Evaluation of the HIV / AIDS Prevention
And Care programme (HAPAC)
In Swaziland
8ACP SW 019 - 9 ACP SW 04
Final report (draft)

Implemented by:
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Acknowledgements

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Executive Summary

The EC has, under the 8th EDF, funded the HIV/AIDS Prevention and Care Programme (HAPAC) in Swaziland which ran from June 2002 to the end of 2005. Its budget of 1.96 million €, is a small proportion (6.5%) of the 8th EDF contribution to Swaziland. HAPAC’s overall objective was to reduce the spread of HIV and alleviate the impact of AIDS in Swaziland.

It aimed at three major problems identified by the Government of Swaziland as priorities for action: 1) Limited access to voluntary counselling and testing (VCT) services for HIV, 2) Lack of resources for home-based care (HBC) for those with AIDS and 3) High rates of sexually transmitted infections (STI), increasing the risk for HIV infection.

Managed by a Project Management Unit in the Ministry of Health and Social Welfare, HAPAC has set up VCT sites in hospitals and as free standing sites. The management of these VCT sites was contracted out to NGOs. HBC was funded through government health services and through an NGO in Lubombo region. STI treatment was improved through training of health workers, strengthening the national reference laboratory, procurement of special antibiotics and piloting pre-packaged treatment kits.

The HIV/AIDS epidemic is one of the worst in the world with a prevalence rate among antenatal that has rapidly risen from 3.9% in 1992 to 42.6% in 2005. The national response has shown various shortcomings as indicated by the 2005 Joint Review.

The evaluation has found that HAPAC’s focus on three aspects of the health sector response is relevant because the VCT and STI treatment are evidence based interventions to reduce the transmission of HIV. Home based care is relevant as this is the only way to provide care as the intramural services cannot cope with the increased demand. The evaluation confirms that the interventions have been carried out in an effective and efficient way. Capacity building has effectively taken place in several forms.

The design of HAPAC looks like an emergency response as it includes significant funding of service delivery without paying sufficient attention to sustainability. During the life of the project no exit strategy was formulated.

HAPAC’s PMU was positioned in the MoHSW, but parallel to, and to some extent competing with the Swaziland National AIDS Programme (SNAP) which is responsible for the health sector response to the AIDS epidemic. This might have been justified by initial weakness of SNAP and might have allowed a swift start of HAPAC, but from a longer term development point of view this might not have strengthened the health sector response as a whole.

The evaluation confirms the successes in service delivery and recommends building on these, while addressing the main issues identified by the 2005 Joint Review, which are organisation, management and coordination in the health sector response. It recommends that future EC support
to HIV/AIDS action focuses on systematic capacity building of SNAP at national and decentralised level.

The evaluation found that while HIV/AIDS action is worldwide recognised as a social problem that needs to be addressed through multisectoral action, and EC’s strategy for Swaziland confirms that HIV/AIDS is the biggest challenge to development, the other EC funded projects have to date not managed to mainstream HIV/AIDS in their work. The evaluation strongly recommends that mainstreaming HIV/AIDS will be vigorously practised and monitored in all EC funded projects.
## Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
</tr>
<tr>
<td>AMICAALL</td>
<td>Alliance of Mayors Initiative for Community Action on AIDS at the Local Level</td>
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<tr>
<td>ARV</td>
<td>Antiretrovirals</td>
</tr>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>AWPCE</td>
<td>Annual Work Programme and Cost Estimate</td>
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<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
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<tr>
<td>CANGO</td>
<td>Co-ordinating Assembly of Non-Governmental Organisations</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
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<td>EU</td>
<td>European Union</td>
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<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
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<td>HAPAC</td>
<td>HIV/AIDS Prevention and Care project</td>
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<td>HBC</td>
<td>Home-Based Care</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<tr>
<td>NAO</td>
<td>National Authorising Office</td>
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<tr>
<td>NAPCP</td>
<td>National AIDS Prevention and Control Programme</td>
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<td>NERCHA</td>
<td>National Emergency Response Committee on HIV/AIDS</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PD</td>
<td>Programme Director</td>
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<td>PHU</td>
<td>Public Health Unit</td>
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<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<td>PM</td>
<td>Programme Manager</td>
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<td>PMU</td>
<td>Programme Management Unit</td>
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<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>RFM</td>
<td>Raleigh Fitkin Memorial</td>
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<td>RHMT</td>
<td>Regional health management team</td>
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<td>RHM</td>
<td>Rural Health Motivator</td>
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<td>RPR</td>
<td>Rapid Plasma Reagin</td>
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<td>SAP</td>
<td>Structural Adjustment Programme</td>
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<td>SHAH</td>
<td>Swaziland Hospice at Home</td>
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<td>SAREC</td>
<td>Department for Research Cooperation at Sida</td>
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<tr>
<td>SHAPE</td>
<td>Schools Health and Population Education</td>
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<tr>
<td>SIDCA</td>
<td>Swedish International Development Cooperation Agency</td>
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<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>TA</td>
<td>Technical Assistant</td>
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<tr>
<td>TAP</td>
<td>Technical and Administrative Provisions</td>
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<td>TASC</td>
<td>The AIDS Information and Support Centre</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations general Assembly Special Session on HIV/AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. Introduction

This is the report of the final evaluation of the EC funded HIV/AIDS Prevention and Care project (HAPAC) in Swaziland, which was carried out from 29 May till 16 June 2006. The expected result of this evaluation is an assessment of the efficiency, effectiveness, and impact, to verify that the results are in line with the Financing Agreement and to make solid recommendations for the 2006-2008 programme. The evaluation took place somewhat belatedly, in the sense that the project had come to a close on 31 December 2005 and that a continuation with similar intervention logic has been approved and is presently up and running. This evaluation can thus not serve to first and foremost guide a possible succession of HAPAC as that has already been decided on. Such a situation could potentially bias the evaluator and evaluation users as this given situation might discourage critical thinking as projects, once approved, are not easily changed. The risk of this bias was well understood in discussions between the evaluator, EC staff and government officials. It was appreciated by all that the outcome of this evaluation would as far as possible be used to guide HAPAC’s current continuation and would also be used to guide possible future EC involvement in the health sector in Swaziland.

The evaluation is based on document review (see Annex C for documents reviewed), interviews with various stakeholders (see Annex B for persons met), and on the proceedings of a workshop for stakeholders held at the end of the evaluation. Field visits were made to health staff and their facilities, users of these facilities, community members trained as home based care givers and the ones they care for. These visits aimed at providing mere illustrations of issues reviewed and discussed and do not serve as primary data collection.

The report begins with an overview of the HIV/AIDS situation in Swaziland and a brief history of HAPAC, as general background. Then various aspects of the HAPAC programme are discussed against this background, following the evaluation criteria as listed in the Terms of Reference (see Annex A). Finally the conclusion and recommendations are presented.
2. Background

HIV/AIDS/STI situation in Swaziland

HIV/AIDS continues to be an overwhelming crisis, rapidly spreading and impacting deeply on social, cultural and economic aspect of the Swazi nation. Since the first case of AIDS was identified around 1986 the country has put up massive efforts to meet the challenges posed by the epidemic. Although important successes have been recorded at different levels the epidemic continues to grow becoming one of the major development challenges of the current time. The dynamics of the epidemic are not different from the regional picture. Global estimates show that between 2001 and 2003 the number of people living with HIV (adults and children) increased from 23 million to 25 million in the Sub-Saharan Africa region. It is estimated that of the 1.1 million people in Swaziland about 220,000 were living with HIV/AIDS in 2004.

The prevalence rate among antenatal clients, as measured by sentinel surveillance, has rapidly risen from 3.9% in 1992 to 42.6% in 2005, placing it among the worst affected countries in the world. The rapid rise has been consistent among Swaziland’s four regions, and is noted in urban as well as in rural areas. The worst affected age category among women appears to be the 20-29 years old, although the prevalence rate among teenage girls (15-19 years) was also extremely high (32.5% of pregnant teenagers infected). Sero-prevalence data among men are scarce. A survey conducted among a high-risk population, namely sugar estate workers, in 2002 showed a similar high-prevalence rate of 37.5%. No population-based HIV sero-prevalence survey has ever been conducted in Swaziland.

As the epidemic matures, the impact is becoming visible through an increasing number of patients suffering from AIDS opportunistic infections, an increase in mortality rates and a rapidly growing population of orphans and vulnerable children. It is estimated that the number of orphans, which was about 32,000 in 2001, will increase to over 120,000 (approximately 15% of the population), by 2010. The burden of orphans is already now beyond the capacity of the extended family to cope and as child headed households are on the increase, school drop outs, hunger and deepening poverty is evident in the population.

The Crude Death Rate has increased, as a result of AIDS mortality, from 9.9 to 22.7 deaths per 1,000 populations and is projected to reach 30.2 deaths per 1,000 populations by 2010. If no action is taken annual AIDS deaths are projected to increase to around 22,000 by 2015, exceeding non AIDS-related deaths by nearly 20,000. The projected population size in 2015 is estimated at 1.58 million, about 41% lower than it would have been in the absence of AIDS.

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1 This text is liberally edited from the 2003-2005 UNGASS Indicators country report, and other government and UN documents
2 UNAIDS, 2003
3 World Bank 2001, Selected Development Impacts of HIV/AIDS
In the education sector it is projected that there will be an increase in children not enrolled in primary education from 3.5% in 1999 to 30% by 2015. The quality of education may also decline due to increased HIV/AIDS related deaths among teachers. The ratio of teachers to students has shifted from 1:35 in 1997 to 1:52 in 2000. In the health sector, the demand for hospital beds has increased with HIV/AIDS-related conditions taking up more than 50 percent of the beds. As a result there is generalised congestion in hospital wards, increasing the burden both at the hospital and at home. The environment at home is ill prepared for this task and the family, affected by a reduction in income because of the loss of their productive members, are struggling to provide basic care.

One of the key features of the HIV/AIDS epidemic is that it affects the most productive part of the population (15 to 49 years). This has significant implications for the labour force, hence contributing to economic decline. The epidemic affects both the quality and quantity of labour supply in the economy. Highly trained and educated individuals are few and their replacement results in great national costs. Evidence from different studies indicates that the main cost to society is not the direct costs of medical care and prevention but rather costs resulting from the loss of economic production and the more complex and less easily estimated costs of social disruption and instability.

The prevalence of sexual transmitted infections (STI), other than HIV, also continues to be high in Swaziland. Although the sero-prevalence of syphilis among antenatal clients (as measured by the sentinel surveillance using the RPR test) has gradually decreased from 11.6% in 1994 to 4.2% in 2002, it remains very high. In 2003 a first round of biological sentinel surveillance of STI among ANC clients at two selected clinics was conducted, showing prevalence rates of 7.8% for gonorrhoea, 18.2% for chlamydia infection, 7.8% for syphilis and 21.9% for trichomonas infection.

**National response to HIV/AIDS**

Immediately after the diagnosis of the first case of HIV infection in 1986 the Swaziland government established a National AIDS Programme within the Ministry of Health and Social Welfare (MoHSW), that later became the Swaziland National AIDS Programme (SNAP). The programme was aimed at reducing the spread of the HIV epidemic through information, education and communication (IEC) campaigns, mainly focussing on prevention. As part of its mandate SNAP was responsible for coordinating all HIV/AIDS activities in the country.

On realising that HIV/AIDS was not just a health problem, other stakeholders started programmes to fight the epidemic. With His Majesty the King declaring HIV/AIDS a “national disaster” in 1999, the Government created the Cabinet Committee on HIV/AIDS and the Crisis Management and Technical Committee (CMTC) to wage a multi-sectoral fight against the epidemic. The CMTC developed a first National Strategic Plan (NSP) for HIV/AIDS (2000-2005) which aligned the response into three areas: (1) prevention; (2) care and support; and (3) impact mitigation. SNAP’s mandate became now focused on the health sector response to the epidemic.

In 2001, the National Emergency Council on HIV/AIDS (NERCHA) was established under the Prime Minister’s Office to replace the CMTC. The mandate of NERCHA is to coordinate the
response to the epidemic, to foster the wider multi-sectoral involvement of all stakeholders and to mobilise and disburse resources. In November 2004 the NSP was reviewed and the main priorities for the next strategic plan were identified. HIV/AIDS is also considered one of the priorities for the Government and is included in all national development policies.

Complimentary to the NSP, the MoHSW has developed a Health Sector Response to HIV/AIDS Plan which is aimed at operationalising the health sector obligations outlined in the NSP. The plan is to guide the implementation of all health sector based interventions under the auspices of SNAP.

Funding for the national response comes from the Government, multi- and bi-lateral donor support, and the private sector. A boost to the response was realised in 2003 when the Government received substantial support from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), for which NERCHA was appointed the Principal Recipient. Of the total budget of 52 million US $, 30 million US $ was made available for the first 2 years. Actual disbursement lagged significantly behind projected expenditure, indicating a major capacity problem in the country 4.

As the number of infected people increases, the emphasis in the national response has gradually shifted to care and support for people living with HIV/AIDS and to the mitigation of the impact of the epidemic on the Swazi society.

In recent years, access to voluntary counselling and testing (VCT) has improved with the creation of VCT facilities in the majority of the urban areas, and outreach activities to the rural areas. Clinical care was strengthened by the development of national guidelines and the introduction of anti-retroviral therapy (ART). In 2003, an ART programme was started with funding from Government and the GFATM. By the end of 2004, it was estimated that about 7,000 people were on ART. The target set for the end of 2005, as part of WHO’s 3 by 5 initiative, is 16,000 of the estimated 32,000 PLWHA in need for ART. In addition, prevention of mother to child transmission (PMTCT) is gradually being introduced in antenatal care facilities. The community home-based care programme has been further strengthened and access to care and support supplies was greatly improved by the introduction of community based supply containers. STI care has received renewed attention with the further strengthening of the capacity to correctly manage STI cases at health facilities.

Activities to mitigate the impact of the epidemic have been initiated. Support to orphans and vulnerable children (OVC) is being scaled up, including the payment of school fees, the provision of food supplements and rehabilitation of shelter.

The 2005 joint review of the national response to HIV/AIDS in Swaziland looked at these key areas; prevention, care and support, impact mitigation, funding and management/coordination. Its recommendations are divided in two tiers. The first tier of recommendations is more fundamental, pointing at the organisational and institutional weaknesses of the national response. These recommendations include the need to formulate a nation wide plan with objectives and strategies followed by an action plan with targets, time frame and budget involving all actors and implementers under the leadership of NERCHA. The second tear of recommendations focus on technical and implementation issues.

4 GFATM, grant performance report, SWZ-202-G01-H-00, 10 March 2006
Although SNAP is widely seen to be responsible for the planning and coordination of the health sector response to the epidemic, it does not seem to have been given the formal authority and position in the MoHSW to effectively execute this role.

The 2005 joint review further points out that coordination at regional level in the country needs to be strengthened.

The EC funded HIV/AIDS Prevention and Care project

A financing agreement was signed in 2001 between the European Commission and the Government of Swaziland for a 3-year HIV/AIDS Prevention and Care (HAPAC) Project. The project was implemented through a Project Management Unit (PMU) based within the Ministry of Health and Social Welfare (MoHSW). The PMU comprises a Project Director (PD), who is the Principal Secretary in the MoHSW, assisted by a Deputy Project Director, who is the Director of Health Services in the MoHSW and a locally recruited Project Manager (PM) and Administrative Assistant for the entire duration of the project. There was also a full time technical support for the first year of the project, and short-term TA inputs. The one year technical assistant (TA) acted as an advisor to the PMU and a maximum of eight months short-term consultants for the entire duration of the programme. The long and short-term technical assistance was provided through a service contract with EPOS Health Consultants. The contract was initiated on 17 June 2002 and after three years extended to 31 December 2005.

The HIV/AIDS Prevention and Care Programme (HAPAC) addresses three major problems identified by the Government of Swaziland as priorities for action. These problems are:

- Limited access to voluntary counselling and testing (VCT) services for HIV
- Lack of resources for home-based care (HBC) for those with AIDS
- High rates of sexually transmitted infections (STI), increasing the risk for HIV infection

The overall objective of the programme is ‘to reduce the spread of HIV and alleviate the impact of AIDS in Swaziland’.

The programme’s purpose has been defined as ‘to reduce the rate of transmission of HIV in Swaziland and to develop programmes for the provision of home-based care for those with AIDS’.

The expected results are:

- Increased number of people presenting for voluntary counselling and testing
- Improved home-based care of persons with terminal AIDS
- Improved management of sexually transmitted infections
- Increased awareness of HIV/AIDS in the community at large

The total cost estimate of the Programme was € 1,960,000 for the three years which was divided as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost (€)</th>
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<tbody>
<tr>
<td>Voluntary Counselling and Testing</td>
<td>700,000</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>280,000</td>
</tr>
<tr>
<td>Home Based Care</td>
<td>320,000</td>
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<tr>
<td>Programme Management Unit</td>
<td>150,000</td>
</tr>
<tr>
<td>Technical Assistance</td>
<td>350,000</td>
</tr>
<tr>
<td>Evaluation/Auditing/Contingencies</td>
<td>60,000</td>
</tr>
</tbody>
</table>
3. HAPAC’s implementation and accomplishments

Before discussing the accomplishments on the basis of the evaluation criteria in the next chapter, HAPAC’s planning and implementation facts are presented, covering its initial situational analysis, the selected approaches and the accomplishments. The description goes into some detail to allow the reader who is not familiar with the project to get insight beyond headings and figures.

3.1 Situational analysis

At the start of the project a situational analysis was conducted. A summary of the major findings include the following.

**VCT:** Although VCT is being offered nationwide by The AIDS Information and Support Centre (TASC) from a free-standing centre in Manzini, the number of people attending is still limited and certain important groups, such as adolescents, are insufficiently reached. Whilst other agencies are also starting up, the need for VCT support remains but careful co-ordination between the different partners is mandatory.

**HBC:** Initially nation-wide home based palliative care for the terminally ill was provided by Swaziland Hospice at Home (SHAH). In recent years several other NGOs have started HBC activities, each following their own model and covering a limited geographical area. MoHSW has also started HBC programmes both through community health workers and from units at hospitals and clinics with nurses who conduct home visits to terminally ill patients. Additional support for HBC is foreseen from the joint UN project, the Global Fund and from the National Emergency Response Committee on HIV/AIDS (NERCHA). Nevertheless, the needs for community home based care and support for people with AIDS remain enormous. Close co-ordination and collaboration between all partners will be required to avoid overlap.

**STI:** MoHSW started to strengthen STI care in the mid-nineties. National STI case management guidelines using the syndromic approach were developed and most health care providers were trained. However, follow-up after training, supervision, and monitoring and evaluation are weak. In addition, the STI case management guidelines have not been integrated in the nurse training colleges’ curricula. The current quality of STI care in the public health facilities is not known and surveillance of STI prevalence is not done. The use of the private and the informal health sector for STI-related complaints is very common.
3.2 HAPAC’s approaches

The following mode of action was proposed to address the three areas:

**VCT:** Following the recommendations of the SNAP, the programme set out to create one health facility based VCT unit and one free-standing VCT centre with outreach capacity in three sub-regions where all VCT activities will be supported. The health facility based VCT activities will be supported through direct funding of the MoHSW or mission hospitals. The free-standing VCT facilities and outreach activities will be contracted out to one or more NGO. The sub-regions chosen were Lubombo North and South, and Hhohho North. A separate contract will be made for an advertising campaign to create awareness and to promote the use of the VCT facilities. Special attention should be given to an appropriate location of the VCT centre; to enhancing access for particular risk groups, such as adolescents; to guaranteeing a continuum of care; and to the creation of support groups for people with HIV/AIDS. All running costs will be covered.

**HBC:** HBC activities will be supported in a well defined geographical area ideally in the same areas that are supported by the VCT component. In a first phase, a mapping exercise of all HBC activities in the country will identify the areas with the highest needs. In those areas, the HAPAC Programme will support the MoHSW model by creating a HBC unit at a central hospital or health centre and by strengthening HBC from the clinics and the Tinkhundla centres, and by the rural health motivators. NGOs interested in implementing HBC activities in the area will also be supported. The programmes should provide a comprehensive package of care and support, should use a strong community based approach, establish clear links with other components of the continuum of care, and have a good working relation and co-ordination with other HBC programmes in the area. All running costs were to be covered.

**STI:** The quality of STI care in the public health sector will be improved by a refreshment training of STI programme managers and supervisors, by continuous on-the-job training of the health care providers through supervision, by strengthening monitoring and evaluation, by the revision of the nurse training colleges curricula, and by the provision of critical STI drugs, reagents and other supplies. Private practitioners will be trained separately. The reference laboratory will be strengthened to conduct surveillance of STI prevalence, quality control and operational research. NGO interested in conducting interventions with youth, high-risk groups or the informal sector will be identified and supported.

**Other issues:**

In addition to the three specific intervention areas HAPAC planned to address other issues that contribute to better HIV/AIDS control.

HAPAC planned to enhance collaboration between the different partners involved in the three programme’s components. The PMU would actively participate in the existing co-ordination mechanisms and create additional ones where needed.

Capacity building of the MoHSW was to be achieved through skills transfer on a day-to-day basis. The institutional capacity of the supported NGOs will be assessed and strengthened if needed. Additional skills building will be done by regional networking and exchange visits with successful VCT and HBC projects in neighbouring countries, and by supporting the attendance of regional and international conferences by key programme staff.
Sustainability was to be enhanced by human resource development; by supporting the most cost-effective models; and by avoiding expensive technologies.

A monitoring and evaluation system was to be developed following the logical framework approach.

Short-term consultants were to be made available for assisting in the development of the terms of reference for VCT and HBC contracts, in the development of the necessary list of laboratory supplies and equipment, in the training to be done, in the development of the third year work programme and cost estimate, and in the surveys and assessments to be conducted.

3.3 Accomplishments

The activities carried out by HAPAC in the three main areas of work and in other sub-areas are described here, based on information from project reports.

3.3.1 Voluntary Counselling and Testing

**Health facility based VCT services:**
There were three sites that were identified with the full participation of the Regional Health Management Teams (RHMTs) and other partners involved in VCT. The areas were Good Shepherd Hospital, Pigg’s Peak Hospital and Sithobela Health Centre.

At Good Shepherd, rehabilitation was done with funds from the project. The recruitment of staff was done by the hospital management, representative from SNAP and HAPAC was invited as an observer. Three counsellors were recruited and one receptionist. The recruited staff members were sent for training and SNAP with the assistance of the National Reference Laboratory was requested to do an inventory and based on their report, the programme then procured the needed equipment, furniture and supplies were procured. Since its inception the site has seen a total of 13,429 and 91% were tested. The site also operates on weekends. About thirty percent are couples and some of them are from polygamous families. The site was inaugurated by the Head of Delegation and a representative from the MoHSW.

At Pigg’s Peak hospital, HAPAC renovated the counselling and care unit. A VCT management committee was established to coordinate the day-to-day running of the site. A total of 4,330 clients have been seen and 75% were tested. The VCT site was officially inaugurated by Her Royal Highness Inkhosikati LaMbikiza in September 2003 during the Pigg’s Peak AIDS Day.

Requested by the Lubombo RHMT a new site was established at Sithobela Health Centre. Rehabilitation and recruitment was done and it started operating in July 2004. A VCT management committee was established and has started incorporating ART. The site has proved to be a good model for the continuum of care and especially provision of ART in a rural setting. The site was inaugurated by the Member of Parliament and the Head of Delegation was also represented. An estimate of more than five hundred community members attended the inauguration ceremony. During the inauguration the Honourable MP and the Regional Public Health Matron took a public
HIV test which really had an impact in terms of people coming for counselling and testing in a rural set up. A total number of 4,970 clients have been seen and 42% were tested.

The difference in the proportion of clients being tested is explained by the different numbers of hospital in- and outpatients that have made use of the VCT facilities.

**VCT services provided by NGOs:**

NGOs were invited to submit proposals for the implementation of VCT services at the three identified areas which were Pigg’s Peak town, Siteki town and later Matata Shopping Complex. The TASC/AMICAALL Consortium was selected for Northern Hhohho, Population Service International (PSI) for Northern Lubombo and Family Life Association of Swaziland (FLAS) for Southern Lubombo.

The TASC/AMICAALL Pigg’s Peak site has ten outreach sites and has formed three support groups. At the PSI Siteki VCT site, ten support groups and twelve outreach sites with special attention to commercial sugar companies and faith based organisations were established. The FLAS Matata VCT site, three support groups and seven outreach sites were established.

An overview of numbers of clients seen is presented in the graph below. The difference in proportion of clients tested could not easily be explained. One explanation is that PSI’s attractive marketing results in many interested clients who want to get only information.
VCT Communication and Advertisement:
To increase the number of people attending VCT services and consequently changing their sexual behaviour, the development and use of a unifying brand name for the VCT centres was planned, combined with and mass media campaigns. PSI Swaziland, with ample experience in social marketing was contracted to do this. On the basis of experiences in Zimbabwe and formative qualitative research a marketing strategy and logo for VCT centres were developed and tested. “Calakabusha Namuhla”, meaning New Start was launched as the slogan for VCT in Swaziland. A management toolkit for the four VCT sites network, including quality assurances tools were developed. The launch of the New Start VCT network was accompanied by media campaigns. The first, with the slogan “Come in, lets talk” addressed the stigmatisation of VCT sites, and the prevailing assumption that once in, one needs to be tested. The second campaign with the slogan “Make a New Start Today” was also seeking to address the issues of fear, now using testimonials of people who had accessed the VCT services and testifying that the services were excellent and the visit provided them with information on what choices to make for them to turn in a new leaf in their lives. The campaign targeted the “worried well” in order to increase the prevention aspect of VCT.

3.3.2 Home based Care

HBC was supported through the MoHSW health services and also through NGOs. Initially a mapping exercise was conducted to identify all agencies and organisations that were active in HBC in Lubombo region. Based on the outcome of the mapping exercise, the region and HAPAC identified the individuals and organisations that should become member of the HBC committees at regional, Tinkhundla (constituency) and chiefdom level in Lubombo region. In November 2003, a workshop was organised by the Regional Health Management Team (RHMT) for all regional HBC stakeholders, and Terms of Reference (ToRs) of the regional HBC committee were agreed upon.
**HBC Coordination mechanism:**
The mapping exercise recommended that clearly defined coordination structures are needed. At the regional level, Regional Community Home Based Care Committee (RCHBCC) in collaboration with the Regional Health Management Team (RHMT) are the key coordinating structures. By the end of the project, a regional HBC committee has been formed and is chaired by the Regional Medical Officer and assisted by the Regional Public Health Matron. Other members are: RHA, representative from the RHM program, representative of all the NGOs involved in HBC, Representative from those living with HIV/AIDS, representative from the private sector, AMICAALL and a representative from the Regional Administrator’s office. The Regional HBC Coordinator is the secretary of the committee. A total of eleven Tinkhundla (constituency) committees have been formed and each had a one day HBC training and orientation on their roles. Prior to their trainings the project supported a three days training of Honourable Members of Parliament (MPs) from the eleven Tinkhundlas and their head of constituencies and clerical officers. They were urged to support the trained carers in their respective constituencies. A community based approach was adopted for the implementation of HBC programmes and full involvement of community leaders, family members and the community at large, and with a strong component of stigma reduction.

**Training and incentives for community caregivers:**
A total of 126 were trained as community caregivers and 2985 as family caregivers, and a total of 230 RHM or other caregivers selected by the project. Community caregivers are considered volunteers and were initially not given monetary support but later they were later upgraded to be RHMS. Initially they were given protective clothing like safety shoes, overalls, torches, umbrellas, bags and rain suits.

Supplies for the community and family caregivers included materials like gloves, soap, plastic sheets, etc, and support supplies for the patient, such as food supplements. A total of about 20,000 HBC kits were distributed. The Lubombo region is the only region that distribute food supplements through the HBC containers and that has played a key role in enhancing the continuum of care. The HAPAC Programme has procured some additional food supplements like the micronutrients (morvite) for the chronically ill.

**HBC supervision, monitoring and evaluation:**
Transport was given to the region for supervision and also to conduct home visits, for the clinic and hospital staff to conduct home visits, for the community caregivers to visit clinics, and for the patients to attend clinics and hospitals. Initially, there was no driver for the car and with an approval of the NAO and endorsement of the EC a driver was recruited and started his contract in November 2003 and ended in April 2004 when government hired a driver for the region under the HBC. Throughout the duration of the project the vehicle has been well managed and running costs are fully paid by government. During the year 2005, all the 35 health facilities were visited by the regional supervisor and a total of 155 home visits were done and a total of 209 clients were seen in 2005.

A pilot of HBC monitoring and evaluation tools were developed and distributed to all the HBC containers and health facilities. Prior to their distribution, the tools were firstly presented to all the four RHMT’s and they had their input and it was agreed that they should be piloted at Lubombo Region. Following that forum of HBC stakeholders, there was a three days orientation of all nurses and public servants that work at the containers (166 health care workers attended a three days workshop) from the public sector with emphasis on monitoring and evaluation as a way to
introduce the new HBC Monitoring tools that were developed. The tools were later evaluated. During the last quarterly HBC Committee meeting in 2005, it was strongly recommended that trainings should focus more at family as a primary carer thus the skill of caring will be within the family and on the other hand ease the load from external carers.

**HBC supported by NGOs:**

Based on the results of the mapping exercise conducted in 2003, which identified the major NGOs who are active in HBC in Northern Lubombo, the HBC recognised the need to support NGOs. A service contract was signed with World Vision Swaziland for the strengthening HBC in the Lubombo region in April 2004. HBC training was conducted for 18 new caregivers and 191 caregivers attended a refresher course. The trained caregivers are currently taking care of 1550 patients and they have further equipped family members on caring for their relatives.

3.3.3 STI Care

**STI care in government services:**

HAPAC has trained 163 service providers with special attention to out patient departments. Selection of trainers from the four regions was done by SNAP and the RHMTs. A total of 18 STI trainers were selected and amongst them were clinic supervisors, community health nurses, and Regional HIV/AIDS Coordinators and Health Education staff. They were trained on the syndromic management and refresher training was organised annually.

A one day workshop was organised for private clinics to exchange experiences and to clarify the rational of the syndromic approach and also introduce the reviewed STI guidelines and protocols.

Representatives from the training institutions were trained as STI trainers. Their pre-service curriculum was reviewed. However, at the end of the project, it was not possible to fund the printing of new curricula.

For the National Reference Laboratory HAPAC has provided equipment and supplies to perform gonorrhoea culture, and trichomonas culture to be able to monitor sensitivity to treatment as well as syphilis confirmatory testing. An operational link has been established with the national Health Laboratory Service (NHLS), South Africa where PCR for the STI surveillance is conducted.

The need for support in extra STI drugs and reagents was discussed during the consultative meeting. It was agreed, that the major need is to improve the distribution and stock management systems. Nevertheless, the HAPAC Programme has contributed by providing funds for the procurement of the essential STI drugs, specified in the national guidelines, and for RPR reagents for syphilis screening in pregnant women. The procurement and distribution of these drugs and reagents were integrated in the existing systems and there was no parallel systems created thus they were distributed through the Central Medical Stores.

A project exploring the introduction and market pre-packaged treatment kits for urethritis was done. The provision of urethritis kits at pharmacies requires that pharmacists are allowed to provide the kits over the counter, without a prescription from a clinician. Currently, in the country antibiotic drugs such as ciprofloxacin and doxycycline should only be provided on prescription. A request to the Drug and Advisory Board of a temporarily exception on this rule for the piloting of
the over-the-counter sale of the urethritis kits was made. However, permission was not granted and the piloting could not take place.

Another pilot project on the distribution of pre-packed kits for the management of sexually transmitted infections (STI) in public health facilities in Swaziland was able to be carried out. Ten health facilities were selected as pilot areas targeting the most five most common STI syndromes like genital ulcer disease, vaginal discharge in non-pregnant women, vaginal discharge in pregnant women and pelvic inflammatory disease. The pilot was evaluated and the results are mixed, confirming that pre-packaged kits have a potential but that several operational difficulties need to be tackled.

**STI care by NGOs:**
An NGO, FLAS, was given the contract to strengthening quality STI care targeting commercial sex workers and long distance drivers along the corridor from the Ngwenya border to the Lavumisa border. The target populations were sensitised through peer education of the importance to seek prompt treatment for genital complaints at the nearest clinic.

### 3.3.4 Short term technical assistance

Areas of work for which short term technical assistance (TA) was obtained include:

**VCT:**
- Development of the terms of reference for the call for proposals and definition of the most appropriate VCT strategies and models.
- Training of the counsellors.
- Assessment of the end-of-project indicators measuring the quality of VCT services.

**HBC:**
- Development of the terms of reference for the call for proposals.
- HBC mapping exercise.
- Measurement of the baseline and end of project indicators.
- Development and evaluation of the HBC monitoring tools.

**STI**
- Evaluation of STI component

Where required the TA produced documents and reports.

### 3.3.5 Collaboration with other programmes:

To ensure close collaboration with other partners and to avoid overlap, technical working committees were formed with key stakeholders like NERCHA, Reproductive Health, Partner NGOs and other stakeholders. The annual consultative meetings have also strengthened the coordination of activities.

The HAPAC programme on the other hand have actively participated in strengthening the existing co-ordination mechanisms especially through the multisectoral approach and has fully participated in the committees created by NERCHA and the donor community. The programme organisational set-up also guarantees a close co-operation with the MoHSW’s programmes.

The mapping of the HBC activities have also strengthened in identifying the geographical areas and the other supported components that are the most in need of assistance.
3.3.6 Capacity building

Several senior health managers have attended courses, study tours, workshops and international conferences:
With the assistance of PSI Regional Office, a study tour was organised to Botswana. All the site managers from the HAPAC supported sites, Regional HIV/AIDS Coordinators, National Reference Laboratory Supervisor and the National VCT Focal Person participated. The VCT Focal Person was supported to attend the ICASA Conference in Kenya and the International AIDS Conference Bangkok, Thailand.
Following the findings of the mapping report, the Mpumalanga Province was identified as an area to be visited by stakeholders that are involved in HBC within the Lubombo Region. The team that went for a study tour consisted of Lubombo Regional Health Administrator, RHM Programme Manager, representative from Good Shepherd Hospital, Regional HBC Coordinator, Regional HIV/AIDS Coordinator and a representative from World Vision-Swaziland.
The National HBC Focal Person was supported to attend the ICASA Conference in Kenya and Abuja, Nigeria and the International AIDS Conference Bangkok, Thailand.
The National Public Health Medical Officer was supported to attend the ICASA Conference in Kenya.
The Program Director was supported to attend the ICASA Conference in Kenya and the International AIDS Conference Bangkok, Thailand whilst the Chief Pharmacist since the theme was on access to treatment was supported to the International AIDS Conference in Bangkok, Thailand. The Deputy Director was also supported to attend the ICASA Conference in Abuja, Nigeria and the International AIDS Conference Bangkok, Thailand. The long-term TA was supported to attend the ICASA Conference in Nairobi, Kenya. The Program Manager was also supported to attend the ICASA Conference in Kenya and Abuja, Nigeria and the International AIDS Conference Bangkok, Thailand.
Swaziland like any other developing country is faced with the high attrition rate of health workers especially nurses to either private sector or developed countries. The Chief Nursing Officer was supported to attend a regional training of health managers in Johannesburg which was aimed at equipping them with skills and knowledge on how to recruit and retain health professionals. She recommended that there is an urgent need to assess the human resource components and procedures including human resource audit, culture and assessing current workforce needs. She further recommended an urgent review of job description since nurses have started doing duties that can be easily done by non professionals. Newly recruited nurses need to be oriented including newly promoted health professionals. She further noted that there is need to improve working conditions starting with rural health facilities and the issues of vacant posts to be urgently resolved.
Four laboratory technicians have been on an attachment for one week with the NHLS. Capacity building within the National reference laboratory has been possible where the programme fully sponsored four laboratory technicians for a one week attachment to the NHLS. Through the support from the HAPAC Programme, training was conducted at site and also assisted the laboratory on the STI diagnostic (review protocols) testing by a consultant through the EPOS Service Contract.
3.3.7 Expenditure

HAPAC’s expenditure at the end of the project amounted to 95% of the cost estimate fully in line with the foreseen division amongst components.\(^5\)

\(^5\) Source: End of Project report, HAPAC 2005
4. The assessment

The ToR require an assessment of HAPAC according to five evaluation criteria; relevance, efficiency, effectiveness, impact, and sustainability. Gender and environment are crosscutting issues to be addressed.

4.1 Relevance

4.1.1 Has HAPAC provided the right answer to the right problem?

To assess HAPAC’s relevance means to assess whether the results HAPAC has committed itself to are an appropriate way to address the correctly identified problems. This assessment will focus on two questions. The first is “were the problems correctly identified?” and the second is “were the HAPAC’s approaches the correct answer to these problems?”. It is only fair to try to answer these questions first with the information available at the time of the project design and secondly with the advantage of hindsight at the moment of this evaluation.

The project design refers to three priority problems within the health sector indicated by government; limited access to VCT, high prevalence of STI and limited HBC. These priority areas do indeed feature in the NSP 2000-2005 list of problems. At the time of the project’s design HIV/AIDS was already for several years understood not to be merely a health problem, but primarily a social problem which can only be addressed by multisectoral action. The first question would thus be why the health sector per se has been selected, and why within the health sector three specific intervention areas were chosen. The answer is most likely that the NSP 2000-2005 was health sector biased and that a multisectoral approach had yet to be formulated in the country. The NSP furthermore provided limited guidance for implementation as it just set out strategies without setting targets and without action plan. The ambiguity at that time about the health sector role of SNAP and the multisectoral role of what was later to be NERCHA might have distracted focus from capacity building needs for management structures. Hence, the need for immediate action in the three priority intervention areas was clear at that moment and the potential for quick changes in these areas must have been much larger than in any other areas.

In order to be able to answer the second question (whether HAPAC’s approaches were the right answer to the problems to be addressed), the role of the health sector in HIV/AIDS control needs to be reviewed. Although most of the HIV/AIDS primary prevention strategies need to be carried out outside the health sector, this sector remains of paramount importance. The three areas of action HAPAC is committed to are globally accepted as important intervention areas. VCT plays a
highly effective role in prevention as it will lead for a considerable part of its clients to a change their sexual behaviour. The cost-effectiveness of VCT is not as clear as limited research has been carried out. Research in a cohort of 10,000 people in Kenya and Tanzania indicated that through VCT the cost per HIV infection averted was $264 and $367, respectively, and the cost per disability adjusted life year (DALY) gained was $12.77 and $17.78. VCT is globally accepted as a cost-effective best practice in HIV/AIDS control. Timely and correct treatment of STI is accepted as an effective strategy in reducing the spread of HIV. One of the few studies on STI treatment cost-effectiveness was done in Mwanza Region, Tanzania. The authors estimated the cost per STD treated to be $2.51, per DALY gained to be $12.31 and per HIV infection averted to be $259.33. This is also considered to be relatively cost-effective and STI treatment remains one of the pillars of the health sector response to the epidemic. Whether support to home based care is justified is easier to answer. A general understanding of the capacity of curative care in Swaziland and the cost of health care for individuals and households makes it clear that intramural palliative care is not affordable for the majority of the population. An understanding of the living conditions of the poorer segments of the population makes it obvious that without support most households will not be able to provide a minimum of basic care. What has dramatically changed since the design of HAPAC is the introduction and rapid scaling up of ART. This changed the perspective of home based care from “care for the terminally ill” as it was defined, to care for the seriously ill including the support for adherence to ART until the patient recovers. This change of perspective has in no way diminished the need for home based care as many PLWHA might still become seriously ill before accepting ART. Treatment failure is also expected to contribute to a continued need for HBC.

At the time of the evaluation, the HIV/AIDS epidemic and the effectiveness of the response are, not surprisingly, much better understood. A comprehensive analysis has been made in 2005, indicating several areas that need urgent attention. It has two tiers of recommendations. The first tier focuses on major strategic management issues for a better coordinated and coherent national response. The second tier of recommendations includes technical recommendations for implementation of interventions. In the second tier, VCT, STI treatment and HBC feature prominently, indicating that HAPAC has operated in areas considered to be of major importance. The review confirms that HAPAC has not operated in the first tier of governance issues. It can be argued that governance issues are of paramount importance or even a precondition to make interventions optimally effective. Coordination as a governance issue is for example crucial to avoid overlap and ensure optimal coverage.

Conclusions:
The problems identified by HAPAC were major and urgent aspects of the AIDS epidemic to be addressed by the health sector. The interventions selected by HAPAC to address these problems are in line with globally accepted best practice. This was true at the design phase of the project and is still valid at the time of the evaluation.

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6 The Impact of Voluntary Counseling and Testing, a global overview of benefits and challenges, UNAIDS 2001
9 Report of the Joint Review of the National Response to HIV/AIDS in Swaziland, NERCHA, 2005
The focus on the health sector per se was most likely caused by the national policy focus at the time of the design. The selection of three specific interventions is most likely caused by the need for action and the potential for quick results. However, a transparent insight in the considerations that lead to these choices is not available.

4.1.2 Coherence with Country Strategy Paper and the National Indicative Programme

Relevance of the interventions can also be defined as being coherent with EC’s development approach in Swaziland, thus contributing to the wider EC-Swaziland development goal. EC’s Country Strategy Paper and the National Indicative Programme (CSP/NIP) for the 8th EDF, which forms the strategy basis for HAPAC, has two focal sectors: Agriculture and Rural Development and Private Sector Development. The total allocation for Swaziland amounted to 29 million €. Under the first focal sector the Lower Usuthu Smallholder Irrigation Development Project (11.4 million €) and the Micro Projects Programme (4.3 million €) were implemented. The second focal sector includes the Private sector Support Project (5.9 million €) and the Strengthening Capacity in Trade Analysis and Negotiations Project (1.2 million €). Besides these focal sectors two additional projects were implemented, the Fiscal Restructuring Programme (5.6 million €) and HAPAC (1.9 million €). HAPAC, which represents the only explicit HIV/AIDS action in this CSP amounts to 6.5% of the total allocation. This is remarkable because at the time of the formulation of this CSP the AIDS epidemic was already 15 years in Swaziland and its devastating impact was predicted in various widely published documents. Anecdotal evidence suggests that there was little or no attention in the other EC funded projects for HIV/AIDS issues. The concept of mainstreaming HIV/AIDS on the basis of the common understanding that HIV/AIDS is foremost a social issue that needs a multisectoral response was not applied \(^\text{10}\). This is remarkable because the focal sectors where the CSP for the 8th EDF had focused on are the main sectors for HIV/AIDS action. This is also surprising because the achievements in these focal sectors themselves will easily be eroded if HIV/AIDS is not specifically addressed. In these focal sectors “effective HIV/AIDS action” should even have been an important assumption in the respective logframes. The current 2001/2007 CSP/NIP for the 9th EDF, under which the present successor of HAPAC is funded, prominently states that “the major challenge is HIV/AIDS, which has been proclaimed a national disaster in view of its implications for the social and economic development of the country. With one of the highest rates of HIV sero-prevalence in the world, Swaziland risks losing the gains it has made since independence in terms of human resource development”. The 2001/2007 CSP/NIP’s political and social assessment concludes that the national response to HIV/AIDS is weak and that there is an urgent need for strong national leadership, prioritisation of activities and implementation of proven effective strategies.

The CSP/NIP focuses on education as the main sector and states that “HIV/AIDS will be a central crosscutting issue in all areas of the 9th EDF programme”. The overall indicative allocation from the 9th EDF for Swaziland amounts to € 43 million. Explicit HIV/AIDS action amounts to 1.9 million €, which is 4.4 % of the total allocation. This figure does not reflect the importance of HIV/AIDS as it is clearly stated in the CSP/NIP. Of course, in line with the current thinking of HIV/AIDS as a multisectoral issue, other sectors and specifically the education sector could play a major role if HIV/AIDS is mainstreamed in these sectors. In the Financing Agreement for the education project HIV/AIDS features prominently. However, the concept of mainstreaming is not described in enough detail so that any implementer would be forced to carry out HIV/AIDS action within this project. The 2001/2007 NIP includes a so called B envelope meant for emergencies, amounting to 11 million

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\(^{10}\) Holden S, mainstreaming HIV/AIDS in development, Oxfam 2004
€. The B envelope was never used and the 11 million € allocation was recently cancelled. Why this source of funding was never used for the HIV/AIDS emergency in Swaziland, which is the worst in the world, and which is comparable or clearly worse than any other thinkable emergency is a stressing question. The EC office in Swaziland has tried to use the B envelope for the HIV/AIDS emergency but proposals were said to be rejected by Brussels.

4.1.3 Coherence with member states’ development activities

The most significant other HIV/AIDS activity in the health sector is carried out by the Italian Cooperation. This project focuses on strengthening the national reference laboratory, and regional hospital laboratories. The coordination with HAPAC’s support to the national reference laboratory was well taken care of.

4.1.4 The Log Frame

The Log Frame (see Annex E) was assessed in terms of quality, clarity and internal consistency of the stated overall objectives, purpose and results, on the basis of the principles in the Manual Project Cycle Management, EC, March 2001.

The project documentation does not provide a problem analysis, neither an analysis of objectives, nor an analysis of strategies. In absence of these the Log Frame matrix is here assessed as it is for its vertical and horizontal logic.

The highest level of objectives, the Overall Objective, is formulated as “To reduce the rate of spread of HIV and alleviate the impact of AIDS in Swaziland”. This is incorrectly defined as an activity and not as a desired state that fully reflects the main problem HIV/AIDS poses to society. If the impact of HIV/AIDS on society is the main problem, then the overall objective could simply be formulated as “a reduced impact of HIV/AIDS on society”.

The next level of objectives, the Purpose, is formulated as “To reduce the rate of transmission of HIV and to develop programmes for the provision of home-based care for those with AIDS”. This is again formulated as activities, and not as the irreversible social or organisational change that will outlive the project, and that will most likely contribute to the overall objective. It might not be wise to single out home based care at purpose level, because the project is supposed to provide just one of several contributions to a broader social or organisational change. The impact of AIDS on society is best addressed by prevention and impact mitigation, so the purpose could be formulated as “decreased HIV transmission and effective care for the affected”.

The Results level of objectives is normally defined as the objectives that can be achieved by the project and which are fully within the control of the project, i.e. for which the project can be kept responsible. The results were defined as:

- Increased number of Swazi’s presenting for voluntary counselling and testing
- Improved management of sexually transmitted infections
- Improved home based care of persons with terminal AIDS

The result would suggest that the project can be kept responsible for an increased number of people accepting VCT, which is obviously not possible as several factors outside the control of the project will determine whether or not people accept VCT. The second two results are better formulated, although the actual case management and home based care might have determinants which are outside the project’s control. Results in these three areas would be better formulated as:
- Increased capacity for voluntary counselling and testing
- Improved capacity for treatment of sexually transmitted infections
- Improved capacity to provide home based care for persons with terminal AIDS

Sufficient human resources are essential for VCT service delivery, STI case management and improved home based, and are beyond the control of a project like HAPAC. Such a precondition should be mentioned under the assumptions that make the project results achievable.

The activities which were supposed to deliver the expected results are straightforward; training, supervision and procurement of supplies and vehicles. Not surprisingly, these service delivery inputs are correct as these consist of conventional activities to provide and improve health services.

The vertical logic, whether the results contribute significantly to the purpose, is discussed in paragraph 3.1.1 and it is repeated here that it is widely accepted that VCT, STI treatment are globally accepted best practices to decrease HIV transmission. Home based care is widely accepted as the only means to provide essential care for those affected by AIDS.

The objectively-verifiable indicators of achievement (OVIs) chosen in the project design reflect the shortcomings discussed above.

The project’s overall objective does not have an OVI at all, which is remarkable as impact of HIV/AIDS on society can be and is currently being monitored in terms of excess mortality, demographic models, number of people living with HIV/AIDS, number of Orphans and Vulnerable Children (OVC), etc.

The project’s purpose has rightly been given HIV prevalence as an OVI, but the OVI “Impact of HBC programmes” does not meet the definition of an OVI.

The OVI’s for the results reflect their wrong definition as the OVI “STI prevalence” cannot be an indicator of the project’s performance. Number of health workers trained in STI treatment on the other hand is a correct OVI.

The Log frame assumptions are of a general nature, confirming the Government’s continued commitment and continues availability, which are sufficient for a service delivery project.

Conclusions:
- The Log Frame shows various explicit formulation flaws, but if the project’s aim is to merely contribute to urgently needed essential services, the implicit intervention logic is adequate.

4.1.5 HAPAC’s relation to the Government policies

Being based in the MoHSW, with the Permanent Secretary in the MoHSW as Project Director and the Director of Health Services as Deputy Project Director, one can assume that HAPAC is part and parcel of MoHSW policies. However, some observations and considerations must be mentioned here. One of the questions raised during the evaluation was how HAPAC relates to SNAP which has the responsibility for the health sector response to the epidemic. SNAP has several staff members who are the technical authorities (“National Focal Persons”) in the country for areas of STI treatment, VCT and HBC. HAPAC has worked closely with these individuals, but organisationally HAPAC was positioned parallel to SNAP, with the HAPAC project manager reporting directly to the PS MoHSW and the SNAP programme coordinator reporting direct to the
Director of Health services. The origin of this organisational set up was mentioned to be the initial weakness of SNAP at the design stage of HAPAC. At this moment however, such a parallel set up is not defendable as HAPAC’s objectives and activities fall entirely within SNAP’s mandate. During the evaluation the impression was even raised that the well branded, but by definition temporary HAPAC project, with its own prominent logo was in some ways competing with SNAP. In general it can be concluded that HAPAC’s set up has not organisationally or institutionally strengthened SNAP, which is the permanent MoHSW structure to guide health sector HIV/AIDS action. At an individual level HAPAC has been beneficial to SNAP by supporting National Focal Persons’ participation in AIDS conferences and in exchange visits. This form of capacity building, which is discussed in another paragraph, has nevertheless been an effective contribution to SNAP’s capacity.

Although coordination of the health sector response was characterised by the 2005 joint review as weak, HAPAC’s activities seem complementary to other government and NGO activities. This appeared to depend in the first place on the excellent communication and network attitudes of the project management. The Project management has furthermore organised stakeholders’ consultations which were de facto coordination and information exchange meetings. That this should ideally have been SNAP’s role, from an organisational development point of view, is an issue discussed in another paragraph. As far as could be assessed in absence of coherent health sector response action plans, indicating what is done by which actor, HAPAC’s activities were coherent with the activities undertaken elsewhere by government and other donors.

4.2 Efficiency

The review of HAPAC’s efficiency in this evaluation looks at the performance of the project management, contributions from other sources, cost benefit ration, and monitoring.

4.2.1 Project management

The day to day management was assessed by a review of (1) management of the budget (2) management of personnel, information, property (3) report production (4) management of the cost estimate (5) respect for deadlines. Financial procedures were followed well by the project management as indicated by a review of documents, from cost estimates, disbursements, and reporting. Two external audits confirm that financial general accepted practice was correctly followed. The third end of project external audit was yet to be done at the time of this evaluation. This delay was caused by EC official procedures. Procurement procedures for goods and services were strictly adhered to. Personnel management in terms of contractual arrangements and adherence to these was conform common management practice. Reports were produced in time and provided the required information. Deadlines were met. These findings were confirmed in discussions with EC office staff and the EC adviser to the NAO.

One event needs to be mentioned here as it might have some consequences beyond the life of the project. As discussed in other paragraphs, four NGOs were contracted by HAPAC to deliver VCT services. This contracting out services was done on the basis of service contract regulations which allow a maximum duration of one year after which the contract can be renewed. After two years,
mid 2005, the project itself was extended till the end of the year. The service contracts with the four NGOs were renewed till that time as well. At the time of this latest renewal it was known that there would be a continuation of HAPAC under the 9th EDF. The 9th EDF procedures would not allow for the type of contracts that were used and instead a call for proposals for grants would be the mode. This would create a gap in operations of at least 6 months between the end of HAPAC and grants being allocated to NGOs under its continuation. Besides the time gap, it could not be guaranteed that all of the four NGOs would qualify for a grant. The project management saw itself confronted with this serious discontinuation which could jeopardise part of the gains that had been realised. To limit possible damage the project management decided to change some clauses in the last service contracts with the NGO, deleting the agreement that assets would become property of the NGOs at the end of the contract. This would allow HAPAC’s continuation to directly run the VCT services as equipment and vehicles would remain in place while staff salaries were to be paid directly to VCT centre staff. The intentions of this manoeuvre were without doubt sincere with the project management having the interests of the beneficiaries in mind. However, the NGOs were taken by surprise by this move and perceived it as breach of contract in letter and in spirit. When the dispute could not be resolved, the NGOs publicly declared that their confidence in the MoHSW had been dented. A review of the events suggest that with a better explanation of the “prisoners dilemma” the HAPAC management had found itself in, and with better communication and consultations with the NGOs this confrontation between government and an important part of civil society could have been prevented.

4.2.2 Contributions from other sources

For the contracting out of VCT services, all costs were born by HAPAC. The mid term review however concluded that the contracted NGOs had contributed from their own means to improve the implementation, although this was not quantified. HAPAC’s other components have contributed to various aspects of health services which receive funding from several sources. For the HBC and STI components there were no data from which HAPAC’s relative contribution to the whole of HBC could be established.

4.2.3 Cost benefit ratio

To assess to what extent the costs of the project have been justified by the benefits that have been generated one needs to compare the intended and unintended material and non material deliverables and their cost to a certain reference. This evaluation looked at the cost of the various capacity building efforts, TA assignments, and the running cost of the VCT centres and compared this to cost ranges which are experienced in similar circumstances in other countries. A review of various training costs showed that these were similar to costs experienced in for example Tanzania, taking local differences into account. The short term TA assignments have without exception lead to relevant deliverables at a cost which is within the usual range. The running of VCT centres by HAPAC was found to cost in average about € 4,500 per month, which is in range with the cost of VCT centres in for example Tanzania. The cost benefit ratio of participation in international conferences is often questioned. The interviews with senior MoHSW officials confirmed that they had benefited from the regional and international conferences they had attended with HAPAC funding. Besides the exposure to international best practice, the contacts that are established during such events often have a long lasting effect. The reports written by the participants also indicate that their participation was taken very seriously and that the experiences
were applied in policy formulation in Swaziland. So, even these “soft” deliverables can be considered cost effective.

4.2.4 The quality of project monitoring

Programme monitoring was done through regular reporting as required by project management procedures, through end of project reports for the three components and a general end of project report. A mid term review was carried out in the first half of 2004, as required in the Financing Agreement. The regular reporting and the end of project reports measure detailed progress towards the set targets. Reasons for less than expected progress (and incidentally more than expected progress) are well explained in these reports, reflecting all aspects of project progress. The Mid Term Review gives a detailed overview of activities carried out and of circumstances that were more or less conducive.

4.3 Effectiveness

To assess whether the project has delivered what it was supposed to, an overview is given here (in addition to the narrative of HAPAC’s achievements in chapter 3.3) of progress towards set targets. In the annual Work Programmes, the objectives as defined in the Financing Agreement were translated into these targets. The end of project report presented a clear overview of progress against targets, which the evaluator validated on the basis of the various project reports. The table shows that most targets have been reached, or even surpassed.

<table>
<thead>
<tr>
<th>Planned result</th>
<th>Target</th>
<th>End of project result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VCT:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased # of people consulting VCT facilities</td>
<td>2% of sexual active population</td>
<td>9%</td>
</tr>
<tr>
<td>Increased # of operational VCT facilities</td>
<td>6VCT facilities</td>
<td>Piggs Peak Hospital, Piggs Peak Town, GSH, Siteki Town, Matata &amp; Sihobela</td>
</tr>
<tr>
<td>Increased # of trained counsellors</td>
<td>12 counsellors trained</td>
<td>15 Trained counsellors</td>
</tr>
<tr>
<td>Increased # of post-test support groups</td>
<td>At least 1 post-test per site</td>
<td>18 active post test support groups from all sites</td>
</tr>
<tr>
<td>Increased # of people reached through advertising campaigns</td>
<td>80% of sexual active population within catchment’s area</td>
<td>60% reached</td>
</tr>
<tr>
<td><strong>HBC:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased # of community HBC programs</td>
<td>150,000 people covered</td>
<td>covered</td>
</tr>
<tr>
<td>Increased # of trained community and family caregivers</td>
<td>400 community and 2,000 family caregivers</td>
<td>335 community, and 2,985 family caregivers and 230 RHMs</td>
</tr>
<tr>
<td>% of household with chronically ill adult receive external support</td>
<td>65.3%</td>
<td>70.9%</td>
</tr>
</tbody>
</table>
Several challenges were faced during implementation of the three main components, varying from technical aspects of the interventions to implementation mode issues. It must be noted that HAPAC was well aware of these challenges and that these were documented in all reports including the end of project. An overview of the main challenges is presented here.

**Interventions:**
- VCT, STI, HBC are not sufficiently linked to provide the necessary continuum of care especially now when ART has become available at a large scale
- Regional coordination where these links should be made is weak
- In VCT men are missed
- Several risk groups like sex workers, men having sex with men and seasonal workers are not reached
- Gender is not sufficiently mainstreamed
- Elderly as care givers are not sufficiently focused on

**Implementation mode:**
- The contracting of NGOs by government has shown to lead to effective service delivery
- If not carefully managed the young relationship between government and NGOs can be easily damaged

Many of these technical and implementation issues will require future operational research to find solutions.

| % of households with chronically ill adult receive help in caring | 54.0% | 55.8% |
| Planned result | Target | End of project result |
| % of caregivers who know that HIV is not transmitted by meal sharing | 66.6% | 60.3% |
| % of caregivers who agree that an infected teacher should be allowed to teach | 75.2% | 69.3% |
| STI: | | |
| % of STI clients attended by HCP trained | 51.7% | 75.1% |
| % of STI clients attended by HCP with correct diagnosis and treatment | 17.5% | 23.8% |
| % of STI clients correctly treated | 56.6% | not available |
| % of STI clients attended by HCP providing counselling and partner notification | 27.4% | 78.5% |
| % of STI clients attending facility with sufficient STI drugs | 26.5% | 42% |
Technical assistance
Technical Assistance was an important component of HAPAC’s set up as reflected in its budget share (18% for short term TA alone). It consisted of the one year long term TA provided through the consultancy firm EPOS and the various short term consultancy assignments listed in paragraph 3.3.4. All stakeholders interviewed were extremely positive about the long term consultant, Dr. Yves Lafort, and his end of assignment report confirms that he has been instrumental in the start of the programme and in its dynamics over the remaining period.

A review of the short term consultancies Terms of Reference were without exception relevant in the sense that they were to provide an answer to issues that are essential for improved services. The reports reviewed all met the required standard.

Capacity building
The assessment of the project’s capacity building component is not so straightforward. The training of health workers in STI treatment and STI curriculum development are conventional aspects of capacity building which are relevant without doubt. The participation of senior managers in international workshops and conferences and study tours is often questioned as an effective capacity building exercise. In the case of Swaziland’s HIV/AIDS managers the evaluator is of the opinion that these investments were worthwhile because of Swaziland’s relative absence in international circles and its consequent limited exposure to new visions, strategies and best practices. However the various capacity building exercises have taken place as isolated investments, not being part of a comprehensive analysis of the health sector’s response to HIV/AIDS. Ideally the organisation in the MoHSW responsible for the health sector response, SNAP, should have been analysed in terms of existing capacity against its expected performance on the basis of its mandate. This would then have lead to a much more systematic exercise looking at various levels of capacity needs, varying from (1) structures, systems and roles, (2) staff and facilities, (3) skills, and (4) tools\(^{11}\). As indicated in the 2005 Joint Review of the National Response, the capacity in the health sector response is notably weak. Besides not addressing capacity needs in a systematic way, HAPAC has to some extent worked in parallel with SNAP and to some extent in the opinion of the evaluator (as discussed above) even competed with SNAP.

HAPAC has aimed at strengthening coordination structures at the level of the administrative region, particularly for VCT and HBC in Lubombo region. The regional level in Swaziland is comparable with what is typically referred to as district in other countries. Although some coordination meetings have taken place in Lubombo region, the actual planning and decision taking remained largely at central level. This was confirmed during the evaluator’s field visit as very few planning tools for budgets and activities were available at regional level. This assessment is also confirmed in the 2005 Joint Review of the National Response, which points at weak regional planning and coordination structures. It should be noted that the decentralisation of the health system in Swaziland is far behind the decentralisation practice in most neighbouring countries. The need for decentralised planning and management in the health sector is universally accepted as best practice. The project could have contributed to more decentralised practice by building capacity for that level accompanied by giving decision power for project planning and implementation to that level.

Conclusions: The project has delivered what it was supposed to deliver and has thus been effective. The capacity building component however could have been more systematic with a more holistic focus on the health sector response and on the basis of a needs assessment of SNAP. Capacity building for regional planning could have been more effective.

Cross cutting issues
The cross cutting issues of gender and environment are particularly relevant to this project. In general the role of men and women in HIV/AIDS action, in behaviour change and in sexuality issues are very different and any approach should be based on a thorough understanding of the differences. Although it is confirmed in various project documents that men are underrepresented as VCT clients, an analysis of the differences and a consequent approach was not made or made available to the project. The counselling itself, carried out by NGOs that specialise in this work was gender sensitive in the sense that different roles were well understood. At an organisational level it seemed that the number of male counsellors was relatively high, and to what extent a male-female counsellor-client relation and vice versa could affect the effectiveness of counselling could not be established. HAPAC itself was manned with two men, which is too small a number to consider gender balance especially when very few skilled staff are available anyway.
In HBC gender was an issue since caring roles are traditionally born by women, resulting in an overburdening of women who are already taking care of their families. This was recognised and made an issue of debate. However in the Swazi traditional culture it cannot be expected that changes are within sight.
In STI contact tracing roles of men and women are different and were taken into account in the project. The fundamental problem of the deprived position of women, violence against women and the link with HIV/AIDS was not explicitly taken up by the project, which in view of the project’s limited mandate seems appropriate.
Environment is an issue for home based care solid infectious waste material like adult napkins, bandages and gloves that need to be disposed of in an acceptable manner. The project was fully aware of this problem and had planned a short term consultancy to find solutions. This consultancy could not be carried out before the end of the project on 31 December 2005, but was one of the first things to carry out under its successor.

4.4 Impact
The determinants of the HIV/AIDS epidemic are manifold. Only few can be addressed from within the health sector itself. The health sector response has certainly been strengthened by HAPAC and it can be stated that the activities have certainly assisted in averting a number of HIV infections and in mitigating the suffering. To what extent this modest impact will be continued after the end of the project is discussed in the next chapter.

4.5 Sustainability
Sustainability is defined in EC Project Management Cycle terminology as the likelihood of a continuation in the stream of benefits produced by the project after the period of external support has ended. HAPAC has built capacity in several areas as is discussed in paragraph 3.3. Especially the training of health workers in proper treatment of STI, training curriculum development, standard
treatment guidelines, branding of VCT facilities, the capacity building of “National Focal Persons” in SNAP are investments that are likely to continue a return, long after HAPAC has ended. However, HAPAC has a strong service delivery component, under which various categories of running cost are covered. If these running costs are not taken over by another source of funding at the end of HAPAC, the services will grind to a halt. This would not only mean an interruption of services, but would also be damaging as confidence in the services by the general public will then be undermined. The evaluation mission noted that the issue of sustainability has been taken up several times by HAPAC management and is discussed in HAPACs progress reports. However, no concrete arrangements by government or other donors have been made to secure future funding for running cost. The project’s 2004 mid term review refers to the Financing Agreement’s Technical and Administrative Procedures, clause 11, which states that a continued need for donor support is foreseen, and concludes that future funding is not necessarily a problem. This is an overly simplified analysis of sustainability, because this approach does not see the risks of aid dependency in an area (e.g. salaries for regular health services) where this is usually avoidable. The current renewal of the project under 9th EDF funding with a similar intervention logic is obviously not an answer to the question of sustainability and will just push forward the issue for some time. One would expect that a service delivery project with such a large running cost component would have designed an “exit strategy”. In emergency relief, where the humanitarian imperative makes sustainability less of an issue than in development cooperation, it is normal practice to have an exit strategy designed on day one of the intervention. If the AIDS epidemic in Swaziland would necessitate an emergency relief approach then an exit strategy should have been designed prior to or early during implementation. However, no considerations to this extent could be found in project documentation.
Conclusions and recommendations

HAPAC has effectively and efficiently delivered services in three areas of the health sector response to the AIDS epidemic in Swaziland. These three areas, VCT, HBC and STI are relevant interventions in AIDS control. Some aspects of the interventions should be addressed to make them more effective:

- VCT, STI, HBC are not sufficiently linked to provide the necessary continuum of care especially now when ART has become available at a large scale
- Regional coordination where these links should be made is weak
- In VCT men are missed
- Several risk groups like sex workers, men having sex with men and seasonal workers are not reached
- Gender is not sufficiently mainstreamed
- Elderly as care givers are not sufficiently focused on

HAPAC has effectively shown that contracting out services by government to NGOs can be an effective way to have services delivered. However, the relationship between government and civil society needs to be managed carefully to avoid distrust.

Capacity building has been effective, but has focused on some individuals rather than the institution (SNAP) that is responsible for the MoHSW’s response to the epidemic. Supporting SNAP is a systematic way by which this capacity building could have been more effective. Being positioned parallel to SNAP with different reporting channels has resulted in a rather competing than in a capacity building relation to SNAP.

Although the EC strategy for Swaziland underscores the importance of HIV/AIDS for development, its response has been limited to service delivery components within the health sector while mainstreaming of HIV/AIDS has not materialised. The budget allocation to HIV/AIDS is relatively small and does not reflect the stated magnitude of the problem.

Sustainability has to some extent been achieved through capacity building, but for the project’s main component, which is service delivery, sustainability has not been addressed at all. This would not only interrupt the services that were strengthened by the project but would potentially damage these services. The continuation of HAPAC under the 9th EDF is not a solution but simply buys time.
Recommendations for future EC support to HIV/AIDS action:

Based on the experiences in the health sector and on the relationships established future EC support to HIV/AIDS action in Swaziland should remain to be focused on the health sector response.

Support to the health sector response should be based on organisational capacity building principles for the MoHSW department responsible for the health sector response, SNAP.

Service delivery should only be a minor part of support to the health sector response as other sources, like Global Fund, are more appropriate for that purpose.

Strengthening SNAP should include strengthening the regional management mechanisms that are needed for an effective service delivery. This would also provide lessons for decentralisation in the health sector in general.

Mainstreaming of HIV/AIDS in other EC funded projects should be vigorously pursued, and be stated as explicit result in every log frame.

*       *       *

*       *

*       *
Annexes

Annex A : Terms of reference

EUROPEAID/ 119860/C/SV/multi

LOT N° 8: HEALTH / REQUEST N° 111046

SPECIFIC TERMS OF REFERENCE

Final Evaluation of the HIV/AIDS Prevention and Care Programme (8ACP SW 019, 9 ACP SW 04)

1. BACKGROUND
Swaziland is at the centre of the HIV/AIDS pandemic with HIV prevalence rates that are amongst the highest in the world. Despite past interventions the HIV/AIDS pandemic in Swaziland continues to spread rapidly. The rate of infection amongst pregnant women has risen sharply from 3.9% in 1992 to 42.6% in 2004. In February 2004, the Government of Swaziland (GoS) announced that the Kingdom of Swaziland faced a humanitarian crisis stemming from the adjoining fundamental trends of drought land degradation, increasing poverty and HIV/AIDS.

Factors that have been identified as contributing to the epidemic include: early age of first sexual activity; high levels of promiscuity; minority status of women; migrant labour; high rates of sexually transmitted infections (STI); low availability and acceptance of condoms, and inadequate knowledge of HIV.

In June 2002, the European Commission and the Government of Swaziland started a three-year HIV/AIDS Prevention and Care (HAPAC) Programme addressing three major problems: (1) Limited access to voluntary counselling and testing (VCT) services for HIV; (2) Lack of resources for home-based care (HBC) for those with AIDS; and (3) High rates of sexually transmitted infections (STI), increasing the risk for HIV infection.

The HAPAC programme commenced in 2001 and was due to end in June 2005. A request was submitted at the end of 2004 for a six-month extension to the Programme and was subsequently signed in April 2004. A Financing Agreement for a similar programme for the period 2006-2008 with similar objectives was signed in December 2005.

The overall objective of the HAPAC Programme is ‘to reduce the spread of HIV and alleviate the impact of AIDS in Swaziland’. The project purpose is ‘to reduce the rate of transmission of HIV
in Swaziland and to develop programmes for the provision of home-based care for those with AIDS’.

The Financing Agreement specifies the HAPAC programme to achieve the following results:

- Increased numbers of Swazis presenting for voluntary counselling and testing.
- Improved management of sexually transmitted infections (STIs).
- Improved home-based care of persons with terminal AIDS.
- Increased awareness of HIV/AIDS in the community at large.

To achieve the above results the following activities were to be implemented under each one of the three components of HAPAC.

**Voluntary Counselling and Testing (VCT):** VCT services, based in the major regional town but with outreach capacity, will be provided through NGOs in each of Swaziland’s four regions. Related activities include staff training, development of a unifying “brand name” for the centres and a mass media campaign to promote VCT.

**Treatment of Sexually Transmitted Infections (STI):** primary health care workers will be trained by MoHSW in the application of the syndromic approach to the management of clients presenting with STIs. To enable accurate diagnosis in complicated cases, diagnostic equipment and medical supplies will be provided to the STI clinic at the Government Hospital.

**Home-based Care (HBC):** Assistance will be provided to the Ministry of Health and Social Welfare (MoHSW) and to NGOs to support the provision of HBC in each region. Support will include training, provision of materials (e.g. kits), and provision of a suitable vehicle.

The programme is implemented by a Programme Management Unit (PMU) based inside the Ministry of Health and Social Welfare (MoHSW) with the Principal Secretary acting as Project Director. The PMU comprised of a technical assistant (TA) for the first 18 months of the project, a local Project Manager (PM) for its entire duration and short-term TA inputs. The long and short-term TA contract was awarded in 2002, and the long term TA mobilised in June 2002. The PM was recruited in December 2002 following local and regional advertising placed by MoHSW.

2. DESCRIPTION OF THE ASSIGNMENT
   a. Global Objective
      The global objective of the evaluation is to assess if the programme has lead to a reduction in the spread of HIV and alleviated the impact of AIDS in Swaziland.

   b. Specific Objective
      The specific objective of the evaluation is to assess if the programme has lead to a reduction in the rate of transmission of HIV in Swaziland and developed programmes for the provision of home-based care for those with AIDS.

   c. Requested Services
      A Consultant is required to carry out a final evaluation of the EC financed HIV/AIDS Prevention and Care (HAPAC) Programme in Swaziland. This study is required under the terms of the Financing Agreement SW/7002/001 under which the EC committed a total grant of Euro 1.96 million from the 8th EDF resources and Euro 247,000 from 9th EDF resources.
The Programme should be evaluated using the following criteria:

Relevance
- assess the appropriateness of the project design in relation to the problems to be resolved both when the project was designed, and at the time of the evaluation.
- assess the projects coherence with the EC’s Country Strategy Paper and the National Indicative Programme.
- assess the quality of the Log Frame and the clarity and internal consistency of the stated overall objectives, purpose and results
- assess whether the objectively-verifiable indicators of achievement (OVIs) were well-chosen.
- review and comment on the current relevance of the project in relation to the Government policy and the real needs of the intended beneficiaries.
- comment on the complementarity and coherence of the HAPAC with relevant activities undertaken elsewhere by government and other donors.
- provide an analysis of sustainability of the project— including the financial and economic sustainability, the environmental impact and benefits to both men and women.

Efficiency
- review the performance of the management of the project in terms of the quality of day-to-day management, including: (1) management of the budget (2) management of personnel, information, property (3) report production (4) management of the cost estimate (5) respect for deadlines.
- assess the partner country contributions from local institutions and government, target beneficiaries and other local parties.
- assess to what extent the costs of the project have been justified by the benefits that have been generated.
- review the quality of Programme monitoring undertaken by the beneficiaries, the contracting authority and the office of the EC.

Effectiveness
- assess whether the planned benefits have been delivered and received, as perceived mainly by the key beneficiaries, but also the contracting authority, the office of the EC and other concerned parties.
- review the performance of the technical assistance in carrying out their Terms of Reference. Comment on the quality and appropriateness of the short-term consultants provided under the project.
- assess whether the balance of responsibilities between the various stakeholders was appropriate.

- assess whether any shortcomings were due to a failure to take account of cross-cutting or over arching issues such as gender, environment and poverty during implementation.

**Impact**
- examine to what extent the planned overall objective has been achieved, and assess how far that was directly due to HAPAC.

- assess to what extent Gender related, environmental and poverty related impacts were achieved.

**Sustainability**
- assess how far all stakeholders were consulted on the objectives from the outset, and whether they agreed with them and remained in agreement throughout the duration of the project.

- review and comment on the sustainability of the project. This should include an analysis of the level of political support from the various Ministries and an indication of whether the Government is likely to continue funding any of the initiatives.

**d. Methodological Aspects**

The consultant will carry out the Evaluation following the EC’s Project Cycle Management integrated approach and logical framework. The consultant should commence by reviewing the following documentation:

- The Financing Proposal and the financing Agreement for HAPAC
- The Terms of Reference for the TA
- The Inception Report
- The start-up and Programme Estimates
- The Mid Term Evaluation Review (MTR) Report
- The Project’s Work plans and Budgets
- The Quarterly Progress Reports
- Reports produced by Short-term Consultants

During the field work in Swaziland the consultant should interview as wide a variety of stakeholders and beneficiaries as possible including the Principal Secretary in the Ministry of Health, the technical assistant and the Programme Manager.

The consultant will organize and facilitate a one day workshop with stakeholders and beneficiaries of the HAPAC programme, with a maximum attendance of 20 people. The consultant will cover the costs related to material, equipment, conference room, secretarial support, refreshments and lunch. Travel, per diems and accommodation will be paid by the participants themselves.

The work will be carried out in close co-operation with the National Authoring Officer in the Ministry of Economic Planning and Development. The consultant will also keep the EC Delegation in Swaziland informed of progress throughout the assignment.
e. Expected Results
The result of the evaluation will be an assessment of the efficiency, effectiveness impact and viability of the project in order to verify that its activities and results are in line with those outlined in the Financing Agreement. It should also make solid recommendations for the 2006-2008 programme.

3 EXPERTS PROFILE
The assignment will be undertaken by a consultant category II with:
- an advanced degree in health or a related field and proven experience on HIV/AIDS.
- at least 10 years of professional experience of which at least five years should be in developing countries, preferably in sub-Saharan Africa.
- an ability to understand the structure of EDF funded projects and project Logframes
- solid experience in conducting previous project evaluations in developing countries.
- excellent communication and writing skills in English
- proficient knowledge of standard computer software (MS word, Excel and project management software)

4 LOCATION AND DURATION
Starting Period
May 2006

The duration of the service will be for 25 calendar days, 20 days in Swaziland and 5 days of report writing. A briefing and debriefing session is envisaged at the start and end of the assignment, respectively at the offices of the European Commission in Mbabane.

The mission will take place in (Mbabane) Swaziland under the guidance of the National Authorising Officer’s office, in conjunction with the EC Delegation. Short trips may be required to key locations in Swaziland as deemed necessary by the expert.

5 REPORTING
A summary of the consultant’s main findings will be presented at a debriefing meeting before departure from Swaziland.

The final draft report on the Evaluation must be presented within 14 days after the end of the mission. The Government and the EC will have a period of 3 weeks to submit their comments on the final draft report. Following this the consultants should present the final report within one week. Both the draft and final report must be presented in 10 copies to the Government and 5 copies to the EC office. The consultants will also be required to submit the report in digital format (Microsoft Word).

6 ADMINISTRATIVE INFORMATION
Not relevant for this assignment.
### Annex B: Persons met during the evaluation

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agai Jones</td>
<td>country representative, PSI</td>
</tr>
<tr>
<td>Arno Schäfer</td>
<td>chargé d'affaires, delegation of the EC, Mbabane</td>
</tr>
<tr>
<td>Beatrice Dlamini</td>
<td>programme manager, SNAP</td>
</tr>
<tr>
<td>Busesiwe Mhabele</td>
<td>home based care giver</td>
</tr>
<tr>
<td>Cedric Musa Mgogo</td>
<td>executive director, FLAS</td>
</tr>
<tr>
<td>Cephine Mabuza</td>
<td>director of health services, MoHSW</td>
</tr>
<tr>
<td>Clement Dlamini</td>
<td>HIV/AIDS officer, CANGO</td>
</tr>
<tr>
<td>Derek von Wissell</td>
<td>national director, NERCHA</td>
</tr>
<tr>
<td>Ephraim Hlope</td>
<td>principal Secretary, Ministry of Economic Planning &amp; Development</td>
</tr>
<tr>
<td>Fortunate Ntombi Fakudze</td>
<td>pharmacist, MoHSW</td>
</tr>
<tr>
<td>Hlobi Ndlovu</td>
<td>adviser to the NAO, Ministry of Economic Planning &amp; Development</td>
</tr>
<tr>
<td>John Sykes</td>
<td>head of cooperation section, delegation of the EC, Mbabane</td>
</tr>
<tr>
<td>Jorge Nieto Tey</td>
<td>HIV/AIDS programme director, Italian Cooperation</td>
</tr>
<tr>
<td>Mauro Almaviva</td>
<td>UNAIDS country coordinator</td>
</tr>
<tr>
<td>Ncamsile Tiwala</td>
<td>HIV/AIDS programme manager, World Vision</td>
</tr>
<tr>
<td>Nhlanhla Nhlabatsi</td>
<td>programme manager HAPC</td>
</tr>
<tr>
<td>Nokuthula Gwebu Lucas</td>
<td>education officer, delegation of the EC, Mbabane</td>
</tr>
<tr>
<td>Nonhlanhla Dlamini</td>
<td>HBC coordinator, AMICAALL-Swaziland</td>
</tr>
<tr>
<td>Rejoice N. Nxumalo-Nkambule</td>
<td>national coordinator VCT, SNAP</td>
</tr>
<tr>
<td>Richard Walwema</td>
<td>head national reference laboratory, MoHSW</td>
</tr>
<tr>
<td>Rudolph T.D. Maziga</td>
<td>national coordinator, AMICAALL-Swaziland</td>
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<tr>
<td>Sharon Moyniha</td>
<td>programme officer, delegation of the EC, Mbabane</td>
</tr>
<tr>
<td>Sibingile Ndzobebe</td>
<td>clinical care coordinator, MoHSW</td>
</tr>
<tr>
<td>Thulane E. Maseko</td>
<td>financial administrator, HAPC</td>
</tr>
<tr>
<td>Thuli Sibiya</td>
<td>chief pharmacist, MoHSW</td>
</tr>
<tr>
<td>Victoria Masuku</td>
<td>VCT network manager, PSI</td>
</tr>
<tr>
<td>Yves Lafort</td>
<td>technical assistant, HAPAC</td>
</tr>
</tbody>
</table>
Annex C : Documents reviewed

End of Project Assessment of HAPAC HBC in Northern Lubombo region
Evaluation of HAPAC STI, September 2005
Evaluation of HAPAC VCT, December 2005
Final report Long term technical Assistance, HAPAC, June 2002 - December 2003
Financing Agreement, HIV/AIDS prevention and care programme, SW/7002/001
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FLAS Matata VCT report January-December 2005
treatment services for sexually transmitted diseases in preventing HIV-1 infection in
Global Fund for AIDS,TB and Malaria, grant performance report, SWZ-202-G01-H
-00, 10 March 2006
Good Shephard Hospital Home based Care Annual Report 2005
HAPAC work programmes
HAPAC annual estimates
HAPAC Quarterly reports
HAPAC, evaluation of HBC monitoring tools in Lubombo region, December 2005
HAPAC, Mid Term Review, April 2004
Holden, Sue, mainstreaming HIV/AIDS in development, Oxfam 2004
Inception report, HAPAC, September 2002
Joint Annual Report 2004 Swaziland-European Community
Joint Annual Report 2005 Swaziland-European Community
Report of the Joint Review of the National Response to HIV/AIDS in Swaziland,
March 2005
Survey report, 9th Round of National HIV Sero-surveillance in Women attending
antenatal care services, March 2005, MoHSW
The Impact of Voluntary Counseling and Testing, a global overview of benefits and
challenges, UNAIDS 2001
The Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008 (draft),
NERCHA
Walker D, 2003, Cost and cost-effectiveness of HIV/AIDS prevention strategies in
developing countries; Is there an evidence base? Health Policy and Planning,
18(1):4-17, 2003
World Bank 2001, Selected Development Impacts of HIV/AIDS
Annex D : Map of Swaziland
### SWAZILAND HIV / AIDS PREVENTION AND CARE PROGRAMME - LOGICAL FRAMEWORK ANALYSIS

<table>
<thead>
<tr>
<th>INTERVENTION LOGIC</th>
<th>OBJECTIVELY VERIFIABLE INDICATORS</th>
<th>SOURCES OF VERIFICATION</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
</table>
| **OVERALL OBJECTIVE** | To reduce the rate of spread of HIV and alleviate the impact of AIDS in Swaziland. | Prevalence of HIV infection  
Impact of HBC programmes | Biennial surveillance  
Project evaluation report and MoHSW surveys and budget appropriations. | Continued commitment by the Government to respond to the HIV/AIDS epidemic as a national crisis and allocate resources as required |
| **PROJECT PURPOSE** | To reduce the rate of transmission of HIV and to develop programmes for the provision of home-based care for those with AIDS. | Number of clients counselled  
Number of clients tested for HIV  
i. Number of health care workers trained in STI syndromic management  
ii. Incidence of STIs  
Number of home visits | VCT centre records  
Project progress reports  
Ministry of Health statistics  
Project progress reports | |
| **RESULTS** | 1. Increased numbers of Swazi's presenting for voluntary counselling and testing.  
2. Improved management of sexually transmitted infections (STIs)  
3. Improved home-based care of persons with terminal AIDS. | Project progress reports  
Ministry of Health statistics  
Project progress reports | Continued availability of confirmatory HIV tests at Central Public Health Laboratory, Manzini  
Continued availability of essential drugs for treatment of STIs  
Improved availability of condoms  
Continued close co-operation between NGOs and government | |
<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>INTERVENTION LOGIC</th>
<th>MEANS</th>
<th>COST (EURO)</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
</table>
| Result 1   | i. Expansion of VCT services to each of Swaziland's four regions, with outreach capacity  
|            | ii. Support for each centre will include provision for salaries for 1/10 counsellors and support staff, rental of premises, vehicle and equipment and HIV rapid test kits, staff training.  
|            | iii. Development of a unifying "brand name" for the VCT centres and mass media campaign to promote VCT.                                                                                                                                                                      | 20 man/months TA Local Office (including Project Manager)            | 350,000     | TA is effective and able to establish good working relations NGOs have capacity to run VCT centres in each of the 4 regions                                                                                                                                                                                                                                    |
|            |                                                                                                                                                                                                                                           | Contracts to NGOs for VCT services                                  | 150,000     |                                                                                                                                                                                                                                                                                                                                                                                                                          |
|            |                                                                                                                                                                                                                                           | VCT Media campaign                                                 | 630,000     | Continued availability of trained counsellors                                                                                                                                                                                                                                                                                                               |
| Result 2:  | i. Training of Primary Health Care Workers throughout the country in the application of the syndromic approach to the management of clients presenting with STIs.                                                                                                                                 | STI training/equipment                                             | 70,000      | Continued allocation of resources by MoHSW to the syndromic management of STIs                                                                                                                                                                                                                                                                                         |
|            | ii. Provision of STI diagnostic equipment to the recently-established clinic at Mbabane Government hospital to enable accurate diagnosis to be made in complicated cases; provision of medical supplies for STI diagnosis and treatment.                                                                                               | Support for home-based care initiatives                           | 280,000     |                                                                                                                                                                                                                                                                                                                                                                                                                          |
|            | iii. Support for community-based care programmes for people living with AIDS  
|            | iv. Coordination mechanisms established and programmes developed for national community-based care support                                                                                                                                                                                        | Evaluation/Auditing                                               | 320,000     | Effective coordination and collaboration between MoHSW and NGOs                                                                                                                                                                                                                                                                                                |
|            |                                                                                                                                                                                                                                           | Contingency                                                        | 80,000      |                                                                                                                                                                                                                                                                                                                                                                                                                          |
|            |                                                                                                                                                                                                                                           | TOTAL                                                              | 1,960,000   |                                                                                                                                                                                                                                                                                                                                                                                                                          |
**INTERVENTION LOGIC** | **OBJECTIVELY VERIFIABLE INDICATORS** | **SOURCES OF VERIFICATION** | **ASSUMPTIONS**
--- | --- | --- | ---
**OVERALL OBJECTIVE** | The impact of HIV/AIDS on poverty significantly reduced |  | Behaviour change takes place, caused by a multitude of multisectoral interventions

**PROJECT PURPOSE** | The health sector response to the epidemic is effective and in line with the National Multisectoral Strategic Plan | SNAP formulating and implementing the strategic plan | Joint Review under UNAIDS/NERCHA auspices | The health sector response is not fragmented and the MoHSW has appointed one department (SNAP) to take the lead. SNAP is not duplicated by parallel projects.

**RESULTS** | 3. Increased planning and management capacity at national level (SNAP) for all health sector interventions | Detailed annual plans and budgets prepared by SNAP | Annual Plans and budgets that are sent to NERCHA | SNAP is provided with capable senior management and leadership.

| 4. Increased decentralised planning and management capacity at regional level for all health sector interventions | Regional Health Management Teams produce comprehensive regional plans and budgets involving all actors | Annual plans and budgets that are submitted to SNAP | Regional authorities are provided with responsibility as well as instruments of authority |
## Annex F: Revised simplified log frame for health sector response Swaziland

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>MEANS</th>
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</thead>
<tbody>
<tr>
<td>Result 1</td>
<td></td>
</tr>
<tr>
<td>iv. Capacity analysis of SNAP looking at all aspects of organisational</td>
<td>Technical assistance</td>
</tr>
<tr>
<td>capacity</td>
<td>Training</td>
</tr>
<tr>
<td>v. Systematic capacity building plan made on the basis of analysis</td>
<td>Construction of offices</td>
</tr>
<tr>
<td>vi. SNAP strengthened through conventional interventions in the areas of</td>
<td>Office supplies</td>
</tr>
<tr>
<td>(1) structures, systems and roles,</td>
<td>Vehicles</td>
</tr>
<tr>
<td>(2) staff and facilities,</td>
<td></td>
</tr>
<tr>
<td>(3) skills, and</td>
<td></td>
</tr>
<tr>
<td>(4) tools.</td>
<td></td>
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<tr>
<td>Similar analysis and action for regional authorities</td>
<td></td>
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Final evaluation of HAPAC