HIV HEALTH SECTOR PARTNERS COORDINATION FORUM

"Achieving the 90-90-90 targets by 2020 & Ending AIDS"

WORKSHOP REPORT

30th – 31st August 2016

Happy Valley Hotel

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ACKNOWLEDGEMENTS

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DISCLAIMER

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INTRODUCTION

The Swaziland Ministry of Health through Swaziland National AIDS Programme (SNAP) leads the Health Sector Response to HIV and AIDS, coordinating about 80% of the HIV response. SNAP leads and coordinates the Health Sector based interventions to that ensure the response is efficiently and effectively managed and coordinated at national, regional and facility level. SNAP deliver services through thematic areas. The thematic areas of the HIV response are HIV prevention, HIV care & support, research cross cutting interventions and programme management

As the nation moves towards ending the HIV epidemic, issues we faced become more complex, partner coordination and partnerships hold much promise. Health sector HIV partner coordination forum aims to contribute to concerted efforts towards a shared vision, goals, objectives, results against set targets, and to share best practices. The forum does not replace any existing multi sectoral coordinating committees and Technical Working groups. The HIV Health Sector partners' coordination forum is a quarterly meeting. Partners include any organizations (national or international) that subscribe and contribute to the goals & objectives of the health sector response to HIV. According to the eNSF2014-2018, the main goal of the HIV response is to halt the spread of HIV and reverse its impact on the Swazi society. The impact levels are as follows:

- 50% and 90% reduction of new HIV infections among adults and pediatrics respectively by 2018.
- Avert 15% deaths among people living with HIV and AIDS.
- Alleviate the socioeconomic impacts of HIV and AIDS among vulnerable groups and across the population generally
- Improve efficiency and effectiveness of the national response

FORUM Statistics
75 participants
35 Institutions represented
20 Presentations

The first HIV health sector partner coordination forum was held on the 30th -31st August 2016, at Happy Valley Hotel, Ezulwini. SNAP conducted the meeting in collaboration with URC and NERCHA. The institutions represented included MOH departments and programmes: SNAP, SRHU, SHLS, CMS, MQMP, NCD; Research unit; Health facilities; Hlathikhulu, Piggs Peak, Mankayane, Lubombo regional , Mbabane hospital, Sithobela health centre: Developmental partners; PEPFAR, UNAIDS & UNICEF; International NGOs: URC, ICAP, CHAI, PSI, CHAPS,EGPAF/AIDSFREE, MSH, MSF, SAFAIDS: National Coordinating Bodies: NERCHA, CANGO, SWABCHA, SWANNEPHA; Local NGOs Cabrini Ministries, Kudvumisa, TASC & Siphililie . Training institution- UNISWA

The 1st forum theme was titled "Achieving the 90-90-90 targets by 2020 and Ending AIDS". This theme recognized the powerful momentum building towards a new narrative on HIV treatment and, ambitious, but achievable 90-90-90 target: 90% of all people living with HIV will know their HIV status. 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. 90% of all people receiving antiretroviral therapy will have viral suppression. The meeting was officially opened by SNAP Programme Manager, Mr Muhle Dlamini who thanked all participants for making it to this meeting. Mr Dlamini give a brief overview of the HIV health sector partners' forum terms of reference, purpose of the forum and meeting frequency which was highlighted that it will be quarterly. Furthermore, he shared the objectives of the 1st forum which were:

- To create awareness among health sector partners on the 90-90-90 targets
- To review progress towards achievement of 90-90-90 targets at national and regional level.
- To identify challenges in accelerating the implementation of 90-90-90 targets at all levels

- To recommend how the health sector will accelerate towards the 90-90-90 targets

Mr Muhle Dlamini acknowledged the presence and participation of CDC Country Director, Dr Caroline Ryan. Dr Ryan, in her remarks appreciated the great work SNAP and HIV health sector partners were doing towards ending AIDS. She further pledged support for continued PEPFAR funding, emphasized on accountability for results and investment. Data and reports are evidence, hence critical for continued funding and justification.

The report provides a concise summary of presentations and lessons learned from HIV Health sector partners working in the fields. The meeting participants were provided with clinical innovations and evidence-based public health interventions such as 90-90-90 targets and ending AIDS definition, HTS and testing models, VMMC, self-testing, ART delivery models and test and start, PMTCT, integration of family planning and focus on key populations . Highlights were provided by the 4 lead regional implementing on their interventions and contribution towards each of the 90-90-90 targets. A synthesis of the 1st HIV Health sector partners' forum presentation will be made and a synthesis report will be shared feedback and made available including on the SNAP WebsiteHttp://www.swazilandaidsprogramme.org

Structure of the meeting

The first day focused on the National goals on HIV response, SNAP key priorities and interim results. The presenters were National Coordinators from SNAP, NERCHA, Sexual Reproductive Health Unit (SRHU), Swaziland Health Laboratory Services (SHLS) and Central Medical Stores (CMS). The meeting was opened by SNAP Program Manager who

The second day of the meeting was focused on HIV Investment case by NERCHA, lessons from the field by lead regional clinical partners URC, AIDSfree/EGPAF, ICAP and MSF; SWANNEPHA, Kudvumisa. Key population and Research updates were also included. As a general observation from the presentations, regional clinical partners support the whole cascade of HIV and the 90-90-90 targets.

Facilitation

A mix of methods were used to facilitate the meeting.

Power point presentations: Presentations were made on progress against the 90-90-90 targets both at national and regional levels. After the presentation, participants were provided an opportunity to seek clarification and provide guidance.

Group discussions and plenary. Participants were divided into three groups and given assignments. Discussions included: Priorities and challenges towards achieving the 90-90-90 targets; Integration and linkages; Recommendations towards acceleration of targets (coordination efforts, service delivery, supply and logistics). This provided an opportunity to discuss and brainstorm possible actions for the teams to reach the 90-90-90 targets

Meeting chairpersons. Each day the programme was directed by 2 persons. Mr. Muhle Dlamini, SNAP and Dr. Marianne Calnan, URC for Day 1 and on Day 2 it was Dr. Nomthandazo Lukhele, SNAP & Ms Allen Waligo, NERCHA.

Rapporteurs: Ms Faith Kukunda, Ms Lenhle Dube and Ms Nokuthula Mdluli

HIGHLIGHTS OF THE PRESENTATIONS AND DISCUSSIONS

A handbook of the presentations will be shared for detailed presentations and discussions. This report aims to provide highlights.

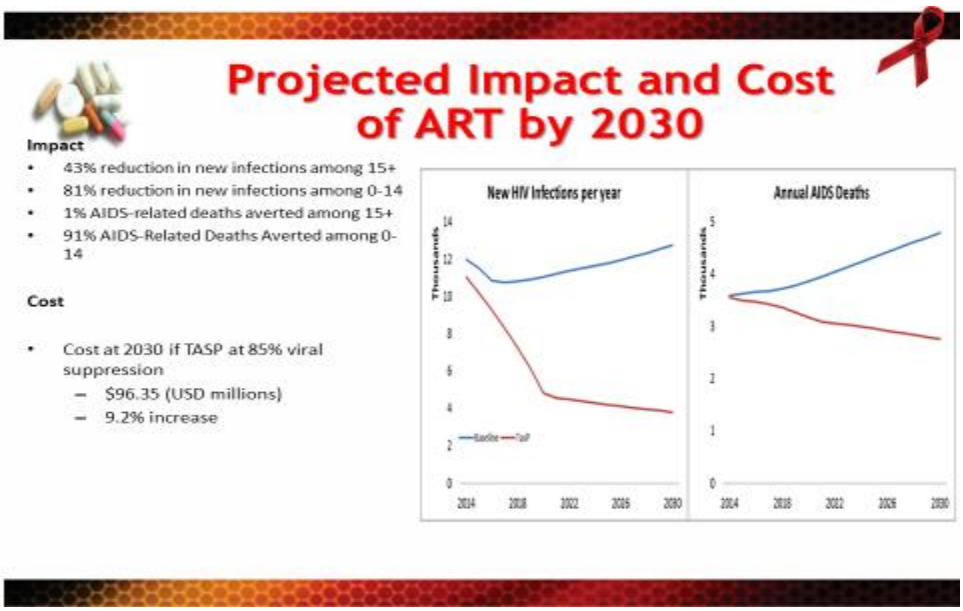
HIV INVESTMENT CASE

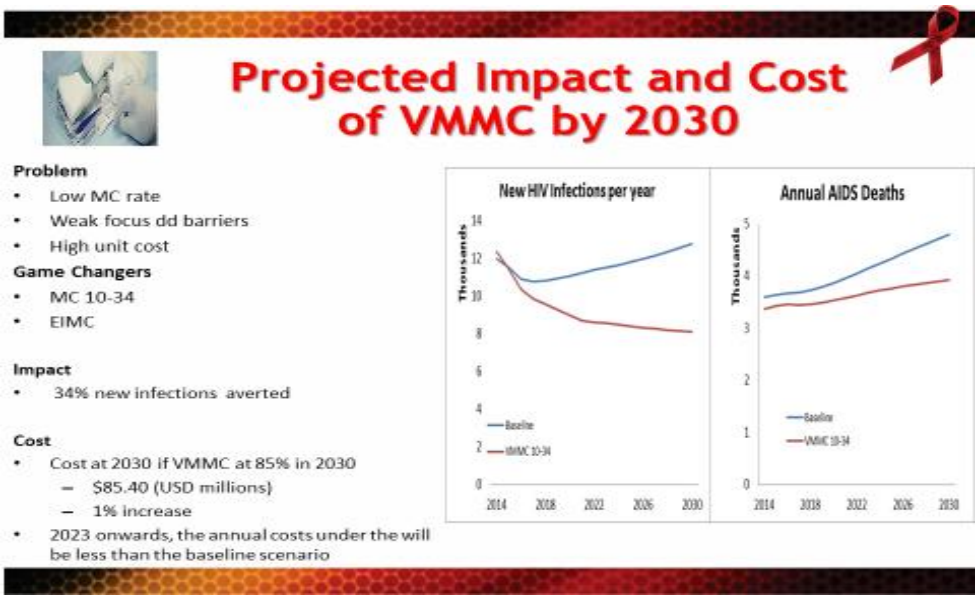
Ms Nokwazi Mathabela from NERCHA gave a presentation on the overview of the Swaziland HIV Investment Case. In the presentation it was noted ending AIDS for us is defined as the public health approach, chronologically leading to the feasibility of HIV and AIDS eradication. The global movement toward making more strategic funding allocations for HIV/AIDS through investment cases holds much promise in an increasingly resource-constrained environment. As the national response matures, there is stronger evidence base for cost and impact of Health Systems Strengthening (HSS) investments in order to do more with less.

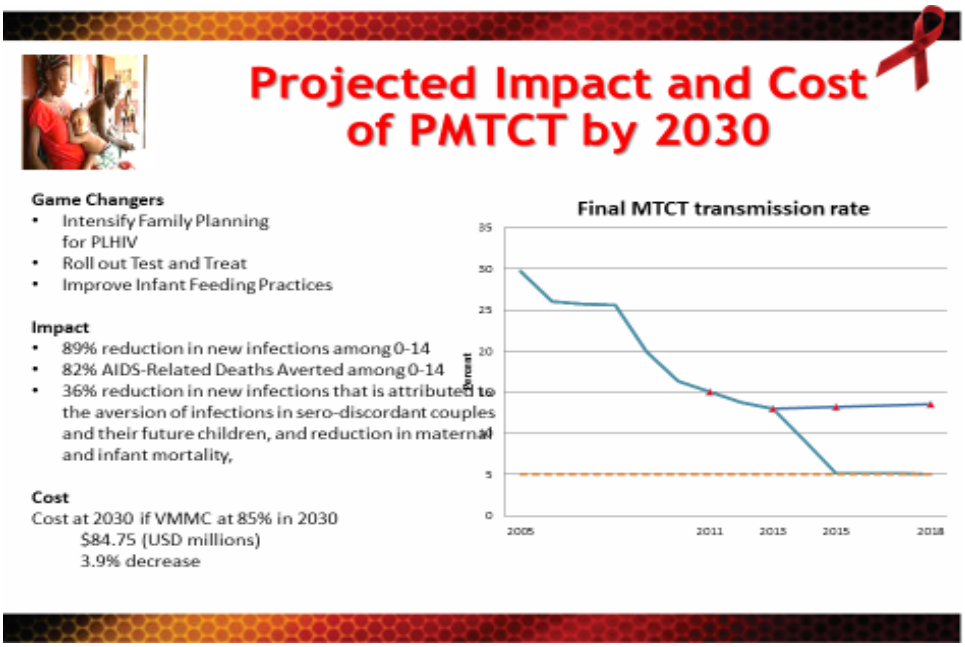
By 2022 we want to prevent new infections and we want those living with HIV not to die from it. Most of our HIV strategies focus mainly on prevention. But because of the successes of HIV treatment, some of our interventions are treatment based, e.g. the Test-and-Treat. Swaziland is aware that in order to implement the "Optimal" set of interventions there is need to strengthen underlying systems that support or enhance program implementation like human resource management, monitoring and evaluation, and the integration of programs

The eNSF has 11 main strategies. Each of the 11 strategies were assessed for their impact on preventing new infections and keeping those living with HIV alive using efficient and sustainable means and 5 were identified.

Below is a synopsis of selected projected impacts



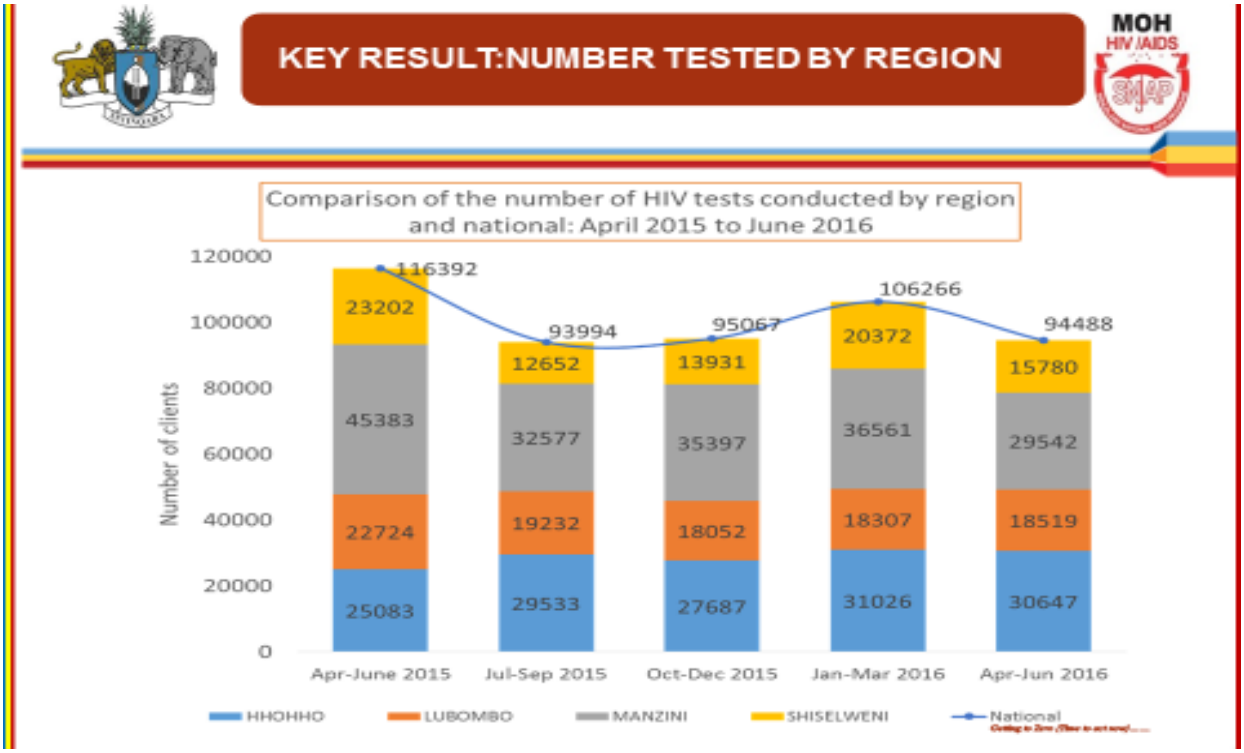


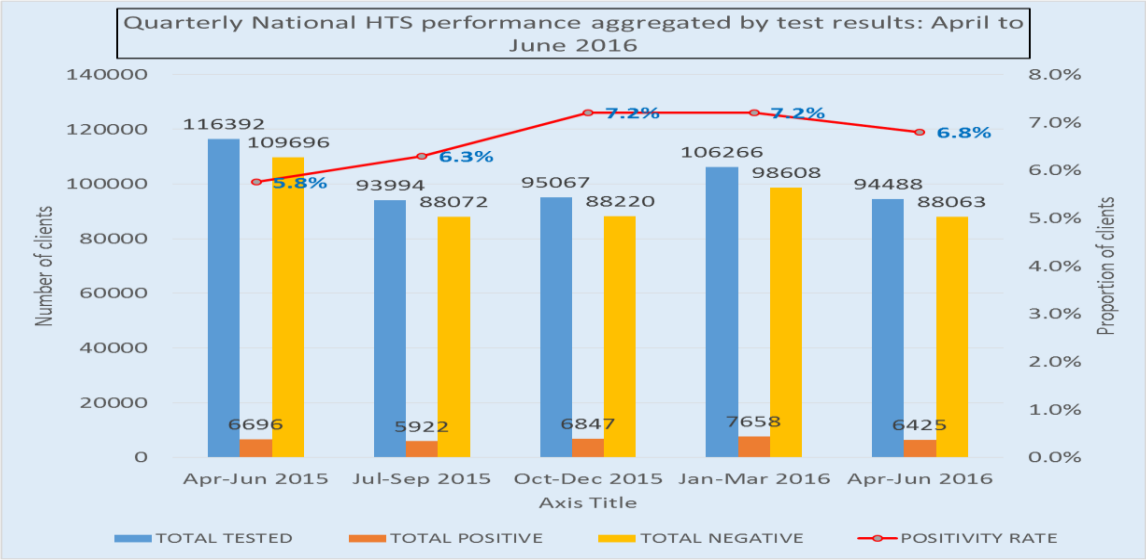


REACHING TARGET 1: 90% of all people living with HIV will know their HIV status (90% diagnosed).

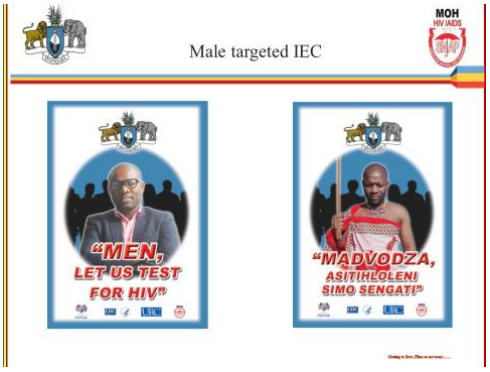
Three Presentations were held in this session. The presentation topics were HTS and testing models including self-testing by Ms Lenhle Dube; Voluntary Medical Male circumcision by Mr. Sabelo Thomas Mlambo and Condoms by Mr Muziwethu Nkambule. The various presenters on reaching target 1 recognised the need that as a country we need to sharply increase the proportion of people living with HIV who know their HIV status.

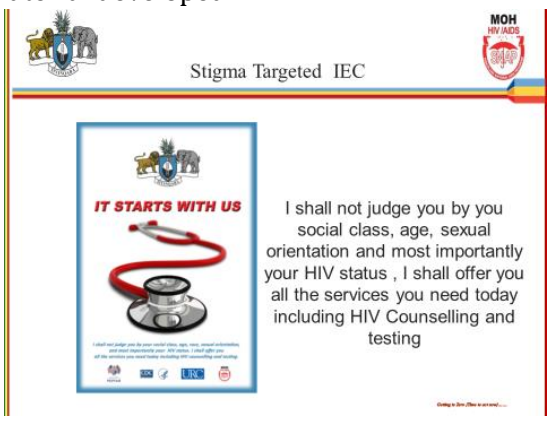
National HTS Coordination Ms Lenhle Dube presented the topic HTS and testing models including self-testing. The presentation covered the overall HTS results by region and HIV positivity rate. The presenter noted that reaching 90% of all people living with HIV to know their HIV status will require moving beyond a passive approach to testing, which relies on individuals to recognize their own risk and come forward on their own to learn their status, often without meaningful education or support. More proactive, rights based testing initiatives will be needed, including focused testing promotion for key geographic and population hotspots, investments in strategies to increase demand for testing services, and utilization of a broader array of HIV testing and counselling approaches, including self-testing, provider initiated counselling and testing and community-based approaches.


KEY RESULT:NUMBER TESTED BY REGION
MOH
HIV/AIDS
Comparison of the number of HIV tests conducted by region and national: April 2015 to June 2016
Number of clients
120000
100000
80000
60000
40000
20000
0
116392
93994
95067
106266
94488
23202
12652
13931
20372
15780
45383
32577
35397
36561
29542
22724
19232
18052
18307
18519
25083
29533
27687
31026
30647
Apr-June 2015
Jul-Sep 2015
Oct-Dec 2015
Jan-Mar 2016
Apr-Jun 2016
HHOHHO
LUBOMBO
MANZINI
SHISELWENI
National


Quarterly National HTS performance aggregated by test results: April to June 2016
Number of clients
Proportion of clients
140000
120000
100000
80000
60000
40000
20000
0
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
116392
109696
6696
5.8%
93994
88072
5922
6.3%
95067
88220
6847
7.2%
106266
98608
7658
7.2%
94488
88063
6425
6.8%
Apr-Jun 2015
Jul-Sep 2015
Oct-Dec 2015
Jan-Mar 2016
Apr-Jun 2016
Axis Title
TOTAL TESTED
TOTAL POSITIVE
TOTAL NEGATIVE
POSITIVITY RATE

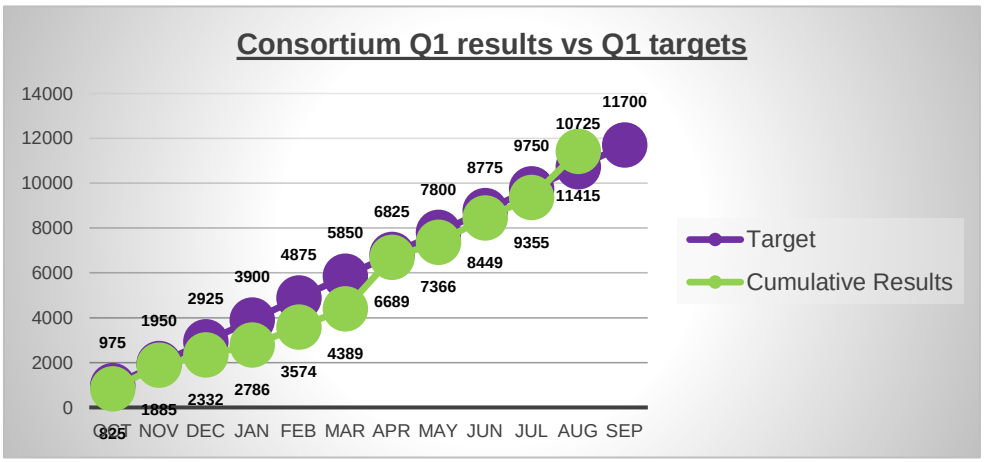
Creating demand for HTS
SNAP shared ASCM activities and IEC material developed

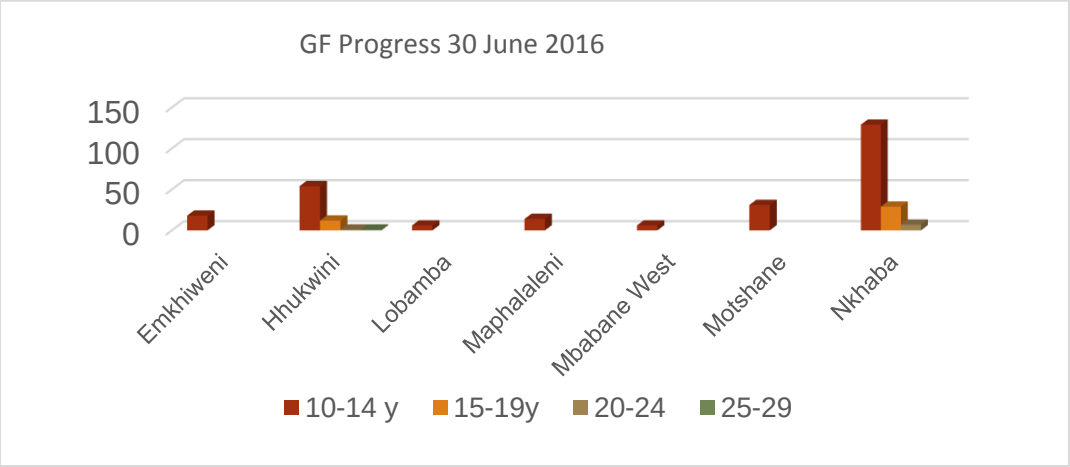




VOLUNTARY MEDICAL MALE CIRCUMCISION

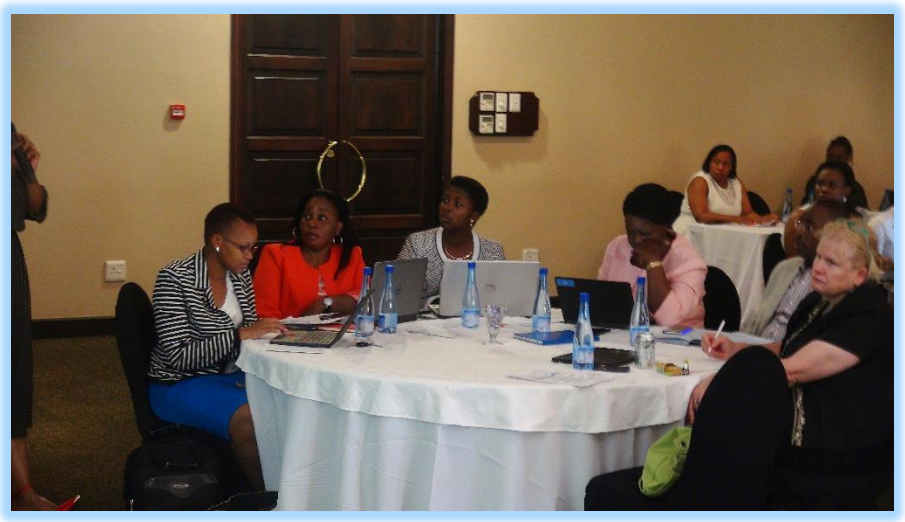
The Centre for HIV and AIDS Prevention Studies (CHAPS) Outreach Manager, Mr. Sabelo Thomas Mlambo presented the Voluntary Medical Male Circumcision Programme updates. The goal of the programme is to achieve 80% Male Circumcision (MC) coverage among males aged 10-49 years. The focus is now on the 'age pivot' i.e. 15-29 year olds. Demand creation is one of the key areas of the MC program. There is a need for a broader focus on males' health. The main service delivery models are: MC Fridays; Back-to-School (BTS); Private-Public Partnerships; Fixed clinics and Mobile Caravans (esp. GF)**.** The presenter shared VMMC 2016/2017 targets as USAID target: 15, 700 and GF target: 4,500





Conclusions and recommendations

- Improvement in reaching older males over the years.
- Demand creation remains crucial and still a challenge. the MOVE model and use of locums is able to cope with increased demand
- Offering a comprehensive males' health package attractive to men. This will include NCDs screening e.g. diabetes and cholesterol screening



A Section of participants with PEPFAR representatives paying attention during the session

CONDOM PROMOTION AND DISTRIBUTION

The National Emergency Response Council on HIV and AIDS (NERCHA) HIV Prevention Manager, Mr. Muziwethu Nkambule presented updates on Condom Promotion and Distribution. The goal of the programme is to ensure that 90% of those that are negative, remain negative.

Key program priorities:

- Strengthen the condom forecasting, procurement and supply management system.
- Intensify access, demand creation and distribution of condoms using multiple approaches including integration with other health care services.
- Intensify and expand condom distribution coverage for specific targeted groups that are at high risk, including young people, MSM, sex workers (SW) and discordant couples.
- Strengthen Social and Behavior Change (SBC) interventions in condom programming.
- Strengthen M&E and research for condoms.

Targets

Program Area	Indicator	Baseline 2011	Targeted in 2015	2015 Achievement	Target 2018	Progress status
Condoms	# of condoms distributed per year	6,5 million male condoms	10 million male condoms	10 733 323 male condoms	14 million (76%) male condoms	
		202 100 female condoms	350 000 female condoms	376 051 female condoms	500 000 (75%) female condoms	

Challenges faced by the program include:

•Condom promotion and distribution strategies have not adequately targeted vulnerable groups and key populations at higher risk of infections, including women and persons in the age group 15-24 years.

•Inadequate procurement and supply chain management of condoms.

•Correct and consistent condom use is low.

•Inadequate data to inform condom programming.

Acceleration to reaching the 90-90-90 targets MEANS CONDOMS FOR THE FOURTH 90: 90% of those that are negative should remain negative. This can be achieved through:

•Strengthening condom forecasting, procurement and the supply management system.

•Intensifying access, demand creation and distribution of condoms using multiple approaches including integration in other health care services.

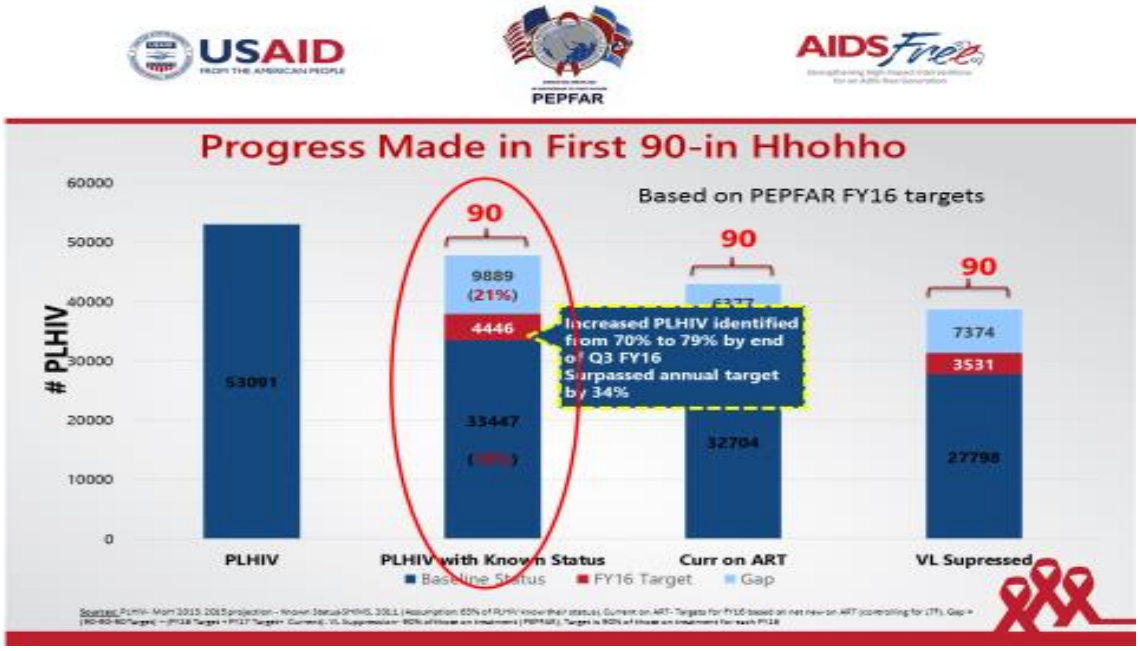
•Intensifying and expanding condom distribution coverage for specific targeted groups at high risk, including young people, men who have sex with men, sex workers and discordant couples.

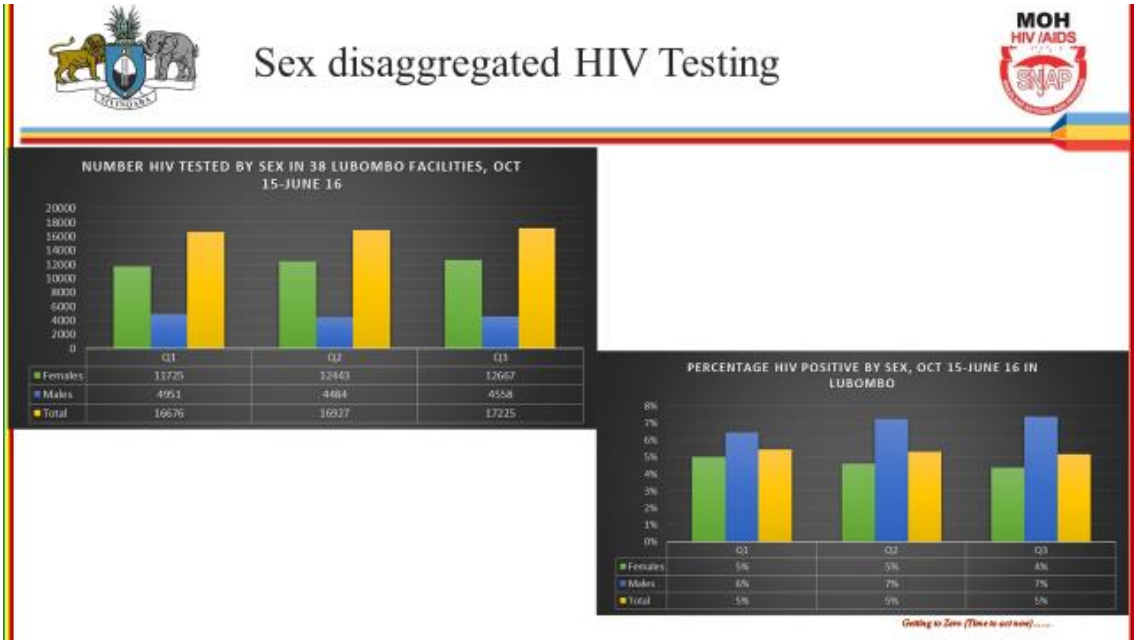
•Strengthening SBC interventions in condom programming. Strengthening M&E and research for condoms.

REGIONAL IMPLEMENTATION TOWARDS REACHING TARGET 1ST 90

The regional clinical implementing partners were URC supporting the Lubombo Region and presenter Dr Marianne Calnan; AIDSfree/EGPAF supporting Hhohho Region and presenter Dr Caspian Chouraya; ICAP supporting Manzini Region and presenter Dr Pido Bongomin and MSF supporting Shiselweni Region and presenter Dr Celeste. The presentation give an overview on the regional clinical HIV response, progress towards achieving the 90-90-90 targets and strategic goals. Regional HIV Coordinators from SNAP and NERCHA were in attendance. Kudvumisa a local NGO also give a presentation.

The figures below are some regional illustrations presentations towards achieving the 90-90-90 targets





SUMMARY OF LESSONS AND RECOMMENDATIONS FROM THE FIELD

The presenters from the field highlighted that placement of HTS counselors in high volume facilities; training of all HCWs and support staff at the supported facilities on importance of confidentiality and non-stigmatizing behaviour; Provision of PIHTC SOPs to all entry points; Intensive mentorship to

HCWs and HTS counselors on HTS to reduce missed opportunities for HTS and regular review of HTS data at regional and facility levels helps to identify gaps and develop strategies to address them.

Recommendations

- Targeted HIV testing as defined by the yield by entry point
- Targeting males. e.g. Engaging male partners of ANC clients and women bringing children for U5's clinic; Engagement of chiefs, pastors, sports coaches
- Family centred approaches (especially for PHUs) including index testing
- Collaboration with community HTC partners e.g. HTS services after hour
- Tracking and reporting on intra-regional referrals of new PLHIV
- Pilot HIV self testing.

KUDVUMISA

Kudvumisa Foundation, Programme officer, Mr. Jabulani Maziya presented updates. Kudvumisa was started in 2008 implementing a project on Children HIV Intervention Programme in Swaziland (CHIPS), later transitioned to Community Health Intervention Programme Swaziland (CHIPS). Kudvumisa works in 18 communities in Lomahasha and Mhlume Tinkundla.

The entry point is HTS. When a patient tests HIV positive, a CD4 count is performed on site using a Pima, and then the patient is referred to a nurse who is trained on NARTIS and is enrolled. If the patient is eligible for ART, the programme provides transport to Good Shepherd Hospital. On return, the nurse at Kudvumisa initiates the patient in the community. Client retention rate is at 95%. Other services provided include ART refills, TB screening and screening of NCDs such as Diabetes. The challenge encountered is stigma and discrimination. "When we conduct door-to-door visits and find positive patients they prefer to be initiated on a different date because the family members are around and the client would like them to think the results were negative. Therefore, we may need to make 3 different trips just to see one patient".

SUMMARY OF DISCUSSION TOWARDS ACHIEVING THE 1ST 90:

Meeting participants noted that:

- The 1st 90 targets have are not been met. The regional targets were not aligned to the linked to the national targets. Recommendation was made that facilities should have targets and furthermore, high density areas should be targeted for testing.
- Improve HTS service coordination to improve coverage and reduce duplication
- Quality of HTS service provision. There is need to focus on the quality of HTS services including compliance to set standards, guidelines and SOPs.
- Promote the use Unique identifier
- Low uptake of HTC was noted in males hence the recommendation to target males. Strategies are in place, challenge is implementation. There is need to actively follow up. HTC Demand creation: strategy is not clear; Resources are focused towards the health sector response almost to the oblivion of community engagement and demand creation. Example cited: Solution: target security forces basing it on population and where they are found
- HIV prevention messages. : There are unclear and not segmented according to the different populations segments; HIV There has been an evolution where it's no longer just ABC, there are issue around treatment as prevention etc. We need to proactively target issue of "Blessers" in HIV

prevention and as a driver of HIV. There has been stock out of HIV rapid test kits. There is need to ensure continual availability of supplies.

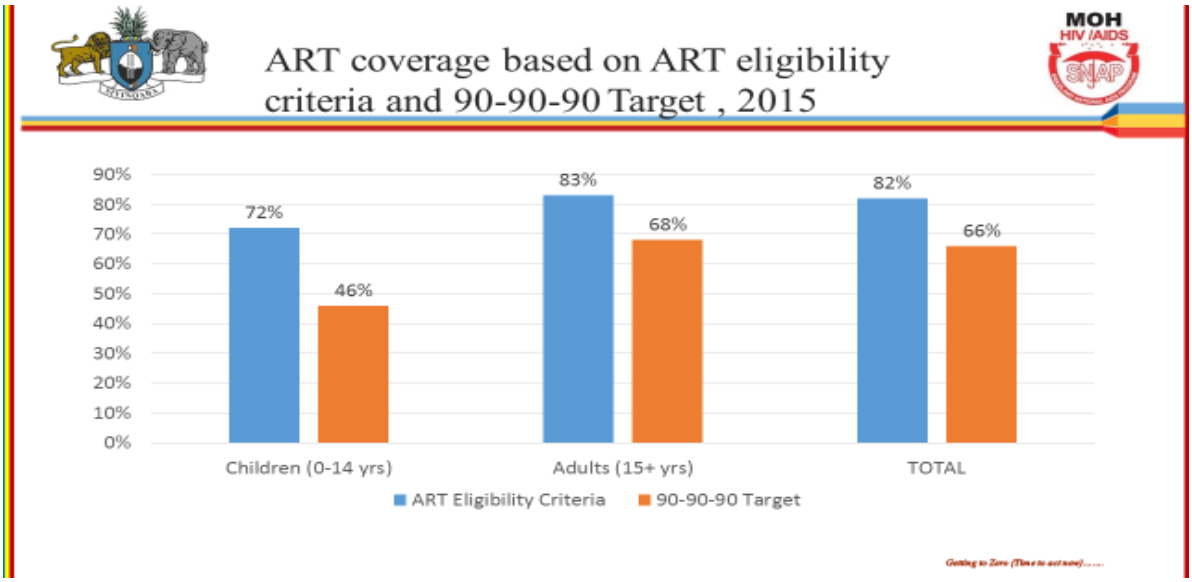
- Consideration for the use PLHIV to create demand for HTS

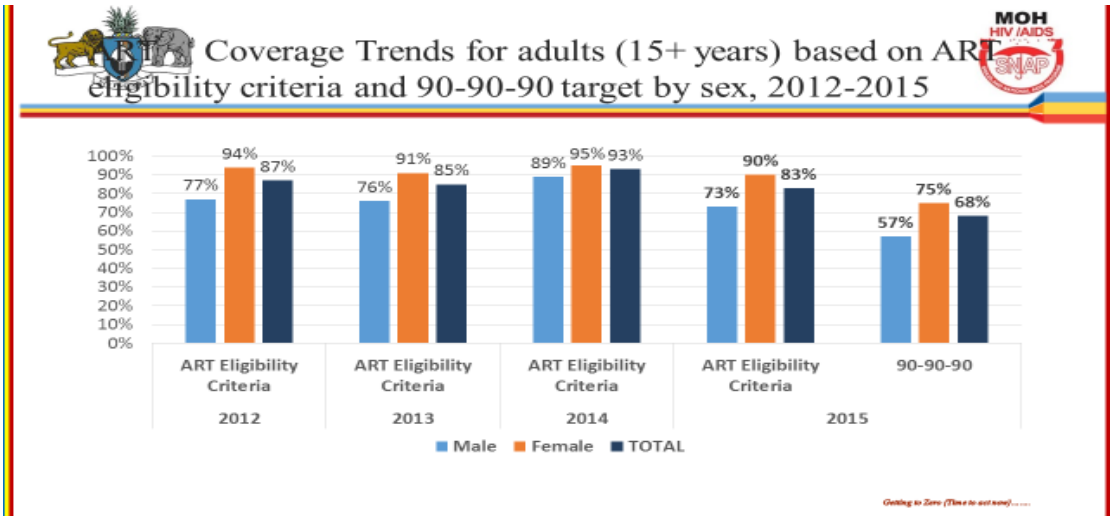
Section of the Partners during the HIV Health Sector Coordinating Forum

REACHING TARGET 2: 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (90% on HIV treatment)

Dr N. Lukhele, National ART Coordinator, gave a broad overview of the country achievement towards achieving the 2nd 90. Sexual Reproductive Health Unit (SRHU) and regional partners shared their contribution in achieving the 2nd 90. The national data presented showed ART coverage based on the ART eligibility criteria to be 82% and 66% towards the 90-90-90 target. As she presented t was mentioned that as a country, Test and start as being adopted effective 1st October. Antiretroviral therapy is recommended to all people with diagnosed HIV infection, without the requirement of a prior CD4 test. To achieve and maintain high treatment coverage levels, the country need to ensure that HIV treatment including diagnostic tests and other treatment-related items, are available. Human resource needs to be capacitated and HR innovations are required for task shifting and or task sharing to allow the scarce HR resource to focus on the clinical aspect.

Below graphs are

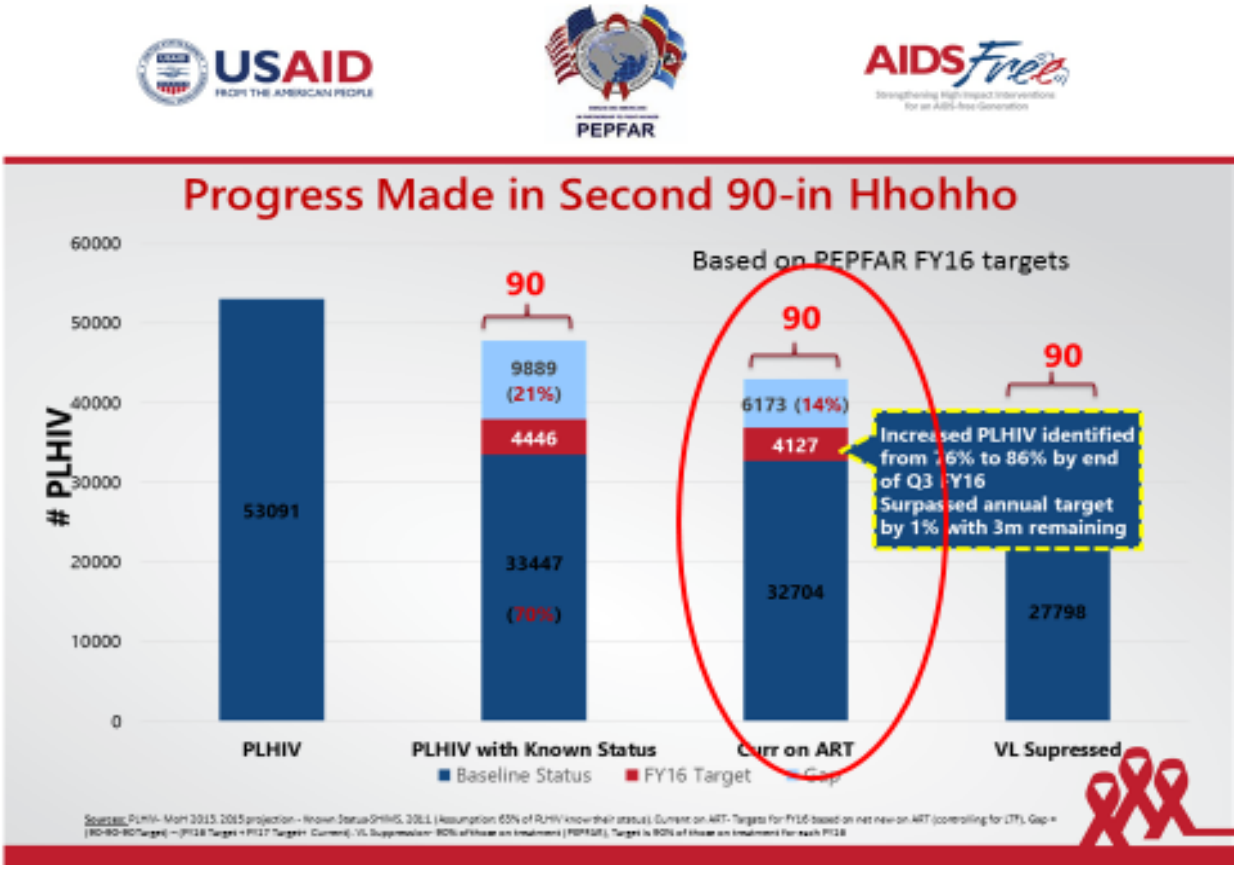


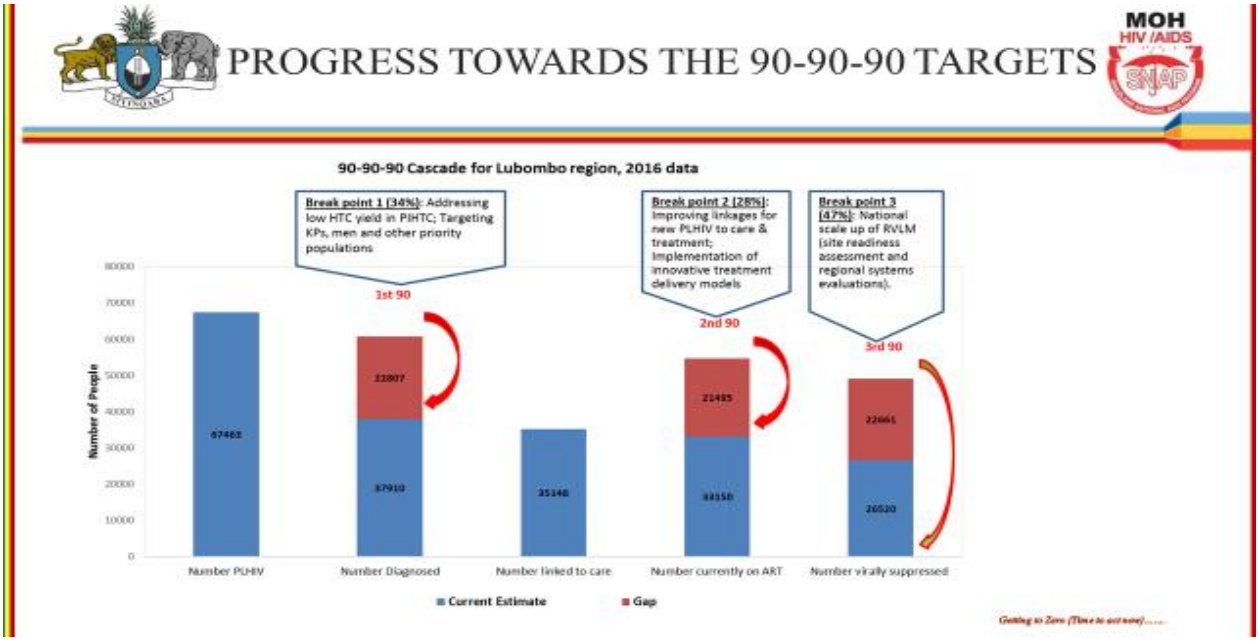


REGIONAL IMPLEMENTATION TOWARDS REACHING TARGET 2nd 90

The regional clinical implementing partners URC supporting the Lubombo Region; AIDSfree/EGPAF supporting Hhohho Region; ICAP supporting Manzini Region and MSF supporting Shiselweni Region made presentations. The presentation give an overview on the regional clinical HIV response, progress towards achieving the 90-90-90 targets and strategic goals. Some presentation have been extracted as an illustration of some of the results.

Panel of Regional Presenters – from far left Dr. Pido Bongomin from ICAP, Dr. Caspian Clouraya AIDSfree, Dr. Marianne Calnan from URC and Dr. Serge Agbo from MSF.





SUMMARY OF LESSONS AND RECOMMENDATIONS FROM THE FIELD

From the different presenters on reaching the 2nd 90 targets, a summary can be drawn on interventions on:

Improving linkages to ART: Placement of referral tools in all testing points in facilities to facilitated referral and linkages of HIV positive clients to care and treatment. Integrate pre-ART services (opening of files) in all testing sites in hospitals and health centres to facilitate linkages of HIV positive clients to care and treatment. Training for all HTS Counsellors in supported facilities on adherence and psychosocial support to ensure proper referral and linkage of clients tested for HIV. Identification and deployment of referral focal persons in each facility to ensure all referred clients are provided with the care and treatment services as needed. Coverage for TB and PMTCT is very high, but we need to continue to examine new strategies to meet current programmatic targets.

Increasing ART initiation: Scale-up of differentiated care to support task shifting in anticipation of higher patient volumes from Test and Start; Mentorship and supervision support ; Review of pre-ART cascades; improve community tracing of pre-ART patients who are eligible for ART; Review medical records of all patients currently enrolled in pre-ART care, who were not eligible for ART and prepare them for ART; Continue to provide TA to ensure all HIV positive pregnant women enroll on B+; Training of HCWs in NARTIS and provision of on-going mentorship to ensure all HIV+ clients are initiated at supported facilities; Support ART initiation in in-patient wards to reduce missed opportunities; Actively track ART performance indicators through routine data reviews ReHSAR and NaHSAR.

TEST AND START

The National ART Coordinator, Dr N. Lukhele, presented on Test and Start. In the presentation, it was noted that Swaziland is partially implementing "Test and Start" for TB/HIV co-infected patients;

pregnant and lactating women, children <5yrs; Discordant couples, Nhlangano Zone and in EAAA/MaxART studies.

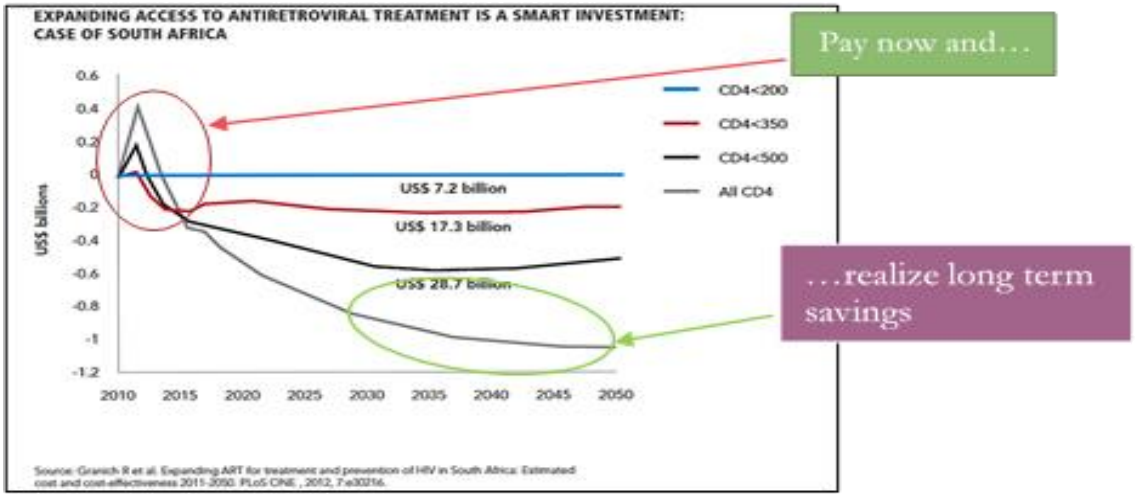
The presenter announced that the country is geared towards full implementation of test and start as of the 1st October 2016. The terminologies 'Test-and-Start' and 'Test-and-Treat' are currently being used interchangeably. Discussions will be held to determine the terminology that will be adopted by the country.

Implementing Test and Start important?

- Plateauing of decline in new HIV infections
- At current eligibility and coverage, targets of the eNSF and to end AIDS by 2030 will not be met
- Current WHO recommendations and international evidence suggest it as best practice
- Local evidence in country show it is feasible

Case studies from different countries (SA, Botswana, Malawi) predict that over time the amount of money saved from reduced morbidity and additional ARVs, number of new HIV infections averted and the improved quality of life for PLHIV are worth the initial high cost.

Figure 1: Cost of implementing Test and Start now and benefits in the future



PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

The Sexual and Reproductive Health Unit (SRHU) National PMTCT Focal Person, Ms Bonsile Nhlabatsi presented PMTCT updates. In the presentation key PMTCT program goals were shared as: Reduction of mother-to-child transmission to less than 2% at 6 weeks and to less than 5% at the end of breastfeeding; keeping the mothers alive and healthy; linking mothers to their babies so that services are provided to them together. (Mother-baby approach). The presenter noted that transmission for

children who are less than 8 weeks is at 2% and transmission for all children is at 3%. This is higher than preferred.

Programme targets: All pregnant women who are HIV positive are to be put on Life-long ART for Pregnant and Lactating mothers (LLAPLa) and all facilities should provide ART. Currently less than 20 health facilities do not provide ART.

Current Programme interventions

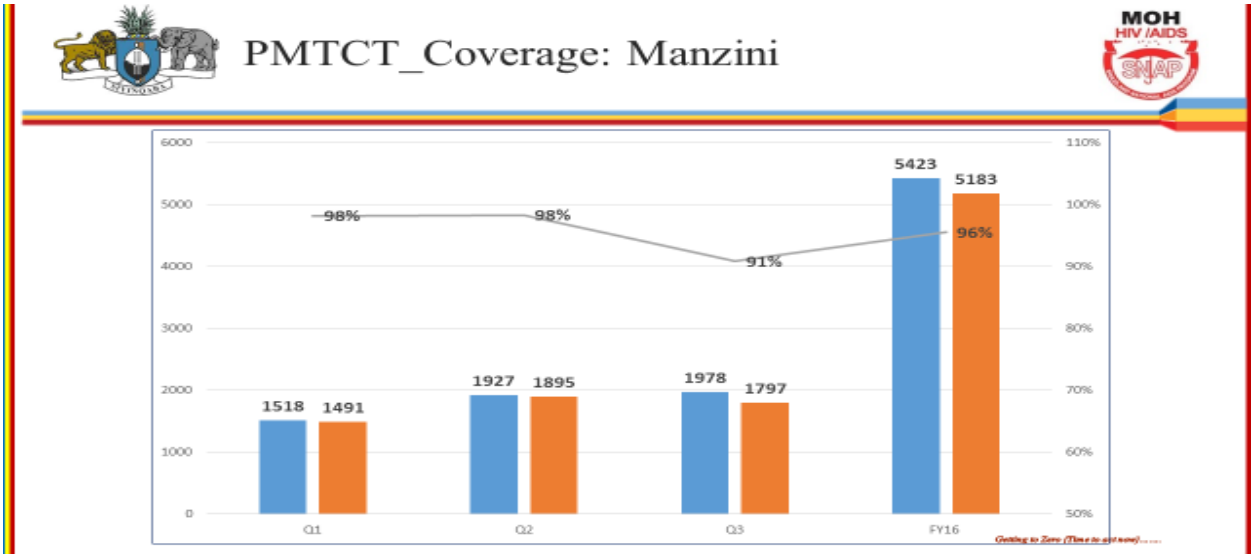
- Aggressive LLAPLa messaging at facility and community level. The community must be aware of what services a mother is expected to receive when she visits a facility. In addition, expert clients are to conduct door-to-door visits to track mothers.
- Innovation – Mothers are to be linked to babies and they are to be followed up together and services should be provided to the mother-baby pair at the same time and at the same place.
- Working with regional partners
  - Timely efforts to bring women who stop treatment back into care may improve long term treatment outcomes.
  - Improved use of appointment registers to identify missed appointments of HIV positive pregnant women and mother-baby pairs.
  - Strengthen the capacity of health facilities and RHMTs in data use for planning through mentorship and support supervision activities.
  - Continue roll out to facilities providing Antenatal Care (ANC) and advocate for provision of ANC in those that do not provide it.

Challenges cited were: The accreditation process is slow; Poor retention in care, (prong 1/2 poor) and There is no ANC in some facilities.

Acceleration to reaching 90-90-90 targets

Increasing ART access and prioritize accreditation for PMTCT sites.
Scale up facilities providing ANC services

The figure below is an illustration of Regional PMTCT coverage



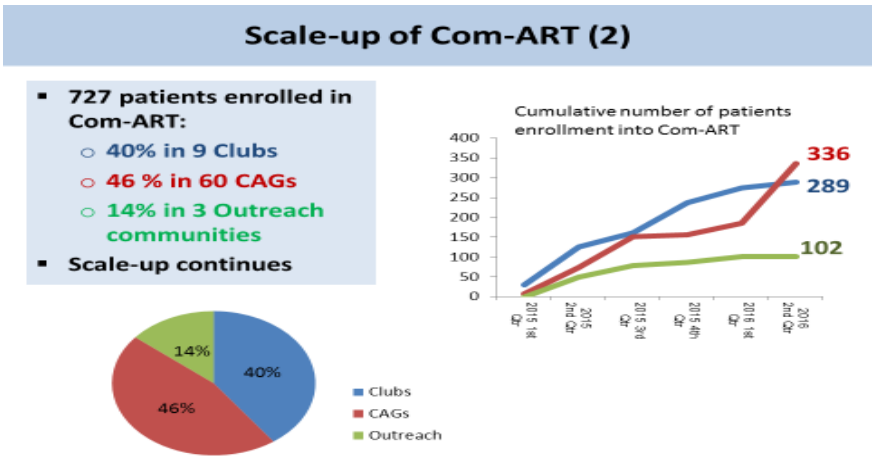
ART DELIVERY MODELS

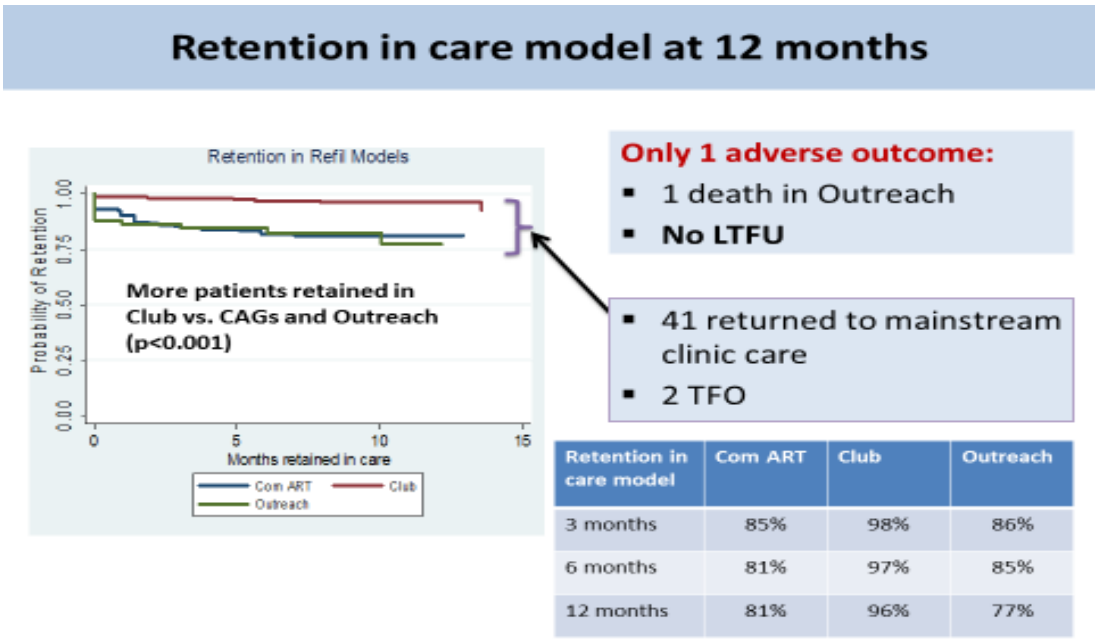
In lieu of the 90-90-90 targets, SNAP has adopted commART with 5 models of ART delivery. The aim of CommART is to: Increase ART coverage; Decongest facilities; Improve the quality of care; Empower clients to be actively engaged in their own care and reduce client related costs for accessing care.

There are 5 models of ART delivery:

1. Mainstream care - mainly for new and unstable clients.
2. Fast track/ drug pick up.
3. Community based ART groups (CAGs).
4. Facility based Treatment clubs (TCs).
5. Outreach model.

Illustration of results from the Shiselweni Region





Retention in care model	Com ART	Club	Outreach
3 months	85%	98%	86%
6 months	81%	97%	85%
12 months	81%	96%	77%

ARV SUPPLY CHAIN

Central Medical stores (CMS) provided information on how and when to order. It was mentioned that ART refilling clinics (baby clinics) submit their orders to the main ART–initiating sites (Mother facilities). The main ART–initiating sites submit orders to CMS who then delivers commodities to the main ART–initiating sites. The main ART–initiating sites than distribute commodities to ART refilling clinics.

HIV and AIDS Commodity distribution Schedule from CMS to facilities (when to order)

It was mentioned that orders are received at CMS at the beginning of the month and to Shiselweni in the first week of the month; Lubombo in the second week of the month; Hhohho in the third week of the month and Manzini in the fourth week of the month.

The meeting participants were reassured that CMS participates in the test and start task team and in addition to the ARVs that are procured by government Global fund and PEPFAR have pledge to procure more drugs to support implementation of test and treat.

Challenges

- Late reports.
- Transport challenges from baby to mother facilities, mother facilities to CMS and from CMS to facilities.
- Funding - funding gaps from the budget, funding gaps from actual MoH release; the ART account must have funds for order placement.
- Data Verification
- Quantification

SUMMARY OF DISCUSSION TOWARDS MEETING THE 2nd 90:

Meeting participants noted that:

- Constant and consistent supply of ARVs is critical towards meeting the 2nd 90 targets. Facilities needed to be capacitated and implement correct supply chain management practices.
- Community education, advocacy, awareness on Test and start is essential to create demand.
- Design special counselling programme for those not ready for test and start
- Accredit more facilities to initiate and increase number of HCWs providing AR
- Improve coordination between the key thematic areas to mention but a few HTS. Care and treatment and psychosocial.
- Facility MDTs to review and use their data on reaching 2nd 90
- ARVs are provided by the government. However the service delivery is supposed to be comprehensive and the challenge is the other essential drugs for opportunistic infections (OIs) and the whole range of drugs that are to be used to treat a patient. Are there any other plans to supply these drugs especially in the NGO sector?
- The NGOs are no longer getting medicines for OIs. They can receive ARVs because they are budgeted for by the government. The government does not have a system to cover supply of OI medicines to NGOs. There is a need for advocacy to the ministry.

REACHING TARGET 3: 90% of all people receiving antiretroviral therapy will have viral suppression (90% suppressed)

Universal access to viral load testing in all settings, urban and rural, will likely require a combination of centralized laboratories and point-of-care tools. The SHLS Principal Technologist, Ms. Gugu Maphalala presented viral load testing updates. Ms Maphalala gave an overview of the SHLS Capacity for viral load testing.

Equipment, the National Molecular Reference Laboratory (NMRL) has two CAP/CTM 96 machines (one of which is for Early Infant Diagnosis). 21-63 samples are run per batch loading. 168 run per 8-hour day continuous loading/per machine. 1x Biocentric has been installed. This machine is used for the EAAA Study and as a backup equipment for routine viral load testing. 186 samples can be run per machine per day. The decrease in VL and EID tests is due to frequent breakdown of analyzers

Human Resource and Training. HR requirement has been addressed - (VL technologists & Phlebotomists); 2x IT, 3 laboratory technologists and 46 Phlebotomists hired by ICAP to support the laboratories under the SHLS network; 5 laboratory technologists recruited by the SHLS (GF); 2 Data clerks are engaged (MoH)

Transport of samples and results. NSTS is serving 26 routes. There are 10 cars in good condition and 3 motorcycles, which visit facilities two - three times a week. Results return - Turnaround Time (TAT) is usually 2-4 weeks.

Challenges

NMRL receives over 250 viral load samples a day. There is a pending backlog of 3000 samples due to various reason and not limited to frequent machine breakdown- most of the machine are old, Staff shortage and turnover. Sample integrity is also a challenge.

Intervention planned to scale up viral load monitoring

- The SHLS will be procuring equipment: 2x CAP/CTM 96 viral load equipment by CDC through ICAP. this will take about 4 months; Awaiting a CAP/CTM 96 from Roche South Africa through a local vendor (this is a loan); centrifuges and refrigerators for lower facilities e.g. Mini Labs;
- Improve the frequency of NSTS trips (PEPFAR through ICAP to support with 4x refrigerated vehicles)
- Decentralization of viral load testing and other tests- to regional laboratories and point of care viral load for Mini Labs
- Develop training modules for Health workers, couriers & drivers.
- Introduction of a Shift system (12 hour). It will be a phased approach.

Groundbreaking News

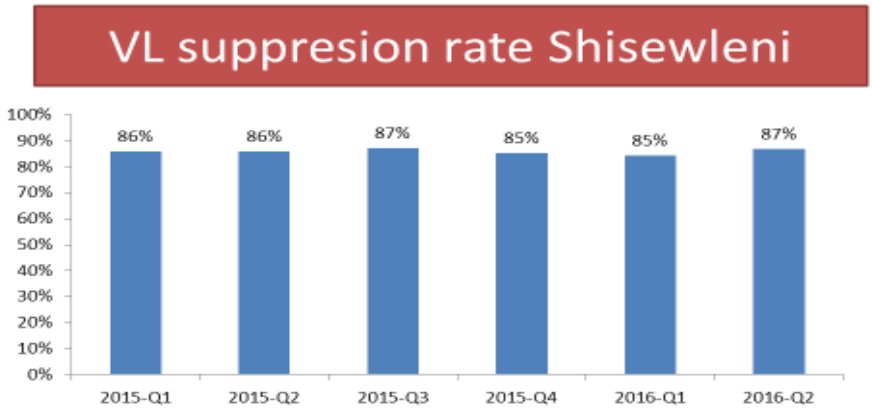
DBS Verification study which was an initiative of the ministry of Health was completed.

Both plasma and DBS samples were collected from the Mbabane Government VCT Clinic and processed. The results show a good correlation between the DBS results and the Plasma results. Venous DBS viral load results and finger prick DBS viral load results are comparable to plasma viral load results.

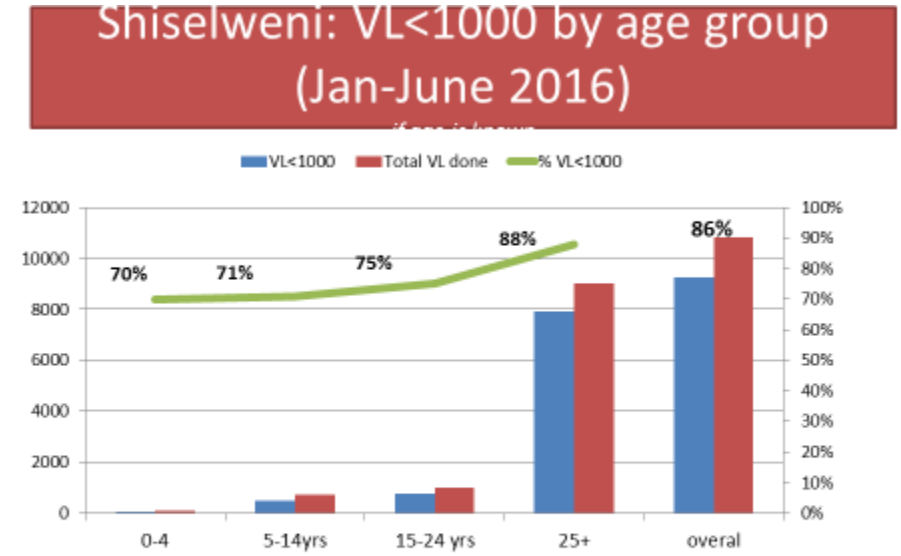
Conclusion

DBS can be introduced as an alternative sample for viral load testing especially in harder-to-reach areas and for children. Introduction of DBS as an alternative specimen will expedite the rollout of routine viral load testing services to include access to infants and patients from hard to reach health facilities with minimal regular sample transportation.

REGIONAL IMPLEMENTATION TOWARDS REACHING TARGET 3rd 90



YearQuarter	VL>1000	VI<1000	TOTAL
2015-1	571	3493	4064
2015-2	820	5012	5832
2015-3	461	3106	3567
2015-4	971	5676	6647
2016-1	1000	5452	6452
2016-2	598	3973	4571
Grand Total	4421	26712	31133



	Total VL done	VL<1000	% VL<1000
0-4	100	70	70%
5-14yrs	710	503	71%
15-24 yrs	998	752	75%
25+	9026	7938	88%
overal	10834	9263	86%

SUMMARY OF LESSONS AND RECOMMENDATIONS FROM THE FIELD

- MSF in the Nhlangano Health Centre is implementing viral load monitoring using a Biocentric machine and performs tests in plasma.
- Continuous Quality Improvement (CQI) for viral load monitoring
- Printing of tools and training of healthcare workers (Viral Load (VL) register and high Viral Load form, stepped up counselling and SOPs)
- Develop and or adapt Viral load counselling job aids

- Use SMS reminder for clients with unsuppressed VL result to return to facilities for speedy action.

SUMMARY OF DISCUSSION TOWARDS MEETING THE 3rd 90:

- Demand creation on VL & transition from CD4 to VL: Patient literacy & Community; Health care workers (including interpretation of results); PLHIV & support groups; Pediatric, Adolescent & pregnant women
- System for collection, Turn Around Time (TAT) & results utilization-Decentralization of VL testing & distribution of results to Regional laboratories (Regional lab hub to expand functions to VL & distribution of results); Point Of Care (POC) VL in Mini Labs; Linking to Laboratory Information System (LIS) to Client Management Information System (CMIS); Improve access to lab networks and SMS system for return of viral load result to facilities & transition to patients
- Optimizing existing system in sample transportation greater involvement of regional partners in results delivery
- Shift to Dried Blood Spot (DBS) specimen collection
- Equipment: Optimizing current use of VL machine; Procurement of VL to meet demand; Follow up on WHO guidance on use of the geneXpert machines to optimize usage of the equipment; Equipment downtime & timely maintenance of equipment; Greater involvement & engagement of Biomed
- Adherence & Retention & Wellness : Step up adherence counseling and Engagement of patients in their care
- Tracking (Data & Monitoring): Recording & reporting tools and Adaptation of key indicators
- Supplies: Quantification ; Procurement and Funding
- Human Resources: Shift system to improve lab capacity ; Development of Competencies & skills (lab & Facilities)- training, mentoring; Increase HR numbers & skills mix; task shifting & task sharing

FAMILY PLANNING (FP)

The Sexual and Reproductive Health (SRH) Family Planning Officer, Ms Lindiwe Malaza, presented the Family Planning/HIV Integration updates. Approximately one in four women in sub-Saharan Africa have an unmet need for family planning, and women living with HIV have even more limited access to family planning and reproductive health services than the general population. Ensuring all women living with HIV have access to these services can significantly reduce unintended pregnancies, maternal deaths (including those related to HIV) and new pediatric HIV infections. Choosing the number, timing and spacing of children is a basic right of all women and couples, no matter their HIV status.

SRHU recognizes that integrating HIV and family planning activities provides opportunities to simultaneously reduce the incidence of HIV and AIDS and the unmet need for family planning. Integration activities will contribute to the achievement of an AIDS- Free Generation. Priorities for the 90 90 90 goals

•Strengthen FP/HIV integration at all level of care.

•FP / HIV test and treat strategy, (Dual method & Dual protection)

•New competency based FP training for service providers.

•Family Planning campaigns- FP demand creation including information dissemination on the importance of FP and HIV prevention.

•Promote long term methods of FP (IUCD, Implants).

SWAZILAND NATIONAL NETWORK OF PEOPLE LIVING WITH HIV AND AIDS (SWANNEPHA)

SWANNEPHA Executive Director, Mr. Dumisani Simelane, presented the programmes strategies for engagement of PLHIV in HIV management. SWANNEPHA is a Network of People Living with HIV and AIDS made up of member organizations namely: SASO, Women Together, Membatsise and Imphilo Isachubeka. SWANNEPHA works with 250 Support Groups. SWANNEPHA represents the interest and rights of PLHIV through lobbying, coordinating and building their capacity for meaningful involvement in the HIV response.

SWANNEPHA contribution to 90-90-90 targets cuts across the cascade of HIV Prevention and Treatment education, Care and Support.

Some of the challenges that were cited involve:

- Stigma and discrimination is still a major challenge within the community, there is need to engage community members in training them to be able to separate personal values and providing support to both infected and affected PLHIV.
- Men present late at health facilities and those that are living with HIV (with advanced viral load as they consult traditional practitioners) and are more likely to die on ART which places the burden of HIV care and support on women.

Recommendations

- There is need to strengthen the relations between clinic administration and community leadership for a holistic approach in addressing community challenges regarding accessing health care services for PLHIV.

KEY POPULATIONS (KPS)

SNAP Key Populations Programme Officer Ms Sindi Matse presented the key populations updates. The presenter noted that stigma leads to lack of disclosure, which leads to lack of social support which leads to challenges in ART adherence which leads to an increased burden of HIV. The program officer gave an overview of the KP program priorities which included:

- Demand creation for uptake of services: through peer education program; community mobilization and promotion and distribution of condoms and lubricants
- Improve access to services through addressing stigma and discrimination in health facilities through mobile outreach; trainings; peer navigation program for linking clients to care and treatment
- Strengthen the KP M&E system to capture IDU,SW & MSM (CMIS)

ANNEX 1: QUESTION AND ANSWER SESSIONS FOR REGIONAL PARTNER PRESENTATIONS

Discussion (Question and Answer) session on the Hhohho Regional presentation by EGPAF (AIDSfree)	**Question:** Most partners are struggling with positive yield, what are the strategies that we are employing to get the positives? What investments are given to demand creation especially at community level? Are there any differences for SRH integration models? **Question:** When you say these were the targets for testing, is it for the region or the site you support? **Response:** It is for the PEPFAR supported sites and it is about 70%. However the denominator is for the whole region.
Discussion (Question and Answer) session on the Lubombo Regional presentation by URC	**Comments**: The issue of yield needs to be looked at especially in the context of the 90-90-90 targets, so there are strategies that we need to look at to get those people and we need to look at our guidelines and the issue of duplication. **Drought impact assessment** – In the preliminary report of the assessment, there is a section on health services. For most of the indicators used there is minimal change on patient flow. There was a slight increase in defaulting but this could be because the assessment was done early. • Drought is monitored in Lubombo and the most affected facilities which include Good Shepherd and Manyeveni are supported with food. • Tracking the number of patients with missed appointments is done in 11 facilities. • Observations were made on how the facilities are prepared for drought conditions. Only 33 out of 40 had back up tanks. **Comment:** We all have to work and build capacities of the RHMTs for coordination of all the activities in the region and take the lead. **Comment:** There is a need to strengthen the coordination of mother-baby care within facilities. **Demand creation**- working with facilities to work with clinic community teams. **In terms of Linkages** –each facility has a facility focal person and there is feedback to partners. **Intra-facility referral** - expect clients escort clients to the initiation department. **Inter-facility referral** - there are facility focal people who follow-up to ensure that the patient has been enrolled in pre-ART. **Service integration** – Communicable Diseases Health Service Delivery (COMDIS-HSD) is an NGO at Good Shepherd delivering services on NCDs.
Discussion (Question and Answer) session on the Manzini Regional presentation by ICAP	**Recommendation:** Please disaggregate data by sex what is done to strengthen intra and inter regional linkage. **Question:** Is there room for accreditation for new sites under PEFAR support? **Response**: There is room as we continuously review our statistics to identify the need for identification.
Discussion (Question and Answer)	**Suggestion:** Please share the best practices for community models which we can learn as a country. **Recommendation:** Map all the partners working in the region

session on the Shiselweni Regional presentation by MSF	**Comment:** Treatment clubs work mostly in rural areas and started with support groups mostly in facilities. **Responses:** • In terms of drought food parcels are given to people on treatment. • There is not much impact on malnutrition. **Comment:** IEC material distributed and sensitised the staff inside the facilities so that everyone new on the activities **Comment:** The targets around the 90-90-90 cascade need to track the progress of the regional partners.

HIV Investment case

Agenda item	Discussion
Discussion on the HIV Investment case	**Question:** The aspect of empowerment for young girls is not clear. How best can they be empowered? **Response:** We have the National Operational Plan in which all these strategies have actions. For example we are working with the Ministry of Sports, Culture and Youth Affairs to consider introducing youth voluntarism national services because most of these youth are idle and so there is a lot of idle sex. We need to keep the youth under economic activity so that there is no time to get idle. Both the government and private sector will take on some of the youth. **Comment**: Girls need to understand who they are. Women should not act like they have the right to receive from men. They must stand on their own and be independent. **Comment:** In 2015, as a country we did about 28,000 viral load tests which were mostly targeted. However even though they were targeted, we still managed to achieve 80% suppression. **Comment**: The data source for PMTCT, It needs to be updated since the data presented is for 2013. **Response:** We will be working with the M&E department to update the data annually. **Question**: What resources are there for community systems? And what is NERCHA offering for community systems? **Response:** There is a budget from Global Fund for the community systems. The resources are organised at regional level by bringing the partners together and NERCHA supports the different small activities. Community systems are organized through the regional coordinators. The four regional coordinators run community planning sessions with partners.

ACKNOWLEDGEMENTS

SWAZIS AND AMERICANS IN PARTNERSHIPS TO FIGHT HIV/AIDS
PEPFAR
URC

SIYINQABA
MOH
HIV /AIDS
SNJAP

CDC
SAFER • HEALTHIER • PEOPLE

AIDS Free
Strengthening High Impact Interventions for an AIDS-free Generation

ICAP
COLUMBIA UNIVERSITY
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unicef

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MAX ART
For Better Health and Zero New HIV Infections

ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

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Healthy lives. Measurable results.

KUDVUMISA FOUNDATION
Help for the Helpless

CANGO
Change · Growth · Empowerment

SWABCHA
Swaziland Business Coalition on Health & AIDS
Healthy Worker, Healthy Business

SWANNEPHA
SWAZILAND NATIONAL NETWORK OF PEOPLE LIVING WITH HIV/AIDS
Swannepha Organisation

SAFAIDS
Southern Africa HIV and AIDS Information Dissemination Service

UNIVERSITY OF SWAZILAND

TASC
Treatment Alternatives for Safe Communities

msh
Management Sciences for Health

CABRINI MINISTRIES
ST. PHILIP'S MISSION
...Restoring life

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ANNEX 2: WORKSHOP AGENDA

HIV HEALTH SECTOR PARTNERS COORDINATION FORUM

DATE: 30th-31st August 2016 **VENUE**: Happy Valley Hotel

TIME	ACTIVITY
30TH AUGUST 2016 **Programme Directors:** *Mr. Muhle Dlamini & Dr. Marianne Calnan* **Rapporteurs**: *Ms Lenhle Dube, Ms Linda Dlamini, & Ms Nokuthula Mdluli*	
08:30-09:00am	Registration
09:00-09:20am	**Objectives of the meeting & Overview of HIV partners Forum** : *Mr Muhle Dlamini*
9:20-09:45am	**MoH goals on HIV response and SNAP 2016 key priority activities and interim results**: *Dr Nomthandazo Lukhele*
09:45-10:45am	**Achieving the 90-90-90 targets and Ending AIDS** :*Dr Munyaradzi Pasipamire*
10:45-11:05am	**TEA BREAK**
11:10-12:00am	**REACHING TARGET 1**: *90% of all people living with HIV will know their HIV status (90% diagnosed)*: Strategy, cutting edge and ground breaking interventions • **HTS and testing models including self-testing** (15 mins): *Ms. Lenhle Dube* • **Voluntary Medical Male Circumcision** (15 mins*): Mr. Vusi Maziya* • **Condoms** (15 mins): *Mr. Muziwethu Nkambule & Ms Lindiwe Malaza*
12:00 noon-12:30pm	Discussions
12:30pm-13:15pm	**REACHING TARGET 2**: *90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy* (90% on HIV treatment): **Strategy, cutting edge and ground breaking interventions** • **Test and start** (15 mins) -*Dr Nomthandazo Lukhele* • **PMTCT** (15 mins) -*Dr Smangele Mthethwa* • **ART delivery Models** (15 mins) -*Dr Munyaradzi Pasipamire*
13:15pm-14:15pm	**LUNCH**
14:15pm-14:45pm	Discussions
14:45pm-15:15pm	**REACHING TARGET 3**: *90% of all people receiving antiretroviral therapy will have viral suppression (90% suppressed)*: **Strategy cutting edge and ground breaking interventions** • **Viral Load monitoring** (15 mins) - *Ms Sindi Dlamini* • **ART Supply Chain** (15 mins) - *Ms Pholile Maphalala*
15:15pm-16:`15pm	Discussions
16:15-16:30pm	Way forward & closure
31st AUGUST 2016 **Programme Directors**: *Dr. Nomthandazo Lukhele, Dr. Welile Sikhondze* **Rapporteurs**: *Ms Lenhle Dube, Ms Linda Dlamini, & Ms Nokuthula Mdluli*	

TIME	ACTIVITY
08:30-09:30am	**HIV Investment case**: *Ms Nokwazi Mathabela*
09:30- 10:30am	**Regional HIV response & progress towards achieving the 90-90-90 targets and strategic goals** by Regional AIDS Coordinator, Regional M&E & Regional Lead Partner • Hhohho (15 mins) –*Dr. Caspian Chouraya* • Lubombo (15 mins)- *Dr Marianne Calnan* • Manzini (15 mins)-*Dr Pido Bongomin* • Shiselweni (15 mins)-*Dr Serge Agbo*
10:30-11:00am	**TEA BREAK**
11:00-12:30	**Integration of HIV towards achieving the 90-90-90 targets and strategic goals** Family Planning (15 mins) – *Ms Lindiwe Malaza* SWANNEPA (15 mins) – Key Pops (15 mins) - *Ms Sindi Matse* National Health Research Agenda – Zandile Mnisi
12:30-13:00pm	Plenary
13:00-14:00	LUNCH
14:00- 15:00	**GROUP WORK** - *Ms Allen Waligo* *Group 1: First 90* *Group 2: Second 90* *Group 3: Third 90*
15:00-15:30	Discussions
15:30-15:45	Closing Remarks – *Mr Muhle Dlamini*
15:45-16:00	Closure