

**EHPA Case Study series:**  
Included! How change happened  
for key populations and HIV prevention

# **A Manual for Swaziland health-care workers**

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**A cooperative venture in developing a  
key population manual**



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## **1. Introduction**

In Swaziland, because HIV is perceived to be linked with sexual promiscuity, stigma associated with HIV and AIDS prevents many people from being tested for HIV or declaring their HIV status. This conundrum is worse for key populations (KP) including men who have sex with men (MSM), sex workers, transgender people and people who inject drugs (PWID). These groups face even greater challenges when accessing health care because of stigma and a lack of knowledge and skills among health workers in relation to the specific needs of key populations.

Against this backdrop, in August 2016, the Swazi Ministry of Health (MoH) launched a training manual for healthcare workers, titled 'Improving Access to Comprehensive Health Care Services for Key Populations in Swaziland'. The manual was the result of a cooperative project between the Dutch NGO COC Netherlands and the Swaziland National AIDS Programme (SNAP) under the MoH. National key populations NGOs were also included as representatives in the key populations technical working group (TWG) and as stakeholders in initial meetings between COC and SNAP.

The manual was developed to train and sensitise health workers about the healthcare needs of key populations, including how to meet those needs in a friendly, non-judgemental, non-discriminatory manner. It is dedicated to 'all individuals who have experienced stigma when accessing health care services and all health care workers and all key stakeholders who continuously strive for a receptive environment in health care settings'. The manual is being used to train health workers. Training of nurses began in October 2016.

The manual is an example of progress for key populations in a context hostile to their rights, social recognition and legal status.

This case study attempts to understand the process that led to the production of the manual – what were the critical factors that enabled its development; what role did members of key populations play in its production?

### **About this paper**

This paper is part of a series, Included! How change happened for key populations for HIV prevention, commissioned by EHPSA to Nordic Consulting Group. The full series of nine case studies and discussion paper is available on the EHPSA website at <http://www.ehpsa.org/critical-reviews/included>.

The series was based on both literature research and interviews with key actors. In-depth interviews for this case study were conducted with representatives of the Swaziland National AIDS Programme and relevant NGOs. The full list of interviewees is given in Annexure 1 on page 11.

### **About EHPSA**

Evidence for HIV Prevention in eastern and southern Africa (EHPSA) is a catalytic intervention, contributing to national, regional and global processes on HIV prevention for adolescents, men who have sex with men (MSM) and prisoners, through generating evidence of what works and why, and developing strategies to inform policymaking processes. It is a five-year programme funded by DFID and managed by Mott MacDonald.

## 2. Context

Swaziland has a population of about 1.2 million people and has the highest HIV prevalence in the world; 27% of its adult population (15-49 years) living with HIV in 2017.<sup>1</sup> Women are disproportionately affected: 32.5% of adult women are living with HIV, compared to 20.4% of men.<sup>2</sup> According to the 2009 modes of transmission analysis (MoT) analysis, heterosexual sex remains the main conduit for HIV transmission and accounted for 94% of all new HIV infections in 2008, including infections in female sex workers, their clients and partners of clients.<sup>3</sup> HIV prevalence remains high among KPs, in particular sex workers (60.5%).<sup>4</sup> Estimates in 2013<sup>5</sup> suggested that HIV prevalence among MSM was 12.6%, which was actually lower than males in the general population (23%).<sup>6</sup>

Swaziland's high AIDS mortality has placed its life expectancy at 50.54 years, higher than only four other countries.<sup>7</sup> Despite the widespread nature of the epidemic in Swaziland, HIV and AIDS is still heavily stigmatised. Most people living with HIV, particularly prominent people such as religious and traditional leaders and media/sports personalities, hide their status.

In recent years, Swaziland has made considerable progress in responding to the HIV epidemic by scaling up national treatment and prevention programmes and increasing domestic funding.<sup>8</sup> New infections almost halved between 2011 and 2016.<sup>9</sup> Swaziland has one of the highest rates of antiretroviral treatment (ARV) coverage in sub-Saharan Africa and its progress towards reaching the 90-90-90 goals is good. In 2016, 84% of people living with HIV knew their status, 87% of those were on ARV treatment and 92% of those were virally suppressed.<sup>10</sup> Nevertheless, the large number of people living with HIV in Swaziland means it is still the country's biggest public health concern.

Although the national HIV and AIDS policy environment is supportive of sex workers and MSM, same-sex relations and sex work are both illegal in Swaziland. Both groups face widespread stigma and discrimination, verbal abuse and physical violence and other human rights violations. Around one-third of men who have sex with men and female sex workers report some form of legal discrimination.<sup>11</sup> More than a third (37%) of female sex workers report being refused police protection. A third (36%) of men who have sex with men report being tortured because of their sexuality.<sup>12</sup> Swaziland lacks anti-discrimination laws to protect gay men, other MSM, sex workers or transgender people, which makes it difficult for them to actualise their human rights, including accessing sexual and reproductive health and HIV services.

There is some ambiguity in Swaziland regarding same-sex practices; some may be charged as indecent acts or a public nuisance. Sodomy is criminalised under the Sodomy Act of the common law if the sodomised party lays a charge. A man convicted of sodomy may face imprisonment of no less than two years, depending on the magistrate or judge and whether the offence is construed as rape. However, few such cases are brought before the courts. Drug injecting is illegal.

The *Extended National Multi-sectoral HIV and AIDS Framework (eNSF) 2014–2018* defines key and vulnerable populations as adolescent girls, sex workers, MSM and PWID and emphasises the need to include them in HIV programming, for example by increasing condom use among female sex workers and MSM and reducing age-disparate sexual partnerships.

1 Presentation at IAS 2017 <http://programme.ias2017.org/Abstract/Abstract/5837>

2 Swaziland HIV Incidence Measurement Survey 2 (2016–2017) (SHIMS2) [http://phia.icap.columbia.edu/wp-content/uploads/2017/11/Swaziland\\_new.v8.pdf](http://phia.icap.columbia.edu/wp-content/uploads/2017/11/Swaziland_new.v8.pdf)

3 Mngadi, S., et al., 2009. *Swaziland: HIV prevention response and modes of transmission analysis*. Mbabane: National Emergency Response Council on HIV and AIDS.

4 R2P, 2013. *HIV among female sex workers and men who have sex with men in Swaziland. A combined report of quantitative and qualitative studies*. John Hopkins University, Baltimore; 2013

5 Ibid.

6 Swaziland HIV Incidence Measurement Survey (SHIMS), 2011

7 CIA, 2015. *The World Factbook*; 2010. See: <http://www.cia.gov/library/publications/the-world-factbook>.

8 UNAIDS, 2016. *Prevention gap report*.

9 Presentation at IAS 2017, op cit.

10 SHIMS2, op cit.

11 Swaziland Ministry of Health, 2014. *Swaziland Global AIDS Response Progress Report*.

12 Ibid.

Of the US\$ 98 million spent on HIV and AIDS in 2012/13 about 65% was from international sources, notably the US government through the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund (GFATM), UN agencies such as the World Bank, bilaterals such as the UK and Japan, the European Union and international NGOs including the Clinton Health Access Initiative (CHAI), World Vision, and Médecins Sans Frontières (MSF). Funds for KP programming come from the PEPFAR Key Populations Challenge Fund (80%), which covers prevention and biomedical interventions. In addition, 15% comes from the Global Fund. Other international sources contribute the remaining budget (5%). The government of Swaziland supports all biomedical interventions in facilities.

### **3. The change process**

The process that led to the launch of the KP manual was characterised by a number of key steps.

#### **3.1 Establishment of a KP programme within SNAP: 2007– 2009**

The first turning point was in 2007, when the UNFPA conducted an assessment among sex workers that revealed their heightened risk for HIV and STIs and described the existence of sex-worker hotspots.<sup>13</sup> The report led to the creation of an STI programme within SNAP in 2008. The programme was set up in collaboration with partners who were part of the assessment to identify sex-worker hotspots and mobilise the first group of sex workers for education sessions.

In the same year, SNAP successfully applied for a grant from the WHO Project Acceleration Fund for a programme focusing on training of sex workers, MSM and injecting drug users (IDUs) as peer educators on HIV prevention. Once the programme was established SNAP saw the need to include these groups in the National HIV Strategic Plan. This was difficult because many people regarded the behaviours of these groups as criminal. The principal secretary of the Ministry of Health played a pivotal role by stating that the mandate of the ministry was to ensure universal access to health services without any discrimination and that legal aspects should be left to the Ministry of Justice. Key populations were clearly defined and included in the National Strategic Plan (NSP) 2009–2014, which identified gaps in services and targets.

With this new 2009–2014 Plan, the Ministry of Health appointed a national coordinator within SNAP who would be responsible for coordinating the KP programme. The programme included orientation of implementing partners on the mandate of MoH; development of guiding documents; resource mobilisation; implementation of services; and, research. The programme would also address the following:

- The uneven spread of services geographically and within the different KP groups.
- Poor harmonisation of HIV activities with the 2009–2014 NSP, and a lack of monitoring and reporting at national level.
- The lack of an official government mandate for partners working with KPs.
- The lack of human capacity, skills development and other resources needed at all levels to address the needs of KPs within health and other governmental sectors.

Initially, the programme was underfunded, but in 2010, SNAP received funding from PEPFAR to implement prevention activities including procurement and distribution of flavoured condoms and lubricants, peer-education programmes and research to target sex workers and MSM.

The key populations technical working group (TWG) was established in 2010 as part of the process of developing the KP national framework. One of its roles was to ensure that stakeholders from all relevant sectors – including relevant government ministries, development partners and the private sector – were engaged at the appropriate levels. Included in its mandate was the coordination of the different KP subcommittees to ensure that responses were harmonised and created opportunities for cross-learning and sharing of experiences.

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<sup>13</sup> Chipamaunga, S., Muula, A.S. and Mataya, R., 2010. An assessment of sex work in Swaziland: barriers to and opportunities for HIV prevention among sex workers. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 7(3).

### 3.2 Building Evidence for Action: 2011 onwards

A critical moment came in 2011, when the results of a Bio-Behavioural Surveillance Study (BSS) were released.<sup>14</sup> The survey by Population Services International (PSI) and John Hopkins University revealed that HIV prevalence among sex workers stood at a shocking 70.3%. The study also reported that among MSM only half used condoms when they had sex and that their HIV-prevalence of 17.7% was lower than that of the male general population. The study also found that 55% of MSM interviewed were afraid to seek health care because of their gender identity.

Before the BSS, little was known about HIV prevalence or risk factors among KPs in the country. In addition to the key findings about HIV prevalence, the study also looked at risks and access to health care for KPs. It found 'perceived stigma from health care settings leads to lack of care-seeking'. Two recommendations from the study were particularly relevant to the development of the manual:

- Members of key populations should be paired with trusted 'expert clients' to help them navigate health-care systems and the processes of diagnosis, disclosure and treatment.
- Clinical providers and staff in HIV clinics should be trained to address stigma and improve their ability to provide key populations with specific, sensitive and effective care.

In 2014/2015 a study carried out to generate data for evidence-based programme planning and delivery of cost-effective and quality HIV prevention, care and support services for FSW and MSM<sup>15</sup> revealed that one in ten MSM reported feeling they received lower quality health care and 13.7% had heard health-care workers gossiping about them. More than one third (36.3%) reported being afraid to access health services, and 34.8% reported actively avoiding health facilities.

### 3.3 Policymaking: The Key Populations at Risk of HIV Strategic Plan 2013–2016

Swaziland developed the Key Populations at Risk of HIV Strategic Plan 2013–2016 to provide a framework for a comprehensive package of services to reach sex workers, MSM, PWID, prisoners and mobile populations.<sup>16</sup> The goal of the plan was to reach 20% of members of these populations by 2016 with a comprehensive package of HIV services – HIV prevention, HIV treatment, care and support, psychosocial support and impact mitigation – that were evidence-informed, accessible and acceptable to specific populations. The package was to be consolidated by evidence-informed strategies and interventions to ensure that linkages were strengthened, in line with the objectives of the National Strategic Plan 2009–2014.

The KP strategic plan also highlighted the need to train health-care workers to deliver tangible HIV services; it was against this backdrop that the need for a manual was identified. A programme guide that clearly defined the minimum package for structural, behavioural and biomedical KP interventions was also developed.

### 3.4 Partnership opportunity: 2015

COC Netherlands had been working with LGBT organisations in South Africa for a several years, implementing various programmes aimed at achieving access to HIV and STI prevention, treatment, care and support for sex workers, LGBTI and PWID, including 'Dignity, Diversity and Rights' (DiDiri) and 'Bridging the Gaps'. COC Netherlands had supported the development of a manual for health-care workers in South Africa<sup>17</sup> and offered their support for the same process in Swaziland. The MoH and the LGBTI organisations engaged COC in discussion about carrying out a similar process in Swaziland. A COC staff representative said that Swaziland was the first country in which LGBT partners and MoH had both been interested.

14 PSI and R2P. MARPS Bio-Behavioral Surveillance Survey (BSS) Results: Men who have sex with men and Sex Workers Stakeholders dissemination meeting, 31 May 2012. Presentation available from: [https://www.k4health.org/sites/default/files/Swaziland\\_MARPS\\_BSS\\_results\\_presentation\\_to\\_stakeholders\\_31M.pdf](https://www.k4health.org/sites/default/files/Swaziland_MARPS_BSS_results_presentation_to_stakeholders_31M.pdf)

15 HIV Prevention for Populations at Risk, Swaziland

16 SNAP. Key Populations at Risk of HIV Strategic Plan 2013-2016

17 Brown, B., Duby, Z. and Van Dyk, D., 2013. *Health care provision for men who have sex with men, sex workers, and people who use drugs*. Cape Town, South Africa: The Desmond Tutu HIV Foundation.

Swaziland was the first country to develop a manual in a cooperative process; COC considers the country a role model in the region. COC staff based in South Africa visited Swaziland to discuss the process with KP organisations, the MoH and other stakeholders including UNAIDS and health education institutions. COC worked with local NGOs to present a concept note to a multi-stakeholder audience including civil society, academia, nursing councils, MoH, religious leaders and UN organisations. Following these events, the MoH took ownership of the manual and led the process. The South African manual was adapted to suit the Swaziland context, which also included changes in the examples and cases provided, as well as the introduction of a transgender module.

In the light of the adverse socio-legal environment for KPs, COC was expecting resistance to the idea of the manual but the process went smoothly. This was largely because it was supported and owned by the MoH;<sup>18</sup> the entire process was led and coordinated by MoH programme officers and the document was endorsed by the principal secretary in the Ministry of Health.

### 3.5 Outcome: The health-care workers manual

The training manual for health-care workers is the response by the Ministry of Health and partners to ensure that the right to health of key populations is not compromised by inadequate access to health care or inferior health services which include SRH services, prevention, care and treatment services for HIV, STI, and TB, as well as mental health and related health services. The aim of the manual is to train health-care workers about the health needs of KP and how best to ensure that non-stigmatising services are available, equitable and technically up-to-date for KP groups. The manual incorporates the WHO's Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014).<sup>19</sup>

The manual is a comprehensive document that consists of 10 modules, and covers topics such as human sexuality and human behaviour; human rights of key populations; stigma and discrimination; risk factors and vulnerabilities among KPs; biomedical interventions for KPs; referrals and linkages; behavioural and psychosocial interventions for KPs and their families; drug use and mental illness among KPs; transgender and gender nonconforming people; and, people who inject drugs. The manual was adapted from *Health Care Provision for Men who have Sex with Men, Sex Workers, and People who use Drugs: An Introductory Manual for Health Care Workers in South Africa*. Two local consultants were contracted to develop and finalise it.

The transgender health component was adapted from the guidelines *Sexual and Reproductive Health for transgender and gender non-conforming people* developed for the South African organisation Gender Dynamix in 2014. The author was contracted to assist in the development of the Swaziland manual. This included a capacity building meeting with KP organisations and the Swaziland MoH in May 2016.

The manual was supported technically and financially by a variety of actors, including UNAIDS, WHO, Health Communication Capacity Collaborative (HC3), ICAP and COC.

Training of health-care workers began in October 2016 following the launch of the manual.

18 Personal communication with Sindy Matse, National Key Populations and vulnerable groups Coordinator, SNAP.

19 World Health Organization, 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. World Health Organization.

## 4. How change happened

### 4.1 Critical actors

Key actors in the process leading to the launch of the manual are summarised below.

Actor category	Actors	Role
National government (MoH/SNAP)	Swaziland National Aids Programme staff	MoH played a critical role in the change process. It committed to ensuring health rights for KPs despite resistance from others. MoH manages KP programmes in the country and 'owns' the manual development process
Key Population Organisations	Rock of Hope, Swaziland Positive Living, House of Our Pride (HOOP), Health Plus for Men	KP organisations from the LGBTI sector were represented in the TWG and provided ongoing feedback and advice on the manual. KP organisations were also partners of COC, who were providing technical and financial support to the manual.
International NGOs	COC, HC3, ICAP	International NGOs played a critical role throughout the change process. COC (and LGBT partners) presented the idea of a manual to MoH and provided technical support throughout the process including development of the transgender module. HC3 and ICAP provided technical support and funding for the manual development
Research institutions (International)	University of Cape Town (UCT), Population Services International (PSI), John Hopkins	International research institutions played a critical role in terms of evidence generation as well as technical support to the manual development. UCT assisted with a module on transgender; John Hopkins and PSI carried out surveys on KPs and HIV.
Multilateral actors e.g. UNAIDS, UNFPA and the World Bank	WHO, PEPFAR, UNAIDS, UNODC	Multilaterals played an important role throughout the change process. UNFPA carried out an early assessment of HIV and sex workers; WHO funded printing of the manual; PEPFAR provides funding to the SNAP KP programme in general; UNAIDS provided technical support. UNAIDS and UNODC are members of the TWG.
National NGOs and other civil society actors	n/a	No significant role

In addition to the actors listed above, members of the KP TWG engaged in validation and discussions during the manual development process. The TWG included MoH/SNAP, international NGOs (HC3 and MSF), health-care workers, KP organisations, UNAIDS and UNODC.

All the KP organisations are broad LGBT organisations. There were no formal organisations for sex workers, transgender or PWIDs involved in the process. Over the years, Swaziland has seen an increase in organisations working on LGBT issues although they are not allowed to register or operate freely because of the hostile socio-legal climate. To avoid official scrutiny LGBT organisations identify themselves as working with HIV and AIDS, marginalised populations or gender. All organisations in Swaziland that were working with HIV and LGBT were involved in the manual process and are mentioned in the above table. HOOP was registered in 2009, Rock of Hope in 2012, and Health Plus for Men in 2014. Over time they have built up their capacity and are engaged in HIV-prevention programmes.

## 4.2 Contributing factors

This case is exceptional in that there was a smooth pathway to the decision in principle and then, to implementation, in a socially conservative country where people living with HIV, and especially to members of key populations, are stigmatised. There was also a high degree of collaboration between the Ministry of Health, international NGOs and emerging local LGBT organisations.

In identifying the critical factors that contributed to the achievement of the manual, especially in such a challenging context, a distinction is made between those that created an enabling environment for change and the tactics used to bring about change in this context. Inevitably there is some overlap between them.

### Creating an enabling environment

**Evidence available:** Knowledge gained from surveys about KPs, particularly regarding their HIV prevalence and challenges with accessing health care, were key to the change process because they made the need for the manual clear. The 2011 Bio-Behavioural Surveillance study was critical because it identified the issues with accessing health care and strongly influenced the Key Populations at Risk of HIV Strategic Plan 2013–2016. This plan, in turn, provided a framework for a comprehensive package of services to reach key populations. International research institutions led the studies which were funded by international aid, particularly from the US government.

**Catalytic event:** Publication of the findings of the 2011 Bio-Behavioural Surveillance Study was critical because it found an extremely high prevalence amongst sex workers against the fact that Swaziland has the highest national HIV prevalence in the world. It also showed that key populations did not use health services because they experienced high levels of stigma.

**Sustained and courageous leadership:** The Ministry of Health provided strong leadership to the process of developing and using the manual once a clear need for interventions for key populations was established in terms of high HIV prevalence amongst sex workers and poor uptake of services. This was despite the strongly conservative socio-legal context. The principal secretary of the MoH played a significant early role by clearly stating that the mandate of the MoH was to ensure universal access to health services to everyone, without discrimination. The Ministry of Justice was to deal with any legal aspects.

**Technical working group:** The key populations TWG was an effective vehicle to bring all the parties together under the leadership of the MoH.

**External funding available:** International agencies covered the costs of the evidence-generation that identified the need for the manual, and development of the manual itself. External funding also provided for all the costs of key population interventions in the manual. The manual thus came at no cost to the Swaziland budget even though the Ministry of Health led the process of developing it.

**Early adoption of international policies:** The content of the manual drew heavily on that of the South African equivalent released soon before; the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014); and, material developed in South Africa for transgender and gender non-conforming people. A consultant was sourced from South Africa to develop the transgender module.

**International NGO LGBT regional programmes:** Regional programmes targeting health rights for LGBT had previously been implemented in southern Africa, in partnership with COC. The process of developing the manual therefore took off on grounds that were already established in terms of contacts, experiences and knowledge of the context and needs of KPs in relation to health and human rights.

### Tactics used to bring about change

**UN agencies played a key facilitating role:** UNFPA and UNAIDS provided financial and technical assistance for development of the manual. WHO provided technical support for training of trainers and training of doctors.

**Framing in terms of public health:** In the context of the devastating HIV epidemic in Swaziland, the use of public health arguments overcame resistance from strongly conservative social perspectives. This meant that at both public and personal levels it was possible to acknowledge and work with sex workers and LGBTI people.

### 4.3 Role of civil society

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Organisations formed from members of key populations played an important role in the change process through three main activities:

- KP organisations were engaged from the start through their participation in the Bridging the Gaps and DiDiRi programmes and, hence, their cooperation with COC.
- Once the process of developing the manual had begun KP organisations participated in the TWG. A community advisory board comprised of the MoH, HC3, UNAIDS/UNODC, and KP organisations performed oversight duties for the manual development. In this way, the contributions of KP organisations ensured that the manual reflected KP needs and priorities.
- KP organisations sensitised their constituencies on the availability of the manual.

Advocacy from Swazi civil society did not play a significant role in the change process. The KP organisations in Swaziland mainly represented LGBTI people and are relatively weak. According to the MoH KP programme officer<sup>20</sup> there are no formally registered organisations in Swaziland that represent sex workers although sex workers from certain hotspots were involved. Mainstream NGOs did not play any role in the process.

The international NGO, COC, was critical to the change process. COC initiated the concept of the manual, and supported the initial convening of partners to discuss the feasibility of the manual, as well as the actual process of manual development – both technically and financially.

## 5. Conclusions

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The Swaziland manual is an example of ‘contextual contrast’ – or contrast between a hostile socio-legal context and ability of government actors to bring about change. This achievement can be partly explained by the fact that the structure for KP programming was already in place within the Ministry of Health at the time the manual for health-care workers was proposed. It built upon an appreciation within the Ministry, based on evidence, for the need to address key population health issues. Therefore, the proposal by COC to develop a manual came when awareness, structure and commitment were already in place in the ministry.

This is one of very few examples of regional collaboration in this series of case studies. After successfully managing regional civil society programmes focussing on the health needs of LGBTI people in the context of HIV, COC was seeking a country in the region in which to introduce the South African manual. The manual went ahead in Swaziland because of the initiative of its partner organisations and the openness of the Ministry of Health to take the lead in developing and using the manual.

The case for developing the manual was based on the need for effective HIV prevention for sex workers given their high levels of infection and their contribution to HIV infection of their clients, and in turn, their clients’ partners and thus, HIV infection in the general population. Furthermore, the surveys established poor uptake of services on the part of both sex workers and LGBTI people. In this context, it is striking that it was LGBTI organisations that dominated civil society contributions to the manual. This has been seen elsewhere in the region in this series of case studies and reflects the relative strength of LGBTI organisations over those that represent sex workers. In the case of sex workers in Swaziland there were no formal structures although their need for uptake of health services was far greater than that of LGBTI.

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<sup>20</sup> Interview on 17 March, 2017

## Annexure 1. Sources of information

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The case study draws on document review and several interviews. The lead researcher was Julie Thrupp. She also produced a synthesis and analysis of the findings.

### 1. Interviews

- Bram Langen, COC
- Khanyisile Lukhele, Key populations Programme Officer, Swaziland National AIDS Programme
- Thuthu Magagula, Rock of Hope, Swaziland
- Philile Malindzisa, FLAS clinic (LGBT friendly services), Swaziland
- Sindy Matse, Key populations and Vulnerable Groups Coordinator, Swaziland National AIDS Programme
- Phindile Nkambule, FLAS clinic (LGBT friendly services), Swaziland
- Dr Olusegun Odumuso, COC

### 2. Documents

Brown, B., Duby, Z. and Van Dyk, D., 2013. *Health care provision for men who have sex with men, sex workers, and people who use drugs*. Cape Town, South Africa: The Desmond Tutu HIV Foundation.

Chipamaunga, S., Muula, A.S. and Mataya, R., 2010. An assessment of sex work in Swaziland: barriers to and opportunities for HIV prevention among sex workers. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 7(3).

Kingdom of Swaziland, Ministry of Health:

- Improving Access to Comprehensive Health Care Services for Key Populations in Swaziland*.
- The Health Sector Response to HIV/AIDS Plan 2014–2018*

Kingdom of Swaziland, National Emergency Response Council on HIV and AIDS (NERCHA): *The Extended National Multi-Sectoral HIV and AIDS Framework (eNSF) 2014–2018*.

Müller A., 2013. *Sexual and reproductive health for transgender and gender non-conforming people: Guidelines for health care workers in primary care*. Cape Town: Gender DynamiX.

PEPFAR/Swaziland, 2016. Swaziland Country Operational Plan (COP) 2016. Strategic Direction Summary, April 20.

PSI and R2P, 2012. MARPS Bio-Behavioral Surveillance Survey (BSS) Results: Men who have sex with men and sex workers. Stakeholders dissemination meeting, 31 May. Presentation available at: [https://www.k4health.org/sites/default/files/Swaziland\\_MARPS\\_BSS\\_results\\_presentation\\_to\\_stakeholders\\_31M.pdf](https://www.k4health.org/sites/default/files/Swaziland_MARPS_BSS_results_presentation_to_stakeholders_31M.pdf)

R2P, 2013. *HIV among female sex workers and men who have sex with men in Swaziland. A combined report of quantitative and qualitative studies*. John Hopkins University, Baltimore; 2013

World Health Organization, 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva: World Health Organization.

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