Strengthening Community Systems for HIV Treatment Scale-up

A case study on MaxART community interventions in Swaziland
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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).
Without the support of all the different partners in Swaziland it would not have been possible to draft this case study report. I would like to thank the respondents from the MoH and NERCHA for their extremely helpful insights in community systems strengthening issues in Swaziland and availing their time to talk to me within their busy time schedules.

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After my return from Swaziland several interviews were set up with people who were no longer involved in the programme. I appreciate the time and effort of everyone to make this possible.

Last but not least I would like to thank Eliane Vrolings from STOP AIDS NOW!, who was always there to provide support during all phases of this work.

Françoise Jenniskens
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ACAT</td>
<td>Africa Cooperative Action Trust</td>
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<td>AHF</td>
<td>AIDS Health Care Foundation</td>
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<td>AMICAALL</td>
<td>Alliance of Mayors Initiative for Community Action on AIDS at Local Level</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARVs</td>
<td>Antiretroviral drugs</td>
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<td>CBOs</td>
<td>Community Based Organisations</td>
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<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>CSS</td>
<td>Community Systems Strengthening</td>
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<td>DCCDs</td>
<td>Demand Creation Community Dialogues</td>
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<td>EAAA</td>
<td>Early Access to ART for all</td>
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<td>FBO</td>
<td>Faith Based Organisation</td>
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<td>FGD</td>
<td>Focus Group Discussions</td>
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<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GIPA</td>
<td>Greater Involvement of PLHIV</td>
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<td>GNP+</td>
<td>Global Network of PLHIV</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>LTFU</td>
<td>Lost To Follow Up</td>
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<tr>
<td>M&amp;I</td>
<td>Monitoring and evaluation</td>
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<td>MaxART</td>
<td>Maximising ART for better health and zero new HIV infections</td>
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<td>MFHDs</td>
<td>Male Focused Health Days</td>
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<td>MoET</td>
<td>Ministry of Education and Training</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MTAD</td>
<td>Ministry of Tinkhundla Administration and Development</td>
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<td>NARTIS</td>
<td>Nurse-led ART initiation in Swaziland</td>
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<td>NASA</td>
<td>National Expenditure on AIDS</td>
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<td>NCPs</td>
<td>Neighbourhood Care Points</td>
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<td>NERCHA</td>
<td>National Emergency Response Council on HIV/AIDS</td>
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<td>NGOs</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PHDP</td>
<td>Positive Health Dignity and Prevention</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PoC</td>
<td>Point of Care</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>REMSHAC</td>
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<td>RHMs</td>
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<td>RHMT</td>
<td>Regional Health Management Team</td>
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<td>SACEMA</td>
<td>South African Centre for Epidemiological Modelling and Analysis</td>
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<td>SAFAIDS</td>
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<td>SHIMS</td>
<td>Swaziland Incidence Measurement Survey Study</td>
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<td>SMS</td>
<td>Short Message Service</td>
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<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
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<td>SWABCHA</td>
<td>The Swaziland Business Coalition on HIV and AIDS</td>
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<td>SWANNEPHA</td>
<td>Swaziland National Network of PLHIV</td>
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<td>SWAPOL</td>
<td>Swaziland for Positive Living</td>
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<td>TASC</td>
<td>The AIDS information and support centre</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UvA</td>
<td>University of Amsterdam</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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**Executive summary**

**The MaxART programme**

This case study describes and analyses the results of the Community Systems Strengthening (CSS) interventions and activities of the Maximizing ART for Better Health and Zero New HIV Infections (MaxART) programme between mid 2011 and mid 2014 in Swaziland. It demonstrates the key role of communities and community system interventions in successfully scaling up access to HIV prevention, treatment and care programmes, and the need for strong community systems when successfully implementing early treatment and reaching ambitious global targets to end the AIDS epidemic.

The MaxART consortium\(^1\) received funding from the Dutch Postcode Lottery Dream Fund to test a radically new way of preventing HIV and responding to the challenges posed by HIV through a *Treatment as Prevention* approach, in the country with the highest HIV prevalence in the world. The programme was designed to address the most critical challenges and needs of the country, identified by the government, NGOs, community based organisations and other stakeholders in Swaziland and in line with the national strategic plan. The case study focuses on the community interventions implemented in the first phase (2011-2014) of the programme aiming to *achieve universal access to treatment for those who are eligible*. The targets for this objective were to:

- Dramatically scale HIV testing to 250,000 people per year;
- Improve access to antiretroviral treatment (ART) so that 90% of those in need at the then current eligibility criteria (CD4 count of up to 350 cells/mm\(^3\)) are on treatment;
- Reduce loss-to-follow-up of clients on treatment from 22% to 10% by 2014.

Two hard to reach groups identified by the Ministry of Health (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. The Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) also undertook research on Positive Health, Dignity and Prevention (PHDP) during the project, which highlighted important experiences, concerns and needs of People Living with HIV (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 implementation learnings were shared and discussed. Through these mechanisms several interventions were adapted along the way.

The MaxART community interventions were geared at mobilising communities with a special focus, but not exclusively, on men and adolescents for HIV testing, uptake of ART and retention in care; as well as improving the linkages between community systems and health systems by removing barriers to access health services.

The community work was complemented by health facility level interventions such as point of care CD4 testing, provider initiated HIV testing, improving linkages from testing to HIV care, nurse-led ART initiation, adherence counselling, supply chain strengthening and SMS reminder appointment systems. These are not part of the case study review.

Phase 1 of the MaxART programme laid the foundation for the second phase (2014-2017): the *Early Access to ART for All* demonstration project in Swaziland. During this phase all PLHIV in 14 health facilities in the Hhohho region will be offered ART regardless of their CD4 cell count. It will put into practice the existing evidence that early ART is not only beneficial for an individual’s health, but also contributes to the prevention of HIV transmission, often referred to as Treatment as Prevention. A prerequisite for this approach is that people know their HIV status and are willing to accept and stay on ART when HIV positive. Phase 1 focused significantly on ensuring this was possible by implementing the necessary interventions and strengthening the related systems.

**Results of the MaxART programme**

By the end of 2013, all three targets of Phase 1 were achieved with over 250,000 people tested annually for HIV and 91% of people in need of ART were on treatment. The proportion of patients on treatment lost to follow-up, showed an increase from 11% to 23% between 2011 and 2012, but the cohort of 2013 shows that only 9% of PLHIV were lost to follow up.

Community mobilisation efforts resulted in many more people visiting the health facilities for a variety of services. The results from the interviews and, especially the FGDs, show that there was impressive stigma reduction and much more openness about HIV in the communities targeted by the programme. Many people are no longer 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).
Factors contributing to the success of the MaxART programme
There are several factors that contributed to the success of the MaxART programme such as:
- The thoughtful design phase of the programme in which an analysis of the core challenges of the country’s HIV response laid the basis for programming. The MOH along with the consortium partners jointly agreed on how to address these key challenges.
- 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.
- 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 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.
- Six different community interventions, all with the same goal, were using different approaches to reach the targets and were complementary when implemented within the same geographical area.
- The community interventions were complemented by health systems strengthening interventions2 thus creating a continuum of care.

Community interventions deployed by the MaxART programme
Engaging traditional leaders in the HIV response proved to be a good concept for entry into communities. The Demand Creation Community Dialogues (DCCDs) were most appreciated by all respondents, as dialoguing forms part of fabric of Swaziland society. Slightly over half of the participants were men. When on-site HIV testing was organised during the events the testing levels went up, especially when traditional leaders were leading the way. The door-to-door home visits were good for reaching women (74% of people reached), and were institutionalised within existing structures of the Rural Health Motivator (RHM) Programme of the MoH and the CSOs working with community based volunteers (CBVs). It was harder to provide accurate data of how many of the people mobilised through door-to-door home visits actually took up the services, but in general respondents in the FGDs felt that the linkages were strengthened between themselves and the clinics.

The Fast Track intervention proved to be working well for increasing uptake of testing and this intervention contributed to over 68,000 HIV tests done. It was well documented and provided pre- and post data on the uptake of HIV testing. A more than fourfold increase was achieved on average during the three-month period. Yet respondents in the communities would prefer interventions that have a longer timeframe and be more sustainable. The interventions for men (Male Focused Health Days) and youth (from a teen club approach to a peer educator model) weren’t further scaled up in year three, as they did not contribute much to achieving the scale up of HIV testing compared to other interventions. Yet, especially the intervention with men showed promising changes in behaviours of this group. It showed that men are receptive to changing their attitudes on health issues and can be agents of change in their families. Men may hold the key to change in the Swaziland society. The interventions with youth evolved over time into a peer educator approach, which showed better results in HIV testing. Yet the research highlighted many challenges for the youth that need a re-think of how to engage young people in the HIV response and address key challenges they experience in their daily lives.

When reviewing the definition of CSS as “an approach that promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures”, the MaxART programme has focused on massive scaling up of interventions, thereby using elements of the CSS framework, but did not intend to develop these more sustainable structures. Five out of the six CSS framework elements were implemented to a certain extent, but not all within the same geographical areas nor with the intention to institutionalise these efforts, with the exception of the engagement of Traditional Leaders and involvement of the RHMs in door-to-door visits. The question remains if even better results would be achieved should all elements of the framework be implemented at the same time within the same geographical areas.

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1 The Kingdom of 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 (SATAIDS), social scientists from the University of Amsterdam and researchers from the South African Centre for Epidemiological Modelling and Analysis (SACEMA).
2 Not reviewed for this case study
Geographical coverage of the MaxART community interventions

It was not easy to quantify the coverage of the MaxART interventions in Swaziland as the partners did not populate the data of people reached against the population living in the different constituencies. Swaziland has a relative small population with just over 1.1 million inhabitants. It would not be impossible to reach almost all of them using a community systems strengthening approach. However, within the confines of MaxART this was not possible. Respondents at the policy level estimated that the MaxART community interventions reached about 40% of the population in Swaziland. Further analysis could provide a more accurate figure of the percentage of the population reached and could set the pace for even further scaling up of efforts.

The MaxART programme provides a good example of how investing in a community approach can yield results in terms of scaling up HIV testing, uptake of ARV treatment and retaining people in care. The second phase of MaxART recognises again the importance of the community systems strengthening approach. Of special importance for the “Early Access to ART for All” demonstration project is continued attention to increasing demand (DCCDs) and a strong communication mechanism related to all aspects of the study. Hereto a Community Advisory Board at the national level will be set up to link the community with the research team. This Board will monitor the research closely. SWANNEPHA will coordinate the Board.

The way forward

UNAIDS, in 2014, has set new targets for combating HIV with a vision of getting to zero. New targets focus on closing the access gap to HIV treatment and prevention by 2020. Target—90-90-90—would enable 90% of people living with HIV to know their HIV status, 90% of people who know their status to access HIV treatment and 90% of people on HIV treatment to achieve viral suppression1. With MaxART phase two Swaziland has embarked on testing if and how this approach can work in practice. Without strengthening Community Systems, it seems unlikely that the 90-90-90 agenda will be achieved.

There is now a strong realisation among policy makers and development partners in Swaziland that an effective HIV response needs strong community systems strengthening approach and steps are taken to build CSS in the concept note for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The extended National multi-sectoral HIV and AIDS Framework 2014-2018 (eNSF) of the Kingdom of Swaziland foresees an important role for communities and civil society organisations including PLHIV in the design of community interventions and in the implementation of the eNSF. One of its strategies is geared at strengthening community systems.

General recommendations for CSS based on the experiences of MaxART

MaxART provides a good example of inclusive planning based on a thorough problem analysis. The planners realised the importance of developing a human rights based approach and especially recognised the important role of networks of PLHIV. The programme was addressing nationally identified needs.

There are some important lessons learned from the programme that can guide other organisations in planning community interventions. These are based on experiences that worked well but also on certain areas that did receive less attention in the programme:

- It is important to plan any CSS programme on the basis of good understanding of how community systems work, who the key actors and decision-makers are, what the key challenges are and ensure that communities are involved in the design of the programme and specific interventions.
- When planning for CSS it helps to unpack the concept within the local context and systematically address the key challenges when operationalising the concept. Ideally, all six elements of the CSS framework need to be addressed. Many organisations focus solely on improving service delivery and capacity development to achieve this, while a more comprehensive approach will enhance institutionalisation of efforts and thus sustainability in the long run.
- MaxART has specifically worked with the networks of PLHIV to support a stronger enabling environment based on human rights. The study on Positive Health, Dignity and Prevention was a good entry point to develop further legal and policy frameworks in the country.
- MaxART used a variety of different approaches in communities all targeted at the same goal. The approaches reinforced each other to a certain extent and diversity in methods helped to reach different target groups. Care should be taken that, if interventions are increasing demand, the health facilities are equipped to cater for this increased demand.
- Community leaders want sustainable interventions that are owned by the communities with accountability at the community leadership level. Those interventions that built on existing structures within the community were appreciated the most. Interventions should be focused at the lowest level of community organisation (chiefdom level in Swaziland). This allows for adjusting activities to the specific needs of that community, reduce travel cost and thus be more effective and sustainable.

Strengthening Community Systems for HIV Treatment Scale-up
Rural communities have a much stronger social cohesion than semi-urban and urban communities. It is much harder to define a community in the towns and townships and therefore reach people living in this setting. Therefore differential approaches are needed to reach people in different kind of communities. Men are best reached “where they are” for example in their workplace, at cattle dips, as regiments, during meetings and during soccer events. For youth these are obviously schools and places where they hang out like sports events, bars etc.

It works well when services are provided on the spot. Specific interventions may be needed to reach hard-to-reach populations, which may include mobile solutions. People prefer services to be closer to the people to reduce travel cost, be it mobile or static.

Social science research can provide answers to numerous operational questions related to intervention development. Combined with a strong learning-by-doing approach, this results in stronger interventions and provides tools for advocacy.

Members include amongst others a traditional leader as chair, representatives from the 14 communities in which the study is implemented, NGOs, CBOs, PLHIV, youth, researchers

1. Background

1.1 The Global HIV challenge

The global community has made extraordinary strides in scaling up treatment for people living with HIV over the past decade. Since 2002, there has been a thirty-fold increase in people accessing antiretroviral therapy (ART) globally, from 250,000 people to more than 13 million people at the end of 2013. New annual infections came down in the last decade from 3.3 million new infections in 1998 to 2.1 million infections globally in 2013. These are the lowest levels of new HIV infections this century. In the last three years alone new HIV infections have fallen by 13%.

Despite this progress, a recent report by UNAIDS shows that 19 million of the 35 million people living with HIV globally do not know their HIV-positive status. It means that the global community is still far from ensuring that virtually all people living with HIV (PLHIV) eligible for treatment are receiving it — which the Millennium Development Goals (MDGs) set as a target for 2015. Without a significant reduction in new infections, the number of individuals in need of treatment will continue to expand, as will the costs of the global response. Identifying and implementing effective prevention interventions to try and get ahead of the epidemic is a crucial next step in the global response to HIV.

Recent advances in HIV research have shown that earlier and expanded access to antiretroviral therapy (ART) could have a significant impact on HIV incidence. Results from the HIV Prevention Trials Network 052 (HPTN 052) trial show that early ART initiation prevents onward transmission of the virus to the uninfected partner in heterosexual HIV-discordant couples. The trial reported not only a 96% decrease in HIV transmission, but also a 41% decrease in HIV-related morbidity from early initiation of ART. The evidence supporting Treatment as Prevention (TasP) is expanding quickly and WHO’s 2013 treatment guidelines now recommend ART initiation when CD4 counts fall below 500 cells/mm3 and treatment regardless of CD4 count for pregnant women and sero-positive partners in discordant couples. As such, expanded interventions are increasingly being promoted as part of the HIV prevention and treatment paradigm.

UNAIDS, in 2014, has set new targets for combating HIV with a vision of getting to zero. New targets focus on closing the access gap to HIV treatment and prevention by 2020. Target—90-90-90—would enable 90% of people living with HIV to know their HIV status, 90% of people who know their status to access HIV treatment and 90% of people on HIV treatment to achieve viral suppression. To reach those targets health and community systems strengthening interventions are needed, and this case study provides an example of how this can be done.

Maximizing ART for Better Health and Zero New HIV Infections (MaxART) was set up as an unique package of interventions and research aimed at addressing the remaining barriers to HIV testing, care and treatment and further strengthening the collective efforts of the many involved programmes and partners in Swaziland. This scale up in access to, and uptake of, HIV testing and treatment sets the stage for an implementation study to put into practice the evidence that early treatment has not only individual health benefits, but also contributes to the prevention of HIV transmission (Treatment as Prevention). By demonstrating the operational effectiveness of an Early Access to ART for All strategy within a national public health system, the results of this study could catalyze a fundamental shift in how the world approaches the epidemic—ensuring a movement away from what is now a costly and incremental process towards a bold new approach.

Communities are at the heart of the response to HIV, yet there has been too little attention in the past decades on strengthening community systems that can help in mobilising communities for HIV testing and increasing the uptake of services and retention in care. Community mobilisation i.e. demand creation dialogues for the uptake of services and appropriate messaging and information sharing (treatment literacy and human rights) to the community about HIV testing, linkages between the community and the health facility and initiation of HIV treatment, adherence and retention are critical for the success of any HIV programme. Reductions in HIV transmission require viral suppression, which can only be achieved with high levels of adherence and retention in care.

This case study reviews the community systems strengthening approaches under the MaxART phase 1 programme, which aimed to address the remaining barriers to HIV testing, care and treatment.

1.2 MaxART vision, objectives and targets

With funding from the Dutch Postcode Lottery’s Dream Fund, 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 is implemented in two phases. The first phase (2011-2014) 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.

The project is implemented by the MaxART consortium comprised of the Ministry of Health (MoH); STOP AIDS NOW!; Clinton Health Access Initiative (CHAI); SAFAIDS; University of Amsterdam (UvA); South African Centre 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.
1.3 Swaziland context

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 prevalence by age and gender (SHIMS 2011)

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 VCT. An earlier 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.

1.4 Community systems and organisation in Swaziland

In Swaziland, rural communities are organised through the traditional set-up where the chiefs are representatives of His Majesty the King at the local level. The Chief is the executive head of the chiefdom. The position of Chief is hereditary. They are responsible for welfare of the people, land distribution and law and order. The Inner Council as an important coordination mechanism. The Inner Council at Chiefdom level is the main decision-making body at this level and is formed by traditional leaders and community members. The Bucopho is the executive committee consisting of persons elected from the chiefdoms within the Tinkhundla. They link the traditional system with the local government system (“Inkundla Level” or constituency level), which in turn links with the regional administration. Each constituency has several chiefdoms, usually 4-6 each. So called “chief runners” link the community members with the Chiefdom headmen (Indvuna yemucuba). Figure 1 shows a graphic explanation of this system.

There are several structures under the leadership of the Indvuna. The National Emergency Response Council on HIV and AIDS (NERCHA) has Kagogo “administrative offices” centres in each community (chiefdom). These centres have coordinators for the HIV response, which are called Kagogo centre clerks. Each chiefdom, constituency and region has a Community HIV committee. Most communities also have PLHIV support groups. There are also Neighbourhood Care Points (NCPs) where Orphans and Vulnerable Children (OVCs) receive food.

The Ministry of Health has been supporting a volunteer health cadre in Swaziland since 1976. These are called Rural Health Motivators (RHMs). They are selected at community level and receive a monthly stipend of 350 SZL. They are responsible for health and social issues within the chiefdoms. RHMs have worked with community members on promoting health for a variety of primary health care topics and have been an important link between community members and health services. Most RHMs are women.
Apart from the government, there are many other actors in the communities such as the private sector, NGOs, CBOs, FBOs often using different delivery systems. The concept note for the GFATM highlighted some key challenges at this level i.e. lack of clear linkages and referral mechanisms to support service delivery, community contribution to care support and treatment and community information does not always filter into national M&E systems (HMIS and SHAPMOS). Capacity assessments have shown that organisations and individuals providing services at community level have technical and organisational capacity constraints ie: inadequate skills; absence of accreditation and standardised training curricula; limited financial resources, lack of harmonised guidelines and standards of operation for provision of quality community based care.

MaxART has built its community interventions on the existing system of local government. Especially the role of the traditional leadership was seen as key to the success of any community intervention including capacity development of community based organisations (CSO).

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12 UN data 2011, Swaziland
13 Swaziland Global AIDS Response Progress Reporting 2014. Kingdom of Swaziland: NERCHA and UNAIDS.
14 National AIDS Spending Assessment 2007-2010. The Kingdom of Swaziland: NERCHA.
16 Swaziland Incidence Measurement Survey Study, 2011
17 Swaziland Multiple Indicator Cluster survey. Swaziland 2010.
18 siteresources.worldbank.org/CMUDLP/Resources/Swaziland_institutional_and_governance_review_presentation.ppt
19 There are 400 chiefdoms in Swaziland whose chiefs report directly to His Majesty the King.
20 The Bucopho is the Inkhundla local government council, which comprises of elected representatives from the chiefdoms. The Indvuna Yenkundla is the political head and chairs this council
21 Figure developed by F.Jenniskens for the Community Score Card Operational Manual. F.Jenniskens and P. Najman. For EU-WB Health, HIV and TB project. April 2014.
22 Swaziland Llalangeni: The equivalent of 350 South African Rand.
23 Draft Concept note TB and HIV to the GFATM. September 2014
2. Objective and Methodology

2.1 Objective of this report

The aim of the case study is to generate evidence to better understand the concept of community health systems and community system strengthening, its results, and impact, based on the experience and results from the first phase of the MaxART programme in Swaziland.

The specific objectives include:
1. Providing descriptions of all community activities and community systems strengthening activities by the MaxART consortium and implementing partners directly involved and/or contracted by MaxART partners (e.g., the 16 implementing partners of SAFAIDS) to scale up HIV testing, treatment and care and support in Swaziland. This excludes activities carried out independently by other partners in the country;
2. Analysing the results and potential impact of these activities based on desk research and interviews;
3. Identifying key success factors and challenges when strengthening and implementing community system activities;
4. Providing a description of the overall community systems strengthening (CSS) approach (including how it is linked to health systems) used by the MaxART consortium.

2.2 Methodology

The methodology for the development of this case study includes several techniques that jointly provide a better understanding of how the community systems strengthening activities contribute to achieving the goals of the programme. The methods used include:

- **A desk review** of the key reports from the different implementers: the national policies, strategies and reports of the HIV programme and other relevant documents related to community systems strengthening. National data were reviewed for outcomes, effectiveness and impact. Most of the graphs were either copied from these reports or developed based on information from these reports. It was assumed for this exercise that these were sufficiently verified.

- **A briefing meeting** with the directors of the three implementing partners was held on the first day of the visit to Swaziland. Thereafter a **start-up workshop** with partners in Swaziland was organised whereby 14 of the 16 implementing partners were present. This meeting was used to review the experiences with implementation of MaxART community interventions. Topics discussed included review of effectiveness, relevance, impact, success and challenges.

- Key informant interviews (KII) were held with policy makers and implementers both at international, national and regional level. These interviews focused on reviewing success and challenges of the community components of the programme. A tool was used in which respondents would rate the different interventions in terms of relevance, effectiveness and impact of the different interventions on a scale of 1-5 (1 lowest and 5 highest). These were analysed in graphic format. The interviews with the implementers were also used to understand the set-up of the interventions, the purposes and steps in the implementation.

- **Focus group discussions** (FGDs) were held with users of the different services with a special focus on youth and men, as these were the two main target groups of the programme. Furthermore, traditional leaders, PLHIV and Rural Health Motivators (RHMs) were interviewed to provide more insight on how communities experienced the interventions.

- At the end of the visit to Swaziland a **verification workshop** was organised with key partners in Swaziland. A total of 11 people participated in this meeting whereby the preliminary results were discussed and validated. Discussions also focused on further interpretation of these results.

- Based on all of the above further **analysis of the findings** was done and results were grouped for different categories of respondents. The case study report ensued from this further analysis.

The key informant respondents can be categorised as follows.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>International level</td>
<td>5</td>
</tr>
<tr>
<td>National level policy makers</td>
<td>7</td>
</tr>
<tr>
<td>National level implementers</td>
<td>6</td>
</tr>
<tr>
<td>Health facility level</td>
<td>2</td>
</tr>
<tr>
<td>Traditional leader</td>
<td>1</td>
</tr>
<tr>
<td>Researchers</td>
<td>4</td>
</tr>
<tr>
<td>Regional level policy makers</td>
<td>6</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>
The following focus group discussions were held.

<table>
<thead>
<tr>
<th>Focus groups with</th>
<th>Number of FGDs</th>
<th>Number in FGD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementers (SAfAIDS partners)</td>
<td>1 group</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Community level:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FGD men</td>
<td>2 groups</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>FGD youth</td>
<td>2 groups</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>FGD Rural Health motivators</td>
<td>1 group</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>FGD PLHIV</td>
<td>1 group</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>FGD community leaders</td>
<td>1 group</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total respondents in FGD</strong></td>
<td></td>
<td></td>
<td><strong>79</strong></td>
</tr>
</tbody>
</table>

The interviews in Swaziland took place between 20th August and 3rd of September 2014. The Focus Group Discussions took place in three different locations in Shiselweni, Manzini and Hhohho region. At the international level, STOP AIDS NOW!, UvA, one former CHAI staff member and GNP+ were interviewed.

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24 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.
3. Results and key findings of community systems strengthening approach of the MaxART project

This section of the report explains the MaxART model for community system strengthening. In the second section of this chapter the different interventions are explained in more detail and the results are described. Section 3 and 4 show the trend analysis based on national statistics for the key targets of MaxART and provides the coverage of the interventions.

3.1 Model used by MaxART for community systems strengthening

The premise around which the community systems strengthening component of MaxART was developed was that at the community level, changing behaviour and addressing cultural barriers would be the biggest challenge, and any failure to do so would present a significant risk to the programme.

The key challenges identified at a national stakeholder meeting prior to the start of the programme were: low treatment literacy within communities; weak mobilization efforts to scale up access to HIV Testing and Counselling (HTC) and ART; weak treatment advocacy efforts; high levels of stigma and limited engagement with community groups around testing and treatment. Communities did not yet have the capacity to support key activities by themselves such as, educating community members, and organising support, follow-up and referrals to clinics. An important part of the MaxART programme was geared at strengthening the linkages between the community systems and the health systems.

The MaxART programme was built around strengthening different components along the continuum of care and formed the model on which implementation was structured. Community interventions are highlighted in green in the graph below. They were geared at mobilisation of communities and target groups for HIV testing, uptake of ART and retention in care, as well as improving the linkages between community systems and health systems by removing barriers to access health services and providing treatment support. The graph also shows which interventions were implemented at health facility level to complement the community work.
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. 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.

**Community systems strengthening definitions**

Initially, MaxART focused on community mobilisation and improving the linkages to health services, using traditional leaders as an entry point. The MaxART Consortium in close collaboration with the MOH chose the mix of interventions. It was believed that the combination of different interventions would have a multiplier effect. Over the course of implementation the concept of CSS evolved and was embraced by the partners, including the government, as it improves the competence and ability of communities to contribute to the HIV response.

Concepts and definitions about community systems strengthening are given in the box below.

**Communities are** “formed by people who are connected to each other in distinct and varied ways. They are diverse and dynamic. Community members may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values.”

**Community systems** have been defined as “community-led structures and mechanisms used by community members and community based organizations (CBOs) and groups to interact, coordinate and deliver their responses to the challenges and needs affecting their communities”

**Community systems strengthening (CSS)** is “an approach that promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures”

**Community Systems Strengthening Framework:**
1) enabling environments and advocacy; 2) community networks, linkages, partnerships and coordination; 3) resources and capacity building; 4) community activities and service delivery; 5) organisational and leadership strengthening; 6) monitoring, evaluation and planning.

### 3.2 Description and results of the MaxART Community interventions within MaxART

The MaxART community interventions were all geared at reaching the same objectives. A distinction can be made between innovative interventions focusing on specific target groups of MaxART and those targeting communities at large through existing systems. This section first provides a description of the intervention. The results section provides the results of each of the interventions taking place in the communities. As explained in the methodology, most respondents were asked to rate the relevance, effectiveness and impact of the interventions on a scale of 1-5. Bar graphs depict the results for different groups of respondents for those interventions where appreciation differs.

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3.2.1 Enabling environment, legal issues and advocacy

MaxART was designed from the beginning as a programme that embraced the Greater Involvement of People Living with AIDS (GIPA) principle. Both the national and international network of PLHIV were involved in the design of the programme and continuously provided inputs as the programme developed further. These inputs translated into better-designed interventions in terms of human rights, ethics and using respectful and rights based language. This approach led to a stronger voice of PLHIV groups and increased awareness of GIPA principles in Swaziland.

Results

- The MaxART consortium conducted a study on Positive Health, Dignity and Prevention (PHDP) amongst 870 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.

- This 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 reviewing the National Stigma and Discrimination Reduction Action Plan; reviewing of communication tools, guidelines, training on human rights, curriculum for treatment support, important inputs in the curriculum for nurse-led ART initiation (NARTIS) and 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.

- Other 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 studies also provided important inputs for advocacy. Several national policy
dialogues were organised based on the learning, for example on Food by Prescription for PLHIV (2012), Indaba with 31 traditional leaders to discuss MaxART progress and lessons (2014) and a Policy dialogue on Men’s Health (2014). There was also a policy dialogue on adolescents living with HIV and ART.

- A key and integral way of work of MaxART is learning from experience and critically assessing and revising interventions during face-to-face meetings held twice per year with all the consortium partners. The PLHIV network was seen by all respondents as 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.

- MaxART, based on their experiences in working with young people, identified the need for a stronger enabling environment for dealing with sexual reproductive health and rights of adolescents in Swaziland. A national conference was organised bringing all different partners working with young people together. As a result the Technical Working Group (TWG) on adolescents led by the MoH was set up to enhance coordination and policy development. MaxART participated in this TWG. It laid the ground for better coordination between the MoH and the Ministry of Education and Training to strengthen the life skills programme in schools.

- During implementation it became clear that stronger coordination was also needed around male engagement activities. Implementers said that the absence of a focal point for male engagement in the MoH hampered the development of a more concerted effort towards reaching men for a stronger Health and HIV response. MaxART placed this on the agenda of the Ministry of Health to be addressed. During phase 1 the coordination mechanism or focal point was not yet in place.

- 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. The network of PLHIV contributed to these shows. The shows were popular and several respondents in the community highlighted that these shows mobilised them to seek care in the clinics.

### 3.2.2 Engaging Traditional and Community leaders for the HIV response

**Description**

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.

The leaders were trained for 2 days using dialogue, questions and answer and information sharing techniques. Special attention was given to the ways in which the leaders could engage themselves in leading the communities. Thus the leaders developed action points and follow-up sessions (2-3 times) were organised. The Civil Society Organisations working in the targeted communities were given small grants and materials to organise meetings or other activities in collaboration with the Traditional Leaders.

This intervention paved the way for community entry for the demand creating community dialogues (DCCDs) and door-to-door visits. To a certain extent it also helped community entry for the Male Focused Health Days (MFHDs) and Fast Track intervention.

**Results**

- 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, yet the exact figures are not known. Traditional Leaders have been participating in the annual Indabas and several communities report about the HIV response through the traditional leaders.

- Most respondents at all levels indicated that the intervention worked very well, was highly relevant and had a high impact on the health seeking behaviours of men, women and their children. Most respondents saw great benefits in working through the existing leadership and mentioned all other programmes should use this entry point as well. It is hard to quantify the impact as...
the results were mostly indirect, but all key informants, community members and implementers agreed that this intervention had a very high impact on all the other community programmes.

Traditional leaders themselves said the impact was high as they could mobilise their community members and especially men. Some leaders monitored follow-up of defaulters and kept a referral book and referral slips in their office. Others asked RHMs and CBVs to report to them on a monthly basis. Some were addressing food insecurity in their communities and provided communal land for a garden for OVCs and PLHIV. Most of these gardens however are no longer operational. Others organised supplemental feeding food through NERCHA and the World Food Programme. In several communities traditional leaders led the way for HIV testing, thus stimulating other community members to do the same. They paved the way for a variety of different community interventions and asked for a policy dialogue on nutrition for PLHIV.

The traditional leaders said most people are now disclosing and stigma and discrimination has almost disappeared. They estimate that about 80% of the community members now know their HIV status. The remaining 20% still believe more in traditional healers. However some of the traditional healers now start to demand an HIV test before they help their clients and one healer acknowledged: “our hands were full of blood, because too many people died because of us not advising people to get tested for HIV”.

“I became part of MaxART after being approached by SAF AIDS. At first everyone was very scared of HIV. It was seen as an animal that could not be attacked, but now we see that it is a disease that can be treated. All leaders must talk about HIV in their meetings. After I started to work with SAF AIDS I was no longer scared to lead my community. People initially shied away from the DCCDs, but I encouraged them to come and then many people came. I led the testing. Now I feel that I am in charge of the PLHIV in my community. It is very important to openly discuss in the communities so that you can help each other”

– Respondent Traditional Leader

“In some communities it was hard in the beginning (“who are you to come to me?”). There was a lot of mistrust about NGOs. It took time before they believed us, but in the end all were reached and became active in reaching MaxART objectives.”

– Respondent implementer

3.2.3 Demand Creating Community Dialogues (DCCDs)

Description

Community dialogues have been used as a methodology to strengthen community responses to HIV elsewhere. 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 SAfAIDS worked with 16 local implementing partners/organisations that were already working with RHMs and Community Based Volunteers (CBVs) in the targeted communities.

In each community a committee consisting of the local nurse, local teacher, one young person, a traditional leader and CBV or RHM was formed. The RHM or CBV would lead the committee. The committee invited people to a half-day gathering, usually on a Saturday. The participants were split into like-minded groups (women, men, youth and traditional leaders) and facilitators from the local implementing partners would lead the discussion in each group. The groups would discuss questions like: why do men not come to the clinic?, What are the constraints for women and youth?, How does culture and beliefs influence the uptake of HIV testing and services? What are the mitigation measures for the identified issues? Each group would summarise their issues and appoint a reporter. Then all the groups would come together and discuss their issues, find solutions and develop action plans. The traditional leader would close the meeting. The issues and action plans were followed up in the meetings of the inner council. The dialogues would take place 2-3 times per community on average.

Initially HIV testing was not available during the DCCDs and people were referred to the health facility. Community members however, were keen on getting tested on the spot for HIV and therefore MaxART organised other partners (ie. PSI, AHF, NATICC) and nurses from the nearby clinics to join the DCCDs for on site testing. Other services offered on site included Point of Care CD4 testing and TB screening. DCCDs were also held with different social groupings such as churches, during soccer games, and some were targeting community leaders as a separate group.

Results

During phase 1, 269 DCCDs were held 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 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. Respondents in the community said that towards the last year of the project many more people knew their HIV status or were already on ARVs. There were few people left that did not want to know their HIV status in the communities. Implementers said 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.

Respondents scored this intervention as highest across all three areas of relevance, effectiveness and impact. Respondents at all levels felt that this intervention was very well embedded into the existing structures and had the highest potential for sustainability because of its linkages to the Inner Council. Chiefs were chairing the meetings and they were held on Saturdays, the day that male community members meet their chiefs. Most respondents indicated the DCCDs were a good way to increase demand for services. Slightly more men than women were reached during the DCCDs, which was one of the targeted population groups of the MaxART programme. Youth were more difficult to reach through the DCCDs, as young people often feel intimidated by their leaders and leaders themselves highlighted they did not know well how to talk to adolescents. In communities where the leadership was motivated the turnout at events and dialogues was higher. Most respondents at community level wanted these dialogues to continue. Communities that were not targeted were asking if the MaxART team could also come to them.

Implementers observed that people really liked to discuss health issues. There was high interest to attend the community dialogues. Real issues were discussed ie women brought up the questions as to why their men would not allow them to attend health services. Men would react and discussions ensued about removing barriers. Men agreed to allow their women to seek health care in the facilities. Most community members in the FGDs said they were no longer afraid to get tested for HIV. They also indicated that it was now easier to disclose to family members and children and the stigma had been reduced tremendously.

“We like to be educated on health and HIV issues and the community dialogues really helped us opening up. We also appreciate the work of RHMs visiting people in their homes. We can see that condom use has increased and we talk more openly about HIV within our families. There are much less people that are dying now”.

– FGD community leaders

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**Results of DCCDs by gender**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended DCCD</td>
<td>15,539</td>
<td>7,027</td>
<td>22,566</td>
</tr>
<tr>
<td>Tested for HIV</td>
<td>12,844</td>
<td>6,663</td>
<td>19,507</td>
</tr>
</tbody>
</table>

**Demand Creation Community Dialogues**

n=25

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34 16 local civil society partners of SAfAIDS being: Ministry of Health (MoH), Ministry of Tinkhundla Administration and Development (MTAD), AMICAALL, ACAT, Cabrini Ministries, Church Forum on HIV and AIDS, FLAS, Khulisa Umrntlwana, Positive Women Together, SWANNEPHA; SWABCHA; Shiselweni Reformed Church; SWAPOL, TASC and WLSA.
3.2.4 Door-to-door visits

Description
Door-to-door visits have been implemented for several years using existing cadres such as RHMs and CBVs. 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.

Results
- 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 3 years (cumulative in the box). It is remarkable that about half of the referrals for SRH resulted in access as compared to about a quarter for HIV testing and ART uptake. It is not clearly understood why this is so.
- A total of 5,761 RHMs/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.
- All respondents at all levels agreed that this intervention worked well and that it was an effective way of targeting people, especially women. It was highly appreciated by community members, PLHIV, men involved in MFHDs and leaders. Impact was said to be very high especially combined with the DCCDs. The activity was embedded well in existing structures and many respondents felt it was cost effective. Many of the volunteers are RHMs and through the lead RHM the region receives reports of the activities of the RHMs.
- Most FGD respondents said that stigma has reduced significantly within the communities and people are no longer afraid to be seen in the HIV clinic. Disclosure of one’s HIV status has become more normalised as people now know they remain healthy when they are on ART.
- RHM in the FGD mentioned, however that there are limitations of what can be achieved when working with volunteers and household visits are labour intensive. RHMs originally were supposed to work 4 days a month and the stipend they receive was based on this. Over the years new tasks were added and some RHMs now work on full time basis in the communities. The NERCHA Executive Director indicated that there have been some challenges in the past year as there is no good recording system for distinguishing active versus non-active RHMs, which resulted in suspension of payment of stipends to RHMs. Despite this the RHMs in the FGD continue their work and were highly motivated.

Trend in people reached, referred and reaching service delivery through the door-to-door visits

“...”

— FGD with RHM

“...”

— FGD with RHM
3.2.5 Fast Track for increasing HIV testing

Description

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. It is an approach first employed in the United States’ private sector and later adapted by NGOs. Fast Track has been used in a number of settings outside of Swaziland including Ethiopia, Malawi, and Tanzania. 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 and the MOH worked towards a mutually defined challenge: scaling up HTC among men and adolescents.

The MaxART Consortium 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. During the planning and scoping phase of each Inkhundla intervention, the Fast Track team collected three-month baseline data for the target population: men and adolescents. Then assembled a consortium of leadership from each Inkhundla—traditional leaders, healthcare workers, NGOs, and regional team members such as health matrons and political district representatives—to identify Inkhundla-specific challenges to HIV testing uptake in the target groups. They selected community volunteers (50-60 for each Inkhundla) to rollout the program in line with the Inkhundla’s needs. This group representing men and youth from different communities under one constituency were trained during 2 days on HIV and community mobilisation. The identification of specific and potential challenges in the community by local leadership allowed the teams to formulate appropriate action plans. These locally developed plans often included door-to-door visits, organising HIV testing at cattle dip-tanks - a gathering place for men, sport events to target the youth etc. It also secured buy-in of the initiative and involvement from all stakeholders. To ensure that activities were coordinated with the Fast Track method, out of a total of 55 in the country (about two thirds of the country). Most were rural and some were in semi-urban areas. In total about 5,000 volunteers were trained to implement the programme.

The fast track team provided initially two-weekly support to the community teams, provided IEC materials and books to register HIV tests and referrals. When activities were being rolled out effectively the teams would be available on demand. These locally developed plans often included door-to-door visits, organising HIV testing at cattle dip-tanks - a gathering place for men, sport events to target the youth etc. It also secured buy-in of the initiative and involvement from all stakeholders. To ensure that activities were coordinated with the Fast Track method, out of a total of 55 in the country (about two thirds of the country). Most were rural and some were in semi-urban areas. In total about 5,000 volunteers were trained to implement the programme.

Results

- A total of 35 constituencies (Tinkhundla) were covered with the Fast Track method, out of a total of 55 in the country (about two thirds of the country). Most were rural and some were in semi-urban areas. In total about 5,000 volunteers were trained to implement the programme.

- Results rolled out effectively the teams would be available on demand. This intervention was well documented and the M&E results show that about 79% of people reached did a HIV test, which is very high. 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). The M&E reports however did not relate the results to the actual size of the target groups in the 35 constituencies. Of those tested HIV positive, an average of 57% were linked to care37. 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.

<table>
<thead>
<tr>
<th>Total people tested over 3 months at baseline and during Fast Track across 35 completed Fast Tracks</th>
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<tbody>
<tr>
<td><strong>Men (20+ yrs)</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>140</td>
</tr>
<tr>
<td>81</td>
</tr>
<tr>
<td>340</td>
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</table>

- **People tested at baseline and during Fast Track average per Fast Track**

35 RHMs are volunteers that receive a monthly stipend from the MoH (350 Rand). The RHM programme has been operational since 1976.
36 16 partners of SAfAIDS being: Ministry of Health (MoH); Ministry of Tinkhundla Administration and Development (MTAD); AMICAAAL; ACAT; Cabrini Ministries, Church Forum on HIV and AIDS; FLAS; Khulisa Umntfwana; Positive Women Together; SWANNEPHA; SWABCHA; Shiselweni Reformed Church; SWAPOL; TASC and WLSA.
Strengthening Community Systems for HIV Treatment Scale-up

3.2.6 Male Focused Health Days

Description
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.

Identification of the 15 clinics was done with the Regional Health Management Team (RHMTs) and Regional AIDS Coordinators (REMSHAC). Criteria used included: clinics where Nurse-led ART initiation in Swaziland (NARTIS) was implemented, where Ministry of Health (MoH) statistics showed that few men were attending the services, availability of male health staff in the clinic, proximity of men, infrastructure development needs and other opportunities to build on male activities, i.e., voluntary male circumcision.

The MFHDs teams first held meetings with the regional health managers and then with the selected facilities. The MaxART team would assist in the facilitation during most of the meetings or otherwise organise for resource persons to discuss specific topics with the men. Men became more and more engaged and also participated in the selection of topics for the monthly meetings. A monitoring system was set up and a plan was developed for phasing out the support of MaxART.

Results
This intervention was implemented in 15 clinics in Swaziland and the M&E results are shown in the table below. The reports show that over the 3-year period, 500 HIV tests were done during 180 events, which included 6,057 participants. However, the men in both FGDs said that all of them were tested, most of them not during the events, hence the reach is expected to be higher. Out of the 15 clinics, 6 were more successful than the others according to implementers 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 mentioned that the linkages between the

- Fast Track was very successful in increasing the uptake of HIV testing. Setting of clear targets helped to motivate volunteers to achieve these. Implementers said that the best place to test men for HIV was at the cattle dip-tanks. Youth were best reached through schools, sports events and through churches. All teams did door-to-door visits. Initially only to mobilise for testing, but later the strategy was revised to HIV testing on site, which increased testing rates. The teams were ensuring that HIV testing was confidential and provided people with a choice to test or not and decide on where to test. Policy level respondents rated relevance as high, but this was lower for implementers, regional level and the lowest for the youth who implemented it.

- Implementation went well in most communities after some start-up problems. Fast Track was visible and implementers said that knowledge levels increased a lot. In semi-urban areas Fast Track was more difficult to implement as especially youth were more mobile and in search for paid jobs. MaxART consortium partners discussed the internal evaluation of this intervention in terms of value-for-money in their face-to-face meeting. It was generally agreed that the intervention was costly and labour intensive, yet successful in reaching its targets. It was hard to transition the method to other partners due to its cost.

- Most key informants indicated that the sustainability of this intervention was low for the investments made. Community leaders, during a FGD, indicated that they preferred interventions with a longer implementation period and are more sustainable and felt this was a donor-driven intervention. Out of the 10 participants in the FGD with adolescents who implemented fast track about 8 month earlier, only one was still mobilising peers for testing. They initially were proud to be part of the group but were mostly disappointed that they did not get paid for their efforts.
Results and key findings of community systems strengthening approach of the MaxART project

Clinic and the communities are now better and the clinic committee takes issues to the chiefs in regular meetings in the community.

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<tbody>
<tr>
<td>New MFHD sites launched</td>
<td>7</td>
<td>8</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>MFHD events held</td>
<td>16</td>
<td>89</td>
<td>75</td>
<td>180</td>
</tr>
<tr>
<td>Participants (including repeat visitors)</td>
<td>583</td>
<td>2,284</td>
<td>3,190</td>
<td>6,057</td>
</tr>
<tr>
<td>Average number of participants per event</td>
<td>36</td>
<td>27</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>Number of HIV tests conducted during events</td>
<td>22</td>
<td>116</td>
<td>362</td>
<td>500</td>
</tr>
<tr>
<td>Active MFHD sites (including after end of programme)</td>
<td>7</td>
<td>15</td>
<td>4</td>
<td>4</td>
</tr>
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</table>

The opinions of different respondents varied significantly, with the implementers giving it the lowest scores on relevance, effectiveness and impact. Policy makers however saw more value in this intervention and the men participating in the groups were highly appreciative.

The men said they joined the MFHDs because they wanted to improve their participation in health issues and saw the need to do so. Most men were invited through the chiefs. They started with a small group, which gradually became larger. They were hesitant at the beginning, but later became strongly involved and were keen to learn more on new topics. Most men said they got tested after the third or fourth visit, when they had overcome their fears. The eating of the cow head was a great encouragement and initially this motivated them to come, but later they started to appreciate the discussions around health and behaviour. All appreciated HIV testing on the spot, and enrolling in the ART treatment programme at the clinic. Most clinics would organise additional nursing staff for counselling and ART treatment during the MFHDs. Most clinics also offered screening and treatment for other diseases like hypertension and diabetes.

Men attending MFHDs encouraged other men to get tested for HIV. The 10 men in one FGD each mobilised other men (in total 36). Most men preferred couple testing and counselling and many encouraged their wives and children to get tested. One man openly acknowledged that he brought HIV in his family and apologised to his wife for this. There are still some men who are scared to take an HIV test and after the MFHD they take leftovers of the cow-head to these men and ask them to come next time. For some men it is still not easy to talk about these issues, but all are trying. One MFHD group remained active and now buys its own cow-head. The other MFHD group became inactive due to the ploughing season, but would like to start again.

Men initially did not feel welcome in the health facilities, which they saw as a place for women. Opening hours of the clinic do not cater for the needs of schooling youth and people with a job. Men (and youth) that were part of the adolescent support programme and the MFHD commented that the attitude of the health workers had changed and they no longer felt excluded from health services.

An internal assessment was done to review value for money of this intervention after 2 years of implementation. This showed that in terms of reaching MaxART objectives there was little direct impact on increasing HIV testing numbers. The cost analysis showed that for each man attending one event the cost was 20$. It was then decided to phase-out support for this activity and not to launch new MFHD sites in the third year of the first phase.

“The head of the household should be in charge of health issues in the family, but we were really lost as men and we also had to get used to more gender balance in our homes. Now women also have a say, but men still make the decisions”.

— Respondent in FGD of men participating in MFHDs
“There is no stigma and no fear for HIV anymore; we openly discuss within our families and also with our kids! We have broken the taboo for the benefit of family health. Nobody wants their child to become infected by HIV, so I also speak about condoms and rape and tell the children to come to me if they are in trouble. Come to me, I will tell you about life, mom and dad care about you the most.”
– Respondent in FGD of men participating in MFHDs

“It was very difficult to talk about HIV in our families. It is because the way that we first learned about HIV and how it was introduced to us. It was associated with adultery and it was brought as an insult to men.”
– Respondent in FGD of men participating in MFHDs

“My dad participated in the MFHDs. This brought a lot of change in the family. His attitude changed and he is now talking “humble”. All people in the family got tested for HIV; he has completely changed. He now tells them how to stay healthy and he also does exercises himself. He also visits the clinic easily.”
– Two boys in FGD with youth who’s father is member of the MFHD

3.2.7 Adolescent Support and HTC Initiative

Description
In the MaxART proposal, the youth intervention was planned as an advocacy intervention to lower the age of consent for HIV testing for young people. At the start of the programme the age of consent was already reduced to 16 years (and later to 12 years – under specific conditions). The approach was then changed to an intervention equipping communities to better understand adolescent needs and provide adequate support to them through the organisation of Teen Clubs. The intervention was piloted in 4 communities.

The intervention consisted of training a support group for adolescents38 of mainly church leaders, other community leaders, teachers, and health workers. Each group consisted of about 22-25 members per community reached and the training took 3 days39. The group then selected a steering committee that would reach out to adolescents and organise events together with the adolescents. They formed Teen Clubs (adolescent peer support groups) and would meet monthly. The Teen Clubs were encouraged to organise events to reach young people with messages around SRHR and HIV. The support structure made action plans and introduced these plans to the chiefdom.

The intervention evolved over time. Leading events turned out to be hard for adolescents and the programme defaulted to adults leading this part, which was ineffective for different reasons. The concept of a support group of adults discussing with the adolescents had challenges. The approach was then adjusted to a Peer Education intervention as of November 2013. MaxART teamed up with the “Super buddies” project, which was doing a similar intervention in schools. The teenagers were now leading the clubs themselves, which gave them the opportunity to define their own needs and approaches. “Super Buddies” trained six of the eight then still active groups. In each of the 6 sites about 20 PEs were trained, during 5 days. Topics included amongst others peer education methods, SRHR, stages in adolescence, pregnancy, basic HIV facts, gender based violence, alcohol and drugs abuse, counselling and stigma and discrimination40. The groups were encouraged to develop action plans and keep track of activities.

Results

The following table provides the M&E results of the intervention. It is not sure how many adolescents were reached during the different events, as it was difficult to distinguish between new and repeat visits. A total of 982 young people were tested for HIV in three years. In total 100 teen club events were organised, which is an average of almost 7 events per club in mostly the last 2 years. There are no data on the numbers of youth that were reached outside the events through the Peer Education programme.

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<tbody>
<tr>
<td>Teen clubs launched</td>
<td>2</td>
<td>13</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Teen club events</td>
<td>2</td>
<td>46</td>
<td>52</td>
<td>100</td>
</tr>
<tr>
<td>Participants (including repeats)</td>
<td>177</td>
<td>3390</td>
<td>4356</td>
<td>7923</td>
</tr>
<tr>
<td>HIV tests done</td>
<td>24</td>
<td>116</td>
<td>842</td>
<td>982</td>
</tr>
<tr>
<td>Peer educators trained</td>
<td></td>
<td></td>
<td>115</td>
<td>115</td>
</tr>
<tr>
<td>Active Communities</td>
<td>2</td>
<td>15</td>
<td>5</td>
<td>5</td>
</tr>
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</table>
Implementers and researchers highlighted the barriers to open communication between young people, parents and community leadership that are part of the cultural fabric of Swaziland society. This led to lack of permission of adolescents to participate in discussions especially at the beginning of the intervention.

An internal MaxART review in year 2 of the programme highlighted low uptake of HIV testing among the target group. The expansion to more than 15 teen clubs was paused to investigate which other activities could yield better results. Since August 2013 the concept of peer education was introduced in five of the best performing teen clubs. More youth were tested for HIV in year 3 as compared to year 1 and 2, indicating that the Peer Education concept worked better.

A total of 115 adolescents were trained as peer educators in 5 communities and about 330 committee members supporting the adolescent programme were trained during three days.

The youth in FGD really appreciated the Peer Education training and they learned a lot about HIV, gender based violence, and other health issues but the information was not sufficient. They all would like more training on additional topics and also learn more about counselling. "Sometimes we get stuck in a dialogue", "We really need more skills". They said sport events are most successful in increasing the uptake of HIV testing for adolescents, followed by road shows and other entertainment like events.

Both implementers and policy makers indicate that it is difficult to reach out-of-school-youth, as they are more mobile and in search of opportunities to sustain their livelihood. Involvement of Neighbourhood Care Points and Kagogo Centres did not help much. One youngster in a FGD highlighted the issue of mobility: they started with 20 Peer Educators, now there are 10 (the others went to college), but there is no new training for new members. The programme stopped suddenly and they were not prepared for this. Most of the Peer Educators trained were in their twenties as it was difficult to find teenagers that could have the skills to lead their peers.

Adolescents were targeted between the ages of 10 – 19 years old.
Topics: creating a better understanding about adolescence and related risk taking behaviours, basics of HIV, adolescents and sexuality, communication and counselling methods for adolescents, healthy living for adolescents, and putting adolescent support into practice

Implementers explained that the programme evolved over time and adopted its strategies to the realities on the ground. Initially the support structure and MaxART, under leadership of the MoH agreed on the topics that were selected for discussion in the Teen Clubs. This approach did not really empower the youth. Over the course of the programme the focus shifted to youth led initiatives at community level. Experiences with implementation of MaxART partners led to a stronger focus on supporting the policy level and coordinating the multiple stakeholders leading to a more conducive environment for youth programming in Swaziland (e.g. TWG on adolescents).

The MaxART social science research on adolescents highlighted that the Ministry of Education and Training prohibits HIV testing and provision of HIV services in school. This limits the uptake of HIV testing among adolescents, while adolescents prefer to be tested in school. It also showed that the age of consent for HIV testing remained a barrier for adolescents to access HIV testing. Health care workers were not comfortable to test adolescents both above and below the age of 16. The Child Protection and Welfare Act 2012 places age of consent at 12 years. Over the course of the project the new national HIV Testing Guidelines (HTC) guidelines now include the age of 12 for consent. The results from the MaxART social science research about barriers for accessing HIV services by adolescents played an important role in this policy change.

This research also showed that parents feel that they cannot talk well to their children yet children would like to learn about sexuality and HIV from their parents. Traditionally parents do not speak to their children about these issues. There were many issues affecting youth still to be addressed i.e., the opening hours of the clinics for ARV refills not well aligned with the schooling hours; teachers disclosing the HIV status of pupils in class; teachers having sex with pupils; condom availability in schools; parents and youth thinking that condoms promote having sex; children wearing a school uniform that are refused an HIV test etc.

“In my home there is change. Before I was empty and there was stigma and discrimination in my family due to lack of knowledge. My mother came with me to one of the events and that helped also. I am looking for the right moment to discuss about HIV”.  
– FGD with youth

“Rape cases are lower now. There is a lot of influence of alcohol and drugs on rape cases and after we had a session about this there seems to be an effect. We also visit the shebeens and talk to the youth there. We feel we brought change.”  
– FGD with youth

“I feel it is most important is to keep young people busy i.e with games and sports and there must be lost of events- otherwise they have nothing else to do but to seek sex in the bushes”.  
– FGD with youth

3.2.8 Networking, linkages, partnerships and coordination

An important element of community system strengthening is the way in which communities are organised and how different partners coordinate their work within the communities and amongst themselves. MaxART tried to build interventions on existing structures and networks, and within the government managed health system. MaxART did not design specific interventions to strengthen networking, partnerships and coordination in phase 1, but coordination with existing actors within the communities around specific interventions was achieved.

Results

Most of the community interventions identified existing partners active in the constituencies and strengthened working relationships. 16 Non-governmental organisations (NGOs) already working in the communities were contracted as collaborating partners for the door-to-door visits and the Demand Creation Community Dialogues. Two of these organisations were networks of PLHIV. MaxART partners worked with HIV testing partners in the communities to ensure HIV testing on the spot was implemented during community mobilisation activities and health or sports events.

Implementers indicated that in Swaziland, communities in general distrust NGOs. All implementers said that it took time to gain trust. Coordination of NGOs in the health sector lies in the hands of CANGO41. The MoH does not yet have a clear framework for organising community systems strengthening work, but clearly sees the value of CSS in the response to HIV and broader health issues. In the region the REMSHAC coordinates HIV related activities by partners. Many respondents indicated that coordination at community level is often problematic while many different NGOs and CSOs are active at that level with different ideologies. Sometimes operating in competition which each other, sometimes duplicating efforts, or sometimes using contradicting messages. MaxART attempted to ensure coordination as related to their projects and interventions within communities, but did not adopt specific activities to enhance coordination at this level. One Ministry of Health (MoH) respondent reinforced this point by stating that at the start of the MaxART programme in 2011 there was no guidance for community work in Swaziland. The MoH was not sure
which of the suggested interventions could yield the best results or how the community work could best be organised. There is now a technical working group under the Swaziland National AIDS Programme (SNAP) for community interventions, but still partners see the need to strengthen national coordination for a more coherent CSS approach.

One of the MaxART objectives was geared at strengthening the linkages between the health facilities and community members. Even though anecdotal evidence indicates that these linkages and also the referral mechanisms were strengthened, these were not well measured. All respondents mention that the queues in the health facilities became longer after events organised in the community. A referral tool was piloted, which resulted in the development of the national health referral card whereby health workers in facilities and community health workers exchange information about the client.

At the national level the MaxART consortium organised face-to-face meetings with all consortium partners twice per year. These meetings were used to share results and discuss successes and challenges. Most partners participating in these meetings placed great value on the open and often critical discussions that resulted in adjusting interventions to improve results. The voice of the network of PLHIV was especially valued and many implementers said that through the MaxART programme the government and civil society partners in Swaziland are now working closer together.

3.3 Trends in national statistics on the MaxART indicators

MaxART targets were set at national level and national health statistics were a key source of information to monitor progress. MaxART and its partners were not the only organisations implementing activities at community level. In fact there are many others focusing on similar issues. Within, but also beyond MaxART, several facility-based interventions took place to improve access to services as well. It is therefore not possible to attribute trends in national data to MaxART solely, or to community-based interventions. MaxART worked under the leadership of the MoH towards increasing access to HIV services.

The first objective of MaxART was to increase the annual number of people tested to 250,000 by mid 2014. This objective had been achieved by December 2013. The graphs below show that the uptake of testing rose steeply as of 2011 when the MaxART project started. Across the different testing interventions, both the provider initiated tests and the client-initiated tests increased. The latter includes the impact of the intensified efforts to mobilise communities and hard to reach focus groups like men and adolescents for testing. The number of tests done increased more sharply for adolescents and women than for men, but almost doubled in all groups as compared to 2009.

Trends in National HTC data between 2009 and 2013 by entry point for testing and for different target groups

Trends in HIV tests done for different target groups
The second objective of the MaxART project was to improve access to treatment (antiretroviral therapy – ART) so that 90% of those in need are on treatment (at eligibility criteria of CD4 less than/equal to 350). This objective was achieved with 91% of eligible PLHIV on treatment at the end of 2013. From 2011 onwards the gap between the number of people eligible for treatment and those on treatment is closing. Every year about 20,000 people are newly initiated in ART.

The third objective was to reduce loss-to-follow-up (LTFU) of clients on treatment from 22% to 10% by 2014. This objective was also achieved, with 9% LTFU for the 2013 cohort. This indicator is measured as retention in care at 12 months by the MoH. It showed a drop from 89% to 77% between 2011 and 2012 and increased again to 91% for 2013. The downward trend was hard to explain. One of the reasons could be that more men were now accessing ART, who are known to have poorer in adherence and retention to ART rates. The MoH also changed the way in which retention was calculated, which could be another reason.

Respondents in the FGDs with PLHIV and men indicated that the SMS reminders (as piloted by one of the MaxART partners) helped a lot and was appreciated by PLHIV after some initial hesitation. RHMs indicated that they were helping clients to stay on treatment. Some chiefs kept records of people on ART and followed regular reports from RHMS on community members on ART. Yet, the community side interventions for increasing adherence were less well thought through and the focus was mainly on clinic-based interventions using SMS reminders and a counselling tool. Initially MaxART had foreseen adherence clubs in the communities, but these never really took off.

### 3.4 Coverage of MaxART interventions

MaxART and its partners have been implementing different community interventions across Swaziland since mid 2011 at different geographical scale. The coverage of the different interventions at the end of 3 years is shown in the map below.

The MaxART partners covered a large part of the country during the three-year phase 1 of the programme intensifying community mobilisation and uptake of services. The training of the RHMs on MaxART was done in all 55 constituencies of the country and all RHMs were trained. Fast Track was implemented in 35 constituencies out of the 55 and for the DCCDs over 225 chiefdoms were covered with around 1,100 community members trained. The MFHD and Adolescent support programme were innovations to be pilot-tested and therefore had a much lower coverage on purpose. The size of the population in each of the constituencies varies from about 6,000 to over 30,000. The MaxART partners did not use population data to calculate exact coverage of the targeted populations in the constituencies. Respondents at the policy level estimated that the programme reached between 30-40% of the population.
Results and key findings of community systems strengthening approach of the MaxART project

Coverage MaxART community interventions phase 1 (2011-2014)

- DCCDs
- Traditional Leaders Training
- Door to Door Home Visits
- Teen Clubs
- MFHDs
- Fast Track Sites

45 This map was kindly prepared by Banele Dlamini from Safaids and Derrick Mduduzi Mahlambi of NERCHA.
4. Discussion and conclusions

Phase 1 of the MaxART programme laid the foundation for the “Early Access to ART for All” demonstration project in Swaziland, whereby all PLHIV in 14 facilities in the Hhohho region will be offered ART regardless of CD4 count. This project will put in practice the evidence that early ART is not only beneficial for individual health benefits, but also contributes to the prevention of HIV transmission on a population basis. A prerequisite for this approach is that people know their HIV status and are willing to accept and stay on ARV treatment when HIV positive, the focus of phase 1.

The figure below provides a summary of the problems that were addressed by MaxART, an overview of the interventions, outcomes and impact. Massive scale-up of HIV testing, uptake of ARV and retention in care was achieved in the 3 years period and national statistics were used to show these effects. All three objectives were achieved. Community mobilising efforts resulted in many more people visiting the health facilities for a variety of services. The results from the interviews and especially the FGDs have shown that there was a massive stigma reduction and much more openness about HIV in the communities. Many people are no longer afraid of HIV nor to be seen in the HIV clinic, now that they have seen the success of ARV treatment. The Siswati name for ART is “rise again” and this is exactly how people expressed the effect of using ARVs.

**Successful programmes usually are designed as a collaborative effort between stakeholders;** based on careful analysis of challenges and successes; respond to these existing needs and challenges; are owned by the people they are designed for, and have a strong learning component with good M&E systems to measure the results. The Postcode Lottery’s Dream Fund allowed MaxART partners to adopt such a bold approach that resulted in a programme that was well thought through, based on a careful gap analysis that was jointly developed with the partners and had the MoH strongly in the driver seat. The programme was addressing key needs and challenges of the Government of the Kingdom of Swaziland with a focus on scaling up HTC, treatment uptake and retention. Two hard to reach groups (men and adolescents) were selected as specific focus groups for the interventions. The partnership was constructed in such a way that the government, civil society, PLHIV networks, researchers and the implementers were bringing different and complementary perspectives to the table. All these design factors of the programme have most likely contributed to its success.

The adoption of a learning-by-doing approach resulted in an open environment where constructive analysis and criticism was leading to changes in the way the different interventions were implemented and course corrections were done for example for the adolescent support programme. The concept whereby social science research was informing the interventions also helped partners to adjust their
interventions based on evidence that became available. The face-to-face meetings — held twice per year— formed the platform in which these discussions took place.

The involvement of the national PLHIV network SWANNEPHA, supported by the Global Network of PLHIV, was an important and crucial factor in the success of the programme and their involvement resulted in the development of several human rights instruments and influenced the way in which interventions were respectful and responding to the actual needs of PLHIV.

MaxART specifically adopted an approach working on the entire continuum of care for PLHIV, which interventions were expected to reinforce each other. However, the focus of this report is on the community systems strengthening efforts of the programme and therefore it is difficult to make inferences how well the health systems strengthening and community systems strengthening approaches reinforced each other. The linkages between community members and the facilities have been strengthened. As a result of the CSS interventions the demand for services in the clinics increased dramatically especially after major events in the community. The health facilities however, were not always prepared well enough to cater for this increased demand resulting in long queues, sometimes stock-out of test kits and heavy workloads for the health workers. Some level of planning with the facilities could have prepared them better. A recent paper 47 tried to unpack the concept of linkages within the context of the continuum of care further. The authors explain that linkages can be conceptualised as either “actor-oriented” or “systems-oriented”. They argue that for linkages to be effective the institutional frameworks within which linkages are formalised, as well as the ground-level interactions of those engaged in care, need to be considered.

Elements of the Community Systems Strengthening concept as explained in chapter 4 were used in the planning phase of MaxART. Over the course of implementation the thinking of the consortium partners about CSS evolved further and the Government of the Kingdom of Swaziland sees the importance of CSS for further strengthening the HIV response.

Internationally there has been increasing attention for a CSS approach also stimulated by the GFATM, who now allows countries to apply for specific CSS interventions in the concept notes. The tools developed for this provide a good framework for intervention development. The framework is shown in the figure below.

46 Phintuvuke= “rise again” and used as a name for ARVs
47 S Lees, K Kielmann, F Cataldo, D Gitau-Mburu. Understanding the linkages between informal and formal care for people living with HIV in sub-Saharan Africa. Global Public Health 7 (10), 1109-1119
The six elements did not all receive similar amount of specific attention. The MaxART community interventions were geared at community mobilisation and improving the interface with the health facilities. More specifically interventions focused on creating an enabling environment and advocacy for human rights and legal frameworks; capacity development of both rural health motivators and community volunteers, the traditional leadership and community members of the different target groups; community activities and service delivery. There was limited attention for strengthening organisations and leadership. To a certain extent community networks, linkages, partnerships and coordination were strengthened but this can be characterised more as using existing partners and structures within communities rather than specifically strengthening networks and partnerships. Monitoring and evaluation systems at community level were not strengthened. When reviewing the definition of CSS as “an approach that promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures”, the MaxART programme has focused on massive scaling up of interventions and service delivery, thereby using elements of the CSS framework, but did not intend to develop these more sustainable structures as per definition. Five out of the six CSS framework elements were implemented to a certain extent, but not all within the same geographical areas nor with the intention to institutionalise these efforts. The question remains if even better results would be achieved if all the elements of the framework were implemented at the same time within the same geographical areas?

What however is clear, is that the different MaxART community interventions together contributed to about 120,500 people getting tested for HIV cumulatively over the three years (as calculated from MaxART M&E). At the end of year 3, annually just over 250,000 were tested by HIV as reported by the government. Many of those testing positive went to the clinics for enrolment in the ART programme. There are no programme specific data about the numbers of people that were put on treatment through the MaxART interventions, but national data show that at the end of the first phase of MaxART 91% of all eligible PLHIV were on ART. These are remarkable achievements. The combination of several community strengthening interventions reinforced each other and those interventions that were building on existing structures were appreciated most by different respondents. The third objective of the programme, retaining PLHIV on treatment and care, was also achieved with 91% at 12 month in the 2013 cohort.

The MaxART community interventions employed different methods and approaches. The training and engagement of the traditional leaders was seen by most as crucial for any community work. In Swaziland community entry is organised through the traditional leaders in the Inner Council. Many leaders that were trained became engaged in the HIV response.

The results have shown that the Fast Track method is a good method for fixing a specific access related problem in a short time frame. It showed good results in increasing uptake of HIV testing. However community leaders and people in the different FGDs indicated their preference for methods that have a longer time span and are more sustainable. They felt this intervention was more donor-driven than the others.

The Demand Creating Community Dialogues were highly appreciated by all respondents. These discussions helped communities to overcome barriers to accessing services and also addressed human rights, stigma and gender issues. The participants and their leaders owned the solutions. Dialoguing is part of the fabric of the Swaziland society and fits well in the tradition also within the family structure. When introducing HIV testing on the spot the numbers of people tested increased sharply.

The door-to-door visits were good in reaching women (74% of all reached), but still 26% of the people reached were men. This intervention relied on referring people to health facilities for testing and other services; therefore it was more difficult to measure whom had actually accessed the services. The data shown in this report are most likely underreported. Existing Rural Health Motivators and CBVs, who are highly respected in their communities and selected through the traditional leadership, implemented this intervention.

The adolescent support programme evolved from a Teen Club initiative to a Peer Educator intervention over time, which resulted in higher number of young people taking a HIV test. The Male Focused Health Days intervention has shown that men actually can be mobilised for health and HIV related issues, be it through more intensive interaction. Men participating in the FGDs indicated impressive behaviour change with regards to HIV testing, stimulating their family members to get tested and allowing them to seek health care, opening up within their families etc. Even though the results of this intervention were more qualitative in nature, the potential impact is very high as men are the key decision makers about access to health for their family members in Swaziland. They were happy that now they could guide their families to better health. The NERCHA Director remarked that the time has come to focus more on the quality and intensity of the interventions and move away from a quantitative approach alone. This intervention with men could very well bring important change that is needed in Swaziland.

The MaxART partners discontinued these two smaller scale innovations after an analysis of value for money. They were labour intensive and yielding too little results on the MaxART outcome indicators.
MaxART research has shown that parents feel that they cannot talk well to their children yet children would like to learn about sexuality and HIV from their parents. This dilemma was not fully addressed by the programme. Traditionally parents do not speak to their children about these issues but the few men in the MFHDs mentioned that were now more at ease to speak to their children. There were many issue affecting youth still to be addressed i.e., the opening hours of the clinics for ARV refills not well aligned with the schooling hours; teachers disclosing the HIV status of pupils in class; teachers having sex with pupils; condom availability in schools; parents and youth thinking that condoms promote having sex; children wearing a school uniform that are refused an HIV test etc. There is still a long way to go in developing strategies that can address the needs of adolescents and get them fully engaged in the response to HIV, but a start has been made through the TWG where MoH and MoE are now planning jointly i.e. for a life skills programme in schools.

Capacity development formed the backbone of the community systems strengthening approach. MaxART partners trained most RHMs (5,761) in the country and about 150 CBVs. Also, 110 traditional and community leaders were trained. For the DCCDs committee members were trained as facilitators for the dialogues. Over 225 chiefdoms were covered with around 1,100 community members trained. For the fast track about 5,000 community members from the target groups – men and adolescents- were trained as volunteers in 35 constituencies with a two-day training and ongoing mentoring during throughout the three-month of implementation. Also 115 adolescents were trained as peer educators in 15 communities and about 330 committee members supporting the adolescent programme were trained during three days. Despite these training efforts there was little evidence of capacity strengthening resulting in better organised community networks, CBOs and partnerships enabling communities to organise their own response. Even though RHMs are institutionalised cadres in Swaziland, there is still scope for strengthening coordination and facilitation of their work.

It was hard to quantify the coverage of the MaxART interventions in Swaziland as the partners did not populate the data of people reached against the population living in the different constituencies. Swaziland has a relative small population with 1.1 million inhabitants. It would not be impossible to reach almost all of them using a community systems strengthening approach. Respondents at the policy level estimated that the community interventions reached about 40% of the population in Swaziland. Further analysis could provide a more accurate figure of the percentage of the population reached and could set the pace for even further scaling up of efforts.

A recent literature review about community-based programmes has shown that a comprehensive continuum of care across health facilities and community-based programmes may be the most sustainable way to improve treatment outcomes and quality of life of PLHIV. The majority of studies under review found that community-based services were the most cost effective option in resource-limited settings. The authors argue that governments and donors should invest in a sustainable community health infrastructure that complements the traditional health sector.

The MaxART programme provides a good example of how investing in a community approach can yield results in terms of scaling up HIV testing, uptake of ARV treatment and retaining people in care. The second phase of MaxART recognises the importance of the community systems strengthening approach. Of special importance for the “Early Access to ART for All” demonstration project is continued attention to increasing demand (DCCDs) and a strong communication mechanism related to all aspects of the study. Hereto a Community Advisory Board at the national level will be set up to link the community with the research team. This Board will monitor the research closely. SWANNEPHA will coordinate the Board.

There is now a strong realisation among policy makers and development partners in Swaziland that an effective HIV response needs strong community systems strengthening approach and steps are taken to build CSS in the concept note for the GFATM. The extended National multi-sectoral HIV and AIDS Framework 2014-2018 (eNSF) foresees an important role for communities and civil society organisations including PLHIV in the design of community interventions and in the implementation of the eNSF. One of its strategies is geared at strengthening community systems.

Discussion and conclusions
5. Recommendations

The recommendations in this chapter are based on experiences of the MaxART programme and some are geared towards the programme itself, while others attempt to be more generic in the broader discussion on community systems strengthening in the context of HIV.

Overall, this case study shows the key role of communities and community system interventions for effectively scaling up access to HIV prevention, treatment and care programmes, and the need for strong community systems for successfully implementing early treatment and reaching ambitious global targets to end the AIDS epidemic. Sufficient funding for community systems interventions as part of integral HIV programming is crucial.

5.1 General recommendations for CSS based on the experiences of MaxART

MaxART provides a good example of inclusive planning based on a thorough problem analysis. The planners realised the importance of developing a human rights based approach and especially recognised the important role of networks of PLHIV. The programme was addressing nationally identified needs.

There are some important lessons learned from the programme that can guide other organisations in planning community interventions. These are based on experiences that worked well but also on certain areas that did receive less attention in the programme:

- It is important to plan any CSS programme on the basis of good understanding of how community systems work, who the key actors and decision-makers are, what the key challenges are and ensure communities are involved in the design of the programme and specific interventions.

- When planning for CSS it helps to unpack the concept within the local context and systematically address the key challenges when operationalising the concept. Ideally, all six elements of the CSS framework need to be addressed. Many organisations focus solely on improving service delivery and capacity development to achieve this, while a more comprehensive approach will enhance institutionalisation of efforts and thus sustainability in the long run.

Example of how to address CSS elements during the planning of community interventions

- Creating an enabling environment means working closely with PLHIV networks. This ensures that the design of the programme addresses the needs of PLHIV and makes interventions rights based and ethically sound. It also means that the necessary policies and guidelines must be developed that define CSS and should include the roles and responsibilities of community health workers and clinic based health workers. Also the rights of key populations need to feature in the legal and policy instruments, so that the response becomes all-inclusive and due attention is given to their specific needs.

- If community interventions are to be sustained, effective coordination mechanisms are needed for organisations working in communities. The community leadership needs to be engaged in this mechanism, as not every community is the same. Therefore the best possible fit and lead should be found for each community. PLHIV networks are crucial partners in the response and they should always be part of it. Representation of different groups and key populations ensure that the voices of all are heard and addressed in the community response. Activities should build on existing structures and partnerships and all partners should ideally be working towards a common goal. Duplication of efforts and competition should be dealt with by the coordination mechanism in place.

- More focused capacity development for organisations already working in the community (both for Government and Civil Society actors) is important and will lead to a more structured and localised support and service delivery. This approach fits well within decentralisation processes ongoing in many countries in Sub Saharan Africa. Often development committees are formed at constituency or lower levels. These committees are important for institutionalising the response, but its members also need training in dealing with the HIV response. Development committees (and the like) in decentralised systems need to have access to resources and funds to take up their responsibilities.

- Effective service delivery means that people are linked to health facilities and health workers to community members. There are many challenges in ensuring these linkages work well, but they are essential for providing the full continuum of care. Quality remains a cornerstone of good health care.
Leadership strengthening at the community level was a key intervention of MaxART. It showed that working within existing structures of local and traditional government facilitated effective community entry. Leaders are important in leading their communities towards healthier behaviours.

Monitoring and evaluation methods at the community level should be relatively simple. The purpose of M&E at the community level is primarily to learn from experiences in order to improve community engagement and improve service delivery. Some data however are needed at the national level and national M&E frameworks will indicate what data needs to be collected by whom and at what time intervals.

MaxART has specifically worked with the networks of PLHIV to support a stronger enabling environment based on human rights. The study on Positive Health, Dignity and Prevention was a good entry point to develop further legal and policy frameworks in the country.

MaxART used a variety of different approaches in communities all targeted at the same goal. The approaches reinforced each other to a certain extent and diversity in methods helped to reach different target groups. Care should be taken that, if interventions are increasing demand, the health facilities are equipped to cater for this increased demand.

Community leaders want sustainable interventions that are owned by the communities with accountability at the community leadership level. Those interventions that built on existing structures within the community were appreciated the most. Interventions should be focused at the lowest level of community organisation (chiefdom level in Swaziland). This allows for adjusting activities to the specific needs of that community, reduce travel cost and thus be more effective and sustainable.

Such as men having sex with men, sex workers, drug users, prisoners etc.
Rural communities have a much stronger social cohesion than semi-urban and urban communities. It is much harder to define a community in the towns and townships and therefore reach people living in this setting. Therefore differential approaches are needed to reach people in different kind of communities. Men are best reached “where they are” for example in their workplace, at cattle dips, as regiments, during meetings and during soccer events. For youth these are obviously schools, places where they hang out like sports events, bars etc.

- It works well when services are provided on site. Specific interventions may be needed to reach hard-to-reach populations, which may include mobile solutions. People prefer services to be closer to the people to reduce travel cost, be it mobile or static.

- Social science research can provide answers to numerous operational questions related to intervention development. Combined with a strong learning-by-doing approach this results in stronger interventions and provides tools for advocacy.

## 5.2 CSS operationalisation in Swaziland

UNAIDS, in 2014, has set new targets for combating HIV and getting to zero. To get on-track, new targets focus on closing the access gap to HIV treatment and prevention by 2020. These include a bold target of providing access to antiretroviral treatment by 2020. Target—90-90-90—would enable 90% of people living with HIV to know their HIV status, 90% of people who know their status to access HIV treatment and 90% of people on HIV treatment to achieve viral suppression. With MaxART phase two Swaziland has embarked on testing if and how this approach can work in practice. Without strengthening Community Systems, the 90-90-90 agenda is unlikely to be achieved.

Internationally there has been increasing attention for CSS approaches also stimulated by the GFATM, who now allows countries to apply for specific CSS interventions in the concept notes. Designing and strengthening interventions across all 6 components simultaneously will allow communities eventually to take charge of their own problems and challenges with regards to HIV and broader health issues. This should result in improved quality and access to services, increased coverage of interventions and reduced risky behaviour and ultimately led to improved health at the community level.

The Government of the Kingdom of Swaziland has been reviewing how best to implement a systemic approach for CSS over the past years. During the development of the Concept Note for the GFATM in 2014 discussions between NERCHA and CANGO focused amongst others on how to operationalise CSS in Swaziland. Several development partners assisted NERCHA in this process.

### Recommendations towards advancing the CSS agenda in Swaziland include amongst others:

- An analysis is needed of all the key actors working at the community level including assessment of how they work together towards a common goal. Formal structures and linkages need to be reviewed in terms of facilitating CSS work. Factors contributing to inclusiveness of all actors need to be analysed as well as factors inhibiting collaboration and harmonisation of efforts. From this study the most logical coordination and oversight structures will ensue.

- CSS means that governments and civil society actors need to work together closely, whereby the government is responsible for setting the policy environment and coordination structures. Civil society needs to ensure inclusiveness of all actors, address human rights and ethical issues and harmonise the efforts geared at service delivery.

- A comprehensive policy and strategy on community systems strengthening needs to be developed. These documents need to address the questions of who should do what and where with which means. It should also include a service package for community level work. Community work in HIV is now often built around the good will of volunteers. If community interventions are to be better institutionalised it is good to consider which cadre could best provide the continuity and services that are needed at the interface between health facilities and communities. Developing a paid cadre will enhance accountability, as job performance and assessments then become part of the contract (i.e. professionalization of RHMs).

- Linking people to health facilities and health workers to community members and structures are essential to provide the full continuum of care. The coordination structure should be made explicit in these documents.

- Capacity assessments of the key actors should lead to a comprehensive capacity development plan. The competence of different actors needs to be further strengthened both in terms of technical content related to health and HIV issues and in terms of leadership, management and accountability. Capacity strengthening is more than just training community members on specific issues. Mentoring and supportive supervisions should be part of the effort. Existing capacities of key actors, responsibilities in the response and identification of gaps form the basis on which a training and support system can be constructed. These actors should include the community leadership, civil society organisations and networks and people managing, implementing and coordinating the response. Management (organisational and financial) trainings and HIV related issues should be part of this.
Regular monitoring of community level efforts is essential for accountability and reviewing efficiency. One tool available for this is the Swaziland community scorecard mechanism whereby communities and health workers interact and dialogue using a specific methodology about access and service delivery related issues, after which plans for improvement are developed jointly. Mapping exercises can assist in ensuring that all the different target groups are reached and their needs are met. There is a vast body of community tools available that assist in delineating what works best for whom. Solutions found by community members themselves have the highest chance of being implemented.

Community Systems strengthening efforts need to be funded. Both by governments and where necessary development partners and other funders could contribute. Funds are needed for strengthening all the six components of the framework, which also includes service delivery. Many donors provide funds for service delivery specifically to NGOs or CBOs but have limited attention for the broader issues in CSS. If the tide is to be turned, sustainable funding for CSS is needed.

Implementers of MaxART suggested focusing interventions at the chiefdom level in the future rather than constituency level. This would allow for adjusting activities to the specific needs of that community, reduce travel cost and thus be more effective with increased and clearly defined ownership. In more general terms this means focusing at the lowest level where communities are organised.

5.3 How can MaxART contribute to advancing a CSS agenda in phase two?

Phase 2 of the MaxART programme called “Early Access to ART for All” demonstration project in Swaziland, focuses on putting in practice the exciting evidence that early ART is not only beneficial for individual health benefits, but also contributes to the prevention of HIV transmission on a population basis.

Within the above context MaxART has set up a Community Advisory Board at the national level to link the community with the research team. Even though the focus will now shift towards the implementation of the demonstration project there are still important lessons on the community approach that can be shared within the country.

The main recommendation for the MaxART programme is therefore to organise a policy dialogue or conference around the results of the case study. This meeting should help the government in advancing its CSS agenda. It should bring together different actors that have been working in communities in Swaziland to share their experiences.

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53 Developed by the WB and applied in many countries one example of which is in Swaziland: F. Jenniskens and P. Najman. Swaziland Community Score Card Operational Manual. For EU-WB Health, HIV and TB project. April 2014.

54 Members include amongst others: a traditional leader as chair; representatives from the 14 communities in which the study is implemented; NGOs, CBOs, PLHIV, youth, researchers.