MaxART final report phase 1
Colophon

MaxART final report phase 1

Published: December 2015
Author: Françoise Jenniskens
Photos: Adriaan Backer (page 7, 8, 18, 21, 24, 29, 32) and Maureen Sellmeijer (cover, page 13, 23, 31)
STOP AIDS NOW! (page 26)
Design: de Handlangers, Utrecht

For more information on the MaxART programme visit: www.stopaidsnow.org/treatment-prevention

The Swaziland Ministry of Health, STOP AIDS NOW!, and the Clinton Health Access Initiative (CHAI) initiated the MaxART project in Swaziland. The programme partners include the Swaziland Network of People Living with HIV and AIDS (SWANNEPHA) and the Global Network of People Living with HIV (GNP+), the National Emergency Response Council on HIV/AIDS (NERCHA), national and international non-governmental organisations including the Southern Africa HIV & AIDS Information Dissemination Service (SafaIDS), social scientists from the University of Amsterdam and researchers from the South African Centre for Epidemiological Modelling and Analysis (SACEMA).
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Executive summary

The MaxART programme

In 2011, STOP AIDS NOW!, in collaboration with the Ministry of Health and six consortium partners launched a pioneering project in Swaziland: “Maximizing ART for Better Health and Zero New HIV Infections” (MaxART). The ambitious goal of MaxART, is to improve the lives of people living with HIV and prevent new HIV infections in Swaziland, a country with the highest HIV prevalence in the world.

This idea received generous funding from the Dutch Postcode Lottery’s Dream Fund (8.8 million Euro) as it attempts to catalyse a fundamental shift in the way the international community approaches the HIV epidemic. The consortium proposed a new and bold approach to virtually eliminate new HIV infections, even in the most difficult of circumstances. Swaziland, then the country with highest prevalence of HIV in the world, was selected as the country to test if this dream could come true.

The vision of MaxART is to reach all people in Swaziland who are in need of treatment with an ultimate goal of preparing the country for the possibility of ending the HIV epidemic that will be exemplary for the Southern African region.

The programme has three goals, further reported on as Keys:

**Key 1: Achieving universal access to testing and treatment in Swaziland**

**Key 2: Assessing the impact of universal access to testing and treatment on prevention efforts**

**Key 3: Demonstrating treatment as an effective form of prevention in a high prevalence setting**

The programme is implemented in two phases. The first phase (2011-2015) of MaxART supported a number of interventions and systems strengthening activities aimed to achieve universal access to HIV treatment and to improve the health of the people of Swaziland. The targets of this phase were:

- Dramatically scale-up HIV testing to 250,000 people per year;
- Improve access to antiretroviral therapy (ART) so that 90% of those in need at the then current eligibility requirements (CD4 less than/equal to 350) are on treatment;
- Reduce loss-to-follow-up of clients on treatment from 22% to 10% by 2014.

Phase 1 focused on the implementation of innovative, evidence-informed, and rights-based interventions, all aligned with the country’s HIV treatment guideline (at this time, individuals were eligible for treatment with a CD4 count below 350 cells/mm3). The network of PLHIV was involved from the start to help the consortium to operationalise human rights based responses and the concept of Greater Involvement of PLHIV (GIPA). Linkages between the community and the health facility were strengthened, to increase the uptake of services and improve retention in care. Community interventions formed an essential part of increasing uptake of HIV testing, treatment and retention in care. MaxART targeted the general population with a particular focus on hard to reach men and adolescents, and embraced community owned and driven solutions. Social science research and human rights monitoring generated evidence on the barriers and opportunities related to scaling up HIV testing, treatment adherence, care and support. Lessons learned were discussed in face-to-face meetings held twice per year. During these meetings evolving evidence and analysis of human rights aspects helped to continuously improve activities.

Phase 2 of MaxART (2014-2017) the consortium embarks on the Early Access to ART for All demonstration project. The aim is to evaluate the feasibility, acceptability, clinical outcomes, affordability, and scalability of offering ART to all People living with HIV (PLHIV) in Swaziland’s government-managed health system. Besides evaluating clinical outcomes, the focus will also be on how communities perceive this intervention, and analysing the economic impact for the country. Community engagement will form an integral part of the implementation of Early Access to ART for All, ensuring that the community’s interests are voiced and protected.

Implementation of Phase 1

Different MaxART partners have contributed to different interventions. In this report we report for MaxART as a whole. The project employed different strategies that were all supporting the targets of key 1 and key 2 and mutually reinforced each other. The following figure depicts the different interventions indicating the support along the continuum of care. Figure 1 shows the concept used by the partners, whereby all community level interventions are highlighted in green and health facility level interventions in black.

Strategies focused on community mobilisation and demand creation for HIV testing and treatment as well as on retention of PLHIV on ART. The linkages between the communities and health facilities were strengthened and at facility level the project contributed with the implementation of several national strategies such as Provider Initiated Counselling and Testing (PICT) as well as Nurse-led ART Initiation in Swaziland (NARTIS). The health system was further strengthened through...
Executive summary

- Nurse-led ART initiation
- Strong adherence counseling
- Improved laboratory services (sample transportation)
- Strong supply chain system
- POC CD4 testing
- Strengthening treatment support
- Improved linkages, including referral system
- SMS appointment reminder system
- Treatment support
- Linkages with community health workers
- Reduced stigma through initiatives by PLHIV
- Strengthen community mobilization through CBVs
- Engage traditional leadership
- Male-focused health days
- Adolescent support initiative
- Demand Creating Community Dialogues
- Mobilising communities
- Reaching out to youth and men
- Bringing services closer to people implementing ‘treatment as prevention’
- Reaching out to youth and men
- Mobilising communities
- Realising human rights
- Responding to realities and needs on the ground

Figure 1. MaxART Key 1 and 2 activities along the continuum of care

Figure 2. MaxART phase 1 project results until June 2014

Mobilize Communities

Enrollment in Care

ART Initiation

Retention in Care

- Strengthen provider initiated testing and counseling
- Fast Track - community-solutions to mobilizing men and adolescents for testing
- SMS appointment reminder system
- Treatment support
- Linkages with community health workers
- Reduced stigma through initiatives by PLHIV

PHASE 1 PROJECT RESULTS

A SELECTION

PHASE 2 2014-2017

ACHIEVEMENTS TOWARDS NATION WIDE GOALS

PHASE 1 2011-2014

ACTIVITIES & RESULTS

260 community dialogues reached 27,656 people
35 fast tracks launched:
- 570 events held
- 80,442 people reached with door-to-door campaigns
15 teenclubs formed:
- 100 events held
- 7923 teens attended
180 Male-focus health days:
- 6057 men attended
53 mobile CD4 count machines supplied:
- 53,520 tests done
- 94% of people received test results the same day
180 health workers trained in provider initiated HIV Testing and Counseling
Training improved rights literacy among PLHIV and understanding of rights amongst health care workers
Community sensitization through radio shows
Simplified Clients Rights Charter
Social science research showed barriers for testing, treatment and retention
Positive Health Dignity and Prevention research for and by PLHIV

Figure 1. MaxART Key 1 and 2 activities along the continuum of care

Figure 2. MaxART phase 1 project results until June 2014

For Better Health and Zero New HIV Infections

Better health and zero new HIV infections in Swaziland

2011: 120,600 people tested
2014: 253,000 people tested
Scaling up testing

100% people on ART

100,138 people on ART

15% reduction in loss-to-follow-up
support to laboratory services and pharmaceutical services for ART. Capacity development at all levels of interventions formed the backbone of the systems strengthening approach.

Chapter 2 describes the results of the different interventions. Figure 2 summarises which activities have been undertaken including their reach. The achievements are provided until June 2014. With some tail-funding phase 1 formally continued until June 2015, therefore the results in table 1 show higher numbers.

**Results against targets**

Over the past three years of implementation of MaxART, Swaziland has made great progress towards reaching the overarching objectives and targets as shown in table 1.

The targets and data showing achievements represent Swaziland as a whole and therefore cannot be attributed to the MaxART project alone. Many development partners have been active in Swaziland during the implementation of phase 1 and we recognise their input in achieving the results of Swaziland.

**Research on Social Science and human rights**

Social science research studies of the MaxART programme focused on men and adolescents, two hard to reach groups; both for accessing HIV testing and ART services. There was limited understanding of the reasons why these groups were not accessing health services. The research created a better understanding of the main barriers for accessing services that these groups experience as well as further understanding of the “leaky cascade”, a study that focused on why people drop out of the services over time. The research was used to inform the different interventions both at the design stage and during implementation. The three researchers from Swaziland were all three accepted in the PhD programme of the University of Amsterdam.

The MaxART consortium conducted operational research on Positive Health, Dignity and Prevention (PHDP) amongst 900 PLHIV at the beginning of the project (data collection end 2011 until beginning 2012). The study was implemented by PLHIV under the leadership of the national network of PLHIV. It showed that 86% of PLHIV respondents had experienced stigma and discrimination; that over 50% of PLHIV got tested for HIV because they were sick and losing weight and 26% mentioned they had ever forgotten to take their ARVs.

**Linking and Learning**

A key and integral way of work of MaxART is learning from experience and critically assessing and revising interventions along the way. There are several ways in which linking and learning is done such as the bi-annual face-to-face meetings with all the partners, presenting the work of MaxART at national and international conferences. Results and findings of the programme have been published in peer-reviewed journals. The programme is well known in the Treatment as Prevention scientific community.

The programme also advocated for change of policies and strategies within the Swaziland context. For example the age of consent for HIV testing was reduced and taken forward in the revised HIV testing guidelines.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Key 1 Target (2014)</th>
<th>Outcome June 2015 (or most recent available data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people tested each year (adults and children)</td>
<td>250,000</td>
<td>389,658 tests (December 2014) 284,680 estimated people tested*</td>
</tr>
<tr>
<td>Number of people on treatment (adults and children)</td>
<td>101,734 (90% coverage based on 2014 need)</td>
<td>134,083 (June, 2015)</td>
</tr>
<tr>
<td>Proportion of patients on treatment lost to follow-up (adults and children)</td>
<td>10%</td>
<td>9% for 12-month follow up on 2013 initiation cohort</td>
</tr>
</tbody>
</table>

* People tested is an estimate derived from number of tests, based on the incomplete, but best available re-testing data

** Based on official reports from the MoH

Table 1: Progress against Key 1 targets, June 2015**

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Key lessons learned from MaxART phase 1

- The MaxART Consortium, under the leadership of the MoH, uniquely brought together a comprehensive group of multi-disciplinary stakeholders by combining government programs, global and local networks of people living with HIV, academic institutions, and local and international NGOs who together had the combined expertise to link community and facility-level initiatives. Each partner is an expert in its corresponding area or responsibility resulting in a consortium that is well-positioned to address the many perspectives required to develop a robust and successful “treatment for all” study.

- Over the years the consortium invested in strengthening collaboration and ensured that the voice of civil society was heard. Specific efforts were made to decrease the natural tendency of partners to work in silos and improve coordination from geographical perspectives to improve impact of our work.

- The thoughtful and inclusive design phase of the programme in which an analysis of the core challenges of the country’s HIV response laid the basis for programming certainly added to the success of the programme. Therefore the programme addressed the real challenges of the MoH. The MOH along with the consortium partners jointly agreed on how to address these key challenges, which were laid down in the proposal to the Dutch Post Code Lottery.

3. Research on Clients’ reasons for discontinuation of pre-ART. Thandeka Dlamini. *Continuum of (pre) ART care: investigating clients’ reasons for discontinuation of pre-ART.*
4. SWANNEPHA with support from GNP+
6. Swaziland’s Ministry of Health is spearheading this initiative by leading the MaxART programme and its corresponding demonstration project. STOP AIDS NOW! is the overall manager of the MaxART programme and oversees coordination of the different partners and organizations. STOP AIDS NOW! is also responsible for evidence based linking, learning and lobbying among the consortium partners and other relevant global stakeholders. Clinton Health Access Initiative (CHAI) is the in-country manager of the MaxART project and the primary technical partner to the Ministry of Health, particularly on issues related to health service delivery. Together with CHAI, SAMAIDS is responsible for community mobilization to scale up testing, treatment and improve retention. The University of Amsterdam (UvA) is assessing the barriers and opportunities related to the scale-up of HIV testing, treatment and adherence through social science. SWANNEPHA, supported by the Global Network of People living with HIV (GNP+) ensure the rights based approach the programme by developing human rights tools and advocacy. The Southern African Centre for Epidemiological Modeling and Analyses (SACEMA) uses epidemiological modeling to inform the potential scalability of the Treatment as Prevention strategy, the estimated impact on HIV incidence in Swaziland, as well as the initial modeling to inform the sample size of demonstration project.
The strong leadership of the Ministry of health was certainly a key success factor of the programme. The Ministry constantly monitored progress and adjusted national strategies based on the learning of the programme as and when required. The MoH shared broader lessons from the programme with other implementing partners in Swaziland.

Collectively the partners were able to support the MoH to achieve the ambitious targets of the programme, with over 250,000 people tested annually for HIV, 91% of people in need of ART (at CD4 count of <350) were on treatment and 9% of PLHIV were lost to follow up. This laid the foundation for MaxART’s Key 3 Early Access to ART for All (EAAA) implementation study. The EAAA implementation study is currently underway and marks an important step toward reaching Swaziland’s and MaxART’s ultimate goal of better health and zero new HIV infections.

The strong involvement of the network of PLHIV ensured that interventions were designed in such a way that the needs and rights of PLHIV were respectfully addressed and thus the principles of Greater Involvement of People Living with HIV and AIDS (GIPA) were operationalised. Moreover, the relationship between the government and the network of PLHIV improved over time and resulted in the successful development of some essential human rights instruments, policies and guidelines such as the Client Rights Charter.

The importance of community mobilization and demand creation is now well established in Swaziland, both in the MoH as well in NERCHA. SAfAIDS became one of the strategic partners of the MoH for community mobilization and a Technical Working Group was set up to address these issues.

The Health Systems Strengthening efforts helped in bringing the services to the people (Nurse Initiated ART, Point of Care Testing and strengthening commodities and logistics) and contributed to higher uptake of ART and higher retention rates.

The social science research provided important insights about the target groups (men and adolescents) and the health and community systems barriers to access, which were, where possible, addressed in the interventions. The team believes that the policy influence of some of the research outcomes was strongly influenced by the embeddedness of the research in a multidisciplinary program, in which implementers, policy makers and researchers work together towards shared goals. This approach can be applied further in future activities by improved sharing of results, challenges and planned activities in order to make social science research more useful during the design, implementation and evaluation of interventions.

The learning-by-doing approach adopted by the MaxART consortium meant safe spaces were created so all partners could engage in open and critical discussions of the different interventions and allowed for course corrections.

The Dutch Postcode Lottery, who generously funded MaxART, is a funder that supports the work from a distance. This approach allowed the partners to reflect and learn along the way and provided the freedom to adjust less effective approaches.

Looking back over the last 4 years, Swaziland has seen significant progress towards creating universal access to HIV care, both through MaxART and other efforts enabling the country to embark on the EAAA implementation study.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AHF</td>
<td>AIDS Healthcare Foundation</td>
</tr>
<tr>
<td>AMMA</td>
<td>Amsterdam Masters in Medical Anthropology</td>
</tr>
<tr>
<td>AISSR</td>
<td>Amsterdam Institute for Social Science Research</td>
</tr>
<tr>
<td>APMR</td>
<td>AIDS Patients Medical Record System</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>CBVs</td>
<td>Community-based volunteers</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>CHTC</td>
<td>Couples HIV Testing and Counselling</td>
</tr>
<tr>
<td>CIHTC</td>
<td>Client-initiated HIV testing and Counselling</td>
</tr>
<tr>
<td>CMS</td>
<td>Central Medical Stores</td>
</tr>
<tr>
<td>DCCDs</td>
<td>Demand Creation Community Dialogues</td>
</tr>
<tr>
<td>EAAA</td>
<td>Early Access to Art for All</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>F2F</td>
<td>Face-to-Face meeting</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater Involvement of PLHIV</td>
</tr>
<tr>
<td>GNP+</td>
<td>Global Network of PLHIV</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
</tr>
<tr>
<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
</tr>
<tr>
<td>LTFU</td>
<td>Loss to Follow Up</td>
</tr>
<tr>
<td>MaxART</td>
<td>Maximising ART for better Health and zero new HIV infections</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MFHDs</td>
<td>Male-Focused Health Days</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Having Sex with Men</td>
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<tr>
<td>MOET</td>
<td>Ministry of Education and Training</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NARTIS</td>
<td>Nurse-led ART Initiation in Swaziland</td>
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<tr>
<td>NASA</td>
<td>National Spending on AIDS</td>
</tr>
<tr>
<td>NATICC</td>
<td>Nhlangano AIDS Training Information and Counseling Centre</td>
</tr>
<tr>
<td>NERCHA</td>
<td>National Emergency Response Council on HIV/AIDS</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental organizations</td>
</tr>
<tr>
<td>NSF/ENSF</td>
<td>National Strategic Framework/Extended National Strategic Framework</td>
</tr>
<tr>
<td>NSTS</td>
<td>National Sample Transport System</td>
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<tr>
<td>PIHTC</td>
<td>Provider Initiated HIV Testing and Counselling</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<tr>
<td>PHDP</td>
<td>Positive Health Dignity and Prevention</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>POC</td>
<td>Point of care</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>RHM</td>
<td>Rural Health Motivator</td>
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<td>SACEMA</td>
<td>Southern African Centre for Epidemiological Modelling and Analaysis</td>
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<td>SACU</td>
<td>Southern African Customs Union</td>
</tr>
<tr>
<td>SAF AIDS</td>
<td>Southern Africa HIV and AIDS Information Dissemination Service</td>
</tr>
<tr>
<td>SHLS</td>
<td>Swaziland Health Laboratory Services</td>
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<tr>
<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SWANNEPHA</td>
<td>Swaziland National Network of People Living with HIV</td>
</tr>
<tr>
<td>TasP</td>
<td>Treatment as Prevention</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UvA</td>
<td>University of Amsterdam</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. Introduction

This report provides an overview of how phase 1 (April 2011 until July 2014 with tail funding until March 2015) of the MaxART project was implemented in Swaziland. It highlights key results against targets and describes how different strategies contributed to the results. The results against the main targets are based on national data from the Ministry of health in Swaziland. Most of more detailed results have already been described in semi-annual reports of the partners (until mid 2014) as well as in two annual reports (April 2011 until July 2013).

1.1. MaxART in Swaziland

With generous funding from the Dutch Postcode Lottery’s Dream Fund (8.8 million Euro), STOP AIDS NOW! and partners hoped to catalyse a fundamental shift in the way the international community approached the HIV epidemic. They wanted to test a new and bold approach with virtual elimination of new infections, even in the most difficult of circumstances. Swaziland, the country with highest prevalence of HIV in the world, was selected as the country to test if this dream could come true.

The vision of MaxART is to reach all people in Swaziland who are in need of treatment with an ultimate goal of preparing the country for the possibility of ending the HIV epidemic that will be exemplary for the Southern African region.

The programme has three goals:
1: Achieving universal access to testing and treatment in Swaziland
2: Assessing the impact of universal access to testing and treatment on prevention efforts
3: Demonstrating treatment as an effective form of prevention in a high prevalence setting

Figure 3. Overview of the MaxART programme

4 Key areas:

- MOBILISING COMMUNITIES
- REACHING OUT TO YOUTH AND MEN
- BRINGING SERVICES CLOSER TO PEOPLE
- IMPLEMENTING ‘TREATMENT AS PREVENTION’

2 Crosscutting issues:

- REALISING HUMAN RIGHTS (including tackling stigma and discrimination)
- RESPONDING TO REALITIES AND NEEDS ON THE GROUND

1 Goal: For better health and zero new HIV infections in Swaziland
The programme is implemented in two phases. The first phase (2011-2015) of MaxART supported a number of interventions and systems strengthening activities aimed to achieve universal access to HIV treatment and to improve the health of the people of Swaziland. The targets of this phase were:

- Dramatically scale-up HIV testing to 250,000 people per year;
- Improve access to antiretroviral therapy (ART) so that 90% of those in need at the then current eligibility requirements (CD4 less than/equal to 350) are on treatment;
- Reduce loss-to-follow-up of clients on treatment from 22% to 10% by 2014.

The programme was built around 3 key areas, presented in the technical proposal that was submitted to the Dutch Postcode Lottery Dream Fund. Key 1 and key 2 were implemented during phase 1 of the programme and key 3 is implemented in phase 2.

- **Key 1** of the programme addressed one of the most pressing needs for Swaziland within the HIV response, which is to target the remaining gaps and key barriers to reaching all those individuals who are in need of HIV testing and treatment based on the then Swaziland Treatment Guidelines (eligible for treatment at a CD4 count of 350). In short, find those who have been left behind, significantly increase the pace at which patients are enrolled into care and treatment, and retain all patients who are on ART.

- **Key 2** of the programme focused on assessing and addressing key barriers and understanding the needs and realities of people living with HIV from a human rights perspective. Social science research collected evidence on how to maximize the quality and utilization of HIV Testing and counselling and evaluated the factors influencing adherence to ART. It also assessed the needs and realities of people living with HIV using the Positive Health Dignity and Prevention framework. The network of people living with HIV monitored that the ambitious targets of this phase were strengthened, to increase the uptake of services and improve retention in care. Community interventions formed an essential part of increasing uptake of HIV testing, treatment and retention in care. MaxART targeted the general population with a particular focus on hard to reach men and adolescents, and embraced community owned and driven solutions. Social science research and human rights monitoring generated evidence on the barriers and opportunities related to scaling up HIV testing, treatment adherence, care and support. Lessons learned were discussed in face-to-face meetings held twice per year. During these meetings, evolving evidence and analysis of human rights aspects helped to continuously improve activities.

Two hard to reach groups identified by the MOH were men and adolescents, both in terms of accessing HIV testing and ART services. However, there was limited understanding of the reasons why these groups were not accessing health services. Therefore, social science research was undertaken to create a better understanding of the main barriers for accessing services. Swaziland National Network of PLHIV (SWANNEPHA) also undertook research on Positive Health, Dignity and Prevention (PHDP) during the project, which highlighted important experiences, concerns and needs of PLHIV. The results were used to inform the interventions during implementation. The MaxART approach is built on learning from experience and critically assessing and revising interventions along the way. This was done through face-to-face meetings and annual stakeholder meetings where social science research, PHDP, and experience and learning from implementation was shared and discussed. Through these mechanisms several interventions were adapted along the way.

**In phase 2 of MaxART (2014-2017)** the consortium embarks on the Early Access to ART for All demonstration project. The aim is to evaluate the feasibility, acceptability, clinical outcomes, affordability, and scalability of offering ART to all People living with HIV (PLHIV) in Swaziland’s government-managed health system. Besides evaluating clinical outcomes, the focus will also be on how communities perceive this intervention, and analysing the economic impact for the country. Community engagement will form an integral part of the implementation of Early Access to ART for All, ensuring that the community’s interests are voiced and protected.

The project is implemented by the MaxART consortium comprised of the Ministry of Health (MoH), STOP AIDS NOW!, Clinton Health Access Initiative (CHAI), SAAFIDS, University of Amsterdam (UvA), South African Centre for HIV/AIDS Research in Sub-Saharan Africa (SACRA)},
for Epidemiological Modelling and Analysis (SACEMA), Global Network of People Living with HIV (GNP+) and Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA).

MaxART’s demonstration project Early Access to ART for All will inform future Swaziland’s HIV guidelines and provide valuable insights for the Southern African region about the possibility of a shift in treatment guidelines in the future.

1.2. The Swaziland context

1.2.1. The HIV epidemic in Swaziland

The Kingdom of Swaziland is a small land-locked country bordering the Republic of South Africa and Mozambique. Its population is just over 1.1 million people and the country is characterized as a lower middle-income country. About 80% of the population lives in rural areas. Before the onset of the HIV epidemic, the country was having economic growth rates of 8-9% per year, which stands now at 1.6% (2013). The first case of HIV was discovered in 1986. Swaziland Incidence Measurement Survey Study (SHIMS) of 2011 showed an HIV prevalence rate of 31% among adults aged 18-49 similarly to the rate found in 2007, indicating a stabilising epidemic. These are the highest rates ever seen in the world. The prevalence in women is much higher than in men with 38.8% of adult women infected and 23.1% of adult men. Young women aged 18-19 have a 14 times higher HIV prevalence than young men. Peak prevalence has shifted to 30-34 and 35-39 age groups.

HIV and AIDS had a devastating effect on the country with life expectancy dropping from 60 years in the 1980’s to 48.9 in 2013. The impact of so many deaths in Swaziland exacerbated poverty, increased the number of orphans and vulnerable children to over 100,000 and led to the breakdown of family support systems. Moreover, now more than 30% of the population is under 15 years of age, 52% under the age of 20 years and only 5.9 % of the female population is over the age of 65.

The Kingdom of Swaziland is one of the few countries in Sub Saharan Africa that is procuring all of its anti-retroviral drugs using government resources. In 2012/13 fiscal year, the total spending on HIV and AIDS was 97.9 million US$ and 38% of funds came from the government, 60% from international partners and 2% from private funders. From this report it is not clear how much of the funds are spent on community mobilisation and Voluntary Counselling and Testing (VCT). An earlier National Spending on AIDS (NASA) report (2007-2010) shows that out of the prevention budget (8.7 million $ on 2009/2010) about 19% was spent on community mobilisation and 1% on VCT. The total budget in 2009/2010 was $ 75,3 million.

A recent study has shown that over 65% of adults living with HIV are not virally suppressed. Viral loads are higher among those who are unaware of their HIV+ status. Of those on ART, 85% are virally suppressed, showing the benefit of treatment. Just over 50% of all HIV positive men were not aware of their HIV+ status in 2011 and in 2010 only 40% of people aged 15-49 had tested for HIV in 12 months preceding the survey.

1.2.2. Key developments during phase 1 implementation

Over the 2011 to 2015 reporting period, Swaziland appointed a new Minister of Health, Sibongile Simelane, and appointed a new leadership team.

1. Dr. Simon Zwane the previous Director of Health Services was appointed as Principal Secretary in April 2014
2. Dr. Vusi Mgagula the previous Deputy Director of Clinical Services was appointed Director of Health Services in June 2014
3. In July 2014, the MOH appointed the former Senior Medical Officer of the Swaziland National ART Program (SNAP), who is also, the Principal Investigator for the MaxART EAAA implementation study, Dr Velephi Okello in the position of Deputy Director Health Services – Clinical at the MOH.

Overall, there have been no major departures from previous plans or changes in strategy as a result of the new leadership. Additionally, the appointment of Dr. Okello is a great compliment for the MaxART program and ensures that the senior leadership of the MOH is well-versed with the program’s objectives and targets.

With respect to the fiscal environment, Swaziland has faced serious economic challenges, predominantly driven by unstable resources and a declining GDP. The government
budget heavily relies on the Southern Africa Customs Union (SACU) receipts, which is an increasingly volatile source of revenue. While SACU receipts contributed to 68% of Government revenue in the 2006/7 fiscal year, a plummet in SACU revenues, reaching an all-time low of 39% in fiscal year 2011/12, has shrunk the resource envelope considerably and contributed to on-going cash-flow issues. This situation has been exacerbated by limited growth prospects as the Gross Domestic Product (GDP) over this same time period has remained at about 2%. Additionally, the classification as a lower middle-income country denies the Swaziland the much-needed concessional resources appropriate for addressing the country’s many socio-economic and health challenges such as high poverty, income inequality, unemployment and HIV and AIDS prevalence rates.

However, the government has committed to prioritizing health, steadily raising the proportion of government resources dedicated to health from 8% in fiscal year 2007/08 year to 14% in 2014/15. This has enabled the government to continue to be the primary source of funding, contributing 53% to total health expenditures, followed by external donors and the private sector at 35% and 13% respectively. Of these total government expenditures, 45% has been dedicated to the HIV response with the overall goal of ensuring free treatment for HIV and TB patients, with majority of these funds focused on care and treatment.

From 2013-2014, Swaziland developed and costed its HIV and AIDS strategic (Extended National Strategic Framework) and operational plans (National Operational Plan), as well as the TB strategic plan. These strategic plans informed the most recent Global Fund grant application process to produce a robust grant application. The MOH submitted its grant application to the Global Fund in October 2014. The application was approved by Global Fund’s and was awarded $74 Million USD for HIV/TB/HSS and fast-tracked to grant-making process. The funds are expected to be available to the MOH by October 2015. The funding is critical to addressing the needs to curb the HIV/TB co-epidemics and vital to the longer-term successes and sustainability of government systems. In addition, the MOH completed the development of a new Health Sector Strategic Plan (HSSP), with support from the World Health Organization (WHO) and other implementing partners including CHAI. This HSSP is focuses on 5 key strategic areas: Clinical Services, Public Health, Health Systems Strengthening, Allied Health, and Health Financing, and will provide strategic direction for the MOH for the next five years.

The new Swaziland Integrated HIV Management Guidelines were launched in February 2015. The new guidelines include expanding the HIV treatment eligibility criteria to CD4-count ≤500 cells/mm3 and offering lifelong ART to all pregnant and lactating HIV-positive women (LaPla) regardless of CD4 and WHO clinical stage, preferably on the day of HIV diagnosis. New targets for testing, treatment, and retention are currently under development, reflecting these changes. A phased implementation is being employed effective October 2015 in order to manage the budget requirements and to prepare for national roll out, in particular from Central Medical Stores (CMS), and Swaziland Health Laboratory Services (SHLS). The different initiatives piloted or rolled out nationally under MaxART provide valuable strategies for the MOH to consider when evaluating the different ways to reach these new targets.

Introduction

8 UN data 2011, Swaziland
9 Swaziland Global AIDS Response Progress Reporting 2014. Kingdom of Swaziland: NERCHA and UNAIDS.
10 National AIDS Spending Assessment 2007-2010. The Kingdom of Swaziland: NERCHA.
12 Swaziland Incidence Measurement Survey Study, 2011
13 Swaziland Multiple Indicator Cluster survey: Swaziland 2010.
2. Key 1 results: Achieving universal access to testing and treatment in Swaziland

MaxART has come to the end of its full implementation for its Key 1 program. MaxART’s Key 1 program supported Swaziland in achieving its highest annual HIV testing rate ever and near nation-wide access to antiretroviral therapy (ART). Additionally, the achievements of Key 1 laid the foundation for MaxART’s Key 3 Early Access to ART for All (EAAA) implementation study. The EAAA implementation study is currently underway and marks an important step toward reaching Swaziland’s and MaxART’s ultimate goal of better health and zero new HIV infections.

2.1. Achievements versus targets

Over the past three years of implementation of MaxART, Swaziland has made great progress towards reaching the overarching objectives to (i) test at least 250,000 people annually, (ii) ensure 90% of those eligible for treatment are on treatment, and (iii) retain 90% of all clients in care each year by 2014.

The targets and data showing achievements represent Swaziland as a whole and therefore cannot be attributed to the MaxART project alone. Many development partners have been active in Swaziland during the implementation of phase 1 and we recognise their input in achieving the results of Swaziland.

2.2. Key strategies contributing to results

Different MaxART partners have contributed to different interventions. In this report we report for MaxART as a whole. The project employed different strategies that were all supporting the targets of key 1 and key 2 and mutually reinforced each other. The following figure depicts the different interventions indicating the support along the continuum of care.

The results of each of these interventions are reported following the continuum of care. Figure 5 shows the concept used by the partners, whereby all community level interventions are highlighted in green and health facility level interventions in black.

2.3. Mobilisation of communities

Several activities were undertaken in the communities to mobilise people for HIV testing, motivate those who tested HIV positive to enrol in care or start ART and to retain PLHIV in care and on treatment. Figure 6 shows the coverage of the community interventions at the end of MaxART phase 1.

1. Engaging traditional leadership in the response to HIV

The engagement of Traditional Leaders built on an ongoing intervention. The leaders had been mobilised for participation in a project called “changing the rivers flow”, dealing with gender based violence and wife inheritance. The approach was broadened reflecting the MaxART objectives. The objective of the intervention was to engage the leadership for mobilising their community members to respond to the challenges posed by HIV.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Key 1 Target (2014)</th>
<th>Outcome June 2015 (or most recent available data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people tested each year (adults and children)</td>
<td>250,000</td>
<td>389,658 tests (December 2014) 284,680 estimated people tested*</td>
</tr>
<tr>
<td>Number of people on treatment (adults and children)</td>
<td>101,734 (90% coverage based on 2014 need)</td>
<td>134,083 (June, 2015)</td>
</tr>
<tr>
<td>Proportion of patients on treatment lost to follow-up (adults and children)</td>
<td>10%</td>
<td>9% for 12-month follow up on 2013 initiation cohort</td>
</tr>
</tbody>
</table>

* People tested is an estimate derived from number of tests, based on the incomplete, but best available re-testing data  
** Based on official reports from the MoH

Table 2: Progress against Key 1 targets, June 2014**
Traditional and political leaders were trained to lead the response to HIV in their communities. The training of the leaders took place in 2011 and a total of 98 traditional leaders and 12 political leaders were trained in 33 chiefdoms (in 31 constituencies) in all regions of the country. Many of these leaders became actively engaged in stimulating the HIV response within their communities. Traditional Leaders have been participating in the annual Indabas and several communities report about the HIV response through the traditional leaders.

2. Demand Creating Community Dialogues

Community dialogues have been used as a methodology to strengthen community responses to HIV elsewhere\(^\text{14}\). This intervention was implemented using existing structures of both local and traditional government. The objective of this intervention was to increase access to HIV related services by discussing community barriers to service uptake and have communities find solutions by themselves. MaxART through SaF AIDS worked with 16 local implementing partners/organisations\(^\text{15}\) that were already working with Rural Health Motivators (RHMs) and Community Based Volunteers (CBVs) in the targeted communities.

During phase 1, 269 Demand Creating Community Dialogues (DCCDs) were held in 220 communities with over 28,300 people attending of whom 56% were men (see figure below as per M&E reports). The dialogues were very well attended with 70-100 people attending each time. Almost 50% of the attendees were tested for HIV. The uptake of testing increased when other testing partners started performing HIV testing on site. For example during one DCCD for men having sex with men (MSM) all 100 attendees tested for HIV. Health workers noted that mobilisation was effective as the queues were long during the DCCDs. After the events health facilities became very crowded and sometimes test reagents ran out of stock. Men realised the importance of testing for HIV and enrolling on ART.

15 16 local civil society partners of SA F AIDS being, Ministry of Health (MoH), Ministry of Tinkhundla Administration and Development (MTAD), AMICAALL, ACAT, Cabrini Ministries; Church Forum on HIV and AIDS, FLAS, Khulisa Umntfwana; Positive Women Together, SWANNEPHA, SWABCHA, Shiselweni Reformed Church, SWAPOL, TASC and WLSA.
Figure 6. Coverage of MaxART phase 1 community interventions
3. Door-to-door home visits by Rural Health Motivators and Community Based Volunteers

Door-to-door visits have been implemented for several years using existing cadres such as RHMs\(^\text{16}\) and CBVs\(^\text{17}\). Each RHM covers around 50 households with whom they have built a long-lasting relationship. During the visit health topics are discussed with the people found in the household varying from immunisations, family planning, other reproductive health issues, maternal care, diarrhoeal diseases, HBC and many others. For the MaxART project the scope of activities was expanded to include the mobilisation of individuals for HIV testing, motivating PLHIV to take ARVs and to adhere to their treatment. PLHIV on ART were also educated on treatment and side effects (HIV and HIV treatment literacy) and other health problems. Community volunteers regularly visit all families in a community and make weekly visits to those with the highest needs. All RHMs report to the RHM supervisor and the CBVs report via their own organisation to the RHM supervisor. These reports all feed into the MoH reporting system.

M&E reports show that in 3 years time 572,673 contacts were made through the door-to-door intervention. Of these 74% were with women, 26% with men and 28% with adolescents. The intervention was an ongoing activity and initially did not register the number of people that actually got tested for HIV, but in the third year of the project (July 2013-June 2014) the number of people that were referred for HIV testing was recorded as 38,259 of which 25% reported accessing the service. The figure below shows the project monitoring data from MaxART for phase 1 (cumulative in the box).

A total of 5,761 RHM/CBVs were trained over the 3 years on the MaxART topics and refresher training was done as well. M&E reports indicate that 95% of the RHMs/CBVs remained active over the 3 years. If each of these volunteers covers about 50 households, they would reach about 288,000 households.

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\(^{16}\) RHMs are volunteers that receive a monthly stipend from the MoH (350 Rand). The RHM programme has been operational since 1976.

\(^{17}\) 16 partners of SAAIDS being: Ministry of Health (MoH); Ministry of Tinkhundla Administration and Development (MTAD); AMICAALL; ACAT, Cabrini Ministries, Church Forum on HIV and AIDS; FLAS; Khulisa Umntfwana; Positive Women Together; SWANNEPHA; SWABCHA; Shiselweni Reformed Church; SWAPOL, TASC and WLSA.
4. Fast Track

Fast Track encourages a community to allocate focus and resources on an objective for 90 days, and to set specific, measurable goals within that period. For Swaziland’s largely rural population (80 percent rural), people are best reached in their local settings, as the definition of community-based programs varies significantly by location. The MaxART Consortium CHAI targeted two-thirds of Swaziland’s 55 Tinkhundla—local constituencies comprised of 6,000–12,000 people—for participation in the Fast Track program between late 2011 and June 2014. A total of 35 constituencies were covered. Most were rural and some were in semi-urban areas. In total about 5,000 volunteers were trained to implement the programme.

M&E results show that about 79% of people reached did a HIV test. The specific target group of men and adolescents was a bit harder to reach but still 39% of the target group got tested. Of these 22% was in adult men, 8% in adolescent boys and 8% in adolescent girls (calculations based on graphs below).

During each Fast Track on average 675 households are visited, with 2471 individuals sensitized, and 3241 male and 400 female condoms distributed.

5. Male focused health days

Men were a specific focus group for the MaxART programme. MaxART organised Male Focused Health Days (MFHDs) in 15 clinics where men gathered for discussions around health and HIV topics and were encouraged to test for HIV, which was offered on site. The days were meant to create greater comfort and stronger relationships between men and their local health facility. These meetings ended with the eating of a cow head, a male-only tradition around which men gather and discuss important issues in Swaziland. Even though the research had shown that men were less comfortable to visit clinics, the clinic was selected as a meeting place so that men could overcome their initial reluctance. Organising these meetings in this setting was giving a signal to men that clinics are also there for them. The meetings took place mostly on Saturdays.

This intervention was implemented in 15 clinics in Swaziland. The results show that over the 3-year period, 500 HIV tests were done during 180 events, which included 6,057 participants. Out of the 15 clinics, 6 were more successful than the others and some of these continued implementation without direct MaxART support. In these 6 clinics there was a significant increase of men being tested for HIV per month. Prior to MFHDs on average 13 men tested for HIV per month, which went up to 30 men per day towards June 2014. Participants of the MFHD reported that the linkages between the clinic and the communities are now better and the clinic committee takes issues to the chiefs in regular meetings in the community.
6. Adolescent support programme

The Adolescent Support and HIV Testing and Counselling initiative focused on strengthening and establishing support structures for youth, with the goal of incorporating testing opportunities into its activities. Adolescents lack adequate support within their daily spheres – schools, communities, churches, health facilities – to deal with challenging circumstances, including psychosocial issues involved in HIV Testing and Counselling.

The number of adolescents testing for HIV directly through teen club events has increased since the start of the intervention. A total of 982 HIV tests were conducted as of June 2014 and a total of 7,923 adolescents attended teen clubs (including repeat attendees, which are on average 30% of total attendance). There has been greater involvement of government partners and NGOs in adolescents’ monthly activities, which will continue to encourage sustainability of the activities.

7. Campaigns and Advocacy

MaxART, together with other in-country implementing partners designed a media campaign called “My health starts with me”. Both TV and radio shows talked about HIV in general, HIV testing, treatment etc. There were 52 episodes on different topics on TV and many more radio shows with an estimated 2,500 listeners per radio slot and 1,500 viewers of each TV show. The shows were popular and several respondents in the community highlighted that these shows mobilised them to seek care in the clinics.

Other campaigns focused on testing. August has been labelled HIV Testing month and February as Couple Testing month – with the slogan “It’s not just an HIV test, it’s a love test”. The campaigns demonstrate the impact of results from coordination between all HTC stakeholders. In the 2014 campaign 631 couples were tested as compared to 197 couples in 2012.

2.4. HIV testing

The activities that were implemented at the community level that included HIV testing were described above. This section focuses on MaxART activities taking place at facility level.

1. Provider initiated testing and counselling

Over the last 4 years, MaxART, in collaboration with the MOH and other in-country partners, implemented innovative strategies to increase HIV testing rates. Focusing on methods that encourage all clients arriving at health facilities to access testing services (Provider Initiated Counselling and Testing (PICT)), Standard Operational Procedures (SOPs) were developed, which outline four patient flows where an HIV test can be provided. Health care workers were responsible for identifying the scenarios that were best suited for their health facility. In total, 555 nurses, 89 supervisors, and over 390 essential cadres members, consisting of expert clients, lay counsellors, phlebotomists, and M2M, were oriented on the SOP. In addition, the SOPs were incorporated in the PIHTC training curriculum, ensuring an effective integration into the national HTC program. Facilities were stimulated to take full ownership of their data through frequent reviews of their PIHTC statistics and discuss existing challenges. This exercise now occurs in health facilities across the country.

The impact of this increased ownership is evident by the 347,966 HIV tests that were conducted in 2013 – well above the target of 300,000 tests for 2013, and on the way to reach the targets of 500,000 tests by 2015 as set by the extended National Strategic Framework for HIV and AIDS. MaxART’s and the MOH’s initial target of conducting 300,000 HIV tests amongst both children and adults in 2014 (equivalent to 250,000 individuals tested) was successfully exceeded by the MOH. The contribution of PIHTC to HIV tests performed in the country significantly increased over time, going from 36.7% in 2009 to 74.5%.

![Figure 12 Testing in Provider-Initiated HTC entry points vs. Client-Initiated HTC entry points, 2009-2014](image-url)

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CSS case study
2.5. Linkages and enrolment in care

Different interventions were trying to track how people were linked to care after an HIV positive test. However, obtaining reliable data on linkage to care has been incredibly difficult during this period due to the difficulty of obtaining the data generally (very manual process, requiring dedicated linkages officers to follow up individual clients), and the range of testing partners used at each of the community testing events (e.g. MSF, PSI, AHF, NATICC). The challenge of accurately tracking linkage from either community or facility testing remains one, which we have not been able to solve during the course of the first 4 years of MaxART.

Despite these challenges, Fast Track reported that of those tested HIV positive, an average of 57% were linked to care. This went up to 67% in a pilot area where increased attention was given to this aspect. Implementers said that data on linkage to care are hard to track even when using the referral slips. People may go to another clinic and will then not be accounted as linked to care. Implementers remarked that during Fast Track the demand for health services went up but the health facilities were not always adequately prepared to cater for this increased demand. For the door-to-door visits the results for documented access to services ranged from 25% to 35% depending on the type of service referred to.

2.6. Strengthening ART services

A Key focus of the MaxART programme was to strengthen the quality of care at health facility level. This was done through a variety of approaches described below.

1. Nurse-led ART Initiation in Swaziland (NARTIS)

The support for NARTIS under MaxART in Key 1 started with a strong push to ensure the NARTIS pilot, started before MaxART was launched, was rolled out nationally. Therefore, the initial rollout focused on NARTIS trainings and ensuring the NARTIS steering committee was established. The NARTIS program gained momentum in 2012, with MaxART phasing out funding for trainings and many partners stepping in to contribute. Since 2013, the support focused on developing a standardized, complete, and effective national training curriculum and participating in NARTIS steering committee meetings. The NARTIS steering committee has continued to meet regularly over the past six months, focusing on revising the NARTIS training curriculum.

In the period from the beginning of 2011 through December 2013, there has been an increase in the number of accredited NARTIS sites; in combination with the ongoing training of nurses in NARTIS, this has resulted in an increasing proportion of clients initiated on ART in a NARTIS site versus a non-NARTIS site, as seen in Figure xxx

According to data on ART initiations from the AIDS Patients Medical Record System (APMR) database, in 2011 only 8% of initiations were done in NARTIS sites while by the end of 2013 a total of 87% of ART initiations were done at NARTIS sites.

By the end of May 2014, a total of 501 nurses have received training in NARTIS. More than 60% of the trained nurses are working in clinics where there is no permanent doctor available for ART initiation. The above graph shows that while NARTIS may or may not be a significant driver of new initiations, it definitely shifts initiations away from doctors.

Figure 13: Number of people newly initiated on ART at NARTIS vs. Non-NARTIS Trained Facilities, Jan 2011- Dec 2013
and towards nurses. Ongoing reports from different sources show that nurses are initiating a significant proportion of new clients as opposed to doctors.

2. Laboratory Services Support

The primary goal of the Laboratory Services Initiative is to provide strategic support to the Swaziland Health Laboratory Services (SHLS) to implement high quality decentralized HIV laboratory services and develop a long-term plan for sustaining and expanding these services. Included in this is the strategic deployment of Point of Care (POC) CD4 machines as well as quality assurance and capacity building for POC CD4 testing and strengthening the National Sample Transportation System (NSTS).

Introduction and Roll out of POC CD4 testing

In the 4 years of MaxART Key 1, significant progress has been made in increasing access to CD4 testing. The MOH, implemented POC CD4 testing for newly diagnosed HIV positive, returning pre-ART, and Prevention of Mother to Cild Transmission (PMTCT) clients in all tiers of the health system beginning in 2011 — clinics, larger hospitals and health centres, and at the central referral hospital.

Since the inception of the program, MaxART worked closely with the MOH to organize and conduct trainings for both phlebotomists and nurses and other device operators in use of the POC CD4 devices (133 nurse operators and 114 phlebotomists). A minimum of two staff per facility receive the training, to ensure minimum disruption to CD4 testing access due to health care worker illness or leave. The laboratory program supports regular training needs assessments to identify refresher-training needs and address issues of staff turnover.

A total of 53 POC CD4 testing devices have been installed at 46 individual facilities since the start of the MaxART program, with the bulk of devices placed at clinics, which have no access to CD4 testing on-site in three regions of the country. Coverage of the program is strong, with access to on-site CD4 testing at public ART facilities increasing from 65% (mostly provided via conventional testing at large facilities, plus MSF-supported clinics in one region with POC testing) to 91% of patients since the beginning of MaxART.

During roll-out the need for on-site mentoring was identified. A POC mentor was recruited reporting to the Chief Technologist, who visits all sites quarterly. The POC Mentor works closely with facility staff to ensure that quality assurance standards for testing are met, to identify and troubleshoot minor operational issues with the devices, and to conduct supportive supervision and ongoing trainings as needed.

20 developed and tested by MaxART and taken over by MoH
3. Support the MOH in Laboratory Reagent and Consumable Supply Planning

CHAI, through the Access to Medicines team, is working directly with the lab to capture laboratory statistics and to support forecasting and supply planning. This is an essential activity, and supported as needed by the MaxART team, in order to ensure that the supply chain for laboratory consumables is consistent and sufficient, which is crucial to reaching the testing, initiation, and treatment goals of the program. Reagents for POC CD4 testing have been incorporated into the laboratory forecast, transitioning support for consumables purchases from MaxART to the MOH.

4. Support the MOH National Sample Transportation System

During the first half of year 3, a volunteer analyst, through the Access to Medicines Team, was hired to analyse the current sample transportation system and work with the NSTS to optimise sample transportation routes and schedules. Findings from the work done during this time are currently being used, in the context of the upcoming rollout of viral load testing in Swaziland, to advocate for appropriate strengthening of the NSTS through the purchase of additional vehicles, the addition of new routes, and the optimization of existing routes. Strengthening the NSTS is crucial to ensuring that reliable laboratory services are available to clinics in all areas. Support for the NSTS is also provided through the purchasing of vehicle insurance and supporting repairs as needed.

2.7. Retention in Care

The impact of POC CD4 testing has been demonstrated to be significant and positive in the early stages following HIV-positive diagnosis. POC CD4 testing has been shown to significantly reduce the number of patients who are lost along the continuum of HIV care between HIV-positive diagnosis and receipt of CD4 results, in addition to significantly decreasing the turnaround time between HIV-positive diagnosis and receipt of baseline CD4 results.

The figures above demonstrate the results obtained from an on-site assessment conducted in 2012. To date, a follow-up assessment has not been carried out, but the results of the initial assessment mirror impact assessments of POC CD4 in other countries: that the impact of POC CD4 is seen early on in the HIV continuum of care and is significant and positive. It remains unclear what, if any, the impact of POC CD4 is on time to ART initiation in Swaziland.
3. **Key 2 results: Assessing the impact of universal access to testing and treatment on prevention efforts**

Key 2 of the programme focused on assessing and addressing key barriers and understanding the needs and realities of people living with HIV from a human rights perspective. Social science research collected evidence on how to maximize the quality and utilization of HIV Testing and counselling and evaluated the factors influencing adherence to ART. It also assessed the needs and realities of people living with HIV using the Positive Health Dignity and Prevention framework. The network of people living with HIV monitored that the ambitious scale up in HIV care and support was done within a human rights framework.

### 3.1. Social science research

*MaxART* conducted theoretically grounded applied social science research with the aims to provide a deeper understanding of socio-cultural factors that contribute to non- or low uptake of HIV services and to offer ongoing input to *MaxART* interventions to address such factors.

The social science research articulated several objectives:
- To build local research capacity through providing theoretical and methodological training in medical anthropology for Swazi researchers at the University of Amsterdam.
- To design relevant research studies that yield in-depth understandings of target populations, focal topics regarding uptake of services, and interventions in *MaxART*, such as adolescents, men, and the reduction of loss-to-follow-up of HIV positive clients.
- To share our (preliminary) findings and provide constructive feedback about ongoing and anticipated *MaxART* interventions based on fieldwork findings during the half yearly Face-to-Face (F2F) meetings, at national policy dialogues in Swaziland and scientific conferences.

In September 2011, the first year of the *MaxART* program, three Swazi researchers came to the University to Amsterdam for an 8-month training course in the Amsterdam Masters in Medical Anthropology (AMMA) at the University of Amsterdam in the Netherlands. Since one of the researchers did not possess a Master’s degree yet he was offered to complete the entire 12 month Master’s programme including writing a master thesis on a topic relevant to the *MaxART* programme. He graduated in September 2012, after which he returned to Swaziland to conduct further fieldwork within the *MaxART* programme. The two other researchers conducted a situational analysis in-country, when they also met with different *MaxART* partners in Swaziland to understand their focal areas and establish how they could link their research to ongoing and planned interventions. The focus of the research proposals was based on the fieldwork and discussions held with partners in country.

In the third year the researchers were evaluated on the basis of the quality of their fieldwork and their academic writing skills to establish whether they qualified for a PhD trajectory at the Amsterdam Institute for Social Science Research of the University of Amsterdam. All three researchers received positive evaluations and were granted a 4th year to write
up their research findings into a PHD dissertation. This fourth year is financed by the AISSR Research Program Anthropology of Health, Care and the Body. From September 2014 onwards they are at the University of Amsterdam to participate in PhD courses and working on their doctoral thesis consisting of academic articles and ethnography under supervision of their professors.

1. Research study: Men’s utilization of HIV services

Full title: The Invisible Men: A Qualitative Analysis of Male’s Utilization of HIV Services.

Researcher: Alfred Khehla Adams.

The main objective of the research was to do a qualitative study on mens’ (poor) uptake of HIV services such as voluntary medical male circumcision and HIV testing and treatment.

Recommendations and implementation of these

During the bi-annual face-to-face meetings, the researcher presented most of his findings on this platform and presented abstracts in different conferences and workshops. The following is a list of recommendations that were derived from data collection and analysis in this project:

- Without disempowering women, men should be empowered by giving them knowledge about health in general, HIV testing, care and treatment to decrease images of ‘toxic’ masculinities;
- Men need to be educated about the services available in health centres and this should be done with clear messaging to avoid misunderstandings such as the circumcision campaign;
- Since most men utilize traditional healing, the MOH should incorporate it in its programs by paying meaningful attention to men’s traditional medicine beliefs and establish collaboration with traditional healers;
- Create a comprehensive health care package for men that will not only focus on HIV but also on other illnesses that men are deeply concerned about such as diabetes and in particular general sexual health, which is intimately connected to Swazi masculinity;
- Health care workers should be trained in confidentiality and hospitality such that men find the offered services male friendly;
- The structural design of public health centres needs to be changed to ensure confidentiality and designated queues for certain illnesses should be abolished and care for these illnesses integrated within general care. This means that VCT rooms should not be in separate structures because this may expose clients.

- The importance of local concepts of masculinity was consistently supported by the findings as well as from literature. These concepts therefore need to be seriously considered when planning interventions for men;
Qualitative research in health has a history of being questioned in its ability to influence policy. However, research shows the increasing usefulness of in-depth qualitative research in improving health interventions. For MaxART, the goal of this project was to support the consortium to reach its goal of zero new infections by helping the team to understand men’s health seeking behaviour. In a general sense this has been delivered and during the three years of the first phase of the MaxART program attitudes among the partner organizations have shifted towards greater understanding of the stakes of Swazi men regarding their health, not only because of findings in this particular research, but also through concuring research and activities of other partners, in particular CHAI, in the field of men’s health.

The MOH is preparing a health package for men and for the first time in history, the country had the whole month of June (2014) dedicated to men’s health. This research as well as CHAI's research and other reports have stated that men (and women) extensively use traditional medicine. Unfortunately this important general finding has not been addressed thus far.

2. Research study: Clients’ reasons for discontinuation of pre-ART

Full title: Continuum of (pre) ART care: investigating clients’ reasons for discontinuation of pre-ART.

Researcher: Thandeka Dlamini

The primary focus of the study was on pre-ART clients’ emic21 perspectives (patients’ perspective), their motivations and decision-making in the contexts of their daily lives. Clients’ decision making does not take place in a vacuum; in Swaziland it is deeply embedded in encompassing socio-cultural norms and belief systems. Perspectives and strategies of clients were studied in interaction with socio-cultural determinants, as well as with processes guiding the local healthcare system and global processes and policies that came with treatment scale up, and affected these local healthcare settings and the experiences of patients. Therefore the second focus was on how all these factors influence clients’ decisions to discontinue HIV care.

Recommendations and status of adoption and implementation:
- Empower married women with skills to negotiate with husbands who refuse to test or start ART and improve communication within relationships
- As the role of expert clients evolves, there is need to lobby for a review of their roles and compensation which is in synchrony with their experience. As the possibility to absorb expert client looms, experience should be prioritised compared to education level
- Institutional policies to improve treatment uptake must include human resource strengthening and staff welfare

Findings that shaped the MaxART project were those relating to counselling quality, clients’ waiting time in the clinics and excessive use of lay counsellors in the HIV continuum of care. CHAI employed services of a HTC quality improvement officer to help step up counselling in HTC. As a result, SNAP and partners, reviewed a counselling toolkit manual that addressed issues raised by this particular research. In general the findings gave visibility to the quality of counselling provided in the health facilities. Also, the 3rd edition newsletter issue for MaxART in 2012 focused on counselling and an article of the findings were published.

The findings around waiting times for patients in the clinics and excessive use of expert clients led to a learning trip to Cape Town to learn of innovations implemented by Medicins Sans Frontiers (MSF) to relieve burden from facilities and decentralizing non clinical responsibilities to non-clinical acumen at community level such as home based care givers, expert clients etc. The lessons were shared with the MaxART consortium and this concept was adopted as a good strategy by the consortium and Ministry of Health. It is being further developed and contextualized by SAF AIDS who has the role for community mobilization with MaxART.

3. Research study: Adolescents’ perceptions of gender and sexuality

Full title: Because their voices matter: How Adolescents’ Perception of Gender and Sexuality influence their Access to and Utilization of HIV Services in Swaziland.

Researcher: Fortunate Shabalala.

The purpose of this study was threefold: (1) to offer insights from a mixed methods approach on how adolescents’ perception of gender and sexuality influence their access to and utilization of HIV services in Swaziland; (2) to provide an in-depth account from ethnographic research on how adolescents living with HIV and on ART navigate the social

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21  emic stands for the internal perspective as expressed by the person concerned
environment in their daily lives with the disease; and (3) to consider the implications of the findings on future programming, focusing on adolescent HIV services in particular and reproductive and sexual health in general.

Recommendations and status of adoption and implementation:

- The research contributed to advocacy on adoption of age of consent at stated in Child Protection and welfare Act, and sensitization of health workers on the change. The recommendation successfully adopted-HTC guidelines changed in 2014 to reflect of 12 years as stated in the Child Protection and Welfare Act. Current trainings of health workers, particularly nurses, are used to sensitizing health workers on new guidelines on age of consent.
- Changing gender stereotypes should be targeted through empowerment of both boys and girls as part of addressing non-biological vulnerabilities to HIV infection. Families need to be involved in changing stereotypical gender ideologies that influence the socializing boys and girls as different from each other. This recommendation so far has not been embraced and thus not implemented.
- Accessing HTC in non-health facility environments such as the school, home or youth centres may increase uptake of the service and should be the approach of choice. This recommendation was acknowledged [school based service provision], but there is need to address it at policy level. A concept note in collaboration with the Ministry of Education and other development partners, as part of the comprehensive sexuality education, was developed and awaits presentation to policy makers. The consortium already was implementing targeted community based services such as Fast track, teen clubs and community dialogues, but there is need to focus one level down to reach families.

- Family involvement [engagement] in adolescents’ care continuum is very important. However despite repeated presentations on the subject matter, this recommendation was not followed through by the MaxART consortium at the end of phase 1.

3.2. Human rights approach

Whilst it was accepted that the programme conceived by the MaxART partners had game-changing opportunities to meet the treatment and prevention needs of many people living with HIV, it also raised many complex human rights and ethics issues. These included the potential lack of informed consent, coercion in the provision of testing and treatment, violations of confidentiality, and an increase in stigma and discrimination, especially against vulnerable populations such as women living with HIV, sex workers, and young people. These human rights and ethical challenges could compromise the well-being of the intended beneficiaries of the programme and impact on the programme’s success. People living with HIV and other users of health services therefore needed to understand their rights and be empowered to assert them as they access services. From this early stage, it became apparent that the involvement of people living with was important to the success of the programme.

The MaxART consortium conducted operational research on Positive Health, Dignity and Prevention (PHDP) amongst 900 PLHIV at the beginning of the project (data collection end 2011 until beginning 2012). The study was implemented by PLHIV under the leadership of the national network of PLHIV. It showed that 86% of PLHIV respondents had experienced stigma and discrimination; that over 50% of PLHIV got tested for HIV because they were sick and losing weight and 26% mentioned they had ever forgotten to take their ARVs.

SWANNEPHA used the results to advocate for human rights in general and through the regional HIV coordinators. The PHDP study provided important information for all the MaxART partners and moreover resulted in the development and review of some important human rights instruments in Swaziland by the network of PLHIV. These included:

- Review of the National Stigma and Discrimination Reduction Action Plan
- Twenty radio programme slots to disseminate the information from the PHDP study
- Review of communication tools and guidelines of the MaxART partners
- Training on human rights for staff and volunteers associated with the programme
Key 2 results: Assessing the impact of universal access to testing and treatment on prevention efforts

- Inputs to the curriculum for treatment support and the curriculum for nurse-led ART initiation
- Support to development of campaign materials used by different MaxART partners

Some key documents developed included “the client friendly Clients Charter”, an advocacy tool called “What are your rights”, the Human Rights Monitoring tool and a drama tool for community information.

All the implementing partners of MaxART used these tools during the implementation of both the community and clinic based interventions and all intervention were scrutinised for use of language and concepts from the perspective of PLHIV.

As a result of the human rights work the awareness around GIPA and the rights of PLHIV was increased in Swaziland. It also helped to place the voice of PLHIV at the heart of the phase 2 EAAA study through the Community Advisory Boards.

**3.3. Modelling for potential impact of the EAAA approach**

Over the course of phase one the modelling component of the programme was revised and during this phase focused on development of a population based simulation model to explore the potential impact of early access to ART in Swaziland, and to write scientific publications and simple size calculations in preparation of phase 2 of Maxart.

The country level core indicators projected over a 10-year period (2013-2023) included:
- Incidence of HIV among 15-49 year olds
- Prevalence of HIV among 15-49 year olds
- Cumulative number of HIV deaths
- Incidence of TB
- Total number of people on ART

Fig 16 and 17 show the projection for the incidence and prevalence for the different CD4 count thresholds.

The modelling component will be further developed as an individual based model during the phase 2 of MaxART. This model will allow for reconstructing the mechanics behind the EAAA study.

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22 SWANNEPHA with support from GNP+
24 Nomination Model Human Rights Programme for the GFATM of SWANNEPHA 2013
4. Linking and learning

A key and integral way of work of MaxART is learning from experience and critically assessing and revising interventions along the way. There are several ways in which linking and learning is done such as the bi-annual face-to-face meetings with all the partners, presenting the work of MaxART at national and international conferences. Results and findings of the programme have been published in peer-reviewed journals. The programme also made efforts to advocate for change and policies within the Swaziland context.

4.1. Face to face meetings

During phase 1, face-to-face meetings have been held twice per year with all the consortium partners and other invited guests. During these meetings the results of the different components were shared and important lessons abstracted. The discussion during the F2F meeting resulted in several adaptations of the way in which the programme was implemented. During the first several meetings STOP AIDS NOW! organised special session on the importance of Linking and Learning. The PLHIV network was a major contributor in these meetings in terms of raising human rights and ethical issues, addressing barriers of PLHIV and adjusting the language used in different interventions and tools.

4.2. Sharing MaxART results

1. Newsletters

During phase 1, five newsletters have been written that were shared with international and national stakeholders. The printed version (800 copies for each edition) is distributed by the partners in Swaziland and serves as promotional materials during meetings and conferences. The electronic version is send to 500 receivers via our internet. The topics of the newsletters were (see Annex 2):

- Edition 1: Better Health and Zero new HIV Infections in Swaziland
- Edition 2: MaxART Reaches out to Men
- Edition 3: HIV testing Saves Lives
- Edition 4: MaxART Reaches out to Young People
- Edition 5: Preparing the ground for Early Access to ART for All

In addition a corporate brochure was published about the programme in general called: Health sector on the move: maximizing ART for better health and Zero new HIV infections.

2. Conferences, meetings and publications

MaxART has been presenting their programme, results and learning at numerous national and international conferences, workshops and meetings. A list of presentations and publications is provided in annex 1. The programme has supported young researchers and programme staff to present their work and get exposure to international conferences for learning purposes. Staff members have been supported in writing abstracts and

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<th>Year</th>
<th>July 2011 - June 2012</th>
<th>July 2012 - June 2013</th>
<th>July 2013 - June 2014</th>
<th>July 2014 - December 2015 (only phase 1)</th>
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<td>5</td>
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<td>Poster presentations at conferences</td>
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Table 3. Number of articles and presentations on MaxART over time by type
STOP AIDS NOW! provided support to the printing of the posters where necessary. All in all MaxART has become known internationally as one of the programmes that implements in practice what research has shown about the benefits of EAAA. Table 3 shows in summary which kind of presentations and publications were done until the end of 2014.

### 4.3. Policy influence and advocacy

The social science studies provided important inputs for advocacy and the results were described in section 3.1 and 3.2. Additional activities are described below.

#### 1. Adolescent programmes

In 2014, MaxART engaged a volunteer to work with the current team to increase support to the MOH and Ministry of Education and Training (MOET) to support working with adolescents. The volunteer worked alongside NGO partners to build capacity for improving education and services for adolescents both in and out of school, particularly in the areas of HIV and sexual and reproductive health. This work has focused on advocacy and coordination of adolescent interventions, in addition to specific technical assistance to those groups.

Significant progress was made in increasing advocacy for adolescent issues, working with officials from both the MOH and MOET and UN agencies to craft a cabinet paper highlighting the facts around adolescent SRH in the country, and the first high-level strategy developed to address them. The advocacy work comes out of a broader coordination effort to create a joint strategy and consolidated action plan for Adolescent Sexual and Reproductive Health (ASRH) across partners and Ministries. Part of the coordination effort also included mapping partner activities and highlighting remaining gaps — an activity which will need further work in the future to ensure it becomes comprehensive, and that specific activities can be targeted at weak areas in the response.

#### 2. Unifying HIV program efforts

MaxART lobbied for the inclusion of PIHTC indicators in the national and regional ART review workshops. In 2014, SNAP with the support of in-country partners, consolidated the data review workshops of all HIV programs. This new comprehensive model will include HIV testing and counselling, PMTCT, Pre-ART, ART, and TB/HIV, and will ensure efficient use of health worker’s time, reducing the number of days they are pulled from facilities to attend workshops. Despite the recent successes in integration of HIV indicators, a challenge remains that registers have not yet been designed to capture a key PIHTC indicator: identifying which clients seen in health facilities do not know their HIV status and are therefore eligible to be tested.

#### 3. Linking MaxART with the Stop AIDS Alliance

During phase 1, the link between the Stop Aids Alliance and the MaxART programme was strengthened for lobby possibilities in Geneva regarding community and health system strengthening based on the realities on the ground in Swaziland. Partners in Swaziland received information about the Global Fund and its New Funding Model through the Stop Aids Alliance via STOP AIDS NOW!.

#### 4. Policy dialogues

Based on the learning over the course of the programme several topics were identified that required discussion at the national level. Hereto several Policy dialogues were organized. There was a policy dialogue on adolescents living with HIV and ART. Others were on Food by Prescription for PLHIV (2012), an Indaba with 31 traditional leaders to discuss MaxART progress and lessons (2014) and a Policy dialogue on Men’s Health (2014).
5. **Broader lessons learned from phase 1**

5.1. **Lessons learned from operational aspects of the partnership**

- The MaxART Consortium\(^{25}\), under the leadership of the MoH, uniquely brought together a comprehensive group of multi-disciplinary stakeholders by combining government programs, global and local networks of people living with HIV, academic institutions, and local and international NGOs who together had the combined expertise to link community and facility-level initiatives. Each partner is an expert in its corresponding area or responsibility resulting in a consortium that is well-positioned to address the many perspectives required to develop a robust and successful “treatment for all” study.

- Over the years the consortium invested in strengthening collaboration and ensured that the voice of civil society was heard. Specific efforts were made to decrease the natural tendency of partners to work in silos and improve coordination from geographical perspectives to improve impact of our work. Initially, partners were focused on areas they were most familiar with, and over time, a decision was made to consolidate around a few areas and have a more holistic approach in fewer areas to maximize impact. With the start of the second phase of the project, the MaxART Consortium reviewed and revised its governance structure, to reflect a collaborative structure for implementing this project. This governance structure has been outlined in a governance document, which is reviewed annually.

- The thoughtful and inclusive design phase of the programme in which an analysis of the core challenges of the country’s HIV response laid the basis for programming certainly added to the success of the programme. Therefore the programme addressed the real challenges of the MoH. The MOH along with the consortium partners jointly agreed on how to address these key challenges, which were laid down in the proposal to the Dutch Post Code Lottery.

- The strong leadership of the Ministry of health was certainly a key success factor of the programme. The Ministry constantly monitored progress and adjusted national strategies based on the learning of the programme as and when required. The MoH shared broader lessons from the programme with other implementing partners in Swaziland.

- The strong involvement of the network of PLHIV ensured that interventions were designed in such a way that the needs and rights of PLHIV were respectfully addressed and thus the principles of Greater Involvement of People Living with HIV and AIDS (GIPA) were operationalised. Moreover, the relationship between the government and the network of PLHIV improved over time and resulted in the successful development of some essential human rights instruments, policies and guidelines such as the Client Rights Charter.

- The inclusiveness of local community partners (through sub-contracts) in the Consortium was a key success factor to the Consortium as they brought local knowledge and networks, recognizing the importance of providing technical assistance and capacity building opportunities to those partners to maximize impact.

- The social science research provided important insights about the target groups (men and adolescents) and the health and community systems barriers to access, which were, where possible, addressed in the interventions. The team believes that the policy influence of some of the research outcomes was strongly influenced by the embeddedness of the research in a multidisciplinary program, in which implementers, policy makers and researchers work together towards shared goals. This approach can be applied further in future activities by improved sharing of results, challenges and planned activities in order to make social science research more useful during the design, implementation and evaluation of interventions.

- The learning-by-doing approach adopted by the MaxART consortium meant safe spaces were created so all partners could engage in open and critical discussions of the different interventions and allowed for course corrections.

- The Dutch Postcode Lottery, who generously funded MaxART, is a funder that supports the work from a distance. This approach allowed the partners to reflect and learn along the way and provided the freedom to adjust less effective approaches.

- Looking back over the last 4 years, Swaziland has seen significant progress towards creating universal access to HIV care, both through MaxART and other efforts enabling the country to embark on the EAAA implementation study.
5.2. Lessons learned from the implementation of MaxART key 1 and key 2 activities

Key 1

Collectively the partners were able to support the MoH to achieve the ambitious targets of the programme, with over 250,000 people tested annually for HIV, 91% of people in need of ART (at CD4 count of <350) were on treatment and 9% of PLHIV were lost to follow up. This laid the foundation for MaxART’s Key 3 Early Access to ART for All (EAAA) implementation study. The EAAA implementation study is currently underway and marks an important step toward reaching Swaziland’s and MaxART’s ultimate goal of better health and zero new HIV infections.

Community mobilisation efforts resulted in many more people visiting the health facilities for a variety of services and the linkages between the community and health facilities had become stronger. The case study on community systems strengthening showed that there was impressive stigma reduction and much more openness about HIV in the communities targeted by the programme. Many people said to no longer be afraid of HIV, nor to be seen in the HIV clinic, now that they have seen the success of ART. The Siswati name for ART is “Phinduvuke”, or “rise again”, and this is exactly how people expressed the effect of taking antiretroviral drugs (ARVs).

The importance of community mobilization and demand creation is now well established in Swaziland, both in the MoH as well as NERCHA. SAF AIDS became one of the strategic partners of the MoH for community mobilization and a Technical Working Group was set up to address these issues.
The Male Focused Health Days intervention showed that targeting men requires a more intensive and longitudinal effort. The case study on community interventions showed that men were willing to get tested for HIV and were happy that they were empowered to take responsibility for the health of the household.

The support to adolescents resulted in a more structured approach towards working with adolescents. A technical Working on Adolescents was set up under the auspices of the Ministry of Health with membership of the Ministry of Education. One of the main results was the reduction in the age of consent for testing that founds its way in the revised HTC guidelines of the MoH.

Health Systems Strengthening in the form of decentralization of ART initiation to nurse level through the NARTIS strategy, contributed to many more people accessing ART. As the scale-up of NARTIS continues, the saturation of NARTIS trained nurses will reduce the impact of the frequent rotations.

The POC Laboratory services and Linkage and Retention were the key initiatives driving increased access to and uptake of treatment. In 2014, Swaziland maintained approximately 90% treatment coverage for adults under the previous WHO guidelines (CD4 ≤350), and therefore felt ready to expand eligibility criteria for ART according to the 2013 WHO guidelines. Both the laboratory services and linkage and retention initiatives were rolled out nationally, reaching sites which cater for over 80% of current patients, and both have been integrated into the national strategy for scaling up high quality HIV treatment in the country. The proportion of patients who have access to CD4 testing on site increased from 65% at the start of the project to 91%, contributing to the continued increase in initiation of eligible clients on ART. The introduction of Point of Care testing also resulted in reducing the waiting time for results of HIV tests from 2 weeks to about 20 minutes.

Support and retention is the area where it has been difficult to measure the impact of MaxART’s interventions – because effects are seen over the longer term. However, two initiatives have exclusively...
focused on this area: the AP Reminder pilot showed that patients who receive SMS reminders for their clinic appointments are more likely to be on time (85.8% vs. 82.8%) and less likely to be loss to follow up (3.1% vs. 8.4%), and the Treatment Support tool has been adopted nationwide, and is even being used for the EAAA implementation study. Considering that both initiatives were envisioned as only pilots, their outcomes were quite a success.

Key 2

Based on the three social science research studies three interrelated social and cultural domains that negatively affect equal access to HTC and ART services were identified:
1. The family context; Within the family, intergenerational relations, child headed households and micro dynamics governing relationships between adolescents and parents/guardians, and husbands and wives, result in delayed ART initiation specifically for adolescents and married women.
2. Therapeutic pluralism; Traditional and spiritual healing compete with biomedical services which causes delayed ART initiation and non-adherence specifically for men.
3. A supportive service delivery legal framework; challenges regarding the operationalisation of age of consent for adolescent HTC as well as staff cadres being overburdened as a result of task-shifting negatively affects the uptake and quality of HIV services for adolescents.

The social science team advised MaxART that health programmers and implementers should acknowledge and address the non-biomedical barriers to ensure EAAA, including age- and gender-specific barriers. They recommend involving families throughout the care continuum; forging collaborative relations with traditional and spiritual healers; and enabling psychosocial and legal support to improve care for adolescents and health care providers. These joint findings were presented at the Swaziland National Health and Research Conference on 15th October 2014, but not all were taken forward in phase 2.

Reflecting on the achieved outcomes the social science team is excited that the research studies has generated much interest among (inter)national organisations, including national policy makers, planners and academic audiences. Especially the research study on adolescent’s perceptions of gender, sexuality and uptake of HIV services, has been met with a great national interest, already resulting in policy changes around the development of SRH and HIV integrated guidelines tailored to the needs of adolescents.

Throughout the last two years of Key 2 a greater acceptance of integrating qualitative research techniques in MaxART partners’ own monitoring and evaluation processes was noted, which in the first year was merely dominated by quantitative figures and a focus on numbers. However, we feel that our objective to provide constructive feedback based on our fieldwork studies during F2F meeting on ongoing interventions implemented by different MaxART partners was less successful. Many of our findings touch upon sensitive issues deeply related to Swazi society and culture. The social relations, perceptions, values, norms and customary approaches to health, health seeking and health care design that were identified in our studies as obstacles for universal access and treatment were sometimes shared and oftentimes not considered changeable by some of our colleagues in partner organizations.

We are extremely proud that all three researchers were accepted within the PhD program at the AISSR. This demonstrates our successful investment in building local research capacity and opens a window to support the long-term changes needed for removing the social, cultural and health system factors that impede Early Access to ART for All.

The network of PLHIV in Swaziland highlighted that in phase 2 there was still a need to continue the implementation of the Clients Rights Charter and edutainment to further reduce stigma and help clients to exercise their right to access of quality services. They also recommended to organise a Community Advisory Board, develop their capacity to monitor human rights in the communities and ensure that all human rights and ethical issues related to the EAAA study will be picked up in the communities and addressed at the right level.
### Appendix 1: List of publications

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<tr>
<th>Medium:</th>
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<td>Soaaid Magazine</td>
<td>Test en behandeling voor iedereen. Swaziland omarmt innovatieve aanpak van hiv en aids.</td>
<td>Anna Maria Doppenberg</td>
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<tr>
<td>Exchange Magazine</td>
<td>Swaziland: Improving client follow-up with automated text messaging</td>
<td>Charles Azih, Anne Pao and Vijay Narayan</td>
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<tr>
<td>Exchange Magazine</td>
<td>STOP AIDS NOW! special edition</td>
<td>Georgina Caswell</td>
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<tr>
<td>Swaziland Observer</td>
<td>Study provides knowledge of Swazi youth, HIV</td>
<td>James Hall, Fortenate Zwane</td>
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<td>Current HIV research</td>
<td>ART in Prevention of HIV and TB: Update on Current Research Efforts</td>
<td>Reuben Granich et al. on behalf of the ART in Prevention of HIV and TB Research Writing Group</td>
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<td><strong>Newsletters</strong></td>
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<td>Dutch Postcode Lottery Commitment to a better world</td>
<td>Louise van Deth</td>
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<td>Amsterdam</td>
<td>SAFAIDS and Community Mobilization</td>
<td>Sara Page-Mtongwiza Deputy Director of SAFAIDS</td>
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<td>SAFAIDS' Regional Summit for</td>
<td>MaxART- For Better Health and Zero New HIV Infection</td>
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<td>the Changing the River’s Flow</td>
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<td>project Harare Zimbabwe</td>
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<td>Marieke van Schaik Director of Dutch Postcode Lottery</td>
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<td>International AIDS Conference</td>
<td>Community Solutions to Community Problems: How PLHIV-Driven Research is Influencing Policy and Practice</td>
<td>Thembi Nkambule Director of Swaziland Network of People living with HIV</td>
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<td>International AIDS Conference</td>
<td>Showcasing the Potential and Role of Mobile Technology in Turning the Tide on HIV and Other Diseases</td>
<td>Dr. Charles Azih - Swaziland Ministry of Health</td>
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<td>International AIDS Conference</td>
<td>How to Integrate Human Rights into Treatment for Prevention Programs</td>
<td>Georgina Caswell and Moono Nyambe GNP+</td>
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**Posters**

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<tr>
<td>Treatment as Prevention</td>
<td>Documenting the experiences of PLHIV in the context of testing and treatments scale-up in Swaziland</td>
<td>SWANNEPHA and GNP+ with support of CHAI and Population Council</td>
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<td>Conference Vancouver</td>
<td>Documenting the experiences of PLHIV in the context of testing and treatments scale-up in Swaziland</td>
<td>SWANNEPHA and GNP+ with support of CHAI and Population Council</td>
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**Film**

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<th>Event</th>
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<td>President Bill Clinton</td>
<td><a href="https://www.youtube.com/watch?v=qNYtUoYiYsA">www.youtube.com/watch?v=qNYtUoYiYsA</a></td>
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<tr>
<td>Alicia Keys</td>
<td><a href="https://www.youtube.com/watch?v=bNUCBmzOuDo">www.youtube.com/watch?v=bNUCBmzOuDo</a></td>
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<td>Does HIV Looks Like Me? Swaziland</td>
<td><a href="https://www.youtube.com/watch?v=RPIDKeQlvng">www.youtube.com/watch?v=RPIDKeQlvng</a></td>
<td>SWANNEPHA, Swapol and Positive Woman Together</td>
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**Appendix 1: List of publications**
## Overview Articles, Newsletter, Presentations, Posters, Radio and TV programs July 2012 until July 2013

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<tr>
<th>Medium:</th>
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<tr>
<td><strong>Articles</strong></td>
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<tr>
<td>Swazi Observer (newspaper)</td>
<td>AIDS Life Line Column</td>
<td>SAF AIDS</td>
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<tr>
<td>Exchange Magazine</td>
<td>The role and experiences of people living with HIV in the context of Swaziland’s MaxART program.</td>
<td>GNP+, SWANNEPHA, Population Council and CHAI</td>
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<tr>
<td>CHAI Evidence for Impact Newsletter</td>
<td>Using Evidence to Monitor, Evaluate, and Improve Interventions in HIV Testing and Treatment and Malaria Elimination in Swaziland: Cross-Program Update.</td>
<td>CHAI</td>
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<tr>
<td><strong>MaxART Corporate Communications</strong></td>
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<tr>
<td>3rd MaxART Newsletter</td>
<td>HIV Testing Saves Lives</td>
<td>MaxART Consortium</td>
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<tr>
<td>MaxART Corporate Brochure</td>
<td>Health Sector on the Move - MaxART: Maximizing ART for Better Health and Zero New HIV Infections</td>
<td>MaxART Consortium</td>
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<td><strong>Learning Event</strong></td>
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<tr>
<td>Swaziland Treatment as Prevention Workshop: Pre-conference for Swaziland’s 2nd National Health and Research Conference</td>
<td>This workshop, conducted as a part of the MaxART project, adopted a linking and learning approach to achieve the following objectives: - Facilitate learning around successes and good practices, as well as challenges related to current TasP implementation efforts; and, - Inform policy making, programming and planning with tangible and concrete advice for current and future TasP efforts in Swaziland and other countries in the region.</td>
<td>MaxART Consortium</td>
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<td></td>
<td>Implementing Treatment as Prevention. From anticipating problems to solving them. An action-oriented report from the Treatment as Prevention Workshop: Pre-conference for Swaziland’s 2nd National Health and Research Conference 2012</td>
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<tr>
<td><strong>Presentations</strong></td>
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<tr>
<td>National Health Conference, Swaziland</td>
<td>Modelling and sample size estimation MaxART Study</td>
<td>Wim Delva (SACEMA)</td>
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<td></td>
<td>A qualitative study on the low utilization of male circumcision services in Swaziland.</td>
<td>Alfred Adams (UvA)</td>
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<tr>
<td>Event / Conference / Workshop</td>
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<tr>
<td>Because their voice Matter: How adolescents’ Perceptions of Gender and Sexuality Influence Access to and Utilization of HIV Services in Swaziland</td>
<td>Fortunate Shabalala (UvA)</td>
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<tr>
<td>Why Clients Drop Out Of Pre ART Care: An Ethnographic Perspective of System Barriers</td>
<td>Thandeka Dlamini (UvA)</td>
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<tr>
<td>National Policy and Discussion Forum, Ezulwini, Swaziland</td>
<td>All I want is to live a normal life: the life journey of an adolescent living with HIV in a rural setting in Swaziland</td>
<td>Fortunate Shabalala (UvA)</td>
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<tr>
<td>International Initiative for Impact Evaluation, (3ie), Lusaka, Zambia</td>
<td>Presentation research findings Alfred Adams</td>
<td>Alfred Adams (UvS)</td>
</tr>
<tr>
<td>Treatment as Prevention Workshop 2013, Vancouver</td>
<td>Modelling the minimum required sample size and expected impact of a Treatment as Prevention implementation study in Swaziland</td>
<td>Wim Delva (SACEMA)</td>
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<tr>
<td>Study Update: MaxART</td>
<td>Dr. Velephi Okello (MOH)</td>
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<tr>
<td>Understanding factors relating to attrition among HIV+ patients on ART in the Swaziland National Program: Implications on TasP implementation</td>
<td>Dr. Chalres Azih (MOH)</td>
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<td>Fast Track increasing uptake of HIV testing and counseling (HTC) services among men and adolescents through locally-owned solutions</td>
<td>Alison End (CHAI)</td>
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<tr>
<td>South African AIDS conference, Durban, South Africa</td>
<td>Modelling the minimum required sample size and expected impact of a Treatment as Prevention implementation study in Swaziland</td>
<td>Cari van Schalkwyk (SACEMA)</td>
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<tr>
<td>2nd International HIV Social Science and Humanities Conference (ASSHH), Paris, France</td>
<td>Closing the Gap between Policy and Practice to Reach Zero: The Dilemma of Consent in Young Adolescents’ Access to HTC</td>
<td>Fortunate Shabalala (UvA)</td>
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<tr>
<td>South African AIDS conference, Durban, South Africa</td>
<td>The Dynamics of Disclosure between stepparents and adolescents in Swaziland</td>
<td>Fortunate Shabalala (UvA)</td>
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<tr>
<td>Closing the Gaps in Care Between HIV Diagnosis and ART Initiation in Swaziland</td>
<td>Thandeka Dlamini (UvA)</td>
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<td>Sex is never the same; men’s refusal of circumcision services in Swaziland.</td>
<td>Alfred Adams (UvA)</td>
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<tr>
<td>Making it work – the role of the social sciences in a TasP implementation study in Swaziland</td>
<td>Eva Vernooij (UvA)</td>
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**Posters**

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<tr>
<th>Event / Conference / Workshop</th>
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<th>Author(s)</th>
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<tbody>
<tr>
<td>Treatment as Prevention Workshop Vancouver</td>
<td>MaxART Implementation Study: Immediate Access to ART</td>
<td>Alison End (CHAI)</td>
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<tr>
<td>“Sorry, I can’t help you”: How parental/guardian consent can be a barrier for young adolescents in Swaziland to access HIV services</td>
<td>Fortunate Shabalala (UvA)</td>
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<tr>
<td>Closing Leaks between HIV Diagnosis and ART Initiation. What the system can do?</td>
<td>Thandeka Dlamini (UvA)</td>
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<tr>
<td>The Sexual and Reproductive Health and Rights of People Living with HIV - Implications for Treatment as Prevention</td>
<td>Thembi Nkambule (GNP+ &amp; SWANNPHRA)</td>
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### Overview Articles, Newsletter, Presentations, Posters July 2013 until June 2014

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<tr>
<td><strong>Articles and Blogs</strong></td>
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<tr>
<td>Blog Yvonne Wilders (in Dutch)</td>
<td>Swaziland MaxART: door-to-door visits (yvonnewilders.blogspot.nl/2013/07/swaziland-maxart-door-to-door-visits.html)</td>
<td>Yvonne Wilders (RvT STOP AIDS NOW!)</td>
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<td>Clinton Foundation Website</td>
<td>In Swaziland’s HIV Fight, A Lesson for Progress</td>
<td>CHAI Swaziland</td>
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<tr>
<td>Human Rights Blog Dutch</td>
<td>Rolls-Royces, hiv en mensenrechten: een bezoek aan Swaziland</td>
<td>Lambert Grijns (Special Ambassador for Sexual Reproductive Health and Rights, Dutch Ministry of Foreign Affairs)</td>
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<tr>
<td>Ministry of Foreign Affairs</td>
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<tr>
<td>One World Love Blog (in Dutch)</td>
<td>Rolls-Royces en hiv in Swaziland (<a href="http://www.oneworld.nl/love/rolls-roycses-en-hiv-swaziland">www.oneworld.nl/love/rolls-roycses-en-hiv-swaziland</a>)</td>
<td>Lambert Grijns (Special Ambassador for Sexual Reproductive Health and Rights, Dutch Ministry of Foreign Affairs)</td>
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<tr>
<td><strong>MaxART Corporate Communications</strong></td>
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<td>4th MaxART Newsletter</td>
<td>Reaching Out to Young People</td>
<td>MaxART Consortium</td>
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<td>5th MaxART Newsletter</td>
<td>Preparing the Ground for Early Access to ART for All</td>
<td>MaxART Consortium</td>
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<tr>
<td>National ART Dialogue, Mbabane, Swaziland</td>
<td>HIV Related Needs of Adolescents Living with HIV Swaziland: Findings From Ethnographic Study in Manzini Region</td>
<td>Fortunate Shabalala (University of Amsterdam)</td>
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<tr>
<td>National Adolescents</td>
<td>Adolescents HIV Risk Perception and Practices</td>
<td>Fortunate Shabalala (University of Amsterdam)</td>
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<td>Dialogue, Manzini, Swaziland</td>
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<tr>
<td>7th IAS Conference on HIV Pathogenesis, Treatment and Prevention (IAS 2013), Kuala Lumpur, Malaysia</td>
<td>Modelling the expected impact of a treatment as prevention (TasP) implementation study on HIV incidence in Swaziland</td>
<td>Alex Welte</td>
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<tr>
<td>3rd Structural Drivers of HIV Conference, Cape Town, South Africa (pre-ICASA)</td>
<td>“If I’m using a treatment with prevention benefits, why do I need a condom?” A qualitative situational analysis on ART for prevention in Swaziland</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<tr>
<td>ICASA Youth Pre-Conference, Cape Town, South Africa</td>
<td>Advocating for good quality comprehensive sexuality education – what role can young people play</td>
<td>Fortunate Shabalala (University of Amsterdam)</td>
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<tr>
<td>International Conference on AIDS and STIs in Africa (ICASA) 2013, Cape Town, South Africa</td>
<td>Successful strategies to routinize Provider Initiated HIV Testing and Counselling in Swaziland</td>
<td>Phumzile Mndzebele, Swaziland Ministry of Health</td>
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<td>Upholding and promoting human rights in the implementation of treatment as prevention (TasP) in Swaziland</td>
<td>Mandhla Mehlo (SWANNEPHA)</td>
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<tr>
<td>Event / Conference / Meeting</td>
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<tr>
<td>National Congress STI&quot;HIV*Seks, Amsterdam, the Netherlands</td>
<td>Lessons from the frontlines: Qualitative situational analysis to inform the MaxART Treatment as Prevention Implementation Study.</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<tr>
<td>Conference on Retroviruses and Opportunistic Infections (CROI), Boston, USA</td>
<td>From Evidence To Policy: Experience From Swaziland</td>
<td>Dr. Okello (Swaziland Ministry of Health)</td>
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<tr>
<td>Combination Prevention Studies Meeting (CROI Side-Meeting), Boston, USA</td>
<td>MaxART Immediate Access to ART for All Implementation Study Design</td>
<td>Fiona Walsh (CHAI)</td>
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<td>Treatment as Prevention Workshop 2014, Vancouver, Canada</td>
<td>Mixed Messages? Perspectives from health providers and clients about Treatment as Prevention in Swaziland.</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<tr>
<td>Health Sector On The Move: Government, People Living With HIV And Civil Society Are Joining Forces In Swaziland For Better Health And Zero New HIV Infections</td>
<td>“If I am using a treatment with prevention benefits, why do I need a condom?” Early findings from a qualitative situational analysis on ART for Prevention in Swaziland</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<td>IAPAC Treatment as Prevention Conference, London, United Kingdom</td>
<td>Professional Ambivalence: the views of HIV service providers about ARVs for prevention in three settings</td>
<td>Eva Vernooij (University of Amsterdam) (with C. Dodds &amp; A. Persson).</td>
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<tr>
<td>3rd Structural Drivers of HIV Conference, Cape Town, South Africa (pre-ICASA)</td>
<td>Navigating and Negotiating Access to Treatment: The Protracted Route to ART Initiation for Married Women Living with HIV/AIDS in Swaziland</td>
<td>Thandeka Dlamini (University of Amsterdam)</td>
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<tr>
<td>International Conference on AIDS and STIs in Africa (ICASA) 2013, Cape Town, South Africa</td>
<td>The Invisible Men: A Qualitative Analysis of the Low Utilization of HIV Services, Client attrition and Sexuality in the Continuum of Care among Men in Zombodze, Swaziland</td>
<td>Alfred Adams (University of Amsterdam)</td>
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<td>Navigating and Negotiating Access to Treatment: The Protracted Route to ART Initiation for Married Women Living with HIV/AIDS in Swaziland</td>
<td>Thandeka Dlamini (University of Amsterdam)</td>
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<td></td>
<td>“If I am using a treatment with prevention benefits, why do I need a condom?” Early findings from a qualitative situational analysis on ART for Prevention in Swaziland</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<td></td>
<td>Health Sector On The Move: Government, People Living With HIV And Civil Society Are Joining Forces In Swaziland For Better Health And Zero New HIV Infections</td>
<td>Yvette Fleming (STOP AIDS NOW!)</td>
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<td></td>
<td>The Impact Of An Automated SMS Appointment Reminder System On Appointment Attendance Among HIV Care Clients In Swaziland</td>
<td>Dr. Okello (Swaziland Ministry of Health)</td>
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**Appendix 1: List of publications**
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<th>Event/Conference</th>
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<tr>
<td>Treatment as Prevention Workshop, Vancouver, Canada</td>
<td>Developing a Communication Strategy for Immediate Access to ART for all: Emerging Lessons from Swaziland</td>
<td>Emma Mafara (MaxART Communications Associate)</td>
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<td>Engaging Family to Improve Retention of Adolescents Living with HIV in Antiretroviral Therapy in Swaziland: Implications for Treatment as Prevention</td>
<td>Fortunate Shabalala (University of Amsterdam)</td>
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<tr>
<td>International AIDS Conference 2014 (AIDS 2014, Melbourne, Australia)</td>
<td>Demand creation community dialogues: An innovative strategy for uptake of HIV services</td>
<td>Andile Phindile Nheklo (SAFAIDS)</td>
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<td>Male Focused Health Days: Evaluating a Strategy to increase the consistent health seeking behavior of men in the context of Swaziland’s HIV epidemic</td>
<td>Dr. Okello (Swaziland Ministry of Health) / Eliane Vrolings (STOP AIDS NOW!)</td>
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**Reports**

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<tr>
<td>AVAC &amp; UNAIDS</td>
<td>Antiretroviral Treatment for Prevention of HIV and Tuberculosis. 2013 Update on current and planned research efforts</td>
<td>Report by AVAC and UNAIDS. Input by MaxART Consortium</td>
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<tr>
<td><strong>MaxART Corporate Communications</strong></td>
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<tr>
<td>MaxART Report</td>
<td>Postive Health, Dignity and Prevention. Finds and recommendations from a study led by and among people living with HIV in Swaziland</td>
<td>SWANNEPHA &amp; GNP+</td>
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<tr>
<td><strong>Presentations</strong></td>
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<tr>
<td>3rd National Health and Research Conference 2014, Investing in Health for Development, Ezulwini, Swaziland</td>
<td>Age and gender issues affecting uptake of HIV services: Implications for Early Access to ART for All</td>
<td>Eva Vernooij (University of Amsterdam)</td>
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<td></td>
<td>Increasing Accessibility of HIV Diagnostic Services through Decentralization of CD4 Testing</td>
<td>Gugu Maphalala (Swaziland Health Laboratory Services)</td>
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<td>Special Session: Implementation science as a tool for informing heath investment: Early Access to ART for all.</td>
<td>Dr. Okello (Swaziland Ministry of Health)</td>
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<td>Paediatric Small Grants: Facility owned innovations to increasing access to HIV testing and treatment</td>
<td>Mrs Nobuhle Mtethwa (Swaziland Ministry of Health)</td>
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<tr>
<td></td>
<td>Fast Track community based solutions to increase HIV testing and counselling among men and adolescents</td>
<td>Tikhona Mkhabela (CHAI)</td>
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<tr>
<td>Ghent University Research Seminar</td>
<td>Uncovering the (lack of) social science behind mathematical models of behaviour change for HIV prevention; MaxART Early Access to ART for All modelling component.</td>
<td>Wim Delva (SACEMA)</td>
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<tr>
<td><strong>Poster presentations</strong></td>
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<tr>
<td>3rd National Health and Research Conference 2014, Investing in Health for Development, Ezulwini, Swaziland</td>
<td>Successful strategies to increase the scale up of HTC through MaxART program</td>
<td>Vera Habedi (CHAI)</td>
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<tr>
<td><strong>Scientific Articles</strong></td>
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<tr>
<td>NAM. Aidsmap</td>
<td>What are the barriers that could stop HIV treatment becoming HIV prevention? Large studies of population impact of treatment as prevention policies underway.</td>
<td>Gus Cairns (Aidsmap)</td>
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<tr>
<td>Vlirusos</td>
<td>AIDS in South Africa: simulating the impact of early HIV treatment (Explaining Simpact model)</td>
<td>Flemish Interuniversity Council</td>
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<tr>
<td><strong>Swazi Media Articles</strong></td>
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<tr>
<td>Swazi Observer</td>
<td>HIV treatment takes priority over Prevention</td>
<td>Winile Mavuso (journalist)</td>
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<tr>
<td>Times of Swaziland</td>
<td>ARVs for All in Shiselweni</td>
<td>Mduduzi Magagula (journalist)</td>
</tr>
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Appendix 1: List of publications
MaxART final report phase 1

Appendix 2: MaxART newsletters edition 1-5
HIV services closer to the people

To ensure that people living with HIV live longer and healthier lives, HIV services need to be within their reach. Although 70% of Swaziland’s population lives in rural areas, many HIV services have been confined to a limited number of larger, often urban health facilities. MaxART brings testing and treatment facilities closer to the people.

In Swaziland, many individuals who test HIV-positive have to travel long distances for check-ups and medication. Now, the government of Swaziland is committed to introducing point-of-care (POC) laboratory equipment in local clinics. Within 20 minutes, the machine determines the strength of the immune system of a person living with HIV by measuring the individual’s CD4 count. Based on this, the doctor or nurse can advise on if and when to start taking antiretroviral medication (ARVs). Thus, the next steps can be planned the same day, saving the person many extra trips beyond the standard check-ups in the clinic. Moreover, in partnership with in-country partners, MaxART is supporting training of nurses to initiate HIV treatment in local clinics under a new activity, Nurse-led ART Initiation (NARTIS). Before this, it was only performed in the larger clinics and by visiting doctors, if at all.

As the MaxART programme progresses, a growing number of Swazis will be able to take advantage of HIV services closer to their homes. Improved access means a new future for numerous individuals.

HIV services closer to the people

SWANNEPHA study sheds light on HIV-related stigma

HIV-related stigma and discrimination discourage some people who do not know their HIV status from taking an HIV test, and can act as a barrier for people living with HIV in accessing treatment. SWANNEPHA and GNP+ surveyed the experiences and perspectives of people living with HIV between December 2011 and February 2012. Preliminary findings indicate that among 870 individuals interviewed in health facilities and support groups, 105 reported they had experienced stigma and discrimination within the last 12 months.

Among 105 people living with HIV who said they had experienced some form of stigma and discrimination, the majority of instances occurred at social gatherings (54%) and amongst family (36%). And 56% reported taking no action when confronted with these instances of stigma and discrimination. Twenty-six percent (W069) thought it was difficult for some people to continue to take ARVs, the main reported reason was stigma and discrimination (85%). In fact, 53% reported they went for an HIV test only after they became ill and were losing weight.

SIDA/ETS/120121/SA032Appendix 2:
MaxART newsletters edition 1–5

Newsflash:

‘Us-them’ feeling among health workers

Self-stigma also exists among health workers in Swaziland. Often they feel less at risk – ‘the ‘us-them’ idea’ – and they avoid HIV testing and care themselves. Swazi health workers overwhelmingly want to know their HIV status, but they fear stigmatisation by clients and colleagues and breaches of confidentiality. This is one of the outcomes of the study ‘Self-Stigmatization of HIV/AIDS Care among Health Workers in Swaziland’ of the University of Amsterdam. The results will feed the development of appropriate services, to benefit both health staff and clients. To learn more about the outcome, please read the article published in the Journal of the International AIDS Society of December 2011.
MaxART Reaches Out to Men

To realise MaxART’s main goals – improved health for all and zero new HIV infections – the programme embraces strategies to better reach out to men. Swazi men have not responded as well as women to HIV prevention efforts, such as voluntary counselling and testing. The outcome of the recent male circumcision campaign in Swaziland is an example of men’s low utilisation of health services.

Several arguments have been mentioned in literature about men’s low uptake of health services. Studies conducted in Sub-Saharan countries show that socialisation plays a key role in how men perceive and subsequently access health services. ‘Real men’ are physically, emotionally and psychologically strong – they are risk takers and resilient to illness.1 One of the latest studies carried out in South Africa concluded that ‘Gender differences in experiences of HIV services relate more to social than health system factors’.2 Contracting HIV is perceived by many men as a threat to their masculinity,3 and being ill belittles their sense of manhood. Health facilities are often seen as gendered spaces. These must be more responsive to men’s needs, and services that enable easier and easier use by men should be designed together with them. Context specific evidence on men’s reasoning for not accessing services in Swaziland is lacking and will be one of the research topics within the MaxART programme.

Services closer to men

The MaxART programme is taking innovative approaches to both bring services closer to men and bring men closer to services. Male-Focused Health Days are special days for men organised monthly at the health facility, often on a Saturday, which include health dialogues. Other efforts are mobilising the community through involvement of traditional and religious leaders, offering voluntary counseling and testing (VCT) at workplaces in collaboration with the Swaziland Business Coalition on HIV and AIDS (SWABCHA), and ‘Fast Track’, a community-owned effort whereby a problem is defined – for instance, low HIV testing uptake by men – and solved by the community itself.

Some of our results, so far:

• We trained 38 traditional leaders, 4 political leaders and 200 community-based volunteers, who are now equipped to mobilise their communities, stimulate HIV testing and treatment adherence, and prevent new HIV infections.
• We deployed 33 lay counsellors at 11 facilities, which resulted in a 61% increase in HIV tests carried out at outpatient units over 3 months.
• We implemented Fast Track in 5 different communities, which resulted in an increase in HIV testing of 560%.
• We worked together with clinics to organise Male-Focused Health Days.
• We reached 44 out of 55 communities (‘Tinkhundla’) and 75 out of 188 public health facilities in Swaziland.

‘More men on board will bring us closer to MaxART’s exciting ambition: zero new HIV infections.’

Alfred Adams, Researcher University Amsterdam

Foreword

The Ministry of Health of Swaziland remains dedicated to lead and support the MaxART programme. MaxART has infused our HIV response with innovative approaches to overcome existing barriers to reach out to all individuals in need of HIV services, including those who are most hard to reach. This newsletter edition highlights exciting results from the first year related to a particularly important group of focus: men. We continue to design and implement activities to effectively support this group. Swaziland in the spotlight, as the country is making substantial progress. We are committed to providing the most beneficial HIV services for all people in Swaziland.

Benedict Xaba, Honourable Minister of Health, Swaziland

MaxART Reaches Out to Men

For Better Health and Zero New HIV Infections

MaxART final report phase 1
An effective method to reach men, and thus contribute to reduction of new HIV infections and keep communities healthy, is involving traditional leaders. MaxART partner Southern African HIV & AIDS Information Dissemination Service (SAfAIDS) strengthens the capacity of traditional leaders, including religious and political leaders, to be promoters of HIV testing and treatment.

To date, SAfAIDS has trained 98 Swazi traditional leaders and 12 political leaders in mobilising their communities for HIV counselling and testing, and when needed treatment and adherence. As traditional leaders can set an example, stimulate conversation, and mobilise behaviour change, they can be the key to the success of community dialogues. The methodology engages women, youth, and men — first separately, then collectively — in issues that affect them and the community. Thus, cultural practices that hinder uptake of HIV testing and treatment are identified.

Dialogues for men only
During dialogues for men only, men feel more free to express their concerns, can have a test and receive information. In Swaziland, the newly trained traditional leaders, partly with community-based organisations, conducted 28 dialogues and reached 1,050 community members, of whom nearly 90% were men. It is anticipated that, by the end of 2012, the methodology reaches over 1,000 men, and at least 60% of them are expected to have an HIV test.

Pilot to Generate Evidence on Treatment as Prevention in Practice

So far, studies on Treatment as Prevention (TasP) have only been done in controlled settings, focusing on the effect of treatment on the prevention of new HIV infections. The MaxART programme in Swaziland will run an implementation study on TasP in a real-life setting.

The pilot study will investigate a number of critical facets in practice feasibility, acceptability, scalability, and clinical outcomes. And it includes a focus on uptake of HIV testing and treatment, retention in care, and viral suppression. Swaziland wants to investigate the feasibility of offering HIV testing to all people in Swaziland, link and keeping them in care, treat them earlier than currently recommended and ensure treatment adherence.

Will it be accepted?
Further, there are unique considerations and questions about how clients and health workers will react when offering treatment to people living with HIV who are not yet feeling unwell — will it be accepted? Moreover, the government needs to understand how much it will cost and what it will take to scale-up coverage of treatment at the national level. Is it a smart investment? What are the known benefits and potential risks for individuals and the country overall?

To make informed policy decisions, governments need to know that TasP can work in a real-world setting within a government-managed health system. Swaziland, the country with the highest HIV prevalence in the world, is ready to lead the way.

Swaziland National Health and Research Conference, 7-9 November 2012, Royal Swazi Conference Center – Ezulwini Valley, Swaziland. The theme of this year’s conference is Strengthening Health Systems to Improve Health Outcomes. The MaxART team will be strongly represented during the conference. We kindly invite you to join one of our sessions and learn all about our work so far.

Events

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Research reveals pros of early treatment

Early treatment of HIV benefits individual health and is very cost-effective. This is claimed by the results of the HIV Prevention Trials Network (HPTN) 052 study.

Expanded analysis of the study shows that earlier initiation of antiretroviral (ART) therapy significantly decreases the number of illnesses experienced by people living with HIV. Modelling the study data demonstrates the cost-effectiveness of treatment as prevention. So, the HPTN 052 study shows the approach is a cost-effective way to increase people’s choices about their sexual relationships and their health and also prevents new infections. For more information: http://www.hptn.org/research_studies/hptn052.asp

Postcode Lottery is proud of MaxART

‘Supporting the MaxART programme fills us with pride,’ states Femke Rottelveld of the Dutch Postcode Lottery. ‘Having visited Swaziland.

‘The Postcode Lottery is extremely enthusiastic about supporting this way to increase people’s choices about their sexual relationships and their health and also prevents new infections. For more information: http://www.hptn.org/research_studies/hptn052.asp

Postcode Lottery is proud of MaxART

‘Supporting the MaxART programme fills us with pride,’ states Femke Rottelveld of the Dutch Postcode Lottery. ‘Having visited Swaziland. ‘The Postcode Lottery is extremely enthusiastic about supporting this chance to fight the AIDS epidemic in a completely new way. The ambition, dedication and quality of MaxART’s multidisciplinary team are truly impressive. Following your moral compass will bring the best results. Good luck!’

Femke Rottelveld is Account Manager Charities at the Dutch Postcode Lottery.

11 Thanks to the financial contribution of the Dutch Postcode Lottery the MaxART Programme is enabled.
HIV Testing Saves Lives!

In Swaziland, MaxART supports initiatives to help people living with HIV lead healthier and longer lives, and to reduce the transmission of HIV. As Voluntary HIV testing and counselling is the entry point to all HIV care, treatment, support, and prevention services, MaxART contributes to the Ministry of Health’s scale up of testing across the country. This is implemented in collaboration with other important partners, including the President’s Emergency Plan For AIDS Relief (PEPFAR) and Médecins Sans Frontières (MSF). In 2013, Swaziland achieved the highest HIV testing numbers in any year so far. The MaxART partners are proud to have contributed to this success.

Counselling Empowers Clients

In Swaziland, the desired scale up in HIV testing uptake and linkage to care, while also ensuring improved quality of counselling, is challenging. Tasks are shifted and the scope of duties of Expert Clients and Counsellors expands – both for HIV testing, counselling and adherence.

As testing increases, Counsellors run the risk of becoming exhausted when offering HIV testing and counselling. They may be inclined to share standard messages without sufficient recognition of individual circumstances. Counsellors might also dominate sessions rather than listening to clients’ real concerns and fears. Expert Clients specifically take on increased responsibility, often without additional training, support and pay, possibly resulting in burnout and decreased motivation.

Link and support

Counsellors can empower clients to take control of their lives, link them to care, and support people who do not have HIV to remain HIV-negative. They can also dispel myths, fears and misconceptions about antiretroviral therapy. Moreover, counselling empowers clients to deal with the harsh socio-cultural environment where they are often influenced against uptake of HIV services.

To ensure linkage and retention in care, MaxART calls upon all involved to work on good quality counselling. This can be accomplished through recognition of Expert Clients and Counsellors, adequate training, proper payment, and coordination.

MaxART final report phase 1
Fast Track Increases HIV Testing Uptake

Fast Track is a community-owned effort whereby a defined problem – for instance, low HIV testing uptake – is addressed by the community itself within 90 days. In Swaziland, compared to the baseline, the average increase in HIV testing across the completed Fast Tracks is significant: 5 times among male adults, 19 times among male adolescents, and 3 times among female adolescents.

Fast Track has been completed in 15 sites and is ongoing in 4 more. These efforts, which are implemented in collaboration with the Ministry of Health and community-based leaders, have included more than 95 chiefdoms. So far, Fast Track teams visited a total of 9,640 households, sensitised 38,670 individuals, and distributed 66,580 female condoms, including both male and female condoms.

Strengthened partnerships Fast Track has also strengthened in-country partnerships, such as with the National Emergency Response Council on HIV/AIDS (NERCHA), national and international non-governmental organisations (NGOs), National AIDS Council and the AIDS Healthcare Foundation, resulted in valuable information sharing and making use of community resources, including community-based volunteers.

Newsflash:

Action-Oriented Report

To move from talking about problems that may affect treatment as prevention implementation to finding solutions, various stakeholders gathered in Swaziland, on 5 and 6 November 2012. They promoted promising solutions, such as: maximise meaningful engagement of people living with HIV and expand community-based services.

For all solutions, see the report on www.stopaidsnow.org/treatment-prevention. From anticipating problems to solving them – An action-oriented report from the Treatment as Prevention Workshop Pre-conference for Swaziland’s 2nd National Health and Research Conference 2012.

Teen Clubs: Forums for HIV Testing

MaxART launched six community Teen Clubs across two regions in Swaziland. These clubs provide opportunities for young people to meet and have fun, and are also forums for health information sharing and outreach, such as HIV testing and counselling.

Key players in the local clinics, schools, churches, and communities plan and organise the monthly Teen Clubs, after receiving leadership training on the importance of adolescent health, development, and support. The Teen Clubs, which are open to in-school and out-of-school youth, are linked to programmes of the government and partner organisations.

‘In the Teen Club, we interact in a different way. There is openness, and the youth approach us with their problems.’

Mudzusi Mayiela, 28 years, Lobamba Teen Club Planning Committee
MaxART Reaches Out to Young People

Foreword

My vision is to see young people accessing information, treatment, care, and support services without discrimination. However, there are several barriers in accessing HIV services in Swaziland, such as judgemental attitudes of health care workers and stigma. At the same time, young people come up with solutions, like youth-specific mobile services. Reaching young people and involving them in our solutions is crucial for the HIV response. MaxART’s strategies to do so are highlighted in this newsletter.

Let us not stand in young people’s way by judging them. Young people are the future of Swaziland and we must ensure they are healthy by providing youth-friendly services. Always remember that young people have a right to know their status and to access the services they need.

Phindile Andile Nhleko
Programme Assistant, SAfAIDS

Successes

In a three-month Fast Track, testing for adolescents (10-19 years) increases on average by 400%, and around 350 young people attended fifteen Teen Clubs per month. There is increasing dialogue between the Ministries of Health and Education about how to better reach young people in schools with HIV education, prevention, and treatment, while reducing stigma.

Challenges

Despite significant progress, challenges remain to adolescents accessing comprehensive services free of stigma and discrimination. There are few truly youth-friendly services available, because health care workers often lack the skills to counsel young people, and health infrastructure has evolved with women and children in mind, rather than providing services in locations and times easy for adolescents to access. In addition, current policies do not allow HIV testing and condoms in schools. Moreover, in the traditional parent-child relationship in Swaziland there is no dialogue on sexuality, and even health workers sometimes have trouble removing themselves from the ‘parent’ role. Parental and guardian consent is another challenge. (See article on consent in this newsletter.) MaxART focuses on strengthening the health system and overcoming policy barriers, while also reaching out to young people and involving them in the solutions.

Key Figures on Young People in Swaziland

Approximately 6.9% of the population is below 15 years old, with young people 15-24 years old accounting for 22% of the population.

Proportion of children aged 0-14 years of which children were orphans or otherwise vulnerable children in 2009 increasing to 25.5% in 2010.

An estimated 3,000 new HIV infections occur nationally in adolescents, though this figure is projected to decline each year.

Adolescents account for 27% of all antenatal care attendance.

More than 31,000 HIV tests were done among adolescents 10-19 years in 2010, 66% of which were positive, and 4,610 adolescents were initiated on antiretroviral therapy (ART). 3

1. Source: UNAIDS Data on the Global AIDS Epidemic
2. Source: UNAIDS Data on the Global AIDS Epidemic
3. Source: Burning Bright on AIDS, 2010
4. National and district level data. 2010

I want to be a doctor and help sick children. The nurse told me that if I take my pills well, I can grow old and do anything I want.’

Seventeen years old boy.

Photo by Adriaan Backer
Consent – A Barrier for Adolescent HIV Testing

Young people have a high risk of contracting HIV, yet many are unaware of their status because of poor access to HIV testing and counselling (HTC) services. In Swaziland, parental and guardian consent still presents a major barrier to adolescents accessing HTC.

Challenges in providing consent, and having consent accepted and acted upon by health workers who may not be comfortable testing adolescents are major barriers for adolescents to access different HIV services, resulting in under-diagnoses of infected adolescents. In 2012, for example, only 14.4% of total HIV tests were among adolescents, despite their being a much larger segment of the overall population.1

In Swaziland, the age of consent in the guidelines for HTC was lowered from 18 to 16 in 2012. In 2013, the Child Protection and Social Welfare Act lowered the age of consent to 12, and the HTC guidelines are now being revised accordingly. Studies from other countries have shown that removing the need for guardian consent for adolescents leads to improved uptake of HIV testing, and consequently positive health outcomes.2 The next step is to implement these new guidelines, in order to create an enabling environment for health care workers and adolescents to test for HIV, supported by the assurance of comprehensive care and support for those who test positive.

2. Journal of Public Health; 87(8):1338-1341
3. MSH, URC, Baylor, FLAS, AHF, M2M, Lusweti, and World Vision.

Teen Clubs Successfully Reach Out to Adolescents

Fifteen adolescent-led Teen Clubs are running throughout Swaziland. So far, over 1,350 adolescents have been reached with comprehensive information on HIV.

Teen Clubs and Fast Track have jointly encouraged and enabled over 15,000 adolescents to get tested for HIV. Sports events are popular occasions to reach adolescents. In future, parent-teacher meetings and family days which encourage parent–teen dialogues will be held to create a supportive environment. Additionally, a dual approach of educating young adolescents (10-19 years) and engaging older adolescents (16-19 years) as advocates for HIV testing among their peers, will be piloted.

Young People’s Leadership to Address HIV

Communities lie at the core of the health care system. To ensure sustainability and to reach out to all those who need to be tested, enquired, and offered continual care and treatment, the people of Swaziland need to be part of our work. In 2013, during the annual MaxART National Advocacy and Policy Dialogue, several issues for adolescents living with HIV were raised. As follow up, the National Policy Dialogue for Adolescents on ART was organised.

The dialogue, the first to be especially organised for adolescents with HIV, was attended by 50 adolescents. They clearly expressed their need for full information, transparency, honesty, and youth-friendly services. The adolescents made policy recommendations to address these needs and overcome barriers, including extending opening hours of clinics beyond school times and peer education.

Working group on adolescents

This movement emphasised the importance of a recently-formed dedicated working group on adolescents within the Ministry of Health. Now, the inputs from the adolescent community are incorporated, as health policies are revised. The adolescents called for action of their government and expressed that they wanted to be actively involved in the planning, implementation, and evaluation of activities. Above all, they encouraged each other to be leaders and to change the HIV epidemic in Swaziland. ‘You are a leader when you know your status and encourage other young people to test and know their status as well’.

2. MSH, URC, Baylor, FLAS, AHF, M2M, Lusweti, and World Vision.

Events

International Conference on AIDS and STIs in Africa (ICASA)
7–11 December 2013, South Africa

The theme is ‘Now More Than Ever: Targeting Zero’. The 17th ICASA expects to welcome 10,000 participants from around the world. MaxART proudly presents three lectures and display/poster sessions. See: www.icasa2013southafrica.org

ICASA Youth Pre-Conference: Scaling up young people’s participation
4–6 December 2013, South Africa

The regional platform of organisations and networks focuses on youth activities and advocacy campaigns, before, during, and after ICASA. The Pre-Conference seeks to connect young people together. MaxART will participate in one of the workshops. See: iaca.youthfront.org/about/2013-icasa-youth-pre-conference/ and www.facebook.com/iaca.youthfront

Appendix 2: MaxART newsletters edition 1-5

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Prepared by: MaxART
MaxART newsletter
Edition 1/2012
July 2012

Content:
Preparing the Ground for Early Access to ART for All
Early Access to ART for All in Practice
Core Message: Early Treatment for Better Health
Dialogue on Men’s Health

Prepared by: Dr. Velphi Okebo
National ART Coordinator, Ministry of Health
Principal Investigator MaxART Early Access to ART for All implementation Study

Foreword
Swaziland has made great progress in the national HIV response over the past three years, and the MaxART programme has contributed to many of these gains. I am excited about the next phase of our programme, where we will offer HIV treatment regardless of CD4 count. This will provide Swaziland and the global community with valuable lessons about how to implement this ambitious approach and improve the lives of many people. Although we have accomplished much, the Ministry of Health and the people of Swaziland are not done yet: we are committed to continue to improve services and address the HIV epidemic to ensure the best health for all of the people of Swaziland.

Dr. Velphi Okebo
National ART Coordinator, Ministry of Health
Principal Investigator MaxART Early Access to ART for All implementation Study

The first phase of MaxART focused on the implementation of innovative, evidence-informed, and rights-based interventions. Moreover, community and health systems were integrated, to address barriers to HIV testing, care and treatment, and retention in care. We particularly focused on hard to reach men and adolescents, and embraced community-owned and driven solutions. After three years of implementation, Swaziland is on track. The country experienced the highest annual HIV testing rate ever. Ninety percent of the people currently eligible for treatment, are actively on ART, while retention has improved.

Success factors
The programme’s key success factors are the strong leadership of the Ministry of Health of Swaziland and the multidisciplinary approach of the consortium. Other crucial elements are the integration of community-based and facility-based interventions as well as the continuous gathering of information and making adjustments based on findings of social science research, experiences of people living with HIV, and human rights monitoring. However, working with partners from different backgrounds can be quite challenging. This is why we regularly organise sharing, linking, and learning meetings. All in all, Swaziland and the MaxART partners are ready for the second phase: implementing Early Access to ART for All. Read about this exciting next phase in the article on the back side.

Key Figures on Mobilising Communities in Swaziland

170 traditional leaders and 10 political leaders were trained to integrate community mobilisation on HIV prevention and health promotion in their communities, and to organise community dialogues.

Since 2011, 260 community dialogues have been conducted, reaching 12,134 females and 25,243 males.

During community dialogues, on-site health services were provided, reaching 6,653 females and 7,627 males with HIV testing and counselling services, and 383 people with tuberculosis screening, while 34,200 condoms were distributed.

I am glad that MaxART recognises traditional leaders as custodians of communities. Being engaged from the start enables us to fully support the programme.

Chef-Prince Susa Dlamini, Nsangzeni Chethom, Swaziland

MaxART final report phase 1
Early Access to ART for All in Practice

In the second phase of the programme (2014-2017), MaxART will be embarking on the demonstration project Early Access to ART for All. The aim is to evaluate the feasibility, acceptability, clinical outcomes, affordability, and scalability of offering ART to all HIV-positive individuals in Swaziland’s government-managed health system.

The demonstration project will take place in the Hhohho region through a ‘stepped-wedge design’ with open enrolment for HIV-positive adults. It is anticipated to begin in August 2014, and will continue for three years.

Beside evaluating clinical outcomes, the focus will be on the community’s perception of the intervention and the economic impact for the country. Using various methods, the consortium partners will address the primary questions through social science research, economic costing, and mathematical modelling.

Community participation Community participation will be an integral part of the implementation, ensuring that the community’s voices are heard and addressed. The formation of a community advisory board (CAB) guarantees the provision of substantive input that is in accordance with community values, culture, and social practices.

MaxART’s demonstration project Early Access to ART for All will inform Swaziland’s HIV guidelines and provide valuable insights for the Southern African region about the possibility of a shift in treatment guidelines.

Stay up-to-date on MaxART and the demonstration project. Visit our website www.stopaidsnow.org/treatment-prevention and subscribe to our e-news via www.stopaidsnow.org/maxart-newsletter.

Core Message: Early Treatment for Better Health

A robust communications strategy is essential for the effective implementation of the demonstration project Early Access to ART for All. Emma Mafara, MaxART Communications Associate, was involved in the development and will be involved in the implementation of the strategy in preparation for the project’s rollout. A short interview with Emma.

Why is a communications strategy so important?

Emma: ‘We want to be sure that everyone understands the importance of early ART uptake. This is why we provide tailored information and support to different target groups, answer questions, and proactively address misinformation. For the development of the communications strategy, it was crucial to take into account the barriers and the potential benefits of early adoption of ART for each group.’

What are barriers for early ART uptake?

Emma: ‘Some people living with HIV are reluctant to start ART when they do not feel sick. Moreover, health providers are not always able to correctly explain the benefits of early ART. Myths, misconceptions, and lack of information about the advantages are major barriers.’

What is the focus of the communications strategy?

Emma: ‘The core message is ‘Early treatment for better health.’ A package of information materials is being developed for use in community and clinical settings, for instance. Our aim is that people can make informed decisions based on appropriate messages via the right channels.’

As a church leader, I had previously questioned the health messages about condom use. Attending male-focused health days has changed my mind-set.

Mr. Paul Dlamini, Mpolonjeni Clinic, Swaziland

Appendix 2: MaxART newsletters edition 1-5