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Strategic Information Department

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CHAI	Clinton Health Access Initiative
CIHTC	Client-Initiated HIV testing and Counseling
DBS	Dried Blood Spot
DNA PCR	Deoxyribonucleic Acid Polymerase Chain Reaction
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
EID	Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
M&E	Monitoring and Evaluation
MC	Male Circumcision
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MSF	Médecins Sans Frontières
NRL	National Reference Laboratory
NSF	National Multisectoral Strategic Framework on HIV and AIDS
PEPFAR	US President's Emergency Plan for AIDS Relief
PIHTC	Provider-Initiated HIV Testing and Counseling
PMTCT	Prevention of Mother to Child Transmission [of HIV]
PSI	Population Services International
QI	Quality Improvement
SAM	Service Availability Mapping
SDHS	Swaziland Demographic Health Survey
SHIMS	Swaziland HIV Incidence Measurement Survey
SID	Strategic Information Department
SNAP	Swaziland National AIDS Program
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infections
TASC	The AIDS Information and Support Centre
TB	Tuberculosis
VCT	Voluntary Counseling and Testing

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EXECUTIVE SUMMARY

Each year, close to 200 000 HIV antibody tests are performed at public and private clinics in Swaziland. According to the Health Management Information System (HMIS), 205 health facilities reported to provide HIV testing and counseling (HTC) services in the country during 2012. From the Swaziland Demographic and Health Survey 2006-2007 (SDHS), HIV prevalence stood at 26% for the 15-49 year age group and 19% for the general population. Since 2006, a dual approach (provider- and client-initiated) to HTC has been followed, which vastly contributed to increased HTC coverage. HTC Guidelines were reviewed in 2010, following a shift from voluntary testing to the dual approach. The guidelines were aligned to other program guidelines, such as those for the prevention of mother-to-child transmission of HIV (PMTCT).

HTC data from the HMIS were extracted and imported into STATA 12 for analysis. In line with the National Strategic Framework on HIV and AIDS 2009-2014 (NSF), this report provides information on progress towards HTC program targets and objectives set for 2012. This report aims to inform policy and be useful to program managers, partners, implementers as well as the public at large.

HTC is offered in health facilities, free standing HTC sites as well as in outreach services. In 2012, Swaziland witnessed a dramatic scale up of HTC in the country, through the combined approaches of Provider-Initiated HTC (PIHTC) and Client-Initiated HTC (CIHTC). The Swaziland National AIDS Program (SNAP), through the HTC Unit and its supporting partners, have implemented many actions to scale up HIV testing through both approaches. Focus areas in 2012 included:

- Increase outreach testing as part of community mobilization efforts
- Improve PIHTC by employing HTC Counselors in high-volume facilities, and implementing a set of PIHTC standard operating procedures
- Continued efforts to increase male circumcision, especially for young males (10-14yrs)
- Expanded training in PIHTC, CIHTC, and Couples' HTC
- An increase in targeted mentoring on HTC at health facilities
- Improved coordination at national, regional, and facility level

These programmatic initiatives have yielded impressive results, including:

- A dramatic increase in overall testing: In 2012, a total of 252 678 HIV tests were performed up from only 180 000 in 2011.
- Testing in outpatient units increased by almost 150%, from 24 184 to 59 477 tests.
- Testing in family planning settings increased from 1 067 to 6 031 tests
- Innovative strategies to reach men and adolescents have improved access to services and increased the number of HIV tests provided for men and adolescents (men increased from 56 839 in 2011 to 74 194 in 2012 and adolescents from 62 166 in 2011 to 85 461 in 2012).
- Over 99.8% people tested received their test results.

Despite major successes, some barriers exist for continued work in 2013, including:

- Testing in the workplace-there are currently no data available in the country to depict testing in the work-place
- Couples Testing-Data on couples testing is also insufficient as the only data available is on PMTCT partners (which increased slightly from 608 in 2011 to 774 in 2012)
- Inpatient HTC is still a challenge. Only 2 121 inpatient HIV tests were performed during 2012.
- Pediatric and adolescent testing, except for the first DBS test for infants, is still lagging behind. Consent remains a challenge.
- Sensitization on PIHTC, both for the public and in terms of changing health care worker attitudes, needs to be strengthened.

To improve on the aforementioned challenges, the program, in collaboration with its partners, will continue to monitor trends and develop and implement new strategies.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

HIV testing is integral to HIV prevention, treatment, and care efforts. HIV testing and counseling (HTC) is the gateway to HIV prevention, treatment and care. Early knowledge of HIV status is also important for linking those with HIV to medical care early and those HIV-negative to prevention services, both of which can reduce morbidity and mortality and improve quality of life.

In 2006-2007, the Swaziland Demographic Health Survey (SDHS) found that HIV prevalence was 26% amongst the adult population (15-49 yrs) and 42% among pregnant women (SDHS 2007). The 2011-2012 Swaziland HIV Incidence Measurement Study (SHIMS) showed that HIV prevalence among 18-49 year olds was 31%, relatively stable from the 2006-2007 SDHS measure which included 15-17 year olds. Incidence of HIV was found to be 2.38% (SHIMS 2012). The HIV testing rate has increased over the years among the general population, moving toward targets set in the National Strategic Framework on HIV and AIDS 2009-2014 (NSF). With the aim of reaching 55% for women and 45% for men by 2015, the 2010 HIV testing rates were 47.3% among women and 31.3% among men in 2010. The Ministry of Health (MOH), their partners and other stakeholders continue to explore innovations and strategies to further promote HTC among women and especially men.

As defined below, Swaziland implements both of the WHO recommended approaches to testing: client-initiated HIV testing and counseling (CIHTC) and provider-initiated HIV testing and counseling (PIHTC).

> *CIHTC: HTC services where people actively seek testing. This may be a stand-alone service or part of a clinical service, in the workplace or a youth center. Some countries use the term voluntary counseling and testing (VCT) to describe CIHTC services.*
>
> *PIHTC: HTC services where as a standard of medical care, healthcare providers routinely recommend testing to people attending health facilities. This may be part of general medical services or special services, for example, for people attending clinics for tuberculosis (TB), sexually transmitted infections (STI), antenatal care (ANC) or family planning.*

Below is a brief description of the focus areas within each approach during 2012.

1.1.1 Client Initiated HIV Testing And Counseling (CIHTC)

The Ministry of Health (MOH) strives to tailor its HTC services appropriately for men, women and children. Based on the evidence, special effort is being made to encourage testing among men as a population with fewer regular encounters with the health care system and as leaders in their families and communities to set a positive example by knowing their HIV status through the "A Man Knows" campaign. Different strategies used at community level to increase HTC access include dip tanks, campaigns at the chiefdom level, workplace programs, mass testing campaigns, door-to-door and bus rank outreach.

1.1.2 Provider Initiated HIV Testing And Counseling (PIHTC)

PIHTC, where health workers offer an HIV test to all individuals coming into the health facility regardless of disease condition, has been part of the county's national HIV policy since 2006. In 2012, the MOH made a significant effort to scale up PIHTC throughout the country. To normalise HTC, this service is offered in line with other laboratory tests. In 2012, PIHTC was scaled up through deployment of HTC Counselors in high-volume facilities, implementation and training on the PIHTC standard operating procedures (SOP), and on-going mentoring and site supervision to improve testing volume and quality.

1.1.3 HTC Guiding Principles

HTC should be offered to all individuals who do not already know their HIV status. The guidelines clearly state that the "Three Cs" of counseling, confidentiality, and informed consent should be followed at all times. The MOH expects that trained HTC providers in all health facilities and community testing sites follow these guidelines. Informed consent, states that all individuals should be informed of the benefits of testing and have the right to refuse an HIV test without being refused access to any other health service.

CHAPTER 2: PROGRAM DESCRIPTION

2.1 Policy On HTC

According to the HIV and AIDS policy, HTC will be made available to all persons. Individual consent shall be sought from persons over the age of consent (18 years) or from parents or guardians for children under the consenting age. The policy highlights the promotion and encouragement of couples' counseling and partner disclosure as well as routine PIHTC.

In Swaziland, HTC is offered at both in-patient and out-patient service points and through stand-alone clinics and outreach mobile units. The first guidelines on HTC were developed in 2004 and were reviewed to integrate PIHTC in 2010. The HTC process includes pre-test counseling and the provision of test results after post-test counseling. HIV testing is mandatory only for blood donated for transfusion.

Early Infant Diagnosis (EID) was initiated in Swaziland in 2007. EID is part of an effort to scale up early initiation of antiretroviral therapy (ART) among children in need of treatment as one of the key strategies is to minimise HIV-related infant mortality the country. Infants are tested for HIV through Deoxyribonucleic Acid Polymerase Chain Reaction (DNA PCR) from six weeks.

2.2 Existence Of HTC Guidelines.

Sound policies and guidelines are basic inputs for ensuring that HTC sites operate in an enabling environment as defined by international and country standards. Clear guidance is required on provision of quality, ethical and rights-based services. All health facilities and sites adhere to the National HTC Guidelines, developed by the HTC program and its partners. A copy of these guidelines is expected to be found at each entry point, with supporting algorithms on how HTC should be conducted.

2.3 HTC Standard Operating Procedures (Sops)

The SOPs are aligned to the existing HTC guidelines and HIV/AIDS policy and provide guidance on the procedures and standards for providing comprehensive HTC services in the country. The SOPs also ensure uniformity of HTC service delivery at all levels. SOPs are in place for PIHTC, home-based HTC, CIHTC and EID.

2.4 HTC Coordination

The **"three ones"** principle guides the coordination of the HTC program:

- One National Coordinating Body,
- One National Strategic Framework
- One National Monitoring and Evaluation Framework (where everybody offering HTC services is expected to submit their data)

The Swaziland National AIDS Program (SNAP) is the coordination body for all HTC services within the MOH. This office is tasked with the responsibility of leading the periodic review of all HTC activities and documents. The SNAP office is supported by a national core HTC team comprising technical and implementing partners and the regional AIDS coordinators.

2.5 Human Resources And Training

The SNAP oversees all HTC trainings in the country. These trainings are provided by the SNAP office and National Reference Laboratory (NRL) in collaboration with HTC implementing partners. The country has developed a standardised training curriculum to which every HTC trainer should adhere. All HTC service providers undergo training and practicum to obtain a certificate of competence. HTC services are provided by both health care workers and non-health care workers. For non-health care workers, training is provided by two MOH-accredited bodies, Population Services International Swaziland (PSI) and The AIDS Information and Support Centre (TASC). Only the NRL provides training on the HIV laboratory section in accordance with the national HTC algorithm. Health care providers working within child welfare services are also trained on EID.

2.6 Quality Assurance

Quality assurance activities in an HTC setting are essential to ensure the provision of quality counseling and accurate, reliable HIV testing. The quality of counseling impacts on a client's decision to test or not to test as well as how the client copes with the test results. The following activities are undertaken to ensure high standard of quality in HTC settings.

- Regular laboratory and point of testing site visits
- Proficiency panel tests
- Rapid HIV testing and DNA PCR refresher trainings
- Re-testing of samples from HTC sites.

- Cold chain management
- Documentation and dissemination of quality assurance assessment reports
- HIV testing register review
- Sample storage and transportation logistics.
- Client satisfaction measuring tools
- Quality assurance tools
- Sit-in counselor observations and supportive supervision for counselors
- Counselor care

2.7 Testing Algorithms

Both rapid HIV tests and DNA PCR for Dried Blood Spots (DBS) are used. ELISA tests are often used for quality assurance on samples that are sent to the NRL or for inconclusive results. For antibody tests the country currently uses the Determine HIV1/2 for sensitivity and Unigold HIV1/2 for specificity. As per the algorithm for antibody testing, the first test is the Determine HIV 1/2. If the HIV test is positive, it is then confirmed using the Unigold HIV 1/ 2. Where the test is inconclusive, the sample test is sent to the NRL for ELISA. For virological testing, the DNA PCR using DBS is used as it is >96% sensitive at detecting HIV in infants from as early as four weeks after birth.

2.8 Referral And Linkages

Referral to care and treatment or to prevention services is key in HTC. All HTC clients should be referred to relevant services after an HIV test. For HIV positive clients, it is mandatory that all clients are referred to Pre-ART services and all HIV negative clients receive prevention services, including male circumcision (MC) for men. The HTC provider is responsible for ensuring that referral forms reach the referral facility.

2.9 Data Management And Monitoring And Evaluation

All sites providing HTC services are expected to report through the national Health Management Information System (HMIS). There are registers in all HTC sites which are to be filled in by the service provider each time an HTC client is seen. These registers are in triplicate and at the end of each month, sites tear off the two perforated sheets and send them to the regional strategic information office. At the regional office, the data are entered to create monthly collations. Quarterly, regional offices are expected to present and dissemiate a report to the sites as feedback. At national level, the M&E unit also presents a quarterly report and shares with the national HTC program, the Directorate and partners. Annually, the national M&E program, the HTC program and its partners consolidate cumulative reports to present the national HTC annual progress report.

The annual report encompasses all components of the HTC program as highlighted in the HTC strategic documents. It also highlights progress towards desired outputs and outcomes. HTC components include social mobilization, advocacy and communication, health systems and M&E.

As noted earlier in this document, outcome and impact indicators are mainly informed by population-based surveys due to the complexity in measuring the actual numbers of people tested as well as follow-up and linking tests to individuals. As a result, this report focuses mainly on output indicators as intermediate results. This report aims to address the following M&E questions:

1. Was there an increase in the number of tests performed from 2009-2012 as targeted by the NSF?
    - Did the number of male and female adults (15+ years) receiving HTC increase over time? And if so, what were the annual increments?
    - Did the number of HIV tests performed among children increase over time? And if so, what were the annual increments?
2. Was there an increase in the number of testing sites?
    - Were there new testing sites added over the years?
        i. Was there an increase in PIHTC?
            1. Was there an improvement in HTC at inpatient facilities?
            2. Was there an improvement in HTC at other entry points?
        ii. Was there an increase in CIHTC?
3. What were the strategies implemented to scale up HTC uptake over the years?

3.1 Introduction

This section of the report presents a summary of HTC data from the HMIS (reporting HTC sites); EID data from the NRL and program records. The report focuses on data collected from 1st January 2012 to 31st December 2012. For ease of analysis, data from the HMIS for infants using DNA PCR were removed from analysis and replaced by EID data from the NRL (analysed separately). All data was imported to STATA version 12 for analysis.

Consultative meetings with stakeholders, implementers and partners preceded the finalization of this report. This report is a result of rigorous coordinated effort by the HTC program, the Strategic Information Department (SID) of the MOH, CHAI, TASC, Médecins Sans Frontières (MSF) and PEPFAR Implementing partners (IHM, EGPAF, and PSI).

3.2 Scope Of Analysis

The level of analysis in this report is of a descriptive nature as it assesses program progress. Data are presented to depict a national picture and to portray regional and further disaggregation where possible and helpful.

3.3 Limitations

The program acknowledges the challenges faced in data collection, which include late reporting (as some sites had not reported at the time of writing this report); not being able to report on the actual number of people tested, but only on the numbers of tests performed; and, that some sites offering HTC services either do not report at all or under report.

During data analysis, three different data sets were used because routine HIV testing data are not linked to the databases capturing DBS and MC. Another challenge in data processing is incompleteness of records with some missing age of HTC client, sex or region as well as HIV status.

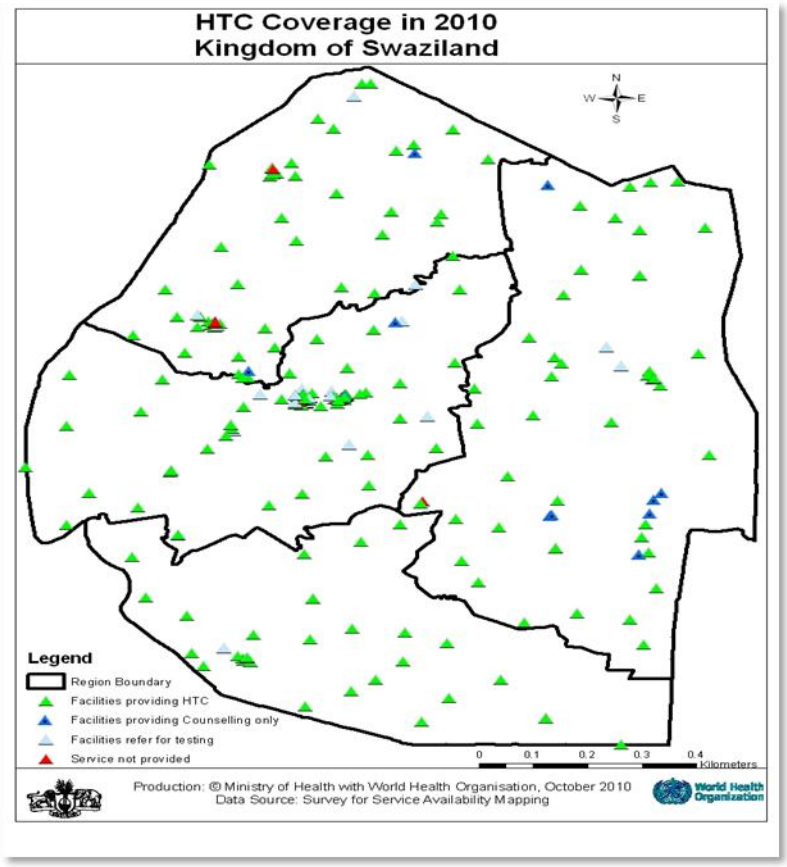
3.4 Program Outcomes For 2012

3.4.1 Service Availability: Facilities That Offer HTC Services

HTC services offered at health care facilities, where they are integrated within routine health service delivery; at HTC free-standing sites; and, through mobile outreach. Data are derived from the Service Availability Mapping (SAM), which is conducted biennially. According to the 2010 SAM, 265 health facilities were available and of these, 205 (76%) reported that they offered HTC services. When compared with 2008 SAM, this shows an increase of over 90% (from 105 sites). There are seven free standing HTC facilities in the country.

For EID, services are expected to be integrated in all child welfare sites, however according to the 2010 SAM, 88% of child welfare sites were implementing EID. Data are not available on EID sites outside of child welfare facilities.

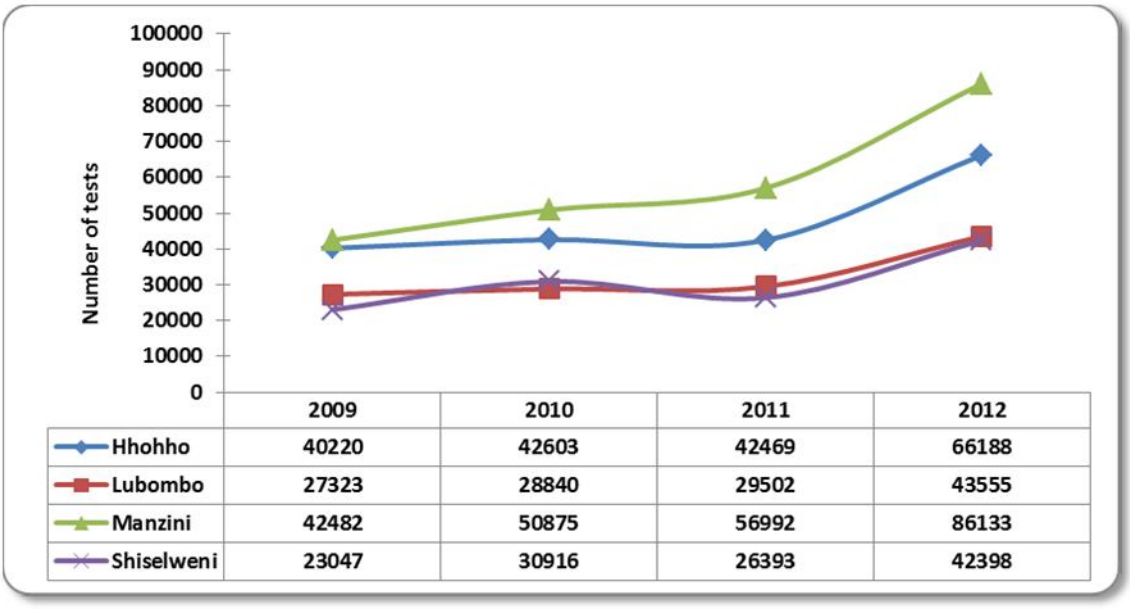
Figure 1: Health Facilities Providing HTC Services, Swaziland 2010



3.4.2 Trends In HIV Testing And Counseling (2009-2012)

As highlighted in previous sections of this document, HTC until 2006 was mainly client initiated. Results from the SDHS 2007 showed that only 26% of the population knew their HIV status. Through the review of the NSF, it was recommended that the focus include PIHTC. Since then, the country witnessed a tremendous increase in the number of tests performed. The figure below shows the national trend since 2009.

Figure 2: Trends In HIV Testing By Region, 2009-2012



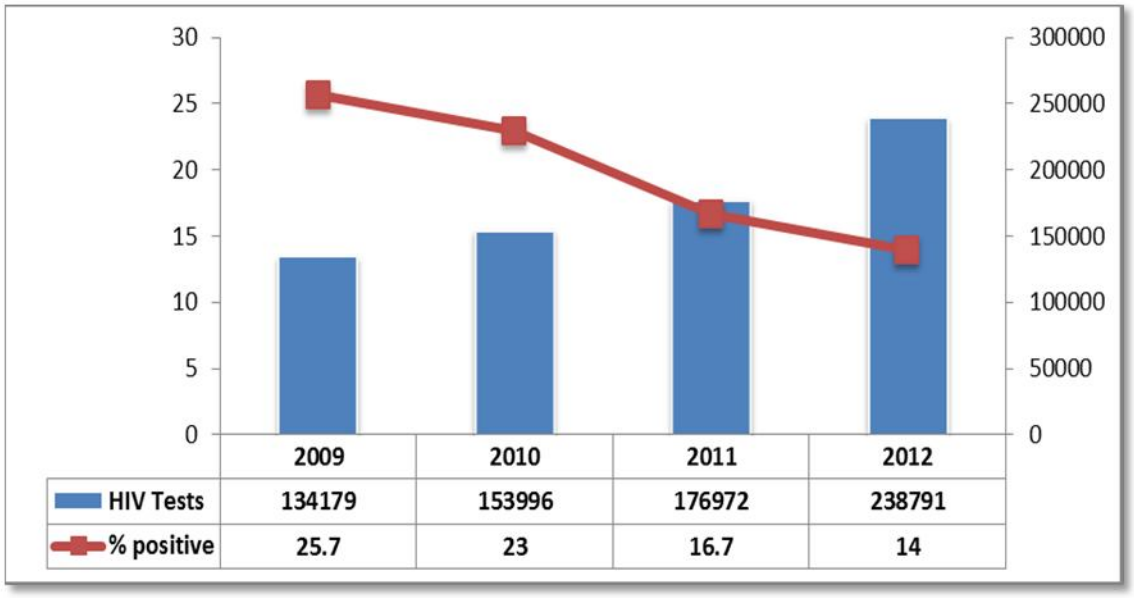
	2009	2010	2011	2012
Hhohho	40220	42603	42469	66188
Lubombo	27323	28840	29502	43555
Manzini	42482	50875	56992	86133
Shiselweni	23047	30916	26393	42398

The figure above also depicts trends in HIV testing at the regional level. Manzini reported the highest number of tests when compared with other regions, followed by Hhohho and the least tests reported were from the Shiselweni region. This has been the trend over the years and is in line with the distribution of the population.

The figure above presents the number of tests performed using antibody testing since 2009. It can be seen that there has been an increase in the number of tests throughout the years. In 2012 alone, 238 791 antibody tests were performed. This translates into about a 35% increase when compared to 2011. It should be acknowledged that these tests also include repeat tests. DBS results are analysed separately in the following section.

It is likely that the significant increase in the number of tests performed can be attributed to the efforts made by the HTC program and partners to scale up services and their uptake. These efforts include the huge focus on PIHTC and expanded outreach initiatives where teams go to communities to conduct door-to-door HTC. Other strategies for scaling up HTC in 2012 included training of lay counselors who were deployed in high volume testing facilities; training of health care workers on PIHTC and the "90 days fast-track campaigns" where communities were mobilised for 90 days to go for HIV testing.

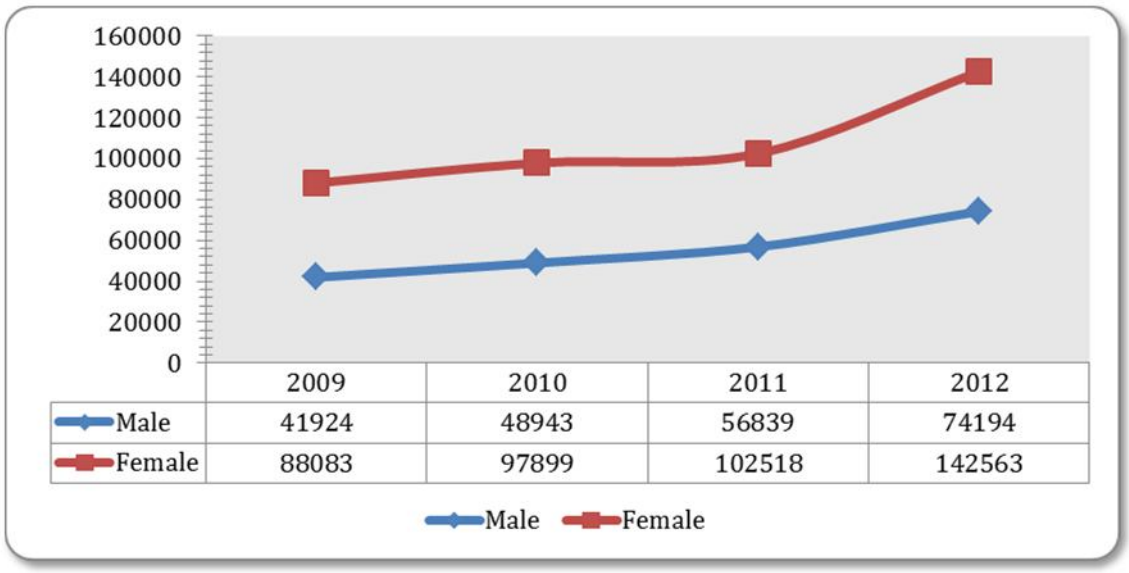
Figure 3: Antibody Tests Trends For Both Adults And Children; 2009-2012



The HIV positivity rate is declining among people tested for HIV. In 2012, the positivity rate is at 14%, showing a reduction of almost 3% when compared with the 2011 positivity rate (16.7%). The positivity rate however should not be confused with the HIV prevalence as the rate is based on tests, not people and only includes those people with a previously unknown or HIV negative status.

The data were further disaggregated by age and sex. The following graph shows the trends of HIV testing by sex for those 15+ years from 2009 to 2012.

Figure 4: Antibody Tests Trends For Adults Only By Sex, 2009-2012

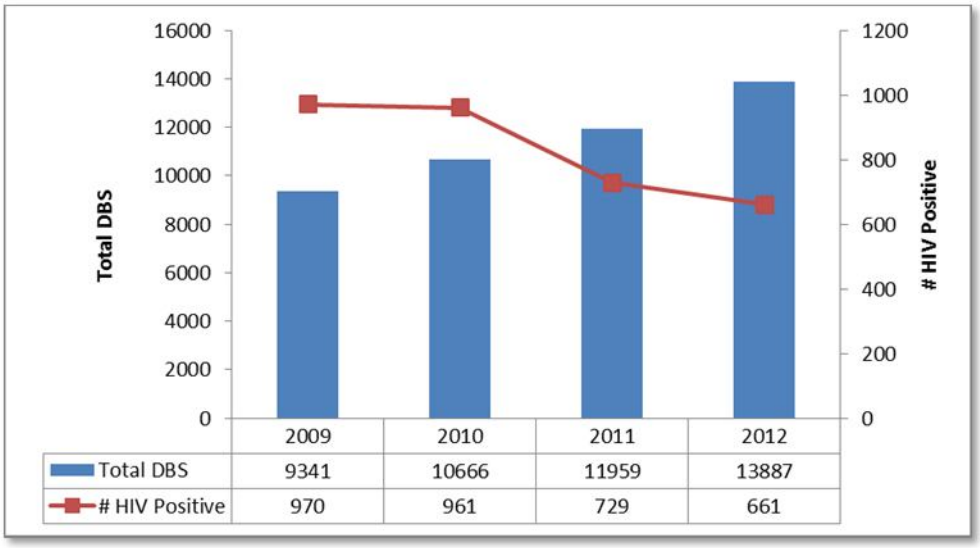


As shown above, HIV tests are increasing yearly for both females and males. What is worth noting is that there has been a steady gradual increase among female tests until 2012 where the increase rose significantly by more than 40 000 tests when compared with 2011. This sudden increase is likely due in large part to the change in PMTCT focus, leading to increased number of tests done during postnatal care and also the increase in door-to-door campaigns where mainly women are found to be at home. Door-to-door campaigns will need to be more strategic in order to reach more men (i.e., scheduled on weekends and holidays or even in work places).

Because of differences in health care seeking behaviour and women's access to reproductive health care, women generally test at a higher rate than do men. Despite this difference, an increase is also noted in the number of tests among men, from 56 839 to 74 194 between 2011 and 2012. This is attributed to the "A man Knows" campaign as well as various community-level campaigns that target adult and adolescent males.

DNA PCR is conducted at Child Welfare Clinics. The pediatric guidelines were reviewed in 2007 to incorporate EID. Since then, an increase in the number of infants tested for HIV from as early as 6 weeks has been documented. The following graph illustrates DNA PCR tests performed for children since 2009.

Figure 5: DNA PCR Tests Trends For Children, 2009-2012

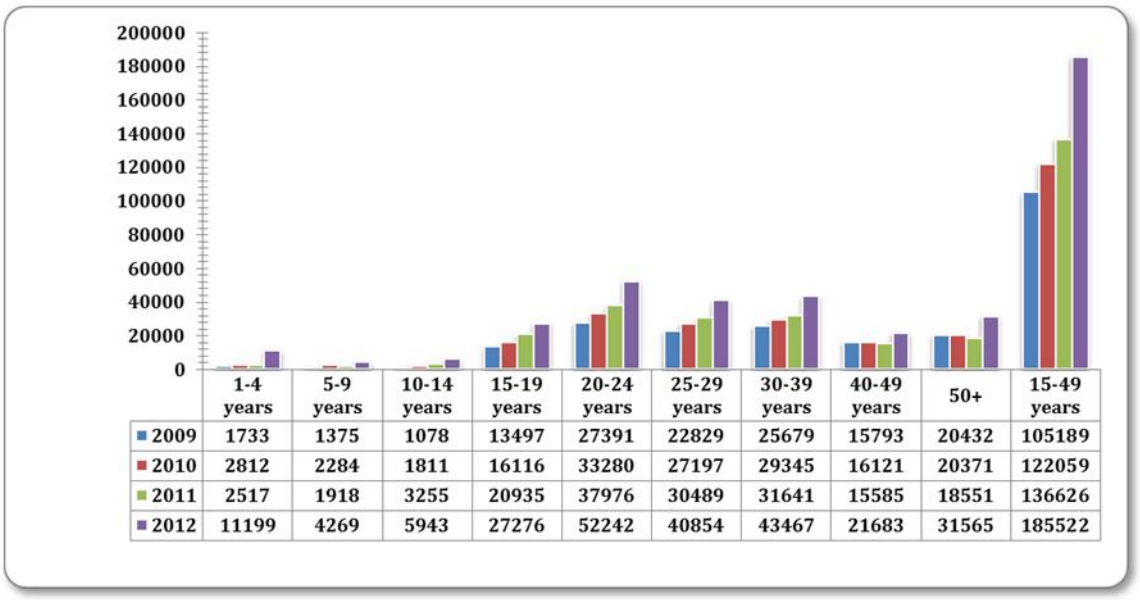


The figure above shows in bars the number of tests performed for children through DNA PCR since 2009. In 2012, 13 887 tests were performed compared with 11 959 performed in 2011. The limitation with the database is that the tests cannot be disaggregated by region as all tests are performed at the NRL. This does not mean that the limitation lies with the data collection tool but with the database itself as it does not have a variable for regional origin of the test.

As illustrated by the red line, the positivity rate has also been declining for children from 729 (5%) in 2011 to 661 in 2012 (4.8%). The guidelines demand that infants are tested at 6-8 weeks after birth, and retested throughout breastfeeding. An outcome result for infants is currently based on HIV estimates and projections. According to the 2010 Prevention of Mother to Child Transmission of HIV (PMTCT) guidelines, the country moved from 21.5% to 16.8% for children born to mothers living with HIV who test positive. Data from the EID database show that at 6-8 weeks, only 2% of infants test positive. Unfortunately, transmission continues through the breastfeeding period so the ultimate rate of MTCT is higher.

The figure below shows tests performed on the general population disaggregated by age.

Figure 6: Disaggregation Of HIV Tests By Age-Group; 2009-2012



	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25-29 years	30-39 years	40-49 years	50+	15-49 years
2009	1733	1375	1078	13497	27391	22829	25679	15793	20432	105189
2010	2812	2284	1811	16116	33280	27197	29345	16121	20371	122059
2011	2517	1918	3255	20935	37976	30489	31641	15585	18551	136626
2012	11199	4269	5943	27276	52242	40854	43467	21683	31565	185522

It can be seen that there is generally an increase in tests performed across all age groups. Of significant note is the testing among children below the age of five years (from 2 517 in 2011 to 11 199 in 2012); the age-group 10-24 years (from 62 166 in 2011 to 85 461 in 2012) and the age-group 50 and above years (from 18 551 in 2011 to 31 565 in 2012). Over the years, efforts to test the age groups 2-14 years and 50+ years have been very weak. Strategies to address HTC among adolescents were incorporated by the program in 2012 through the community campaigns, which contributed to increasing numbers for both adolescents and those over 50 years of age.

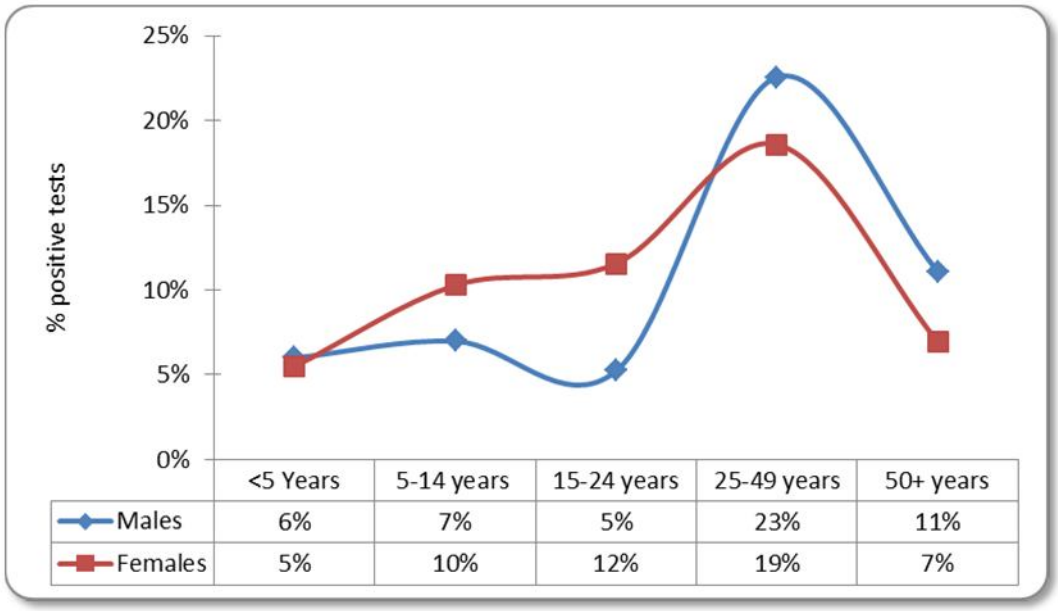
The following table shows the positivity rates by age group for the period 2012. This table has been simplified using the standard age groups normally used for national reports.

Table 1: HIV Testing Trends By Age Group, 2012

Age in years	Tests	Number of positive tests	%Positivity
<5 Years	11 199	816	7.3%
5-14 years	10 212	852	8.3%
15-24 years	79 518	7 826	9.8%
25-49 years	106 004	21 315	20.1%
50+ years	31 565	2 713	8.6%
TOTAL	238 498	33 522	14.1%
15-49 years	185 522	29 141	15.7%

The overall positivity rate for the 2012 tests is 14.1 per cent. From the table above, it can be noted that HIV positivity is highest for tests performed in the 25-49 year age group and lowest for tests performed in the <5 year age group. The 15-49 year age group have a positivity rate of 15.7 per cent. Tests performed for persons over the age of 50 years have a positivity rate of 8.6 per cent.

Figure 7: HIV Positivity Rates By Sex And Age Group, 2012

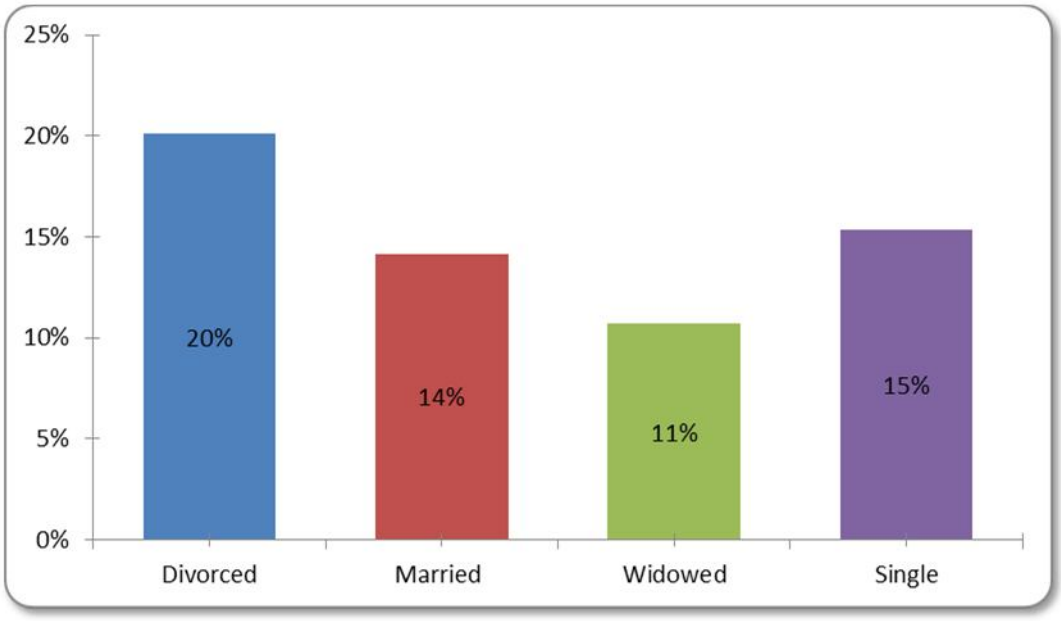


The figure above shows that the positivity rate for under 5 years age group is similar for both males and females, but increases at age group 5-14 years for females. This may signal the early sexual debut among female children, but this may also be attributed to the increase in number of sexual offenses involving female children. As females enter their reproductive years (age group 15-24 years) there is a significant increase in positivity among females (12%) when compared with their male counterparts (5%). This may reflect intergenerational sex between older males and younger females.

Age group 25-49 years shows a slight change, where men begin to have a higher positivity rate than their female counterparts (23% men and 19% women). This is mainly attributed to high sexual involvement among men and the burden of intergenerational sex, as a similar trend is notable from 25 years and above (even for those age 50 years and older).

Trends in HTC by marital status help to determine programmatic strategies for HIV prevention services. It can be postulated that marriage provides some safety net against HIV as it is expected that married are monogamous, but the 2012 data show that married people are also at high risk of contracting HIV. This is likely due to extramarital affairs (multiple concurrent sexual partnerships).

Figure 8: HIV Positivity Rate By Marital Status, 2012



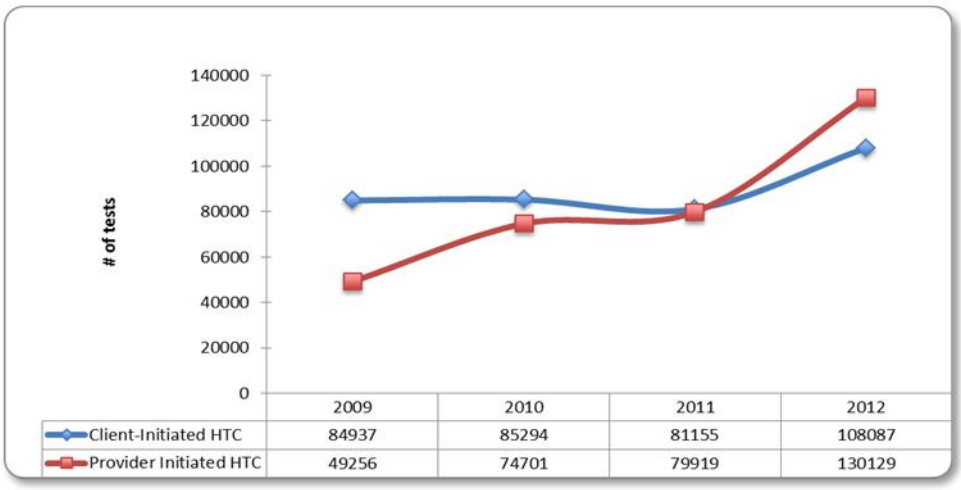
In the figure above, it may seem that the positivity rate was high among divorced persons, but there are too few people who were reported as divorced. The positivity rate was high among tests of people reporting a single marital status (15%), followed by people reporting that they married (14%). It should be acknowledged that the data for marital status is subjected to bias as it is self-reported.

3.4.3 HTC Points

This section of the report looks into the effectiveness of PIHTC and CIHTC in terms of service delivery as well as uptake of HTC in the different entry points for 2012. According to the 2012 HTC annual strategic plan, the main focus for the country is PIHTC as a complement to CIHTC aimed at reaching as many people as possible.

The following table shows the number of tests performed using each of the two HTC approaches.

Figure 9: HIV Testing By Approaches; 2009-2012



It can be noted from the figure above there was a shift in focus and more tests were performed through PIHTC in 2012. Looking at the figure above, it is also noted that the strengthening of PIHTC has brought about a rapid increase in the number of tests performed.

The table below shows HIV tests by the different entry points, 2009-2012

Table 2: HIV Tests By Entry Point, 2009-2012

Entry points	2009	2010	2011	2012
CIHTC/VCT	58 500	70998	66395	62 085
Clinic Referral	362	225	214	186
FP	627	1 147	1 067	6 031
Home-based care	101	2 404	559	33
In-Patient	734	1 585	1 766	2 077
MC	1 967	8 315	11 880	5 597
OPD	13 631	21 767	24 119	59 477
Outreach/Mobile	26 604	14 733	14 745	46 002
Post exposure prophylaxis (PEP)	132	176	189	195
ANC	20 198	25 049	30 510	34 867
Child Welfare	2 175	3 169	4 424	7 863
Maternity	3 391	1 209	667	820
Postnatal care	1182	2 796	4 761	6 450
PMTCT-Partner	383	454	605	773
STI	329	435	466	377
TB	4 128	6 148	4 821	5 383
TOTAL	**134 444**	**160 610**	**167 188**	**238 216**

There are 17 entry points defined in the HTC register. The table above shows trends in HIV testing at the different entry points since 2009. For ease of analysis, the program has defined the top eight entry points, which this section of the report will focus on. The selected entry points account for almost 80% of the tests performed in 2012 and are presented in the table below.

Table 3: HTC Summary Data From Selected Entry Points, 2009-2012

	2009	2010	2011	2012
CIHTC/VCT	58 500	70 998	66 395	62 085
Family planning	627	1 147	1 067	6 031
Inpatient	734	1 585	1 766	2 077
MC	1 967	8 315	11 880	5 597
PMTCT*	26 946	32 223	40 362	50 000
Outpatient	13 631	21 767	24 119	59 477
PMTCT-Partner	383	454	605	773
TB	4 128	6 148	4 821	5 383
TOTAL	**106 916**	**142 637**	**151 015**	**191 423**

*PMTCT data from ANC, PNC, maternity and CWF has been collapsed into a single column as it is further analysed in the PMTCT Annual report.

CIHTC and OPD contributed 32% and 31% respectively, followed by PMTCT (26%). There is also a notable increase over the years for tests performed among PMTCT male partners, from 605 in 2011 to 773 in 2012.

The section below presents data on the specific selected HTC entry points for 2012. The data is disaggregated by age, sex marital status, and region. Positivity rates within these categories are also presented. Tables also show proportions where results are received by those testing for HIV. Due to the quality of data, numbers may vary from those in table 4 as missing data were removed from further analysis.

3.4.3.1 Client Initiated HIV Testing And Counseling As An Entry Point, 2012

Table 4: HIV Tests Conducted At CIHTC Entry Points; 2012

Background Characteristics	HIV Tests performed	Positive Tests	% positive	Clients receiving results (%)
Age				
<5 Years	1 444	114	7.9%	1 437
5 – 14 Years	1 548	261	16.9%	1 542
15 – 24 Years	17 799	2 070	11.6%	17 768
25-49 Years	32 914	6 770	20.6%	32 836
50+ Years	8 257	843	10.2%	8 245
**Undocumented	123	17	13.8%	122
TOTAL	**62 085**	**10 075**	**16.2%**	**61 950 (99.8%)**
Marital Status				
Married	25 112	3 954	15.7%	25 049
Single	35 361	5 832	16.5%	35 290
Widowed	1 022	197	19.3%	1022
Divorced	185	40	21.6%	181
**Un-documented	173	20	11.6%	172
TOTAL	**61 853**	**10 043**	16.2%	**61714 (99.8%)**
Gender				
Male	25 641	4 013	15.7%	25 595
Female	36 335	6 044	16.6%	36 246
**Undocumented	109			
TOTAL	**62 085**	**10 057**	16.2%	**61 841 (99.8%)**
Region				
Hhohho	16 469	2 501	15.2%	16 408
Lubombo	11 596	1 706	14.7%	11 592
Manzini	21 450	4 081	19.0%	21 409
Shiselweni	12 464	1 768	14.2%	12 436
**Undocumented	106			
TOTAL	**62 085**	**10 056**	16.2%	**61 845 (99.8%)**

** Not included in calculations of positivity rates

For CIHTC, 99.8% of people tested received results, which is an improvement when compared to previous years (2010), where more than 2% of people testing did not receive results. All HIV testing, except for EID, is now done on site using rapid tests. In 2012, 26% of the tests performed were done in CIHTC/ VCT settings, with Manzini having the largest number of tests. The positivity rate within the CIHTC/VCT settings was 16.2%, highest in Manzini region (19%) and among the 25-49 years age group (20.6%). Females also had a higher positivity rate when compared with their male counterparts within the CIHTC/VCT settings (16.6% vs 15.7%).

3.4.3.2 Family Planning As An Entry Point

For this report, family planning analysis focused on women age 15 years and older. Data were disaggregated by age, marital status and region.

Men tested within family planning settings were removed because they were too few to give substantial analysis. The next section looks at the family planning section as entry point to HIV testing and counseling.

Table 5: HIV Testing In Family Planning Settings

Background Characteristics	HIV Tests performed	Positive Tests	% Positive	Clients receiving results (%)
Age				
15-24	2 744	178	6.5%	2 735
25-34	2 231	182	8.2%	2 228
35-44	795	49	6.2%	795
45-54	101	6	5.9%	101
TOTAL	**5 882**	**415**	7.1%	**5 859 (99.8%)**
Marital Status				
Married	2 998	163	5.4%	2 996
Single	2 869	250	8.7%	2 859
Widowed	6	1	16.7%	6
Divorced	0	0	0	0
Undocumented	9	1	11.1%	9
TOTAL	**5 882**	**415**	7.1%	**5 870 (99.8%)**
Region				
Hhohho	1 136	82	7.2%	1 135
Lubombo	1 955	143	7.3%	1 954
Manzini	1 861	106	5.7%	1 853
Shiselweni	922	84	9.1%	920
TOTAL	**5 874**	**415**	7.1%	**5 862 (99.8%)**

Of HIV tests provided in family planning settings, Lubombo region conducted the highest number (1 955), followed by Manzini (1 861). The age group 15–24 years constituted the highest number of tests (46.7%). Women age 25-24 years constituted 38% of the tests. 99.8% of people tested within family planning settings received results and the positivity rate was 7.1 per cent.

3.4.3.3 HIV Testing In Inpatient Wards

One of the strategies employed by the HTC program since the beginning of PIHTC was to target inpatients. In 2009, only 734 tests were performed in inpatient facilities. This has been increasing over time and in 2012, 2 077 HIV tests were reported under inpatient. HIV testing in inpatient settings was analyzed by age, sex, and region for 2012.

Table 6: Inpatient HIV Testing And Counseling

Background Characteristics	HIV Tests performed	Positive Tests	% positive	Clients receiving results (%)
Age				
<5Years	206	37	18.0%	201
5 – 14 Years	167	28	16.8%	164
15 – 24 Years	316	68	21.5%	309
25-49 Years	763	272	35.6%	747
50+ Years	615	90	14.6%	594
Undocumented	10	2	20.0%	9
TOTAL	**2 077**	**497**	23.9%	**2 024 (97.5%)**
Gender				
Male	1 012	253	25.0%	992
Female	1 049	242	23.1%	1 016
Undocumented	16	2		
TOTAL	**2 077**	**497**	24.0%	**2 008 (97.5%)**
Region				
Hhohho	555	141	25.4%	552
Lubombo	240	52	21.7%	237
Manzini	953	215	22.6%	912
Shiselweni	313	83	26.5%	308
Undocumented	16	6		
TOTAL	**2 077**	**497**	23.8%	**2 009 (97.5%)**

There are eleven public inpatient facilities in the country that all report through the HMIS. In Mbabane Government Hospital, the largest facility, 2 061 tests were conducted inpatient with a positivity rate of 23.8 per cent. Shiselweni region had the highest positivity rate (26.5%), followed by Hhohho (25.4%). Within inpatient facilities, men had a higher positivity rate (25.0%) when compared with their female counterparts (23.1%). The positivity rate was highest within the age group 25-49 years (35.6%).

3.4.3.4 Sexually Transmitted Infections As Entry Point To HIV Testing And Counseling

STIs contribute to HIV transmission and therefore it is important to offer HIV testing at facilities that manage STIs. Testing for HIV in this entry point has been very weak and still remains weak, considering the high numbers of people presenting with STIs performed in STI settings.

Table 7: HIV Tests Through STI Clinics, 2012

Background Characteristics	HIV Tests performed	Positive Tests	% positive	Clients receiving results (%)
Age				
<5 Years	2	0	0.00%	2
5 – 14 Years	10	1	10.00%	10
15 – 24 Years	164	28	17.07%	164
25-49 Years	184	59	32.07%	183
50+ Years	15	1	6.67%	14
Undocumented	2			2
TOTAL	**377**	**90**	23.87%	**375 (99.47%)**
Gender				
Male	196	44	22.45%	195
Female	178	46	25.84%	177
Unknown	3	0	0.00%	3
TOTAL	**377**	**90**	23.87%	**375 (99.47%)**
Region				
Hhohho	82	19	23.17%	178
Lubombo	78	15	19.23%	82
Manzini	179	50	27.93%	78
Shiselweni	37	6	16.22%	36
TOTAL	**377**	**90**	23.87%	**375 (99.47%)**

Only 377 tests were performed at STI settings during 2012. As presented in the table above, the positivity rate of 23.9% was high. Worth noting is that the positivity rate was highest (32.1%) among the 25-49 year old age group. Women also presented with a higher positivity rate (25.8%) when compared with their male counterparts (22.5%). Also worth noting is that the positivity rate tended to be higher in the Manzini region (27.9%) followed by Hhohho (23.2%).

3.4.3.5 HIV Testing In Male Circumcision (MC) Clinics

According to the MC national program guidelines, all MC settings should offer HTC as part of the MC minimum package. HTC is critical in MC so as to manage clients and minimize adverse events. A total of 11 202 men were circumcised in 2012. Due to underreporting in the HTC database, data from PSI was used. Table 8 below shows HTC uptake among MC clients.

Table 8: HTC In MC Clinics, 2012

	Total MCs	Total Tested	HIV positive	Unknown
Hhohho	2 900	2 816 (97.1%)	120 (4.3%)	84
Manzini	4 348	3 981 (91.6%)	386 (9.7%)	367
Lubombo	2 541	2 484 (97.8%)	45 (1.8%)	57
Shiselweni	1 419	1 108 (78.1%)	59 (5.3%)	311
Total	**11 208**	**10 383 (92.7%)**	**610 (5.4%)**	**819 (7.3%)**

Table 8 above shows that there were 10 383 (92.7%) people tested for HIV at MC settings. Lubombo region tested more people at MC sites (97.8%) when compared to other regions. Shiselweni tested the smallest proportion (78.1%). The overall positivity rate was 5.4 per cent. Manzini had the highest positivity rate (9.7%) and Lubombo had the lowest (1.8%).

The table below presents HTC by age and region in MC settings. Because of the "Back-to-School" campaigns in all regions, the number of school-age children circumcised has increased. Through the neonatal programs, the number of infants getting circumcised has also increased. In 2012, 1 734 infants were tested for HIV as part of MC services.

Table 9: MC By Region And Age

	<1	10 - 14	15 - 19	20 - 24	25 - 49	50+
Hhohho	349	235	446	808	633	305
Manzini	1 145	495	556	947	977	351
Lubombo	71	305	394	961	605	206
Shiselweni	169	144	209	428	336	133
Total	**1 734**	**1 179**	**1 605**	**3 144**	**2 551**	**995**

3.4.3.6 HIV Testing In Outpatient Facilities

HIV testing in outpatient settings is also increasing from 24 119 in 2011 to 59 477 in 2012. This is in line with the objectives of the HTC program to offer PIHTC in all health care settings.

Table 10: HIV Testing In Outpatient Settings, 2012

Background Characteristics	HIV Tests performed	Positive Tests	% positive	Clients receiving results (%)
Age				
<5Years	1 988	167	8.40%	1 981
5 – 14 Years	2 600	338	13.00%	2 594
15 – 24 Years	15 186	2 088	13.75%	15 147
25-49 Years	28 184	7 815	27.73%	28 115
50+ Years	11 430	1 150	10.06%	11 409
Undocumented	89	9	10.11%	89
TOTAL	**59 477**	**11 567**	19.45%	**59 335 (99.76%)**
Gender				
Male	23 015	5 067	22.02%	22 967
Female	36 338	6 480	17.83%	36 245
Unknown	124	20	16.13%	123
TOTAL	**59 477**	**11 567**	19.45%	**59335 (99.76)**
Region				
Hhohho	17 653	3 328	18.85%	17 611
Lubombo	9 640	1 843	19.12%	9 628
Manzini	19 495	4 173	21. 4%	19 448
Shiselweni	12 594	2 204	17.50%	12 553
Unknown	95	19	20.00%	95
TOTAL	**59 477**	**11 567**	19.45%	**59,335 (99.76%)**

About 99.8% of individuals tested in outpatient settings received their results. The positivity rate was 19.5 per cent. The rate was highest in the age group 25-49 years (27.7%) and lowest among children under the age of five years. The table also shows that positivity rate was higher among males (22.0%) as compared to females and highest in the Manzini region (21.4%).

3.4.3.7 TB As Entry Point To HTC

With the high TB-HIV co infection rate in Swaziland, it is mandatory that all TB patients are tested for HIV to ensure their best possible care and treatment. All TB patients who test positive for HIV are eligible for initiation on ART, which makes it even more essential that TB patients be tested for HIV immediately at the time of their TB. The table below shows HTC uptake in TB settings.

Table 11: HIV Testing In TB Settings, 2012

Background Characteristics	HIV Tests performed	Positive Tests	% positive	Clients receiving results (%)
Age				
<5Years	157	28	17.83%	157
5 – 14 Years	288	60	20.83%	288
15 – 24 Years	1 085	218	20.9%	1 084
25-49 Years	2 764	1 202	43.49%	2 756
50+ Years	1 080	178	16.48%	1 076
Un-documented	9	6	66.67%	9
TOTAL	**5 383**	**1 692**	31.43%	**5 370 (99.76%)**
Gender				
Male	2 693	855	31.75%	2 686
Female	2 652	821	30.96%	2 646
Unknown	38	16	42.11%	38
TOTAL	**5 383**	**1 692**	31.43%	**5 370 (99.76%)**
Region				
Hhohho	1 023	244	23.85%	1 022
Lubombo	487	129	26.49%	487
Manzini	3 002	1 106	36.84%	2 991
Shiselweni	864	212	24.54%	863
Unknown	7	1	14.29%	7
TOTAL	**5 383**	**1 692**	31.43%	**5,370 (99.76%)**

From table 10 above, it can be noted that the HIV positivity rate among TB patients was 31.4% and this again, was highest in the Manzini region (36.5%). The positivity rate was also highest in age group 25-49 years (43.5%).

3.4 Referral And Linkages

Referral of people who have been tested for HIV to care and prevention services in a timely manner is a subject of great concern for both the health of the individual and for the prevention of further spread of HIV. The goal of HIV referral is to ensure that both HIV-infected persons and individuals at increased risk for HIV infection have access to appropriate medical, preventive, and psychosocial support services. Referral encompasses a series of activities including assessment and prioritization of the client's needs for care and supportive services; assistance with accessing services; follow-up efforts to facilitate initial contact with care and support service providers; and documentation of the referral. During 2012, the HTC card was used in community sites and clients were traced with an average linkage rate of 56 per cent. The MOH is still working to better link patients to care in health facilities and a national Linkages and Referral

Framework addressing this challenge will be introduced in 2013.

3.5 Focus On Repeat Testing

According to the HTC guidelines, all persons testing HIV negative at initial testing should be retested after two months. This clause in the guidelines has been re-enforced and aligned to all other existing HIV guidelines, such as PMTCT guidelines 2011. The data are limited in that they rely on providers noting if people are retested and also on the understanding of what constitutes a "retest". There is however currently no clear line of demarcation on the definition of retest. With the data available, the following table shows the number of retests performed during the year.

Table 12: Retests Performed In All HTC Settings, 2012

	Male			Female		
	# of Tests	# Positive	% Positive	# of Tests	# Positive	% Positive
Re-tests	22 650 (26%)	35	0.15	59 268 (39%)	84	0.14
All tests	85 689			152 507		

About 33% of the tests performed were repeat tests and of these, 26% were among males and 39% were among females. The HIV positivity rate among those retesting was 0.15% among males and 0.14% among females.

The main aim of the National HTC Program is to improve access and uptake of HTC services. The MOH has designated officers to coordinate HTC services at national level working closely with the technical working group to plan and develop national HTC documents which help in improving quality HTC services in the country. The MOH has also strategically placed Regional AIDS Coordinators who oversee implementation of HTC in the regions. They are guided by the Regional Health Management Teams and the national office. At each of the HTC testing sites, there are HTC focal persons who oversee the implementation of services in that facility and also collate the monthly HTC report and submit to the regional M&E offices.

4.1 Achievements In PIHTC:

Testing in PIHTC settings has greatly increased in 2012, as compared to 2011. This is true for in for both males and females, across age groups and in all regions. Some of the factors contributing to this achievement are:

- **Development and implementation of PIHTC SOPs:**

Not all patients attending the facility with an unknown HIV status were being tested. Not all patients testing or identified as HIV positive were being successfully linked to pre-ART care. In respose, the national office developed and disseminated PIHTC SOPs to all health facilities. Health care workers were trained on the SOPs and began implementing PIHTC. This has resulted in an increase in the number of people testing in outpatient departments (from 24 119 in 2011 to 59 477 in 2012) and most other types of testing sites. The SOPs include PIHTC indicators, including linkage to care, that assist the facilities to develop an action plan to improve PIHTC in their facility.

- **Couples' HTC:**

The NSF encourages increased counseling and testing of couples. The MOH, in collaboration with its partners, developed a couples' HTC training manual and training has been conducted. The "Love Test" campaign was also introduced in an effort to increase couples' HTC throughout the year and especially in February.

- **Placement of lay counselors:**

HTC uptake in most of the health facilities in Swaziland was historically low. One of the reasons cited for this low uptake is the challenge with human resources to provide HTC services. To alleviate this challenge and improve uptake of HTC services in the main health facilities, HTC partners supported MOH in hiring lay counselors to be placed in the high volume facilities, mainly in the outpatient departments, TB settings and clinics. This has resulted in a dramatic increase in the uptake of HTC in these entry points. For instance, HIV testing in TB settings has increased from 4 821 in 2011 to 5 383 in 2012.

- **Mentoring and Supportive Supervision:**

To strengthen the quality of HTC services, the MOH has set up a mentoring team to observe staff providing HTC, identify strengths and limitations and review records in order to gradually transfer skills through feedback and modelling.

4.2 Achievements In CIHTC

- **Innovative Strategies for community mobilisation to test for HIV:**

Maintaining and increasing testing rates requires a continued emphasis on mobilizing communities for voluntary testing. In 2012, the MOH through its partners increased access to HTC in communities while targeting men, couples and adolescents. Different strategies are used at community level, including dip tanks, chieftaincy campaigns, workplace programs, mass testing campaigns, door-to-door and bus rank outreach. HTC coverage maps are generated as needed to identify underserved areas and share resources to reach the population. One strategies that has been successful is "Fast Track", a problem-solving approach that has been used internationally in various settings. The strategy addresses a well-defined challenge through tangible actions and measureable outcomes within a 90 day time frame. The "Fast Track" approach was used to overcome the challenge of low HTC uptake among men and adolescents in communities. On average, HTC uptake increased 5 to 6 times over the baseline during the 90 day period.

- **Referrals and Linkages:**

The SNAP recognizes that both linkages to and retention in care are major issues in the quality of the service they are providing. Testing is not a complete intervention and people must be assisted with referrals and linkages to HIV prevention, care and treatment as appropriate. Community testing uses the HTC card and clients are traced and linked with an average of 56% linkage rate. The MOH is still struggling to link patients to care in health facilities, but a national Linkages and Referral

Framework addressing this challenge will be introduced in 2013.

- **Male Focused Health Days:**

Men are often seen as a hard-to-reach group for health services. In 2012, Male Focused Health Days were introduced in 15 clinics, where one day per month is dedicated to men's issues and bringing men to the clinic to increase their engagement with their local clinic and the health system overall.

4.3 Program-Level Achievements

4.3.1 Trainings

The national office in collaboration with partners successfully trained HTC providers in health facilities to confidently offer PIHTC. Trainings in CIHTC were also conducted to increase the pool of HTC providers in the communities.

4.3.2 Quality Assurance/Quality Improvement

The MOH and its partners support quality improvement (QI) by attending Multidisciplinary Team QI Meetings where they support facilities to develop and implement their QI plans. Observed sessions of HTC are still done and exit interviews are conducted to improve the quality of counseling

4.3.3 Partner Support

HTC partners have played a major role in supporting the MOH to increase access to HTC hence the increased number of people testing during the year.

4.3.4 Monitoring And Evaluation

The national health sector is guided by one M&E office. To assess the efforts that are made by the MOH and partners, a report is produced each year. HTC providers are expected to fill in an HTC register and submit a monthly report to the regional M&E offices.

5.1 Challenges

The major challenges faced by the national HTC program are listed below along with recommendations for improvement.

- Shortage of Skilled MOH/SNAP Personnel for Clinical Mentoring and Site Support supervision
  - Recommendation: Capacitate existing regional teams (Mentoring Teams, and Clinical Supervisors) on HTC Mentoring and Supervision.
- Shortage of human resources for health more broadly
  - Recommendation: Government to absorb lay HTC Counselors into the establishment to permanently provide support in HTC
- Limited data specificity (Relying on test data as opposed to individual data for estimating the actual number of persons tested for HIV) and data collection, including data capturing tools.
  - Recommendations:
    - Implement a revised HTC register. Modify other existing tools to capture required indicators (couples' HTC, retesting, referrals, knowledge of status prior to test)
    - Implement a unique patient identifier to obtain individual testing data.
    - Clarify to health care workers the definition of a "retest" (needs to be supported by new HTC register with better data collection space).
    - Continue to mentor on completion of all data fields in registers.
- Stock outs of HTC Commodities
  - Recommendation: Higher level advocacy for funding availability, tax exemptions, and lab support.
- Limited couples' HTC
  - Recommendation: Sensitization and mobilization of the general community about the benefits of couples testing together
- Testing in inpatient units remains low.
  - Recommendation: Continued training of doctors and supervisors, and general education of the public on PIHTC. Intensive follow up on barriers to testing in inpatient units and barriers to accurate documentation.
- Under-reporting (many facilities), or non-reporting (biggest problem for private facilities)
  - Recommendations:
    - Implement recommendations from reporting assessment done in 2012, including ongoing follow up from regional M&E for non-reporting sites. Assessment of reporting should be done on annual basis.
    - Institute Quarterly Review Meetings for facilities to review their own data.
    - Implement data quality audits through regional M&E to review data completeness at facility level.
- Weak linkage to care and tracking of referrals
  - Recommendations:
    - Implement the National Referrals and linkages system.
    - Capacitate health care workers in tracking referred clients
    - Work with the ART and Prevention units to track and complete the referrals process.
- Inadequate quality assurance
  - Recommendation: Work closely with the Laboratory to train health care workers on quality assurance activities for testing

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