic resources.
- A single HIV sustainability response roadmap with coordinated governance, clear results, and accountability developed and implemented.
- Sector-wide stakeholder engagement at all administrative levels.

3.2.5.1 Health Products and Technology Security

Context

The Eswatini pharmaceutical and laboratory departments play a crucial role in supporting universal health coverage and enhancing the healthcare system's performance by ensuring access to safe, effective, affordable, and quality-assured medicines and laboratory commodities. This responsibility is in line with Eswatini's National Medicines Policy, National Health Policy, the Eswatini Health Laboratory Services Strategic Plan, and the National Health Strategic Plan. Both departments are mandated to ensure the availability, affordability, and rational use of essential medicines and laboratory commodities that adhere to the highest standards of quality, safety, and efficacy. This is vital for reducing morbidity and mortality related to HIV and AIDS and for achieving favourable treatment outcomes.

To fulfil these mandates, the pharmacy department and the Eswatini Health Laboratory Services (EHLS) oversee various policy and operational matters in their respective areas. These include the selection of medicines, test kits, reagents and commodities, and monitoring their use to ensure that it is appropriate and rational. It also involves reviewing and ensuring adherence to national guiding documents, such as Treatment guidelines and Standard Operating Procedures (SOPs). Additionally, these departments carry out crucial regulatory functions to ensure that all medicines and test kits approved for use in Eswatini meet strict standards of safety, quality, and efficacy. These regulatory functions include licensing pharmaceutical outlets, conducting inspections of operating laboratories and pharmacies, pharmacovigilance, oversight of clinical trials, monitoring the quality of outsourced laboratory testing, verification of test kits and controlling the import and export of medicines. These departments also ensure that medical and laboratory supplies are availed to all healthcare facilities through an effective transport delivery system under the Central Medical Stores. The EHLS also provides access to testing to all facilities through its National Sample Transportation System (NSTS) which is responsible for the referral of samples from peripheral health care facilities to testing laboratories. Through these comprehensive efforts, the departments significantly contribute to maintaining the integrity and effectiveness of Eswatini's healthcare system, particularly in critical areas such as diagnosis and treatment of TB, HIV and AIDS.

Gaps and challenges

- Inefficient inventory management at primary healthcare levels, resulting in significant wastage, shortages, and stockouts.
- The data available is not fully synchronized with the supply chain needs.
- Inadequate regulatory capacity for safety and quality assurance.

Strategic Objective

- To improve supply chain management to ensure the availability, accessibility, and security of health products for HIV,TB and Malaria.

Strategic Outcomes

- Strengthened supply chain of HIV, TB and Malaria commodities, products and technologies
- Improved governance and accountability for health products and technologies, including stronger regulatory systems and mechanisms for reporting and addressing shortages or stockouts.
- Increase in use of digital technologies to improve supply chain management, enhance efficiency and accountability, and improve access to health products and technologies for populations.
- Improve quality assurance, compliance, and coordination of the supply chain.

Priority Strategies

- Strengthen supply chain and workforce capacity for managing HIV, TB and Malaria commodities, products, and technologies
- Enhance regulatory capacity, governance, and accountability for health products and technologies, including promoting digital solutions.
- Strengthen supply chain management of Maternal and Neo-natal Child Health (MNCH) and FP commodities such as dual HIV-syphilis test kits, Hepatitis B test kits, and long-acting reversible FP commodities.
- Enhance supply chain, quality assurance, and compliance for the treatment of HIV, NCDs, and opportunistic infections.
- Strengthen supply chain management for HIV, TB and Malaria opportunistic infections, NCDs, diagnostics and therapeutics.

3.2.5.2 Strengthening the HIV Response Workforce

Context

In Eswatini, a contemporary healthcare strategy is essential. A healthcare strategy that is contemporary focuses on aligning healthcare services more closely with the population's needs while enhancing cost-effectiveness. Central to this is the realization that integrated, patient-centered healthcare, especially at the primary care level, can significantly improve health outcomes. In Eswatini's context, healthcare services are often fragmented, leading to gaps in care and an inability to comprehensively address the health needs of individuals throughout their lifespans.

The integration of contemporary healthcare services in Eswatini should take into consideration the specific needs of its population and health system. It will require adjusting the levels of investment in health services, reforming education policies for healthcare training, and providing appropriate incentives for the health workforce. This approach is not just about addressing the shortage and maldistribution of health workers, but also about tackling the issue of unemployment among healthcare professionals in the country. Such a strategy will help address the labour market challenges in the healthcare sector and ensure that the unmet health needs of the population are adequately addressed.

Gaps and challenges

- Inadequate staffing leading to attrition, burnout, and need for capacity building.
- Insufficient Involvement and Engagement of Ministries of Finance and Economic Planning in human resources for health (HRH) Policy Development.
- Misaligned remuneration and support between development partners and the Government.
- Ineffective transitioning plans between partners and the Government in all aspects of the programme.
- Limited projections of human resources against service delivery requirements.

Strategic Objective

- To build and retain a capable HRH workforce that can provide quality services to support the national HIV response.

Strategic Outcomes

- Increased number of skilled healthcare workers providing HIV and AIDS services.
- Address knowledge and skills gaps through regular mentoring, training, and continuous professional development courses.
- Established pipeline of future healthcare workers from medical tertiary institutions.
- Enhanced remuneration and protection packages, and improved working environment.

Priority Strategies

- Implement a partnership-driven model to enhance the capacity of healthcare workers in the areas of HIV services.
- Conduct routine assessments and enhancement of training programs for HIV, TB, and STI, with a focus on comprehensive healthcare workforce development and capacity-building, along with specific initiatives to retain staff and reduce burnout.
- Intensify engagement with the Ministries of Finance and Economic Planning for HRH Policy Development.

3.2.5.3 Empower and Engage Communities in The HIV Response

Context

Eswatini's HIV response places a significant emphasis on engaging and empowering communities as a central component of its approach, despite the progress made in certain populations and regions. This strategy aims to prioritize coordination specific to the geographical regions and demographic groups most affected by HIV, including key population communities. Their engagement is critical to continued success in Eswatini's HIV response. The NSF is designed to foster community-led interventions and build community resilience, enhancing the impact of the response and ensuring its adaptability to evolving challenges, such as pandemics and public health emergencies.

Key to this strategy is the recognition of communities not merely as recipients of interventions but as active agents of change. Their involvement and leadership are crucial as Eswatini strives to end AIDS as a public health threat by 2030. Progress in recent years underscores the essential role of community-led HIV responses, demonstrating the effectiveness of these approaches. Additionally, there is an increasing acknowledgment of the advantages of partnering with community-led organizations to deliver people-centered HIV services. This collaborative approach is instrumental in making the HIV response more effective, inclusive, and responsive to the specific needs of the community, ultimately contributing to the broader goal of combating the HIV and AIDS epidemic in Eswatini.

Gaps and challenges

- Inadequate meaningful engagement and empowerment of communities in the HIV response.
- Weak coordination of community-led interventions including community-based workers.
- Suboptimal capacity and coverage of community-led monitoring.
- Insufficient evidence for understanding the impact of community-led interventions.
- Limited funding opportunities for community-led and community-based organizations.
- Minimal funding capacity for strengthening institutional capacity for community-led and community-based institutions.

Strategic Objective

- To strengthen community participation in the national response for transformative HIV programs that address inequalities in the HIV response.

Strategic Outcomes

- Testing and treatment services delivered by community-led organizations.
- Programmes supporting the achievement of societal enablers delivered by community-led organizations.
- Service delivery for HIV prevention programmes for key populations delivered by community-led organizations.
- Services for women delivered by community-led organizations that are women-led.

Target Populations

Geographic and population community groups in their diversity.

Priority Strategies

- Strengthen engagements with communities and development partners to advocate for sustained political commitment to the HIV response, promote human rights and dignity, and eliminate all forms of inequalities and HIV-related stigma and discrimination.
- Enhance community engagement and capacity in designing, delivering, and monitoring expanded, quality, differentiated, and tailored HIV and health interventions.
- Empower communities to play their crucial roles and generate evidence for better and more effective community-led strategies in the delivery of community-based interventions.
- Engage community-led organizations to understand and advocate for Governments to fulfill their commitments outlined in the 2021 UN General Assembly Political Declaration on HIV and AIDS.
- Integrate and strengthen community health information systems for improved efficiency and effectiveness.
- Implement and effectively manage social contracting mechanisms for community organizations.
- Advocate for increased and ring-fenced budget allocations for community-led responses.
- Strengthen institutional capacity building for Community Led Organizations (CLO) and Community Based Organizations (CBOs).

3.2.5.4: Strategic Information and Use

Context

Eswatini has made significant strides in managing its HIV response by implementing robust Information Management Systems at national, sectoral, and organizational levels. These systems are designed to track, analyse, and provide timely feedback crucial for effective HIV response management. However, the full potential of these data management systems is yet to be realized due to challenges in governance, coordination, and capacity building.

Data gathered on HIV programs in Eswatini needs to extend beyond mere HIV surveillance and expand to incorporate action-oriented and tactical use of data. It requires a comprehensive multisectoral approach to effectively address the complexity of the HIV epidemic. This calls for the interpretation of data collected by different data systems to improve the use of data.

To gauge the impact of its HIV response, Eswatini conducts regular national surveys, including SHIMS, MICS, the Stigma Index Survey, and TB Surveys. These surveys collect household data, providing valuable insights into the effectiveness of HIV response strategies. These concerted efforts are a testament to Eswatini's commitment to achieving the ambitious UNAIDS 95-95-95 targets by 2025. Eswatini's approach, marked by the integration of robust information systems and comprehensive surveys, is a progressive step towards these goals.

Gaps and challenges

- Inadequate governance and management of HIV Strategic Information.
- Insufficient capacity for HIV research implementation at levels lower than the national level.
- Lack of periodic population-based surveys that are timely to inform policy and programming.
- Weak integration of monitoring and evaluation (M&E) systems.
- Limited coordination and implementation of non-health HIV research.

Strategic Objective

- Improve coordination and partnerships among stakeholders in the collection and use of data to ensure a comprehensive and adaptive response to the HIV epidemic.

Strategic Outcomes

- Enhanced data sharing and integration.
- Strengthen collaboration and partnerships.
- Enhanced data use for decision-making.

Priority Strategies

- Strengthen governance and management of HIV strategic information.
- Intensify capacity-building efforts for sectors to implement HIV research.
- Strengthen the investment in the implementation of timely population surveys and studies.
- Strengthen the integration of the National M&E Systems.
- Scale up implementation and coordination of HIV research to include the non-health sectors.

3.2.5.5 Leadership, Advocacy and Coordination

Context

Eswatini has demonstrated consistent high-level political and policy support for HIV response, with the Prime Minister's Office playing a pivotal role in multi-sectoral coordination and integration of HIV initiatives into the Government's budget. Strategic frameworks have been developed to guide stakeholders in their response efforts. Coordination is a key aspect, managed by the National Emergency Response Council on HIV and AIDS (NERCHA), a government parastatal established in 2001.

NERCHA focuses on upstream coordination of HIV services while gradually reducing its involvement in downstream activities. This approach remains vital, especially considering the reduction in new HIV infections and the improved health outcomes of PLHIV. The multisectoral response plays a critical role in maintaining these gains and mitigating the risk of regressing from the current state nearing epidemic control.

Addressing the legal and socio-economic determinants of HIV infections, along with promoting treatment uptake, continuation, and viral suppression, is essential for sustaining progress and achieving the remaining goals for epidemic control. The primary objective of this strategy is to ensure robust and responsive coordination in the HIV response, thereby accelerating the journey towards and maintaining epidemic control. This comprehensive approach underscores the importance of collaboration, effective policy implementation, and a focus on both prevention and treatment to achieve long-term success in combating the HIV epidemic.

Gaps and challenges

- Sub-optimal coordination of resources, planning, implementation, monitoring, and reporting of the response due to partial implementation of the coordination framework.
- Limited capacity and evolution of the coordination body to respond to an evolving response.
- Inadequate regulation of NGOs leading to unregulated and unaccredited organisations implementing the response.
- Unavailability of effective functional networks for key and priority populations for the HIV and AIDS response e.g., networks of PLHIV.
- Weak accountability of multisectoral stakeholders on the response implementation leading to not attaining the goals of the HIV and AIDS response.

Strategic Objective

- To strengthen multisectoral coordination, collaboration, and accountability for an integrated and coherent HIV and AIDS response.

Strategic Outcome

- >90% of the NSF outcome-level targets have been met.

Target Populations and Structures

The implementation stakeholders of the HIV response are the Public, Private, Civil Society Sectors, and Development Partners listed in Table 9 with roles and responsibilities according to their mandates.

Table 9: Roles and Responsibilities

Stakeholder	Roles and Responsibilities
Office of the Prime Minister	• Provide political leadership in the national multi-sectoral HIV and AIDS response. • Advocate for improved political commitment and sustainability of the response. • Advocate for sustainable financing for the national multi-sectoral response, collaborating with government bodies and development partners. • Promote national and community ownership of the response. • Ensure an enabling social, policy, and legal environment for the response. • Review programmatic and management policy documents and proposals submitted by the NERCHA. • Champion the continued prioritization of HIV and AIDS response within national social, economic, and political agendas. • Ensure National AIDS Council's (NAC) adherence to the stipulations of the NERCHA Act, National HIV and AIDS Policy, and other relevant policies and laws.
National Emergency Response Council on HIV and AIDS (NERCHA)	• Collaborate with various ministries and sector leads to align and prioritize initiatives for HIV prevention, care, and treatment. • Advise the Prime Minister on the progress and challenges of the national HIV and AIDS response. • Advocate for continued prioritization of HIV and AIDS response on the national social, economic, and political agenda. • Advocate for sustainable financing of the national multi-sectoral response with government and development partners.
Ministry of Health	• Regulation, formulation, and review of health sector policies and guidelines on HIV prevention, treatment, and care. • Strengthening, availing, and quality assurance of the health system, including infrastructure and equipment, and human resources at and linked to health facilities. • Procurement and supply chain management of pharmaceuticals, vaccines, laboratory commodities, health equipment, and other technologies. • Adequate budget allocation for HIV within the health sector. • Ensuring strong laboratory systems and managing the health information management system. • Ensuring access to services by the general population, PLHIV, people affected by TB, and key and priority populations.

Stakeholder	Roles and Responsibilities
Ministry of Education and Training	• Facilitate the integration of HIV and AIDS education into curricula and activities in learning institutions. • Focus on HIV prevention among children and young people, including through comprehensive sexuality education (CSE) delivery. • Promote the uptake of HIV prevention and treatment services and products. • Implement social protection measures, such as school feeding programs and the provision of menstrual hygiene kits. • Identify survivors of SGBV and other children who require legal
Deputy Prime Minister's Office	• Influence change in policies and legislation to address gender equality, gender-based violence, OVC, social protection, and delivery of social services.
Ministry of Sports, Culture and Youth Affairs	• Develop effective response strategies based on sports, arts, and culture. • Create opportunities for young people's involvement and enhancement in sports and culture.
Ministry of Labor and Social Security	• Integrate all HIV programs and policies in the workplace and surrounding communities. • Identify individuals qualifying for social protection provided by other ministries or sectors to alleviate the social and economic impacts of HIV and AIDS • Provide social security to vulnerable individuals in collaboration with other implementers. • Diversify strategies for creating jobs and employment to mitigate the effects of low socio-economic status, which is associated with risky behaviours. • Collaborate with NERCHA to coordinate the identification and targeting of vulnerable individuals.
Ministry of Finance	• Mobilize resources for HIV and influence other sectors to mainstream HIV and AIDS through sector budgets to increase HIV financing.
Ministry of Economic Planning and Development	• Secure funding for HIV initiatives and programs. • Advocate for HIV integration into broader development priorities. • Ensure HIV considerations in various sectoral plans and budgets. • Promote economic strategies benefiting vulnerable populations affected by HIV.
Ministry of Public Works and Transport	• Implement prevention measures for both construction workers and local communities. • Offer HIV services tailored to the needs of mobile transport operators.
Ministry of Tinkhundla Administration and Development	• Coordinate regional and community-based HIV and AIDS interventions. • Strengthen regional AIDS committees to more efficiently coordinate the response on behalf of the government and other sectors.

Stakeholder	Roles and Responsibilities
	• Mobilise communities to access HIV services.
Ministry of Housing and Urban Development	• Coordinate urban municipal and ward-based HIV and AIDS interventions. • Strengthen municipal AIDS committees to more efficiently coordinate the response on behalf of the government and other sectors. • Mobilise urban communities to access HIV services. • Facilitate decent housing programmes in both rural and urban environments.
Ministry of Agriculture	• Ensure the integration of HIV and AIDS activities within the agriculture sector. • Implement suitable interventions to address the HIV and AIDS disease burden and vulnerability, as part of major programs in the sector. • Lead the effort to incorporate HIV and AIDS considerations into livelihood programs, agricultural research, and extension services.
Ministry of Natural Resources	• Ensure equitable access to natural resources, mainly portable water and sanitation.
Ministry of Public Service	• Coordinate the Public Sector workplace wellness programme. • Develop Public Sector Wellness policy and strategy and facilitate its implementation. • Ensure integration of the Public Sector Wellness programs in the overall Human Resource management systems.
Ministry of Tourism and Environmental Affairs	• Develop effective HIV strategies that can reduce risk exposure among tourists and mobile population. • Ensure that all Environmental Impact Assessments (EIA) include HIV externalities.
Ministry of Commerce, Industry and Trade	• Promote income generation programs for vulnerable populations and promote HIV and AIDS responses within commercial systems.
Ministry of Justice and Constitutional Affairs	• Ensure the review, implementation, and monitoring of appropriate legislations and policies that support the national response to HIV. • Address drivers of HIV infection related to violations of rights. • Enforce regulations against sexual and gender-based violence, stigma, and discrimination, while promoting good governance and accountability.
Ministry of Home Affairs	• Ensure all persons have legal identification documents, especially vulnerable populations.
Ministry of Foreign Affairs and International Cooperation	• Develop and administer a sound foreign policy on safeguarding national interest. • Foster bilateral and multilateral relations. • Support cross-border treatment for Swazi nationals abroad.
Ministry of	• Ensure dissemination of HIV and AIDS information.

Stakeholder	Roles and Responsibilities
Information, Communication and Technology	• Ensure interoperability of all data systems, for ease of data sharing and use.
Ministry of Defence	• Empower forces to adopt positive prevention behaviours and support treatment.
Development Partners	• Implement a partnership sustainability and accountability framework (National and Regional level) to ensure alignment of resources to NSF priorities. • Facilitate planning by reporting contributions to NSF priorities annually. • Mobilize technical and financial resources for the HIV response.
Civil Society	• Engage in the development and review of HIV and AIDS policies, focusing on aspects like prevention, care, support services, program financing, and structural challenges such as stigma, discrimination, and gender-based inequalities. • Utilize digital technologies to enhance the use of data from community scorecards for quality improvement in HIV and AIDS responses. • Carry out evidence-based advocacy at local and national levels to ensure accountability from duty bearers for HIV prevention services, AIDS treatment, and social support, particularly for key and Priority populations such as persons with disabilities (PWD), key populations (KPs), women, and girls. • Enhance collaboration and networking with various actors in the public and private sectors to ensure effective linkage and coordination. • Work with stakeholders to drive social mobilization efforts for improved service uptake in HIV and AIDS care and prevention. • Foster collaboration and networking to reduce vulnerabilities and promote equity in HIV and AIDS response, engaging with actors in both public and private sectors. • Lead capacity-building initiatives for community-based organizations at lower levels, enabling them to effectively participate in social mobilization, education, and resource mobilization. • Support NERCHA and the government in implementing the National Strategic Framework (NSF) for HIV and AIDS. • Encourage and support self-regulation among civil society members involved in HIV and AIDS activities. • Conduct regular reporting on HIV and AIDS activities undertaken to ensure transparency and inform future strategies.
Private Sector	• Develop a strategy for the private sector to effectively contribute to achieving national HIV and AIDS response goals. • Utilize market-based approaches to enhance access to patient-centred HIV services and products in private outlets, facilitate access

Stakeholder	Roles and Responsibilities
	to private financing for local private health organizations, and introduce innovative technologies to improve patient outcomes. • Engage in high-level advocacy, leveraging their influence to promote accountability and transparency in reporting social welfare program expenditures, reduce the costs of drugs and supplies, and participate in innovative public-private research and development partnerships. • Establish and support workplace AIDS committees to manage education, condom distribution campaigns, informational sessions for people living with HIV, and awareness events, especially around World AIDS Day. • Foster healthy workplaces by defining roles and responsibilities at all policy and decision-making levels, implementing and evaluating workplace HIV programs by national and International Labour Organization (ILO) standards on HIV and AIDS and the world of work. • Promote and support the private delivery of HIV and AIDS services and the development of related markets. • Advocate for blended financing models in the HIV response. • Assist in modernizing supply chain management for HIV and AIDS services and products. • Support the development of social enterprises and public-private partnerships in the HIV response.

Priority Strategies

- Strengthen coordination systems to align and respond to current coordination needs (review of coordination framework, and coordination structures).
- Strengthen the composition and capacity of the coordinating body to coordinate an evolving response.
- Institutionalise and routinize transparent multisectoral period review to account for progress and adjustments and remain responsive to emerging issues of the response.
- Establish the advocacy of multisectoral stakeholders in the regulation and accreditation of NGOs.
- Strengthen the networks of key and priority populations to facilitate advocacy, engagement, and participation in the HIV response.
- Enhance line ministries to facilitate collaboration among implementing partners at the implementation level for the provision of comprehensive services.
- Strengthen inclusive and transparent accountability of multisectoral stakeholders implementing the HIV response to facilitate complementarity in addressing health and education and socio-economic vulnerabilities of key and priority populations.

3.2.5.6 Sustaining the HIV Response Beyond 2030

Context

As countries work to reach the goal of ending AIDS as a public health threat by 2030, planning is urgently needed for sustaining what has already been achieved and scaling up towards global targets. The strategies and delivery modalities required for scaling up prevention and treatment services and ensuring a stable enabling environment to reach the 2030 target will differ from those that will be needed for long-term sustainability. Leveraging societal enablers will be especially critical for sustainability, including minimizing HIV vulnerability and ensuring access to services in future decades.

Rather than build incrementally on what is already in place, sustainability will demand transformations in human rights-based and people-centred policies, programmes, and systems.

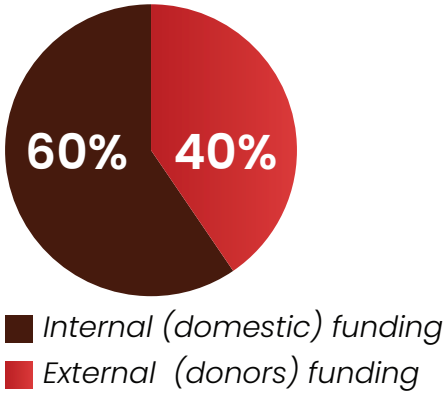
Objective of the HIV Response Sustainability

The objective of the HIV response sustainability is not to perpetuate the HIV response in its current form but rather to ensure the durability of the impact of the HIV response. The aim is to galvanize efforts and drive sustainable HIV response transformations to reach and maintain epidemic control beyond 2030.

Importance of the Sustainability Road Map

As the country moves towards achieving epidemic control, sustainability planning and management becomes an essential discipline for ensuring that the gains already attained are sustained and that existing gaps are closed. After the 95 95 95 achievements, the next phase of the HIV response is centered around building a sustainable HIV response characterized by strong political leadership and resilient programmatic and optimised financial systems. In addition, reaching the 2030 goal of ending AIDS as a public health threat, and sustaining these gains beyond 2030 will require active engagement of multiple groups, including communities, civil society, people living with HIV, and key and vulnerable populations. Resources will need to be mobilized from both domestic and international sources, including ensuring efficiencies in the utilization of existing financial resources. Service approaches and systems will need to be adapted to deliver holistic, integrated, person-centred care, with attention to comorbidities experienced by people living with HIV across the life cycle. Counterproductive policies that increase vulnerability and diminish service access will need to be repealed or reformed. Both service approaches and policy reforms will need to take account of the unique needs of key and vulnerable populations, which are often poorly served by mainstream systems.

Furthermore, HIV response financing is at a huge risk. The substantial and widening funding gap for the global HIV response poses a potentially critical impediment to long-term sustainability. According to the UNAIDS 2023 financial estimates report, HIV financing from other donors has fallen by 61% since 2010. These declines are unfortunate, as investing in the HIV response yields high returns on saving lives, reducing mortality, strengthening systems for health, contributing to health security, and generating both social benefits and economic growth. Unfortunately, these declines will continue as the demand on the world to respond to various phenomena like global warming, political conflicts, emerging health crisis and others continue to make demands on the global financial envelope. As shown in figure 8 below, the HIV response in Eswatini is largely resourced by external funders.



Although international financing is essential to reach global AIDS targets and to sustain gains beyond 2030, mobilizing donor funding for HIV is becoming ever more difficult. Domestic investments are already overstretched and may not be a source of new HIV resources due to many reasons such as the challenging global macroeconomic environment. Many low- and middle-income countries have struggled to return to pre-COVID economic growth and government spending trajectories, particularly for health, education, and social spending.

***Adopted from NASA 2020 (26)*

Figure 8: HIV Response Sources of Funds

As such this framework has prioritized the development, implementation, and monitoring of Eswatini's HIV Response Sustainability Road Map that encompasses various aspects of the roadmap to include political commitment, integration, health program strengthening, health systems improvement, and a financing landscape. To sustain health financing the country also must seriously consider undertaking efficiency studies to identify areas of savings that will stretch the already available resources.

Components of the Sustainability Road Map

The proposed sustainability roadmap will outline five components that are required in Eswatini to achieve the global AIDS targets for 2030 and sustain these gains beyond as articulated in Figure 9.

Figure 9: Components of the Sustainability Road Map

The Process of Developing the Roadmap

The Government of Eswatini will set up a high-level committee to develop an approach, set the vision for how the process will be structured, and oversee the processes of developing the roadmap. With support from NERCHA, UNAIDS, PEPFAR, and the Global Fund, the Government of Eswatini, led by the Secretary to Cabinet, will convene and engage in multiple discussions with relevant key stakeholders to develop a country-led HIV response sustainability roadmap. The roadmap will be built around the existing government structures and work that has been done thus far.

Partners will support the Government of Eswatini to create a roadmap that will complement the existing National Multisectoral HIV and AIDS Response Strategic Framework (NSF) and other national health and economic planning strategies. His Excellency, the right honourable Prime Minister will launch the process of developing the roadmap.

Key Roles & Responsibilities

- **The Government of Eswatini** will identify a sustainability champion within the office of the Secretary to Cabinet who will act as the main focal person for HIV sustainability in Eswatini. This champion will work closely with the consultant and the committee to lead and guide all stakeholders throughout the process of developing the roadmap. He or she will establish clear metrics and milestones to guide all partners and key stakeholders.
- **Development Partners** will fund a consultant to work directly with an identified sustainability champion within the office of the Secretary to the Cabinet and continuously offer technical expertise during the development process.
- **NERCHA** will offer coordination and resource support for logistics, meetings, and any other administrative support identified to ensure multisectoral stakeholder engagement throughout the roadmap development process.

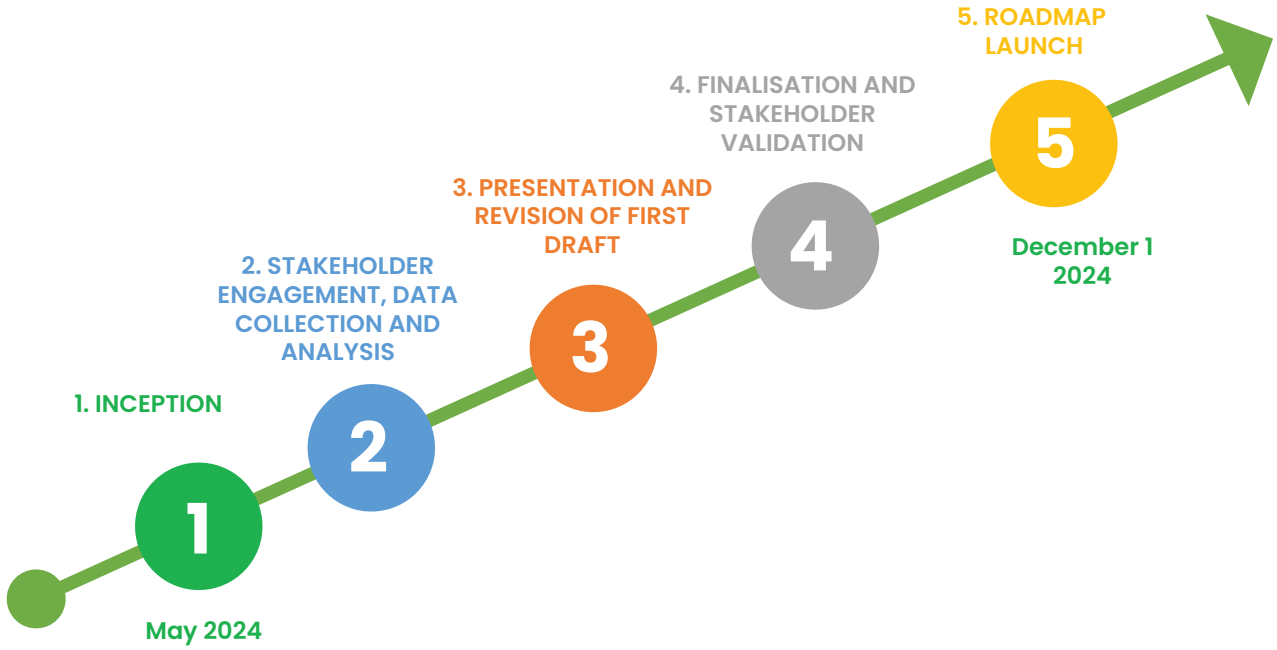


Figure 10: Key timelines

Emergency Preparedness and Contingency Plan

Health emergencies have double effects on national economies, people's health, livelihoods and national development reversing economic gains. The COVID-19 pandemic negatively impacted the health of Eswatini's population. The pandemic illuminated and magnified major gaps in Eswatini's health system and emergency preparedness. with a high HIV prevalence, persistently high maternal and child mortality, and a rise in non-communicable diseases, COVID-19 affected the country's economic advancements. To successfully implement the strategic framework, an intersectoral approach will be utilized. NERCHA will provide oversight for the multisector response incorporating lessons learnt and best practices from the COVID-19 pandemic and other civil instability, including Community Commodity Distribution and structured treatment preparation in the country.

The focus will be on:

- Strengthening the collaboration with the National Disaster Management Agency (NDMA) for risk mitigation against emergencies that result in negative impacts to the HIV response.
- Continued capacity building on risk identification, classification, and management.
- Established feedback mechanism during emergencies.
- Build knowledge and skills on risk reduction.
- Health systems strengthening.
- Strategic and technical guidance as well as coordination with stakeholders.
- Sustaining high retention and viral suppression rates among PLHIV.

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ANNEX I: M&E RESULTS FRAMEWORK

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
	NATIONAL IMPACT LEVEL TARGETS							
Reduced new HIV infections by 50%		HIV incidence rate among people aged 15+ years	0.62	2021	SHIMS3	Sex	0.55	0.31
		HIV incidence rate among females aged 15-49 years	1.45	2021	SHIMS3	Sex	0.90	0.73
Reduced AIDS related deaths by 50%		Total annual AIDS-related deaths	2,600	2023	Eswatini HIV Estimates and Projections Report	Sex Age	2,000	1,300
Reduction of MTCT rate to less than 1% by 2028	HIV I-6	Percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	1.34	2023	EPIMS (Eswatini HIV Estimates and Projections Report)		<1.0	<1.0
OUTCOME AND OUTPUT TARGETS								
Strategic Priority 1: Optimize HIV Testing and Linkage Services for Key and Priority Populations to close the Gaps in the HIV care continuum.								
Focus Area 1.1: HIV Testing Services								
OUTCOMES								
95% of people within sub-populations who live with HIV know their status		Percentage of people living with HIV who know their HIV status at the end of the reporting period	94%	2021	SHIMS3	Sex Age	>95%	>95%
95% coverage in all populations, age groups and geographic areas of HIV testing services		Percentage of integration of HIV testing into all health service delivery points	82%	2019	MoH, End of term review, TB/HIV/EMTCT SHIMS3	Sex Age	90%	95%
OUTPUTS								
		Number of people tested for HIV	186,786	2023	MOH HIV Annual Report	Sex Age Pop group Geographic	198,029	239,615
		Number of HIV self - tests distributed	79,947	202 2	MOH HIV Annual Report		109,118	250,967
		Number of health service delivery points with integrated HIV testing	287	2022	MOH HIV Annual Report	Facility type	311	320
Strategic Priority 2: Precision prevention of new HIV among all Emaswati at high risk of HIV infection.								
Focus Area 2.1: Risk Reduction Communication								
OUTCOMES								
90% of at risk and vulnerable key and priority populations take up combination prevention services.		Percentage of risk and vulnerable key and priority populations demonstrate low risk behaviours	72% (F) 87% (M)	2023	MICS	Sex	80% 90%	90% >90%
OUTPUTS								
	YP- 2	Percentage of adolescent girls and young women	32%	2022	SHAPMoS	Age	50%	80%

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
		reached with HIV prevention programs - defined package of services						
	KP- 1a	Percentage of MSM reached with HIV prevention programs - defined package of services.	48%	2022	SHAPMoS	Age	75%	90%
	KP- 1c	Percentage of sex workers reached with HIV prevention programs - defined package of services	10%	2022	SHAPMoS	Age	50%	90%
Focus Area 2.2: Condom and Lubricants Programming								
OUTCOMES								
Increased availability of both male and female condoms by 50%. Increased correct and consistent use of condoms (male and f emale) by 50%.	HIV O - 10	Percentage of AGYW (15 - 24) who say they used a condom the last time they had sex with a non - regular partner, of those who have had sex with such a partner in the last 12 months	72%	2023	MICS	Age	80%	90%
	HIV O-4a	Percentage of men reporting using a condom the last time they had anal sex with a male partner	60%	2021	IBBS	Age	80%	90%
	HIV O-5	Percentage of sex workers reporting using a condom with their most recent client	50%	2021	IBBS	Age	80%	90%
OUTPUTS								
		Number of condoms distributed	9,900,00 (Male)	2022	SHAPMoS		13,000,000	15,000,000
			380,000 (Female)	2022			500,000	600,000
Focus Area 2.3: ARV- Based Prevention								
OUTCOMES								
>95% of all eligible clients receive PrEP for HIV prevention purpose.		>95% adherence rates for clients on PrEP	30%	2022	MOH Annual Report	Sex Age KP Migrant population	60%	>95%
>95% of all eligible clients receive PEP for HIV prevention purpose		>95% of eligible clients initiated on PEP	65%	2022	MOH Annual Report	Sex Age Geographic	80%	>95%
OUTPU TS								
		Percentage of eligible clients who initiated on PrEP during the reporting period.	12%	2022	MOH Annual Report	Sex Age Geographic Pop group	60%	>95%
		Percentage of eligible clients receiving PEP	65%	2022	MOH Annual Report	Age Sex Pop group	75%	85%

Focus Area 2.4: Voluntary Medical Male Circumcision (VMMC)								
Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
OUTCOMES								
Increased VMMC coverage in men 15 - 49 years from 41% to 60% by the end of the strategy.		Percentage of men 15 – 49 that are circumcised.	41%	2022	MOH Annual Report	Age	50%	60%
OU TPUT								
		Number of medical male circumcisions performed	6,426	2022	MOH Annual Report	Age	7,199	7,711
Focus Area 2.5: Elimination of Mother to Child Transmission (EMTCT)								
OUTCOMES								
<1% MTCT rate between 18 - 24 months by 202 8		<1% MTCT rate between 1 8 - 24 months	1.34	2023	EPIMS		<1%	<1%
OUTPUTS								
	TCS - 10	Percentage of pregnant and breastfeeding women living with HIV who received antiretroviral therapy to reduce the risk of vertical transmission of HIV	97%	2022	MOH Annual Report		98%	98%
	VT - 2	Percentage of HIV - exposed infants receiving a virological test for HIV within 2 months of birth.	88%	2022	MOH Annual Report		100%	100%
	VT - 3	Percentage of women accessing antenatal care services who were tested for syphilis	4 1%	2022	MOH Annual Report		70 %	90%
Focus Area 2.6: Harm Reduction for HIV Prevention								
OUTCOMES								
90% of PWID utilised appropriate HIV prevention and treatment services.		Percentage of PWIDs who access combination HIV prevention services	No baseline		SHAPMoS	Sex Age	70%	>90%
OUTPUTS								
	HTS - 3d	Percentage of PWID that have received an HIV test during the reporting period in KP - specific programs and know their results	22%	2022	MOH Annual Report	Sex Age	70%	90%
		Percentage of eligible PWID who initiated oral antiretroviral PrEP during the reporting period	4 2%	2022	MOH Annual Report		70%	90%
Strategic Priority 3: Address emerging gaps and ensure equitable access to care and treatment for All PLHIV								
Focus Area 3.1: STIs and Viral Hepatitis Prevention, Screening and Management								
OUT COMES								
95% of at - risk populations screened and treated for STI by 202 8		Percentage of people aged (15 – 49) who had a sexually transmitted infection in the past 12 months	No baseline		MOH Annual Report	Sex Age Type Pop group	100%	100%
OUTPUTS								
		Pe rcentage of people with STIs who receive an HIV	No baseline		MOH Annual Report	Sex Age	100%	100%

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
		test and receive post test results				Pop group		
Focus Area 3.2: HIV Care, Treatment and Quality of Life								
> 95% of all individuals and sub - populations diagnosed with HIV are on ART > 95% viral suppression among all sub - populations of PLHIV on ART 50% reduction in AIDS - related mortality by 202 8	HIV O - 21	Percentage of patients initiated on ART are retained in care at 12 months	97%	2021	SHIMS 3	Sex Age Pop group	> 95%	> 95%
	HIV O - 12	Percentage of people living with HIV and on ART who are virologically suppressed	98%	2022	SHIMS 3	Sex Age Pop groups	> 95%	> 95%
OUTPUTS								
		Number of PLHIV on ART	209,344	2023	MOH Annual Report	Sex Age Pop groups	214,759	220,174
	HIV O - 12	Percentage of people living with HIV and on ART who are virologically suppressed	98%	2022	MOH Annual Report		> 95%	> 95%
		Number of AIDS related deaths	2,600	2023	Eswatini HIV Estimates and Projections Report	Sex Age	2,000	1,300
Foc us Area 3.3: Integrated service provision to address the HIV/TB syndemic								
OUTCOMES								
100% of PLHIV visits are screened for TB. 100% TB/HIV co - infected people are started on optimal ART. Mortality among TB/HIV co - infected patients < 5%		Percentage of TB/HV col-infected patients receiving both TB treatment and ART	98%	2023	MOH Annual Report	Sex Age	100%	100%
		TB/HIV mortality rate per 100,000 population	54	2022	Eswatini Draft TB Profile (WHO)	Sex Age	33	27
OUTPUTS								
	TB/HIV-3.1a	Percentage of people living with HIV newly initiated on ART who were screened for TB	88%	2022	MOH Annual Report	Sex Age	100%	100%
	TB/HIV-7.1	Percentage of people living with HIV currently enrolled on antiretroviral therapy who started TB preventive treatment (TPT) during the reporting period	76%	2022	MOH Annual Report	Sex TPT regimen Age	>95%	>95%
Focus Area 3.4: NCDs, Cervical Cancer among PLHIV								
OUTCOMES								
At least 90% of all PLHIV are screened for all defined NCDs		Percentage of all PLHIV screened for all defined NCDs (DM, HTN, cervical	No baseline		MOH Annual Report	Sex Age	80%	90%

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
(DM, HTN, cervical cancer) and Mental health at least once a year		cancer) and Mental health at least once a year						
OUTPUTS								
		Number of all PLHIV screened for all defined NCDs (DM, HTN, cervical cancer) and Mental health at least once a year	No baseline		MOH Annual Report	Sex Age	TBD	TBD
		% of female PLHIV who were screened for cervical cancer at least once during the past 12 months	<45%	2020	MOH Annual Report	Sex Age	50%	>50%
Strategic Priority 4: Eliminate Structural Barriers and Enhance Social Enablers to Achieve HIV Outcomes								
Focus Area 4.1: Economic Strengthening Enabling HIV Prevention, Care and Treatment								
OUTCOMES								
95% of vulnerable key and priority populations at risk of contra cting HIV start and sustain economic development interventions		Percentage of PLHIV engage in sustainable economic activities	No baseline	2022	SHAPMoS	Sex Age PLHIV PWD	80%	95%
		Percentage of AYP engage in sustainable economic activities	No baseline	20 22	DREAMS Database		80%	95%
OUTPUTS								
		Number of young people aged 15 - 24 who are out of school engaged in entrepreneurship activities	3,725	2022	SHAPMoS	Sex Age PLHIV PWD	20,000	50,000
		Number of PLHIV engaged in economic strengthening activities	No baseline		SHAPMoS	Sex Age PWD	TBD	TBD
		Percentage of vulnerable young people aged 15 – 24 reached with at least one economic empowerment intervention	22%	2022	SHAPMoS	Sex Age PLHIV PWD	50%	70%
Focus Area 4.2: Reduce gender inequities and Sexual and Gender Based Violence (SGBV)								
OUTCOMES								
<10% of women, girls, PLHIV and key and priority populations experience gender inequality and violence.		Percentage of people who experience gender - based violence	28%	2023	MICS	Sex Age Pop groups PWD	<20%	<10%
OU TPUTS								
		Percentage of children aged 0 - 14 who experience sexual violence	29%	2021	SHIMS 3	Sex Age	<20%	<10%
		Percentage of women aged 15 and older who experience sexual violence	5%	2019	National HIV Prevention Policy	Pop groups Age;	<3%	<1%
		Percentage of women aged 15 and older who experience GBV	48%	2022	VAC	Pop groups Age; P	<20%	<10%

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
		Percentage of PLHIV and key and priority populations who experience gender inequality and violence	No baseline			Sex Age Pop groups	<20%	<10%
Focus Area 4.3: Education enabling HIV Prevention, Care and Treatment								
OUTCOMES								
100% of priority populations are enrolled, retained and complete all levels of education		Percentage of people enrolled, retained and complete all levels of education Enrolment rate	98%		EMIS	Sex Age Levels	98%	98%
		Completion (Survival) rate	57.8%		EMIS	Sex Age Levels	70%	75%
		Completion rate	57.8%		EMIS	Sex Age Levels	70%	70%
100% of priority populations are appropriately linked to relevant bio medical and structural interventions		Percentage of people appropriately linked to relevant bio medical and structural interventions	No baseline		SHAPMoS	Sex Age Pop groups	50%	70%
100% of priority populations who drop out of education system are linked to economic and social protection programmes		Percentage of priority populations who drop out of education system linked to economic and social protection programmes	6%		SHAPMoS	Sex Age Pop groups	TBD	TBD
OUTPUTS								
		Number of in - school youth who have attended life skills education at school	152,333	2019	EMIS	Sex Age PWD	269,656	270,812
		Number of out of school youth reached with HIV prevention education	88,349	2022	SHAPMoS	Sex Age PWD	116,763 90% (105,087)	122,462 90% (110,216)
Focus Area 4.4: Stigma and Discrimination Reduction Enabling HIV Prevention, Care and Treatment								
OUTCOMES								
<10% PLHIV and KP report experiences of stigma and discrimination <10% of AGYW and boys and young men reporting fear to access HIV prevention services >90% PLHIV and KP accessing health care services		<10% of PLHIV, key and priority populations report experiencing stigma and discrimination	10%	2019	Stigma Index	KPs	<10%	<10%

Result	Ref	Indicator	Baseline Value	Year	Data Source	Disaggregation	Target 2026	Target 2028
At least 95% of PLHIV are taking HIV treatment consistently								
OUTPUTS								
	HIV O - 15	Percentage of PLHIV who report experiences of HIV - related discrimination in health - care settings	15%	2022	Stigma Index	Age PWD	11%	<10%
	HIV O - 28a	Percentage of MSM who report having experienced stigma and discrimination in the last 6 months	2%	2022	Stigma Index	Age PWD	<2%	<1.0%
	HIV O-28c	Perce ntage of sex workers who report having experienced stigma and discrimination in the last 6 months	16%	2022	Stigma Index	Age PWD	12%	<10%
Focus Area 4.5: Social Protection Enabling HIV Prevention, Care and Treatment								
OUTCOMES								
95% of OVC receiving compreh ensive package of HIV services		Percentage of OVC receiving comprehensive package of HIV services	88%	2023	DREAMS Database	Age	90%	95%
OUTPUTS								
		Number of OVC receiving comprehensive package of HIV Services	27,883	2022	SHAPMoS	Age	49,362	53,484
		Number of orphans receiving social grants	58,847	2023	DPMO Annual Perfomance Report	Age	61,703	64,181
		Number of young people aged 15 - 24 who are out of school who receive a school subsidy	No baseline		DREAMS Database	Age	5,000	10,000
Strategi								
Focus Area 5.1: Health Products and Technology (HPT) Security								
OUTCOMES								
Strengthened supply chain of HIV commodities, products and technologies								
Improved governance and accountability for health products and technologies, including stronger regulatory systems and mechan reporting and addressing shortages or stock outs								
Increase in use of digital technologies to improve supply chain management, enhance efficiency and accountability, and improve access toisms for health products and technologies for populations								
Improve quality assurance, compliance, and coordination of the supply chain								
OUTPUTS								
		Percentage of facilities reporting a stock out of preferred first line HIV drug	3%	2020	National Health Sector Strategic Plan, 2020-23		<2%	<1%
		Percentage of facilities with a functional Electronic Logistics Information Management Systems	90%	2020	National Health Sector Strategic Plan, 2020-23		95%	>95%

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