

## RESEARCH DOSSIER: HIV PREVENTION FOR GIRLS AND YOUNG WOMEN Swaziland

This Research Dossier supports the **Report Card on HIV Prevention for Girls and Young Women in Swaziland** produced by the United Nations Global Coalition on Women and AIDS (GCWA). It documents the detailed research coordinated for the GCWA by the International Planned Parenthood Federation (IPPF), with the support of the United Nations Population Fund (UNFPA), United Nations Program on AIDS (UNAIDS) and Young Positives.

The Report Card provides an 'at a glance' summary of the current status of HIV prevention strategies and services for girls and young women in Swaziland. It focuses on **five cross-cutting prevention components**:

1. Legal provision
2. Policy context
3. Availability of services
4. Accessibility of services
5. Participation and rights

The Report Card also includes background information about the HIV epidemic and key policy and programmatic **recommendations** to improve and increase action on this issue in Swaziland.

This Research Report is divided into two sections:

**PART 1: DESK RESEARCH:** This documents the extensive desk research carried out for the Report Card by IPPF staff and consultants based in the United Kingdom.

**PART 2: IN-COUNTRY RESEARCH:** This documents the participatory in-country research carried out for the Report Card by a local consultant in Swaziland. This involved:

Two **focus group discussions** with a total of 29 girls and young women and boys and young men aged 14 – 25 years. The participants included girls and young women who are: living with HIV; in/out-of/school; involved in sex work; living in urban and suburban areas; and working as peer activists.

Five **one-to-one interviews** with representatives of organisations providing services, advocacy and/or funding for HIV prevention for girls and young women. The stakeholders were: a country representative of an international NGO; a nurse at a national NGO focusing on sexual and reproductive health; a counsellor at an NGO/government voluntary counselling and testing centre; a programme officer of a United Nations agency; and a Technical Adviser of an international donor agency.

Additional **fact-finding** to address gaps in the desk research.



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**One-to-one interview: UNAIDS Programme Officer**

**One-to-one interview: Acting Director, Family Planning Association**

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**One-to-one interview: Counsellor, The AIDS Support Centre**

**One -to-one interview: Peer Educator (HIV)**

## **Abbreviations**

ARVs	Antiretrovirals
BVE	Bereaved and Vulnerable Elderly
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIA	Central Intelligence Agency
CRC	Convention on the Rights of the Child
HTC	HIV Testing and Counselling
IEC	Information, communication and education
IPPF	International Planned Parenthood Federation
MCH	Maternal Child Health
MTCT	Mother-to-Child Transmission
NERCHA	National Emergency Response Council on HIV/AIDS (NERCHA)
OVC	Orphans and vulnerable children
PLHA	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
SNAP	Swaziland National AIDS Programme
SRH	Sexual and Reproductive Health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TASC	The AIDS Support Centre
UNAIDS	United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary, Counseling and Testing
WHO	World Health Organisation

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# **PART 1: DESK RESEARCH**

## COUNTRY PROFILE

- **Size of population:** 1,136,334 (established July 2006)  
*note:* estimates for this country explicitly take into account the effects of excess mortality due to AIDS; this can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **Life expectancy at birth :** *total population:* 32.62 years, *male:* 32.1 years, *female:* 33.17 years (2006 est.) (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **% of population under 15 (0 – 14 years):** 40.7% (male 233,169/female 229,103) (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **Population below income poverty line of \$1 per day:** 69%  
Draft poverty reduction strategy and action plan vol 1. Mbabane : Ministry of Economic Planning and Development – 2005, p. 15
- **Health expenditure per capita (2003):** 3.3 % (UNDP (2006) Human Development Report Swaziland [http://hdr.undp.org/hdr2006/statistics/countries/data\\_sheets/cty\\_ds\\_SWZ.html](http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_SWZ.html) (date accessed 11/4/2007))
- **Contraceptive prevalence rate (% of married women ages 15-49) 1996-2004 :** 28 (UNDP (2006) Human Development Report Swaziland [http://hdr.undp.org/hdr2006/statistics/countries/data\\_sheets/cty\\_ds\\_SWZ.html](http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_SWZ.html) (date accessed 11/4/2007))
- **Fertility rates:**, 3.53 children born/woman (2006 est.) (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **Maternal mortality ratio adjusted (per 100,000 live births), 2000:** 370 (UNDP (2006) Human Development Report Swaziland [http://hdr.undp.org/hdr2006/statistics/countries/data\\_sheets/cty\\_ds\\_SWZ.html](http://hdr.undp.org/hdr2006/statistics/countries/data_sheets/cty_ds_SWZ.html) (date accessed 11/4/2007))
- **Ethnic groups:** African 97%, European 3% (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **Religions:** Zionist 40% (a blend of Christianity and indigenous ancestral worship), Roman Catholic 20%, Muslim 10%, other (includes Anglican, Bahai, Methodist, Mormon, Jewish) 30% (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))

- **Languages:** English (official, government business conducted in English), siSwati (official) (CIA (2006) The World Factbook – Swaziland <https://www.cia.gov/cia/publications/factbook/geos/wz.html> (Date accessed 10/04/2007))
- **AIDS deaths (adults and children) in 2006:** 16,000 (estimate)
- **Adult (15-49) HIV prevalence rate (end of 2006):** 39.2%  
The Swaziland Sentinel Sero Surveillance report 2006  
25.9% preliminary findings of the Demographic and Health Survey DHS –released in June 2007
- **Number of women (15-49) living with HIV (end of 2006):** 120,000  
31.1% (Swaziland Vulnerability Assessment)  
39.2% Swaziland Sentinel Sero Surveillance report 2006
- **Number of children (0-15) living with HIV (ages 0-14 years, 2006):** 15,000
- **Estimated number of orphans (0-17 years):** 95,000 (UNICEF (2005) ([http://www.unicef.org/infobycountry/swaziland\\_statistics.html](http://www.unicef.org/infobycountry/swaziland_statistics.html) (accessed on 10/4/2007))

## PREVENTION COMPONENT 1: LEGAL PROVISION (national laws, regulations, etc)

### Key questions:

#### 1. What is the minimum legal age for marriage?

*The legal age of marriage is 21 for both men and women. However, with parental consent and approval from the minister of justice, girls age 16 and boys age 18 married. The government recognized two types of marriage: civil marriages and marriages under law and custom. Traditional marriages under law and custom can be with girls as young as 14.*

(Bureau of Democracy, Human Rights, and Labor, US Department of State (2005) Swaziland: Country Reports on human Rights Practices 2005 <http://www.state.gov/g/drl/rls/hrrpt/2005/61595.htm> (date accessed 10/4/2007))

*Proposed legislation will also make it illegal to marry a child under 18 without consent, and prohibits the traditional practice of widow inheritance (where a man automatically inherits his deceased brother's wives) without a woman's consent*

(UNAIDS (2006) UNAIDS Best Practice Collection Helping Ourselves: Community Responses to AIDS in Swaziland (accessed on 12/4/2007)) [http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland\\_en.pdf?preview=true](http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland_en.pdf?preview=true) date accessed 12/4/2007)

#### 2. What is the minimum legal age for having an HIV test without parental and partner consent?

18 years

Provided by in-country consultant from National Multisectoral HIV and AIDS policy

#### 3. What is the minimum legal age for accessing SRH services without parental and partner consent?

16 years

Provided by in-country consultant from UNFPA – Swaziland

**4. What is the minimum legal age for accessing abortions without parental and partner consent?**

Abortion is illegal in Swaziland

Age and info needed

Grounds on which abortion is permitted:

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	Yes
Foetal impairment	No
Economic or social reasons	No
Available on request	No

(Population Division of the United Nations Secretariat - *Abortion Policies: A Global Review* (2002) <http://www.un.org/esa/population/publications/abortion/profiles.htm> (Date Accessed 21/03/07))

**5. Is HIV testing mandatory for any specific groups (e.g. pregnant women, military, migrant workers, and sex workers)?**

Only the military has recently (June 2007) put in place a policy that makes HIV testing mandatory for recruitment. Sero Surveillance surveys although relying on pregnant women, these surveys are not mandatory for every pregnant woman especially those not using government health facilities.

(Information provided by in-country consultant)

**6. Is there any legislation that specifically addresses gender-based violence?**

*In terms of structural violence, until 2006 women occupied a subordinate role in society. In both civil and traditional marriages, wives were legally treated as minors, although those married under civil law could be accorded the legal status of adults if stipulated in a signed prenuptial agreement. A woman generally needed her husband's permission to borrow money, open a bank account, obtain a passport, leave the country, gain access to land, and, in some cases, obtain a job. Women routinely executed contracts and entered into a variety of transactions in their own names. With the implementation of the February 8 constitution (2006), women are now able to open bank accounts, obtain passports, and take jobs without the permission of a male relative. Banks still refuse personal loans to women without a male guarantor. The constitution provides for equal access to land; however, in practice this right was not enforced. On July 31, the coordinator of Women in Law in Southern Africa told journalists that she had been told that most of the constitutional benefits for women will be delayed until several existing acts are amended to bring them into line with the constitution, including the Marriage Act, the Administration of Estates Act, the Deeds Registry Act, and others.*

*Women have the right to charge their husbands with assault under both the Roman Dutch and the traditional legal systems. Penalties for men found guilty of assault not involving rape depend on the court's discretion. The Roman Dutch legal system sometimes hands out light sentences in cases of abuse against women.*

*Rape is against the law; however, a sense of shame and helplessness often inhibited women from*

*reporting such crimes, particularly when incest was involved. In the Roman-Dutch legal system, the acquittal rate was high and sentences were generally lenient.*

*(All cases of rape are dealt with under common law, so there is also a need for stronger legislation to deal with issues of rape and sexual abuse or domestic violence against women as was done for children in 2002)*

Bureau of Democracy, Human Rights and Labor, U.S. Department of state (2005) Swaziland : Country Reports on Human Rights Practices <http://www.state.gov/g/drl/rls/hrrpt/2006/78760.htm> (accessed on 11/4/2007) and Bureau of Democracy, Human Rights and Labor, U.S. Department of state (2006) Swaziland : Country Reports on Human Rights Practices <http://www.state.gov/g/drl/rls/hrrpt/2006/78760.htm> (accessed on 11/4/2007))

(UNAIDS (2006) UNAIDS Best Practice Collection Helping Ourselves: Community Responses to AIDS in Swaziland (accessed on 12/4/2007)) [http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland\\_en.pdf?preview=true](http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland_en.pdf?preview=true) date accessed 12/4/2007)

*The law provides some protection from sexual harassment, but its provisions are vague and largely ineffective.*

Bureau of Democracy, Human Rights and Labor, U.S. Department of state (2005) Swaziland : Country Reports on Human Rights Practices <http://www.state.gov/g/drl/rls/hrrpt/2006/78760.htm> (accessed on 11/4/2007))

**7. Is there an AIDS Law – or equivalent – that legislates on issues such as confidentiality for testing, diagnosis, treatment, care and support?**

No legislation. However, Government policy states that confidentiality should be upheld at all times.

(Information provided by in-country consultant)

**8. Is there any legislation that protects people living with HIV/AIDS, particularly girls and young women, from stigma and discrimination at home and in the workplace?**

Currently there is inadequate legislative framework for the protection of the rights of vulnerable groups

There have been efforts to legislate and create structures that provide a protective environment for the legal and social rights of orphans and vulnerable children (OVC), such as child protection committees and community courts. However, these structures are not backed by any existing legislations, and there is also low reporting and follow-up of socio-culturally-driven cases of child abuse.

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008 [http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

**9. Are sex workers legally permitted to organise themselves, for example in unions or support groups?**

Prostitution is illegal, and police continued to enforce the law.

(Bureau of Democracy, Human Rights and Labor, U.S. Department of state (2006) Swaziland : Country Reports on Human Rights Practices <http://www.state.gov/g/drl/rls/hrrpt/2006/78760.htm>

(accessed on 11/4/2007))

**10. Are harm reduction methods for injecting drug users (such as needle exchange) legal?**

Not legal

(Information provided by in-country consultant)

**Discussion questions:**

- **Which areas of SRH and HIV/AIDS responses are legislated for?**
- **What are the biggest strengths, weaknesses and gaps in legislation in relation to HIV prevention for girls and young women?**

*Efforts have been made to identify traditional practices that seem to be related to the spread of HIV and to address these within the legal framework so that no one is forced into risky behaviours without consent.*

*A number of studies have been done on gender and child abuse and the results have informed the review process of the Marriage Act and the 1920 Girls and Women Protection Act. However, limited documentation on the nature and extent of stigmatization, discrimination and victimization still hampers the development of legislation, policies and ethical codes of conduct to address these issues.*

(UNAIDS (2006) UNAIDS Best Practice Collection Helping Ourselves: Community Responses to AIDS in Swaziland (accessed on 12/4/2007)) [http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland\\_en.pdf?preview=true](http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland_en.pdf?preview=true) date accessed 12/4/2007)

- **Is action taken if laws are broken (e.g. if a girl is married below the legal age)?**
- **Is there any specific legislation for marginalised and vulnerable groups<sup>1</sup>? If yes, is the legislation supportive or punitive? And what difference does it make to people's behaviours and risk of HIV infection?**
- **To what extent are 'qualitative' issues – such as confidentiality around HIV testing – covered by legislation?**
- **How much do girls and young women know about relevant legislation and how it relates to them? Are there any initiatives to raise awareness about certain laws?**
- **Overall, how is relevant legislation applied in practice? What are the 'real life' experiences of girls and young women? What difference does it make to their vulnerability to HIV infection?**
- **How do the effects of legislation vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

**PREVENTION COMPONENT 2: POLICY PROVISION**  
(national policies, protocols, guidelines, etc)

**Key questions:**

**11. Does the current National AIDS Plan address the full continuum of HIV/AIDS strategies, including prevention, care, support and treatment?**

<sup>1</sup> Examples include: people living with HIV/AIDS, sex workers, injecting drug users, migrant workers, refugees and displaced people, street children, school drop-outs, lesbians and ethnic minorities.

*According to the report of the Joint Review of the National Response to HIV and AIDS in Swaziland, (2000 – 2005) the national response accomplished a wide range of objectives (establishment of NERCHA- (National Emergency Response Council on HIV and AIDS); assurance of a supply of safe blood; introduction of a program for preventing mother-to-child transmission of HIV; initiation of a public sector antiretroviral therapy program; establishment of sub-coordination structures; implementation of innovative impact mitigation activities; improvement of the food security situation for vulnerable people, especially orphans and vulnerable children; availability of micro credit schemes; mobilization of grass-root community structures to provide psychosocial support to orphans and vulnerable children; establishment of the monitoring and evaluation frame work.)*

*The joint review also listed the following as challenges to the national response in Swaziland - unmet demand for safe blood; insufficient funding for a fully fledged free antiretroviral therapy program; inefficient systems for delivering antiretroviral therapy; limited antiretroviral therapy literacy; limited capacity of the health sector to implement national antiretroviral therapy; lack of national guidelines to facilitate identification, delivery and monitoring of orphans and vulnerable children; over-centralized and top down national response; weak link between monitoring and evaluation systems of partner institutions; limited funding for sentinel surveys.' Development of the Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008' was based on findings of the Joint Review, a literature review, community focus group discussions as well as stakeholder and key informant interviews and covers 4 thematic areas including 1) prevention 2) care, support, treatment 3) mitigation of impact and 4) management of the national response.*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

## **12. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of girls and young women?**

When planning for HIV and AIDS, responding agencies shall ensure that actions taken are...sensitive to gender, age and disability...

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

*The national priority on HIV prevalence reduction has been to focus on the youth. Together with other stakeholders, the Swaziland National Youth Council (SNYC) programs are founded on the 'youth menu', a national response to HIV/AIDS targeting the youth.*

(Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report  
[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?view=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?view=true)) accessed 12/4/2007))

## **13. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of marginalised and vulnerable groups, including people who are living with HIV/AIDS?**

When planning for HIV and AIDS, responding agencies shall ensure that actions taken are...sensitive to gender, age and disability...

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008

[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

*Although the epidemic in Swaziland is generalised, the most at risk populations have not been ignored.*

Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report  
[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ%20ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ%20ew=true) accessed 12/4/2007))

#### **14. Does the National AIDS Plan emphasise confidentiality within HIV/AIDS services?**

*One of the 'Strategic Issues' listed in the thematic area of prevention in the 'The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008' is confidentiality in HTC.*

*'Client Initiated HTC and confidentiality—The voluntary aspect of HTC and confidentiality are a bone of contention as some people still maintain the importance of confidentiality while others suggest compulsory testing and disclosure of HIV positive status since some people continue with unprotected sexual relations even if they know that they are HIV infected. On the other hand others emphasize the need for shared confidential and beneficial disclosure of the status. Stigmatization, discrimination and denial still hinder access to HTC services in the country.'*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

*As a result of these attitudes emphasis in the Strategic Plan has been placed on 'Strengthening of national capacity to provide country expanded facility and community based quality and confidential HIV testing and counselling services according to the specified national guidelines' And 'Strengthening of human rights protection and reduction of stigma and discrimination in facilities and communities'*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

*HIV testing is voluntary and confidential. Pre-test counselling and informed consent are required, and test results are provided after post-test counselling. Testing is mandatory only for blood transfusion*

*(World Health Organization Country Profile on Antiretroviral therapy for Swaziland (2005)  
[http://www.who.int/hiv/HIVCP\\_SWZ.pdf](http://www.who.int/hiv/HIVCP_SWZ.pdf) (accessed on 12/4/2007))*

#### **15. Does the national policy on VCT address the needs of girls and young women?**

No mention of targeting girls and young women specifically...

*'Strengthening of facility and community based psychosocial support capacity for people who are considering or have been tested for HIV infection.'*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date

accessed 10/4/2007)

**16. Does the national protocol for antenatal care include an optional HIV test?**

*93 % of women in Swaziland access antenatal health care at least one time*

*Although national PMTC guidelines are available, it should be noted that there is currently no national PMTCT policy.*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008

[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

**17. Does the national protocol for antenatal care include a commitment that any girl or young woman testing HIV positive should be automatically offered PMTCT services?**

***Inadequate national capacity to implement PMTCT***— *Although PMTCT is being implemented in the country and national PMTC guidelines are available, it should be noted that there is currently no national PMTCT policy. Coverage of the service is limited and available guidelines are not comprehensive in that they lack mechanisms for follow-up of program clients and requirement for community support structures. It has also been indicated that Maternal Child Health facilities in the country lack human resource and infrastructural capacity for implementation of the PMTCT services. Not all relevant health care workers have received orientation on PMTCT.*

***Insufficient public awareness and health education on PMTCT***— *The public is also not mobilized for PMTCT services. As a result, PMTCT-related public awareness is low. Despite the substantially high prevalence levels in the country, evidence shows that antenatal clinic services lack sufficient HIV and AIDS related education. According to an unpublished study report by a partnership of MOHSW, EGPAF, AED and AMICAALL, it was indicated that only 13% of the surveyed mothers in 2004 reported receiving health talks on PMTCT while 51% and 53% respectively, reported receiving talks on HIV transmission and HIV prevention. The study further points out that 27% did not know what a woman could do to reduce the risk of transmitting HIV to their babies during pregnancy and 4% indicated that nothing can be done.*

***Gender disparity***—*Lack of empowerment of women (abuse of power by men over women) and stigmatization of HIV and AIDS presents a challenge for implementation of a successful PMTCT program. Gender disparities make it difficult for women ...prevent unwanted pregnancies as a result of a positive HIV status and to decide on the choice of infant feeding. Furthermore, some women are poor and cannot afford purchasing artificial feeding formulas.*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008

[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

**18. Is there a national policy that protects the rights and needs - including HIV prevention, SRH services, employment opportunities and education - of young women or girls at risk or affected by early marriage?**

*Not specifically*

(Information provided by in-country consultant)

*Swaziland has high rates of early marriage and childbearing, yet has a contraceptive prevalence of less than 30 per cent. Teenage girls can be stigmatized and ridiculed, and are often expelled from school or forced to drop out. Such marginalization has also led to a wave of child dumping*

(Newline of the United Nation's Girl's Education Initiative) - Swaziland  
[http://www.ungei.org/gaproject/swaziland\\_279.html](http://www.ungei.org/gaproject/swaziland_279.html)

#### **19. Is HIV prevention within the official national curriculum for both girls and boys?**

*Limited coverage of HIV and AIDS based life skills education—There are attempts in providing HIV information including life skills education in the country's education system. The school HIV and AIDS program is one of the oldest components of the national response, having been initiated by Care International in 1991 and passed on to School HIV and AIDS and Population Education (SHAPE). However, coverage of the school program is limited, given that some schools do not have career guidance teachers or administration support for HIV initiatives. HIV and AIDS issues have been integrated into the primary and high school curricula. The process of integrating issues at pre-school and tertiary levels is on-going.*

*Gender and human rights dimensions are not integrated into the school curricula and in out of school youths HIV initiatives.*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

#### **20. Is key national data about HIV/AIDS, such as HIV prevalence, routinely disaggregated by age and gender?**

The demographic and health surveys has brought a dimension of gender disaggregation in HIV prevalence data otherwise the Sero Surveillance was only disaggregating by age since the sample only focussed on pregnant women.

(Information provided by in-country consultant)

#### **Discussion questions:**

- **To what extent are relevant bodies – such as the Ministry of Education, NGO networks, religious organisations, etc – engaged in policy-making around HIV prevention for girls and young women?**
- **To what extent do those bodies work in partnership or in isolation? What areas of HIV prevention responses (e.g. behaviour change, counselling, treatment, home-based care) have national protocols or guidelines?**
- **To what extent do those protocols address the needs of girls and young women, including those that are marginalised and vulnerable?**
- **What does school-based sex education cover? Does it help to build young people's confidence and skills, as well as knowledge?**
- **To what extent do policies help to reduce stigma and discrimination? For example, do**

they encourage people to stop using derogatory language or 'blaming' specific groups for HIV/AIDS?

- To what extent are different areas of policy provision – such as for HIV/AIDS and antenatal care – integrated or isolated?
  -
- What policy measures exist in relation to consent, approval and confidentiality? For example, can girls and young women access services such as VCT without having to notify their parents and/or partner? And are they informed of their right to confidentiality?
- Overall, how are relevant policies applied in practice? What are the 'real life' experiences of girls and young women? How much do they know about them and how they relate to them? What difference do these policies make to their vulnerability to HIV infection?
- How do the effects of policies vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

### PREVENTION COMPONENT 3: AVAILABILITY OF SERVICES<sup>2</sup> (number of programmes, scale, range, etc)

#### Key questions:

**21. Is there a national database or directory of SRH and HIV/AIDS services for young people?**

Yes there is a national database (Health Information System) that is prepared by the Statistics Unit of the Ministry of Health and Social Welfare. Although information is general, data pertaining to young people (girls and young women) can be generated should the need arise/or should anyone request such data.

(Information provided by in-country consultant)

**22. How many SRH clinics or outlets are there in the country?**

154 health facilities (clinics and hospitals) all provide SRH services.

(Information provided by in-country consultant)

**23. At how many service points is VCT available, including for young women and girls?**

*In 2004 the Ministry of Health estimated 25 sites available for HIV testing and counselling There are currently 38 VCT centres in the country (Information sources from the Swaziland National AIDS Programme (SNAP) under the Ministry of Health and Social Welfare)*

(World Health Organization Country Profile on Antiretroviral therapy for Swaziland (2005) [http://www.who.int/hiv/HIVCP\\_SWZ.pdf](http://www.who.int/hiv/HIVCP_SWZ.pdf) (accessed on 12/4/2007))

*VCT services sites have increased from 14 in 2003 to 37 in 2005. The number of people accessing VCT services increased from 13, 576 in 2003 to 95,000 in September 2005*

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<sup>2</sup> (Refers to the full range of SRH and HIV/AIDS services relevant to girls and young women. These include antenatal care, STI information and treatment, HIV prevention, condoms, VCT and other counseling, positive prevention, treatment of opportunistic infections, care and support, treatment (including ARVs), skills building, economic development, etc).

(Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report  
[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ  
ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ<br/>ew=true)) accessed 12/4/2007))

**24. Are male and female condoms available in the country?**

In 2003, 5,100,000 were available in the country. This number divided by the number of people aged 15-49 at that time is 11.9.

(World Health Organisation (2004) Epidemiological Factsheet on HIV/AIDS and Sexually Transmitted Infections  
[http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS\\_PDFs/EFS2004\\_SZ.pdf](http://www.who.int/GlobalAtlas/predefinedReports/EFS2004/EFS_PDFs/EFS2004_SZ.pdf) (Date accessed 13/4/2007))

**25. Is a free HIV test available to all pregnant girls and young women who wish to have one?**

*93 % of women in Swaziland access antenatal health care at least one time*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

**26. At how many service points are PMTCT services (such as nevirapine) available for pregnant girls or young women who are HIV positive?**

*In 2003 the majority of health services did not offer PMTCT services.*

(International Community of Women Living with HIV/AIDS(2005) Policy report ICW / SIPAA Workshop Swaziland [www.icw.org/tiki-download\\_file.php?fileId=187](http://www.icw.org/tiki-download_file.php?fileId=187) (Date accessed 13/4/2007))

*'Existence of opportunities for PMTCT—Prevention of mother to child transmission services are integrated in the MCH settings. Given that almost all (93%) pregnant women attend antenatal clinic services at least once; this presents a real opportunity for implementation of PMTCT. In addition, the availability of antiretroviral drugs provides an opportunity to offer women, children and their families identified through the PMTCT program, the needed care and support (PMTCT plus). The referral between PMTCT and care, support treatment services is currently limited...*

*Inadequate national capacity to implement PMTCT—Although PMTCT is being implemented in the country ... Coverage of the service is limited and available guidelines are not comprehensive in that they lack mechanisms for follow-up of program clients and requirement for community support structures. It has also been indicated that Maternal Child Health facilities in the country lack human resource and infrastructural capacity for implementation of the PMTCT services. Not all relevant health care workers have received orientation on PMTCT.'*

(The Government of the Kingdom of Swaziland(2006) The Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008  
[http://www.sarpn.org.za/documents/d0002279/Swaziland\\_AIDS\\_plan\\_Jun2006.pdf](http://www.sarpn.org.za/documents/d0002279/Swaziland_AIDS_plan_Jun2006.pdf) (Date accessed 10/4/2007)

*By the end of 2004, there were 16 PMTCT sites increasing to 44 in September 2005. These sites are spread across the rural and urban areas in Swaziland.*

(Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report  
[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ ew=true)) accessed 12/4/2007))

**27. At how many service points are harm reduction services for injecting drug users available?**

None

(Information provided by in-country consultant)

**28. Are there any specific national projects (such as camps, conferences, and training courses) for boys/girls and young people living with HIV/AIDS?**

*The national priority on HIV prevalence reduction has been to focus on the youth. Together with other stakeholders, the Swaziland National Youth Council (SNYC) programs are founded on the 'youth menu', a national response to HIV/AIDS targeting the youth. The youth menu lays out five key intervention strategies that are to be targeted to the youth which are Life skills; Arts and Culture; Sports; Recreation/Entertainment; and Games and Health. In 2004, SNYC identified 16 rural sites where youth centres were to be built to provide life skills education targeting mainly the out of school youth.*

*There are a number of organisations that provide youth services including School Health Education Programme (SHAPE), The Family Life Association of Swaziland (FLAS), Swaziland Youth United Against HIV/AIDS, the Churches and Community Based Organisations.*

*The Ministry of Health and Social Welfare incorporated youth friendly services in addressing reproductive health problems (Sexual and Reproductive Health Programme)*

*Recognizing the importance of individual behaviour change, the country has embarked on a national campaign targeting the youth. With the theme 'Likusasa ngelami – the future is mine' a total of 91,007 youth were reached in 2005 through various media sources such as print, radio and posters and billboards.*

Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report  
[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ ew=true)) accessed 12/4/2007))

**29. At how many service points are ARVs available to people living with HIV/AIDS?**

*In 2005 there were 17 service points (exceeding the target by one site), service coverage for ART has also increased from one facility per region to two.*

*The country adopted the WHO 3 x 5 target of reaching 13,000 people with ART by December 2005. 11, 550 had been reached in September of 2005*

Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report

[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ ew=true)) accessed 12/4/2007))

*32,000 people are in need of ARVs in Swaziland; only 3200 are currently receiving ARVs (WHO 2004)*

(International Community of Women Living with HIV/AIDS(2005) Policy report  
ICW / SIPAA Workshop Swaziland [www.icw.org/tiki-download\\_file.php?fileId=187](http://www.icw.org/tiki-download_file.php?fileId=187) (Date accessed 13/4/2007))

**30. Are there specific positive prevention services, including support groups, for young women and girls living with HIV/AIDS?**

*A number of support groups have been formed in the country. However, stigma and discrimination is still a major challenge in the country and not everyone including young women and girls are able to openly discuss their HIV positive status.*

(Information provided by in-country consultant)

**Discussion questions:**

- **What scale and range of HIV prevention services is available for girls and young women? For example, do programmes go beyond 'ABC' strategies? Do programmes cover social issues (e.g. early marriage)?**
- **To what extent are SRH, HIV/AIDS and broader community services integrated and able/willing to provide referrals to each other? For example, could most SRH clinics refer a girl testing HIV positive to a support group for people living with HIV/AIDS?**
- **services available through 'non-traditional' outlets (e.g. religious organisations, youth clubs)?**

*A study in 2003 found that 70% of in-school youth – girls and boys – were not sexually active, whereas more than 70% of out-of-school youth were*

(The Global Coalition on Women and AIDS – Educate girls, fight AIDS Issue #1

[http://www.ungei.org/infobycountry/files/EDUCATE\\_GIRLS\\_FIGHT\\_AIDS.pdf](http://www.ungei.org/infobycountry/files/EDUCATE_GIRLS_FIGHT_AIDS.pdf) accessed on 12/4/2007))

Community Involvement is the foundation of the country's response to the epidemic. It is extremely important for the communities not just to participate in the programmes but to own the programmes. The community must internalize the response.

(UNAIDS (2006) UNAIDS Best Practice Collection Helping Ourselves: Community Responses to AIDS in Swaziland (accessed on 12/4/2007)) [http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland\\_en.pdf?preview=true](http://data.unaids.org/Publications/IRC-pub07/jc1259-swaziland_en.pdf?preview=true)

**To what extent are HIV prevention**

- **Are there community programmes on gender awareness/dialogue for girls/boys and young women/men? Do they explore power differences and social 'norms' for sexual behaviour? Is there mentoring, peer support and economic development that targets females?**
- **How available is prevention information and support for girls and young women living with HIV/AIDS?**
- **How available are HIV prevention 'commodities' (e.g. condoms)? How are they distributed?**
  - **How much do girls and young women know about the availability of services, such as where to get condoms or ARVs?**
  - **Overall, what does the availability of HIV prevention services mean in practice? What are the 'real life' experiences of girls and young women? What difference do these services make to their vulnerability to HIV infection?**
  - **How do the effects of availability vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

**PREVENTION COMPONENT 4: ACCESSIBILITY OF SERVICES**  
(location, user-friendliness, affordability, etc)

**Key questions:**

**31. Are all government HIV prevention and SRH services equally open to married and unmarried girls and young women?**

Yes. But in the majority of cases young girls shy away from these services because of the attitudes of the service providers who are in the majority of cases much older for fear that they will harbour prejudice about the young person's sexual reproductive issues.

(Information provided by in-country consultant)

**32. Are all government HIV prevention and SRH services equally open to girls and young women who are HIV positive, negative or untested?**

Yes, there is no discrimination

(Information provided by in-country consultant)

**33. Are VCT services free for girls and young women?**

Yes, for all categories of the population

(Information provided by in-country consultant)

**34. Are approximately equal numbers of females and males accessing VCT services?**

*The majority of users of voluntary counseling and testing (VCT) services are women of childbearing age, including pregnant women, followed by the youth. Male clients who use VCT services tend to be those who are suffering from chronic illnesses and STIs or those who are members of the army (Zungu-Dirwayi et al 2004).*

(International Community of Women Living with HIV/AIDS(2005) Policy report  
ICW / SIPAA Workshop Swaziland [www.icw.org/tiki-download\\_file.php?fileId=187](http://www.icw.org/tiki-download_file.php?fileId=187) (Date accessed 13/4/2007))

**35. Are STI treatment and counseling services free for all girls and young women?**

STI treatment is not free since it is accessible through the outpatient facilities in clinics and hospitals which are paid for. Counselling on the other hand is free.

(Information provided by in-country consultant)

**36. Are condoms free for girls and young women within government SRH services?**

Yes

(Information provided by in-country consultant)

**37. Are ARVs free for all girls and young women living with HIV/AIDS?**

*In 2003, Swaziland together with the support from international partners introduced free access to ART for People Living with HIV/AIDS.*

(Swaziland National Emergency Response Council on HIV/AIDS (2005) 2003-2005 UNGASS Indicators Country Report

[http://data.unaids.org/pub/Report/2006/2006\\_country\\_progress\\_report\\_swaziland\\_en.pdf?previ  
ew=true](http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf?previ<br/>ew=true)) accessed 12/4/2007))

*Free-of-charge ART has been offered since November 2003*

(Kober, Katharina and Wim Van Damme in Human Resources for Health (31 May 2006) Public sector nurses in Swaziland: can the downturn be reversed?

<http://www.human-resources-health.com/content/4/1/13> (Date Accessed 13/4/2007))

**38. Are issues relating to HIV/AIDS stigma and discrimination included in the training curriculum of key health care workers at SRH clinics?**

*Anecdotal evidence tells that one health worker entered a clinic and asked those seeking STI treatment go this way, thus singling out those who wanted the treatment.*

(International Community of Women Living with HIV/AIDS(2005) Policy report ICW / SIPAA Workshop Swaziland [www.icw.org/tiki-download\\_file.php?fileId=187](http://www.icw.org/tiki-download_file.php?fileId=187) (Date accessed 13/4/2007))

**39. Are issues relating to young people included in the training curriculum of key health care workers at SRH clinics?**

Nurses do acquire training on service delivery to the different types of clientele they serve and this includes young women and girls. Nurses serving in particular the Youth Friendly corners are trained.

(Information provided by in-country consultant)

**40. Are there any government media campaigns (e.g. television commercials and newspaper advertisements) about HIV/AIDS that specifically address prevention among girls and young women?**

Yes. The Ministry of Health and Social Welfare has a health education component which provides television and radio programmes on HIV and AIDS on a weekly basis. These programmes however, do not necessarily focus only on girls and young women but are general.

(Information provided by in-country consultant)

**Discussion questions:**

**Are HIV prevention services truly accessible to girls and young women, including those that are marginalised and vulnerable? For example, are they: safe? Affordable? Reachable by public transport? in appropriate languages? Non-stigmatising? open at convenient times?**

**What are the cultural norms around prioritizing females and males for health care?**

**To what extent are informed and supportive SRH services accessible for girls or young women living with HIV/AIDS?**

**What are the client/service provider ratios in different types of HIV prevention services? What is the gender ratio for staff in those services?**

**Do services make proactive efforts to attract girls and young women? For example, do SRH clinics have separate rooms for young women so that they do not risk seeing family members or familiar adults?**

**What are the attitudes of service providers to girls and young women, including those who are marginalised and vulnerable? Are they kind, non-judgemental and realistic (for example about young people's sexual pressures and desires)? Can they encourage girls/boys to assess their risks of HIV infection and change their behaviour? Are attitudes generally getting better or worse?**

**Do HIV prevention information campaigns, etc, target girls and young women? For example, are they culturally and linguistically appropriate? Are materials distributed through appropriate media and outlets?**

**Is there a national monitoring and evaluation framework? Does it encourage data to be disaggregated (according to gender and age) – to help assess the extent to which girls and young women are accessing programmes and services?**

**Are referrals and follow-up provided during HIV/AIDS, SRH and antenatal care services for young women and girls?**

**Overall, what difference does accessibility to services mean in practice? What are the 'real life' experiences of girls and young women? What difference is made to their vulnerability to HIV infection?**

**How do the effects of accessibility vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

**PREVENTION COMPONENT 5: PARTICIPATION AND RIGHTS**  
(human rights, representation, advocacy, participation in decision-making, etc)

**Key questions:**

**41. Has the country signed the Convention on the Rights of the Child (CRC)?**

Ratified on the 6<sup>th</sup> of October 1995

**42. Has the country signed the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages (CCM)?**

- **CEDAW** – Acceded on the 25<sup>th</sup> Of April 2004
- **CCM** – not signed

**43. In the National AIDS Council (or equivalent), is there an individual or organisation that represents the interests of girls and young women?**

National AIDS Council (NERCHA) divided into themes -

1) Prevention 2) Care and Support 3) Impact Mitigation 4) Technical Support Unit

Girls and young women are provided for under various objectives

(Information provided by in-country consultant)

**44. In the National AIDS Council, is there an individual or organisation that represents the interests of people living with HIV/AIDS?**

*Within NERCHA PLWH are accounted for under the Impact mitigation theme*

*-Objectives for them being*

*To increase to at least 80% by 2008 public awareness about the rights and obligations of PLHIV and other vulnerable groups*

*To increase the proportion of eligible households with child heads, PLHIV, PWD and BVEs that have access to basic services (clean water, sanitation and shelter) to 50% by 2007*

*To ensure that by 2008 at least 50% of registered OVC, PLHIV, BVEs, PWD and caregivers receive counseling and emotional care To ensure that by 2008 at least 50% of OVC, PLHIV, BVEs, PWD and caregivers receive appropriate mental health services To increase to 100% by 2008 the proportion of eligible vulnerable OVC, PLHIV, BVEs who have access to at least one nutritious meal a day*

The Swaziland National Emergency Response Council on HIV/AIDS  
<http://www.nercha.org.sz/focus.html?FrameLoad=100>

*Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA) was launched in 2004 and serves as an umbrella body for all organizations of people living with HIV, the first of which was established in 1993.*

*(UNPD Responding to HIV AIDs in Swaziland <http://www.undp.org.sz/hivaid.htm> (date Accessed 19/4/2007))*

**45. Was the current National AIDS Plan developed through a participatory process, including input from girls and young women?**

*The strategy does not mention the involvement of HIV positive women and men in developing policies and programmes – therefore GIPA is not a consideration.*

*(International Community of Women Living with HIV/AIDS(2005) Policy report  
ICW / SIPAA Workshop Swaziland [www.icw.org/tiki-download\\_file.php?fileId=187](http://www.icw.org/tiki-download_file.php?fileId=187) (Date accessed 13/4/2007))*

**46. Is there any type of group/coalition actively promoting the HIV prevention and SRH needs and rights of girls and young women?**

Yes FLAS is one of the main organizations involved in the area of SRH needs and rights of girls and young women. In addition, there are also two organizations, the Swaziland Youth United Against AIDS and the Swaziland National Youth Council which to a large extent promote HIV prevention for young people including girls and young women.

(Information provided by in-country consultant)

**47. Is there any type of national group/coalition advocating for HIV prevention (including positive prevention) for girls and young women?**

*ICW has a regional office in Swaziland which promotes HIV prevention and SRH needs for women by running training courses*

E-mail correspondence with Ms. Emma Bell of ICW London - 17/4/2007

**48. Is the membership of the main network(s) for people living with HIV/AIDS open to young**

**people, including girls and young women?**

Yes membership is open to all those interested in joining.

(Information provided by in-country consultant)

**49. Are there any programmes to build the capacity of people living with HIV/AIDS (e.g. in networking, advocacy, etc)?**

*ICW held a training seminar for women to help build their capacity for advocacy in local bodies 2004*

(Emma Bell, Oxford journal of Gender and Development Advocacy training by the International Community of Women Living with HIV/AIDS <http://www.icw.org/node/173> (Date Accessed 17/4/2007))

**50. Are there any girls or young women living with HIV/AIDS who speak openly about their HIV status (e.g. on television or at conferences)?**

Yes a few girls and young women speak in meetings and newspapers but the majority openly speak in their support groups and not in the general public domain.

(Information provided by in-country consultant)

**Discussion questions:**

- **How are international commitments (e.g. CRC, CEDAW, and CCM) applied within the country?**
- **Is the national response to HIV/AIDS rights-based? For example, does it recognise the SRH rights of women living with HIV/AIDS?**
- **Do key decision-making bodies (e.g. the Country Coordinating Mechanism of the Global Fund to Fight AIDS, TB and Malaria) have a set number of seats for civil society? Are any of them specifically for representatives of girls and young women or people living with HIV/AIDS?**
- **Are HIV prevention programmes generally developed 'for' or 'with' girls and young women, including those who are marginalised and vulnerable? Are girls and young women seen as 'implementers' as well as 'receivers' of services?**
- **To what extent are girls and young women aware of decision-making processes? Are they encouraged to have a voice? Are they seen as an important constituency within committees, management groups, etc?**
- **How high are issues relating to HIV prevention for girls and young women (e.g. early marriage and stigma) on the agendas of local leaders and decision-making groups (e.g. district AIDS committees)? To what extent do girls and young women participate in those type of bodies?**
- **To what extent are people living with HIV/AIDS organised, for example in networks? Are girls and young women involved in those bodies?**
- **How are issues of participation affected by stigma? For example, is it safe for people living with HIV to speak openly about their HIV status?**
- **Overall, how are participation and rights applied in practice? What are the 'real life'**

**experiences of girls and young women? What difference is made to their vulnerability to HIV infection?**

- **How do the effects of participation and rights vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?**

**PART 2:**  
**IN-COUNTRY RESEARCH**

**GEGE FOCUS GROUP****Area: Rural****Age group: 16 – 24 years****Number of participants: 11****Profile of participants: All girls and young women, 7 had children, 4 had tested for HIV****Date of Interview: 14<sup>th</sup> May, 2007****Prevention component 1: Available services**

1. Services providing information on HIV prevention, condoms, treatment for STIs are all available from the local clinic. There are no VCT services available at the clinic and one has to travel either to a Mission clinic which is about 15 km away or to a health centre which is about 20 km away or a hospital which is 35 km away. The area also has a Youth Centre (YC) where young people can access services such as HIV prevention information and condoms.

2. There is enough information for all young people including boys and young men on HIV prevention services. However, boys are not co-operative when partners discuss HIV/AIDS prevention. They refuse to use condoms and do not want to go for HIV tests and threaten to leave you if you insist.

3. VCT services should be brought to all communities as the places where it can be accessed are too far and young people do not have money to travel to these places. *"If VCT was nearer boys and young men would also see the need to undergo a test"*

**Prevention component 2: Accessibility of services**

4. Experiences of using services vary, there are those that are to a large extent not good because *"some nurses ill-treat patients, while some nurses divulge information about people with STI's, telling us to behave in front of everyone present at the clinic"*. This is particularly the case with adult nurses.

- Goods experiences relate to the fact that recently there have been *"an increasing number of younger nurses who are very good with young people. Such a situation makes young people comfortable to discuss anything with them"*. In addition, the clinic has introduced the separation of services according to age groups where those between 12 and 25 years are separated from older patients.

5. The location of services is a barrier to young people. *"The clinic is far from the community and there is a forest where you pass and the possibility of being raped is very real"*

- *"The YC is also supposed to provide services to a number of communities some of which are very far. It therefore only benefit those who live nearby"*.

- Not all services are free. The clinic charges E2.50 if you are sick and young people do not have money.

- The mission clinic only offers VCT services to pregnant women and not just anyone. *"long queues make counseling for HIV testing very shallow"*

- *"If you have an STI, the clinic insists that you bring your partner, which is not always possible for fear of being beaten up since do not own up to anything"*

- *"The concept of peer educators seems to have failed in most areas as they are no longer active. This affects access to condoms and information for young people in the community especially those far from the YC"*

6. There is no distinction in accessing services for all groups of women.

**Prevention component 3: Participation and rights**

7. The YC is the one project that brings young people together to talk about HIV prevention. However, it is difficult to motivate most young people to come to the centre because of distance, lack of interest and understanding of the importance of the YC.

8. *"Young people need to be more organized in order to be encouraged to get involved and participate in HIV prevention in their communities so that they can help each other"*

#### **Prevention component 4: Legal provision**

9. Participants were not aware of any laws that would affect how they would protect themselves from HIV. They were aware that sometimes girls get married at an early age. They indicated that parental consent is not required when accessing services.

#### **Prevention component 5: Policy provision**

10. Schools have career guidance teachers who provide lessons on HIV/AIDS – abuse etc. Biology lessons include STI's, HIV and AIDS even though lessons are offered at a shallow level with nothing in-depth.

- Schools should have lessons on HIV/AIDS and trained young teachers who are approachable to the youth.

11. *"More HIV education needed in all communities to address the issue of fear. There is fear of testing as a result of the emphasis on HIV/AIDS being transmitted through from sex which is linked to promiscuity as if you cannot get infected through other ways. Sometimes the lack of confidentiality among service providers also contributes and People Living with HIV and AIDS cannot form support groups because of fear of being stigmatized".*

#### **Summary**

12. More education on HIV/AIDS is still needed in all communities. There should be YCs in all areas, not the structure as such but the services.

- YCs should have facilities for girls.

- Peer educators to be reactivated

- HIV education to be provided to children at primary school.

- Female condoms should be available and more accessible and should be really advertised as much as the male condoms.

- There is also need to advertise and promote the use of condoms as a way of family planning and not just as a means of preventing HIV/AIDS.

#### **Swaziland Network of People Living with HIV and AIDS (SWANEPHA)**

**Area:** Mbabane

**Age Group:** 20 – 25 years

**Number of Participants:** 8

**Profile of Participants:** All young women who are members of the SWANEPHA support group. All have children 4 with one child and the other 4 with two children each. Seven have tested and know their status, 5 of who are HIV positive.

**Date of Interview:** 15<sup>th</sup> May, 2007

#### **Prevention component 1: Availability of services**

1. Information on HIV and condoms are available from network offices, clinics, hospitals, shops, pharmacies, public offices and toilets, bars etc. Treatment of STIs, VCT, ART and PMTCT services are available from most clinics in the city and hospitals. The network also holds HIV and AIDS workshops for members at least three times a year. These began in 2004 and members are now informed about most aspects of HIV and AIDS. Support group members also meet once every week to discuss HIV related issues.

2. There is sufficient information for everyone the only problem is that *"boys and young men do not always seek information. What we know is that they are aware of the*

available services such as of condoms, treatment of STIs, VCT and ART services". They however, do not give support to girls and young women because they always think that it will not happen to them.

*"my boyfriend and father of my child left me when I disclosed my HIV positive status, he was not interested in knowing his own status even though it was possible that he was also HIV positive, he just refused to go for an HIV test. Others (like my current boyfriend) however understand and accept your status and agree to use condoms"*

*"There are some young people who still refuse to believe that there is AIDS"*

3. To make ART available at the network offices because there are always long queues at the hospital so that those on the therapy do not wait the whole day. Such a service would be possible because we use cards to collect ART from the clinics and pharmacies also refer to the card and give you the tablets. This would also *"encourage other young people including men to join the support group if they know the access will be easy"*.  
- All services should also be free because sometimes we do not have money to access these.

### **Prevention component 2: Accessibility of services**

4. - Experiences have not been good because of the long queues when one need to get ART.

- Some of the nurses are also difficult to deal with. However they do not disclose your status even to your parents if you do not want this and have to find a way of making them support you when you are sick with home based care.
- After an HIV test, you have to come back for further tests before you get the ART and sometimes the period in-between is long.
- *"If you miss a day to collect your ART for whatever reason, you are in trouble because nurses turn you away saying that you are not serious about your health"*

5. Most of the services are free of charge from government facilities. It is only in private clinics and hospitals where you pay for services. The main barrier is money for transport as most of us do not live in the city centre where you can walk to access services.

- Despite the unfriendliness of some of the service providers, we have no option but to go to these places.
- People talk about others who they have seen at VCT centres and this discourages others from using available services.

6. Service provision is the same for all types of girls and young women.

### **Prevention component 3: Accessibility of services**

7. The support group has a few members who are male the majority being girls and young women. The formation of the support group has brought together members to talk about HIV prevention. The group has managed to give members a sense of belonging, understanding and acceptance of each other's HIV status which would otherwise not be possible to find in other formations or environment. *"One takes comfort in knowing that you are not alone in your situation and you get the courage to continue with life because of the support you receive from other members"*

- To be a member you have to pay E20.00.
- Members of the support group are also involved in some projects where they were supplied with seedlings to establish backyard gardens at home for a healthy diet and also to get an income from selling the surplus.

8. The elimination of discrimination and stigmatization would encourage many young people to participate freely without fear of victimization or being ostracized by family.

- More services such as education for men to facilitate HIV prevention for women in relationships. This would result in men agreeing to use condoms and undergoing HIV testing.

- "VCT services to be offered at the network offices because sometimes people are afraid that those who see them at the VCT centre in hospital will tell others about them"

#### **Prevention component 4: Legal provision**

9. Group was not aware of laws affecting the protection of girls and young women from HIV and AIDS. They believe that there are no laws that force girls to marry at a young age even though they were aware of young girls below 16 years who were married under customary law and that parents have to consent to such marriages.

#### **Prevention component 5: Policy provision**

10. The only sexual reproductive health education received in schools is related to biology. The discretion is left to the individual teachers and most teachers are not keen on sex education. Sexual reproductive health education related to HIV prevention is not a lesson on its own.

- Clinic personnel and teachers also emphasize on abstinence until marriage.

11. Fear and stigmatization discourages people from accessing VCT services.

- Government therefore has to address the issue of stigmatization so that the fear of an HIV test or being seen going to a VCT centre is addressed as this is the reason people are discouraged from going for an HIV test.

- Compulsory testing for every member in the community would help curb the fear about AIDS.

- More HIV education is necessary in order to treat PLHIV as normal people instead of looking at them as different and on the way to the grave as is the case currently.

#### **Summary**

*12. "There is need to design projects that will bring income for girls and young women so that they do not engage in sex for money, rarely using condoms, as this increases their vulnerability to HIV infection*

*- "Laws to be enacted to enforce abstinence among those who have not started sexual relationships.*

*- The use of condom to be made compulsory for sexually active young men and women.*

*- There is need for more education n HIV prevention strategies particularly those targeting girls, boys, young women and men*

*- ART has to be brought closer to communities as we need to travel by public transport and if you are very sick, this becomes a problem as you sometimes cannot go to hospital.*

*- Community leaders have to ensure that those living together are married instead of just living together as this would minimize the situation whereby people move from one lover to another*

*- Community leaders have to close all liquor outlets in their communities as liquor consumption causes people to be careless about who they have sex with and do not normally use condoms*

## FOCUS GROUP DISCUSSIONS

**Age group : 14 – 25 years**

**Number of participants: 11**

**Date: 17 / 05 / 2007**

**Area: Ludzeludze (Rural area).**

**Profile of participants: This was a mixed group of girls, boys, young women and young men. There were 3 girls / young women and 8 boys / young men. Two (2) of these are in-school whilst 9 are out of school, 3 had children (2 females and 1 male), 2 had undergone an HIV test and knew their status with one young woman very vocal about her HIV positive status and the challenges she faced whilst trying to access some of the services related to HIV and AIDS.**

**There is a Youth Centre established by the National Emergency Response Council on HIV and AIDS (NERCHA) in the area where young people access some of the HIV prevention services and come to play games to while away time. HIV prevention lessons, positive living and life skills education are held on a regular basis by the Youth Co-ordinator at the centre.**

### **Prevention component 1: Availability of HIV prevention services**

1. Free male and female condoms are available at different places in the community, these include the Youth Centre (YC), some of the shops, Peer Educators, Rural Health Motivators, a clinic (which is about 15 km away).

- HIV and AIDS information and materials are also available in the form of pamphlets from some of these places for example, the clinic and YC. Lessons on HIV and AIDS and discussions on issues affecting young people are also held at the YC.

- VCT services are scarce as this service is only available from the clinic. In some of the schools in the community, personnel from clinics and NGOs make yearly visits to provide VCT services to school children. However, *“they only return with the results the following year when some of those tested have already left school and they therefore never know their results.”*

2. Knowledge about HIV prevention services in the community

- Most boys and young men know about HIV prevention services available in the community. However, despite this knowledge some of them still refuse to use condoms with their girlfriends and in this way do not support HIV prevention for girls and young women.

3. What sort of HIV prevention services would you like more in your community?  
How would they make a difference to your lives

- VCT facilities and services should be available in the community so that people do not have to travel as far as the clinic to access this service. In addition, *“the YC should facilitate the provision of this service even if service providers such as nurses or NGOs come once a month as this would encourage more young people to know their HIV status and take the necessary prevention precautions”*

- There is also need to continue educating people about HIV and AIDS so that issues of stigma and discrimination are dealt with. Many people living with HIV and AIDS are in denial, they need support to be able to openly declare their status. – Parents have to be educated to understand the importance of

supporting their children who are HIV positive since most do not give the necessary support. An HIV positive participant said, *"I would never dare tell my father about my HIV positive status because **he would evict me from home and since I am unemployed, I would have no where to go and no means of survival**".*

#### **Prevention component 2: Accessibility of services**

##### 4. Experiences/Challenges/barriers of using HIV prevention services:

- Experiences of using services that are provided by adults are not good because they are likely to tell your parents if you come to seek for example STI services, or condoms etc.
- Using the YC has provided young people with an alternative to be free in accessing services. However, services are limited in the centre as young people only access information and condoms.

##### 5. The main barriers to using HIV prevention services

- Distance from available services for the majority of girls and young women presents serious problem of access because they do not have money. *"Even in situations where they would have some money, there are other needs which are a priority compared to using the money to access HIV prevention services"*. Most young people rely on parents for money because they are unemployed. However, *"parents will only give you money when you are really sick rather than to just to access any of the services"*
- It is mostly boys and young men who use the youth centre because the games available are mainly for boys / young men (eg snoker).
- In addition, it is not easy for girls / young women to get permission from parents to come to the centre because of the numerous chores they have to do at home, and the fact that parents are strict on girls than boys. The centre was not well advertised to enable parents to know what goes on at the centre and how this would benefit young people. *"Girls / Young women are therefore left out of all the information and services available to assist them to prevent HIV"*
- The YC services a large number of communities and those who live far away cannot therefore have access to the available services as it would mean having money to travel to the centre.
- The young people in charge of the YC are not well versed on HIV issues so information is not comprehensive as there are a lot of gaps in the HIV information received from the centre.
- Rural Health Motivators are older people and it is not easy for young people to seek condoms from them, they prefer their peers.
- Once a person is tested positive to HIV, there is need for follow up tests such as CD 4 cell count, liver functioning test to determine the type of drugs to give to the person. These tests are only done in Mbabane which is far from the area. The tests also take about 3 weeks to be completed. *"for a person who is now sick and needs the treatment immediately, this is too long a period to wait"*
- *"Counselling is not thorough because counsellors now do not give themselves time to make sure you are ready for an HIV test, they just scratch the surface maybe this is because of the long queues of people needing this services. In addition, there are no follow ups by VCT staff when ART is administered"*
- ART is not available in the nearest clinic and anybody who needs this service has to travel to Manzini (about 20 km) to get it.

- Testing for viral load is impossible and *"it seems this service is only available to certain people, how they are selected is not clear"*
  - PMTCT services for pregnant HIV positive young women is not available in the clinic and one has to go to the hospitals in Mbabane (about 35 km) or Manzini to access this service. *" a proper reference system is lacking in the country and even when you go to some of these hospitals, most of the time you do not get assistance unless there is someone you know working there"*
6. Access to HIV prevention services is generally hard for all groups of girls and young women

### **Prevention component 3: Participation and rights**

*"The level of participation by young people in HIV prevention decisions can be said to be non-existent. There is token representation because even though some representatives may be selected, in most cases they do not consult or report back to their peers what goes on in some of these workshops or where they are supposed to represent the youth".*

7. The YC is the only place that brings together girls and boys or young women and young men to talk about HIV prevention. *This is one place that belongs to young people, where they are on their own and where they make decisions about how to address issues of HIV prevention". A national life skills manual with a lot of information on HIV and AIDS has been developed by the Swaziland National Youth Council and this is the tool that is used to guide discussions among young people at the centre".*

- PSI has also been recently run a training called "Ladies Opportunity Forum". This forum / training focused on HIV and AIDS, economics, gender. *"This forum should have however, been accompanied with VCT services because it transpired during the discussions that a number of young women would like to know their status"*

8. Parental involvement and support in youth activities would encourage youth to be more involved in HIV prevention in communities.

- Meetings at the Inkhundla should give time to young people to explain their activities at the youth centre to adults in the community so that they can give young people the necessary support.

- More education is needed for adults (parents) in communities necessary for them to change their negative views about girls / young women attending youth centre activities

### **Prevention component 4: Legal provision**

9. Participants did not know any laws that allow girls and young women to be married at a young age. They were aware however, of the practise where young some girls marry at a young age under customary law.

- Abortion is illegal but there have been cases of young people aborting

- On the issue of parental consent, there were different views on whether girls in particular would require parental consent to use any of the services. Such a situation was said to be a result of the fact that in some cases parental consent is required whilst in other cases similar it is not required. It seems it all depends on the service provider who either enforces or does not enforce the need for parental consent.

- Young married women are expected to get the consent of their husbands before accessing family planning services and also before undergoing an HIV test.

### **Prevention component 5: Policy provision**

10. Sex education in schools is mostly limited to biology. AIDS is not a subject on its own where pupils would write exams and therefore whatever is taught is very scanty as it might be one period or 40 minutes in the whole year and a mention now and again whenever a teacher feels they want to mention it.

- Anti-AIDS clubs in most schools in the community have died a natural death even though they used to exist in the past. Teachers do not seem to be motivated to assist pupils to form and sustain anti-AIDS clubs.

11. There is need for government to continue with HIV prevention education programmes to address the issue of fear about AIDS that is still very common. The approach when the epidemic began where *"the final stages of AIDS and death were portrayed when the epidemic started and this instilled a lot of fear among people"*.

- Although there have been programmes to promote positive living, some people are still afraid to openly declare their HIV positive status for fear of victimization and stigmatization (see newspaper clip).

### **Summary – 3 – 4 key actions**

- *More clinics and health facilities should be established in communities to address the problem of distance and lack of funds to access available services especially by young people who most of the time are unemployed*

- *VCT services should also be available in all communities and follow ups made to assist those who have been diagnosed HIV positive*

- *Service providers should have specific days when they come to the youth centres to provide more information and education which cannot otherwise be provided by the youth coordinators.*

- *There has to be mandatory HIV testing for someone to get a job*

- *Young people should have representatives at all levels of government be it traditional or modern*

- *Focus of government interventions to be community based rather than based on tinkhundla because these are too big to enable all young people to access these.*

- *The King should be a role model and should stop accumulating wives who are as young as his own kids.*

- *Major cultural changes have to be effected especially with regards to the number of wives and children that a person can have to address poverty issues as families with many children tend to be poorer than those with fewer children resulting in the children's exposure to HIV as a survival strategy.*

- *Government should channel more money towards ART to increase access for a wider section of the community*

- *Sex work should be legalised and regulated so that protection can be ensured particularly because the majority of those in this trade are young people.*

**Sobhuza Clinic - Manzini**

**Nurse Counsellor**

**Date of interview : 16<sup>th</sup> May, 2007**

1. *"The situation of HIV prevention for girls and young women seems to be getting worse because of the increase in teenage pregnancy which is an indication that many young people continue to engage in unprotected sex".*

### **Prevention Component 1: Legal provision**

2. The country does not have any laws that make HIV prevention for girls and young women better. Under customary law there is no indication of the age at which girls should get married. Abortion and sex work are illegal. Parental consent is required at the clinic for those under 16 years. *"However, it is sometimes not easy to detect what a person's age is because clients are not required to bring identity documents"*.
4. Some of the laws that need to be changed relate to single women needing husbands to access land. *"For women, remaining single means no access to land and therefore women get married and compromise their health because of the likelihood of getting infected with HIV"*. The law has to give equal access to resources such as land to both women and men.

There is need to enact laws that will make it compulsory for everyone in the country to undergo an HIV/AIDS test. Polygamy has to be abolished so that every man has one wife. Once pregnant both girls and their boyfriends should be forced to take HIV tests. Chiefs or community leaders should enforce laws that will make it illegal for men to wed girls as young as 13 years.

### **Prevention Component 2: Policies provision - guidelines**

5. There is an HIV and AIDS policy which stipulates that services for HIV prevention have to be accessible to young people. As such antenatal care for those who are pregnant, condoms and VCT Service are available to all girls and young women who come to the clinic.
6. Sex education has been introduced in schools under social studies from grade 3 in primary school.
7. Government should make policies that will empower girls and young women not to depend on men and instead be independent. There should be equal opportunities in the workplace for women and there should not be sex for jobs

### **Prevention component 3: Availability of services**

8. Girls and young women are able to get the following available services, female and male condoms, the treatment of STIs, VCT, ART, PMTC.
9. HIV prevention services are available for all types of young women without any distinction of whether they are married or not, in or out of school.
10. Services at the clinic are available to everybody with no specific services targeting boys/young man.

### **Prevention Component 4: Accessibility of services**

12. Most services are accessible to all types of young women because they are free and this includes VCT and ART in all government health facilities. In addition, most of these are located in areas that are accessible. The clinic also has outreach services to rural areas and mobile VCTs services have also been introduced even though coverage is still limited.

The main barriers are the following: opening hours also limit access to services, attitudes of some of the staff and Lack of privacy and confidentiality.

13. It seems that it is easier for single women to access services than those who are married because married women have to consult husbands for permission to access some of the services eg VCT. Another group that finds it harder to access services are girls who are still in school particularly if they are in uniform.

14. Boys and young men do not seem to be playing any role in making access to services easier for girls and young women. They should be taught to accept condoms from their girl friends rather than thinking that those suggesting condom use are promiscuous. They should also have open discussions with their partners regarding HIV prevention. Men should be discouraged from having multiple partners because this practice compromises the safety of women to be protected from HIV and aids.

15. Priority action should include more HIV prevention education to emphasize the importance of condom use and other prevention measures, strengthening school and parental roles to teach young people about sexual reproductive health issues in relation to HIV prevention.

#### **Prevention Components 5: Participation and Rights**

16. None of the Conventions are applied in the country as the rights of the child and those of girls and women are not respected despite the fact that both International Conventions have been ratified. Discrimination against girls and women is still widespread.

17. The national response and national AIDS policy addresses rights of HIV positive women. However, the extent to which in reality such rights are observed is not possible to tell.

18. There has been an attempt to involve representatives for young girls and women living with HIV and AIDS in decision-making about AIDS.

19. Girls and young women should be empowered and involved in decision-making about AIDS at primary school level.

#### **Summary:**

*20. Government and donors have to initiate programs that will facilitate the empowerment of young girls and boys so they can make independent decisions about sexual reproductive health and HIV prevention issues.*

*- Laws protecting young girls from the abuse by old men including marrying girls as young as 13 years should be enacted and enforced.*

**One-To-One-Interview**  
**Unaid Programme Officer**  
**Date of the Interview: 18 May, 2007**

**1. What is your impression about the general situation of HIV prevention for girls and young women in Swaziland? Are things getting better or worse and why?**

The situation is neither better or worse. *"It is business as usual because we are not seeing interventions that are targeting girls and young women particularly in terms of behavioural change. HIV prevention messages are general without any gender dimensions or any attempt to target the most vulnerable groups such as girls and young women"*.

Maybe this is not deliberate as the country may not know what kind of messages to develop that would specifically address circumstances of particular groups. Different sectors do not seem to know where they fit in, in the country's efforts to prevent HIV.

**Prevention component 1: Legal provision**

2. -There are no laws that I am aware of that target HIV prevention among girls and young women. In fact there are no laws that address HIV throughout all age groups. Courts find themselves having to use whatever legislation (most of which are outdated) eg rape laws to address HIV related issues.

-There is currently a Gender Based Violence Bill that has been drafted which is awaiting enactment into law. However, I am not sure the extent to which this Bill will address HIV prevention issues of girls and young women. There has been a lot of debate in the country where HIV positive people are saying, the Law should criminalise rape or sexual violence but not HIV because other people were calling for stiffer sentences against rapists who are HIV positive.

- A girl can get married at 16 years but she needs parental consent whilst a boy may get married at 18 years. *There have however been instances where children younger than 16 have been married particularly according to Swazi Law and Custom and the parents are said to have consented."* What is lacking in the country is for an institution to take up issues of girls married below 16 years so that parents who consent to young girls marriage are jailed. *What is happening is that even though the press brings out these cases, no one seems to act on them"*.

- Sex work is not legal in Swaziland and there is no way therefore that there can be any legal recourse to protect girls and young women in the trade.

- Abortion is also illegal in the country. There have been cases however of abortions.

- What I know is that young people below 18 are supposed to get parental consent in order to use any sexual reproductive health services. However, the practise is that clinics and hospitals do not enforce this requirement except in cases where the young person needs an operation.

3. Because of the lack of laws for HIV prevention for girls and young women, it is difficult to say how it affect the different groups

4. Government has to seriously begin the process of domesticating CEDAW because the country has already ratified this Convention. Laws have to be revised based on CEDAW and I believe this would make a significant difference in the HIV protection of girls and young women.

**Prevention component 2: policy provision**

5. There are a number of policies that government has developed such as the HIV and AIDS policy, Gender policy, the Sexual Reproductive Health policy and the Youth Policy. Apart from the Youth policy, the other policies are general guidelines not disaggregated by age so that they would specifically target girls and young women. *"Most of the policy documents are weak and the challenge is maybe the issue of capacity to strengthen these documents and make them applicable"*.

- There are also guidelines on VCT

6. Schools are supposed to have guidance and counselling units which embrace all issues affecting the child. *“Government had a plan to ensure that all schools have one period per class per week for sexual reproductive health related issues. Whether this plan has been implemented is the big question. The challenge is that because there are no exams on guidance and counselling, no serious attention is paid to this aspect it depends on the diligence of the individual teacher”.*

7. When the HIV and AIDS policy was developed there should have been a law that would be in line with the policy to ensure compliance. *“The HIV and AIDS policy has a section on activities for HIV prevention for young people, however, these are mere statements that do not say how these will be implemented and who will facilitate implementation”* . There is therefore a need for government to revisit the available policy so that clear strategies are indicated on how for example young people will be encouraged to abstain from sex.

### **Prevention component 3 : Availability of services**

8. Condoms are now widely available in a number of outlets in the country. These include clinics, hospitals, shops, pharmacies, drinking places (pubs/bars), youth centres, public toilets and from designated people within communities eg Rural Health motivators and Peer Educators. Although there has been an increase in the supply of female condoms recently, these still fall far too short of male condoms. There are also a number of youth friendly corners in a number of clinics and hospitals in the country where girls and young women can access sexual reproductive health services freely.

- Behavioural change materials is also available in some of these places especially clinics, hospitals and youth centres. These however are dependent on the girls diligence to get the information, there are no programs that are run nationally encouraging these young people to get the information and the importance of such information.

- More VCT centres have also been established recently and young people can also access these. However, according to the HIV and AIDS policy, such a service for those below 18 years requires parental consent.

- PMTCT services are also available for young pregnant women if found to be HIV positive. *“There is however, still need to educate these young pregnant women about the importance of PMTCT services as this service depend on whether they inform the hospital before delivery about their HIV status and the need to be given the tablet when they are in labour and to further give the baby a dose of nevirapine. Most of the young women are not well informed and may not even inform those assisting with delivery of the baby. The situation becomes worse if a young woman delivers outside of a health facility for example at home”.*

9. There are no differences in service provisions for particular types of girls and young women. All young women will get a service whenever they seek such.

10. The National Emergency Response Council (NERCHA) has recently introduced a program targeting men on HIV prevention. This program facilitates male discussion of the importance of protecting themselves and their partners against HIV infection. There is also a Swaziland Action Group Against Abuse (SWAGAA) intervention on male involvement in domestic violence issues. Whether these are making a difference in the situation of HIV prevention for girls and young women is difficult to say as there has'nt been a study to evaluate their impact.

11. Services have limited coverage and do not reach out to all as most are available in towns are those in rural areas struggle to get most of the services. There is need therefore to increase coverage of available HIV prevention services to reach all girls and young women in the country.

#### **Prevention services 4: Accessibility of services**

12. Costs of services present barriers to many young people because they do not have money to access these.

- Distance from services is also another barrier because clinics and hospitals are far spaced. There are people who have to travel many kilometres to get to a health centre. *"There are no outreach HIV prevention services for girls and young women"*

- To some extent, one can say there is some privacy in the provision of services. However, this depends on the attitude of the services provider. *"One of the major challenges is that there is no punitive system in place for those who violate the rights of privacy of service recipients"*

- Opening hours for most services present serious challenges. Some open at 9am and close at 1 pm while others close at 3 pm. Most services are not available on weekends.

- Language is not a barrier because Swaziland has one local language and most service providers speak the language.

- Culturally girls are socialised to stay at home and not to be assertive and therefore end up not getting available services.

13. There are no differences in access of services for different types of girls and young women.

15. *"There is need for the expansion of services so that areas without health facilities are provided with outreach HIV prevention services. There is also need to integrate all services eg PMTCT, VCT, ART should be available in all the health centres. The nation also has a serious challenge of providing basic materials for HIV care and support. There is serious lack of coordination of services between different organizations providing services. There is need for a survey to identify gaps and provide the necessary services."*

#### **Prevention component 5: Participation and rights**

16. UNICEF has assisted the country in addressing issues pertaining to the rights of children. The extent to which these interventions have been possible is subject to investigation.

*"CEDAW needs to be domesticated so that relevant laws are in place to address issues of HIV prevention for women"*.

17. The national policy does talk about the need for the protection and empowerment of People Living with HIV and AIDS and vulnerable groups such as women and girls. However, these are statements that do not indicate how this will be done and by who.

18. There is limited involvement because there is *"no forum for girls and young women to discuss issues related to their protection against HIV and AIDS. This also goes for boys and young men as there are no girls/boys networks. Even though there is a young person's representative at the CCM level, the question is, to what extent does she/he consult with young people?"*

19. There is need to target girls and young women to form a group that will represent them. *"One of the forums that could be used to get the views of a wider group of girls are the national events such as the Reed Dance as this is where thousand of girls meet every year"*

#### **Summary**

20. *There is need to review policies and enact the necessary laws to address the protection of girls and young women from HIV infection*

- *Donors need to make a concerted effort to fund programmes targeting girls and young women*

- *Service providers should also target girls/boys/young women and young men*

- Community leaders need to be educated so that they have a plan and act on issues that put girls and young women at risk of HIV infection in their areas eg taking action against parents who marry off young girls

- The country has to design and improve on men's programs to facilitate the protection of girls and young women

There is need for skills development programmes for young women and girls

The country needs a practical vision on how to lobby for support for young people and be able to identify critical needs of different groups of young people to be responded to.

- There is need for the sustainability of programmes eg the Corridors of Hope project for sex workers has to be continued.

### **One-To-One Interview**

**Acting Director**

**Family Life Association Of Swaziland**

**Date Of Interview: 21<sup>st</sup> May 2007**

1. The general situation of HIV prevention for girls and young women is neither getting better or worse because *"there are no concerted efforts for HIV prevention intervention messages targeting girls and young women. Messages are general and not gender specific"*.

#### **Prevention component 1: Legal provision**

2. There are no laws in the country that facilitate HIV prevention for girls and young women. *"Instead, the minority status of women as reflected in the Marriage Act perpetuates the problem of female subordination and women find it difficult to negotiate safe sex with partners"*.
  - Sex work is illegal. However, *"FLAS has been running a cross border HIV prevention programme targeting sex workers and truck drivers and or mobile populations. Unfortunately this program had to come to an end because donors argued that studies indicate that HIV infection is generalised in the country and not confined to specific groups."*
  - *Abortion is illegal but our clinics do come across clients presenting symptoms of abortion and these are either treated or referred to hospitals*
  - *FLAS provides SRH services to all age groups without requiring parental consent except in cases of male circumcision for those below 18 years .There are VCT guidelines indicating that a person below 18 years requires parental consent. However, if a person is already sexually active, and needs a test, we test the person without insisting on parental consent"*
3. The only difference in impact of legislation would be in relation to married women who are minors according to the law and therefore need permission from husbands.
4. Government has to remove the minority status of women.
  - Government should also enforce laws that are in place eg Statutory rape when young children below 16 years are married off with parental consent.

#### **Prevention component 2: Policy provision**

5. A number of policies are in place and some of these are under review such as the youth policy and the reproductive health strategy to integrate issues of HIV prevention, job creation as sometimes vulnerability is perpetuated by poverty situations.

6. Sex education is supposed to be included in the school curriculum. FLAS has a programme for out of school youth once every week where sessions discussing a range of SRH issues are held. On Saturdays, FLAS clinics are open to enable in-school youth to access services.
7. Government has to operationalize CEDAW by putting in place the necessary laws and policies to facilitate government's commitment to remove discrimination against women at all levels.
  - Available policies need to be strengthened as they are ill equipped to address issues of HIV prevention for different groups of people especially girls and young women

### **Prevention component 3: Availability of services**

8. Male condoms are widely and easily accessible. Female condoms are expensive and therefore access is limited. Education on the use of female condoms for both sexes is also lacking
  - STI drugs are available in urban clinics and health centres. Rural clinics do not have some of the necessary supplies for treatment which then compromises quality of services.
  - VCT services have increased in the past two years. However, coverage is still a challenge as many areas still do not have VCT services.
  - ART are accessible in major hospitals for all groups. The major challenges relate to the long queues to access service otherwise government's commitment is evident.
  - PMTCT is lagging behind. Although this service is available in hospitals, clinics are not designated as PMTCT centres and have to refer patients. Follow ups are also limited and the referral system is very weak.
9. HIV prevention services are available for all groups and categories of people without singling specific groups.
10. SWAGAA has a male involvement programme. This is a new programme and the extent to which it is making a difference in HIV prevention for girls and young women cannot as yet be indicated.
  - *FLAS is packaging male circumcision as a male intervention service for HIV prevention and the response has been good.*
11. There is need to promote female condoms and make sure that they are used
  - There is need to introduce and make available in all health centres, post exposure prophylaxis for girls and young women who are raped to reduce the possibility of HIV infection.
  - PMTCT has to be widely available in all health facilities.

### **Prevention component 4: Accessibility of services**

12. Young people are not able to access services because of cost as most are unemployed.
  - Some STI drugs are very expensive and can therefore not be accessible.
  - Distance and location of services are also a barrier as some young people are too far away from these services.
  - Cultural values are also a barrier as sometimes parents would not expect a young girl to be sexually active which makes it difficult for those girls to access available services if they need these.
  - Peer pressure, inaccurate information or lack of it leading to young persons getting into sexual relationships early is another barrier to accessing services
  - Lack of privacy in health centres where there are youth friendly corners
  - Hours of operation

- Lack of knowledge of sign language for most service providers results in inaccessibility of services to people with disabilities
  - VCT services resulting in increased client waiting time is a barrier to accessing services. Service providers have to convince clients of the need to undergo an HIV test
  - There is need for parental involvement so that parents are comfortable with their children accessing services
13. Services are the same for all types of girls and young women
14. The role played by boys and young men is not visible. There is no evidence that they are supporting and ensuring that women are protected from HIV.
15. Appropriate HIV messages that target different age groups of women need to be developed.
- A conducive environment for girls and young women has to be created to facilitate to access services
  - There is need to provide outreach services to underserved communities
  - The impact of services has to be monitored

#### **Prevention component 5: Participation and rights**

16. A number of donors have been supporting government to address for example, gaps in law particularly in relation to CEDAW, SHR programmes to facilitating HIV prevention among girls and young women among other interventions. The extent to which government has in place mechanisms to address these issues is the challenge.
17. The national response is not rights based. There is need to make a linkage between SRH issues and STI drugs the focus of HIV prevention strategies and the use of available funds such as the Global fund. The rights of People Living with HIV and AIDS also have to be taken on board.
18. There is limited involvement of girls, young women and Living with HIV and AIDS in decision-making as these groups are scantily represented yet they need to have a strong voice in HIV prevention issues. Although there is representation of young people in the CCM, the necessary consultations present a serious challenge.
19. Efforts have to be made to have special representation of girls/boys and young women/men at all levels of decision-making starting at the lowest to the highest levels.
- Programmes have to target specifically girls and young women in order to empower them to protect themselves from HIV infection.

#### **Summary**

- *Donors such as UNICEF, UNFPA who have mandates for young people should encourage and support interventions for HIV prevention for young people. They are in a better position to get support from their international partners.*
- *There is need to draw lessons from other countries on how they are addressing issues of girls and young women HIV prevention issues and then upscale the interventions to cover the whole country.*
- *Community leaders have to be gatekeepers and ensure that girls and young women are protected in their communities from all forms of abuse. Unless attitudes of community leaders change and equality between boys and girls is emphasized, very little will be achieved.*

1. *I would say that things are getting better even though there is still need to improve. There are new programs that have been introduced in the country that target women on HIV and AIDS issues such as PMTCT. However, these programs do not single out girls and young women.*

**Prevention component 1: Legal provision**

2. The National Constitution has a provision for the rights of women and girls even though such rights are not yet practiced. *"The process of reviewing different laws to address different aspects women's lives has been started and once enacted into law, these will to a large extent address issues around strengthening women's positions in HIV prevention. The laws that have been reviewed include, the Marriage Act and the Deeds Act. In addition a Sexual Offenses and Domestic Violence Bill has also been drafted"*  
The law does not allow girls below the age of 16 years to be married. There have however, been instances where it is practiced and nothing is done to punish parents who consent to such marriages. Poverty seems to be a factor contributing to parents marrying girls off at an early age.  
-Sex work and abortion are illegal even though they are practiced.
3. The law is silent on how it affects the vulnerability for girls and young women to HIV except in as far as protecting them from sexual abuse is concerned eg statutory rape and rape laws.
4. Some of the major gaps in law that need to be changed have been addressed by the constitution e.g. access to land. However law reform is necessary to ensure that the provisions of the constitution are catered for.

**Prevention component 2: Policy provision**

5. HIV Testing and Counseling guidelines provide services to adults and young people to get consent of parents or guardians.
6. There is official sex education for school going young people in the country. Schools teach family life education covering mainly growth and development.
7. Review age of consent which is 18 years for treatment e.g for HIV testing because some girls need this service before they reach 18 years if they know that they have been exposed which then discourages them from taking an HIV test and the necessary precautions.

**Prevention component 3: Availability of services**

8. HIV prevention services are available such as male and female condoms, HIV information from youth friendly corners and youth centers in the country. Services for the Treatment of STIs are also available from clinics and the general outpatient departments in hospitals. ART services are available from clinics and hospitals and PMTCT services are available in about 34 health facilities in the country. There is need for scaling up of this service because the coverage is still inadequate.
9. Available services are for all young women and girls and access does not distinguish by whether the person is unmarried, out of school and all the other listed types. There are care points for feeding orphans, school fees and bursaries grants from government but these are not related to HIV prevention.

10. Condoms, HIV prevention information and the treatment of STIs services that are available for boys and young men in clinics and youth centers. *"There is evidence that sexually active young men use condoms in sexual relationships which then positively affect the situation for girls and young women. They do not only collect male condoms but take female condoms as well"*

11. YCs have to be equipped to provide HIV testing and counseling for young people. Dialogue has to be stimulated on HIV prevention among young people. Income generating projects for all young people to be initiated and strengthened because girls sometimes engage in risky sexual behavior because of poverty.

#### **Prevention component 4: Accessibility of services**

12. The main barriers to girls and young women using HIV prevention services in Swaziland include the following: Location which requires the youth to travel long distances, the cost of the services, unfriendly services and environments as some youth services are accessed in the same areas with adult services especially sexually reproductive health services, lack of space disregarding the need for privacy

13. Access to services are easier for unmarried young women and some such as access to condoms favor out of school youth as schools do not allow supply of condoms.

14. *"Boys and young men are sometimes proactive in initiating the use of condoms with their partners because due to socialization and the fact that young women are expected to stay at home, they are the one's who are able to access services more than girls from Youth Centers etc"*.

15. There is need to strengthen life skills and family life education in schools. Also to increase number of YCs including the youth friendly services. There is need to lobby the Ministry of Education to allow condom distribution in high schools because studies have indicated that some girls become sexually active at an early age .

#### **Prevention component 5: Participation and rights**

16. *"Swaziland has ratified CEDAW and what is remaining is that it has to be domesticated. There are also efforts to apply the Convention on the Rights of the Child where government is trying to fulfill the concept of Education for All by providing school bursaries for Orphans and other vulnerable children and these include girls"*.

17. The national response is somewhat "rights based" as it does address the sexual and reproductive rights of girls and young women but there is room for improvement.

18. Young people including those living with HIV and AIDS are represented at the CCM level. PLHIVS are a recognized as a sector in HIV prevention and care programs in Swaziland.

19. There is need for programs for the educating, information sharing and dialogues to empower girls and young women with decisions-making skills.

#### **Summary**

- *The country needs to revisit and finalize, as a matter of urgency, all the law reform processes that have begun to ensure that the necessary linkages between legislation and HIV prevention for girls and young women is in place.*

- Strengthen linkages between HIV prevention services and adolescent sexual and reproductive health
- Increase access to basic HIV prevention services
- Provide resources for projects that promote economic independence for girls and young women.
- Facilitate Education for All.

**The AIDS Support Centre (TASC)**  
**One-to-one interview: Counsellor – Female**  
**Location: Manzini**  
**Date of Interview: 23rd May, 2007**

**General**

1. My impression about the general situation is that things are getting worse because we are seeing an increase in the numbers of those infected.

**Prevention component 1: Legal provision**

2. Legally young girls should get married at 16/18 years but some parents are after cattle and marry them off at an early age.

- sex work is not legal.
- Abortion is not legal.

3. In-school girls get VCT services as long as they are above 16 years. Those below 16 should fetch a guardian or parent. Otherwise there is no distinction between married or single, between rural or urban as well as between HIV positive or negative. There is also no discrimination against marginalized groups.

4. To address the situation of HIV prevention for girls and young women, government has to “abolish polygamy and make it mandatory that each one man has one wife.”

**Prevention component 2: Policy provision**

5. It is government policy to make available and accessible, both male and female condoms as well as information on their proper use. There is evidence in the country of improvements in the distribution of condoms as these are available in all communities even though the female condoms are sometimes in short supply. However, “*increases in HIV infection does not seem to tally with availability as people continue to be infected.*”

In line with government policy to provide VCT services, the country has witnessed an increase in VCT services points. This service will hopefully make the HIV prevention better for girls and young women.

TASC has a policy that young people below 16 years have to be accompanied by parents if they need an HIV test.

6. There does not seem to be a national sex education program in the country. What is available seems to be ad hoc depending on the planned programs for different organizations.

7. Government should make it policy to organize intensive sexual reproductive health education to all places where girls and boys meet such as the reed dance and lusekwane ceremonies because thousands will be reached.

### **Prevention component 3: Availability of services**

8. All types of services all available in most places such as HIV information and condoms available in all health centers, now also available in a number of shops and other outlets in both rural and urban areas. *"The availability of VCT, ART and PMTCT services are however limited to urban areas with most rural youth having to travel long distances to access these."*

9. There is no discrimination on who should access services but these are widely available to all types of girls and young women who need them.

10. Service provision is not provided according to gender and boys are also able to access services if they need them and access to services for boys should be improving the situation for girls and young women. In reality however, such a situation is not evident.

### **Prevention component 4: Accessibility of services**

12. Some of the barriers to accessing services include the following: costs of accessing services. *"Even though most services are free in government health facilities, some of these are located far from most rural communities and transport costs are incurred in order to access these."* In addition, privacy at service point is lacking which discourages young people from access. Services are not open on weekends, yet most people are free on these days. Fear is another barrier as people still think confidentiality is breached.

12. Services are easy to access for all types of women whether in school or out of school, married or unmarried or HIV positive.

13. Programs to support boys to support girls should be introduced as boys may not be conscious of the role they have to play.

14. Men should play an active role in HIV prevention for girls and young women.

### **Prevention component 5: Participation and rights**

15. Swaziland has made progress in applying the Convention of the Right of the Child particularly with regards to education as government is trying to provide education for all children through and plans to introduce universal free primary education. CEDAW is still not applied.

16. The national AIDS policy addresses the sexual and reproductive health rights for girls and young women.

17. Young women including those living with HIV are to a large extent involved in decision-making about AIDS at the national level because they are represented in both the National AIDS Committee and CCM.

### **Summary**

20. Government has to involve men in HIV prevention programs for girls and young women so that they can appreciate the importance of supporting this group.

HIV positive men should take a lead in educating other men on HIV and AIDS. Community leaders should insist on men attending meetings where discussions on AIDS are held in communities because it is always women who attend.

NGOs have to be funded in order to scale up services to remote rural areas which are currently not reached.

There has to be compulsory VCT and the necessary support systems for everyone in communities.

### **One -To-One Interview**

#### **Peer Educator**

**Date Of Interview: 25<sup>th</sup> May, 2007**

1. HIV prevention for girls and young women is not getting better because young people are not changing behavior as some continue not to use condoms "Others still ask you about the advantages of condoms".

### **Prevention component 1: Legal Provision**

2. There are no laws that are making HIV prevention for girls and young women better. This group is still faced with increased vulnerability. Although civil law does indicate the age at which girls have to get married, "*customary law on the other hand is not specific on the age at which a person should get married and many people manipulate this silence and marry very young girls*". A recent of a 13 year old married to a 46 year old men was reported in the media.

4. There is need for laws to protect HIV positive people especially girls and young women.

- Government has to change the Marriage Act so that young girls vulnerability to HIV is addressed.

- There should be stiffer penalties for sexual offences and other abuse against girls and young women.

### **Prevention component 2: Policy provision**

5. There is an HIV and AIDS policy which addresses HIV prevention, however most of the people do not know what it says.
6. Sex education for young people in Swaziland is very shallow. Young people have never been exposed to sex education resulting in young people having problems when they have to take decisions pertaining to sex.
7. "*All government policies should have an HIV prevention component addressing HIV issues*".

### **Prevention Component 3: Availability of Services**

8. Condoms are available to youth in urban areas. Youth in rural areas do not have easy access because there are no restaurants, bars, public toilets where condoms are placed as is the case in towns. Female condoms are not known by many rural women and girls and hence the difficulty to use them. Information on STI's is not enough for young people. Only urban areas have VCT facilities. Most people have difficulty accessing ART as the service is not available in all communities. Rural areas do not have ART outlets. Rural people find themselves skipping days while trying to get money to go to town. PMTCT services are also available in towns and again rural areas suffer.
9. In rural areas services are scarce for all types of girls and young women whilst in urban centers services are available for all types of young women. Networks and support groups of People Living With HIV and AIDS are only available in urban areas.
10. Youth Centers have peer educators who impart knowledge emphasizing behavioural change or condom use to young women but those who frequent these centers are young men.
11. VCT should not be voluntary but compulsory to ensure that everybody knows their status. Education on ART is needed to encouraging people to take ARVs as most people are reluctant. There is need also to increase training of young people in livelihood skills in order to address HIV AIDS issues.

**Prevention Component 4: Accessibility of services**

12. Costs of services particularly for those in poverty stricken rural areas.
  - All services should be decentralized to other regions.
  - Attitude of staff, as some nurses do not treat clients with respect.
  - There is still a lot of stigma around HIV and AIDS and this affects accessibility for some people.
  - Cultural norms affect accessibility because whilst it might be easy for boys to access services, girls remain at home to do household chores.
15. A strategy to ensure equal access to services for both boy and girls should be put in place by government.
  - HIV and AIDS education to be brought to all people at constituency level.
  - Youth centres should be utilized as a way of reaching rural youth.

**Prevention component 5: Participation and rights**

16. International Conventions are not applied in the country they are there on paper only.
18. Young people are left out of decision making.
19. There is need for government to ensure that what is on paper is actually practices such as adhering to International Conventions.
  - Young people should be part and parcel of decision-making processes that impact on their lives

**Summary**

*-Government needs to invest in young people by giving them knowledge to facilitate HIV prevention.*

- The concept of peer educators has to be revived as most have stopped being active because there is no motivation since they are not paid.*
- Community leaders should make sure young people are involved in decision making processes especially those that directly affect them.*
- Tinkhundla system does not have a development strategic plan for their communities where it would be stated how they intend dealing with issues such as HIV – AIDS, gender, number of PLHIV and HIV prevention services available.*
- To ensure that there are facilities to cater for the economic empowerment of girls and young women.*