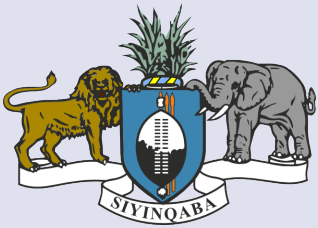
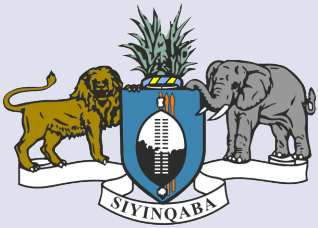


Kingdom of Eswatini

NATIONAL HIV PREVENTION POLICY 2019

Towards Ending AIDS



Kingdom of Eswatini

National HIV Prevention Policy 2019

Towards Ending AIDS

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ENAP	Swaziland National AIDS Programme
GBV	Gender-based Violence
HC4	HIV Response - Coordination Community Capacity and Communication – Breakthrough Action
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
NERCHA	National Emergency Response Council on HIV and AIDS
NSF	National Multisectoral HIV and AIDS Strategic Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
PEP	Post-Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PPCU	Public Policy Coordinating Unit
PrEP	Pre-Exposure Prophylaxis
SADC	Southern African Development Community
SBCC	Social and Behaviour Change Communication
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection(s)
TWG	Technical Working Group
VMMC	Voluntary Medical Male Circumcision

FOREWORD

This second National HIV Prevention Policy 2019 for the Kingdom of Eswatini demonstrates the milestones achieved thus far in the country's HIV and AIDS response. The country is geared towards ending AIDS as a public health threat by 2022. The policy provides for an enabling environment to intensify the prevention response implementation towards this goal. It emphasises the need and focus towards the over 800 000 emaSwati who are HIV negative while treating those living with HIV to prolong their lives. The policy development process took to account the state of the epidemic to date and evolved its guidance from programmatic issues to more policy and systems issues that will facilitate scaling up prevention interventions. The policy is human-centred and focuses on the needs of the local communities using different tested prevention technologies.

Wide consultations with various stakeholders in HIV prevention facilitated the development of this policy. Together, key international prevention best practice, a comprehensive thorough study of the Kingdom of Eswatini's previous response documents and strategies, and stakeholder consultation have contributed to a national policy that will serve the Kingdom of Eswatini and its people, far into the future.

A number of HIV response documents informed the development of this policy, and these are: the Eswatini National Multi-sectoral Strategic Framework for HIV and AIDS, 2019 - 2023; the eSwatini HIV Estimates and Projections Report, 2017; Swaziland HIV Prevention Response and Modes of Transmission Analysis, 2016; Swaziland HIV Incidence Measurement Survey 2017; and, the Swaziland National Multi-sectoral HIV and AIDS Policy, 2006. As addressed above, the previous policy focused on scaling up interventions. This policy focuses on policy and systems issues based on achievements of the Extended National Multisectoral Strategic Framework for HIV and AIDS of 2014 to 2018.

The National HIV Prevention Technical Working Group (TWG) and all the HIV prevention sub-thematic groups provided insight to the development of policy statements that are crucial for implementing HIV prevention interventions. The Public Policy Coordinating Unit (PPCU)— an entity that coordinates policy formulation in the public sector guided the development of this policy. The national HIV prevention

TWG will provide the overall leadership and programme coordination in translating this policy into implementation. The HIV prevention sub-thematic programmes lead the implementation of HIV prevention programmes.

This policy is an overarching guiding tool for HIV prevention, and it shall be used by a wide range of stakeholders, from policymakers to HIV prevention programmers and implementers.

Mr. Ambrose Mandvulo Dlamini
PRIME MINISTER
KINGDOM OF ESWATINI

ACKNOWLEDGEMENT

The National Emergency Response Council on HIV and AIDS (NERCHA) wishes to thank all the individuals and organisations that contributed during the process of the development of this policy. In particular, gratitude is for the guidance towards the development and finalisation of this policy provided by PPCU, members of the National HIV Prevention Technical Working Group and the HIV prevention sub-thematic technical working groups who are as follows: HIV Testing and Counselling, National Blood Transfusion Services, Voluntary Medical Male Circumcision, Prevention of Mother-to-Child Transmission, Social and Behaviour Change Communication, Sexually Transmitted Infections, Key Populations, Pre-Exposure Prophylaxis, Post-Exposure Prophylaxis, Condoms, Care and Treatment, Gender and GBV Technical Working Groups. We also acknowledge the critical contributions made by the eSwatini Network of People Living with HIV and AIDS, NERCHA Staff and the HIV prevention team for coordinating, leading and facilitating the process.

NERCHA also extends its sincere gratitude for the technical leadership and invaluable support provided by ENAP, Ministry of Health, UNAIDS, UNICEF, UNFPA, USAID/PEPFAR, HC4 and Mr Tom Mabururu the consultant who led the process of developing the policy. Special appreciation to UNICEF for their generous financial support that made the development of the policy possible.

Finally, a special thank you to all stakeholders, Government representatives, international development partners, and Parliamentarians for their participation and contributions during the consultations and discussions on the drafts of the policy document.

Mr. Nick Jackson
CHAIRPERSON OF NERCHA COUNCIL

DEFINITION OF TERMS

Coordinating entity: This is an organisation designated by the ministry responsible for this policy to coordinate all entities implementing and supporting HIV interventions in the country.

Technical leadership: This is an entity that leads the development of HIV prevention plans, guidelines and service packages for programme(s) relevant to its mandate. The implementation lead also defines the implementation approaches relevant to a specific HIV programme.

Implementation lead: This is an entity or organisation that leads the implementation of an HIV prevention intervention.

Implementers: Implementers are all organisations involved in the implementation of HIV prevention interventions at national, decentralized and community levels and in all sectors. These are organisations reaching the targeted populations.

Interventions: HIV prevention interventions refer to specific services offered to targeted populations to prevent the transmission and acquisition of HIV.

HIV prevention programme: A programme refers to a set of interventions logically designed to lead to the achievement of specified HIV outcomes and impact.

HIV services Integration: Integration refers to colocation and sharing of services and resources for HIV care and other primary healthcare services such as sexual and reproductive health, tuberculosis and maternal and neonatal healthcare among others. This allows people seeking HIV services to also have access to the other primary healthcare services, and those seeking services in any of the primary healthcare services will also have access to HIV services.

HIV Combination Prevention: This is a strategic mix of structural as well as biomedical and behavioural approaches that are required to meet the needs of specific vulnerable and key populations, focusing both on their risks and underlying causes of vulnerability.

Community led prevention response: These are interventions implemented by civil society, including CBOs, FBOs, local NGOs working with community structures and all groups in the community.

Risky Sex: Oral, Vaginal or anal sex without protection

CHAPTER 1

1.1 Introduction

The Kingdom of Eswatini has made considerable progress in the response to HIV and AIDS in the last five years in both prevention of new HIV infections and treatment of people living with HIV (PLHIV). New HIV infections have reduced by 44 percent since 2011, 84.7 percent of PLHIV know their status, 87.4 percent of the people with an HIV+ diagnosis are on antiretroviral therapy (ART) while 91.9 percent of the PLHIV on ART are virally suppressed[1]. Political commitment has also remained at the highest level with the country setting targets to "end AIDS as a public health threat" by 2022, eight years ahead of the global date to achieve this goal.

The HIV incidence among people 15 years and older is estimated at 1.4%. HIV incidence is highest among women than men. The variation is most pronounced among adolescents and young people with HIV incidence among females being more than double that of their male counterparts. The total number of annual new infections in adult was estimated at 7,000 in 2017[2].

There have been notable successes since the HIV Prevention Policy was developed in 2012. Over 90 per cent of the HIV positive pregnant women are initiated on ART and mother to child transmission of HIV at six weeks is estimated at 2 per cent. HIV tests conducted annually increased from 179,000 in 2011 to over 445,000 in 2017. Male condoms distributed annually increased from 18 million in 2015 to over 26 million in 2017[3]. The proportion of males 15 years and older medically circumcised increased from 19.1 per cent in 2010 to about 26.7 per cent in 2017[4]. Progress has also been made in providing youth, key populations and male friendly services; the integration of HIV with TB, Sexual and Reproductive Health (SRH) as well as integration of HIV into workplace wellness programmes. On the other hand, HIV prevention faces challenges which contribute to the slow pace in reduction of new infections. These include inconsistent and, in some cases, low condom use among people engaged in risky sex,

[1]Eswatini HIV Incidence Measurement Survey, 2017
[2]National HIV estimates, 2018
[3]Data from programme monitoring reports
[4]Eswatini HIV Incidence Measurement Survey, 2017

an increase in MTCT in the postpartum period to over 5 per cent[5], low uptake of voluntary medical male circumcision and low knowledge as well as poor HIV risk perception among young people.

The revision of the 2012 HIV prevention policy seeks to sustain and build on the gains made in HIV prevention. The HIV Prevention Policy will guide the implementation of the National HIV and AIDS Strategic Framework 2018-2023, programmatic guidelines and service packages.

1.2 Profile of HIV epidemic

HIV incidence among persons 15 years and older is estimated at 1.4 percent (1.7 per cent for females and 1.0 per cent for males). The variation in HIV incidence is most pronounced among adolescents and young women 15 – 24 years old with females having 1.9 per cent and males having 0.8 per cent incidence rates[6]. The total number of new infections was estimated at 7,000 in 2017 broken down into 6150 infection among people 15 years and above and 850 new infections among children 0-14 years. Adolescents and young people 15-24 years account for about 40 per cent of new infections[7].

Key drivers accounting for new HIV infections in the country include:

(i) Low in-depth knowledge of HIV among adolescents and young people, that is estimated at 49.1 percent among males and 50.9 per cent among females. Knowledge levels among 10-14-year olds is estimated at 34 per cent[8].

(ii) Early sexual debut with 3 percent females and 2.8 percent males having sex before the age of 15, compared to 48 percent females and 34% males who begin sex by age 18[9].

(iii) Dropping out of school especially among adolescent girls. 80 per cent of girls aged 15-22 years who are out of school are sexually active compared to 30 per cent of girls of the same age who are in school[10].

(iv) Intergenerational sex between adolescents' girls and young women aged 15-24 years and older men within age groups with high HIV prevalence.

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[5]PMTCT programme data
[6]Eswatini HIV Incidence Measurement Survey, 2017
[7]National HIV estimates, 2018
[8]Eswatini HIV Incidence Measurement Survey, 2017
[9]Multi-indicator Cluster Survey 2014
[10]Sitakhela Likusasa Impact Evaluation

(v) Inconsistent condom usage during risky sex: condom use among persons aged 15-49 years during high risk sex declined from 82.6 per cent in 2014 to 66.2 per cent in 2017[11].

(vi) Gender based violence with 1 in every 3 women experiencing sexual violence by the time they are 18 years old and 4.6 per cent of married women aged 15-49 years reporting intimate partner violence[12].

(vii) Onward HIV transmission from persons recently infected and not yet on treatment: This group comprises a cohort of 15 per cent PLHIV who are not on ART and it has become harder to find, test and put them on treatment.

(viii) Transactional sex and high HIV prevalence amongst sex workers and other key populations.

1.3 Policy gaps

The current HIV prevention policy does not adequately address the following areas of the prevention response:

- Programmes for key populations
- New technologies such as pre-exposure prophylaxis
- HIV self-testing as an innovative differentiated service delivery approach.
- HIV prevention coordination, leadership, financing, evidence-based programming and service integration issues.
- Changes in prioritized HIV prevention programmes and approaches including the shift from standalone social and behaviour change communication, abstinence, comprehensive knowledge of HIV to integrated risk reduction and demand creation.
- Unbalanced investment to both prevention and treatment. Primary HIV prevention does not have the same level of success as treatment, care and support of people living with HIV.

1.4 Policy rationale

Although the Kingdom of Eswatini has made progress in reducing new HIV infections, there is a need to reinvigorate HIV prevention to achieve the 2022 targets. This policy seeks to strengthen and sustain leadership and commitment to HIV prevention, transform HIV prevention to provide services tailored to populations and locations, prioritize interventions proven to have a more direct impact in preventing new infections and increase capacity and investment in HIV prevention.

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[11]Eswatini HIV Incidence Measurement Survey, 2017

[12]Study on violence against children and young women, UNICEF, 2017

1.5 Alignment of this policy to other policies and planning frameworks

This policy recognizes and is aligned to the following national and international documents:

1. National HIV Policy, 2006
2. National Health Policy, 2016
3. National HIV Prevention Policy 2012
4. National Social Assistance Policy, 2018
5. The Gender Policy, 2010
6. The Education and Training Sector Policy, 2018
7. National Policy on Sexual and Reproductive Health, 2013
8. National Population Policy
9. National Youth Policy, 2009
10. National Strategic Framework on HIV and AIDS 2018-2023
11. Sustainable Development Goals
12. Global HIV Prevention 2020 Road Map
13. SADC Regional Indicative Strategic Development Plan 2016-2020
14. African Union agenda 2063

1.6 Methodology for the review and updating of the policy

The process for development of this policy was led by a steering committee and a core technical team who dedicated their time to guide all stages of policy development. The policy was developed in a two-stage process. The first stage involved a review of the 2012 HIV prevention policy followed by the second stage on the development of this policy document. Extensive consultations with stakeholders drawn from all sectors – government, civil society, private sector and development partners - to solicit inputs on the achievements and gaps of the 2012 HIV prevention policy and policy recommendations was done. A stakeholder feedback report was produced outlining the key findings from stakeholder consultations. This report informed the development of the first version of the updated HIV prevention policy. The draft policy was reviewed by the core technical team and international partners and their comments were incorporated to produce the second version of the HIV prevention policy. The second draft of the policy was presented to stakeholders for review and validation. The final HIV prevention policy was reviewed and approved by the Steering Committee.

1.7 Application of this policy

This policy shall apply to government ministries, civil society organizations, private sector organizations, media, academia, researchers, development partners and all other stakeholders involved in coordinating, supporting and/or delivering HIV prevention services. The policy will be used by relevant government ministries and organizations, partners and other stakeholders to mainstream HIV prevention in their plans and programs. The policy shall guide the development and implementation of national strategies and action plans, program specific plans and guidelines.

1.8 Policy Implementation through National Strategic Frameworks

The implementation of this policy shall be guided by Global Prevention frameworks and the National Strategic Frameworks on HIV and AIDS developed from time to time.

CHAPTER 2

2.1 Vision

A healthy and well informed Eswatini population that has overcome the vulnerabilities to HIV infection.

2.2 Mission

To provide well-coordinated, adequately resourced, people centred, human rights based, and integrated HIV prevention services tailored to the needs of all populations in the country.

2.3 Policy objectives

The objectives of this policy are to:

a) Provide guidance to strengthen the oversight, coordination and implementation of HIV preventions interventions at all levels;
b) Strengthen community engagement in HIV prevention;
c) Improve access to quality, gender sensitive and stigma free HIV prevention services;
d) Increase investment in HIV prevention programmes;
e) Prevent the transmission and acquisition of new HIV infections.

2.4 Guiding principles

This policy is grounded on the following principles:

a) Good governance, accountability, transparency and effective leadership;
b) Respect for human rights, gender equality, protection, non-discrimination and non-stigmatization of all people in need of HIV prevention services;
c) Multi-sectoral, holistic and integrated approach;
d) Community engagement, social accountability and consumer empowerment;
e) Efficient and effective use of resources;
f) Equitable service coverage combination prevention services and products.

CHAPTER 3

Policy statements and implications
This section outlines the policy statements and implications to guide implementation of HIV prevention interventions.

3.1 Coordination and leadership

Policy statement
- The coordinating entity shall provide oversight and overall coordination of the development, management and implementation of the HIV prevention interventions.
- Technical leads shall provide technical leadership on implementation of HIV prevention interventions in line with their mandates.

Policy Implications
a) A coordinating entity for HIV prevention shall facilitate identification and coordination of technical lead institutions to provide technical leadership for a multisectoral HIV prevention response in line with their mandates. These institutions shall be technical and implementation lead entities for biomedical, behavioural and structural HIV prevention programmes.
b) A coordinating entity for HIV prevention shall promote multisectoral systems for coordination of HIV prevention programming at all levels.
c) A coordinating entity for HIV prevention shall facilitate the development and implementation of the national prevention coordination framework.
d) Technical leads shall define the guidelines for implementation of the HIV interventions related to their mandates.

3.2 Accountability framework

Policy statement
- All HIV prevention implementers shall be registered with the coordinating entity in collaboration with technical leads.
- All implementers shall report on HIV prevention interventions they implement using defined systems and tools.
- Every individual, population group, community and institution have the responsibility to prevent new HIV infections.

Policy implications

a) A coordinating entity and technical leads shall strengthen systems that tracks implementation of the HIV prevention programmes and interventions respectively across all sectors facilitating cross referrals and linkages to provide a holistic picture of HIV prevention.
b) The coordinating entity and technical leads shall facilitate a system that maps all HIV implementers.
c) All implementers and development partners shall report data on their programmes to all relevant national systems.
d) All individuals, groups, communities and institutions shall access HIV prevention information and services and remove all barriers that promote the spread of HIV.

3.3 Delivery of the HIV Combination Prevention Program

Policy statement

All implementers of HIV prevention interventions shall adopt and collaboratively implement the HIV Combination Prevention Program and operational guidelines put in place to provide holistic services based on behavioural and epidemiological evidence.

Policy implications

a) HIV prevention coordinating entity and technical leads shall ensure that all implementers provide services in accordance with defined guidelines and service packages tailored to specific populations and report regularly on defined indicators.
b) Biomedical, structural and behavioural interventions shall be strengthened to ensure prevention interventions address all dimensions of vulnerabilities.
c) The National HIV and AIDS Strategic Framework shall define priority HIV prevention intervention and target populations.
d) HIV prevention programmes shall be prioritised based on epidemiological and behavioural data.
e) Resource allocation to HIV prevention shall be guided by an evidence-based analysis and priority needs.
f) HIV prevention packages tailored to the prioritised populations shall be developed, taking into account age, sex, social and economic status and other relevant factors.
g) A social marketing approach shall be adopted to ensure increased demand for prevention services.

3.4 Access to HIV prevention services

Policy statement
HIV prevention interventions shall be made available to all persons living in Eswatini regardless of age, sex, location, religion and sexual orientation and without stigma and discrimination.

Policy implications
a) Prioritized HIV prevention interventions shall be implemented in a client centred manner at scale.
b) A system for profiling, targeting and tracking all populations that is acceptable to the community shall be strengthened to ensure they continuously have access to HIV prevention services.
c) The age of consent for HIV prevention and treatment services shall be revisited to ensure that it is not a barrier to access to HIV prevention services.
d) Co-location/integrated delivery of a package of HIV prevention information and services shall be promoted and offered to everyone at risk of HIV infection.
e) Client friendly HIV prevention information and services tailored to risk, vulnerability and the needs of specific populations shall be strengthened.
f) Appropriate mechanisms shall be established to ensure meaningful client participation in the delivery of HIV prevention information and services.
g) Prevention programming will entail a client-led approach to ensure client empowerment.
h) The use of technology shall be enhanced to facilitate the provision of HIV prevention information and services.

3.5 Quality of service

Policy statement
- All HIV prevention interventions shall be in line with quality standards defined in national and international guidelines.
- All HIV prevention interventions shall be integrated with all health services and sectoral national development programs.

Policy implications

a) All HIV prevention intervention leads shall establish service delivery guidelines and standards.
b) All HIV prevention programmes shall develop and implement quality assurance plans.
c) HIV prevention service quality assurance and improvement shall be carried out continuously in all sectors.
d) HIV implementers shall have requisite capacity to meet quality standards of the combination prevention programme.

3.6 Human rights and gender

Policy statement

- All HIV implementers shall promote and protect the rights of all people.
- Legal and policy instruments shall be put in place to facilitate HIV prevention and removal of existing barriers.
- All HIV prevention implementers shall mainstream gender in their interventions.

Policy implications

a) All implementers shall protect the rights of all populations with a particular emphasis on key and priority populations.
b) All interventions shall be right based, with particular attention to structural issues, gender-based violence including inequality and universal human rights.
c) All HIV implementers shall promote gender equality and address negative gender norms to facilitate HIV prevention.

3.7 HIV prevention community response

Policy statement

The HIV prevention response shall engage decentralized and community structures in planning, implementation and monitoring of all HIV prevention interventions.

Implementers shall be accountable to communities they work in and the targeted populations.

Policy implications

a) Implementers of HIV prevention interventions shall be accountable to community structures.
b) Interventions shall be implemented with the involvement of community structures and targeted populations in developing, implementation and monitoring of the interventions.
c) Social accountability mechanisms for HIV prevention service delivery shall be established to promote community ownership.
d) Monitoring systems for collecting data and reporting on community HIV prevention services shall be strengthened and linked to national monitoring systems.
e) Formal relationships between relevant ministries and community structures shall be promoted and enhanced.

3.8 Sustainability

Policy statement

- All HIV prevention interventions shall be sustained to ensure epidemic control.
- All HIV prevention intervention shall be anchored in existing country structures at all levels.

Policy implications

a) The coordinating entity shall put in place sustainable approaches that include reduced reliance on donor funding, increase in domestic resources and strategic engagement with the private sector.
b) HIV prevention interventions shall promote institutionalisation of services especially those offered through the community-led response.
c) All technical leads and development partners shall promote sustainable HIV interventions based on established guidelines.
d) The capacity of HIV prevention service providers shall be strengthened to offer integrated services.
e) HIV prevention shall form part of the essential professional education and training curricular across social sectors.
f) HIV prevention service providers shall have requisite capacity to offer integrated services.
g) HIV prevention coordinating entity shall establish mechanisms for donor coordination.

3.9 Research and innovation

Policy statement

- Integrated and client-centered research and evidence (behavioral and epidemiological) shall be generated to guide HIV prevention interventions.
- The coordinating entity shall coordinate all technical leads to establish guidelines for the use of research and adoption of innovations.

Policy implications

a) HIV prevention research shall be conducted and guided by a national research agenda and national and international research standards.
b) Implementers interested in research shall have capacity to undertake prevention research.
c) HIV prevention interventions shall be continuously reviewed and adjusted as new evidence becomes available.
d) All relevant national research and data institutions shall facilitate HIV prevention research in line with their mandate.
e) Communities shall be engaged in research and use of evidence to inform programming with an appropriate feedback loop.
f) The coordinating entity, in collaboration with all technical leads shall establish guidelines for fast tracking adoption of innovations and/or new technologies.

3.10 Monitoring and evaluation

Policy statement

- There shall be an integrated and harmonized multisectoral HIV prevention monitoring and evaluation system and coordination of data flow from all sources.
- All state and non-state entities involved in HIV prevention shall actively report to the relevant national systems.

Policy implications

a) HIV prevention coordinating entity shall integrate and harmonize data systems from all sectors for a holistic view of the HIV response.
b) HIV prevention coordinating entity shall facilitate the timely data dissemination and use in line with national and international standards and obligations.
c) HIV prevention coordinating entity shall build the capacity of data systems to allow evaluation of programme coverage by age bands, sex, geographical locations and social and economic status.
d) All HIV programmes shall have access to HIV prevention data to inform continuous reviews.

3.11 Financing of HIV prevention

Policy statement

Adequate financing of HIV prevention shall be made available to support the provision of information and services at scale and sustain the reduction of new HIV infections.

Policy implications

a) HIV prevention shall be allocated at least 25% of all HIV funding in line with HIV Prevention 2020 Road Map.
b) A social contracting mechanism shall be established and implemented.
c) Mechanisms shall be progressively put in place to ensure at least 30% of service delivery interventions shall be community led in line with the 2016 political declaration on HIV and AIDS.
d) HIV prevention goals and targets will be used to inform HIV prevention resource needs, allocation and HIV prevention expenditure assessments shall be conducted periodically.
e) A coordinating entity for HIV prevention shall establish and implement a mechanism for tracking financing and establishing the cost of providing HIV prevention services, with a focus on priority populations.

CHAPTER 4

Policy Implementation Framework

4.1 Implementation mechanisms

i) The Ministry responsible, through NERCHA, shall be responsible for overseeing the implementation of this policy.

ii) The Ministry responsible, through NERCHA, shall disseminate this policy to all implementers and other stakeholders at all levels.

iii) An implementation plan shall follow the development of the policy to ensure accountability of its implementation.

iv) The responsible Ministry, through NERCHA, shall monitor the implementation of this policy.

v) The policy shall be implemented with effect from November 2019.

4.2 Roles of key stakeholders

4.2.1 Government ministries

a) Provide technical leadership in HIV prevention in their areas of mandates;

b) Provide guidance on requisite plans, guidelines and tools for translating this policy into action in their respective sectors;

c) Strengthen partnerships at all levels to ensure all implementers are effectively involved in implementation of this policy;

d) Build capacity as necessary to implement this policy in their mandate areas;

e) Monitor implementation of this policy in their respective sectors;

f) Budget for and ensure the provision of sector specific HIV prevention information and services.

4.2.2 Civil society and private sector organisations

a) Actively support the implementation of this policy;
b) Align their programmes, funding requests and action plans to this policy;
c) Report on their programmes in line with national monitoring systems as required;
d) Meet their obligations under social contracting strategy;
e) Comply with the HIV prevention policy statements;
f) Participate in the annual reviews of this policy and propose any adjustments necessary;
g) Advocate for funding for HIV prevention to be aligned to this policy.

4.2.3 Development and donor partners

a) Provide financial and technical support for the implementation of this policy;
b) Align their financial support to the provisions of this policy;
c) Advocate for funding support from Government to be aligned to this policy;
d) Participate in annual reviews of this policy and propose any adjustments necessary.

4.3 Policy Monitoring, Review and Evaluation Process

a) NERCHA shall be responsible for monitoring and evaluation of this policy.
b) The policy shall be monitored based on performance indicators to be established.
c) NERCHA shall convene stakeholders to review implementation of this policy annually.
d) Emerging evidence and lessons from implementation of the policy shall inform policy adjustments.
e) A comprehensive review of this policy shall be undertaken after five years.

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