Swaziland

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

Country Context: Swaziland is a landlocked kingdom at the epicenter of the global HIV/AIDS pandemic, struggling to mitigate the world's highest prevalence rates of HIV and TB. Economically, Swaziland is closely tied to South Africa, from which it receives 90 percent of its imports and a large proportion of its public sector financing through the Southern African Customs Union (SACU). Compounding the economic situation and exacerbating the strains on the health and social systems was a precipitous fall in revenue resulting from two-thirds cut of SACU customs receipts in 2009.

More than half of the population is under 20 and nearly half of the youth are at extremely high risk of HIV. The 2010 Multiple Indicator Cluster Survey (MICS) reported that 45.1% of children and youth fit the definition of orphaned or vulnerable. Traditional family structures have all but collapsed, with only 22 percent of children raised in two-parent households. Gender-based inequalities, violence, poverty and income disparities persist in the country and create significant barriers to effective HIV prevention interventions and the up-take of care and treatment services. Economic growth and development have been deeply impacted by the health crisis, which literally threatens the future of the kingdom. The 2010 MICS reported high rates of malnutrition, with 40.9 percent of children experiencing moderate to severe stunting. Furthermore, anecdotal reports show that food insecurity is one of the main reasons that eligible individuals will not initiate treatment; they fear not having food to take with ARVs.

The Swaziland HIV Incidence Measurement Survey (SHIMS) published in late 2012, provides the best data available to date on the epidemic. SHIMS identified a national HIV prevalence of 31 percent among adults 18-49 years of age. A reanalysis of the 2007 Demographic Health Survey data determined prevalence of 31 percent in adults 18-49, indicating that the HIV prevalence in Swaziland has stabilized in the last five years. Adult incidence is high at 2.4 percent, with a significantly higher incidence for women of 3.1 per cent (1.7. per cent for men).

Swaziland has the highest incidence of TB in the world and it continues to grow; 1,257 per 100,000 in 2010; 1,320 per 100,000 population in 2012 (WHO TB Reports) which is further compounded by high rates of DR-TB; 7.7% in all new TB cases and 33.9% in all retreatment cases (TB Drug Resistant Survey Report 2010).

Despite these challenges, significant progress has been made over the last few years in strengthening the Swazi health sector. Life expectancy plummeted from 60 years in the 1990s to 43 years in 2007, and is estimated to have rebounded to 47 years in 2009 due in large part to the success of the national

anti-retroviral therapy (ART) program. Based on the Spectrum model, with support from PEPFAR, the Antiretroviral Therapy (ART) program now reaches over 80 percent of the eligible population (at CD4 count threshold of 350). Eighty-five percent of pregnant women attending ANC sites are reached with prevention of mother-to-child transmission (PMTCT) services. Increases in coverage of ART, PMTCT, VMMC, TB and testing and counseling programs demonstrate the commitment by the public sector to remain resolute despite the daunting strain on the health system.

II. PEPFAR FOCUS in COP FY2013: With the exception of a concerted effort to implement a more robust combination prevention program (CPP), informed primarily by the results of the Swaziland HIV Incidence Measurement Survey (2012) and current program coverage information, the FY2013 COP will not reflect major changes from our FY2012 submission.

The priorities for FY2013 are to 1) Ensure effective coverage of an optimal combination of prevention programs that include core interventions such as PMTCT, VMMC, HTC, targeted MARPS activities and condoms, assuring adequate treatment coverage, and a community-led response to directly address the vulnerabilities of HIV transmission and promote uptake of services. 2) Increase TB case detection given the HIV/TB burden, the team has increased its investment in HIV/TB. 3) Focus on specific vulnerabilities faced by young women and girls.

Country Ownership: The GOKS is in the process of extending its National Strategic Framework (NSF) 2014-2018. The corner stone of the framework is a multi-sectoral, multi-level approach to combination prevention with a strong focus on engaging communities to lead the response. GOKS recognizes that a key reason for underachievement of NSF targets was inadequate attention to the social, cultural and gender norms that underpin the epidemic, which create barriers to the up-take of high impact interventions, and increase vulnerability to HIV infection. GOKS believes that to address these barriers, communities and traditional leadership structures must be capacitated to plan, coordinate and oversee implementation of the response. PEPFAR Swaziland is working closely with GOKS to finalize the extended NSF. This presents an opportunity for PEPFAR to build a five year plan that will align with GOKS priorities, and outline how PEPFAR will contribute to national targets and programs. In February 2012, PEPFAR Swaziland convened a national stakeholder meeting to present the PEFPAR Blueprint and launch the process of the review of the PFIP and a process for future collaboration between the USG and GKOS beyond the end of the PF in 2013. During the first half of 2013, PEPFAR will hold a stakeholder meeting to review our progress under the current PF commitments.

Global Fund: The Global Fund continues to face significant challenges to disbursement and resolution of Conditions Precedent (CP). Through the Global Fund Collaboration Initiative technical assistance will be provided to the Principle Recipient, the CCM Secretariat, and the Ministry of Health. Implementing

partners, through existing scopes of work will continue to support resolution of CP related to supply chain management, human resources and health information systems. Since late 2012, PEPFAR has had monthly meetings/calls with the Local Fund Agent and Portfolio Fund Manager to ensure that issues are addressed more systematically and that PEPFAR partners target their support appropriately to assist collaboration with Global Fund. PEPFAR will work with UNAIDS to map support currently provided to various GF actors in-country with the goal of strengthening coordination of the support and identifying opportunities for efficiencies. Recently established monthly meetings between UNAIDS and PEPFAR also aim to coordinate our support to the GF processes.

Elimination of MTCT (e-MTCT): PEPFAR Swaziland will continue to focus on the e-MTCT, supporting the Swaziland Elimination of Pediatric AIDS program, with the aim of reinforcing all four prongs of PMTCT, but with emphasis on prongs 1, 2 and 4. To achieve e-MTCT goals, communities must lead the response. In COP FY2013, PEPFAR will engage a new partner, the Johns Hopkins University HC3 project to strengthen existing community structures to lead the e-MTCT response and address social/cultural barriers that impact uptake and adherence to care. Also in COP FY2013, through ICAP, PEPFAR will support a stepped wedge study of Option B+. This will help to inform the GOKS PMTCT treatment policy decision expected in 2015. In addition, PEPFAR will continue to strengthen reporting and laboratory systems.

Voluntary Medical Male Circumcision: PEPFAR/Swaziland will continue promote, expand and scale up VMMC services as part of the combination prevention program. PEPFAR will strengthen MOH leadership and support MOH in the finalization, implementation and monitoring of its VMMC operational plan, using current data to inform programming decisions. This will include: mapping of VMMC coverage (by age and region) to focus efforts, and setting realistic but ambitious targets. PEPFAR will also support implementation of the national evidence-informed communication and demand creation strategy based on the recent Ministry led “DELTA” workshop; integration of VMMC services into major health facilities, while scaling up outreach and targeted national campaigns such as the successful Back to School campaign. The HC3 project will strengthen the community-led response and include substantial promotion for VMMC services and will also address gender issues. PEPFAR will support the MOH in their expansion of EIMC and strengthening quality assurance. In late 2012, the OGAC VMMC TWG Co-Chair visited Swaziland and expressed support for the team’s approach and program progress. The team continues to work closely with the TWG to ensure a well-coordinated, effective and country-led program.

III. Progress and Future: In February 2013, PEPFAR hosted a stakeholders’ meeting to present and discuss the PEPFAR Blueprint, Country Ownership and the next steps for the PF/PFIP which end in December 2013. The PEPFAR team has already discussed an assessment with NERCHA and the MOH as well as next steps for the development of a follow-on PF in context of the Blueprint. PEPFAR and

GOKS see the Blueprint and the ending of the PF as an opportune time to define Country Ownership for Swaziland. Based on the recently released national budget for 2013/2014, in total, approximately US $475.6 million will be spent on health services, education, sanitation, safe water and social protection. The MOH is now receiving an additional 3.2% of the total budget above the 2012 allocation. Spending on drugs has nearly tripled from 4% in 2008/2009 such that 13% of total spending on goods and services by Government is going to drugs. The national ARV supply chain has been completely absorbed into the public budget.

Under the leadership of the U.S. Ambassador to Swaziland and the Office of Global Health Diplomacy, PEPFAR will advocate for greater multisectoral engagement to ensure an effective national response. For example, for an effective prevention response the Ministry of Education, traditional government structures, Department of Social Welfare and Ministry of Justice must be more fully engaged targeting their programs to the most vulnerable and affected. In addition, to ensure that current donor-funded positions are absorbed by the MOH over the long term, Swaziland's Civil Service Commission and the Ministry of Finance must be engaged in planning, to ensure that human resources are available to support the national response.

Trajectory in FY2014 and beyond: While PEPFAR/Swaziland, does not expect its base budget to increase significantly in the coming years, the team has an opportunity to evaluate population level impact of an optimal combination of prevention interventions in a 'real life' setting. PEPFAR intends to capitalize on our unique position of being the only country in the world with a national incidence survey – the Swaziland HIV Incidence Survey (SHIMS, 2012) that can serve as a baseline. PEPFAR and GOKS intend to use the SHIMS to establish targets and coverage for an optimal combination of prevention interventions in line with the extended NSF prevention pillar. With PEPFAR support, GOKS would be able to repeat the HIV incidence survey, which will be cross-sectional incidence measure using laboratory methods that were calibrated during SHIMS.

While our combination prevention efforts will benefit from the PMTCT Acceleration funding to support interventions for pregnant women and their infants, we will need additional funding to assure a balanced, quality, rigorously monitored and appropriately targeted combination prevention program that will include community-led efforts to promote uptake of high impact services, a national HTC campaign, improved access to and distribution of condoms, VMMC, PMTCT, and high ART coverage with a focus on linkage to and retention in care. PEPFAR/Swaziland is committed to supporting GOKS in this effort, and will continue working to strengthen combination prevention efforts in COP FY2013, including enhancing the synergies among implementing partners and strengthening linkages along the continuum of response. Additional funding will be required to achieve the intensity and dose of response required for impact.

The exercise to identify the optimal combination of prevention programming with GOKS will take place during the first half of 2013. We anticipate that planning for SHIMS (Part II) would be initiated in early 2015—four years after SHIMS (Part I) started.

IV. Program Overview

Prevention: As noted above, PEPFAR Swaziland in partnership with GOKS is focusing on expanding and intensifying its multi-sectoral HIV combination prevention approach. Anchored in the OGAC HIV prevention guidance and the UNAIDS Investment Framework, the GOKS prevention strategy seeks to establish coverage of an optimal combination of prevention interventions that are tailored to different age groups/populations and with sufficient intensity and quality for impact. PEPFAR's combination prevention efforts are focused on reducing HIV risk and vulnerability and assuring the up-take of high impact services including HIV/TB treatment and care.

To achieve sufficient uptake and impact of biomedical interventions, Swaziland must address structural and behavioral issues. In 2013 PEPFAR's combination prevention program emphasizes efforts to reduce social, cultural and gender norms that create barriers to HIV services including HTC; treatment and care including STIs, SRH and condoms, access to post-exposure prophylaxis (PEP), VMMC; and vulnerability to HIV including intergenerational sex, multiple concurrent sexual partnering (MCP), early sexual debut, low condom use, and sexual and gender-based violence.

Given the demographic profile of Swaziland, with over half of the population under 15 years of age, PEPFAR will assure that prevention messages and interventions specifically target this age group with an aim towards an AIDS- free generation. In addition, with nearly half of the young people identified as OVC, PEPFAR will intensify prevention to include improved access to SRH services especially targeting the adolescent girls. Through the Key Population Challenge Fund (KPCF), PEPFAR will intensify targeted interventions with sex workers and MSM with an aim of expanding services and creating an enabling environment.

In COP FY2013, PEPFAR sexual prevention activities will focus on: 1) strengthening GOKS leadership for combination HIV prevention at national, regional and community levels; 2) reinforcing community and civil society engagement to lead a quality HIV response; and 3) supporting the expansion of an optimal combination of evidence-informed structural, behavioral and biomedical interventions to reduce the risk of HIV infection and enhance protective behaviors. As part of a combination prevention approach, sexual prevention will be fully integrated with HTC, care and treatment, PMTCT, and VMMC. PEPFAR will reinvigorate its focus on condom programming.

To engage communities to lead a high quality response and strengthen the capacity of national level

leadership to address the important structural issues, PEPFAR will work with a new partner, Johns Hopkins Health Communication Capacity Collaborative (HC3) to expand community level coverage and create linkages with all PEPFAR partners.

The purpose of the HC3 activity is to strengthen community systems and capacitate stakeholders to lead an effective HIV response including addressing the socio-cultural and gender norms that create barriers to service uptake and increase vulnerability. The primary focus of the community engagement will be to scale up all four prongs of PMTCT through a community led process. This process will become the foundation for communities to address all aspects of the HIV response especially sexual prevention. Furthermore, addressing norms, beliefs, and practices for PMTCT will result in reduced stigma and vulnerability for HIV in general.

HC3 is aligned with the GOKS NSF extension 2014-2018 and falls squarely within the guiding principles and the core priority prevention strategies for community engagement and ownership of HIV interventions. It will contribute to prevention outcomes including reduced exposure to HIV infection. HC3 will build on the existing decentralized coordination structure through the local government structure, reinforce CBO efforts, and actively link with other partners. The objectives are: 1) to create an enabling environment for PMTCT and sexual prevention by strengthening community capacity to use local and national information for community-based planning and monitoring of the HIV response; supporting a community process to maximize their assets and address barriers to prevention; and supporting a rights-based community approach to stigma reduction and norm change; 2) to improve access to and uptake of PMTCT and HIV prevention services by empowering communities to lead social and behavior change communication; strengthening the community based cadres; and strengthening linkages with CBOs and FBOs to promote uptake of services and healthier behaviors.

The following highlights other key aspects of the CPP:
HIV TESTING AND COUNSELING: HTC is a critical gateway to HIV prevention and care services. HIV prevalence rates are similar across all four regions in Swaziland. PEPFAR therefore supports HIV testing and counseling (HTC) services in equal proportions across these regions. A 2011 survey on stigma suggests that underlying social and cultural norms, and stigma are the major barriers to people's willingness to know and disclose their status, and seek needed services. In addition, studies have shown that men are less likely to know their HIV status than are women; therefore interventions are focused on encouraging more men to test. The ongoing VMMC campaign, for example, has provided an opportunity for more men to get tested. Because Swaziland such a high prevalence rate of HIV among TB patients and pregnant women, substantial effort has gone into integrating HTC into routine TB and ANC services, resulting in more than 90 percent of both groups being tested for HIV annually. This has helped to increase the number of pregnant women who are eligible for ART initiation at the ANC.

Since the major entry point of clients to prevention, care and treatment services is HTC, in COP FY2013 PEPFAR will prioritize the scale up of HTC programs. PEPFAR will continue to scale-up the provision of home-based HTC in hard-to-reach communities as well as the implementation of provider-initiated HTC services at all levels of national public health facilities. The HC3, project will address the normative barriers and establish community targets for testing. Together, these activities aim to strengthen and further scale-up the accessibility of HTC services, making HTC available in every health facility and, through outreach, to every community. In addition to enhancing HTC coverage and quality, the programs focus on linkages to care/treatment, laboratory diagnostics, and sustainability.
Provider-initiated HIV Testing and Counseling (PIHTC) efforts in COP FY2013 will continue to focus on HTC at primary care settings, including clinics and PHUs, as the entry point for individuals to access HIV services. Expanding HTC to all service points, particularly STI, TB, inpatient and outpatient department clinics, and expansion of routine screening of child and mother health cards, will significantly reduce missed opportunities for HTC and subsequent care and treatment services. PEPFAR will bring HTC services into the community through door-to-door-testing, HTC outreach activities including for MARPS, and support for VCT centers. In addition, PEPFAR will expand the availability and accessibility of HTC services in the workplace.

CONDOMS: Prevention of sexual transmission through biomedical, behavioral and structural approaches is a pillar of the current and extended NSF and condom promotion and use is a cornerstone of this strategy. The Swaziland condom response is clearly articulated in the Reproductive Health Commodity Security Strategy, and the National Condom Strategy (2010-2015). Management and coordination of condom programming is lead by SNAP and SRHU. The National Condom TWG provides TA to the MOH. Procurement and distribution is coordinated through the Central Condom Program. Swaziland has repositioned family planning with HIV prevention and condoms are a part of the family planning commodities offered free through public sector clinics. GFATM, UNFPA, the AIDS Health Care Foundation, Swaziland Defense Force all procure condoms for free distribution through traditional and non-traditional channels. PSI, with Dutch funding, provides socially marketed condoms. Free condoms are distributed through public sector clinics and NGOs, FLAS, AMICAL, PSI and others distribute to non-traditional outlets. PSI distributes 45% of the condoms nationally.

In 2012, with the support from UNFPA, the MOH conducted a rapid condom assessment. The assessment revealed that the key barriers to condom use particularly among the youth were social, cultural and gender norms that create stigma around condom use; low condom negotiation skills especially among young women; and inability to access condoms readily (the majority knew where to find condoms, but said it would take 24 hours or more to get them). The findings of the assessment will inform the national condom strategy implementation and the development of a national condom promotion

campaign to be launched in 2013.

Despite this strong strategic foundation, Swaziland experienced a serious condom supply shortage in late 2012. GFATM is responsible for funding the bulk of the condoms and the substantial delay in disbursement for 10,000 condoms caused a domino effect resulting in depletion of buffer stock and extremely low stocks at distribution points over the holiday period. Partners responded by providing emergency stock. USAID provided an emergency shipment of 780,000 blue/gold condoms, UNFPA provided 1,200,000, and AHF 1,500,000.

In COP FY2013, condom programming will be front and center. PEPFAR will 1) improve condom access and availability with assistance through SCMS to strengthen the condom forecasting and logistics management to avoid stock-outs and even distribution; and support to the MOH through PSI to assure consistent availability of condoms at local level at all hours through non-traditional outlets. 2) Support aggressive promotion of condoms at multiple levels: at national level, PEPFAR will assist the MOH in creating innovative approaches and launching their condom campaign; at local levels, HC3 and PSI will actively address social, cultural and gender barriers to condom use; all PEPFAR partners will support active promotion and distribution of condoms to their beneficiaries with a strong focus on OVCs. PEPFAR's care and treatment programs will emphasize the promotion of condoms and their correct and consistent use. PEPFAR will also prioritize the integration of condom distribution in reproductive health and family planning facilities.

MEDICAL MALE CIRCUMCISION: VMMC is an important component of the GOKS combination prevention strategy. PEPFAR began support to the GOKS VMMC program in 2007, with the development and implementation of a national scale-up plan. This was followed by an accelerated plan with the extremely ambitious target of circumcising 80% of the 15-49 year old men in a one year period. While these targets were not achieved, important lessons were learned and incorporated into the Country’s new operational plan; good progress is being made in increasing the number of VMMC. In 2012, the MOH reduced the age for VMMC to 10 years. 66% of the 2012 circumcisions were aged between 10 and 19; demonstrating the high demand among youth. The program includes an appropriate mix of VMMC surge campaigns such as the successful back to school initiative, and static, mobile and outreach services including a promising rural model for VMMC that offers comprehensive mobile health and social services. The MOH has also made substantial inroads with EIMC, offering services in all but one public hospital and health centers, and 69 providers have been trained.

BLOOD SAFETY: In COP FY2013, PEPFAR will continue to support the Swaziland National Blood Transfusion (SNBTS) in line with its Strategic Plan. A fully capacitated SNBTS will provide at least 18,000 units of safe blood per annum to the health service; currently SNBTS provides 16,000 units of safe blood

per annum. PEPFAR will continue working with the SNBTS to develop a set of quantitative indicators modeled after WHO standards.

CARE: In 2012, the Essential Health Care Package (EHCP) was approved by the Ministry of Health. The USG is supporting a temporary position with the MOH, to support the roll-out and implementation of the EHCP within decentralized services. PEPFAR will continue to partner closely with the MOH, MSF and CHAI in piloting the country's treatment as prevention intervention called MaxART – the pilot began in February of 2013. Improving linkages between facilities and communities continues as a key priority for this COP FY2013, especially addressing referral 'leakages' between HTC, pre-ART and ART.

ADULT CARE AND SUPPORT: PEPFAR-supported programs promote a minimum package of care for HIV-infected persons which includes condoms, TB screening, cotrimoxazole, isoniazid preventive therapy, adherence counseling, disclosure support and family planning. Rollout of this package has been slowed by the MOH's reluctance to initiate a true system of enrolling and following up with HIV-positive people who were not yet eligible for ART. New pre ART M&E tools will assist in reaching the mandate for universal cotrimoxazole prophylaxis for all people who are enrolled in HIV as established by the 2010 national guidelines update.

HIV prevention services need to be consistently delivered to HIV-infected persons as part of their routine care. PEPFAR partners have been working with the MOH ART unit on the integration of family planning into ART clinics which are currently being piloted. PEPFAR and other partners are also working on community and facility-based stigma reduction efforts, including community dialogues and identification of HIV-positive role models. Regarding partner testing, PEPFAR HTC partners have expanded training in couples testing beyond antenatal clinics to sites (e.g., TB outpatient facilities) where patients, especially men, may also be accessed.

Standard operating procedures for linkage, retention and tracing of HIV patients (initiated by PEPFAR partners, but owned by the MOH) relies on the use of a referral system that alerts facilities to the expected date for a first appointment chosen by someone who is newly diagnosed as HIV-positive (or being re-linked to care) and provides contact information for patients who fail to appear.

Pediatric Care and Support: Specific focus areas include: 1) Early identification of HIV exposed and infected infants and children: work with HCW at the supported sites to ensure early identification of HIV exposed and infected infants through systematic screening of child and mother health cards at each service contact; improve HCW skills in pediatric counseling through training and mentorship; support EID through DNA PCR using DBS for exposed infants at every entry point within MCH; provide pediatric PITC using antibody tests for children >12 months and strengthening exit test at 18 months; use of presumptive

diagnosis of HIV 2) Reduction in HIV morbidity and mortality in exposed and infected infants and children: work with health care workers through mentorship and support supervision to ensure proper provision of infant feeding counseling; routine immunizations according to the national EPI guidelines, growth monitoring and developmental assessment for all infants and children; prompt clinical and immunological assessment of HIV-positive children; pain assessment and management; screening for TB and OIs; prophylaxis with NVP, CTX, INH; regularly assess for ART eligibility; and ensure all early ART initiation for all HIV-positive infant and children less than 2 years; provision of HWC with different job aids including for clinical staging to ensure confidence in provision of the care services; support to the integration of these activities within the broader MCH program. 3) Linkages and retention: strengthen the use of patient cards and referral forms for effective referral linkages according to the new SOP; work closely with expert patients and Mentor Mothers in ensuring that caregivers are well counseled on care services and complete referrals; establish and strengthen referral linkages between services and clinics; improve follow-up counseling to improve adherence; work with health workers to utilize pre-ART and appointment registers to identify defaulting and lost to follow up children; develop mechanisms (mobile phones) to trace clients who have not returned for follow-up or results; develop a directory for all facilities to encourage linkages and feedback between facilities. 4) Support supervision and mentorship, including QI: Continue to provide regular visits for data review, QI activities, case management and mentoring. Support efforts to establish and empower the Regional Clinical Mentoring teams and facility-based multi-disciplinary teams to absorb this work. 5) Psychosocial Services: PEPFAR will continue support to psychosocial services through the formation of support groups for children living with HIV.

TB/HIV: The key priorities in COP FY2013 include strengthening implementation of guidelines for infection control, intensified case finding and isoniazid preventive therapy; maintaining high rates of HIV testing among TB patients (currently >95% of TB patients are tested); improving rates of initiation of HIV+ TB patients on ART; and planning for continued expansion of access to HIV and TB diagnosis and treatment initiation services. Additional resources have been allocated in COP FY2013 to support these efforts. With central funding to procure GenXPert machines for Swaziland, and increased funding from the country budget, the team hopes to show measurable progress in the fight against TB by 1) increasing TB case detection and improve diagnosis of smear negative and drug-resistant TB 2) increase timely and appropriate treatment initiation among detected TB cases 3) Reduce delays in diagnosis of pulmonary TB and initiation of appropriate treatment. This, coupled with increased resources to improve HCW training and strengthen community-based interventions will allow for a more robust support to the MOH response to the HIV/TB epidemic. MOH with support from PEPFAR will continue to monitor the rates of case finding and initiation closely through regular laboratory data, enabling us to measure the impact of additional Gene Xpert machines in terms of program outcomes and, potentially, lives saved.

ORPHANS AND VULNERABLE CHILDREN: Impact mitigation with a focus on children and their

families is one of five pillars in Swaziland's Partnership Framework. USG interventions support the impact mitigation component of the National Strategic Framework 2009-2014 as well as the National Plan of Action for Children 2011-2015. All documents include a common focus on expanding and improving support for vulnerable children in core services areas, including health, education, protection, psychosocial support, food security and economic strengthening.

PEPFAR support for impact mitigation has three components: 1) improving the policy environment, 2) strengthening national and community systems, and 3) supporting community-based service delivery, including building better linkages between largely adult focus clinical services with child-focused community-based services.

Priorities for improving the policy environment will be supporting line ministries to implement the recently enacted Child Protection and Welfare law, and the dissemination of information on key child protection provisions through community partners. A new activity in COP FY2013 will focus on social protection: While Swaziland has several social assistance programs benefiting vulnerable children and families; these are poorly coordinated and not functioning optimally. PEPFAR will provide technical assistance to galvanize momentum for a process to develop a national protection framework.

The priorities for strengthening systems will continue to focus on the Department of Social Welfare (DSW), which is expected to undergo re-structuring. USG will support strategic planning and development of the social welfare work force, including professional upgrading of current DSW staff and support to the University of Swaziland to set up a degree course for social work. TA partners will work with DSW to establish standards and administration systems for social workers. PEPFAR will continue to support the strengthening of the child protection system, following the completion of a child protection mapping currently underway which will identify bottlenecks and gaps to be addressed. With additional funding from Together for Girls, standards and referral protocols for post-rape care through a 'One-Stop-Centre' will be formulated, and are expected to lead to better health and psychosocial care for survivors as well as more successful prosecution of perpetrators. M&E for child abuse will be strengthened through the national surveillance system on child abuse.

Service delivery will focus on quality improvement through the monitoring of the implementation of the OVC service standards which were launched and rolled out in 2012. Community partners will ensure HIV prevention is mainstreamed in OVC programming, including promotion of VMMC. An expanding service area continues to be economic strengthening (ES), with TA provided to community partners to ensure that income generation activities are market-oriented, feasible and sustainable. As an incentive to retain community child protection volunteers, these often elderly female caregivers will be supported to establish savings and loans groups. A project focusing on community livelihoods will facilitate community resources

and market linkages to identify workable livelihood opportunities with a strong gender and child protection component. Peace Corps will continue to play a key role in our community-based activities through small grants, which allow volunteers to implement child-focused activities within their communities.

TREATMENT

In COP FY2013, PEPFAR will continue to support decentralization, and focus on strengthening sustainable mentorship systems, working through its implementing partners. Regional Clinical Mentoring Teams (RCMT) were established in 2012 to provide on-site clinical mentoring to all health facilities. The long term goal is for the RCMT quality improvement and mentoring activities to be adopted as a core MOH activity. PEPFAR has been requested by the MOH to evaluate the RCMT model, in order to assist MOH determine the best way to implement mentoring and supervision.

PEPFAR Swaziland is working to strengthen administrative, planning and financial management skills of the RHMT in preparation for their enhanced role in management and mentorship. The vision is to ensure that the RHMTs can prioritize and manage their own program activities, including the RCMTs, in a financially prudent manner. PEPFAR is also working with the MOH Planning Unit and Quality Assurance Program to create a regular forum at which the RHMTs will meet together with the central MOH leadership and be held accountable for setting and reaching standards of work.

ADULT TREATMENT: Swaziland updated its national treatment guidelines in 2010, to reflect a CD4 threshold for initiation of <350 cells/mm3 and the first line regimen is TDF/3TC/EFV. PEPFAR will continue to support the integration of treatment services with prevention, care, TB/HIV and MCH/primary care. Key prevention activities such as male circumcision, PMTCT, and HTC now feature a standard operating procedure (SOP) for linking those who test positive for HIV to care.

The integration of HIV within MCH and primary care settings is also an ongoing process. Since 41% of all pregnant mothers in Swaziland are HIV+, HIV testing and PMTCT services have been well-integrated into antenatal care. Integrating Family Planning is an ongoing priority. PEPFAR has successfully supported a high rate of ARV prophylaxis uptake among HIV+ pregnant women; however, the challenge now is to ensure that these women subsequently enroll in HIV care and initiate ART when eligible. Qualitative studies are underway to examine reasons why pregnant HIV+ women refuse care, and PEPFAR is planning a pilot of “Option B+” (using PMTCT Acceleration Funds) as a strategy for improving uptake. The NARTIS program will be a key component of this pilot and also serve to link general HIV care to MCH and primary care settings in the most rural facilities in the country.

PEPFAR will continue its engagement with the Supply Chain TWG to: (1) coordinate and share technical and programmatic information on supply chain management of health commodities; and (2) strengthen

the system so as to assist the MOH and partners in making informed decisions that will ensure health commodity security at all levels of health care delivery.
PEDIATRIC TREATMENT: As of December 2012, there were 6567 children <15yrs currently enrolled and 8424 children < 15yrs ever enrolled; 4162 children aged 5-14yrs are currently enrolled (5196 children 5-14yrs ever enrolled); 2098 children aged 1-4yrs are currently enrolled (2829 children 1-4yrs ever enrolled); 307 children <1yr are currently enrolled (399 children < 1yr ever enrolled). These numbers encompass 9.6% of all ART enrollments. Key priorities include improving access to early ART initiation and quality of care for HIV positive children. PEPFAR will improve access by decentralizing pediatric initiations and follow up to more facilities in Swaziland and promote better quality by strengthening providers' capacity in pediatric phlebotomy and overall management of pediatric patients through an ongoing sub-award with Baylor. Roll-out of the NARTIS program will also allow doctors more time at rural clinics where they can mentor nurses and manage difficult cases. The USG-supported pediatric HIV treatment program in Swaziland is fully integrated into public health facilities and their MCH programs. The expansion of NARTIS into most rural clinics will ensure that this integration is sustained and streamlined.

V. GHI, Program Integration, Central Initiatives, and other considerations
Swaziland's USG interagency team continues to incorporate GHI principles into the GOKS-PEPFAR Partnership Framework signed in June 2009. Swaziland's GHI strategy demonstrates GHI principles by: Strengthening USG-GOKS partnership and GOKS ownership; Intensifying efforts to address cross-cutting areas of Gender and Health Systems Strengthening; Increasing efforts to integrate PMTCT and MNCH; Promoting research and innovation; building more sustainable systems; and Strengthening donor coordination.

Together for Girls (TFG): Coordinated by the National Children's Coordinating Unit (NCCU), the GOKS is in the process of setting up a One-Stop Center aimed at addressing the medical, psychosocial and legal needs of victims of sexual violence. The Center aims to bring together service providers from various sectors (health, police, justice, social welfare, civil society) to provide comprehensive services to survivors of sexual abuse in a way that reduces secondary victimization, improves access to essential HIV and other health services, increases access to justice and assists in the healing and recovery process. Space has been identified and partially refurbished and equipped, and health workers from the Mbabane Government Hospital have been identified to staff the facility. There is a great deal of commitment within GOKS to see the Center functioning, but technical capacity is limited and as a result the initiative has been slow to get off the ground.

This initiative will also support improving quality of post rape care services by supporting the dissemination of recently finalized guidelines which will guide HCW in the care and support provided to

victims.

TFG will also support strengthening inter-sectoral action planning for the prevention and mitigation of child sexual abuse. Currently several different line ministries lead elements of the response to violence against children, yet there is no structure or mechanism in place for joint planning. While activities aimed at preventing and responding to child violence are sprinkled across various policy documents and plans, there is no over-arching strategy in place to guide the response. As a result coordination mechanisms, as well as the response itself, are fragmented. TFG will: 1) support coordination mechanisms at policy-setting and implementation levels to improve the joint planning, implementation and reporting that is fundamental to the response. 2) strengthen the ability of the Surveillance Working Group to collect, analyze and feedback data on reported cases of abuse to decision-makers and implementers. 3) Build on the 2007 Violence Against Children Study (VACS), undertake research to document drivers of sexual violence towards children in Swaziland to assist with future violence prevention efforts. 4) develop a National Strategy on Preventing and Responding to Violence Against Children.

Key Populations Challenge Fund (KPCF): The KPCF will provide targeted, focused programming and access to services for marginalized FSW and MSM/LGBTI (including training service providers), while making important linkages with other PEPFAR-funded priorities including gender, sexual violence, and access to post rape services and counseling. These priorities are closely tied to the GOKS's important efforts to empower and improve services for OVCs-- especially vulnerable girls and young women-- and reinforce programs for Positive Health Dignity and Prevention (PHDP). The KPCF represents an enormous opportunity for PEPFAR and the GOKS to mobilize a comprehensive and targeted response to address the HIV risks, and needs for support and improved access to HIV prevention services for FSW and MSMs. The anticipated outcomes of the three year activity are: 1) 80 % coverage of KPs with a minimum package of high quality comprehensive services and interventions that are affirming and free of discrimination 2) A capacitated cadre within the MOH that can effectively lead and coordinate a comprehensive KP program and empowered sex worker association and MSM/LGBTI group(s) that provide psychosocial support within their communities and have the capacity to advocate for legal, policy and social norm changes that respond to their needs, issues, and dignity.

All activities will be designed, implemented, monitored and evaluated jointly with the GOKS (NERCHA, MOH and the Swaziland National KPTWG). Civil society (NGOs and CBOs) especially the FSW and MSM/LGBTI groups will be fully engaged in the design, implementation and monitoring of this. The PEPFAR COP FY2013 contribution to the KPCF is $695,000 over three years. This includes: support through JHU HC3 to conduct a mapping/enumeration, operations research, finalizing the MOH training guidelines, broad dissemination of the BSS, and strengthening capacity of MOH and other stakeholders to use program and survey data for improved programming; support through PSI for HCT and outreach

counseling, training of peer educators, mentors and expert clients.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	170,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	26	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	17,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	6,800	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	12,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	13,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	35,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	11,000	2011	WHO			
Number of people living with HIV/AIDS	190,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to	75,000	2011	AIDS Info,			

HIV/AIDS			UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	87,537	2011	WHO			
Women 15+ living with HIV	100,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	Decentralize and improve the quality of treatment services within a HIV and AIDS comprehensive care package to increase access and improve outcomes		
1.1	By 2013, 60,000 people living with HIV and AIDS (PLWHA) should be receiving high quality ART services	T1.1.D	T1.1.D Number of adults and children with advanced HIV infection newly enrolled on ART
		T1.2.D	T1.2.D Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]
		T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy
2	Reduce behaviors that increase the risk of HIV infection and increase protective behaviors in the general population		
2.1	By 2013, six per cent of males should	P8.1.D	P8.1.D Number of the targeted

	report having multiple concurrent partners within the last 12 months		population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
		P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
3	Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males		
3.1	Ensure that 80 per cent of males aged 15-24 years are safely circumcised	P5.1.D	P5.1.D Number of males circumcised as part of the minimum package of MC for HIV prevention services
4	Improve living circumstances for vulnerable children in Swaziland		
4.1	By 2013, 50 per cent of vulnerable children should be receiving at least three basic support services on a continuous basis	C5.1.D	C5.1.D Number of eligible clients who received food and/or other nutrition services
		C1.1.D	C1.1.D Number of eligible adults and children provided with a minimum of one care service
5	Improve human and institutional capacity of the MOH and Civil Society to respond to the HIV epidemic		
5.1	By 2013, 80 per cent of established positions in the Ministry of Health should	H2.1.D	H2.1.D Number of new health care workers who graduated

	be filled		from a pre-service training institution within the reporting period
		H2.2.D	H2.2.D Number of community health and para-social workers who successfully completed a pre-service training program

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?

PEPFAR has provided technical support in Global Fund grant proposal during application for Transition Funding Mechansim. The TFM received conditional approval with comments, and PEPFAR technical leads participated in responding to the clarifications. The TFM has been approved, and signing of the grant will be done towards the end of 2013.

PEPFAR is also preparing to support the country in the New Funding Model working through the CCM, as well as ensuring that implementing partners actively participate in all the different forums or stages during the New funding Model stages. Currently USG technical leads are actively engaged in the process of revising the Swaziland National Strategic Framework for HIV/AIDS (2009-2014), which will factor heavily into any funding opportunity sought in the future.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?

Yes

If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).

The HIV Round 7 grant is coming to an end in December 2013. The total grant amount is US$ 80,687,840, yet only US $ 55,234,715 has been disbursed as of December 2012, and remaining US $ 25,453,125 still not disbursed. It seems unlikely that the country will be able to absorb the funds before the closing date, and it is likely the country will lose a portion of this money.

Although the country has applied for Transitioning Funding Mechanism (TFM) of US$ 13,232,298, the Global Fund Secretariat gave the country a conditional approval (Category 3- Recommended with issues as conditions or matters to be cleared by the Secretariat and the TRP), and the queries were on: Human Resources under PMTCT support; ARV treatment on Laboratory support, and therapeutic feeding support to malnourished women receiving PMTCT. USG has assisted the country through the proposal development committee (CCM, UN, and other partners) in responding to the Technical Review Panel Clarifications.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?
Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?
Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	Evaluation of the Safety, Efficacy and Acceptability of the PrePexTM Device for Male Circumcision for HIV Prevention in Swaziland	Other	General Population	Planning	06/01/2013
Survey	A population study of seroprevalence of Hepatitis infection in HIV infected	Laboratory Support	General Population	Planning	07/01/2013

	individuals in Swaziland				
Survey	A population study of seroprevalence of Toxoplamsa Gondii infection in HIV infected individuals in Swaziland	Laboratory Support	General Population	Planning	06/01/2013
Survey	Bantwana Schools Intergrated Program Evaluation	Evaluation	General Population	Planning	09/01/2013
Surveillance	Behavioral Surveilance Survey	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Male Commercial Sex Workers	Publishing	12/01/2012
Survey	CHESHIRE - Knowledge Attitudes and Practises amongst intelectually Disabled Students	Population-based Behavioral Surveys	Youth	Planning	08/01/2013
Survey	Evaluation of the performance of GeneXpert and LPA	Laboratory Support	General Population	Planning	05/01/2013
Survey	Facility staffing and workload to inform the development of staffing norms	Other	Other	Data Review	12/01/2013
Survey	HTC and Condom TRaC	Population-based Behavioral Surveys	Other	Planning	07/01/2013
Survey	Intensified case finding for childhood TB:	TB/HIV Co-Surveillance	Other	Development	05/01/2013
Survey	Investigate the role of QI projects in Fast tracking	Laboratory Support	Other	Planning	05/01/2013

	laboratory accreditation				
Survey	Key Populations Survey	Other	Female Commercial Sex Workers, Men who have Sex with Men	Planning	12/01/2013
Survey	LINK 4 HEALTH	AIDS/HIV Case Surveillance	Other	Development	05/01/2015
Survey	Linkage of Newly HIV Diagnosed to care services	Evaluation	Other	Development	06/01/2013
Survey	MC TRaC	Population-based Behavioral Surveys	Other	Planning	07/01/2013
Survey	NARTIS	Evaluation	Other	Data Review	03/01/2013
Survey	Prepex Safety and Acceptability Study (this may change depending on guidance from PEPFAR and WHO)	Other	Other	Development	04/01/2013
Survey	Prevalence of Cryptococcal Antigenemia (CrAg) among a population based sample of HIV positive individuals in Swaziland	Laboratory Support	General Population	Development	04/01/2013
Survey	Referrals and Linkages Demonstration Study	Other	General Population	Development	06/01/2013
Survey	SAFE GENERATIONS - SITUKULWANE LESIPHEPHILE	Evaluation	Pregnant Women	Development	07/01/2015
Survey	SCSWD-Child Profiling	Other	Youth	Development	07/01/2013

Survey	SCSWD-WORTH Endline	Other	Other	Data Review	03/01/2013
Survey	Swaziland National ART Programme Evaluation	Evaluation	Other	Publishing	03/01/2013
Survey	Utility and Feasibility of a Cryptococcal Antigenemia (CrAg) screening programme among HIV infected adults and children	Other	General Population	Development	05/01/2013
Survey	WORTH Endline Survey	Evaluation	Other	Other	03/01/2013

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		0		**0**
DOL		0		**0**
HHS/CDC	746,332	13,912,332		**14,658,664**
HHS/HRSA		85,000		**85,000**
PC		970,000		**970,000**
State		296,365		**296,365**
State/AF		0		**0**
USAID		3,889,971	6,900,000	**10,789,971**
Total	**746,332**	**19,153,668**	**6,900,000**	**26,800,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency								Total
	State	HHS/CDC	HHS/HRSA	DOL	PC	State/AF	USAID	AllOther	
CIRC							187,107	0	**187,107**
HBHC		2,359,846					380,000	0	**2,739,846**
HKID					7,000		3,323,584	0	**3,330,584**
HLAB	0	1,419,809						0	**1,419,809**
HMBL		500,000							**500,000**
HTXD		59,961							**59,961**
HTXS		2,374,828					770,000	0	**3,144,828**
HVAB				0	5,000	0	542,815	0	**547,815**
HVCT		299,922					70,000	0	**369,922**
HVMS	254,496	799,809			950,000		1,224,990		**3,229,295**
HVOP				0	8,000		737,815	0	**745,815**
HVSI	13,222	804,809		0			445,000	0	**1,263,031**

HVTB		2,368,236			0		685,000	0	**3,053,236**
MTCT		0					187,107	0	**187,107**
OHSS	28,647	954,819	85,000	0	0		1,958,553	0	**3,027,019**
PDCS		1,233,313					74,000	0	**1,307,313**
PDTX		1,483,312					204,000	0	**1,687,312**
	296,365	**14,658,664**	**85,000**	**0**	**970,000**	**0**	**10,789,971**	**0**	**26,800,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: Essential Medicine List						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			FY10	FY11	FY 13	
Narrative			Revised list has been developed & is under review	MoH approval expected in FY11	The policy was combined with the standard treatment guidleines and now called "Standard Treatment Guidelines and Essential Medicines List". PEPFAR will provide resources to support implementation from FY13 and beyond	
Completion Date				FY11	FY12 and beyond	FY13 and beyond
Narrative				MoH has approved and expects	Policy printed and disseminate	

				to launch the revised EML before the end of calendar year 2011.	d in late FY12. The policy was combined with the standard treatment guidleines and now called "Standard Treatment Guidelines and Essential Medicines List". PEPFAR will provide resources to support implementation from FY13 and beyond.	

Policy Area: Orphans and Other Vulnerable Children						
Policy: Child Welfare Bill						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				FY12	FY 13	
Narrative				Renewed emphasis and energy on the part	Government intends to employ a phased	

				of the National Children's Coordination Unit was placed on passing the bill in FY11. Several dialogues were held with parliamentarians and communities. PEPFAR partners have been closely involved with the advocacy process. The Bill passed in the House in October, 2011 and is currently being debated in the Senate.	approach for developing regulations and implementation (incl gazetting in stages)	
Completion Date			FY10			
Narrative			The Child Protection and Welfare			

			Bill has been under development for several years. A draft was tabled in 2010, put movement stalled due to controversy around particulars of the Bill that were viewed to be in conflice with traditional Swazi culture.			

Policy Area: Orphans and Other Vulnerable Children						
Policy: Minimum Standards for Quality Service Delivery to OVC						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date				FY12	FY11 & beyond	
Narrative				Piloting will be completed by 12/2011. Standards will need final		

				revision based on pilot results. Final approval is expected in late FY12.		
Completion Date			09-2010	FY 12		
Narrative			Standards drafted, reviewed, revised in FY10. They were piloted in FY11.	Piloting completed and standards revised and finalized. Launch scheduled for Nov 2012		

Policy Area: Other Policy						
Policy: Guidelines for TB Intensified Case Finding, Isoniazid Preventive Therapy and Infection Control						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					FY 13	
Narrative					PEPFAR provided resources for printing of the guidelines and disseminati on is	

					ongoing. PEPFAR will provide resources for implementation.	
Completion Date				FY 12	FY12 and beyond	
Narrative				The document was approved by MoH in 2012	PEPFAR provided resources for printing of the guidelines and dissemination is ongoing. PEPFAR will provide resources for implementation.	

Policy Area: Other Policy						
Policy: Health Care Waste Management Guidelines						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					FY 13	
Narrative					Under the auspices of the	

					accelerated male circumcisio n initiative, PEPFAR, through SCMS, supported the drafting of National HCWM Guidelines, which include Standard Operating Procedures, tranining curriculua and materials and a HCWM monitoring tool. The Guidelines and tools are in final draft form and are expected to be completed in FY13.	
Completion Date			FY 13			
Narrative			Under the			

			auspices of the accelerated male circumcisio n initiative, PEPFAR, through SCMS, supported the drafting of National HCWM Guidelines, which include Standard Operating Procedures, tranining curriculua and materials and a HCWM monitoring tool. The Guidelines and tools are in final draft form and are expected to be completed in FY13.			

Policy Area: Other Policy						
Policy: Human Trafficking Act						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date					FY11 & beyond	
Narrative					USG has a DRL funded program with World Vision & WLSA to advocacy and awareness raising around the new law. Secretariat set up to coordinate implementation and has started to develop an action plan. Slow progress.	
Completion Date				10-2009		
Narrative				Human trafficking bill was enacted to law at the beginning of	Secretariat set up to oversee implementation of law, and related	

				FY10.	coordination. But it's not well funded and high level support required to see movement is somewhat limited. USG has a DRL funded program with World Vision for awareness raising on trafficking and support to secretariat.	

Policy Area: Other Policy						
Policy: Medicines and Related Substances Control Bill						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			completed in 2012			
Narrative			"The subject of this Bill is to provide: a. For the			

			establishment of the Medicines Regulatory Authority b. For the registration of medicines "			
Completion Date			FY12			
Narrative			The subject of this Bill is to provide: a. For the establishment of the Medicines Regulatory Authority b. For the registration of medicines			

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	2,739,846	0
HKID	3,330,584	0
HVTB	3,053,236	0
PDCS	1,307,313	0
Total Technical Area Planned Funding:	**10,430,979**	**0**

Summary:
OVERALL PROGRAMMATIC STRATEGY

OVER THE PAST TWO YEARS
PEPFAR has supported a number of key efforts that have improved the standards of HIV/AIDS and TB care in Swaziland. Significant successes have included: roll out of the "3 I's" for TB (Intensified Case Finding, Infection Control, Isoniazid Preventive Therapy); ensuring that over 90% of TB patients are tested for HIV; and establishing a program where people not yet eligible for ART can be followed longitudinally and provided with necessary services.
The mainstreaming of pre-ART care in health facilities is the key to a number of other successes:
- *TB screening among HIV+ clients has improved to 75%.*
- *Guidelines for cotrimoxazole prophylaxis have been revised in line with WHO 2010 guidelines so that all HIV positive individuals (both adults and children) receive cotrimoxazole prophylaxis for life. A milestone general assembly meeting was recently held with key stakeholders to address the perennial problem of cotrimoxazole stock-outs at health facilities. As a result of the meeting, streamlined drug requisition and reporting approaches were developed and the stability of cotrimoxazole stocks at facilities have improved significantly.*
- *Isoniazid Preventive Therapy (IPT) was successfully piloted in Swaziland in 2010. The project's findings informed the crafting of national guidelines for IPT and the subsequent roll out of IPT to 12 high-volume health facilities.*

PEPFAR'S KEY PRIORITIES AND MAJOR GOALS FOR THE NEXT TWO YEARS include: supporting universal access and quality of the 3I's; improving initiation of co-infected TB patients on ART within the first month (currently only 55% are initiated); establishing a strong pre-ART system at every health facility offering HIV services in the country; integrating family planning into routine HIV services to address women's issues of unwanted and unplanned pregnancies with risk of HIV transmission to their spouses and/or infants; and prevention with positives emphasizing positive living, adherence, condom use, household TB screening, disclosure and couples counseling. All of these priorities and goals are well-aligned with government strategies and priorities as outlined in the National Strategic Framework, the Health Sector Strategic Plan and the various implementation plans of national TB and HIV control programs. Along with PEPFAR, other development partners in the country-- particularly the UN agencies, the World Bank, the EU, MSF and CHAI-- are well-engaged in the planning and implementation of all Care and Support activities. However, the final approval of a number of key policies (e.g. the

Adult Malnutrition Guidelines and Pediatric Adherence and Psychosocial Training Guide) is still required to more fully support the success of these activities.

PEPFAR's efforts in coordinating with its partners and across development agencies has built a strong collaborative foundation from which to achieve efficiencies. In particular, PEPFAR is moving forward with an initiative to establish Regional Clinical Mentoring Teams which are hired with the Chief Nursing Officer's close involvement, staffed by Swazi health professionals, based at the Regional Health Management Teams and paid through a parastatal mechanism. The establishment of these teams will support the overall sustainability of clinical mentoring and is a critical aspect of PEPFAR's exit strategy and its coordination with other development partners, all of whose support is intended to be coordinated through the MOH regional teams. (See Treatment TAN for more detail.)

DATA-DRIVEN DECISION MAKING
PEPFAR-Swaziland utilizes existing evidence to make key decisions and actively seeks out new information when relevant data is not available. Some examples include: the successful pilot of IPT therapy at 12 sites to assess acceptability and potential for adverse events before a national roll-out; the measurement of acceptability and challenges of nurse-led initiation of ART; participation in the PEPFAR-sponsored Linkages and Retention Workshop in Maputo in November, 2010 which informed subsequent development of a standard operating procedure (SOP) for HIV care linkage and retention; active planning for a CDC-funded initiative using this SOP as a baseline and evaluating if a modified case management approach would lead to improved outcomes; and a CDC-endorsed application by ICAP to institute a randomized controlled trial on the impact of providing routine packages of care at enrollment to improve retention.

ADULT CARE AND SUPPORT

PEPFAR-supported programs promote a minimum package of care for HIV-infected persons which includes condoms, TB screening, cotrimoxazole, isoniazid preventive therapy, adherence counseling, disclosure support and family planning. Rollout of this package has been slowed by the MOH's reluctance to initiate a true system of enrolling and following up with HIV-positive people who were not yet eligible for ART. After years of advocacy from PEPFAR and other development partners, this Pre-ART system is just being rolled out in late 2011. New pre ART M&E tools will assist in reaching the mandate for universal cotrimoxazole prophylaxis for all people who are enrolled in HIV as established by the 2010 national guidelines update. Isoniazid preventive therapy will be another component of minimum packages rolled out through the end of 2011 and into 2012—those guidelines were published in September 2011. Finally, guidelines for the responsible introduction of family planning conversations in HIV clinics were also just created and are expected to be piloted in health facilities towards the end of 2011. Now that the policy and guidelines issues have been overcome for the most part, the biggest hurdle will be the government's fulfillment of its commitment to pay for the commodities. PEPFAR partners are working closely with the government to keep the supply chain quantification, forecasting and distribution systems functioning smoothly so that any issues that arise can be managed.

The HIV prevention services that are consistently delivered to HIV-infected persons as part of their routine care are noted in the previous paragraph. As above, PEPFAR partners have been working with the MOH ART unit on the integration of family planning into ART clinics. This guidance is now complete, but requires piloting. PEPFAR partners and CHAI are also working on creating curricula aimed at ART and pre-ART patients (whom we recognize have different concerns and needs) to address adherence, risk reduction, the importance of partner testing and disclosure. Along with MSF, these partners are also working on community and facility-based stigma reduction efforts, including community dialogues and identification of HIV-positive role models. Regarding partner testing, PEPFAR has recently re-emphasized to its HTC partners the importance of expanding training in couples testing beyond antenatal clinics to sites (eg, TB outpatient facilities) where ill patients, especially men, may also be accessed.

All HIV-infected persons are eligible to receive community-based services. These services are not consistently

offered throughout the country and since there are numerous different partners supporting the effort, it is difficult to quantify numbers of recipients. The services may include in-person or phone reminders about appointments, home-based care, directly-observed therapy (for TB), nutritional support, adherence and psychosocial support. To strengthen community based services, community expert clients and community health nurses have been introduced into some facilities. A new standard operating procedure for linkage, retention and tracing of HIV patients (initiated by PEPFAR partners, but owned by the MOH) will govern the connections between the patients, their communities and the facilities which they choose to attend. The SOP relies on the use of a referral system that alerts facilities to the expected date for a first appointment chosen by someone who is newly diagnosed as HIV-positive (or being re-linked to care) and provides contact information for patients who fail to appear. In some testing sites, an HIV+ expert client is on hand to help the newly diagnosed accept their status and encourage them to access care. At receiving sites, another expert client is waiting to greet them and completes appropriate paperwork in the pre-ART system to enable follow-up. Community expert clients then collaborate with Rural Health Motivators (paid by government) to follow up patients in the community as well as provide health education, adherence and psychosocial support and they also engage in setting up or strengthen existing patient support groups to improve treatment literacy. PEPFAR is currently engaged in an exercise with the MOH to rethink the community health worker program and is providing technical assistance to the program management.

PEPFAR's efforts to optimize quality of care are partially defined in the Treatment TAN and the Governance TAN. In short, PEPFAR supports Regional Clinical Mentoring Teams that engage in quality improvement work at all facilities providing TB and HIV care. All facilities are required to present their results on key indicators at a regular public form (semiannual for HIV and quarterly for TB). Furthermore, PEPFAR is supporting the creation of a national Quality Management office that will evolve from the currently separate offices of Quality Assurance (housed in the main MOH) and Quality Improvement (housed in the AIDS Program). It is expected that this Quality Management program will liase with the MOH Planning Unit on the establishment of regional forums for sharing key health indicators including, but also going beyond, HIV and TB. These forums will be PEPFAR-sponsored in the beginning, with the expectation of improved transparency, accountability and the creation of incentives for improving the quality of care offered to patients in Swaziland.

PEDIATRIC CARE AND SUPPORT

Due to the lack of pre-ART system until this year, we cannot estimate the retention rate over the past two years for children enrolled in care. As described above, PEPFAR will continue to support programs that prioritize the collection of such data and will hopefully be able to present this information in the future.

Swaziland's major pediatric care and support achievements in the last two years mirror the achievements for adults. PEPFAR has supported the expansion of early infant diagnosis and early infant initiation; implemented pre-ART programs that will track all HIV+ children from the point of testing to encourage linkage to care according to the new patient follow-up SOP; and provided support for disclosure counseling and psychosocial programming.

Swaziland's key priorities and goals for pediatric care and support for the next two years continue in the same paths. At the national level, PEPFAR will support both efforts through participation in the Pediatric HIV sub-TWG. This sub-TWG is responsible for planning for pediatric HIV services in Swaziland; reviewing and developing national pediatric HIV care tools and job aids. PEPFAR will also provide TA and financial support in the training of health care workers in HIV care services and provide TA in the orientation of health workers on the revised Pediatric HIV guidelines. Specific focus areas include:

- *Early identification of HIV exposed and infected infants and children: work with health care workers at the supported sites to ensure early identification of HIV exposed and infected infants through systematic screening of child and mother health cards at each service contact; improve health worker skills in pediatric counseling through training and mentorship; support EID through DNA PCR using DBS for exposed infants at every entry point within MCH; provide pediatric PITC using antibody tests for children >12 months and strengthening exit test at 18 months; use of presumptive diagnosis of HIV*
- *Reduction in HIV morbidity and mortality in exposed and infected infants and children: work with health*

care workers through mentorship and support supervision to ensure proper provision of infant feeding counseling; routine immunizations according to the national EPI guidelines, growth monitoring and developmental assessment for all infants and children; prompt clinical and immunological assessment of HIV-positive children; pain assessment and management; screening for TB and OIs; prophylaxis with NVP, CTX, INH; regularly assess for ART eligibility; and ensure all early ART initiation for all HIV-positive infant and children less than 2 years; provision of health care workers with different job aids including for clinical staging to ensure confidence in provision of the care services; support to the integration of these activities within the broader MCH program.

- *Linkages and retention: strengthen the use of patient cards and referral forms for effective referral linkages according to the new SOP; work closely with expert patients and Mentor Mothers in ensuring that caregivers are well counseled on care services and complete referrals; establish and strengthen referral linkages between services and clinics; improve follow-up counseling to improve adherence; work with health workers to utilize pre-ART and appointment registers to identify defaulting and lost to follow up children; develop mechanisms (mobile phones) to trace clients who have not returned for follow-up or results; develop a directory for all facilities to encourage linkages and feedback between facilities.*
- *Support supervision and mentorship, including QI: Continue to provide regular visits for data review, QI activities, case management and mentoring. Support efforts to establish and empower the Regional Clinical Mentoring teams and facility-based multi-disciplinary teams to absorb this work.*
- *Psychosocial Services: In the coming two years, PEPFAR will support psychosocial services through the formation of support groups for children living with HIV. The support groups will empower children with knowledge about HIV/AIDS and help them develop coping skills; and provide information for children so that they can understand the course of HIV infection and be able to adhere well to ART*
- *TB diagnosis and treatment: A PEPFAR partner is planning a research study that will assess the use of mucus extractors to increase diagnostic yield of sputum. Gene Xpert is also being rapidly introduced into the country, which, given a good sputum collection method, will lead to improved TB case detection among children.*

TB/HIV

The key priorities and major goals to strengthen TB/HIV activities in the next two years include implementation of the recently completed guidelines for infection control, intensified case finding and isoniazid preventive therapy; maintaining high rates of HIV testing among TB patients (currently >95% of TB patients are tested); improving rates of initiation of HIV+ TB patients on ART; and planning for continued expansion of access to HIV and TB diagnosis and treatment initiation services.

The scale up of infection control, intensified case finding and isoniazid preventive therapy in the next two years will build directly from the PEPFAR-supported efforts to develop and pilot new policies and procedures that have now been codified into national guidelines. PEPFAR partners provide extensive support to the national AIDS program, the national TB program as well as the national TB/HIV coordinating committee.

All of these activities provide opportunities for cross-fertilization of ideas, alignment with government priorities and assurance of appropriate geographic coverage. For example:

- *the recent development and introduction of the new preART tools allowed for indicators for TB screening and IPT to be directly integrated into national M&E systems.*
- *the national Quality Assurance Program sponsors the infection control agenda and also receives extensive PEPFAR support by the same partners that sponsor HIV and TB efforts.*
- *the national TB/HIV coordinating committee is spearheading the effort to plan a path to universal access for HIV and TB treatment and diagnosis.*
- *the creation of a national TB laboratory diagnostic strategy in light of donors' (PEPFAR, MSF, FIND and Global Fund) investments in a bio-safety level 3 national TB reference laboratory, new Gene Xpert machines and new culture and drug sensitivity testing equipment. By the end of 2011, we expect that the new lab will be up and that Gene Xpert machines will be partially introduced into the country. We will monitor the rates of case finding and initiation closely through regular laboratory data (soon to be housed in a new PEPFAR-funded laboratory information and patient management information systems) and thereby measure its impact in terms of program*

outcomes and, potentially, lives saved.

The recommendation for early initiation of ART for all people with TB was included in the 2010 revision of the ART guidelines and currently some 50% of eligible TB/HIV patients are initiated. To ensure that the other 50% are also initiated early, PEPFAR technical support and the Regional Clinical Mentoring Teams described above are providing guidance to the facilities which includes quality improvement exercises. Also, PEPFAR partners are supporting the regular forums for data quality review described above. At these reviews, issues are addressed related to the national programs such as supply chain, personnel or guidelines. High quality performance is rewarded and low performers are subject to a great deal of peer pressure to improve. These reviews also provide an additional forum for partners and donors to ensure that their programs are coordinated and in alignment with government priorities.

FOOD AND NUTRITION

Food and nutrition is a relatively new area for PEPFAR in Swaziland and we plan to address it more fully in the coming two years. A food by prescription policy, targeting individuals living with HIV and/or TB, has recently been drafted by the MoH, with support from WFP and Action Against Hunger. PEPFAR's primary care and treatment facility-based partner ICAP will support the implementation of the policy through provision of technical assistance to the Nutrition Council and the health facilities. Strengthening the continuum of care and referral systems is an ongoing priority.

Building on an assessment conducted by the AED-LIFT program, PEPFAR is in the process of developing a new award that focuses on Economic Strengthening/Livelihoods/Food Security (ES/L/FS) for households affected by HIV/AIDS. Part of the scope of this award includes strengthening referral systems, so that clinical and community interventions are appropriately linked and families living with and affected by HIV/AIDS have greater access to ES/L/FS services. In addition to savings groups and employment creation (which directly influences household food security), the project will include the expansion of permaculture consumption gardens for vulnerable households, a strategy that has proven effective in Swaziland but is presently implemented on only a limited scale.

Secondly, through a grant to UNICEF and building on previously PEPFAR funded work through Action Against Hunger, PEPFAR will be piloting the introduction of growth monitoring to neighborhood care points (NCP) which provide a safe space, hot meals, and basic early childhood education to particularly vulnerable pre-school aged children. Linkages will be formed between NCPs and nearby health facilities so that referrals and follow-up can be made through the formal health system. There are approximately 1500 NCPs across Swaziland; should the pilot prove effective and feasible, a plan for scaling up the service will be developed and supported.

Third, PEPFAR- Swaziland is proposing to use some of its PMTCT Acceleration funds to provide ongoing support to the national Nutrition Council, seek improvements in the implementation of new guidelines regarding infant feeding practices described in the updated PMTCT Guidelines and increase support to malnourished infants.

ORPHANS AND VULNERABLE CHILDREN

Impact mitigation with a focus on children is one of five pillar areas in the Swaziland Partnership Framework, and the area is being developed to support both the National Strategic Framework 2009-2014 and the National Plan of Action for Children 2011-2015. All documents include a common focus on expanding and improving support for vulnerable children in core services areas, including health, education, protection, psychosocial support, food security and economic strengthening.

PEPFAR Swaziland began investing in impact mitigation in 2009. Highlights of progress include:

- *In partnership with UNICEF, PEPFAR enabled 400 neighborhood care points (NCPs) serving 20,000 pre-school aged children to be equipped with basic furniture, improved sanitation facilities, early learning kits and play materials, and for caregivers to be trained. Takalani Sesame developed a set of learning materials for*

pre-school age children which will be used in NCPs across the country.

- *More than 100,000 children 0-5 years each year with package of high impact health services during MOH's National Child Health Day campaign.*
- *Nine NGOs have been supported to scale up their OVC service delivery models reaching children and caregivers with a variety of services. These organizations also received organizational development support to improve overall organization functioning, program and financial management, quality of interventions and M&E.*
- *Supported the expansion of the community-based child protection program, and gender and child protection are being systematically mainstreamed into NGO/CBO activities. The WORTH model of savings group is the process of being piloted with child protection caregivers and is showing promising results.*
- *Guidelines were developed and a competitive process was launched, which will enable 10-12 local organizations to access small grants to support the strengthening of community efforts to assist vulnerable children through the Embassy's small grant program. Through Peace Corps, numerous small grants were awarded to support grass roots efforts to assist children.*
- *Supported the National Children's Coordination Unit to develop Quality Service Standards for OVC programs, a monitoring system and database for NCPs has been developed, and the National Plan of Action for 2011-2015 and associated results matrix have been finalized.*
- *A new activity focusing on national child welfare systems strengthening was developed, awarded and is in the early stages of implementation.*
- *An assessment of ES/L/FS activities, gaps and opportunities was carried out in FY11. The assessment contributed to the development of a new activity (award is imminent) focusing on strengthening ES/L/FS capacities among households affected by HIV/AIDS*

A major goal will continue to be to enhance coordination and standardization of community based services, and we continue to pursue ideas for how to better link largely adult-focused care and treatment clinical services, with largely child-focused community based services. While the impact mitigation portfolio includes activities that address the needs of most children across the age span from early childhood (3) through school, there are a number of outstanding problems. First, there are issues with coverage—not all services for the different age groups are available in all areas. Second, there are key gaps including infants and very young children, which may be covered for a time in PMTCT, but missed during the time that support ends and enrollment in an NCP can begin. This is a critical age in terms of child development and health, and an area we feel we can address given the relatively good coverage of NCPs and PMTCT services. A delegation comprised of USG staff, Government representatives and key partners will participate in the HIV/MNCH Health and Social Support Needs of Mothers and their Young Children in November 2011. It is envisaged that participation in the forum will stimulate greater commitment around the need to better coordinate services, as well as key priority areas for action.

PEPFAR support for impact mitigation has three components: 1) improving the policy environment, 2) strengthening national systems, and 3) supporting community-based service delivery. Over the next two years, the priorities are as follows.

PEPFAR will continue to work with the Government and other stakeholders to ensure that key policies and guidelines, such as the Child Welfare Bill and Domestic Violence and Sexual Offences Bill, are adopted and implemented. Advocacy for reform of the birth registration system will also be supported. System strengthening activities will be designed with a view to supporting full implementation of child-focused policies (e.g Social Development Policy, Child Welfare Bill).

The priorities for strengthening systems over the coming years will include 1) strengthening and decentralization of the Department of Social Welfare (DSW), 2) strengthening the child protection system, and 3) enhanced M&E for impact mitigation.

With a view to improving the DSW's overall functioning and bringing operations in line with the Social Development Policy, PEPFAR will avail technical and financial assistance to the DSW in the following areas: strategic planning, organizational restructuring, social worker and auxiliary social worker training and

development, and decentralization of services including linking with community volunteers and structures. PEPFAR resources will leverage the investments of UNICEF, which has been the primary donor to the DSW to date, and the World Bank which has recently begun working with the DSW to develop a system for delivering cash transfers for OVC.

Beginning with a mapping exercise, PEPFAR will co-fund with UNICEF a systems-based approach to strengthening child protection efforts in Swaziland. An assessment will be carried out to examine the child protection system components and how they are (or are not) functioning and connecting to one another. Major system bottlenecks and cracks will be identified and technical assistance will be targeted accordingly. PEPFAR will support the capacity building of different service providers (community child protectors, DSW, police, health facilities, etc) for the successful implementation of the Referral Protocol for Sexual Abuse. Protection services to vulnerable children and survivors of abuse will continue to be supported. It is expected that these efforts will result in concrete linkages between service providers and improved quality of services provided to survivors of abuse. Note that this activity will be coordinated with the Care and Treatment pillar area which is strengthening and expanding post-exposure prophylaxis services for survivors of sexual assault in public clinics.
In cooperation with UNICEF, PEPFAR will continue to support the development and implementation of a national M&E framework and system that is aligned to the NPA. PEPFAR will also work closely with the National Children's Coordination Unit to identify additional areas of capacity building required to ensure gains are made in the coordination of the national response. PEPFAR will continue to provide technical and financial support to finalize and implement Quality Service Standards for OVC Programs. The Standards are in the last stages of the piloting process.

PEPFAR will continue to provide funding to local NGOs to improve and expand services for vulnerable children. These NGOs will model key aspects of impact mitigation (e.g. family-centered care, reaching adolescents, child protection, economic strengthening, etc) and will work closely with national forums to share lessons learned and explore strategies for sustainability and potential for scale up.

PEPFAR will continue to support the national NCP initiative, however the focus will shift from equipment and caregiver training in a large number of NCPs to working with a fewer number of NCPs on sustainability strategies. Also, with UNICEF, PEPFAR will activities aimed at strengthening the coordination, management and M&E systems of the NCP program nationally.

PEPFAR is in the process of bringing on a new implementing partner to rapidly scale up sustainable and market-led livelihood and economic strengthening activities for OVC, their families and caregivers; this project will have a strong gender component. An assessment was carried out in early FY11 that informed the program design and specific funding priorities. A combination approach of technical assistance to existing impact mitigation partners and direct service delivery will be employed. Proven interventions, such as the honey industry and savings and lending communities, permaculture gardens, will be expanded. A variety of methods will be used depending on households' needs and abilities. Of particular interest is developing workable models of transitioning older OVC, including those heading households, to self-sufficiency. The new livelihood and economic strengthening activity will be implemented in collaboration with the care and treatment pillar area.

Funds will continue to be provided to the Peace Corps for small grants to allow volunteers to implement child-focused activities within their communities. Given the numbers of children in need of assistance, approximately 70% of the HKID programmatic budget will be devoted to reaching children directly with services.

PERTINENT CROSS-CUTTING AREAS

GENDER
Increasing gender equity in HIV/AIDS programs and services—in adult care support, results show that fewer men are accessing services than women. This relates directly to the fact that fewer men test for HIV, and there are fewer opportunities for men to be linked into care. With the acceleration of the national plan for male

circumcision, and enhanced strategies to engage men in testing, the expectation is that many more men will undergo HIV testing, and with strong referral protocols in place, be linked into care. Health facilities are also beginning special initiatives such as men's health days, employing male expert clients and adjusting opening hours to fit the work schedules of men in order to make services more appealing to men. Efforts continue to strengthen service data and monitoring to ensure that gender inequities are tracked and appropriate strategies are implemented in response. PEPFAR Swaziland will continue to work to ensure that all key indicators are disaggregated by gender, that national and PEPFAR partner data collection mechanisms are in place and that gender data are being used for program improvement.

REDUCING VIOLENCE AND COERCION—over the next two years PEPFAR will expand efforts to strengthen the department of social welfare, which has a key role to play in addressing domestic violence and abuse, and the child protection system which includes social welfare, health, education, police, justice and civil society actors. Impact mitigation efforts will continue to support the national community-based child protection initiative that trains community members to identify and respond to cases of child sexual and other abuse.

ADDRESSING MALE NORMS AND BEHAVIORS - PEPFAR will continue to support activities to address social norms and behaviors that promote imbalances in gender power and decision making. Several partners have integrated community dialogues, boys' and girls' groups, men's discussion groups into their routine work on prevention and/or with vulnerable children. In addition, the expansion of strategies such as couples counseling and testing will continue to be prioritized to facilitate access to care and treatment and help reduce the potential for violence.
Increasing women's legal protection—PEPFAR and its partners will continue to work with other donors to advocate for the approval of legal instruments (Child Welfare Bill, Domestic Violence Bill) that are critical for protecting the right of women and children. The new ES/L/FS award also has a specific objective that focuses on the protection and promotion of women's and children's rights.
Increasing women's access to income and productive resources—is a key area of expansion for PEPFAR. The aforementioned new ES/L/FS award will be the main vehicle for implementing this strategy since it has a particular focus on households with a high burden of OVC, households affected by HIV/AIDS, female headed households, young women age 16-25, and other vulnerable women (e.g. GBV survivors, women with disabilities, single mothers). The WORTH savings group model, which has demonstrated success with caregiver groups (largely female), will also be scaled up.

PUBLIC-PRIVATE PARTNERSHIPS
Swaziland does not yet have a legal framework that can manage private-public partnerships.

MARPS
While it is generally accepted that Swaziland has a generalized HIV epidemic, PEPFAR-Swaziland is engaging in studies among MSM and CSWs to assess prevalence of HIV among them and their access to services. Results are expected in early 2012.

HRH
Swaziland supports health workforce development to expand HIV and has recently launched the Essential Health Care Package (EHCP) and Task Shifting Framework defines the type of health care services to be provided at all level of care. Staffing norms are being developed through PEPFAR and GF to define the appropriate staffing levels, cadres, and task shifting roles that will operationalize the EHCP and has as a priority shifted initiation of ART to the nurses as a pilot. Other cadres that are being considered are Phlebotomists, Laboratory Technicians, and Pharmacy Technicians. Different cadres of health workers currently exist that receive variable under the government systems and NGO's and there is no system to monitor and supervise them. The Community Linkages Project is being implemented as a pilot to look at innovate ways to improve health care services and is an opportunity for PEPFAR to model a program for the country. Further, PEPFAR is evaluating the RHM/Community program n that will build to the pilot. Donors have demonstrating support in this area. At every facility level, a multidisciplinary clinical team is supported by PEPFAR partners with the plan to gradually

handover to the government. The mentoring and supervision framework has been launched to support the multidisciplinary teams.

CAPACITY BUILDING
Capacity building activities in care focus on skills and competencies in service delivery and mainstreaming QI. Specifically the training is divided into the following:
- *NARTIS training that is being piloted t support the Task Shifting of ART initiation by the nurses in line with the decentralization of services*
- *IMAI training that is focuses on basic skills for chronic management of HIV*
- *On-site training and mentoring of clinical skills that is cost effective and allows immediate transfer of skills and understanding of roles*

Coordination of training is being addressed by the MOH's Training Unit and a Training database is being developed through the GF to allow the MOH to track all training supported by government and partners.

LABORATORY

Currently the clinical laboratories are providing services to support the following healthcare areas:
- *Diagnostic: Laboratory services provide diagnostic services for all levels of health services*
- *Treatment /curative: Laboratory services support ART centers, TB treatment programs and STI clinics*
- *Prevention: Laboratory services support all public health prevention programs such as PMTCT, HIV Counseling and Testing*
- *Surveillance: Laboratory services support surveillance programs such as SNAP–HIV Sentinel Surveillance, National TB Program -TB drug resistance, Reproductive Health program –antenatal care.*
- *Research: Laboratory services are supportive of clinical trial programs such as HIV vaccine trial and other clinical trials*

There are five types of clinical laboratory services:
- *Routine clinical laboratories*
- *National reference laboratory*
- *Public health laboratories*
- *Research laboratory*
- *Histology and cytology laboratory*

The laboratory ensures accurate and efficient ordering, collection, receipt, transportation and processing of specimens for clinical laboratory testing. Analytical systems are in place to provide quality analytical services to clients these consists of all processes leading to accurate, precise and timely analysis of testing samples as well as processes that ensure that the laboratory results are accurately reported and archived. Specimen management is part of the process to ensure proper storage of specimens for future reference in the event of questionable laboratory results. The laboratory conducts SLMTA workshops and has developed continuous quality improvement projects to maximize laboratory effectiveness, efficiency and adaptability. All laboratories take part in External Quality Assurance programmes to ensure adherence to international standards.

STRATEGIC INFORMATION

ACCOMPLISHMENTS:
- *Development and utilization of two softwares have been supported by PEPFAR, including the RxPMIS and the RxSolution software. The RxPMIS software is used for electronic medical record in the national HIV program and includes data on TB/HIV and is being redeveloped to ensure interoperability and capability to capture data on pre-ART, TB/HIV etc. The RxSolution software is an inventory / logistics management software for pharmaceutical and laboratory commodities which is used in hospitals and health centers for dispensing of medicines to patients.*

KEY PRIORITIES AND MAJOR GOALS FOR NEXT TWO YEARS:

- *PEPFAR will support the MOH in introducing the Health Services Recipients Unique Identifiers and evolution of Rx-PMIS to Client Management Information System (CMIS) to maximize the efficiency of routine information system in tracking PLWHIV and to ensure their access and linkage to care and treatment services*
- *PEPFAR will continue to support data systems appropriate for the clinic level, including paper-based systems and electronic medical records. PEPFAR will work through the Technical working group to update/develop national protocols for data quality assurance assessment and to update when needed current data collection tools.*
- *To enhance sustainability of quality M&E, PEPFAR will continue to mentor facility level staff in a phased approach to ensure timely and accurate data collection, recording and reporting. PEPFAR will continue to support clinic multi-disciplinary teams to use their data for quality improvement. PEPFAR will also continue to mentor regionally based strategic information staff to provide supportive M&E supervision and incrementally take on the M&E mentoring role.*
- *PEPFAR will provide national quarterly TB/HIV treatment data review meetings to facilitate sharing opportunities for best practices and to support writing of annual program reports.*

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,419,809	0
HVSI	1,263,031	0
OHSS	3,027,019	0
Total Technical Area Planned Funding:	**5,709,859**	**0**

Summary:

MAJOR ACTORS AND CONSTRAINTS IN THE HEALTH SECTOR
Building capacity in national institutions is an overarching need in the Swazi context, and thus is a cross-cutting focus of all USG HIV investments. The diverse contributed assets of the GOKS, PEPFAR, civil society and national and international partners are dedicated to: achieving measurable results while reinvigorating the country's health infrastructure and workforce to respond to the long-term social and chronic care needs related to the HIV epidemic; creating efficient systems to procure and manage the equitable distribution of drugs, supplies, services and other health products; and strengthening management and governance structures for bold leadership and informed decision-making. By bolstering the foundations of health and community systems, USG is strategically positioning Swaziland's institutions, empowering Swazi leadership, and engendering ownership over the longer term.

Investments and technical support from bilateral and multilateral stakeholders – including USG, the World Bank, the European Commission (EU/EC), the UN family, the Republic of China on Taiwan, the Global Fund, Médecins Sans Frontières (MSF), the Clinton Health Access Initiative (CHAI) and several international NGOs – are on balance supporting national systems rather than setting up parallel vertical programs. While international development partner programming is largely focused on support to the HIV/AIDS and TB response, there are smaller projects supporting malaria, children's feeding programs, social welfare, health infrastructure, microenterprise and livelihoods, social transfers, family planning and agricultural development.

STRATEGIC ENGAGEMENT - USG engages national stakeholders at policy and implementation levels on the strategic use of PEPFAR resources under the GHI Country Strategy and PEPFAR Partnership Framework Implementation Plan. To improve donor coordination and leverage GHI/PF planning, the USG team founded the Health Development Partners' Working group to ensure that development partners are appropriately coordinating

their position within bilateral and multilateral forums. The PEPFAR team also represents the U.S. Embassy at the broader bilateral, UNDP-led Development Partners Working Group. To ensure accountability against mutual commitments, the USG/PEPFAR interagency management team holds monthly GHI/PF management meetings with the directorates of MOH, NERCHA and WHO. As stewards of the health sector, the MOH directorate holds independent and joint planning meetings with USG implementing partners, in addition to periodic USG-GOKS bilateral planning forums. Internally, USG staff continues strong interagency collaboration and coordination in the implementation and monitoring of the GHI strategy.

GLOBAL HEALTH INITIATIVE
Swaziland's USG interagency team has been focused on GHI since the initiative was first announced by President Obama. This focus is reflected by the incorporation of GHI principles into the GOKS-PEPFAR Partnership Framework signed in June 2009. Because the only funding stream for U.S. global health investments in Swaziland is the PEPFAR program, the team has worked thoughtfully and diligently to ensure that PEPFAR programming is continually enhanced to reflect the core principals of GHI. Swaziland's GHI strategy demonstrates GHI principles by: Strengthening USG-GOKS partnership and GOKS ownership; Intensifying efforts to address cross-cutting areas of Gender and Health Systems Strengthening; Increasing efforts to integrate PMTCT and MNCH; Promoting research and innovation; Building more sustainable systems; and Strengthening donor coordination.

With the world's highest HIV prevalence, significant health sector capacity constraints and widespread poverty, the GOKS and USG recognize that this will be a long term partnership and endeavor. Through the Partnership Framework (PF) and corresponding Partnership Framework Implementation Plan (PFIP), the GOKS and USG have agreed to a five-year joint strategic agenda, in collaboration with other key stakeholders, to strengthen, scale up and sustain key components of the HIV/AIDS response and the overall health sector capacity in support of the National Strategic Framework on HIV/AIDS 2009-2014 (NSF). The overarching vision of USG is to strengthen public health and community systems to support a sustained response to HIV/AIDS well beyond the lifespan of the PEPFAR program.

LEADERSHIP AND GOVERNANCE - CAPACITY BUILDING
Solid institutional capacity is at the heart of increasing access to quality HIV, TB and social welfare services at all levels of the HIV response. Building capacity in national institutions is an overarching need in the Swazi context, and thus is a cross-cutting focus of all USG HIV investments. The diverse contributed assets of the GOKS, PEPFAR, civil society and national and international partners are dedicated to: achieving measurable results while reinvigorating the country's health infrastructure and workforce to respond to the long-term social and chronic care needs related to the HIV epidemic; creating efficient systems to procure and manage the equitable distribution of drugs, supplies, services and other health products; and strengthening management and governance structures for bold leadership and informed decision-making. By bolstering the foundations of health and community systems, USG is strategically positioning Swaziland's institutions, empowering Swazi leadership, and engendering ownership over the longer term.

MOH INSTITUTIONAL CAPACITY DEVELOPMENT. Through a PEPFAR-MOH Cooperative Agreement, USG provides direct support to enhance institutional capacity in areas in which USG has a comparative advantage of technical expertise, including: strengthening laboratory systems, strategic information, blood safety, quality assurance systems, pre-service training for key cadres of health care workers, strategic planning and policy development. With USG assistance, the MOH established a Strategic Information Department (SID), and is making strides in using data to improve the quality and delivery of services. USG continues to support the MOH human resource information system and the development of workforce data for recruiting, retaining and training skilled health care professionals. Technical support for health sector coordination and planning activities, such as the Health Sector-Wide Approach (SWAp), is a direct and focused USG intervention.

GLOBAL FUND INSTITUTIONAL CAPACITY DEVELOPMENT. A growing focus of the USG team is support to Global Fund governance and oversight structures, risk management, proposal development (including alignment with PEPFAR programming) and grant implementation. USG helped establish the Country Coordinating

Mechanism (CCM) governance structure and funded the creation of one of the first CCM Secretariats in the world. USG is a voting member of the CCM, and USG team members help staff the CCM Executive Committee, Oversight Committee and Proposal Development Team. USG technical officers and implementing partners play key roles in Global Fund grant development and improving grant performance. Recently, Swaziland was awarded funding under the PEPFAR-Global Fund Collaboration Initiative to enhance ongoing technical assistance activities with the CCM, NERCHA (a principal recipient) and to augment capacity-building efforts with civil society to be effective USG and Global Fund implementers. Under this approach, local NGOs are being jointly capacitated to meet international standards for program management and implementation, an effort that should strengthen Swaziland's civil society as a whole. Importantly, USG and its implementing partners are leading contributors to addressing conditions precedent and findings raised by a recent Global Fund Office of Inspector General (OIG) report.

STRATEGIC INFORMATION

It is recognized in Swaziland that principles of good governance, accountability, and evidence-based planning and budgeting rely on routinized use of high quality information. It is further understood that, perhaps more than any other health systems component, health information systems require solid foundational design inputs, heavy infrastructural investments, and development of a highly trained and technically supported work force to manage.

An M&E Framework for the health sector, which encompasses all main health priorities, has been developed and the USG in collaboration with the MOH is in the process of harmonizing MOH indicators with those covering existing USG programs in Swaziland. One of the main challenges is with regard to development of community based program indicators, which are not well conceived and for which workable measurement tools have not been well established.

The USG program in Swaziland has made it a central tenant of its work in Swaziland to avoid development of parallel information systems. So, unlike most PEPFAR country programs, PEPFAR Swaziland have made the decision to invest in a single national system and place reliance for USG reporting on these national systems. Major care, treatment and prevention partners are not permitted to have their own software systems and databases but instead work through national workgroups and invest in the MOH HMIS (aggregate data), MOH Patient MIS (electronic individual medical record), MOH Human Resource Information System (HRIS), and NERCHA's multisectoral SHAPMoS (Swaziland HIV/AIDS Program Monitoring System). The USG team believes these investments are well placed. Given far greater human resource deficits in Swaziland around M&E, compared to other countries in the region, the road to improved HIS has been long and challenging one. Still, much improvement has been seen over the last few years as the USG has used HIV funding to leverage improvements in broad-based health sector HMIS. These systems do provide the basic data required for essential USG reporting, but not much more. Data quality assurance systems are being developed with USG support and regular HIV-focused and broad-based health statistics reports are published on a quarterly and annual basis. These tend to be a month or two late and lack uniform completeness across all indicators.

Having understood that the development of high quality information products depends on a demand for those products, the USG SI team has decided to focus its investment at the intersection of HIS (Strategic Information Department), the nascent Quality Improvement Office of the MOH and the MOH Directorate where strategic decision-making on public health priorities are made vis-à-vis budget, staffing, and planning. In this way, we are promoting an ongoing information exchange and evidence-based dialogue which will at once enhance the quality of strategic information products and create the basis for accountability in program units to meet targets and encourage stewardship of USG and other partner funds.

STRATEGIC INFORMATION STRATEGIES/INTERVENTIONS

- *Strengthened coordination and integration of HMIS through provision of short- and longer-term technical assistance with tin the MOH in collaboration with WHO, UNICEF, Clinton FD, academic institutions and others*
- *Support program evaluations in the areas of linkage to care, ART program outcomes, costing and PMTCT to build capacity and enhance the culture of data use for program improvement.*

- *Continue to expand and enhance the MOH data QA/QI systems*
- *Establish and institutionalize the MOH Data Use and Research Development Committee of the MOH*
- *Establish a national surveys and surveillance action plan, and support selected surveys/surveillance efforts*
- *Place a senior SI liaison with the MOH Health Services Directorate (for 2 years only) to guide and support the SID during transition to self sufficiency*

SERVICE DELIVERY - CONTINUUM OF RESPONSE

There is great momentum towards integration of prevention, care and treatment services in Swaziland. Key prevention activities such as male circumcision, PMTCT, and HTC now feature a standard operating procedure (SOP) for linking those who test positive for HIV to care. The SOP includes a provision for newly diagnosed HIV clients to be actively linked to care with the assistance of immediate post-test counseling at the HTC site by a trained "expert client" (someone on ART who models good behavior). Patients are then referred to HIV care beginning with a newly implemented pre-ART program in which patient information is managed using appointment books, a pre-ART register and an individualized chronic care files. If a patient misses any appointment (including the first), it is planned that a second "expert client" stationed at the care site will actively trace this patient using SMS, phone or home visits. This SOP is in final stages of completion, but has already been partially rolled out to a pilot group of sites. It will be the focus of a great deal of support in the coming years, and its impact will be monitored through the addition of a new set of referral and linkages indicators to the HMIS.

PEPFAR is working closely with the MOH and other partners on a TB/HIV decentralization plan with the goal of providing universal access to diagnosis, initiation and ongoing care services for TB and HIV in Swaziland. New 3Is guidelines (infection control, ICF and IPT) have recently been completed and call for the creation of infection control committees at all public health facilities and for renovations at some facilities. These new guidelines are in various stages of rollout, with 75% of all HIV patients currently being screened for TB on each visit to a facility and IPT being actively implemented in the country. (Please see the Care TAN for detail on TB/HIV integration.)

The integration of HIV within MCH and primary care settings is also an ongoing process. Since 41% of all pregnant mothers in Swaziland are HIV+, HIV testing and PMTCT services have been well-integrated into antenatal care. Integrating Family Planning is an ongoing priority. (See the Prevention TAN for more detail.) PEPFAR has successfully supported a high rate of ARV prophylaxis uptake among HIV+ pregnant women; however, the challenge now is to ensure that these women subsequently enroll in HIV care and initiate ART when eligible. Qualitative studies are underway to examine reasons why pregnant HIV+ women refuse care, and PEPFAR is planning a pilot of "Option B+" (using PMTCT Acceleration Funds) as a strategy for improving uptake. The NARTIS program will be a key component of this pilot and also serve to link general HIV care to MCH and primary care settings in the most rural facilities in the country.

PEPFAR-supported programs promote a minimum package of care for HIV-infected persons which includes condoms, TB screening, cotrimoxazole, isoniazid preventive therapy, adherence counseling, disclosure support and family planning. Rollout of this package has been slowed by the MOH's reluctance to initiate a true system of enrolling and following up with HIV-positive people who were not yet eligible for ART. After years of advocacy from PEPFAR and other development partners, this Pre-ART system is just being rolled out in late 2011. New pre ART M&E tools will assist in reaching the mandate for universal cotrimoxazole prophylaxis for all people who are enrolled in HIV as established by the 2010 national guidelines update. Isoniazid preventive therapy will be another component of minimum packages rolled out through the end of 2011 and into 2012—those guidelines were published in September 2011. Finally, guidelines for the responsible introduction of family planning conversations in HIV clinics were also just created and are expected to be piloted in health facilities towards mid- 2012. Now that the policy and guidelines issues have been overcome in many of these key areas, the biggest hurdle will be the government's fulfillment of its commitment to pay for the commodities. PEPFAR partners are working closely with the government to keep the supply chain quantification, forecasting and distribution systems functioning smoothly so that any issues that arise can be managed.

The HIV prevention services that are consistently delivered to HIV-infected persons as part of their routine care are

noted in the previous paragraph. As above, PEPFAR partners have been working with the MOH ART unit on the integration of family planning into ART clinics. This guidance is now complete, but requires piloting. PEPFAR partners and CHAI are also working on creating curricula aimed at ART and pre-ART patients (whom we recognize have different concerns and needs) to address adherence, risk reduction, the importance of partner testing and disclosure. Along with MSF, these partners are also working on community and facility-based stigma reduction efforts, including community dialogues and identification of HIV-positive role models. Regarding partner testing, PEPFAR has recently re-emphasized to its HTC partners the importance of expanding training in couples testing beyond antenatal clinics to sites (e.g., TB outpatient facilities) where ill patients, especially men, may also be accessed.

All HIV-infected persons are eligible to receive community-based services. These services are not consistently offered throughout the country and since there are numerous different partners supporting the effort, it is difficult to quantify numbers of recipients. The services may include in-person or phone reminders about appointments, home-based care, directly-observed therapy (for TB), nutritional support, adherence and psychosocial support. To strengthen community based services, community expert clients and community health nurses have been introduced into some facilities. A new standard operating procedure for linkage, retention and tracing of HIV patients (initiated by PEPFAR partners, but owned by the MOH) will govern the connections between the patients, their communities and the facilities which they choose to attend. The SOP relies on the use of a referral system that alerts facilities to the expected date for a first appointment chosen by someone who is newly diagnosed as HIV-positive (or being re-linked to care) and provides contact information for patients who fail to appear. In some testing sites, an HIV+ expert client is on hand to help the newly diagnosed accept their status and encourage them to access care. At receiving sites, another expert client is waiting to greet them and completes appropriate paperwork in the pre-ART system to enable follow-up. Community expert clients then collaborate with Rural Health Motivators (paid by government) to follow up patients in the community as well as provide health education, adherence and psychosocial support and they also engage in setting up or strengthen existing patient support groups to improve treatment literacy. PEPFAR is currently engaged in an exercise with the MOH to rethink the community health worker program and is providing technical assistance to the program management.

HUMAN RESOURCES FOR HEALTH
USG's overall goal is to create a strengthened public sector, NGO workforce and institutional base sufficient for rapid national scale up of the HIV response and with benefit across the health and social welfare sectors. The PEFPAR program is working to bolster human resources capacity in key areas such as HR management, policy reform, recruitment, retention and training as well as building institutional capacity. Human and institutional capacity building cut across all program areas of the PEPFAR support. USG is providing technical assistance and financial support to assist the GOKS to fast track recruitment to fill vacant posts , and to ensure that positions are filled in sites designated for rapidly scaled up services. Direct support to the MOH facilitates the linkage of HR planning with infrastructure planning and decentralization of service delivery. In 2012/2013, a central focus will be supporting the restructuring of the Department of Social Welfare (DSW) and planning for development of the social welfare workforce, supporting the newly-formed National HR Technical Working Group, institutionalizing the HR Policy and HRH Strategic Plan, and EHCP staffing norms. A model HR Unit is being developed through WHO technical support that is in line with the MOH restructuring supported by an HR Advisor that will be placed in the unit. This will all feed into the consolidated MOH workforce plan, and supporting pre-service training for key cadres of health care and allied professionals.

HEALTH INFRASTRUCTURE
Many of the government owned health facilities in Swaziland are inadequate for current needs. Some are in outright disrepair; others are not designed in a manner that meets the chronic care needs of the current population: waiting areas are too small; infection control needs (windows, ventilation) are unmet; adequate space for consulting rooms, record keeping, point of care laboratories, and waste management facilities are often completely lacking. As a result, patient flow is inefficient and, with the high rates of TB and poor infection control, often dangerous to both patients and staff. While care services for this lifelong disease increases daily, much of Swaziland's health resources remain directed at the requirements of a few decades ago: acute primary health care

aimed at treating simple infections and tertiary care for people who require hospitalization. PEPFAR support in this area will be leveraged with resources from the MOH and other donors like the World Bank, Clinton Foundation and MSF. To coordinate the effort, PEPFAR lobbied successfully for the creation of an Infrastructure and Equipment Technical Working Group which is tasked with establishing standards, assessing needs and determining priority facilities for upgrades. USG is supporting the MOH to make this key transition to the provision of high quality long-term (chronic care) services in all areas of the country. The transition requires attention to each of the WHO's six building blocks for health systems - leadership and governance; health information system; health financing; human resources for health; essential medical products and technologies; and service delivery.

LABORATORY
PEPFAR supports TB/HIV laboratory related activities that aim at: standardizing TB/HIV best laboratory practices and provide associated training; providing for uniform quality assurance measures among laboratories; working with NCLS to standardize equipment (introduce new technologies and equipment), commodities, and supportive maintenance training; and supporting capacity building for a unified approach to procurement and distribution of laboratory commodities. PEPFAR Swaziland strives to ensure an adequate number of clinical laboratories perform quality testing for TB/HIV/AIDS diagnostics and monitoring tests for care and treatment services. We also assist in strengthening referral transport systems for specimens and implement practical and sustainable quality management systems by conducting laboratory management training programs and assisting in the adoption of the WHO Laboratory accreditation scheme (utilizing a stepwise approach for reference and peripheral laboratories).

The lab project activities are linked to the attainment of the National Clinical Laboratory Development plan for July, 2008,-June, 2013, addressing eleven of its Strategic Objectives. PEPFAR's strategy for strengthening laboratory services builds on the following principles: ensuring strong country ownership; integrating project activities within Swaziland's health systems to ensure long-term program sustainability; capacity building through training/mentoring lab staff in quality assurance/quality management on both general lab-related and TB diagnostic services.

PROGRAMMING FOR EFFICIENCIES
In 2012/2013, USG will leverage the assets of globally recognized public health research institutions to build capacity and create valued "space" within key Swazi institutions for evidence-based priority setting and improved planning based on what works best in delivering improved health outcomes. PEPFAR is working with stakeholders to design and implement one or two national costing/cost effectiveness studies that will inform resource allocation across the broader pillars of the national HIV response. Program specific efficiencies studies include a national ART Outcomes and Costing Review, recently commenced by CDC and WHO working together to support the MOH. Additionally, PEPFAR is supporting several costing and evaluation exercises that will be in progress during 2012, including a male circumcision (MC) costing and PMTCT outcome evaluation.

While the current focus of USG research efforts has been on HIV and TB programming, USG will continue to emphasize the building of human and institutional capacity and promote the application of the principles of intervention science to other public health problems. As part of the GHI Country Strategy, USG is currently in discussions with the MOH to establish a center for health intervention science. The proposed mission of the Centre is to provide a capacity-building environment in which applied health evaluation research can be conducted by national institutions, including MOH and NERCHA, with support leveraged from USG partnerships. The Swaziland HIV Incidence Measurement Survey (SHIMS) study provides a cost efficient platform on which to strengthen the country's data utilization and health program evaluation capacity.

USG RESOURCES: In cooperation with national leadership, PEPFAR/Swaziland has committed to programming for public health impact, and has worked diligently to position resources to maximize return on investment. Currently, the program has only one "TBD" mechanism after carrying TBDs in successive COPs while the contracting process was finalized. With 98 percent of activity funding programmed under active implementing partners, the program's financial performance should improve significantly. Also, after extensive pipeline and portfolio reviews, the team identified approximately $4 million in funding that could be redirected for immediate

impact. In line with HQ policy, several implementing partners that have experienced delays in project startup have had COP 2012 funding significantly reduced or deferred entirely to a future COP. The team will continue to prioritize partners' programmatic and financial performance, while recognizing that programs whose core objective is to strengthen national institutions require a higher level of guidance and support from USG staff. The PEPFAR interagency management team is in the process of drafting a Mission-specific policy around 'tripwires' for implementing partner programmatic and financial performance that would trigger an automatic review of funding and targeting.

SUPPLY CHAIN AND LOGISTICS
PEPFAR Swaziland is working to support and strengthen the national health supply chain system to ensure availability of key health commodities in a number of ways. First, we have supported the creation of key national policies and documents on which supply chain is based—the Pharmacy Bill, the Medicines Regulatory Bill, Essential Healthcare Package, Standard Treatment Guidelines, Essential Medicines List, and Essential Laboratory Commodities List. Second, we are supporting the reorganization and capacity building of the Central Medical Stores leadership and staff—including the establishment of the nation's first pharmacy professional training program. Third, PEPFAR Swaziland is actively working with the MOH on a policy that will allow task shifting of some pharmacy tasks to lower level cadres and with local universities to develop training plans for all pharmacy professionals. (Currently Swaziland does not have any pharmacy professional training schools.) Fourth, after a great deal of advocacy on our part, the recent economic crisis and shortage of ART led to the creation of a national Supply Chain TWG that should provide a forum for decision-making related to health commodities. This TWG also serves as a means for coordinating with other donors—each of whom tries to fill gaps in the supply chain that may be left by the MOH. (Of note, 2011 has seen serious gaps in supplies of medicines and laboratory reagents related to the economic crisis. On both counts, PEPFAR has stepped in to help after the government proved that they understood the supply situation in detail, had a plan for addressing current and future shortages, and made a specific request for shortterm support to rebuild buffer stock.) Fifth, PEPFAR is the main actor behind the original introduction and now updating of an electronic medical record and pharmacy system, which provides the data being used by the TWG.

GENDER
A groundbreaking 2007 UNICEF-CDC study documented high rates of sexual violence among girls in Swaziland - one third of girls aged 13-24 experienced sexual violence before the age of 18. Since this study, the GOKS and other stakeholders have worked to strengthen the national response to addressing GBV and considerable progress has been made. However a major barrier to systemic and sustained progress is the slow passage of the Domestic Violence and Sexual Offences Bill.

In late 2010 an assessment was conducted by the (then AED, now FHI 360) LIFT project which identified opportunities for improving the impact of PEPFAR-funded economic strengthening programs for households affected by HIV/AIDS in Swaziland. The results of this assessment informed the development a new integrated project focused on economic strengthening of households affected by HIV/AIDS, particularly those with orphans and vulnerable children and female headed households. This activity also examines the overall enabling environment for women and children, addressing legal frameworks and services as well as access to nutrition, clinical and social services.

The USG team will develop a gender strategy in FY 2012 which will articulate specific priority actions and how gender will be further mainstreamed across all program areas. While an initial analysis was carried out as part of the gender challenge fund planning in 2012, the USG team believes that the program as a whole will benefit from a more detailed gender analysis and strategizing process.

The Gender Focal Point for the team is the USAID Acting Country Director/Impact Mitigation Specialist.

The USG invests substantially in health systems strengthening, particularly in human capacity development for nurses and allied health staff as described elsewhere in the COP. The initiatives are not targeted to females to the

exclusion of men, and all health staff have equal opportunity to participate, but the vast majority of nurses in Swaziland are female and therefore women tend to benefit greatly from such support. The program is acutely aware of the danger of overloading nurses and rural health motivators (also predominately female) with tasks (i.e. as part of task shifting policies), and consequently a strong retention component is being implemented alongside decentralization and task shifting. The Regional Clinical Mentoring Teams approach and mentoring of clinic supervisors are two examples described in detail elsewhere in the COP.

All PEPFAR partners underwent gender mainstreaming training in early 2012 and the USG team will continue to provide TA to partners so that gender is appropriately integrated within all program areas. With regards to gender equality in the provision of health services, a major challenge is the uptake of HIV testing, care and treatment services among men. With the acceleration of the national MC plan, and enhanced strategies to engage men in testing, the expectation is that more men will undergo HIV testing, and with strong referral protocols in place, be linked into care. USG is also assisting health facilities to implement special initiatives such as men's health days, employing male expert clients and adjusting opening hours to fit men's work schedules in order to make services more appealing to men.

Two PEPFAR special initiatives, the PMTCT Acceleration Plan and the PEPFAR Gender Challenge, have afforded the USG with an excellent opportunity to work closely with the GOKS to promote women, girls and gender equality. Additionally, USG prevention/SBCC programs will continue to proactively address harmful gender norms and ensure that mass media, community outreach and interpersonal communication activities facilitate the adoption of more positive gender norms in the workplace and elsewhere. Under the Combination Prevention Program, the National Gender Unit and NERCHA will be supported to mainstream gender in all HIV prevention interventions, through capacity building exercises for GOKS and local partners. A major priority over the coming two years is to support the restructuring of the Department of Social Welfare, and the related Departments (e.g. National Children's Coordination Unit, Gender Unit, Disability Unit) under the Deputy Prime Minister's Office. The exercise is expected to produce a structure that can more effectively respond to the needs of vulnerable populations such as survivors GBV.

USG will continue to collect evidence from ongoing monitoring and evaluation of gender-programs to assess program effectiveness. The gender equitable men (GEM) scale is being used among a small group of partners implementing gender-focused community dialogues, and provided the pilot is positive, it will be scaled up across relevant activities. USG will continue to closely monitor sex-disaggregated program targets and results to ensure that any disparities are identified and that mechanisms are put into place to address them.

Tools such as the draft document Linking PEPFAR's Fight against HIV to Ending Gender Based Violence, and the GHI Supplemental Guidance on Women and Girls and Gender Equality will be used to guide discussions and prioritization. As part of the strategy development process, basic procedures, tools and checklists will be developed for activity managers to promote understanding of and compliance with the gender strategy. Furthermore, assisting key partners to mainstream gender within their programs is expected to be of fundamental importance. Technical assistance from the Gender TWG has already been sought for this activity, which is planned for FY 2012.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	3,229,295	0
Total Technical Area Planned Funding:	**3,229,295**	**0**

Summary:

(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	187,107	0
HMBL	500,000	0
HVAB	547,815	0
HVCT	369,922	0
HVOP	745,815	0
MTCT	187,107	0
Total Technical Area Planned Funding:	**2,537,766**	**0**

Summary:

EPIDEMIC OVERVIEW
Swaziland has a generalized epidemic with all regions affected almost evenly among the population 15 – 49 years. The four regions (Hhohho, Manzini, Shiselweni and Lubombo) have HIV prevalence rates of 28.9%, 24.9%, 23.1% and 26.2% respectively. The high generalized prevalence of HIV across all four regions makes it impossible to prioritize HIV prevention interventions and resources in favor of a particular geographic area.

Twenty-six percent of the adult population is infected with HIV (31.1% among females and 19.7% among males), while prevalence amongst pregnant women attending ante-natal care (ANC) facilities stands at 41 percent. The HIV incidence rate stood at 3% (3% for males and 2% for females) in 2009 and the goal is to reduce it to 2.3% by 2014. Women are disproportionately affected, comprising over 55 percent of all HIV-infected adults. Ninety percent of all new infections occur through heterosexual contact: multiple concurrent partnership (MCP), low and inconsistent condom use, intergenerational sex, income inequality and low levels of male circumcision are seen as the main drivers of the HIV epidemic. In 2007, before the country embarked on accelerating medical male circumcision, the rate of medical male circumcision stood at a mere 8.2 percent among the 15-49 year age group. The country's target is to increase this rate to 80 percent by the end of 2014. Gender inequality, sexual violence and alcohol abuse are also major contributors to the epidemic. Mother-to-child transmission further contributes to new HIV infections, while other minor sources include unprotected anal sexual intercourse and needle-sharing amongst injecting drug users.

A significant percentage of Swazis are mobile. 42 percent of the population was away from home for more than five days each time for 5 times in the past 12 months, mostly for work-related reasons. This oscillatory migration by mobile partners is a significant factor in sexual behaviour and therefore new HIV infections. HIV prevalence levels amongst these short-term mobile partners are more than double the general population prevalence. A regional study confirmed that patterns of risky sexual behaviour differed for men and women who are away from each other, and that there was a need to also focus on the non-travelling partner.

Overall, there is lack of local data on the estimated size of sex workers and injection drug users and the level of HIV prevalence among them. In Swaziland, nine out of ten new HIV infections occur through heterosexual contact. As noted above, minor sources of new adult infections are through anal sexual intercourse and needle-sharing amongst injecting drug users. Only 1 percent of tertiary students reported having tried heroin in 2002. This is not expected to be a major factor influencing transmission. However, current PEPFAR-supported research on sex workers and

MSM will add insights into these populations and inform future programming.

According to the SDHS, twenty-four percent of Swazi males aged 15-48 reported having 2 or more sexual partners in 2006. Among males and females in this age group, more than half of the males (58.2%) and almost half the females (43.9 %) reported sex with non-marital, non-cohabiting partners as well, many without the protection of condoms. Couples in stable relationships are of special interest with 4 percent of women and 18 percent of men in marital or cohabiting relationships reporting higher-risk intercourse. The SDHS showed HIV prevalence higher among urban residents (31%), the employed (32.9%) and the most mobile segments of the population. People who sleep away from home 5 or more times in a year demonstrated HIV prevalence of 36 percent compared with 29 percent among those who do not sleep away from home. Among couples tested in the SDHS, 55 percent were HIV negative; 29 percent HIV-positive and 16 percent discordant. HIV infection among women with higher income levels is slightly lower than HIV infection amongst women with lower income levels. In contrast, men in the same economic position exhibit the highest HIV prevalence within their group.

The recent National SBCC Strategy summarized the behaviors and conditions which represent key factors driving HIV transmission: multiple and concurrent sexual partnerships; low levels of male circumcision; early sexual initiation and late formation of stable relationships; low levels of consistent condom use; age-disparate sexual relationships; income inequality; gender inequality and sexual violence; and mobility and migration. These findings have been echoed in other reports and studies.

Several studies have informed the PEPFAR prevention portfolio in recent years, including the SDHS, the Multiple Indicator Cluster Survey (MICS) as well as the 2008 Modes of Transmission Study. The Modes of Transmission Study underscored the need for HIV prevention programs to transform social norms around sexual concurrency, and highlighted key intervention areas, namely; innovative strategies to improve awareness on dangers of MCPs and empowering the girl child and women and engaging men and traditional structures in reducing violence against women. The low prevalence of medical male circumcision (from SDHS) and high prevalence of HIV has been used to support the scaling up of voluntary medical male circumcision. The MICS study also found out that there are low rates of condom use. This information has resulted in the strengthening of messaging around proper and consistent condom use in the country. The constellation of all these factors in the continued spread of HIV/AIDS has resulted in Swaziland adopting a mix of combination (biomedical and behavioral) interventions. Swaziland intends to conduct more of these assessments to assess the effectiveness of these combination prevention programs.

Building upon the existing knowledge base, and recognizing the need for more robust data, the PEPFAR team has several important studies underway. PEPFAR has recently completed the initial phase of a groundbreaking evaluation of HIV incidence trends - the Swaziland HIV Incidence Measurement Survey (SHIMS). SHIMS will evaluate the impact of male circumcision and broader HIV combination prevention efforts, using "real world" conditions. Another important prevention-related SI effort is a current study which examines the social and structural factors associated with HIV-related risk behaviors and prevalence among MARPS. The goal of this study is to provide a comprehensive set of data that can be used by municipal and national governments in Swaziland to design evidence-based HIV prevention programs for MARP populations. In addition, PEPFAR is supporting the development of a national PMTCT impact evaluation study.

Major accomplishments include the development of the National SBCC strategy, the MC Accelerated Saturation Initiative, a successful pilot of home-based HIV testing, and the establishment of an expanded provider initiated testing and counseling. With assistance from PEPFAR, the Swaziland government has been able to expand PMTCT services to all the eligible government facilities the past financial year.

In 2012, the PEPFAR prevention portfolio will enter its fourth year of using a combination prevention approach to achieve the goals laid out within the Partnership Framework (PF) on HIV and AIDS (2009-2013). Priority will be given to high impact HIV prevention interventions as outlined in the new PEPFAR prevention guidance. The adoption of a combination prevention approach (tying behavioral interventions to biomedical interventions) improves the efficiency of the national HIV prevention strategy, thereby increasing the returns on USG investments

in the country. In 2012, PEPFAR Swaziland will continue strengthening comprehensive and evidence-based prevention strategies and support the harmonization of biomedical, clinic-based and community-level prevention campaigns. PEPFAR will strengthen the coordination of social and behavioral activities with structural and biomedical interventions in order to create a cohesive program that effectively decreases the incidence of HIV in the general population. Prevention partners in Swaziland have developed a strong network of linkages to encourage the "cross-fertilization" of prevention messages and to improve the effectiveness of their respective programs. PEPFAR through its partners will continue to assist in the creation of an enabling policy and political environment that encourages local leadership for HIV prevention efforts.
The NSF identifies 22 priority outcomes for prevention and prioritizes five interventions to move the national response towards the national goal. The priorities are: 1) Increased comprehensive knowledge of HIV and AIDS; 2) Reduced numbers of concurrent partners among the sexually active population; 3)
Increased reach, scope and coverage of PMTCT services; 4) Increased circumcision of HIV negative males, with special attention to infants and males aged 15-24 years and 5) Integration of prevention programs targeting key populations at risk (migrants populations, sex workers and girls).

The NSF, along with other key Government of Swaziland (GOKS) documents (Swaziland National Prevention Policy, SBCC Strategy, national VMMC plan, and the National Strategic Framework for Accelerated Action towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive) are key in informing and directing PEPFAR's HIV intervention efforts in Swaziland. Collaboration with other partners working on HIV prevention (UN agencies, CHAI, World Bank and MSF) is one of PEPFAR's key priorities as it maximizes our core strengths.

PMTCT
Please refer to the Swaziland PMTCT Acceleration Plan.

HIV TESTING AND COUNSELING
HIV prevalence rates are similar across all four major regions in Swaziland; PEPFAR therefore supports HIV testing and counseling (HTC) services in equal proportions across these regions. In Swaziland, studies have shown that men are less likely to know their HIV status than are women; recent strategies have therefore focused on encouraging more men to test. The ongoing MC campaign, for example, has provided an opportunity for more men to get tested. Swaziland has a very high prevalence rate of HIV among TB patients and pregnant women (82% and 42%, respectively). As such, much effort has gone into integrating HTC into routine TB and ANC services, resulting in more than 90 percent of both groups being tested for HIV annually. This has helped to increase the number of pregnant women who are eligible for ART initiation at the ANC. Currently, about 52 percent of pregnant women in need of HAART and 55 percent of HIV/TB co-infected patients eligible for treatment are receiving this therapy. With the introduction of the Nurse-led ART initiation in Swaziland (NARTIS) at ANC and TB clinics, and ongoing scale up, PEPFAR will be capitalizing on improved efficiencies and this figure is set to further improve.

The MOH's Prevention Technical Working Group (TWG), working in partnership with the Swaziland National AIDS Program (SNAP), sets annual HTC targets and priorities to guide partner support. The group meets to review these targets, discuss implementation strategies and the progress of activities. Since the major entry point of clients to prevention, care and treatment services is HTC, in FY12 PEPFAR will prioritize and support the scale up of HTC programs. PEPFAR will scale-up the provision of home-based HTC in hard-to-reach communities as well as the implementation of provider-initiated HTC services at all levels of national public health facilities. Together, these activities aim to strengthen and further scale-up the accessibility of HTC services, making HTC available in every health facility and, through outreach, to every community. In addition to enhancing HTC coverage and quality, the programs focus on linkages to care/treatment, laboratory diagnostics, and sustainability.

Provider-initiated HIV Testing and Counseling (PIHTC) efforts will focus on HTC at primary care settings, including clinics and PHUs, as the entry point for individuals to access HIV services. Expanding HTC to all service points, particularly STI, TB, inpatient and outpatient department clinics, and expansion of routine screening of child

and mother health cards, will significantly reduce missed opportunities for HTC and subsequent care and treatment services. PEPFAR will bring HTC services into the community through door-to-door-testing, HTC outreach activities including for MARPS, and support for VCT centers. In addition, PEPFAR will expand the availability and accessibility of HTC services in the workplace.

PEPFAR will strengthen referrals and linkages of patients and clients to HIV and other services through a variety of efforts. PEPFAR partners are also assisting the MOH in the creation of referral and linkage-to-care Standard Operating Procedures (SOP) for all patients who test HIV positive. A text message system is being piloted as a technique for tracking the success of clients who test positive at HTC sites in linking to care. Community health nurses and community expert clients have been introduced to help with tracking patients who do not get linked into care or who are lost to follow up. Other activities include mapping available complementary prevention, treatment, and care services; supporting the development and implementation of national referral and linkage guidelines; and improving the quality post-test counseling through training and mentorship.

CONDOMS
In Swaziland, condom supply and distribution is managed by UNFPA and PEPFAR partners. There is little variation in condom availability (both geographic coverage and penetration rate) between regions, which are all close to the national average of 42 percent. The national target was to increase the proportion of local outlets (including outlets at community level) that offer condoms to 50 percent in 2011. As part of condom programming efforts, PEPFAR will support the implementation of the national condom strategy, and collaborate with UNFPA and the Sexual and Reproductive Health Unit (SRHU) to support NGO and community level condom logistics and distribution.

The Swaziland condom program is targeted at improving uptake among the general population and people at higher risk of HIV exposure, especially women and the MARPs. Through a number of traditional structures (Royalty, Chiefs and traditional organizations), PEPFAR-Swaziland will work to address gender and cultural norms limiting access of these populations to male and female condoms and related information. In FY12, emphasis within PEPFAR's care and treatment programs will be placed on the promotion of condoms and their correct and consistent use. PEPFAR will also prioritize the integration of condom distribution in reproductive health and family planning facilities in order to further reduce patients' risk of HIV infection/transmission.

Challenges hindering the efficient distribution of condoms in Swaziland include: inefficiencies in the current national distribution system, insufficient penetration in non-traditional outlets, low condom availability in certain areas, periodic stock outs and ineffective use of data to inform condom supply and distribution. The establishment of a national Condom TWG to oversee the policy and programmatic aspect of condom procurement and distribution in Swaziland was an important initiative to address these challenges. The Swaziland program intends to increase condom availability through eliminating stock-outs and improving the national supply chain management and distribution of both the female and male condoms. Furthermore, private-public partnerships with breweries (Swaziland Beverages) and bakeries (Swaziland United Bakeries) are being explored to assist in the distribution of condoms to non-traditional outlets.

PEPFAR, through its partners, will strengthen national capacity – through the national Condom TWG - to ensure that quality male and female condoms are available, accessible, acceptable, affordable, and efficiently distributed to outlets in rural and urban areas. PEPFAR partners have started rebranding the male condom in order to increase uptake in the country. Many men have been shunning the free issue condoms as they were not as appealing as the commercial ones. PEPFAR will increase the reach of its pilot female condom through targeting hair salons and increasing its uptake in workplaces and tertiary institutions.

MEDICAL MALE CIRCUMCISION
In 2007, PEPFAR supported the GOKS in the development and implementation of a national male circumcision (MC) scale-up plan which led to the circumcision of over 25,000 men in Swaziland between 2008 and 2010. In 2010, the GOKS revised this plan to accelerate the scale-up of services and expanded its target to reach 80 percent

of 15-49 year old men within a one-year period with male circumcision services (approximately 152,000 MCs).

With funding from OGAC and collaboration from the MC TWG, and launched in February 2011, the Accelerated Saturation Initiative (ASI/Soka Uncobe) was launched to provide a comprehensive package of HIV prevention, care and treatment services centered on MC as the entry point to services. Some successes from the ASI program include: development and implementation of an adverse event management system and monitoring electronic system; design and implementation of a supply chain management system; training of a significant number of nurses; and high levels of awareness of a recognized brand. However, despite significant funding and efforts, ASI results remained less than anticipated, with demand for MC services low.

PEPFAR, with close support from OGAC and the MC TWG, is working hand-in-hand with GOKS and partners to assess successes and challenges with ASI, and determine appropriate next steps. A visit from OGAC and the MC TWG in November 2011 provided an opportunity to conduct meetings with GOKS and partners; and to brainstorm next steps for MC programming in Swaziland. Moving forward, PSI, through the Combination Prevention Program (CPP) will work closely with Futures Group to ensure a smooth transition from ASI (ending March 2012) to the CPP program. PEPFAR and partners will work closely with MOH and NERCHA to ensure GOKS enhanced ownership of the program, and assess ways for providing funds to GOKS for MC program aspects.

In FY12, CPP will continue supporting the provision of safe and effective adult and neonatal MC services. CPP will capitalize on the systems put in place by ASI to respond to demand created by campaign activities while also building the capacity of hospitals and health centers to continue to offer adult and neonatal MC as integrated health services.. CPP will collaborate closely with the GOKS to implement targeted VMMC campaign activities that complement service integration and support a comprehensive approach to achieving the GOKS' MC national goal as outlined in the National Strategic Framework.

The campaign nature of the ASI program in Swaziland warranted the establishment of dedicated MC sites within (or away) from public health facilities. Because of the nature of the MC program during FY11, there were minimal refurbishments of government health facilities during this period. However, the current re-strategizing plan will see the delivery of a more integrated MC program within public health facilities. Based on the final outcome of these deliberations, PEPFAR-Swaziland will consider supporting public health facility renovations in sites where dedicated staff and space for MC is provided. In a bid to improve efficiencies in the implementation of the MC program, CPP scaled down VMMC services from the average of 18 sites maintained during ASI to 5 permanent sites, spread across four regions in Swaziland. In addition, the size of each clinical team was scaled back from 17 to 5 total staff on average. Outreach teams will be established in each region (4 in total) to provide mobile outreach services that are more flexible and responsive to actual demand.

POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP)
To date, PHDP programs have been weak and HIV prevention services targeting PLHIV limited to condom and adherence education integrated within routine care. In recognition of this, PEPFAR is working to promote couples counseling and undertaking a PHDP technical review to identify gaps and prioritize interventions. In FY12, PEPFAR will advocate for the development of a national PHDP strategy, which emphasizes the role of PLHIV in HIV prevention efforts and includes both community-and facility-based interventions. Based on the findings of the technical review, PEPFAR partners will work to ensure comprehensive PHDP services are more systematically integrated into routine HIV care within health facilities and community linkages activities. This includes couples HIV testing and counseling; treatment as prevention for discordant couples; identification and prevention education for discordant couples; condom promotion; reducing unintended pregnancies; early identification and treatment of STIs; and nutrition counseling and collaboration with the World Food Program on food per prescription.

PEPFAR will work with the MOH to create specific curricula to address the different needs patients, including adherence, risk reduction, active condom distribution and STI management. PEPFAR will continue to provide technical assistance in a new pilot program that integrates family planning/safer pregnancy counseling activities

into HIV care services. To address the needs of discordant couples, PEPFAR will work with the MOH and other development partners to capitalize on the high local interest in "treatment as prevention". By emphasizing the value of a high coverage of testing in multiple settings (community-based, facility-based, couples testing) followed by strong programs in linkage and retention, PEPFAR hopes to protect discordant couples without being hindered by the complicated issue of defining what a "couple" is in the Swazi context.

MARPS
In FY12, PEPFAR will continue supporting local organizations to roll out activities under the national SBCC strategy. The results of the forthcoming MARPS behavioral survey for Sex Workers and MSM (see above) will inform future programming, including selection of specific target groups for activity expansion. New evidence-based behavioral change activities targeted to reach the general population and MARPs will be designed, coordinated and disseminated in order to achieve maximum results. PEPFAR, through its partners, will continue to work with MSM, SWs and transport operators as key target audiences. Peer education programs targeting MARPs will be used and their activities monitored in conjunction with other programs to increase the services provided to these populations. Activities will include mobile outreach, socially marketed and public sector condom distribution, and linkages and referrals to key health services. Partners will also work with the GOKS to develop a minimum package of services for MARP populations. Minimal effort will be placed on IDUs, due to their low prevalence. A Behavioural Surveillance Survey carried out in 2002 revealed that only 1% of tertiary students in Swaziland reported having tried heroin.

The ongoing MARPS research will enable PEPFAR to have a better picture of how HIV-positive MARPS are accessing services. The results from this study will provide useful program inputs for strengthen prevention programs' linkages of MARPS to appropriate, accessible and friendly HIV prevention, care and treatment services. Key to programming will be advocacy with government, civil society and health care providers to develop appropriate support policies and address barriers for MARPS-friendly services.

GENERAL POPULATION
As one of the PF pillars, sexual prevention is a priority within the PEPFAR program. The National Multisectoral Strategic Framework 2009-2013 emphasizes the need to reduce multiple concurrent sexual partnering (MCP), along with improved access to services for sexually transmitted infections (STIs), post-exposure prophylaxis (PEP), and HIV counseling and testing (HTC) for the adult general population. Through the PFIP, PEPFAR has successfully collaborated with SNAP and NERCHA to reconstitute the national HIV prevention TWG. This key achievement has resulted in the approval of key national prevention guideline documents. The TWG has also been instrumental in setting the national prevention agenda in Swaziland.

In FY12, PEPFAR sexual prevention activities will focus on: 1) creating an enabling policy and political environment through which leadership for HIV prevention efforts will ensure successful programmatic activities; and 2) supporting the expansion and coordination of evidence-based behavioral interventions which reduce the risk of HIV infection and enhance protective behaviors in the general population. As part of a Combination Prevention approach, sexual prevention activities will be integrated with MC and HTC efforts to improve efficiency and cost-effectiveness.

Due to the generalized nature of the HIV/AIDS epidemic in Swaziland, HIV prevention strategies consist of a mix of interventions targeting the general population countrywide. Given current evidence suggesting that behavioral interventions are crucial in supporting biomedical interventions, PEPFAR has adopted a combination prevention approach to slow down the spread of HIV. Since HTC is an important entry point for both HIV prevention and care and treatment services, PEPFAR Swaziland will scale-up facility and community-based HTC programs in FY 12. The scale-up will further strengthen and improve accessibility of HTC services in the country. Furthermore, it is envisaged that the structural/policy pillar of the combination prevention approach will continue creating an enabling platform on which both the biomedical and behavioral interventions are anchored. VMMC, condom and behavioral programs will continue receiving special attention in order to reduce new infections in the general adult population in Swaziland. PEPFAR intends to carry out rigorous evaluation of this strategic mix of HIV prevention

interventions in the near future through impact evaluation, Lot Quality Assurance Sampling (LQAS), service and/or data quality assessments.

Crucially, PEPFAR partners will work to improve comprehensive knowledge of HIV prevention and reduce risky behaviors within the general population. This will be done through a variety of means including the provision of training and technical assistance to local organizations to improve SBCC programming, linking behavior change programs with the promotion of correct and consistent condom use, strengthening programs to reach youth with HIV prevention messages, and a renewed focus on addressing MCP through the "Choose One" campaign. Programs will strengthen their community mobilization components, ensuring the harmonization of messages at all levels. Strong monitoring and evaluation components will ensure that programs are having the intended impact and outcome.

PEPFAR, through its partners, has been offering school-based HIV prevention programs, though on a low scale, through the "Super Buddies" program. The "Super Buddies" visit different schools where they teach on HIV prevention issues. PEPFAR plans to collaborate and coordinate with other stakeholder in order to improve the coverage of the "Super Buddies" program. Through the assistance of UNICEF, the GOKS is developing an HIV prevention curriculum to be used in schools upon completion in early 2012. PEPFAR, through its partners will work with UNICEF and the Ministry of Education to ensure that the curriculum articulates all relevant issues including gender and VMMC issues before it is disseminated. PEPFAR will also ensure that the national HIV prevention curriculum is aligned with the Swaziland National Prevention Policy. Behavior change activities will specifically target youth in the 10-14 and 15-18 year age groups. Through its partners, PEPFAR will continue to assist the GOKS in providing life skills training for teenage boys and girls in schools. However, out-of-school youth in Swaziland remain underserved in HIV education; PEPFAR will work with other donors and implementing partners to address this gap.

A key focus will be to strengthen the Prevention TWG to lead and coordinate the finalization and implementation of the national SBCC strategy/HIV prevention policy and operational plan. Champions will be identified to serve as spokespersons for key HIV prevention issues and engage with cultural leaders and the media. PEPFAR will work with NERCHA to ensure implementation of the national action plan and continue to strengthen the Prevention TWG. Furthermore, PEPFAR will work with the national prevention TWG to ensure HIV prevention priorities guide development of national HIV prevention minimum packages.

HEALTH SYSTEMS STRENGTHENING/HUMAN RESOURCES FOR HEALTH
In FY12, PEPFAR will work with stakeholders to ensure that the draft Swaziland National Prevention Policy is finalized - the first such document for Swaziland. PEPFAR, through its partners, will facilitate the adoption, printing and dissemination of the policy. Key local leaders and politicians will receive orientation on the policy to ensure their support and active role in translating the policy into local action. Parliament will be engaged and encouraged to lobby for these new HIV prevention policies.

PEPFAR will also support the MOH in the streamlining of different health care cadres. This approach will ensure that there are clear job descriptions and a uniform incentive system for all health care workers. As part of this approach, the MOH is developing a task shifting framework that will more clearly define the specific functions of health workers (e.g. the definitions of professional versus support staff). PEPFAR is advocating for task-shifting in new areas such as neonatal MC and nurse-initiated ART. In addition, PEPFAR partners are working to increase the role of volunteers (paid or otherwise) through initiatives such as expert clients and Mothers to Mothers. Please see Capacity Building section for information on how PEPFAR is building the capacity of local NGOs.

MEDICAL TRANSMISSION
The prevention of medical transmission is addressed across the portfolio. At the policy level, PEPFAR partners have worked with their MOH counterparts to produce key documents - Clinical Guidelines for Blood Transfusion; TB Infection, Prevention and Control Guidelines; and Infection Control and Health Care Waste Management guidelines. These guidelines include recommendations for vaccinations like Hepatitis B and PEP, the

implementation of which is supported as a MOH initiative. PEPFAR has built the capacity of the national Infection Control Technical Working Group, created a cadre of infection, prevention and control (IPC) trainers that work in rural areas, piloted IPC committees at certain facilities, and worked with the Environmental Health unit to initiate the first national Health Care Waste Management Stakeholders Conference. The most successful of these pilot interventions will be adopted and expanded by the national TWG. On the infrastructure side, PEPFAR has made substantial contributions, purchasing and installing incinerators and doing minor renovations in the National Reference Laboratory.

In FY12, PEPFAR will continue to support the Swaziland National Blood Transfusion (SNBTS) in line with its Strategic Plan, which will have cross-cutting benefits for several PEPFAR programs. A fully capacitated SNBTS will provide at least 18,000 units of safe blood per annum to the health service. The establishment of a nationally-coordinated blood transfusion service, collection of blood from voluntary non-remunerated blood donors from low-risk populations, as well as testing of all donated blood for HIV, including screening for transfusion-transmissible infections, blood grouping and compatibility testing, are all critical elements of a successful program. PEPFAR will continue working with the SNBTS to develop a set of quantitative indicators modeled after WHO standards.

GENDER
PEPFAR recognizes the critical importance of addressing issues of gender inequality as a critical approach to HIV prevention. The program focuses its gender activities around the five PEPFAR gender strategies: 1) Increasing gender equity in HIV/AIDS programs and services; 2) Reducing violence and coercion; 3) Addressing male norms and behaviors; 4) Increasing women's legal protection; and 5) Increasing women's access to income and productive resources. Since the signing of the PF, PEPFAR has made considerable progress in mainstreaming gender throughout all pillar areas. For example, current PEPFAR support includes: secondary education for vulnerable girls in programs that include psychosocial support; roll out of the National SBCC Strategy which includes key gender-based messages; involvement of women in the scale up of MC; male engagement strategies; support and legal aid services for survivors of GBV; women-focused savings and lending groups; and community dialogues which address norms and behaviors that make women and girls vulnerable to HIV.

USG plans to develop a gender strategy which will articulate specific priority actions and how gender will be further mainstreamed across all program areas. Implementing partners will be provided with training to ensure that gender is appropriately mainstreamed in existing work plans and in all new activities. In FY12, with supplementary funding awarded from the OGAC Gender Challenge Fund, PEPFAR will award a new Community-based Livelihoods Development (C-BLD) program to specifically address the fundamental causes of young women's vulnerability to HIV infection in Swaziland: poverty and gender inequality. C-BLD is based on findings from the PEPFAR-funded Livelihoods and Food Security Technical Assistance Project which assessed opportunities for improving the impact of PEPFAR-funded economic strengthening programs for people living with and affected by HIV/AIDS.

Through implementation of the PMTCT Acceleration Plan, life saving interventions targeting mothers and infants will be scaled up in order to reduce HIV transmission to women and infants and reduce maternal and infant mortality. PEPFAR prevention/SBCC programs will continue to proactively address harmful gender norms and ensure that mass media, community outreach and interpersonal communication activities facilitate the adoption of more positive gender norms. With the acceleration of the national MC plan, and enhanced strategies to engage men in testing, the expectation is that more men will undergo HIV testing, and with strong referral protocols in place, be linked into care. Health facilities are beginning special initiatives such as men's health days, employing male expert clients and adjusting opening hours to fit men's work schedules in order to make services more appealing to men. At the policy level, the National Gender Unit and NERCHA will be supported to mainstream gender in all HIV prevention interventions, through capacity building exercises for GOKS and local partners. Finally, USG activities will strengthen supporting the delivery of care, support and legal aid services for survivors of GBV, advocacy and GBV prevention activities, and technical assistance for the implementation of PEP for survivors of GBV.

PEPFAR will continue to collect evidence from ongoing monitoring and evaluation of gender-programs to assess program effectiveness. The gender equitable men (GEM) scale will be piloted among a small group of partners implementing gender-focused community dialogues, and provided the pilot is positive, scaled up across relevant activities. USG will continue to closely monitor sex-disaggregated program targets and results to ensure that any disparities are identified and that mechanisms are put into place to address them.

STRATEGIC INFORMATION
There is a severe shortage of personnel in the country who are trained in the management and use of strategic information (SI) critical for monitoring and responding to epidemic. Although the MOH currently houses a Strategic Information Department (SID), a lack of clarity in its role and management structure have impeded the hiring of a sufficient number of qualified senior staff members and the effectiveness of its overall planning and budgeting processes. In order to address these challenges, PEPFAR is supporting the MOH and its partners in a number of key SI target areas. Central among these targets is the development of a decentralized health management information systems (HMIS) and patient MIS (ART, chronic care) system to improve patient follow up and overall site and program management. PEPFAR is ensuring that the various elements of HMIS, driven by different partners and regional sites, are integrated within the MOH's overall framework. PEPFAR has further identified a number of specific SI strengthening interventions to address current gaps in both infrastructure and HR. For example, support for program evaluations will target areas of linkage to care, ART program outcomes, costing and PMTCT to build capacity and enhance the culture of data use for program improvement.

Through its implementing partners, PEPFAR will work with the national Prevention TWG to identify existing and planned behavioral research in Swaziland and to identify research gaps. PEPFAR partners will work with the Prevention TWG and MOH SID to establish a coordinated agenda for HIV prevention activities; the M&E unit at NERCHA will be assisted to improve the Swaziland HIV/AIDS Program Monitoring System (SHAPMoS) data collection tools and reporting flow. PEPFAR will continue supporting and strengthening MOH's ability to conduct HIV prevention surveillance and surveys - for example, PEPFAR is currently providing technical assistance for an ongoing PMTCT impact evaluation study in Swaziland.

CAPACITY BUILDING
Severely limited human and institutional capacity is a major constraint to scaling up the HIV response in Swaziland. The number and skill level of the current health and social welfare work force is inadequate, as are the management of human resource capabilities. Public sector institutions and local NGOs lack the organizational, financial and technical wherewithal to manage rapidly scaled up programs and services. Through the PFIP, PEPFAR continues to be a lead partner with GOKS in responding to these challenges. In FY12, PEPFAR will build the capacity of MOH staff in HIV prevention, as well as provide ongoing support and technical assistance to the CCM, SNAP, and NERCHA in a wide range of areas.

PEPFAR through its implementing partners provides a range of capacity building efforts to local NGOs implementing both PEPFAR and GFATM resources. Initiatives aim to strengthen local NGOs in umbrella grant management, provide technical assistance to local NGOs to deliver quality HIV/AIDS services in the community, and train/mentor GFATM civil society recipients. In FY12 PEPFAR will, through SNAP, develop a capacity building plan for behavioural, biomedical and structural interventions to target policy makers, doctors, nurses and lower health cadres; this capacity building plan will be shared with key stakeholders for resource mobilization and cost sharing. Local NGOs will be strengthened to deliver quality SBCC interventions and ensure implementation of national HIV prevention strategies. PEPFAR will work closely with NERCHA in disseminating and training partners to use the recently launched HIV prevention toolkit; implementing partners will redouble efforts to strengthen the capacity of community level workers to deliver HIV prevention programs. PEPFAR will further strengthen pre-service and in-service training of different health care cadres in order to maintain high quality standards of care as the host country takes a greater role in leading and managing the HIV/AIDS response. PMTCT and HTC partners will continue to build the capacity of the MOH to lead the national response, and work with local organization and facilities to strengthen service delivery.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	59,961	
HTXS	3,144,828	0
PDTX	1,687,312	0
Total Technical Area Planned Funding:	**4,892,101**	**0**

Summary:

INTRODUCTION

The success of PEPFAR Swaziland's work in improving health care facilities has been based on two programmatic cornerstones: (1) decentralizing to increase the access of rural populations to care; and (2) establishing sustainable mentorship systems to enable healthcare workers to provide quality care. We have achieved good success in decentralization in the past few years, alleviating overcrowding in the major hospitals by establishing ART services in more than 75% of the country's rural primary health clinics. In order to ensure the long- term success of these decentralization efforts, PEPFAR will assist the MOH in developing and institutionalizing systems of quality management.

In 2012/2013, while continuing to decentralize, we will focus on the second objective of establishing sustainable mentorship systems, PEPFAR Swaziland, working through its implementing partners, has established Regional Clinical Mentoring Teams (RCMT). These teams of health professionals were established in collaboration with the MOH as sub-committees to pre-existing Regional Health Management Teams (RHMT). Previously, the RHMT did not provide any clinical mentoring to health care providers. The main role of the RCMT is to fill this gap, providing on-site clinical mentoring to all health facilities in the regions as well as leadership for decentralization of HIV and TB services. The approach for such decentralization will focus on the task-shifting of ART initiation from doctors to nurses and the mentoring of clinic supervisors on facilitative supervision processes which, for the short term, will require a great deal of active support from PEPFAR partners and the RCMT.

The long term goal is for the RCMT quality improvement and mentoring activities to be adopted as a core MOH activity. To improve the likelihood of this outcome, PEPFAR has ensured that Swazi nationals are prioritized for recruitment as RCMT members where possible, their salaries are supported through a sub-award to a parastatal agency (NERCHA); and that the recruitment process is led by the Chief Nursing Officer. It is expected that responsibility for direct mentorship of the facilities will eventually pass from the PEPFAR mentoring teams to the RCMTs.

PEPFAR Swaziland is working to strengthen administrative, planning and financial management skills of the RHMT in preparation for their enhanced role in management and mentorship. The vision is to ensure that the RHMTs can prioritize and manage their own program activities, including the RCMTs, in a financially prudent manner. PEPFAR is also working with the MOH Planning Unit and Quality Assurance Program to create a regular forum at which the RHMTs will meet together with the central MOH leadership and be held accountable for setting and reaching standards of work.

To support these quality improvement and decentralization efforts, PEPFAR has engaged in another key effort: active coordination of CDC and USAID implementing partners whose work overlaps within facilities. Once a month, eight organizations with varying responsibilities related to HIV care and treatment, PMTCT, TB, laboratory,

pharmacy, health information systems, infection control and nutrition come together to coordinate their activities in policy and mentoring support to best support the above objectives.

At the national level, PEPFAR and its partners support coordination, development of policies, guidelines and standards through the respective technical working groups. The partners have also developed a web-based technical activity log that will serve as a tool for planning, documenting, follow up and coordination of on-site technical activities by all stakeholders, including MOH partners like the RCMTs.

ADULT TREATMENT

ACCESS AND INTEGRATION

GUIDELINE REVISION AND IMPLEMENTATION
Swaziland updated its national treatment guidelines in 2010. The CD4 threshold for initiation is now <350 cells/mm3 and the first line regimen is TDF/3TC/EFV. Treatment is currently being provided at all 11 of the country's largest health facilities and 95 of 138 prioritized government clinics in the country. The number of clinics offering ART services is increasing daily with the recent introduction of the Nurse-led ART Initiation in Swaziland (NARTIS) program. The new guidelines have already been introduced nationwide and their progress is being monitored through the national HMIS system that reports ARV regimens, CD4 count and other baseline information at initiation of treatment. The HMIS system is queried quarterly by the MOH Strategic Information Department (SID) and the results are discussed at a National Semi-annual ART Review (NASAR) meeting hosted by the Swaziland National AIDS Program (SNAP) with PEPFAR support. At these meetings, all of the major ART centers in the country present their performance, including that of their satellite sites, from previous six months of work. The aim is to improve quality by sharing best practices, innovations and key achievements.

PLAN FOR SCALE-UP
Currently there are slightly more than 70,000 people on ART in Swaziland. Based on the best data available at this time, this figure represents about 70% of those in need given a treatment threshold of CD4< 350 cells/mm3. We anticipate that the country will reach 80% coverage (~80,000 people on ART) by the end of 2012, a feat which will require significant commitments from the government to cover needed medical and laboratory commodities.

The Government of the Kingdom of Swaziland (GKOS) committed to independently fund the national supply of antiretroviral (ARV) medications in 2010 (Global Fund had supported most of the cost since scale up began in 2005). However, as a result of the current fiscal crisis, the GKOS requested that PEPFAR augment the ARV supplies in September, 2011with a $7million contribution from the Emergency Commodity Fund. It is planned (and agreed to by the Prime Minister and the Ministry of Finance) that this one-time donation will give the GKOS an opportunity to recover from the immediate effects of the fiscal crisis and achieve its stated priority to "ring fence" ARV funding within the national budget.

Unfortunately, laboratory commodities have not been similarly ring-fenced. As a result, PEPFAR partners are working closely with the GKOS' National Laboratory to reconsider existing guidelines on frequency of routine testing. New leadership in the Laboratory is also working closely with PEPFAR partners to establish improved supply chain systems.

INTEGRATION OF TREATMENT SERVICES WITH PREVENTION, CARE, TB/HIV AND MCH/PRIMARY CARE
There is great momentum towards integration of prevention, care and treatment services in Swaziland. Key prevention activities such as male circumcision, PMTCT, and HTC now feature a standard operating procedure (SOP) for linking those who test positive for HIV to care. The SOP includes a provision for newly diagnosed HIV clients to be actively linked to care with the assistance of immediate post-test counseling at the HTC site by a trained "expert client" (someone on ART who models good behavior). Patients are then referred to HIV care beginning with a newly implemented pre-ART program in which patient information is managed using appointment books, a pre-ART register and an individualized chronic care files. If a patient misses any appointment (including

the first), it is planned that a second "expert client" stationed at the care site will actively trace this patient using SMS, phone or home visits. This SOP is in final stages of completion, but has already been partially rolled out to a pilot group of sites. It will be the focus of a great deal of support in the coming years, and its impact will be monitored through the addition of a new set of referral and linkages indicators to the HMIS.

PEPFAR is working closely with the MOH and other partners on a TB/HIV decentralization plan with the goal of providing universal access to diagnosis, initiation and ongoing care services for TB and HIV in Swaziland. New 3Is guidelines (infection control, ICF and IPT) have recently been completed and call for the creation of infection control committees at all public health facilities and for renovations at some facilities. These new guidelines are in various stages of rollout, with 75% of all HIV patients currently being screened for TB on each visit to a facility and IPT being actively implemented in the country. (Please see the Care TAN for detail on TB/HIV integration.)

The integration of HIV within MCH and primary care settings is also an ongoing process. Since 41% of all pregnant mothers in Swaziland are HIV+, HIV testing and PMTCT services have been well-integrated into antenatal care. Integrating Family Planning is an ongoing priority. (See the Prevention TAN for more detail.) PEPFAR has successfully supported a high rate of ARV prophylaxis uptake among HIV+ pregnant women; however, the challenge now is to ensure that these women subsequently enroll in HIV care and initiate ART when eligible. Qualitative studies are underway to examine reasons why pregnant HIV+ women refuse care, and PEPFAR is planning a pilot of "Option B+" (using PMTCT Acceleration Funds) as a strategy for improving uptake. The NARTIS program will be a key component of this pilot and also serve to link general HIV care to MCH and primary care settings in the most rural facilities in the country.

QUALITY AND OVERSIGHT

ENSURING THE QUALITY OF TREATMENT PROGRAMS
As noted in the "guideline revision and implementation" section above, the quality of treatment programs is ensured through review of data collected by the HMIS on individual patients. This review occurs at multiple levels. At the facility level, PEPFAR-supported MOH employees (the RCMTs described above) provide regular clinical mentoring through in-service trainings and evidence-based (data driven) quality improvement exercises. At the treatment cluster level (mother facility + satellites), data is aggregated for presentation at semi-annual ART review meetings where best practices are shared and a spirit of friendly competition motivates the doctors-in-charge to improve their performance before the next meeting. At the national level, the MOH Strategic Information Department aggregates all of the data within an electronic database that serves as the source for quarterly and annual reports. In addition, CDC and WHO are working together to support the MOH in conducting an ART Outcomes and Costing Review which commenced at the end of 2011.

TREATMENT FAILURE
Treatment failure is handled on a case-by-case basis by individual ART doctors who are encouraged to discuss cases with a multidisciplinary team which focuses first on adherence issues. While the laboratory has the equipment for testing viral loads, its function has been severely limited by a shortage in the supply of reagent necessary for performing these tests. As a result, viral load testing is rarely conducted in Swaziland and determination of treatment failure is based on clinical judgment and CD4 testing, despite the treatment guidelines' provision for the use of viral load testing to confirm treatment failure where it is available. Nurses initiating ART in the NARTIS program are required to work with a physician before prescribing a change to second line treatment. Currently 3.5% of all patients on ART are on second line treatment.

Two different studies are underway to assess the degree of drug resistance in Swaziland. First there is a WHO-supported drug resistance early warning indicator study, based on data collected at sentinel facilities from current ART patients. This study is being complemented by a second study of resistant virus among incident HIV cases identified during the Swaziland HIV Incidence Measurement Survey (SHIMS). Results are expected to be released from these studies in mid-2012 and programmatic changes will be made accordingly. There is also an ongoing HIVDR surveillance with support from WHO that conducts genotypic drug resistance testing on patients in

care at the major ART facilities.

PHARMACOVIGILANCE
PEPFAR has introduced a pilot program to establish Pharmacy Therapeutic Committees at three hospitals in Swaziland. It is expected that these committees (and others that may be initiated in the future) will help improve recording, reporting and coordinate the tracking of ARV-related adverse events as part of pharmacovigilance activities at the facility level. The MOH identified a representative to lead pharmacovigilance activities in the country and recently sent this individual to Uppsala, Sweden, for training on establishing a national pharmacovigilance program. In the next two years, the focus of this program will be to build a national system of reporting and monitoring adverse events of ARV and TB medicines to be expanded subsequently to other essential medicines.

CONTINGENCY PLANS FOR ART PROGRAMS IN CASE OF EMERGENCIES
As noted above in "Plan for Scale Up," PEPFAR donated ARVs to GKOS in September 2011. This donation is expected to be a one-time augmentation of existing stocks to allow the government to get its systems in place. PEPFAR, along with partners such as CHAI, MSF and the Global Fund are actively supporting a reorganization of the Central Medical Stores (CMS) to improve operational efficiency and capacity of the MOH procurement unit. These activities will also support the function of a newly established Supply Chain Technical Working Group (SCTWG) that has been granted responsibility to coordinate the entire system. The main objectives of the SCTWG are: (1) to coordinate and share technical and programmatic information on supply chain management of health commodities; and (2) to strengthen the system so as to assist the MOH and partners in making informed decisions that will ensure health commodity security at all levels of health care delivery. Political will is the key issue in sustainability of the government commitment to ring-fence ARVs. To that end, we have attained verbal assurances from the Prime Minister and written assurances from the Ministry of Finance.

SUSTAINABILITY AND EFFICIENCY

EXPENDITURE DATA AND COST MODELING
A national ART outcomes and costing study was initiated at the end of 2011. We anticipate that the resulting data will help guide the national conversation on reaching the last 30% of HIV positive people eligible for ART at a CD4 threshold of 350cells/mm3. The results will also be instrumental in determining the country's appetite for raising that threshold further towards implementation of a fully-realized program of "treatment as prevention."

LEVERAGING WITH OTHER DONORS/GFATM
PEPFAR Swaziland is actively involved in current Global Fund grants and the development of proposals for future awards. The PEPFAR coordinator sits on the Country Coordinating Mechanism (CCM) as a voting member and activity managers and implementing partners provide technical support in the drafting and implementation of GF activities. Furthermore, PEPFAR Swaziland has received support from OGAC to initiate a PEPFAR/GF coordination unit within the MOH. PEPFAR's implementing partners work closely with the principal recipient to monitor and support implementation of grant activities. PEPFAR staff hold regular meetings with other donors and implementers, including MSF, CHAI, the World Bank, EU, UNICEF, UNFPA, WHO and other UN agencies, to ensure consistency of approaches. For example, in order to mitigate the effects of the recent fiscal crisis on the supply of ARVs, a health donor group consisting of the above members met almost weekly. MOH sites supported by PEPFAR are often staffed by doctors, data officers, and pharmacy technicians whose salaries are paid by GF. These GF-paid providers are mentored by PEPFAR partners like any other MOH employee to ensure quality service delivery to clients.

PROCUREMENT EFFICIENCY
In conjunction with the MOH, PEPFAR partners have just completed a final draft of Swaziland's first Standard Treatment Guidelines which includes a revision of the Essential Medicines List. In parallel, PEPFAR is working with the MOH, CHAI and the newly created Supply Chain TWG on improving drug forecasting and logistics procedure for medicines and laboratory commodities. See "contingency planning" section above for more detail.

A process of harmonization and standardization of laboratory equipment and reagents has also been initiated. These efforts will go a long way in ensuring that the MOH is spending its limited resources in procuring those items that address both quality and cost effectiveness of supplies.

In the past year, PEPFAR has supported activities for improving data availability to inform forecasting and procurement of ARVs. Electronic and manual tools, for example, have been introduced at ART treatment sites and at the Central Medical Stores to collect and generate information on consumption of ARVs. PEPFAR has also provided technical assistance to the MOH's procurement unit to support their preparation of tender documents and evaluation of bids. Using CHAI's ARV price guide and MSH's Indicator Price List, the MOH has been assisted to consider cost efficiency in awarding tenders for medicines (ARVs, TB and other essential medicines). Through technical assistance from PEPFAR partners (URC and MSH), the MOH has managed to procure cost-effective and quality TB medicines through direct procurement from Global Drug Facility (GDF).

Central to all such interventions are the regular supply planning and update activities necessary for ensuring that the procurement process is linked to program scale up. As such, the procurement team and the National ART Program with technical assistance from PEPFAR, CHAI and MSF meet every quarter to monitor supplies and identify gaps in the procurement. This has created an early alarm system for cases of potential stock out of ARVs and laboratory commodities.

OTHER POTENTIAL COST-SAVINGS
The MOH is considering the introduction of atazanivir/ritonovir as the protease inhibitor of choice for second line treatment. It has similar efficacy to lopinivir/ritonivir, but is cheaper and has a lower pill burden.

There is also an ongoing discussion regarding the placement of data officers in high volume clinics to minimize the workload on nurses. The data officers will take over the responsibility of patient registers and data reporting so that the nurses may focus on clinical care. This will avoid the need to hire additional nurses whose salaries are significantly higher than those of data officers.

PEDIATRIC TREATMENT

BACKGROUND
The major pediatric accomplishments in the last 1-2 years include: the completion and publication of national pediatric guidelines using the WHO 2010 recommendations; the change in medication formulations from liquids to fixed dose combination dispersible tablets; the introduction of pediatric HIV attachments for nurses at Baylor clinics so they could learn pediatric care and pediatric phlebotomy; the establishment of a pediatric hotline by Baylor; and the decentralization of pediatric initiation and follow-up to nurses in rural clinics.

As of December 2011, there were 6567 children <15yrs currently enrolled and 8424 children < 15yrs ever enrolled; 4162 children 5-14yrs currently enrolled and 5196 children 5-14yrs ever enrolled; 2098 children 1-4yrs currently enrolled and 2829 children 1-4yrs ever enrolled; 307 children <1yr currently enrolled and 399 children < 1yr ever enrolled. These numbers encompass 9.6% of all ART enrollments. We intend to improve this percentage in the next years through the efforts described below. There are no national targets for pediatric enrollment. We are working with the MOH to have a meeting to create them.

In Swaziland, PEPFAR only provides technical assistance to government facilities. At all of the supported facilities, pediatric refills are provided on an ongoing basis. Initiations are currently provided at 20 facilities and, via NARTIS, PEPFAR expects to expand this support to at least 29 more in the next 2 years.

KEY PRIORITIES AND MAJOR GOALS FOR NEXT TWO YEARS

USING DATA TO IMPROVE PROGRAMS
As noted in the Adult Treatment section above, Swaziland conducts ongoing reviews of pediatric outcomes through

HMIS reporting, semi-annual doctors meetings and national outcomes studies. Building off from this data, PEPFAR and other partners such as CHAI and Baylor plan to support a comprehensive pediatric ART program evaluation under the auspices of the MOH Pediatric HIV TWG. We will use this evaluation to develop a plan to increase initiation and retention among children and adolescents. These efforts will be closely tied to the NARTIS program integration with MCH as described above.

In terms of ongoing pediatric HIV-surveillance, the primary activity is conducted by the MOH (with PEPFAR and CHAI technical assistance) which maintains "dashboards" to describe PMTCT inputs and outcomes related to early infant diagnosis and initiation. CHAI and Baylor are the primary partners providing support for this activity with technical assistance from PEPFAR.

SNAP recently started implementing a comprehensive chronic HIV care registration system including registers and individual patient charts for all HIV positive infants, children and adults. PEPFAR is providing key support in this initiative and is also advocating for the use of a national unique identifier to enhance capacity for tracing patients as they are referred from one setting to another. This information system will allow for documentation of outcomes such as retention, morbidity, mortality, etc.

DEFINING KEY PRIORITIES AND GOALS
Key priorities include improving access to early ART initiation and quality of care for HIV positive children. PEPFAR will improve access by decentralizing pediatric initiations and follow up to more facilities in Swaziland and promote better quality by strengthening providers' capacity in pediatric phlebotomy and overall management of pediatric patients through an ongoing sub-award with Baylor. Roll-out of the NARTIS program will also allow doctors more time at rural clinics where they can mentor nurses and manage difficult cases.

ALIGNMENT WITH GOVERNMENT STRATEGY AND PRIORITIES
Swaziland does not have up-to-date national scale up plans, targets or operational plans specific to pediatric or adult treatment. To remedy this gap, PEPFAR is working closely with SNAP and National Tuberculosis Program (NTP), the TB/HIV National Coordinating Committee and the Pediatrics ART TWG to create one integrated path to universal access for TB/HIV services. The ART care, treatment and support TWG has identified pediatric ART initiations as a priority intervention for FY2012. PEPFAR is collaborating with a range of other development partners in Swaziland to provide the MOH with treatment-related trainings, supply chain management, M&E, and ongoing mentoring; Baylor provides staff, clinical expertise, mentors and infrastructure to support these efforts; CHAI provides technical assistance for pediatric ARV forecasting and quantification, as well as donation of commodities through the UNITAID grant; UNICEF also provides technical assistance; and EGPAF manages non-PEPFAR donations of commodities from donors such as Abbott.

CHALLENGES
Key challenges to this process of decentralization have been related to issues of pediatric phlebotomy, older caregivers and adherence. Expansion of pediatric HIV treatment services, for example, has been hindered by nurses' discomfort with pediatric phlebotomy. Without baseline laboratory results, nurses are unable to initiate and manage pediatric cases and therefore refer them (with often no further follow up) to larger facilities. We are addressing these competency issues through pediatric attachments, as mentioned above. Many caregivers of these children are older and illiterate making accurate pediatric dosing (especially suspensions) difficult and resulting in poor adherence. To address these issues, CHAI is ordering syringes with dosing aides ("clips") that will assist in ensuring proper dosing. PEPFAR will help distribute these clips and mentor nurses on training patients and families to use them.

EFFORTS TO ACHIEVE EFFICIENCIES
The USG-supported pediatric HIV treatment program in Swaziland is already mostly integrated into public health facilities and their MCH programs. The expansion of NARTIS into most rural clinics will ensure that this integration is sustained and streamlined. By encouraging a coordinated TB/HIV decentralization planning process, PEPFAR is promoting the efficient use of other key inputs such as laboratory, supply chain, monitoring and

evaluation, and technical assistance from PEPFAR partners which benefit pediatric care at all levels of service.

HEALTH SYSTEMS STRENGTHENING EFFORTS TO IMPROVE PEDIATRIC HIV PROGRAMS
PEPFAR provides technical assistance to the MOH's SID to improve its capacity to collect, analyze and use pediatric HIV program data. PEPFAR has also supported tours to other countries to review related best practices. All of these activities improve local capacity for monitoring HIV-infected children and identifying treatment failures of individuals and across cohorts. These activities are augmented by combined residential trainings in Integrated Management of Adult and Adolescent Illnesses (IMAI) and Integrated Management of Childhood Illnesses (IMCI) as well as on-site mentoring from the regional clinical mentoring teams. The development of standard treatment guidelines and essential medicines lists for childhood illnesses amongst children infected with HIV has also enhanced providers' expertise in managing pediatric HIV cases using quality medicines for opportunistic infections.

KEY PRIORITIES AND MAJOR GOALS FOR NEXT TWO YEARS (ARVS):
The Supply Chain TWG led by the MOH and including PEPFAR partners, CHAI and MSF will continue to improve forecasting and ensure financial support for procurements in the future. Also, as part of the PMTCT Acceleration Funds, PEPFAR will be implementing a pilot of Option B+. If successful (and cost-effective), PEPFAR will consider supporting a nation-wide expansion of this effort.

In the current tender of ARVs, the MOH has managed to budget for 50% of the annual pediatric ARV requirement while CHAI/UNITAID is procuring the remainder. The main challenge, which is not unique to Swaziland, is that the market for pediatric ARVs is small and countries with low pediatric numbers do not enjoy the benefit of getting competitive prices as was the case through UNITAID. The CHAI ARV price guide is used by the procurement unit to ensure that the country also benefits from globally negotiated prices of pediatric ARVs. It is anticipated that the MOH will be able to absorb 100% of the pediatric ARV procurement in the tender starting April 2012. The country is phasing out single drug ARVs to FDC.

KEY ADVANCES OR CHALLENGES (IDENTIFIED IN PF/PFIP)
Currently, 78% pediatric clients are on FDCs of which 60% are on AZT based regimen and 38% are on d4T based regimen. This reflects an ongoing strategy to transition from d4t to AZT based regimen in line with the WHO 2010 guidelines. The country also adopted lopinavir/ritonavir option for infants being initiated on ART who were exposed to NVP. It is projected that over the next two years, the country will need 7,177 doses of LPV/r 100/25mg/ml tablets and 20,118 doses of LPV/r 80/20mg/ml syrup.

SUPPLY CHAIN

The key international procurement and supply chain stakeholders in Swaziland are MSH (PEPFAR-funded), CHAI and MSF. All three participate in the newly formed Supply Chain TWG. MSH supports an end-to-end supply chain system of both medicines and laboratory commodities. MSH has been assigned the role of introducing and refining the electronic pharmaceutical dispensing system and the related patient management information system (RxPMIS®). PEPFAR is also supporting APHL as an implementing partner to create and refine a laboratory information system that will "talk" with the other electronic medical record systems and provide consumption data. CHAI mainly provides technical support to the quantification, forecasting and procurement of pediatric ARVs and laboratory commodities through the UNITAID grant, but also works with MSH on mentoring MOH pharmacists. MSF supports rural clinics in one region with on-site mentoring, supply chain logistics and emergency inputs. The UN agencies and other PEPFAR partners such as ICAP, URC, EGPAF and PSI also provide input in support of on-site stock management activities.

With support from the national Supply Chain TWG the MOH will be in a better position to respond in time to stock outs. At the centre of ensuring continuous availability of products, is the availability of quality data of consumption and tracking. Through PEPFAR and Global Fund resources, the MOH is implementing a commodity tracking system that will ensure that supplies are available, distributed throughout the country according to need. Also through partnership with PEPFAR and Global Fund resources (NERCHA), the storage capacity for medicines in

the country has been increased significantly. This will help in increasing the country stock holding to about 8 months' buffer hence minimizing the occurrence of stock outs.

The strategy for promoting sustainability and country ownership of supply chain issues requires: (1) policies and regulations including the Pharmacy Bill and the Medicines and Related Substances Bill (2) inventory management systems like RxSolution® and RxPMIS® to track consumption and local human capacity with adequate skills to support and maintain these software(3) regular coordination of activities though the Supply Chain TWG and adherence to procurement schedules (4) task shifting of dispensing responsibilities to appropriately trained and supervised cadres of pharmacy assistants, and (5) creating a pharmacy professional training curriculum at local universities. These last two issues are the main HR-related challenges with supply chain into which the USG will be putting its resources in the next two years.

ARV DRUGS: PEDIATRIC SECTION
The Pediatrics ART TWG (a sub-TWG of the HIV Treatment, Care and Support TWG) is responsible for pediatric ARV drug selection. The Supply Chain TWG is responsible for forecasting, procurement and distribution. The USG partners represented on these committees include MSH, ICAP, EGPAF and URC.

There have been no stock outs of pediatric ARVs in the past two years, in part because CHAI has taken responsibility for procurement through their UNITAID grant. However, there are still challenges in the area of pediatric ARV procurement, such as the GKOS' inability to negotiate reduced prices for pediatric ARVs due to its low volumes requirement despite its commitment to allocate funds for the procurement of pediatric ARVs in the next two years. Under the PMTCT acceleration plan, the country has set targets for increasing the number of children on ARVs. Regular forecasting and supply planning updates will monitor this scale-up to ensure that the increased demand is commensurate with the procurement process.

LABORATORY

PEPFAR supports TB/HIV laboratory related activities that aim at: standardizing TB/HIV best laboratory practices and provide associated training; providing for uniform quality assurance measures among laboratories; working with NCLS to standardize equipment (introduce new technologies and equipment), commodities, and supportive maintenance training; and supporting capacity building for a unified approach to procurement and distribution of laboratory commodities. PEPFAR Swaziland strives to ensure an adequate number of clinical laboratories perform quality testing for TB/HIV/AIDS diagnostics and monitoring tests for care and treatment services. We also assist in strengthening referral transport systems for specimens and implement practical and sustainable quality management systems by conducting laboratory management training programs and assisting in the adoption of the WHO Laboratory accreditation scheme (utilizing a stepwise approach for reference and peripheral laboratories).

The lab project activities are linked to the attainment of the National Clinical Laboratory Development plan for July, 2008,-June, 2013, addressing eleven of its Strategic Objectives.

PEPFAR's strategy for strengthening laboratory services builds on the following principles: ensuring strong country ownership; integrating project activities within Swaziland's health systems to ensure long-term program sustainability; capacity building through training/mentoring lab staff in quality assurance/quality management on both general lab-related and TB diagnostic services.

GENDER
PEPFAR's approach to gender incorporates the 5 PEPFAR gender strategies in a comprehensive manner. A planned USG Gender Assessment will facilitate the adoption of future gendered programming throughout the Treatment portfolio. Planned focus in FY12 (see Prevention and Care TANs for other examples) includes:
- *Increasing gender equity in HIV/AIDS programs and services - Results show that fewer men are accessing testing, care and treatment services than women; this relates directly to the fact that fewer men test for HIV, and*

there are fewer opportunities for men to be linked into care. Measures to address this include: 1) utilizing the national MC acceleration, and enhanced strategies to engage men in testing, to increase greatly number of men who undergo HIV testing, and ensure strong referral protocols are in place to link with care and treatment; 2) exploring ways to make services more male-friendly, including health facility implementation of special initiatives such as men's health days, employing male expert clients, and adjusting opening hours to fit the work schedules of men in order to make services more appealing; 3) using PMTCT as entry point to reach men, and ensuring PMTCT services offer testing and treatment for male partners; and 4) strengthening service data and monitoring to ensure that gender inequities are tracked and appropriate strategies are implemented in response.

- *Reducing violence and coercion - PEPFAR will expand efforts to address GBV, including through strengthening the Department of Social Welfare and the child protection system which includes social welfare, health, education, police, justice and civil society actors. USG activities will support the delivery of care, support and legal aid services for survivors of GBV, including technical assistance for the implementation of PEP services for survivors of GBV.*
- *Addressing male norms and behaviors—PEPFAR will continue to support activities to address social norms and behaviors that promote imbalances in gender power and decision making. Several partners have integrated community dialogues, boys' and girls' groups, men's discussion groups into their routine work on prevention and/or with vulnerable children. In addition, the expansion of strategies such as couples counseling and testing will continue to be prioritized to facilitate access to care and treatment and help reduce the potential for violence.*
- *Increasing women's legal protection—PEPFAR and partners will continue to work with other donors to advocate for the approval of legal instruments (Child Welfare Bill, Domestic Violence Bill) that are critical for protecting the right of women and children. The new C-BLD award (see Care TAN) includes a focus on the protection and promotion of women's and children's rights.*
- *Increasing women's access to income and productive resources— C-BLD will focus its economic strengthening activities on households with a high burden of OVC, households affected by HIV/AIDS, female headed households, young women age 16-25, and other vulnerable women (e.g. GBV survivors, women with disabilities, single mothers). All efforts will ensure appropriate referrals and linkages to care and treatment activities.*

STRATEGIC INFORMATION:

ACCOMPLISHMENTS:

- *Development and utilization of two softwares have been supported by PEPFAR, including the RxPMIS and the RxSolution software. The RxPMIS software is used for electronic medical record in the national HIV program and includes data on TB/HIV and is being redeveloped to ensure interoperability and capability to capture data on pre-ART, TB/HIV etc. The RxSolution software is an inventory / logistics management software for pharmaceutical and laboratory commodities which is used in hospitals and health centers for dispensing of medicines to patients.*

KEY PRIORITIES AND MAJOR GOALS FOR NEXT TWO YEARS:

- *PEPFAR will support the MOH in introducing the Health Services Recipients Unique Identifiers and evolution of Rx-PMIS to Client Management Information System (CMIS) to maximize the efficiency of routine information system in tracking PLWHIV and to ensure their access and linkage to care and treatment services*
- *PEPFAR will continue to support data systems appropriate for the clinic level, including paper-based systems and electronic medical records. PEPFAR will work through the Technical working group to update/develop national protocols for data quality assurance assessment and to update when needed current data collection tools.*
- *To enhance sustainability of quality M&E, PEPFAR will continue to mentor facility level staff in a phased approach to ensure timely and accurate data collection, recording and reporting. PEPFAR will continue to support clinic multi-disciplinary teams to use their data for quality improvement. PEPFAR will also continue to mentor regionally based strategic information staff to provide supportive M&E supervision and incrementally take on the M&E mentoring role.*
- *PEPFAR will provide national quarterly TB/HIV treatment data review meetings to facilitate sharing opportunities for best practices and to support writing of annual programme reports.*

MARPS: Please see section in Care TAN.

HRH
The national priorities addressed in the key national documents (Essential Health Care Package, Task Shifting Framework, and Mentoring and Supervision Frameworks) define the direction the country is going in defining treatment support. PEPFAR support has been significant in supporting the government vision in developing these documents working with other donor partners and represented in the various stakeholder workshops and TWG's through its partners. Rapid expansion of ART services to 75% of the country's rural primary health facilities has huge HR implications. This will require having trained HCW's and support cadres in all the clinical areas to implement service delivery. The Regional Clinical Mentoring Teams that are PEPFAR supported have been established in the four regions collaboration with the MOH and serve as sub-committees to the pre-existing Regional Health Management Teams (RHMT) to support the clinical mentoring and supervision to roll out the program. While the entry point is HIV the vision is that this will include other health services. PEPFAR support is geared towards capacitating the RHMT's that have not been providing mentoring and supervision before to start taking an active role of this function and PEPFAR partners gradually moving away from direct service delivery in the facilities. The Chief Nursing Officer (CNO) is involved in the recruitment of these teams to ensure ownership of the program and that gradually the USG partners will hand over this function to government.

The development of the staffing norms is critical in operationalizing the EHCP that has been recently launched supported by PEPFAR/GF. This will define the staffing requirements for treatment at all levels of care that takes into account task shifting of functions to address bottlenecks in the delivery of HIV services. The NARTIS pilot is one example where nurses are now being trained to initiate patients on treatment that has time to convince the government. The MOH is taking ownership of this program. At facility level the Expert Client program is critical in supporting treatment scale-up.

CAPACITY BUILDING
Capacity of the RHMT's is a priority for PEPFAR and MOH and other donor partners. The focus is onsite mentoring and training to ensure practical application of technical skills on the site. While PEPFAR is taking the lead in implementation of the frameworks, other partners like MSF, GF, and potentially the World Bank that are involved and the vision is that the program is seen more as a national program and not PEPFAR driven. The fact that the RHMT's are now involved ensures that the activities are aligned with other stakeholders and that work plans are also shared to improve coordination. Quality improvement is an on-going process and at the centre of this program to ensure delivery of quality services. The challenge is that the MOH/ HR Unit is not involved because of the huge capacity challenges and for this reason the treatment
partners have forged ahead without their involvement and needs to pulled in.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	28,107	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	98 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	10,799	
	Number of HIV-	11,020	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	4,322	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)		
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	6,256	
	Single-dose nevirapine (with or without tail)	221	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Sum of regimen type disaggregates	10,799	
	Sum of New and		

	Current disaggregates		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	17,500	Redacted
	By Age: <1	2,000	
	By Age: 1-9	112	
	By Age: 10-14	7,361	
	By Age: 15-19	3,995	
	By Age: 20-24	2,532	
	By Age: 25-49	1,500	
	By Age: 50+	0	
	Sum of age disaggregates	17,500	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached	383,282	

	with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	104,400	
P8.3.D	P8.3.D Number of	n/a	Redacted

	MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	20,396	
	By MARP Type: CSW	2,804	
	By MARP Type: IDU	0	
	By MARP Type: MSM	496	
	Other Vulnerable Populations	17,096	
	Sum of MARP types	20,396	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	221,416	Redacted
	By Age/Sex: <15 Male	21,564	
	By Age/Sex: 15+ Male	64,767	
	By Age/Sex: <15 Female	16,365	
	By Age/Sex: 15+	118,721	

	Female		
	By Sex: Female	135,086	
	By Sex: Male	86,330	
	By Age: <15	37,929	
	By Age: 15+	183,487	
	By Test Result: Negative		
	By Test Result: Positive		
	Sum of age/sex disaggregates	221,417	
	Sum of sex disaggregates	221,416	
	Sum of age disaggregates	221,416	
	Sum of test result disaggregates		
P12.1.D	Number of adults and children reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS	214,800	Redacted
	By Age: <15	60,272	
	By Age: 15-24	102,326	
	By Age: 25+	52,202	
	By Sex: Female	106,037	
	By Sex: Male	108,763	
P12.2.D	Number of adults and children reached by	199,233	Redacted

	an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS		
	By Age: <15	13,475	
	By Age: 15-24	79,770	
	By Age: 25+	105,988	
	By Sex: Female	98,915	
	By Sex: Male	100,318	
P12.3.D	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV/AIDS	10,250	Redacted
	By Age: <15	984	
	By Age: 15-24	4,153	
	By Age: 25+	5,113	
	By Sex: Female	5,308	
	By Sex: Male	4,942	
P12.4.D	Number of adults and children who are reached by an individual,	7,687	Redacted

	small-group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS		
	By Age: <15	750	
	By Age: 15-24	4,138	
	By Age: 25+	2,799	
	By Sex: Female	5,337	
	By Sex: Male	2,350	
C1.1.D	Number of adults and children provided with a minimum of one care service	169,598	Redacted
	By Age/Sex: <18 Male	24,522	
	By Age/Sex: 18+ Male	37,876	
	By Age/Sex: <18 Female	31,075	
	By Age/Sex: 18+ Female	76,125	
	By Sex: Female	107,200	
	By Sex: Male	62,398	
	By Age: <18	55,597	
	By Age: 18+	114,001	
	Sum of age/sex disaggregates	169,598	
	Sum of sex disaggregates	169,598	
	Sum of age	169,598	

	disaggregates		
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	86,765	Redacted
	By Age/Sex: <15 Male	4,038	
	By Age/Sex: 15+ Male	26,120	
	By Age/Sex: <15 Female	5,191	
	By Age/Sex: 15+ Female	51,415	
	By Sex: Female	56,606	
	By Sex: Male	30,159	
	By Age: <15	9,230	
	By Age: 15+	77,535	
	Sum of age/sex disaggregates	86,764	
	Sum of sex disaggregates	86,765	
	Sum of age disaggregates	86,765	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	90 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	77,867	
	Number of HIV-positive individuals receiving a	86,765	

	minimum of one clinical service		
C2.3.D	C2.3.D Proportion of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	630	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.	0	
	By Age: <18		
	By Age: 18+		
	Sum by age disaggregates		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	92 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	80,075	

	Number of HIV-positive individuals receiving a minimum of one clinical service	86,765	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	10 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	8,910	
	Number of HIV-positive individuals receiving a minimum of one clinical service	86,765	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	95 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	10,447	
	Number of HIV-positive pregnant women identified in the reporting period	11,020	

	(include known HIV-positive at entry)		
	By timing and type of test: virological testing in the first 2 months	306	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	22,878	Redacted
	By Age: <18	8,891	
	By Age: 18+	13,987	
	By: Pregnant Women or Lactating Women	1,030	
	Sum of age disaggregates	22,878	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	13,300	Redacted
	By Age: <1	295	
	By Age/Sex: <15 Male	668	
	By Age/Sex: 15+ Male	4,251	
	By Age/Sex: <15 Female	796	
	By Age/Sex: 15+ Female	7,585	
	By: Pregnant Women	1,177	

	Sum of age/sex disaggregates	13,300	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	63,023	Redacted
	By Age: <1	398	
	By Age/Sex: <15 Male	2,688	
	By Age/Sex: 15+ Male	19,961	
	By Age/Sex: <15 Female	3,078	
	By Age/Sex: 15+ Female	37,296	
	Sum of age/sex disaggregates	63,023	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	81 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	8,577	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period,	10,546	

	including those who have died, those who have stopped ART, and those lost to follow-up.		
	By Age: <15	637	
	By Age: 15+	6,981	
	Sum of age disaggregates	7,618	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	37	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	13	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	117	Redacted
	By Cadre: Doctors	0	
	By Cadre: Midwives	29	
	By Cadre: Nurses	63	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	292	Redacted

H2.3.D	The number of health care workers who successfully completed an in-service training program	12,100	Redacted
	By Type of Training: Male Circumcision	43	
	By Type of Training: Pediatric Treatment	20	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
10157	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	3,583,000
10247	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	8,280,000
10621	International Labor Organization	Multi-lateral Agency	U.S. Department of Labor	GHP-State	0
10694	Ministry of Health and Social Welfare, Swaziland	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	1,960,000
10695	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	55,000
10703	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	1,150,000

10822	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	55,000
11673	U.S. Department of Defense (Defense)	Other USG Agency	U.S. Department of Defense	GHP-State	0
13144	University Research Corporation, LLC	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,550,000
13357	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	30,000
13360	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	20,000
13630	Population Services International	NGO	U.S. Agency for International Development	GHP-State	0
13645	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHP-State	0
13738	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Department of Health and Human Services/Centers	GHP-State	15,000

			for Disease Control and Prevention		
13742	FHI 360	NGO	U.S. Agency for International Development	GHP-State	820,000
13743	Eastern, Central and Southern African Health Community Secretariat	NGO	U.S. Agency for International Development	GHP-State	0
13772	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	0
13791	Population Services International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	180,000
14201	Mothers 2 Mothers	NGO	U.S. Agency for International Development	GHP-State	0
14374	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0
14437	World Health Organization	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	0
14842	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of	GHP-State	0

			African Affairs		
16760	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	350,000
16812	African Society for Laboratory Medicine	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	20,000
16815	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	2,315,000
16821	Johns Hopkins University Bloomberg School of Public Health	University	U.S. Agency for International Development	GHP-USAID, GHP-State	320,000
17048	U.S. Agency for International Development (USAID)	Other USG Agency	U.S. Agency for International Development	GHP-USAID	185,000
17096	United Nations Children's Fund	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	0

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 10157	**Mechanism Name: PACT**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 3,583,000	
Funding Source	**Funding Amount**
GHP-State	1,403,971
GHP-USAID	2,179,029

Sub Partner Name(s)

Bantwana Initiative	Cabrini Ministries Swaziland	Cheshire Homes
Khulisa	Salvation Army Swaziland	Save the Children Swaziland (SCSWD)
Swaziland Action Group Against Abuse	Swaziland Business Coalition Against HIV/AIDS	Swaziland National Network of People Living with HIV/AIDS
TechnoServe	Voice of the Church Swaziland	

Overview Narrative

Pact supports several PFIP goals and objectives. One of PACT's key goals is to develop human capacity in Swaziland's NGOs, CBOs, and FBOs to promote the establishment and strengthening of viable and sustainable civil society organizations. Pact develops the capacity of partners to deliver HIV services which include HIV Counseling and Testing, home and facility-based care and support, ARV Treatment, and TB/HIV. Pact also develops the capacity of partners to deliver HIV prevention messages that promote positive behavior change through one-on-one and group based activities. Pact will develop the capacity of partners to deliver quality OVC services which include food and nutrition, education support, PSS, protection and legal support, economic strengthening, shelter and care,

and health care. Pact provides extensive assistance to partner organizations in developing comprehensive program design documents that accurately reflect planned activities and clearly articulate defined goals and objectives. Pact supports teamwork between program and finance units and conducts organizational capacity assessments. A resource mobilization course provides information on strategies for diversifying their funding base for sustainability. Pact partners work in all four regions. Since HIV is affecting the general population, the targeting of HIV prevention is also generalized, with specific partners targeting specific groups. Pact partners target PLHIV for positive prevention, clinical care, ART, TB/HIV and support care. Impact mitigation activities target OVCs and caregivers. Pact will mentor CANGO to become a local UGM that will provide support to partners. Pact's strategic information support is provided through staff and institutional M&E capacity and M&E systems strengthening.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	65,516
Education	1,265
Food and Nutrition: Commodities	29,540
Human Resources for Health	16,756

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Workplace Programs

Budget Code Information

Mechanism ID:	**10157**

Mechanism Name:	PACT
Prime Partner Name:	Pact, Inc.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	250,000	0

Narrative:

Pact partners will provide a range of facility and community based clinical and support care services. These services will include clinical, psychological, food and nutritional support, spiritual, social and prevention services. The primary emphasis for these activities is comprehensive direct service delivery for improved quality of life for PLHIV, TB-infected individuals, and training of caregivers and counselors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,918,584	0

Narrative:

Pact partners will scale-up existing care and support services to improve the lives of vulnerable children affected by HIV & AIDS. Partners will deliver services for vulnerable children across all seven service areas based on the needs of vulnerable children, their families, and communities. Service areas include access to basic education, health care services, targeted food and nutritional support, protection and legal aid, shelter and care, psychosocial support, and economic strengthening as well as the training and support of caregivers. TechnoServe will provide technical support to OVC partners to improve the socio-economic status of households with vulnerable children. Pact will build the capacity of partners to support family units/primary caregivers and strengthen community structures. Pact will coordinate technical assistance through the following: strengthening capacity of local organizations; strengthening monitoring and QA systems; and advocating for sound strategies, policies, and programs that benefit vulnerable children. Pact will share impact mitigation lessons and strategies across partners and within the region through meetings, workshops, and visits. Pact participates in the national network forums and coordinates an Impact Mitigation Technical Working Group. Pact capacity building efforts will ensure that programs reflect sound practices; are evidence-based; remain sensitive to the dynamics of the Swaziland HIV epidemic; and work to meet the needs of OVCs in a measurable way. Pact will support the NCCU in finalizing the development of the OVC quality service standards. Pact will work with two partners piloting the WORTH model to improve the socio-economic status of women through micro-finance savings and lendings. Pact will conduct training in Gender Mainstreaming to continue to build the technical and institutional strength of partners working in prevention and HTC. As part of the training Pact will collaborate with gender experts in the region to explore and share innovative approaches to gender programming. Pact will strengthen the capacity of SWAGAA to provide technical support to other partners in responding to issues of GBV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVTB	40,000	0

Narrative:

Pact will continue to prioritize capacity development of local organizations to integrate TB/HIV screening in their programs for early detection and treatment of TB resulting to improved care and treatment services. This intervention supports the national strategic focus of early identification of TB so that referrals for treatment are made in a timely manner. Capacity development of partners will continue to focus on TB/HIV co-infection, TB screening, referrals for treatment, and guidelines to prevent the spread of TB. Pact will work in partnership with the National TB Program and URC to support partners providing TB/HIV interventions in communities by providing IEC materials, complete the national registers, and report data to the national M&E system. Pact's partner TB/HIV programming emphasizes mobilization activities for awareness, testing, and treatment to promote early detection and diagnosis of TB in the communities. Activities include sputum collection and testing at TB diagnostic centers, collecting TB test results and giving them to clients, and providing treatment adherence support within a community setting. Pact's primary goal is to provide necessary technical support while building the institutional capacity of partners to increase their effectiveness and capacity to achieve expanded, quality services and strengthening the management of financial and human resources. Pact will continue to build the technical and institutional strength of partners that will be working in the TB/HIV technical area.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	74,000	0

Narrative:

Pact will support the care and support partners to systematically integrate pediatric care and support activities. Pact will build the technical and institutional strength of partners that will be working in Pediatric Care and Support for effective management of acute malnutrition, early detection and treatment of OIs, and creation of effective relevant referrals for further care and support as. HIV exposed infants will be monitored through regular DBS, and home visits to assess homestead situation. Nutritional supplements will be provided as necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	260,000	0

Narrative:

Pact's Strategic Information support to partners is provided through two broad areas: staff and institutional M&E capacity and M&E systems strengthening, with the overall aim of generating program improvement decision support information. Pact will provide training on MER, data quality management, data analysis, and database development for MER and program staff. Pact will continue to assist each partner in developing results frameworks that tracks success against both PEPFAR program and organizational indicators. Pact will assist partners in the development of MER plans and data quality management plans. Pact provides additional MER systems

strengthening assistance to all partners in the following areas: review and development of effective data collection, analysis, and reporting tools; setting realistic and achievable targets; establishing and strengthening data quality management systems; conducting internal data quality audits; and verifying and validating partner and sub-partner data submissions. The primary emphasis areas for these activities are training and one-on-one mentoring and TA. Pact will conduct data quality assessments aimed at meeting quality requirements for reporting to internal and external audiences including PEPFAR. These assessments will enable Pact and partners to identify and strengthen the data management processes that are critical in ensuring high quality data. Pact will work with each partner to undertake and document findings from their programs data quality assessment and develop mitigation plans to address system gaps identified. Pact will provide comprehensive mentoring MER support to a UGM partner. Pact will conduct an assessment of the UGM's MER capacity, which will provide benchmark information on the status of human capacity and systems development, as well as processes for generating, managing, and using program data for decision making.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	135,000	0

Narrative:

Pact carries out organizational capacity and technical assessments to develop individualized and crosscutting plans for tailored interventions for each partner. Primary emphasis areas are one-on-one mentoring, TA, and grant and financial management support. Interventions aim to strengthen and institutionalize organizational systems and processes and improve quality and standards of services delivery. Activities target local partner staff member who work directly on program implementation and monitoring as well as senior management. Pact will ensure adherence and compliance of Partners to USAID rules and regulations through grants management workshops. Pact will conduct MCAT (Management Capacity Re-assessments) for all existing partners. The findings from reassessments will assist Pact in developing specific grants and financial management TA for each partner. Technical re-assessments analyze key gaps in technical programming and are used to develop tailored plans for targeted interventions. All local Partners receive direct one-on-one TA to strengthen the design of programs to improve quality of service delivery, address gaps, and identify opportunities for scale-up. Pact will support its grantees to mainstream gender in all their HIV/AIDS focus areas by conducting gender assessments and developing strategies to address the gaps identified. Pact will continue to work with the identified UGM partner to transfer skills required for managing a UGM and mentoring implementing partners. Pact will develop a program of technical assistance to enhance civil society's involvement and success in the Global Fund program in Swaziland. Pact will work closely with the PEPFAR team, the CCM, NERCHA (and/or other principal recipients) and key stakeholders to design and implement technical assistance program that will address the capacity needs of civil society organizations including such areas as proposal writing, program planning, monitoring and evaluation and financial management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	305,708	0

Narrative:

Programming will support the National Strategic Framework prevention objectives of behavior change (including a workplace focus). Many activities link to HCT, which the NSF recognizes as a key strategy in prevention. Pact will support partners to implement prevention activities which support the attainment of the NSF, Partnership Framework, and SBCC strategy. Activities will address the drivers of the HIV epidemic in Swaziland: rates of partner change, prevalence of concurrent partners, sexual mixing patterns, sexual practices and condom use, age of sexual debut, and levels of sexual and physical abuse especially for women and girls. Pact partners' prevention activities focus on appropriate messaging for social and behavior change in target populations. Social behavior change communication will be directed at specific behavioral outcomes including correct and consistent condom use, delayed sexual debut, fewer partners/reduction of MCPs, and issues of abuse and violence. Pact partners implement activities in schools, churches, community centers, and households. Approaches include community volunteers and peer educators to conduct age-appropriate activities, working with religious leaders to reach congregations with value-based prevention strategies, promoting HIV counseling and testing, and the use of other preventive services, road shows, and radio programming. All partners implementing HIV prevention activities will mainstream gender in their prevention activities to address some of the underlying gender norms and behaviors that influence further spread of HIV. Pact will strengthen and support the linkages of HIV prevention programs with MC programs. Sexaul prevention activities will support pre and post MC interventions. To ensure consistent, coherent and comprehensive HIV programming across all partners, and to be in line with the NSF, PF, and NSBCC, all partners implementing prevention activities will take part in the Pact Partners Prevention Technical Working Group (PPPTWG).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	70,000	0

Narrative:

HIV testing and counseling (HTC) has been identified as the entry point for HIV prevention, treatment, and care and support. It is a key strategy to empower individuals at a personal level to make informed choices and decisions in seeking appropriate health care. Pact will build the technical and institutional strength of partners to increase testing opportunities and enable people who test positive to seek appropriate care and prevent transmission. HIV testing and counseling services to be supported will be both provider and client initiated. Pact will also ensure that partners scale up HTC services by increasing the number of both free-standing and provider initiated testing and counseling sites nationwide, targeting both key and rural populations, improving the ratio of male to female counselors and development of programs aimed at increasing couple/partner testing and counseling and disclosure of some services to lay counselors. Pact's partners provide HTC services from mobile sites, linking clients to

treatment and care services including referrals for CD4 counts and referrals to support groups. HTC activities are utilized for personalized HIV prevention education to clients through pre- and post-test counseling sessions. Pact will strengthen the HTC partners' capacity to mainstream gender in HTC and address underlying gender norms and behaviors and gender based violence issues that influence further spread of HIV. Partners will also forms strategic partnerships with MC providers to facilitate easy referrals and linkages of HTC to MC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	280,708	0

Narrative:

To strengthen programming in this area, partners will focus on reduction of new infections amongst sexually active individuals and also target high risk sexual populations such as commercial sex workers, truck drivers, uniformed forces, and mobile populations. This will entail dissemination of information on correct and consistent use of condoms in preventing sexual transmission of HIV, as well as systematic and continuous condom distribution. Partners will work with other stakeholders to ensure constant supply of condoms for distribution to sites. Partners will educate, demonstrate, and distribute condoms to sexually active adults. This intervention will increase: the availability and use of male and female condoms; the proportion of sexually active persons who use condoms consistently; and the number of new condom outlets per region. The primary emphasis for these activities is direct reach, service delivery, and training. Prevention activities will also be implemented to support the attainment of the NSF, Partnership Framework, and SBCC Strategy. All partners will mainstream gender in their prevention activities to address some of the underlying gender norms and behaviors that influence further spread of HIV. Pact will strengthen and support the linkages of HIV prevention programs with MC programs. Prevention activities will support pre and post MC interventions, and will continue to encourage the use of condoms before and after MC. Pact will work with traditional authorities to address the male norms and behaviors that influence further spread of HIV. Traditional authorities include a "women regiment" who are recognized as the cultural gate keepers in the country. Khulisa Umtfwana is an organization established by the Queen Mother to protect the traditional ways of raising children in communities. The program will address young people on gender norms and behaviors and GBV issues that are entrenched in the Swazi culture which have a direct impact on the spread of HIV. Partners will use community dialogues as the main tool to initiate discussions and develop strategies for positive cultural influences on gender and HIV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	175,000	0

Narrative:

Pact partners will support and provide ARV treatment at the local level to support the MOH's decentralized ART strategy. Partners will provide services which include HIV Counseling and Testing, CD4 count monitoring, ART initiation including Pre-ART counseling, ART treatment (act as a refill /outreach site to an ART centre), managing

opportunistic infections, TB screening, TB treatment, and adherence support. Partners will be supported by the MOH with the supply of test kits, drugs and medication for treatment activities. Pact's partners will build on PEPFAR-funded activities to strengthen treatment services through specialized training that will improve and expand quality of care, as well as support grassroots initiatives for positive living treatment adherence.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	74,000	0

Narrative:

Pediatric treatment will include routine assessment and treatment of OIs through the two partners. CD4 will be monitored every 3 months or more often if it seems that the symptoms are increasing. Cotrimoxazole will be initiated at different CD4 levels depending on the age and size of the child. Education is done every step of the way and in the presence of the child's care taker. The children will be given special attention along with their care-givers to teach how to take the medicine, when to ask for help, etc. Nutritional supplements will be given as needed.

Implementing Mechanism Details

Mechanism ID: 10247	**Mechanism Name: ICAP/CDC: Improving Quality of Treatment Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Contract
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 8,280,000	
Funding Source	**Funding Amount**
GHP-State	8,280,000

Sub Partner Name(s)

Baylor University	Cabrini Ministries	Nazarene Compassionate

		Ministries
NERCHA	Pact, Inc.	World Vision International

Overview Narrative

For COP 2012, ICAP aims to continue working closely with the Government of Swaziland's Ministry of Health (GOS MOH) at the national, regional and site level to ensure sustained access to high quality, comprehensive, family-focused HIV care and treatment services for people living with HIV (PLHIV). Decentralization of HIV services to all planned sites will be achieved and consolidated while building up the self-sufficiency of the Regional Health Management Teams (RHMTs). The community linkages program will be further integrated within the Rural Health Motivator (RHM) community cadre of the MOH. ICAP supports the MOH at the national, regional and site level covering three of the four regions in the country, Hhohho, Manzini and Lubombo. The target population for service delivery is an estimated 140,000 PLHIV and their family members. The target populations for capacity building include the MOH at national, regional, site and community (e.g. RHMs) levels, as well as local community groups. ICAP's main strategy is to directly support and strengthen existing national systems and to avoid any parallel efforts. Although a portion of staffing supplementation is required to achieve scale up objectives within the project time frame, most of the program effort has been devoted to strengthen national policies and guidelines, existing MOH cadres and service delivery, M&E and supervision systems. In line with this approach, the community linkages program will increasingly shift its focus to engaging and better linking RHMs to health facilities. A major thrust during this period with management capacity development support from Pact will be to ensure the self-sufficiency of the RHMTs in managing and supervising the clinics.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Human Resources for Health	1,000,000
Renovation	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Military Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10247**
Mechanism Name:	**ICAP/CDC: Improving Quality of Treatment Services**
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	2,000,000	0

Narrative:

ICAP will support the MOH to firmly establish sustainable HIV care and support services in all 114 public and mission facilities in the three regions. This effort will include full roll out of pre-ART as part of the Package of Care (POC), strengthened adherence and psychosocial support (APS) and PwP, the Expert Client initiative, clinical mentoring and supportive supervision, as well as the community linkages program. A major ICAP effort will include the phased transfer of full responsibility for facility support to the RHMTs. [PREART] The pre-ART register and systems will be fully rolled out to all health facilities. [APS] ICAP will continue to support the integration of standardized APS services into the overall health service delivery at sites. [PwP] Based on the findings of the PwP technical review and national strategy scheduled for year 3, comprehensive PwP services will be more systematically integrated into routine HIV care within all health facilities and community linkages activities. This includes couples HIV testing and counseling (CHTC); treatment as prevention for discordant couples; identification and prevention education for discordant couples; condom promotion, reducing unintended pregnancies, early identification and treatment of sexually transmitted infections as well as nutrition counseling and collaboration with the World Food Programme on food per prescription. [EXPERT CLIENTS] ICAP will continue to support Expert Clients at health facilities to work with patients in treatment literacy and will expand their scope to include a greater focus on PwP, TB screening and encouraging clients to bring family members in for testing. [CLINICAL MENTORING AND SUPPORTIVE SUPERVISION] ICAP will support the RHMTs to develop a set of performance-related criteria to assess each facility's need for clinical mentoring and supportive

supervision. Stronger performing facilities might be "graduated" to quarterly mentoring visits while weaker facilities may be visited twice each month. [COMMUNITY LINKAGES] ICAP will support greater involvement of RHMs in tracking clients who miss their appointments. ICAP will train over 2,000 RHMs and assign a clinic level RHM Coordinator to provide supportive supervision.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,333,333	0

Narrative:

ICAP will continue to work in close collaboration with URC and the National TB Program to fully integrate sustainable TB services within ART sites. In particular, ICAP will focus on scaling up TB screening and INH prophylaxis among HIV clients and improved infection control. Specific activities will include:

Intensified Case Identification and Follow Up
• Ensuring systematic and periodic TB screening for all PLHIV, including expanding the scope of Expert Clients to include periodic TB screening and education on self-screening
• Initiating or ensuring successful linkage of identified TB cases to treatment services,
• Provision of quality TB information and education for clients by health care professionals, Expert Clients and RHMs,
• Support through Baylor for better integration of TB services within pediatric HIV care and treatment.

INH Prophylaxis
• Support for INH prophylaxis in hospital ART programs and roll out to the clinics

Infection Controls: Administrative & Engineering
• Promotion of cough screening and cough hygiene/etiquette
• Support for better ventilation and separate waiting areas, including the possibility of minor renovations as required.
• Prioritization and separation of TB suspects.

Many of the government owned health facilities in Swaziland are inadequate for current needs. Some are in outright disrepair; others are not designed in a manner that meets the chronic care needs of the current population: waiting areas are too small; infection control needs (windows, ventilation) are unmet; adequate space for consulting rooms, record keeping, point of care laboratories, and waste management facilities are often completely lacking. As a result, patient flow is inefficient and, with the high rates of TB and poor infection control, often dangerous to both patients and staff. The funds in this project will be used to undertake minor renovations to facilities to bring them up to minimum standards and provide the basic furniture needed to run the facility to

support quality chronic care services (eg, filing cabinets). The funds will be leveraged with resources from the MOH and other donors like the World Bank, Clinton Foundation and MSF.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	1,083,334	0

Narrative:

In addition to the main areas of support described under Adult Care and Support, ICAP will continue to work with Baylor College to support strengthened capacity for pediatric HIV service provision in all supported facilities. Areas of priority emphasis during this period will include:

• Intensified follow up of HIV exposed infants and children who test positive using both facility and community strategies. This will include better tracking, systematic use of cell phones to send follow up message and home visits through the community linkages program.
• Health care workers, Expert Clients and RHMs encouraging PLHIV to bring their families for HTC.
• Promoting APS messages for children and for parents to talk with their children about the status and care and treatment needs.
• Bidirectional support to integrate HIV services within child clinics and to ensure that HIV exposed and infected children receive their immunizations and other well child services.
• Better equipping RHMTs to mentor and supervise pediatric HIV services.
• Support facilities through the procurement of pediatric-specific equipment and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	545,000	0

Narrative:

ICAP provides a range of services to augment the delivery of services within the MOH.
Through a salary support mechanism to the Swaziland National Aids Program they provide
1.ART program management support which helps standardize the delivery of services throughout the health sector.
2.Data and research expertise to define data to be collected and to ensure collection and collation of information to direct program initiatives and measure the impact of interventions in HIV specific areas.
3.Advise on systems for clinical mentoring at the national level.

ICAP also supports the Regional Health Management Teams through regional mentoring teams which provide updates and mentorship to doctors, nurses, data clerks and M+E within three of the four regions within Swaziland.

To motivate ART clients on adherence and compliance ICAP supports a cadre of 84 expert-clients who are HIV

positive individuals who work on a daily basis at the ART centers to inform clients, through firsthand experience, on potential situations that may arise as they deal with their condition on a day to day basis. They also encourage clients to adhere to treatment requirements.

In addition ICAP working closely with the planning unit and the micro-projects department to provide expertise to identify priority renovation sites among the clinics and health centers in three regions, and then to develop the bill of quantities and select and monitor the contractors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,985,000	0

Narrative:

In addition to all of the work described above under Adult Care and Support, the additional activities listed below will be undertaken in support of Adult Treatment. (1) Expansion in numbers reached with ART initiation: through ICAP support, it is expected that more than 12,000 people will be initiated on ART in FY 2013 and nearly 64,000 people will be currently enrolled on ART. This level of enrollment slightly surpasses the PFIP target of 60,000. (2) Nurse-initiated ART has been implemented in 15 sites to date. During this period, ICAP will work with the MOH to provide evaluation of the pilot initiative and further roll out of nurse-initiated ART to most facilities, including expansion of pediatric ART initiation and providing training to all registered nurses. (3) ICAP will support full implementation of treatment initiation for clients with a CD4 count of 350 or lower. This will include development and implementation of a communication strategy on the lower treatment threshold, targeting the community through HCWs and through traditional community structures. (4) Quality of service: The major thrust of effort during this two year period will be on improved and sustained quality of ART services. Multi-disciplinary teams will be supported to consolidate their skills in clinical systems mentoring and ongoing quality improvement. (5) Prisons and Uniformed Services: ICAP will continue its effort to establish quality on-site ART and effective linkages for the prison populations and uniformed services in need of HIV care and treatment.(6) Treatment as Prevention: ICAP will work with MOH and other stakeholders to improve areas in the health system that needs to be strengthened in order to introduce a higher CD4 threshold for initiating treatment.

Many of the government owned health facilities in Swaziland are inadequate for current needs. Some are in outright disrepair; others are not designed in a manner that meets the chronic care needs of the current population: waiting areas are too small; infection control needs (windows, ventilation) are unmet; adequate space for consulting rooms, record keeping, point of care laboratories, and waste management facilities are often completely lacking. As a result, patient flow is inefficient and, with the high rates of TB and poor infection control, often dangerous to both patients and staff. The funds in this project will be used to undertake minor renovations to facilities to bring them up to minimum standards and provide the basic furniture needed to run the facility to support quality chronic care services (eg, filing cabinets). The funds will be leveraged with resources from the

MOH and other donors like the World Bank, Clinton Foundation and MSF.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	PDTX	1,333,333	0

Narrative:

In FY 2013, ICAP expects to support the initiation of more than 1,600 children under the age of 15 years on ART. During that year, it is anticipated that over 6,700 children will be currently enrolled on ART.

In addition to the activities described under Pediatric Care and Support, ICAP will continue to work with Baylor College to support the following activities specifically targeting pediatric treatment:

• Intensified efforts to test all children of clients enrolled in HIV care and treatment.
• More aggressive facility and community follow up of children on ART who miss their appointments.
• Better integrated and strengthened APS for children on treatment and their caregivers.

Implementing Mechanism Details

Mechanism ID: 10621	**Mechanism Name: DOL-ILO HIV/AIDS in the Workplace**
Funding Agency: U.S. Department of Labor	Procurement Type: Cooperative Agreement
Prime Partner Name: International Labor Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

With PEPFAR support, the International Labour Organization provides technical assistance to national partners to

establish a sustainable national workplace program as well as prevent HIV and provide services using the workplace as an entry-point. The program covers 26 enterprises plus 26 government ministries. It assists in the development of workplace HIV policies, and implementation of programs using a combination of approaches. COP 2012 will support the expansion and extension of HIV workplace policies, programs and activities as there are planned new HIV/AIDS workplaces program initiatives. By using a combination of approaches for prevention (biomedical, information, behavioural and structural) and by using the workplace as an entry point , the ILO contributes to a coordinated and comprehensive response for sexual prevention. The ILO brings to the response its understanding and expertise in the world of work. ILO knows that the workplace is a key location for HIV/AIDS prevention and care program. Issues in relation to TB in the workplace and gender equity are fully integrated in the training curriculum of the peer educators.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**10621**

Mechanism Name:	DOL-ILO HIV/AIDS in the Workplace
Prime Partner Name:	International Labor Organization

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The ILO M & E framework and plan will be reviewed to be in alignment with the national thematic area of response management, where the project will contribute to the monitoring and evaluation strategies listed as item 5.5.8 in the National Strategic Framework(NSF). The program will create an enabling environment at the implementers level for national monitoring and evaluation activities to operate effectively through the below listed activities.

- *Conduct M&E training and workshops to develop, pre-test, review and adopt data collection tools to improve quality of data obtained from peer educators*
- *Mentoring and audit checklist review and orientation for workplace programs to strengthen their alignment with new labour standard on HIV/AIDS and the World of Work (Recommendation No. 2000).*
- *Conduct workshops to review and follow up on peer educator work plans and provide technical guidance on areas with challenges*

The project will share M & E reports with the national M & E technical working committee. The Project M & E Officer will be a member of the national M & E committee. The ILO M & E plan will be aligned, implemented and monitored along the national M & E framework. This alignment and support at national level will strengthen the coordination of data management and use to avoid overlaps plus improve on data accessibility when it comes to monitoring workplace interventions.

With the support of COP 2012, the project will work on developing a data collection tool for peer educators and train them on its use to improve data integrity and quality. The peer educators will be trained on using the tool to collect/record data to be submitted at enterprise level, then at regional level through Regional Multi-Sectoral HIV/AIDS Coordinating Committee (REMSHAC) structures, REMSHAC will feed the national M & E structures.

A presentation has already been made with NERCHA on how ILO can contribute to harmonizing the national M & E activities at national level. Making inroads to national M & E platforms can be attributed as an achievement, as we are addressing the gap identified by ILO impact survey.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	OHSS	0	0

Narrative:

The project's partner enterprises contribute in-kind and financial resources by virtue of allowing workers to attend workshops during official time. In addition they support the development of banners and other resource materials during the commemoration of the World AIDS Day. Some enterprises have clinics in their premises which provide services at no cost to the employee.

- *Establish and capacitate HIV/AIDS committees in workplaces form the private and public sectors to coordinate the HIV responses and mainstream HIV in current activities (workplace health facilities, occupational safety and health structures)*
- *Provide technical assistance to the HIV/AIDS workplace committees for the development of HIV/AIDS workplace policies and programs in line with the ILO Code of Practice and new international labour standard on HIV/AIDS and the World of Work (Recommendation No. 200).*
- *Review existing HIV/AIDS workplace legal and policy framework at the enterprises and national levels in accordance with the new international labour standard.*
- *Monitor and evaluate the implementation of the workplace policies.*
- *Build program management capacity among partners*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

The Government of Swaziland/ILO/USDOL/PEPFAR HIV Workplace Education Project supports the implementation of HIV/AIDS Workplace programs with enterprises from agriculture, manufacturing, retail, uniformed and public service sectors. A large proportion of the workers from these sectors are mobile in nature and their priority is to earn a salary and not access HIV/AIDS services due to non conducive structural, environmental and behavioral conditions, therefore the need for HIV/AIDS workplace interventions.

The Demographic and health Survey (2006) showed that the country has the highest HIV prevalence rates in the world of 26%. This being the target population of the ILO (15-49).

The ILO with support from PEPFAR and in consultation with its constituents, will therefore ,on the strength of the above support efforts to combat HIV/AIDS in the world of work across the four regions in Swaziland(national) targeting 23 000 workers from private sector and 27 000 workers from public service. The major thrust of the project is workplace education, protection against stigma and discrimination and increase worker access to prevention, care and support and treatment services. The strategy is building upon the ILO's comparative

advantage in advocacy and policy development, particularly drawing on its Code of practice on HIV/ AIDS and the world of work.

The major strategies to be used in the project include, advocacy for policy formulation and implementation of prevention, care and support interpersonal communication and capacity building activities within the workplace. With the support of COP 2012 the project will conduct;

- *Mentoring and refresher workshops HIV/AIDS workplace committees members and peer educators from the private and public sectors in the implementation of behavior change program for the workplace with the objective of reducing number of individuals involved in multiple and concurrent partnerships*
- *Mentoring and refresher courses through structured workshops of master trainers for peer educators in workplaces from the public sector and private sectors to ensure the sustainability of the interventions*
- *Development of tailor-made behavior change materials for specific target groups of workers taking into account age, gender, attitudes and practices and dissemination through most effective channels to reach them during a significant period to sustain behavior change.*
- *Mentoring and refresher workshops of government officials, key member of employers' and workers' organizations in the implementation of behavior change strategies and program and policies to create an enabling environment to behavior change at workplace even at national level.*

The above activities will be evaluated and monitored through a built –in Project monitoring Plan identifying impact as well as strengths and weaknesses for any preplanning needed. A Performance Monitoring Plan (PMP) with country-specific indicators was developed to assess project impact. The monitoring system rests on three pillars:

1) Workers' survey to measure impact on knowledge, attitudes and practices of target workers;
2) Workplace monitoring to assess impact on the partnering workplaces of policies and programs, including a workplace audit checklist;
3) National monitoring to collect information on the technical assistance provided for activities of the national partners to strengthen their capacity and allow them to contribute to national strategies and framework

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

The Government of Swaziland/ILO/USDOL/PEPFAR HIV Workplace Education Project supports the implementation of HIV/AIDS Workplace programs with enterprises from agriculture, manufacturing, retail, uniformed and public service sectors. A large proportion of the workers are females who are involved in transactional sex and have a high HIV prevalence of 50% (Preliminary results of the Swaziland Behavioral and

Surveillance Survey 2010)

The Demographic and health Survey (2006) showed that the country has the highest HIV prevalence rates in the world of 26%. This being the target population of the ILO (15-49)

The ILO with support from PEPFAR and in consultation with its constituents, will therefore ,on the strength of the above support efforts to combat HIV/AIDS in the world of work across the four regions in Swaziland(national) targeting 23 000 workers from private sector and 27 000 workers from public service. The major thrust of the project is workplace education, protection against stigma and discrimination and increase worker access to prevention, care and support and treatment services.. The strategy is building upon the ILO's comparative advantage in advocacy and policy development, particularly drawing on its Code of practice on HIV/ AIDS and the world of work.

The major strategies to be used in the project include, advocacy for policy formulation and implementation of prevention, care and support, interpersonal communication and capacity building activities within the workplace. With the support of COP 2012 the project will conduct;

- *Mentoring and refresher workshops of peer educators in condom promotion and distribution, including dialoging around condoms*
- *Conduct structured dialogues specific to target groups of workers taking into account age, gender, attitudes and risk behavior (transactional sexual relationships, use of alcohol) and dissemination through most effective channels to reach them during a significant period to sustain behavior change*

The above activities will be evaluated and monitored through a built –in Project monitoring Plan identifying impact as well as strengths and weaknesses for any preplanning needed. A Performance Monitoring Plan (PMP) with country-specific indicators was developed to assess project impact. The monitoring system rests on three pillars:

1) Workers' survey to measure impact on knowledge, attitudes and practices of target workers;

2) Workplace monitoring to assess impact on the partnering workplaces of policies and programs, including a workplace audit checklist;

3) National monitoring to collect information on the technical assistance provided for activities of the national partners to strengthen their capacity and allow them to contribute to national strategies and frameworks.

Implementing Mechanism Details

Mechanism ID: 10694	**Mechanism Name: MOH Capacity Building**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Ministry of Health and Social Welfare, Swaziland	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1,960,000	
Funding Source	**Funding Amount**
GAP	126,029
GHP-State	1,833,971

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The capacity to deliver quality services in Swaziland is constrained by a number of interlinked factors,including the need for strengthened management,planning,monitoring and evaluation capacity,greater accountability and improved coordination.Although efforts are underway to decentralize the health system,the roles and functions of the different levels of the system are not yet clearly defined while necessary reorientation and capacity building are not yet being implemented.To be effective therefore,the health system at the national regional,inkundl (district),community and facility levels will require improved technical and managerial capacity in order to cope with the new and additional responsibilities that will come with the health sector reforms and decentralization.Under the Partnership Framework strategic objective of building capacity of the public sector to coordinate,manage and fund its own HIV/AIDS response,this mechanism establishes a direct funding relationship between PEPFAR and the GKOS.It is anticipated that being an implementing partner for this mechanism will benefit the MOH not just though program outputs but also by strengthening its capacity around coordination,oversight and cooperative agreement management.Efforts of the MOH under this cooperative agreement will be directed at building capacity for the following strategic priority areas:laboratory capacity and infrastructure,strategic information, quality assurance, and planning and policy development.While activities under this service delivery area are intended to specifically improve the management and delivery of HIV/AIDS and TB services, capacity of targeted health systems will have broad-based effects on improving service delivery throughout the health sector.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10694		
Mechanism Name:	MOH Capacity Building		
Prime Partner Name:	Ministry of Health and Social Welfare, Swaziland		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	120,000	0

Narrative:

The MOH CDC Cooperative Agreement (Coag) works on systems strengthening that focuses on supporting care and treatment for people with HIV. Portions of this budget code therefore will fund coordination of these system strengthening efforts, including related laboratory services and systems to provide blood transfusions as a result of AZT-induced anemia. Another key area in which the Coag is giving increased support is strategic planning, capacity building and implementation of quality improvement and quality assurance activities. Consistent use of QI and QA methodology is the key to tracking, evaluating and improving clinical outcomes and other performance data, both nationally, regionally and at the site level. In addition, the Coag has funds reserved for renovations as many of the government owned health facilities in Swaziland are inadequate for current needs. Some are in outright disrepair. Others are not designed in a manner that meets the chronic care needs of the current population: waiting areas are too small; infection control needs (windows, ventilation) are unmet; adequate space for consulting rooms, record keeping, point of care laboratories, and waste management facilities are often completely lacking. As a result, patient flow is inefficient and, with the high rates of TB and poor infection control, often dangerous to both patients and staff. Some of the funds in this budget code will be used to renovate facilities to bring them up to standard and provide the basic furniture needed to run the facility to support quality chronic care services (eg, filing cabinets). The renovation funds will be leveraged with resources from the MOH and other

donors like the World Bank, Clinton Foundation and MSF.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	120,000	0

Narrative:

In FY13 in partnership with URC assist aims to: scale up and strengthen provision of integrated TB/HIV including MDR-TB care and treatment services to PHC clinics and communities; institutionalize Quality Improvement/Quality Assurance for TB/HIV services at national and health facility levels; strengthen the capacity of MOH Tuberculosis Control and AIDS programs to lead and manage roll out of TB/HIV care and treatment services; contribute to health systems strengthening; conduct operational research to inform current practices; strengthen the programmatic and clinical MDR-TB management; and improve TB/HIV knowledge management, monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	120,000	0

Narrative:

The PEPFAR Swaziland Pediatric HIIV care and support covers a target population of 0-15yrs. PEPFAR Swaziland supports the government of swaziland's family-centered approach to HIV care and treatment which includes family testing strategies at health care facilities (DBS for infants 0-18months and rapid test thereafter) as well as during home-based HTC. Children are tested as part of the family during home-based testing and are referred for care and support services similar to standard protocols for adult care and support. At health facilities, a family tree approach is used to identify all children in the family who need to be tested, using the parent as an index case at pre-ART and ART care points. There is an efficient system in place at health facilities to identify exposed infants for DBS. More than 95% of exposed infants currently receive DBS. The far majority (79%) of exposed infants are initiated on co-trimoxazole and over 95% are initiated on extended Nevirapine. The main challenge is tracking exposed infants to know what happens to them. PEPFAR Swaziland is currently working with the national strategic information department to set up a surveillance system to follow up exposed infants. PEPFAR supports adolescent clubs to provide peer support for adolescents living with HIV. These clubs meet regularly to discuss adherence issues, and how to live positively. Efforts are in place to strengthen adolescent care and support through special clinics where adolescents will receive more attention to issues specific to adolescents and to ensure smooth transition into the adult care and support programme to minimize lose to follow up. An adolescent TWG has recently been formed at the national level. This TWG which is a sub-committee of the Pediatric TWG will focus of adolescent specific issues to ensure that their issues are not lost between the adult and pediatric TWG discussions. PEPFAR Swaziland partners will participate in these meetings to provide technical support for both pediatric and adolescent issues. PEPFAR will support job aides and IEC materials that are kid friendly to support psychosocial and adherence counseling. PEPFAR Swaziland is supporting efforts to improve early enrollment of infants testing

positive from DNA-PCR into care and treatment. Nurses are being trained both in didactic trainings and clinical attachments through a sub-award to Baylor Center of Excellence to acquire more knowledge and skills in diagnosis and management of pediatric opportunistic infection, pediatric phlebotomy as well as psychosocial and adherence needs of pediatrics. Starting from FY 13 through FY 14, the pediatric guidelines will be revised in line with current evidence to improve pediatric HIV care and support. World Food Programme has a food for prescription programme for children from 5yrs and above. PEPFAR partners support the implementation of this program by training healthcare workers on how to identify malnourished children using MUAC and/or BMI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	300,000	0

Narrative:

All laboratory testing, including rapid/simple testing for HIV consists of a series of processes and procedures that must be carried out correctly in order to obtain accurate results. An approach that monitors all parts of the testing system is needed to ensure the quality of the overall process, to detect and reduce errors, to improve consistency between testing sites, and to help contain costs. This approach to laboratory quality, called a quality system, is defined as the organizational structure, resources, processes, and procedures needed to implement quality management of the laboratory or testing site. This component of the MOH Cooperative Agreement will focus on strengthening the quality system for laboratory services. The MOH through the national laboratory will establish a national quality system for HIV testing. This will include a national office for laboratory quality management, identification of a national quality officer or manager.

In order to extend the quality system to all aspects of testing practices and to avoid vertical decisions and assessments the national laboratory will develop an overall, country-wide plan for the management of HIV rapid testing, including the introduction of proficiency testing and on site supervision and mentoring. Monitoring processes will be established to identify problems and solutions to the problems to ensure that the system is working efficiently. Scheduling of training programs to coincide with national program implementation, budgeting for supplies, kits, printing of training materials, etc will also form part of the plan. Protocols for Preparing HIV Positive Quality Control Materials and instructions for making a supply of HIV positive samples at a desired reactivity level to be used as a daily control, or as part of a proficiency testing panel will also be developed.

On the job mentoring will constitute a central part of facilitative supervision and QA approach to in the laboratories. The MOH will establish an organizational structure to assure that on-site monitoring occurs in all locations. This will require a sufficient number of staff who has been trained to conduct the monitoring. Visits will be conducted at least twice yearly to established sites with experienced personnel. New sites or sites with new staff will be visited at least quarterly. In sites with demonstrated problems, the number of visits will be increased in order to provide training and technical assistance. The findings from each site visit will be recorded according to the national policy, and the findings should be reviewed and corrective action taken when required. A report and

the completed checklist will be submitted to the relevant authorities for review and corrective action if needed. PEPFAR will fund activities to ensure accessibility of laboratory services throughout the country especially amongst the rural population. It will address specifically the areas of TB diagnostics, HIV testing and CD4 enumeration. Emphasis will be placed on developing a system that will ensure timely delivery of comprehensive quality laboratory services that are effective, efficient, accessible and affordable to all.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	450,000	0

Narrative:

Swaziland's MOH has a Strategic Information (SI) Department, comprised of HMIS, M&E, and Epidemiology sections and having statutory responsibility for managing all health and health service data for the country. However, due to capacity constraints, the SI department is often unable to meet the informational needs of the MOH in terms of high quality information products. Poor coordination has led to redundancy in data systems and overburdening of peripheral staff who are charged with collection and processing of information. The consequence of these twin "storms" (low capacity and inefficient/redundant systems) is that reports are often incomplete, late, and of generally low quality.

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on the determinants of health, health system performance and health status. Actions to strengthen the health information system will include:

• Strengthening personnel skills and procedures

• Acquiring appropriate equipment to facilitate or improve the generation of data;

• Strengthening capacity of regional level in compiling, analyzing or synthesizing health data into strategic information.

• Strengthening analytical skills and in-depth data utilization for program improvement

The Cooperative agreement specifically targets MOH institutional capacity and thereby supports the Partnership Framework pillar concerned with human and institutional capacity building. At the same time, the other four service delivery pillars are given support though improved health systems and higher quality, more timely information for decision making. Given the wide scope of the SI activities, some of the costs of the Cooperative agreement coordination unit are borne by the SI budget code.

The MOH in collaboration with PEPFAR/CDC will build a project management and M&E functionality within the Project Management Unit (PMU) of the MOH which will track key objectives and outputs under the MOH-PEPFAR Cooperative Agreement including:

• Increase strategic training outputs

• Enhancing the SI budgeting and planning process

• Improved timeliness and completeness of national HMIS data,

• *Enhancing availability of SI products for decision-making*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	110,000	0

Narrative:

The main functions of the MOH at the national level include policy formulation, standards and quality assurance; programming and planning; resource mobilization and allocation; capacity development and technical support to the lower levels of the system; provision of public health services, such as epidemic control, co-ordination of health services; monitoring and evaluation of the overall sector performance. Appropriate capacity building measures will be undertaken to strengthen corporate governance and management procedures, practices and systems in order to engender institutional growth, efficiency, cost-effectiveness, responsiveness and sustainability.

The purpose of the MOH decentralization program is to facilitate equitable, timely, efficient and cost-effective management of the health system and delivery of health services. Specifically, it is the aim of decentralization program to devolve authority and responsibility in the implementation, management, coordination, monitoring and evaluation of health services.
A key strategy to support and accelerate effective decentralized service delivery is to develop essential planning skills at regional planning units. For this to happen, the MOH's planning unit will itself need to be strengthened in a sustainable way.

Functionally, while the central MOH will seek to empower the regional and the other decentralized structures to function autonomously, the MOH will effectively relate to the regions in executing their roles by:

• *Developing service standards and guidelines for service delivery and management in line with the MOH Essential Package of Health Services*
• *Ensuring that the annual planning and budgeting cycle is strictly implemented by providing Health Policy and Planning Department's technical support to the regions as requested*
• *Establishing systems for monitoring the state of infrastructure and equipment, prioritizing needs and coordinating the use of MOH, PEPFAR and other donor resources to respond to them.*
• *Support to the QA/QI program, institutionalizing QA/QI practices into daily practice-- building from the foundation provided by the male circumcision program*
• *Support to the Global Fund/PEPFAR collaboration*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	500,000	0

Narrative:

In FY12, PEPFAR will continue to support the Swaziland National Blood Transfusion (SNBTS) in line with its Strategic Plan, which will have cross-cutting benefits for several PEPFAR programs. A fully capacitated SNBTS will provide at least 18,000 units of safe blood per annum to the health service. The establishment of a nationally-coordinated blood transfusion service, collection of blood from voluntary non-remunerated blood donors from low-risk populations, as well as testing of all donated blood for HIV, including screening for transfusion-transmissible infections, blood grouping and compatibility testing, are all critical elements of a successful program. PEPFAR will continue working with the SNBTS to develop a set of quantitative indicators modeled after WHO standards. A safe blood supply is increasingly acknowledged as a critical treatment adjunct to manage HIV related anemia with up to 70% of all patients with HIV developing anemia.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	120,000	0

Narrative:

The MOH CDC Cooperative Agreement (Coag) works on systems strengthening that focuses on supporting care and treatment for people with HIV. Portions of this budget code therefore will fund coordination of these system strengthening efforts, including related laboratory services and systems to provide blood transfusions as a result of AZT-induced anemia. Another key area in which the Coag is giving increased support is strategic planning, capacity building and implementation of quality improvement and quality assurance activities. Consistent use of QI and QA methodology is the key to tracking, evaluating and improving clinical outcomes and other performance data, both nationally, regionally and at the site level. In addition, the Coag has funds reserved for renovations as many of the government owned health facilities in Swaziland are inadequate for current needs. Some are in outright disrepair. Others are not designed in a manner that meets the chronic care needs of the current population: waiting areas are too small; infection control needs (windows, ventilation) are unmet; adequate space for consulting rooms, record keeping, point of care laboratories, and waste management facilities are often completely lacking. As a result, patient flow is inefficient and, with the high rates of TB and poor infection control, often dangerous to both patients and staff. Some of the funds in this budget code will be used to renovate facilities to bring them up to standard and provide the basic furniture needed to run the facility to support quality chronic care services (eg, filing cabinets). The renovation funds will be leveraged with resources from the MOH and other donors like the World Bank, Clinton Foundation and MSF.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	120,000	0

Narrative:

he PEPFAR Swaziland Pediatric HIIV treatment covers a target population of 0-15yrs. PEPFAR Swaziland supports the government of swaziland's family-centered approach to HIV care and treatment which includes family

testing strategies at health care facilities (DBS for infants 0-18months and rapid test thereafter) as well as during home-based HTC. Children are tested as part of the family during home-based testing and are referred for care and support services similar to standard protocols for adult care and support. At health facilities, a family tree approach is used to identify all children in the family who need to be tested, using the parent as an index case at pre-ART and ART care points. There is an efficient system in place at health facilities to identify exposed infants for DBS. More than 95% of exposed infants currently receive DBS. The far majority (79%) of exposed infants are initiated on co-trimoxazole and over 95% are initiated on extended Nevirapine. The main challenge is tracking exposed infants to know what happens to them. PEPFAR Swaziland is currently working with the national strategic information department to set up a surveillance system to follow up exposed infants. PEPFAR supports adolescent clubs to provide peer support for adolescents living with HIV. Efforts are in place to strengthen adolescent treatment, care and support through special clinics where adolescents will receive more attention to issues specific to adolescents and to ensure smooth transition into the adult care and support programme to minimize lose to follow up. An adolescent TWG has recently been formed at the national level. This TWG which is a sub-committee of the Pediatric TWG will focus of adolescent specific issues to ensure that their issues are not lost between the adult and pediatric TWG discussions. PEPFAR Swaziland partners will participate in these meetings to provide technical support for both pediatric and adolescent issues. PEPFAR will support job aides and IEC materials that are kid friendly to support psychosocial and adherence counseling. PEPFAR Swaziland is supporting efforts to improve early enrollment of infants testing positive from DNA-PCR into care and treatment. Nurses are being trained both in didactic trainings and clinical attachments through a sub-award to Baylor Center of Excellence to acquire more knowledge and skills in diagnosis and management of pediatric opportunistic infection, pediatric phlebotomy as well as psychosocial and adherence needs of pediatrics. Starting from FY 13 through FY 14, the pediatric guidelines will be revised in line with current evidence to improve pediatric HIV treatment World Food Programme has a food for prescription programme for children from 5yrs and above. PEPFAR partners support the implementation of this program by training healthcare workers on how to identify malnourished children using MUAC and/or BMI.

Implementing Mechanism Details

Mechanism ID: 10695	**Mechanism Name: ICAP/UTAP**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 55,000	
Funding Source	**Funding Amount**
GHP-State	55,000

Sub Partner Name(s)

Eastern & Southern Management Institute	Johns Hopkins University Bloomberg School of Public Health	

Overview Narrative

The ICAP/UTAP implementing mechanism focuses on evaluative activities and documentation of key programmatic areas for all ICAP and MOH supported work.

ICAP/UTAP supports the strategic information component of the Human and Institutional Capacity Development pillar the PFIP. Specifically, this activity contributes to strengthened systems for strategic information and data for decision making. Better use of data for decision making in turn contributes to program improvement under the care and treatment pillar of the PFIP.

The target population for ICAP/UTAP is the MOH Strategic Information Department (SID) at the national and regional levels, facility staff and community-based sub-grantees.

ICAP/UTAP is contributing to efforts to improve the cost efficiency of M&E support activities in Swaziland by working within one national M&E system and by participating in forums to reduce duplication and overlap for improved coordination and impact of M&E support.

ICAP/UTAP is building the capacity of the National ART program to undertake routine data quality assessment and utilize routinely collected data for decision making. ICAP/UTAP is also strengthening the capacity of SID to conduct a range of M&E activities that can better document program implementation and inform program planners. The ICAP/UTAP effort will be assessed on its adherence to planned activities and achievement of set targets, including strengthened local M&E capacity.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 10695 Mechanism Name: ICAP/UTAP Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	55,000	0

Narrative:

During COP 2012/13, ICAP/UTAP will continue to build the capacity of the Swaziland National ART Program (SNAP) in data analysis and utilization. ICAP/UTAP will also undertake the following three special evaluative activities.

1. Based on the findings of the FY2011 feasibility study, ICAP/UTAP will undertake a nationwide comparative study to establish the effect of expert client support on long term clinical outcomes. This will be an important study to determine the value of sustaining the expert client program for the MOH.
2. ART initiation and services have been rapidly decentralized throughout the country with ICAP's support. During this funding period, ICAP/UTAP will support an evaluation of service quality within this decentralized public sector system. The findings of this evaluation will contribute to planning for the sustainability of decentralized ART services.
3. ICAP/UTAP will support an evaluation of the effectiveness of community and health facility efforts to retain clients in pre-ART. The findings of this review will help to guide future resource investments.

Implementing Mechanism Details

Mechanism ID: 10703	**Mechanism Name: Strengthening**

	Pharmaceutical Services
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 1,150,000	
Funding Source	**Funding Amount**
GHP-State	0
GHP-USAID	1,150,000

Sub Partner Name(s)

Luvit Solutions		

Overview Narrative

The goal of the SPS program is to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. SPS aims to promote and utilize a systems strengthening approach consistent with GHI, which will result in improved and sustainable health impact. According to WHO (2007), medical products, vaccines and technology are one of the 6 health systems building blocks. The SPS program is designed to reflect a dynamic relationship among the five building blocks with a Medical Products building block overlay. The above goal is linked to the PFIP key intervention area which aims to decentralize and improve quality of care and treatment services in order to increase access and improve outcomes for PLWHA through improved supply chain management (selection, procurement, distribution/storage, and use). SPS aims to contribute to this objective by ensuring the availability of trained pharmacy professionals, information systems and high quality essential medicines and commodities across the key intervention area of decentralized care & treatment services. SPS will provide central and facility level support to strengthen pharmaceutical and supply chain systems. ART program site support will be provided in collaboration with ICAP at 3 regions (Lubombo, Hhohho and Manzini) and Medecins San Frontieres (MSF) at Shiselweni region. Priority populations will be the people living with HIV/AIDS (adult and children), health workers, prisoners, military personnel, women and girls. Activities will be planned to support the sustainable availability of commodities for the Medical Male Circumcision program.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	5,000
Human Resources for Health	640,000
Motor Vehicles: Purchased	60,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10703**		
Mechanism Name:	**Strengthening Pharmaceutical Services**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	130,000	0

Narrative:

In order to ensure the continuous availability of essential medicines for priority health conditions in the country, the supply chain system should be so robust that it ensures an uninterrupted supply. The key priority intervention for the next two years is to revise the full spectrum of the supply chain system in the country. The SIAPS program will work to improve coordination, integration and accountability within the government's supply chain system. The

Central Medical Stores will be restructured to improve operational efficiencies and accountability. Infrastructure improvements will be carried out to ensure the availability of appropriate space for storage and dispensing of medicines at both HIV treatment initiation and refill sites. With the expansion of HIV care and treatment service points, SIAPS will work to ensure that there is an uninterrupted supply and rational use of all medicines for opportunistic infections and the management of pain. SIAPS will continue the work started by SIAPS in ensuring availability of Co-trimoxazole and Fluconazole for the comprehensive management of opportunistic infections. Working with the Malaria Control Program, SIAPS will monitor the availability and use of malaria products. SIAPS will also work with the Central Medical Stores to improve the management and distribution of supplies for the Home Based Care (HBC) program. Support will be provided to local palliative care service providers to promote the rational use of opiod and non-opiod analgesics for terminally ill patients. SIAPS will work to improve the rational use of medicines through providing technical support to Pharmacy and Therapeutics Committees (PTC) at the 4 hospitals in the country. These committees are tasked with managing the selection of medicines for the formulary, evaluating the medicines' use and then implementing strategies to improve their use at facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	295,000	0

Narrative:

SIAPS will support the supply chain of the National TB Control Program to strengthen the implementation of the 3 I's of TB management. Activities will also be targeted at providing information for the management of TB and surveillance of DR – TB. The SPS program has in the past worked directly with the National TB Control Program to ensure an uninterrupted supply of TB medicines and the availability thereof at health facilities including ART treatment clinics. The focus of support activities has been on quantification, estimation and improving the overall procurement planning of first line and second line drugs procured through Global Drug Facility mechanism. The support will also focus on improving the quantification and procurement of second line drugs (MDR-TB drugs). During the next two years, SIAPS will work to support the implementation of the Isoniazid Prophylaxis Therapy (IPT). The SIAPS program will work with MOH and partners to ensure anti-TB medicines and diagnostic commodities are available to support the TB program. With the introduction of Gene-Xpert®, the case load for DR-TB is expected to increase as the confirmation of the DR strain will be quicker. Gene-Xpert® (Xpert) is currently procured by various partners – Global Fund round 10 and MSF. The SIAPS program will support the MOH in ensuring the availability of commodities for this instrument. The logistics management information system for TB medicines will be improved to ensure that reporting and requisition of TB medicines is integrated into the national supply chain systems. A system of commodity tracking will be developed to monitor the availability of commodities at all levels of the supply chain. The target activities in the next two years will be to ensure the continuous availability of CPT and IPT including vitamin B6. Through support to the Pharmacy and Therapeutic committees, SIAPS will support the facilities to ensure the availability of supplies for Infection Prevention Control. SIAPS will train health workers and develop job aids to support the health workers in

dispensing of TB medicines to children.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

A well functioning laboratory supply chain will enhance the availability of essential commodities and supplies required to provide necessary laboratory services towards achieving health outcomes. Laboratory supply chain is an essential element in the scale up of treatment and care services. It is also critical in ensuring the quality of the diagnostic services provided in the country. With additional resources and activities aimed at scaling up treatment and care services, such as the introduction of point of care equipment and the Xpert technology for DR-TB diagnosis, it is critical that the commodities and supplies of highest quality be available consistently. SIAPS will support the supply chain management in the laboratory system, capacity building in the logistics management system, policy guidance in procurement of reagents and equipment, logistics information systems. SIAPS will work with University Research Council (URC, LLC) to improve the management of laboratory supplies and commodities in support of program scale up and expansion. Activities will be focused on ensuring an uninterrupted availability of laboratory commodities for HIV&AIDS (including HTC commodities for the Medical Male Circumcision program), TB and Malaria programs. SIAPS will work with partners such as MSF, CHAI and URC / APHL to ensure commodity security for the laboratory services (POC, Xpert). The Supply Chain Technical Working Group will work to develop a commodity security strategy for laboratory services. This will also coordinate all inputs from donor and government to ensure an uninterrupted availability of commodities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	595,000	0

Narrative:

SIAPS will work closely with the National AIDS Program to improve the quality of pharmaceutical services provided in the country's ART initiation and refill sites. A total of over 500 health workers have been trained under the SIAPS program on ARV supply chain management, HIV Pharmaceutical Management and also general principles of inventory management. Personnel from the country's 234 facilities [clinics, hospitals and health centres] have been trained. In addition, funds will go to support a pharmacy training program at UNISWA. SIAPS will work with the 4 regional pharmacists in the country to improve medicines' use at facilities with the development of Standard Operating Procedures and other interventions to improve quality pharmaceutical services at clinics and health centers. The capacity and skills of these regional pharmacists will be improved to provide supportive supervision and systems approach mentoring. The SIAPS program procured storage equipment for the 9 newly constructed additional medicines dispensaries and stores to improve the storage capacity for essential medicines. Additional storage facility refurbishments at peripheral facilities will be undertaken under the SIAPS program in support of the decentralization of ART services. The focus on these refurbishments will be on medicine storage

space, equipment and supplies for dispensing medicines. In the next two years, SIAPS will work to rationalize the use of storage space for essential medicines and laboratory commodities. SIAPS will work to support ART scale-up services at additional facilities to ensure the provision of quality pharmaceutical services at these facilities. Projects such as the NARTIS (Nurse ART initiation in Swaziland) will be supported on aspects of adherence monitoring, pharmacovigilance and other aspects of quality pharmaceutical services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	130,000	0

Narrative:

SIAPS will work to support the expansion of pediatric HIV Care and Support services through strengthening the supply chain and rational use of medicines for the management of opportunistic infections. SIAPS will support the early access to services, diagnosis and care for exposed infants through improvement in the commodity availability to support pediatric care programs. Support is provided as part of the comprehensive, family oriented approach where medicines for children, care-givers to manage their condition – opportunistic infection - are available in a one-stop centre. The most common causes of death amongst children with HIV are pneumonia and diarrhea. SIAPS will work with the MOH in improving the management of childhood illnesses through the implementation of treatment guidelines which are linked to the IMCI (Integrated Management of Childhood Illnesses). In the development of these guidelines, conditions such as pneumonia, diarrhea, malaria, measles and other HIV infections are considered as key conditions that should be managed appropriately at primary health care (PHC) level. Medicines for these conditions will be monitored to ensure continuous availability at all PHCs according to the national essential medicines list. These medicines include, antibiotics, co-trimoxazole, zinc supplements. SIAPS will work to ensure an uninterrupted supply of Co-trimoxazole; appropriate forecasting, and quantification principles will be used. Providers will be mentored on stock monitoring and dosing of pediatric co-trimoxazole. The co-trimoxazole is available to all eligible patients (infants and caregiver) at no cost. SIAPS will support MOH budgeting and procurement functions in view of the transitioning out of the UNITAID/CHAI that has been procuring CTX for the national program.

Implementing Mechanism Details

Mechanism ID: 10822	**Mechanism Name: ICAP-HRSA**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No

Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 55,000	
Funding Source	**Funding Amount**
GHP-State	55,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The ICAP/HRSA activity is directly linked to the Partnership Framework Implementation Plan Human and Institutional Capacity Development Pillar Objectives one (management of the health care workforce) and three (training of the health care workforce). The ICAP/HRSA projects works through the ICAP/CDC platform to target the Ministry of Health training department at the national, regional and facility level and the Swaziland Nursing Council. The HRSA activity aims to support the MOH to put in place a sustainable professional development and in-service training program that will rationalize training provision, reduce overlap and duplication and ensure that all nurses are trained in the requisite skills to provide quality care.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10822
Mechanism Name:	ICAP-HRSA
Prime Partner Name:	International Center for AIDS Care and Treatment Programs, Columbia University

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	55,000	

Narrative:

ICAP will continue to support the scale up of mentorship, preceptorship and facilitative supervision and will conduct an evaluation of the progress made to date.

ICAP/HRSA will support the MOH and the Swaziland Nursing Council to rationalize IST specifically for nurses, but with benefit for other cadres as well. Specifically, ICAP/HRSA will:

Support the MOH to develop an IST policy and strategic plan;

Support the establishment of an IST database and M&E tools to track IST provided and monitor the quality of that training; and,

Strengthen the capacity of IST Coordinators through training and information dissemination on the IST policy, strategic plan and M&E tools.

ICAP supported the MOH to establish a national Wellness Center for health care workers to access health care, behavior change communication and psychosocial support to maintain good health and better manage the demands of their work. The Wellness Center currently operates at the national level. During this period, ICAP/HRSA will contribute to the:

Roll out of a lifestyle behavior change communication strategy for health care workers;

Implementation of biannual wellness days within the four regions, including a know your status campaign and regional dialogues aimed at reducing HIV-related stigma among health care workers; and,

The development of an integrated advocacy and communication strategy and training materials on health care workers' occupational health and safety rights and responsibilities.

As part of its professional development support for nurses, ICAP will assist the MOH to participate in international nursing conferences.

ICAP, in collaboration with key stakeholders, will support an end of program evaluation of the INCI initiative to assess progress and inform future plans.

Depending on the continuation of the International Nursing Capacity Initiative and available funding, ICAP will support the University of Swaziland in the development of a part time masters program in clinical diagnosis and management of common morbidities in Swaziland, including HIV and TB (at nurse practitioners level).

Implementing Mechanism Details

Mechanism ID: 11673	**Mechanism Name: DoD/USDF Umbutfo Swaziland Defence Force**
Funding Agency: U.S. Department of Defense	Procurement Type: USG Core
Prime Partner Name: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The program directly contributes to the prevention care and treatment strategies of the National Strategic Framework on HIV and AIDS 2009 -2014 and the PEPFAR Partnership Framework Implementation plan by expanding comprehensive prevention, care and treatment to the military their families and the civilian community within reach of the military program. Through combination prevention, the program aims to reduce the rate of new infections among the USDF troops. MC services are provided through the Phocweni clinic supported by other USDF clinic staff and Soka Uncobe. The USDF will continue to support decentralized services at all the military clinics. This will be achieved through improving HIV testing and counseling at all the USDF sites and ensuring that the USDF provides quality laboratory services to support clinical care for the USDF and the Ministry of Health. Pre-service training for all the critical health systems support will continue to be supported. Health systems support will continue through funding the support for a non-military physician.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Military Population

TB

Workplace Programs

Budget Code Information

Mechanism ID:	11673		
Mechanism Name:	DoD/USDF Umbutfo Swaziland Defence Force		
Prime Partner Name:	U.S. Department of Defense (Defense)		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

The goal of the program are to provide quality HIV treatment and care for military personnel, their partners and families, and community members who live in the surrounding areas. The basic care package includes clinical staging and baseline CD4 counts for all patients, CD4 cell count monitoring every 6 months, prevention of opportunistic infections (OIs) through prophylaxis with cotrimoxazole (CTX) to eligible patients based on national guidelines, diagnosis and treatment of opportunistic infections (OIs), psychosocial counseling (including counseling and referrals for HIV-positive female victims of domestic violence), and referrals for people living with HIV/AIDS (PLWHA) to community-based basic care and support (BCS) services based on their individual needs. HIV care packages will be provided to all HIV+ individuals receiving care in 9 military sites. In order to improve the quality of HIV care and treatment services, a minimum of 5 military health providers will be trained at the facility level in

the diagnosis and treatment of STIs/OIs/mental health disorders and these services will be integrated into 9 clinics. To improve the health of HIV+ patients, a mobile treatment and care unit (MTCU) affiliated to the health facility, will be maintained.

An outreach approach for HIV staging, clinical evaluation, and treatment initiation and follow-up with hard-to-reach HIV+ patients will be conducted. The MTCU will provide a continuum of care and treatment services, which includes but are not limited to: basic HIV laboratory tests, STI/OI screening and treatment, provision of CTX prophylaxis, ART, ART adherence support, psychosocial support, family planning, nutrition counseling, prevention with positives (PWP), HIV status disclosure, spiritual care, bereavement care, and hygiene and malaria education. BCS activities are implemented in conjunction with other services such as VCT, FP, ART, TB/HIV, OIs, and/or STIs in military delivery settings. Peer educators will be retrained to provide social support to members.

Periodic inter-brigade/community interactive, experience-sharing discussion group workshops will be organized to increase treatment adherence and share success stories witnessed during the course of HIV therapy. PLWHA and their families will be referred to malaria prevention services, including the provision of bed nets. For clinically-stable, healthier PLWHA, the USDF will work to strengthen referral to community-based support groups to encourage treatment adherence and increase access to non-clinical HIV care services. The USDF provides OI-related drugs, CD4 testing, and OI diagnostics for the clinical management of PLWHA enrolled in care. Technical assistance will be provided to the military to strengthen linkages between community-based and clinic-based HIV care services. At brigade and/or community levels, activities will include 1) the formation of civil-military allied associations of PLWHA and training of members in the provision of home-based care services, 2) access to locally-available and/or self-initiated nutritional support and 3) HIV prevention with positives which includes training of caregivers on adequate management, distribution and use of the care package and 4) HIV clinical case detection and referral.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

Care for OVC is a growing concern in the USDF and Emergency Plan funding will support activities that strengthen communities and families to meet the needs of children and families affected by HIV/AIDS.

Activities will include hosting technical assistance from Naval Medical Center San Diego to enable development of OVC programs. Based on needs assessments, specific interventions may include training caregivers, and providing increased OVC access to education, food, and other supportive services.

All 4 regions will be targeted for OVC services. Assessments and interventions will include participatory approaches and program evaluations. This initial focus will determine the numbers and needs of the OVC dependents for service delivery in the USDF, and integrated service delivery program, with related activities described in the prevention and palliative care sections of this document.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

The goal of this budget code narrative is to decrease HIV/TB co-infections in the USDF. It is expanding on previous capacity building for the USDF in opportunistic infections, palliative care, and integrated management of adult illness (IMAI). This activity is a priority because military staff is at high risk for HIV and troops reside in congregate living settings that facilitate TB transmission.

The budget code has three main components that will assist the USDF to: (1) build capacity in service delivery, monitoring, and evaluation; (2) establish referral systems; and (3) strengthen infection prevention. They key activities of this budget code narrative include: assisting the military to scale-up the current TB services for HIV-infected clients, the MOH/URC will provide technical assistance to the USDF to conduct a situational analysis of TB prophylaxis and TB/HIV treatment in the military. To build capacity in service delivery, the MOH will continue to train military nurses and doctors to offer TB treatment and prophylaxis to HIV-infected clients. Nurses and counselors will be trained in adherence counseling to promote completion of drug regimens. In addition, the USDF will be assisted to establish a recording and reporting system for Isoniazid Preventive Treatment (IPT). URC will continue to support the USDF to reinforce linkages with the National TB Control Program for the reporting of TB cases.

URC will assist the military to build a strong referral network for cases with drug resistance beyond the military's capacity to treat, or sputum negative TB suspects at facilities not staffed by a physician. Military sick bays on each base can also assist MoH to promote adherence and trace defaulters, besides other defaulter tracing mechanisms such as telephone contacts.

Supportive supervision and quality assurance (QA) activities will ensure linkages with the National TB Control Program and strengthen USDF clinical systems. Through linkages to the national program, the USDF will participate in quarterly regional monitoring and evaluation reviews of TB services. In addition, MOH will assist the USDF to establish systems for internal and external quality assurance, including quarterly palliative care meetings and annual supportive supervision visits. To complement these systems, MOH/URC clinical and nursing mentors will assist military staff through regularly scheduled on-site mentoring and support that includes support for TB prophylaxis services, screening for and treatment of TB disease in HIV-infected clients, and referral follow-up.

Through this capacity building effort, MOH / URC will also ensure that USDF take full ownership of managing the TB/HIV program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The USDF sites have approximately 1200 HIV-positive adults are enrolled in care. Of these, 800 are receiving ART. In FY 2012 the USDF will provide support to significantly increase services for the pediatric population reached through military health care facilities. In FY 2011, the USDF provided an integrated package of care and support services for HIV-exposed infants and HIV-positive children at the Phocweni clinic, including infant and child testing, initiation of ART for eligible children, provision of prophylactic treatment and management of opportunistic infections.

In FY 2012, the activities established in FY 2011 at the Phocweni clinic will continue. These include USDF will provide care and support for HIV-exposed as well as infected children.

Care and support for HIV-exposed infants identified in PMTCT will include access to early infant diagnosis using dried blood spots, provision of Co-trimoxazole prophylaxis until their HIV status is known, infant feeding support, and tracking of mothers and infants lost-to-follow-up for re-engagement in care.

To provide early initiation of ART for all HIV-positive infants, EGPAF will assist in the implementation of early infant diagnosis and follow-up through training for PMTCT staff as well as lab technicians, and through the implementation and support of the transportation system. EGPAF's care and support model for HIV-positive children includes provision of regular clinical assessments (monthly for HIV-exposed infants and every six months for older, stable children); staging and baseline CD4 counts or percentages for all HIV-positive children; follow-up CD4 every six months or more frequently as needed; management of HIV-related illnesses, including OI diagnosis and treatment; and routine provision of Co-trimoxazole prophylaxis for eligible children and for all HIV-exposed infants.

USDF will implement the new pediatric care and treatment guidelines through training and supervision.
All pediatric patients will be screened for TB at least once every six months. Children suspected of having TB will be investigated to establish a diagnosis, and treatment will be initiated as per national guidelines. Children without active TB disease but who were exposed to an active case will be provided with INH prophylaxis.

Swaziland Hospice at Home will support, pain and symptom management, end-of-life care integrated management of childhood illness (IMCI) will be provided at all the USDF clinics. The clinics will also distribute long-lasting

insecticide-treated nets (LLIN), implement safe water interventions, and provide basic hygiene education and community outreach services including referral for complimentary food support.

Activities aiming at strengthening nutritional services at the USDF supported sites will include training of health care providers and counseling to HIV-positive mothers during pregnancy and after delivery to enable them to make informed choices about infant feeding. The nutritional support package for children is comprised of nutritional assessments using anthropometric indicators, the provision of food support to HIV-exposed infants, and management of malnutrition with micronutrient and multivitamin supplements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

Laboratory support is essential for implementation of a comprehensive and decentralized ART program in the military. Emphasizing the unique nature of the military and the issue of confidentiality of data, the USDF has established their own laboratory facilities where ART services will be provided. CDC and URC works very closely with the USDF and the MOH to support this laboratory. It is estimated that by the end of the reporting period military members will be receiving ART within the military settings during FY 2012. This includes services provided to the neighboring MOH facilities and clinics within the USDF laboratory catchment area. Laboratory services will therefore cater for patient evaluation before initiation of ART, monitoring the clients on ART and the counseling and testing services. This laboratory will provide backup services to the National Laboratory in times of need.

The USDF is in the process of providing a pre-service training 2 medical laboratory technicians. The MOH has seconded a laboratory supervisor in the interim the USDF human capacity is being developed to support the laboratory facilities. An additional 4 students will be enrolled in FY-12 to train at diploma level. The National Referral laboratory will facilitate the training of at least 12 military laboratory personnel through MOH in order to ensure appropriate use of the new equipment and provision of quality services and sustainability of services at the military facilities. As the ART services expand, further training needs assessment in this important program area will be conducted so that additional military personnel can be trained to ensure sustainability. The USDF will continue to collaborate with the MOH in identifying and selecting critical members to be trained as laboratory technicians in order to ensure the suitability of services in the USDF facilities.

In addition, the USDF will also continue to seek the support of MOH in terms of quality assurance of the services provided in the military laboratory facilities. CD4 testing is an important tool for determining clinical eligibility for HAART and coupled with other basic laboratory tests for monitoring HIV-disease. The USDF recognizes that it essential to perform CD4 testing as well as other basic monitoring tests within military laboratories in order to

ensure effective and sustainable ART service provision within the military health delivery system. CD4 tests, chemistry and hematolgy are currently being sent to MOH. Due to increased referrals from the military counseling and testing services and the need to regularly monitor patients on HAART, it is anticipated that the requests for CD4 counts will increase markedly in the short term. Logistics for the procurement of pharmaceuticals will be discussed in details between the USDF and the MOH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

Currently counseling sessions are recorded manually making it difficult to adequately track which HIV positive personnel are receiving required counseling, who is missing appointments, and to coordinate support between the various medical, social welfare, and religious offices who are providing support to an HIV positive soldier or family member. The lack of automation at unit level also makes it difficult for counseling to continue as soldier deploy to other camps. An additional benefit is that those involved in counseling and support activities will now have access to on-line support materials and a wider network of expertise.

Activities will include training of personnel from the USDF HIV/AIDS program office, chaplain's office, and medical services in monitoring and evaluation techniques and reporting. This is currently one of the weakest aspects of the USDF's effort. This activity will specifically target military personnel and their family members, especially those living with HIV AIDS. Estimated current target population is about 3000. Results from the survey will enable better service delivery planning, and targeting of prevention programs to those behaviors associated with highest risk in the military. This activity will support the strategic plan by providing information on male behaviors in the USDF and directly linking behaviors to sero-positivity

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

Health System Strengthening is fundamental to the USDF and is in line with GOKS and USG partnership framework and, consequently, intersects all technical areas under the USDF's HIV/AIDS program activities. A common thread of institutional capacity building is woven throughout all activities, promoting USDF's competency at conceptualizing, planning, designing, managing, monitoring and evaluating effective HIV prevention strategies.

PEPFAR funding supports currently 4 students as undergraduates: 1 medical student in year 2 in FY-12, 1 Pharmacy student – year 2 in FY-12, upgrading 2 nursing assistants to fully fledged nurses – year 2. Due to the

current cash flow problems of the government 2 nursing students will be assisted to complete their course work at the University of Swaziland and Southern Africa Nazarene University respectively.

In FY-12 the USDF would like to enroll a total of 9 students: 4 new students in medical laboratory technology diploma, 1 degree in medicine, 4 for a diploma in Pharmacy tech and 2 students trained in palliative care at diploma level.

A total of 7 staff members of the USDF will be sent for in service training at IDI: 2 nurses will be sent for in-service training in ART, 1 laboratory assistant will be trained in ART laboratory, 2 TOT, 2 counselors in TOT counseling through IDI in Uganda.

Salary support for the USDF physician will be supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

The overall goal of this activity is to decrease new HIV infections in the USDF through the expansion of male circumcision (MC) services, emphasizing that MC be offered as part of an expanded approach to reduce HIV infections in conjunction with other prevention programs, including HIV testing and counseling (TC), treatment for other sexually transmitted infections (STIs), promotion of safer-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package. In FY 10, PEPFAR worked closely with the Ministry of Health (MOH) and other donors in a national task force to develop policy that recognizes MC as an effective HIV prevention method alongside the ABC strategy. Expanding MC in the military is considered vital since the military is predominately male, typically young, within the reproductive age group and highly mobile, and is considered a high risk group. The military provides an ideal institutional setting to roll out of MC as an HIV prevention intervention as it has taken the lead in controlling HIV transmission among troops.

In FY 12, the Umbutfo Swaziland Defense Force will ensure that male circumcision efforts are rolled out as an additional method for HIV prevention. Through PEPFAR support, the military has expanded HIV care and treatment to 8 military-operated clinics. The USDF will build capacity for MC in the military through the training of providers, sensitization of soldiers and their partners for circumcision. The physical infrastructure of clinical sites is ready to conduct proper circumcision.

MC is conducted on a voluntary basis on all soldiers requiring this service irrespective of HIV status and services are attentive to socio-cultural context, human rights and ethical principles, health services strengthening, training,

gender implications, service delivery, and program evaluation. These activities address the key legislative issues on gender, particularly with respect to male norms and stigma reduction.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

The overall goal of this activity is to decrease new HIV infections through behavior change communication. The focus is on abstinence and fidelity targeting military personnel. While some soldiers practice sexual abstinence and fidelity, factors such as separation from families, mobility and age make them vulnerable to HIV. The USDF is implementing community-based activities among soldiers, their sexual partners, and surrounding communities to promote abstinence and safer sexual behaviors.

Key prevention strategies are 1) capacity building for peer education and interpersonal communication (IPC) sessions (including edutainment /dramas"), 2) capacity building for the chaplaincy program, and 3) promotion of counseling and testing services. The USDF will update communication materials to reflect best practices in the following areas: couples counseling and testing, integration of family planning (FP) into HIV/AIDS prevention (including PMTCT), men as partners, gender-based violence (GBV) and prevention of alcohol abuse.

In FY 2012, these activities will continue to reach at least 8 000 members of the military with prevention messages. The military AIDS support clubs will work to sensitize surrounding communities about risky sexual behavior. The soldiers will be strongly encouraged to get tested with their partners. MC activities (described in CIRC narratives) will be closely integrated into this activity. This activity is related to HVOP, HVCT and CIRC activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

The activity supports the USDF's HIV/AIDS program by providing counseling and testing services to the military members and community members in the vicinity of the USDF sites. Funds for this activity will be used to provide in-service training for military nurses and HIV/AIDS counselors who conduct counseling and testing and to support the monitoring, evaluation and quality assurance. This activity will continue to support the USDF's HIV/AIDS program by providing military community with counseling and testing services at the military counseling and testing centers. Additional VCT centers will be opened, where not existent yet and the existing 8 USDF's clinics will be strengthened. At least 2500 soldiers will receive HIV counseling and testing services through these initiatives. The USDF will train 30 soldiers in counseling and testing thereby increasing the capacity of the USDF towards addressing the impacts of the epidemic. Soldiers who test positive will be referred to an ARV program and will be monitored by the clinic staff and expert clients to ensure adherence to treatment. At all levels attention will be given

to increasing the gender equity in accessing HIV/AIDS programs and addressing stigma and discrimination as well as positive living. In collaboration with the MOH, VCT IEC materials will be improved and disseminated to all VCT centers in the military. The program will also work closely with the MOH Supply Chain Management System in procuring test kits and other medical consumables. Quality assurances will be done in close collaboration with the MOH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Combination prevention is being promoted as an effective strategy for HIV prevention. Having an appropriate mix of behavioral, biological, structural and cross-cutting activities is expected to lead to improved HIV prevention. Militaries require strong HIV prevention programs and provide excellent sources for evidence based programming for effective interventions. Military programs generally already contain some elements of combination prevention. In FY-12, this military will fill in major activity gaps for HIV prevention and increase the intensity of interventions. Evaluation of this approach will be done with a prevention approach to evaluations and comparison of incidence and prevalence (where baseline is available) before and after application of this approach. The USDF recently completed a biological/behavioral survey. Data from the survey will be used as baseline for evaluations.

The overall goal of this activity is to decrease new HIV infections in the military through behavior change communication (BCC) with a focus on correct and consistent use of condoms. As indicated before, although some soldiers practice sexual abstinence and fidelity, factors such as separation from families, mobility and age are significant factors thay may increase their risk to acquiring HIV. The USDF is implementing community-based activities among soldiers, their sexual partners, and surrounding communities to promote safer sexual behaviors. Similarly, the key prevention strategies here include; 1) peer education and interpersonal communication (IPC) sessions (including "cine-mobiles, edutainment/dramas"), and 2) promotion of counseling and testing services. The USDF will update communication materials to reflect best practices in the following areas: couples counseling and testing, integration of family planning (FP) into HIV/AIDS prevention (including PMTCT), condoms for dual protection, and men as partners, gender-based violence and prevention of alcohol abuse. In FY-12, the USDF will continue these activities emphasizing correct and consistent condom use, ensuring condom access and availability (including minimizing the stigma surrounding condoms), promoting condom negotiation skills with partners, and emphasizing the role alcohol plays in risky behavior. Additional IEC materials promoting condom use will be developed. Peer educators will be retrained to reach 8000 individuals with prevention messages. The military drama group will work to sensitize surrounding communities about risky sexual behavior. Soldiers will be strongly encouraged to have HIV tests together with their partners. Male circumcision activities (early on described in CIRC narratives) will be equally closely integrated into this activity. Approximately 500 000 condoms will be distributed in FY-12. This activity is also related to HVAB, HVCT and CIRC activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

In the military health network there are 9 military clinics throughout the country. In FY12, the USDF will work to increase access to prevention of mother-to-child transmission (PMTCT) services in military settings. PMTCT services will be integrated into existing infrastructure in military HIV/AIDS service delivery sites. The PMTCT partner will provide technical assistance for PMTCT services in 9 military clinic sites. The military will offer a standard package of PMTCT services to pregnant women which includes counseling and testing with informed consent, male partner and family-centered testing, intermittent preventive treatment (IPTp) in collaboration with the President's Malaria Initiative (PMI), antiretroviral (ARV) prophylaxis using combination ARV regimens and HAART for eligible women, services for women who may be victims of gender-based violence including referrals to appropriate care, informed counseling and support, referral for family planning (FP) and maternal and child health (MCH) services, follow-up of HIV-exposed infants for referral to appropriate services, and early infant diagnosis, if possible. In addition, the USDF will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services. Military providers and technical staff at 9 military clinics will be trained through new and refresher on-the-job training in the expanded national PMTCT protocol, including use of site-level algorithms and checklists, as well as laboratory monitoring. The USDF will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E of PMTCT. Efforts will support the development of QA and M&E skills, including in data collection, data use, and reporting. In collaboration with local services, providers will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bed nets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health-seeking behaviors which will intensify case finding and improve adherence to the new regimen. In addition will ensure referrals of pediatric patients from PMTCT to ARV services. The USDF through MOH, will provide ARV drugs, CD4 tests, rapid plasma reagin (RPR) test kits, polymerase chain reaction (PCR) tests, rapid HIV test kits, and hemoglobin testing materials to all supported sites.

The USDF will also collaborate with local organizations to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. The USDF will refer PLWHA and their families to malaria prevention services including bed net provision. The will provide weaning food for exposed infants in need. In addition, the USDF will leverage food aid from other local resources to meet the other nutritional needs of these food insecure households. In collaboration with MOH, USDF will update the tools for community mobilization for PMTCT, provide training to community volunteers to promote PMTCT, and will work with clinical

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

The activity supports the USDF's HIV/AIDS program by providing a comprehensive care and treatment package that includes, but not limited to Pre-ART, ART and post-ART care, treatment and support services, to the military personnel, their families and community members within the neighborhood of the USDF clinics. The basic elements of care being; enrolment into chronic care for all HIV positive individuals, providing cotrimoxazole prophylaxis, TB screening for all HIV positive individuals using the national screening tool, sputum testing and radiologically using chest X-rays. Also, monitoring of CD4 levels, liver and kidney function, and complete blood count tests form the essential elements of care. All individuals found eligible for ART are started on treatment and clinically monitored according to the national HIV/ART treatment guidelines.

The USDF HIV/AIDS program shares the same ART clinical monitoring database, developed by the MOH in collaboration with other partners (MSH and ICAP), and the information obtained from this system is used to enhance quality patient care through direct use of data at point of care and data review exercises. At the site level, the data is used to inform the on-going quality improvement exercises, being technically supported by other partners besides MOH. All individuals initiated on antiretroviral therapy are followed up using MOH developed tools and also telephonically, with the support of some partners (ICAP), in order to improve retention into the treatment program. This is helping tremendously in reducing the observed low defaulter rates in the USDF HIV/TB treatment program. Besides, the use of the expert client in provision of Pre-ART and ongoing counseling is increasingly becoming an evident strategy worth expanding. The physician, with support from MOH and other partners (ICAP) provide onsite mentoring and preceptorship, through continued medical education sessions and clinical update meetings for both nurses, counselors, expert clients and other staff involved in HIV/ART care. Direct supervision on HIV/ART care and treatment is provided by the physician. In-Service (short) nurse training in HIV/ART care among other areas is critical part of the HIV/ART services decentralization exercise to other USDF clinics. With the exception of the physician who is non-military personnel, all the care treatment and support services are being carried out by the USDF military personnel.

Funds for this activity in FY-12 will therefore be used to expedite decentralization of care and treatment services to all the 9 USDF clinics, strengthen the capacity of the clinics to provide quality and timely comprehensive care, enhance in-service training for military nurses, HIV/AIDS counselors, expert clients and other staff cadres involved in HIV/ART care, strengthen the monitoring and evaluation, and quality assurance component of the care and treatment, through training more data clerks among others. The funds will also USDF's HIV/AIDS program by providing a means to monitor and follow-up individuals initiated on therapy, to improve retention into the treatment program and ultimately improve on treatment outcomes that is a better quality and prolonged life the military community, their families and the communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	0	0

Narrative:

Pediatric treatment is currently available at a very limited extent at the Phocweni military clinic where there is only one doctor trained in pediatric management.

The USDF in collaboration with EGPAF will train providers, including doctors, nurses, and other health cadres in the management of pediatric HIV using national guidelines. This training is a part of the series of trainings on core competencies for these cadres and will also include ART and PMTCT management, in an effort to strengthen linkages between ART and other HIV/AIDS prevention, care and treatment services to ensure more comprehensive and continuous care for people leaving with HIV/AIDS. EGPAF will train health care providers in early infant diagnosis using the Dry Blood Spot (DBS) technique and link the USDF system to the national system of specimen collection and testing. Links to integrate clinical and community activities to improve early identification of clients, follow up, and retention in care will also be ensured.The USDF will also offer pediatric / child counseling to the children, their parents and other family members and this will involve firstly, the training of identified family personnel in the area of child counseling.

Following the training, supervision visits to the service providers will be jointly conducted by EGPAF and the USDF using supervisory tools that have been developed.

To support performance improvement systems and quality ART service delivery, EGPAF will conduct supportive supervision visits to the 9 facilities. EGPAF will continue supporting the USDF in conducting workshops using the orientation package for lay workers on HIV/AIDS prevention, care and treatment, covering CT, PMTCT, Care and ART as well as linkages to other services such as TB and STIs, to educate them on HIV/AIDS and provide them with accurate and relevant information they can disseminate to more diverse populations.

To ensure sustainability, EGPAF works within the existing USDF structures and plans the USDF will facilitate the development and dissemination of appropriate standard guidelines, protocols, and plans. EGPAF will continue to strengthen and expand facility-based performance improvement systems, providing increasing opportunities for the trained staff from model sites to lead supervision and mentorship programs, while still mentoring and actively supporting the sites whenever necessary.

Implementing Mechanism Details

Mechanism ID: 13144	Mechanism Name: URC-Lab
Funding Agency: U.S. Department of Health and	Procurement Type: Cooperative Agreement

Human Services/Centers for Disease Control and Prevention	
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,550,000	
Funding Source	**Funding Amount**
GHP-State	1,550,000

Sub Partner Name(s)

Medical Research Council	National Emergency Response Council on HIV and AIDS	National Health Laboratory Services

Overview Narrative

URC's strategy for strengthening laboratory services builds on the following principals: ensuring strong country ownership; integrating project activities within Swaziland's health systems to ensure long-term program sustainability; capacity building through training/mentoring lab staff in quality assurance/quality management on both general lab-related and TB diagnostic services; linking project activities with other PEPFAR and donor funded initiatives to increase returns on USG investments in the country; and working with GKOS and other partners to ensure that laboratory services are strengthened as an important component to TB/HIV services. The two URC/USG projects share costs of offices, procurement and financial management systems making the program to be cost efficient. URC will collaborate with other PEPFAR partners to assist in the implementation of a comprehensive Laboratory Information Systems. URC also provides direct TA and support to Laboratory organizational leadership in implementation of the 5 year laboratory strategic development plan (2008-2013) and policy, and enhance capacity development for laboratory supervisors. Quarterly reviews meetings facilitate data reviews and quality improvement. Support is also given to attend regional and international trainings. In addition, URC will assist with the implementation of external quality assurance (proficiency testing) for all test parameters including HIV Rapid Testing and TB microscopy countrywide. The final stage of their intervention will be performing of internal audits to determine readiness for accreditation, followed by facilitation of a formal accreditation process. Experience shows that quality services and compliance to standards only occurs when adequate support and mentoring is in place.

Cross-Cutting Budget Attribution(s)

Education	50,000
Gender: Gender Equality	50,000
Human Resources for Health	500,000
Renovation	100,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**13144**
Mechanism Name:	**URC-Lab**
Prime Partner Name:	**University Research Corporation, LLC**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	750,000	0

Narrative:

The project will support TB/HIV laboratory related activities that aim at: standardizing TB/HIV best laboratory

practices and provide associated training; providing for uniform quality assurance measures among laboratories; working with NCLS to standardize equipment (introduce new technologies and equipment), commodities, and supportive maintenance training; and supporting capacity building for a unified approach to procurement and distribution of laboratory commodities. The project will strive to ensure an adequate number of clinical laboratories perform quality testing for TB/HIV/AIDS diagnostics and monitoring tests for care and treatment services. The project will also assist to strengthen referral transport systems for specimens and implement practical and sustainable quality management systems by conducting laboratory management training programs and assisting in the adoption of the WHO Laboratory accreditation scheme (utilizing a stepwise approach for reference and peripheral laboratories).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	800,000	0

Narrative:

The lab project will work together with the NCLS to develop and strengthen laboratory systems and facilities to support TB/HIV/AIDS-related activities including: strengthening of laboratory leadership and management; purchase of equipment and commodities; strengthening of laboratory supply and equipment management systems; promotion of quality management systems, laboratory monitoring and evaluation, and laboratory information systems; and provision of staff training and other technical assistance. The project will continue to support SLMTA (strengthening laboratory management towards accreditation) trainings. The project will also support 8 additional laboratory sites to start the process of accreditation. These are Phocweni, Pigg's Peak, RFM, Good Shepherd, Hlatikhulu, Siphofaneni, Baylor and National TB hospital. In addition the project will continue working with NRL towards attaining accreditation stars to the 8 laboratories which are namely HIV Molecular/EID Referral Lab, Clinical chemistry Lab, Hematology lab, Microbiology lab, Flowcytometry Lab, Cytology/Histology Lab, Immunochemistry referral lab, TB Reference Lab.

Implementing Mechanism Details

Mechanism ID: 13357	**Mechanism Name: HealthQual**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Contract
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Total Funding: 30,000	
Funding Source	**Funding Amount**
GHP-State	30,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main goal of HEALTHQUAL is to build the capacity of MOH to create a government-led and -owned national quality management (QM) program that supports and sustains the quality improvement (QI) work of the clinics. Improved systems at the clinic and national level promote sustainability of the overall program.

A key activity of HEALTHQUAL is building clinic level capacity to:
• understand and maintain data quality,
• analyze data for use in systemic changes to improve patient outcomes,
• maintain a clinic infrastructure to support activities, and
• contribute to the national discussion of improving healthcare delivery systems.

HEALTHQUAL provides and/or supports clinic-level training for using a sampling methodology for data collection to maintain a 90% or 95% confidence interval, adapted for the specific data system they utilize (clinic registers, paper medical files, electronic medical records). Where gaps in data are discovered, we provide the technical assistance to remedy those gaps. Clinics are guided to develop quality management committees that provide the infrastructure to support the performance measurement, data analysis, QI activities, and dissemination of results. Aggregated clinic data is used by MOH to inform and set national priorities for broader improvement strategies.

HEALTHQUAL'S capacity building work with MOH helps to support and maintain these improvement activities and monitor progress nationally. Linking SI and QI reinforces skills developed by both, furthering respective goals and creating complementary and synergistic activities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13357		
Mechanism Name:	HealthQual		
Prime Partner Name:	New York AIDS Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	30,000	0

Narrative:

The main goal of HEALTHQUAL is to build the capacity of MOH to create a government-led and -owned national quality management (QM) program that supports and sustains the quality improvement (QI) work of the clinics. Improved systems at the clinic and national level promote sustainability of the overall program. A key activity of HEALTHQUAL is building clinic level capacity to:

• understand and maintain data quality,

• analyze data for use in systemic changes to improve patient outcomes,

• maintain a clinic infrastructure to support activities, and

• contribute to the national discussion of improving healthcare delivery systems.

HEALTHQUAL provides and/or supports clinic-level training for using a sampling methodology for data collection to maintain a 90% or 95% confidence interval, adapted for the specific data system they utilize (clinic registers, paper medical files, electronic medical records). Where gaps in data are discovered, we provide the technical assistance to remedy those gaps. Clinics are guided to develop quality management committees that provide the infrastructure to support the performance measurement, data analysis, QI activities, and dissemination of results. Aggregated clinic data is used by MOH to inform and set national priorities for broader improvement strategies. Our capacity building work with MOH helps to support and maintain these improvement activities and monitor progress nationally. Linking SI and QI reinforces skills developed by both, furthering respective goals and

creating complementary and synergistic activities.

Implementing Mechanism Details

Mechanism ID: 13360	**Mechanism Name: Peace Corps Volunteer Projects**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 20,000	
Funding Source	**Funding Amount**
GHP-State	20,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PC/Swaziland projects in FY12 will include the following cross-cutting areas: Education, Gender, Food and Nutrition, Economic Strengthening, Human Resources for Health, Water and Construction/Renovation. Most small VAST grant projects focus heavily on one of these areas but it is common that projects include multiple cross-cutting areas in each project. Additionally, Volunteers do include key issues such as comprehensive health issues and gender into projects. In the past, Volunteers have utilized VAST grants to implement girls' empowerment camps, train peer educators in prevention, organize prevention and anti-stigma community dialogues, and train caregivers in psychosocial support techniques. They also work with school teachers and guidance counselors to teach life skills to youth and to improve the quality of education and other support services to OVC. Volunteers have conducted workshops for community members introducing business and vocational skills such as animal husbandry. These projects have sometimes included small renovations to existing structures to support garden projects. Volunteer projects are often aimed at strengthening the ability of families and caregivers to meet OVC and PLHA needs and therefore include supplemental information and trainings about general health issues (such as TB and (PMTCT). Volunteers address HRH by collaborating with other partners to provide in-service training for community-based Kagogo Clerks and other NGO/CBO service providers. Volunteers also work with community partners to reduce violence and coercion through interpersonal communication and community mobilization aimed

at empowering female youth and mothers and promoting men as partners.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	**13360**
Mechanism Name:	**Peace Corps Volunteer Projects**
Prime Partner Name:	**U.S. Peace Corps**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	7,000	0

Narrative:

Approximately 85 Volunteers and their community counterparts, who receive PEPFAR-funded pre- and in-service training, support service providers and organizations in designing and implementing care programs for PLHA, OVCs and their caretakers in the underserved rural communities and schools of Swaziland. PC/Swaziland promotes the use of evidence-based programs to respond to community needs for a variety of services to mitigate the effects of HIV, improve health outcomes for HIV positives, improve the developmental growth of OVCs, improve

household nutritional status and optimize the quality of life of adults and children living with and affected by HIV. Volunteers and their counterparts prioritize community support and coordination, and family/household strengthening by working within existing community-level structures, such as schools, churches, Neighborhood Care Points and KaGogo Social Centres. Activities focus on male and female vulnerable children (<17 years) and their caregivers, and include forming and strengthening psycho-social support groups, conducting health and HIV education, developing life skills, supporting economic strengthening activities among young people, and bringing mobile resources and services to the community. More specifically, Volunteers train vulnerable children in nutrition, decision making, peer support, forming positive relationships, good study habits, and more. Psychosocial support includes assisting vulnerable children and caregivers with coaching to manage grief and loss, training on stigma reduction, and partnerships with churches and other support organizations to meet spiritual and social needs. To assist with economic strengthening, Volunteers help OVC or caregivers to begin or enhance small-income generation activities to support themselves, such as production of household cleaning products, crafts, garden produce, or other items which fit the local market.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

Not Provided

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	5,000	0

Narrative:

Approximately 85 Peace Corps Volunteers and their community counterparts, who receive PEPFAR-funded pre- and in-service training, implement HIV prevention activities focused on promoting abstinence and being faithful in underserved rural areas of Swaziland. PC Volunteers work with communities to design and implement context-appropriate prevention interventions addressing the keys drivers of the epidemic, including sexual and behavioral risk and harmful gender/cultural norms.

Given Swaziland's generalized epidemic, with multiple concurrent sexual partners as one of the key drivers, these activities target behavior change among male and female youth under age 25, including in- and out-of-school youth, and other vulnerable children, and male and female adults. PC/Swaziland promotes behavior change through use of evidence-based programs and integration of efforts of other USG agencies and implementing partners. Programs typically include a cross-cutting focus on reduction of stigma and discrimination. Volunteers and their counterparts also engage religious leaders and church goers in activities emphasizing faithfulness as well as acceptance and support of PLHA. Through simple daily interactions and more structured training programs, Volunteers train and provide technical support to community-based service providers to enhance their ability to

deliver AB messages. Volunteers address gender inequality and male norms by promoting girls' and women's empowerment among the most disenfranchised rural females, as well as promoting men-as-partners among males. Volunteers collaborate with local labor and workplace programs to provide prevention training to employees such as teachers, clerks, and field workers. Volunteers' activities include youth camps, trainings, public-awareness events, school health clubs, and mentoring programs.

PC/Swaziland uses PEPFAR funds for small community-initiated AB-focused activities through the small VAST grant projects.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	8,000	0

Narrative:

Approximately 85 Peace Corps Volunteers and their community counterparts, who receive PEPFAR-funded pre- and in-service training, implement HIV prevention activities focused on promoting the use of condoms and other prevention (C/OP) in the underserved rural areas of Swaziland. Volunteers and their community counterparts promote behavior change, emphasizing the correct and consistent use of condoms, HIV testing, and STI management among males and females ages 15-24. These activities support other PEPFAR-partners' promotion of male circumcision. Activities for both males and females include one-on-one mentoring, small group trainings, public-awareness events, and distribution of materials. Venues to reach these audiences include Kagogo Social Centres, clinics, churches, local shops, youth centres, factories and other places of employment. PC/Swaziland will use PEPFAR funds for small community-initiated C/OP-focused activities through small VAST grant projects. VAST grants support peer educator programs and activities of Rural Health Motivators and other community partners enaged in promoting C/OP messages. In addition, VAST grants fund activities that address public norms regarding sexual coercion and promoting the role of parents and other protective influences. Activities include public demonstrations or awareness campaigns, small training events, one-on-one teaching, or other meaningful techniques to engage the audience. Volunteers live in their communties and work closely with their counterparts for two years. Volunteers and their counterparts receive training in monitoring and evaluation and report results to Peace Corps and local partners. PC/Swaziland staff oversee the work of the Volunteers, provide technical assistance as needed, and collaborate with other PEPFAR-funded partners to assure the quality of its interventions.

Implementing Mechanism Details

Mechanism ID: 13630	**Mechanism Name: CPP-PSI (Combination Prevention Program)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Population Services International	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Elizabeth Glaser Pediatric AIDS Foundation	Family Life Association of Swaziland	JHPIEGO
Lusweti Insitute		

Overview Narrative

PSI will support the following objectives in line with PF objectives: create an enabling policy and political environment through which leadership for HIV prevention efforts will ensure successful programmatic activities; support the expansion and coordination of evidence-based behavioral interventions which reduce the risk of HIV infection and enhance protective behaviors in the general population; and support the sustainable integration of adult and neonatal medical MC services throughout the national health system and provide mobile and outreach services to increase the prevalence of MC across the country. All PSI programs are national. Target populations include infants, youth, adults, MARPs and men. Male Circumcision targets 15-49 year males, parents, from birth to 8 weeks for EIC; Behavioral interventions target youth, men, MARPs. Cost sharing will be done with other partners where possible. Private sector partnerships will be utilized to match resources for HIV prevention interventions. The community HTC Award will be used as an opportunity to harmonize activities and cost share. PSI will continue engaging the public sector despite the economic challenges to make sure that a clear handover strategy is discussed and agreed upon for long term ownership and sustainability. PSI will build capacity for local NGOs to increase ownership of interventions beyond this funding period. PSI will continue to work with its sub-awards in ensuring quality data reporting and the formalization of data quality improvement processes. Program monitoring will use the national monitoring and evaluation framework. Further, PSI will adopt an RDQA process in line with the national SI objectives of quality and clean data, supporting the MOH in RDQA on HTC, MC and Condoms.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Mobile Population
Safe Motherhood
Workplace Programs
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13630**		
Mechanism Name:	**CPP-PSI (Combination Prevention Program)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	0	0

Narrative:

There are two components: voluntary medical male circumcision (VMMC) for adult males and early infant male circumcision (EIMC). PSI will capitalize on the systems put in place by the accelerated saturation initiative (ASI) to help capacitate the hospitals and health centers to offer adult MC services as an integrated health service. PSI will work with RFM, Hlatiklulu, Piggs Peak, Nhlangano Health Center and Good Shepherd hospitals to strengthen the integration of VMMC services and start work with Mbabane Government Hospital, Mkhuzweni Health Center, Dvokolwako Health Center, Sithobela Health Center and Matsanjeni Health Center. PSI will conduct outreach and mobile services at clinics and community sites. PSI will leverage the M&E, supply chain and human resource systems that have put into place. PSI will work with SCMS for logistics, procurement and commodities support. PSI will work with JSI to transition the M&E function. For EIMC, PSI will focus on strengthening service delivery

systems at Nhlangano Health Center, Mankayane Hospital and Hlatiklulu Hospital by coordinating with the MoH on the M&E systems and putting the task shifting framework into action. PSI will work with several new facilities on EIMC. Jhpiego will provide EIMC trainings using the WHO curriculum and work with the MoH on supportive supervision and mentorship. Jhpiego and PSI sit on the National QA Committee and will ensure that all sites undergo internal and external QA assessments. Jhpiego will ocus on integrating VMMC training into pre-service education for nursing students. PSI will work closely with Futures Group to ensure a smooth transition. PSI will continue interpersonal EIMC communication activities at both the facility and community level and expand EIMC testimonials. EGPAF will integrate EIMC messages into PMTCT activities. VMMC services will be provided along with HTC, STI diagnosis and treatment and the provision of condoms. EIMC messages will be integrated at PMTCT, ANC, waiting huts and in the communities. PSI will support facility-based and community-based expert clients to help facilitate post-test support for those who test HIV-positive and ensure linkages to care and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

PSI will continue to work closely with Khulisa Umntfwana and train a network of peer educators who will be responsible for spreading the message amongst their peers. Targets for Umhlanga are young girls, aged from 10 to 18 and for Lusekwane, young men aged from 10 to 18. In order to renew its approach, after several years of successful interventions, PSI will develop new education and promotional material, based on target audience insights. These materials will be developed jointly with behavioral intervention partners and will leverage the cultural component of both events. Messages during these two events will include broader prevention messages, including faithfulness messages. Beyond these youth targeted events, PSI will increase its messaging around faithfulness by expanding its 'Choose One' campaign. This campaign has been a great success, as it is based on a simple and catchy phrase, on the channels it exploits (clubs, street theatre, guerrilla marketing) and the tone is adopts (light, positive, non judgmental). Four main actions surrounding Choose One will be deployed: development of a full M&E plan, using PSI's TRAC 2010 as a baseline; consolidation of partnership to turn Choose One into a 'franchise' that prominent people and place in Swaziland will own: a club, a soccer team, a media house; development of an ambassador program based on prominent people disclosing that they chose one, who it is, and why; and renewal of the Above the Line visibility by extension of murals, stencils – to 'engrave' the slogan. PSI will focus on specific activities to increase adoption of a safer culture among youth: development of a single national standard Life Skills curriculum to be taught in the schools and used by community-based organizations, NGOs and faith-based organizations; development of targeted IEC material and educational activities for 10-14 yrs and 15-18 yrs. Monitoring and evaluation of SBCC activities will performed through routine monitoring reporting to the national M&E system. A behavioral TRAC survey will be conducted in 2013.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	0	0

Narrative:

PSI will increase its pilot female condom project 'Angel' by extending it to more regions, targeting more hair salons and increasing its uptake in workplaces and tertiary institutions. The target audience for 'Angel' is women between 18 and 30. The support mechanism will include branding material to be displayed in hair salons, and IEC material to educate the target audience on product use. Messaging towards men will also be increased. PSI will work with the Condom TWG to implement the national condom strategy and develop a national condom brand for free issues, following the DELTA process which includes identification of issues in demand creation, advocacy, and definition of a target audience, definition of a positioning statement and writing of a creative brief. PSI will continue to work with MSM, CSW and Transport Operators. Activities include the provision of product and services – mobile outreaches, public sector condom distribution and other HIV prevention products – as well as promotional materials. Through its Corporate Aids Program, PSI will continue providing prevention messages and services to companies. PSI will partner with Lusweti on the following: identify HIV champions; develop a coordinated Behavioral Research Agenda; support national SBCC systems to ensure implementation of the national SBCC strategy; build capacity for government spokesperson on media relations for HIV prevention; and advocate for the development of the national prevention with positives strategy to emphasize the role of PLHA in HIV prevention. To create an enabling environment for the scale up of biomedical and non biomedical HIV prevention interventions PSI will support the following: develop the national coordination framework; support implementation of the national HIV and AIDS action plan; strength the national HIV Prevention TWG; disseminate the HIV prevention mapping report; disseminate and ensure implementation of National HIV prevention policy; lobby for policy improvements; and develop a National HIV Prevention minimum package. Targets will be NERCHA, MOH and HIV prevention implementing partners and the national and regional level.

Implementing Mechanism Details

Mechanism ID: 13645	**Mechanism Name: EPAS-PMTCT (Eliminating Pediatric AIDS in Swaziland)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	

Funding Source	Funding Amount
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The broad objectives of Elimination of Pediatric AIDS in Swaziland (EPAS) are to: 1) achieve universal access to PMTCT with expanded delivery of services to achieve elimination of mother-to-child transmission of HIV; 2) support and sustain s quality, comprehensive, integrated PMTCT services at GKOS health facilities; 3) strengthen the National Health System in accordance with the MOH's plans for PMTCT; and 4) promote the regular review and improvement of MOH's policies, protocols and guidelines for PMTCT services. As described in the PF, improving the quality of PMTCT services and the integration into broader MCH and HIV care and treatment programs will continue to be a priority for EPAS. EGPAF works in all the 4 regions serving primarily HIV pregnant women, their spouses, children and other family members. EPAS supported the MOH to achieve 100% coverage of government health facilities with PMTCT services in 2011. Combined with additional FBO and private sector facility coverage, this will result in EGPAF's support reaching 83% of pregnant women in Swaziland. EGPAF's approach to building national capacity and sustainability ensures cost-efficient programming. The decentralization of integrated services for HIV prevention, care and treatment in MCH settings brings all services under one roof, saving costs on separate buildings, staff, and maintenance. Seconding program staff to the MOH with ultimate absorption by the MOH will have an added value of ensuring long-term ownership and sustainability. To minimize disruption of service provision caused by the MOH policy of frequent staff rotation, EGPAF will continue to provide ongoing training and site support. Progress and results will be tracked through a comprehensive performance monitoring plan.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13645**
Mechanism Name:	**EPAS-PMTCT (Eliminating Pediatric AIDS in Swaziland)**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

Clinical HIV care services will be supported in 34 health facilities in the four regions while the psychosocial support services will be mainly through establishment of support groups for people living with HIV. EGPAF will participate in the HIV Care and treatment TWG and its sub-TWGs to help review and plan for HIV care services; provide TA in the review and development of national HIV care tools e.g. M&E tools, job aids; provide TA and financial support in the training of health care workers in HIV care services; support the decentralization of comprehensive care services to the PHUs, health centers and clinics; and work with the MOH SNAP to ensure successful implementation of pre-ART services in the 34 facilities. EGPAF will work with health care workers to ensure early identification of HIV-positive pregnant women, partners and children at all care points and enrollment into pre-ART care. This will be done through mentorship and support supervision to health workers to provide PIHTC at all points of contact; encouraging use of patient hand held cards; and encouraging a family centered approach to care and support. EGPAF will pilot use of family files for care in a few high volume sites. EGPAF will work with health care workers to ensure prompt clinical and immunological assessment of HIV-positive pregnant/lactating women and other individuals; pain assessment and management; screening for TB and OIs; prophylaxis with CTX, INH; regularly assess for ART eligibility; and ensure all HIV-positive individuals are assessed nutritionally. EGPAF will strengthen the use of patient cards and referral forms for effective referral linkages; work closely with expert patients and Mentor Mothers; establish and strengthen referral linkages

including MNCH/FP; improve follow-up counseling to improve adherence; work with health workers to identify defaulting and lost to follow up clients; and develop mechanisms to trace clients. EGPAF will provide regular visits for data review, QI activities, case management and mentoring. EGPAF and partners will support psychosocial services through the formation of support groups for women and men living with HIV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

Clinical services will be supported in 39 health facilities in the four regions of the country while the psychosocial services will be mainly through establishment of support groups for children living with HIV. EGPAF will participate in the Pediatric HIV sub-TWG; provide TA in the review and development of national pediatric HIV care tools; provide TA and financial support in the training of health care workers in HIV care services; and provide TA in the orientation of health workers on the revised Pediatric HIV guidelines. EGPAF will work with health care workers to ensure early identification of HIV exposed and infected infants through systematic screening of child and mother health cards at each service contact; improve health worker skills in pediatric counseling through training and mentorship; support EID through DNA PCR using DBS for exposed infants at every entry point within MCH; provide pediatric PITC using antibody tests for children >12 months and strengthen exit test at 18 months; and use of presumptive diagnosis of HIV. EGPAF will work with health care workers to ensure proper provision of infant feeding counseling; routine immunizations, growth monitoring and developmental assessment for all infants and children; prompt clinical and immunological assessment of HIV-positive children; pain assessment and management; screening for TB and OIs; prophylaxis with NVP, CTX, INH; regularly assess for ART eligibility; and ensure all early ART initiation for all HIV-positive infant and children less than 2. EGPAF will strengthen the use of patient cards and referral forms for effective referral linkages; work closely with expert patients and Mentor Mothers; establish and strengthen referral linkages between services and clinics; improve follow-up counseling to improve adherence; work with health workers to utilize pre-ART and appointment registers to identify defaulting and lost to follow up children; and develop mechanisms to trace clients. EGPAF will support psychosocial services through the formation of support groups for children living with HIV. 2 support groups will be established in the two years bringing the total of the support groups for children to 6.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

At present EGPAF is supporting 93 sites. By the end of FY2012 EGPAF will add 20 new facilities making a total of 113 health facilities. In FY2013 EGPAF will expand its support to 10 high volume private sector facilities. EPAS will accelerate its support to optimize comprehensive PMTCT services using the four PMTCT prongs: Prong 1: Strengthen PITC for pregnant women at first contact and PITC for couples/partners and retesting of HIV negative

pregnant women in ANC, labor and delivery and after delivery; strengthen prevention for HIV negative women to keep them HIV negative and identification sero-discordant couples and linking them to HIV care. Prong 2: Integrate family planning services into ART services in 6 PHUs. Prong 3 & 4: Strengthen health workers skills on CD4 testing and clinical staging to determine ART eligibility; advocate for the procurement of point of care CD4 machines; support implementation of the more efficacious ARVs for HIV positive women (option A); support effective implementation of extended infant NVP prophylaxis for breast feeding infants; strengthen the implementation of the national infant feeding guidelines to maximize HIV free survival; integrate neonatal/adult male circumcision messages into PMTCT counseling and training; support provision of essential HIV care for pregnant women and HIV exposed infants according to the national comprehensive HIV Care Package; and strengthen follow up care along the continuum of ANC, labor and delivery and post partum care for pregnant and breastfeeding women, their partners and family members through integration and linkages of comprehensive PMTCT services within MCH settings, using mobile phones, fast tracking of HIV positive pregnant and breastfeeding women eligible for ART initiation, strong peer support such as mentor mothers and expert clients and support groups, and use of hand held mother and child health cards. EGPAF and its partners will intensify community-level interventions including: strengthening linkages between communities and facilities, women's and men's support groups, male dialogues, community family days and mass media campaigns as strategies to generate demand for HTC and PMTCT.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	0	0

Narrative:

EGPAF will support the provision of comprehensive and integrated HIV treatment for infants and children less than 2 years in 7 PHUs and one clinic. Children initiated on ART at the PHUs will be kept at the PHU for approximately 2 years after delivery to allow for continuity of services for both mother and child in the PHU/MCH setting and then transferred out to the main ART centers. Through mentorship and support supervision, EGPAF will ensure sustainability of treatment services at all supported sites. National level activities: participate in the Pediatric HIV sub-TWG to help review and plan for HIV treatment services for infants and children; provide TA to MOH in the review/development of national ART policies, guidelines, job aids, M&E tools; support MOH in the roll out of the Nurse-Led ART Initiation (NARTIS) through training, mentorship, and support supervision of nurses; and support training of nurses in basic IMAI which includes pediatric ART. EGPAF will continue to support sites in improving uptake and quality of HIV treatment for children services as follows: work closely with mentor mothers and expert clients to ensure that caregivers are adequately counseled and prepared for ART to improve uptake and adherence of ART among children less than 2 years; provide onsite trainings on pediatric phlebotomy to improve immunologic staging of infected infants and children; work with and support health workers in drug stock management to ensure uninterrupted supply of ARVs and other OI drugs; support and mentor health care workers to ensure proper follow up and monitoring of children on ART and management of any side effects or complications that might arise; and

identify any treatment failures; encourage adherence to treatment by regular ongoing ART adherence counseling and active tracing of defaulters and lost to follow up patients using mobile telephones; establish facility based support groups for children living with HIV to help improve adherence to treatment; and support proper documentation of treatment services provided in the facilities and timely reporting of data to the national M&E unit.

Implementing Mechanism Details

Mechanism ID: 13738	**Mechanism Name: EGPAF-PIHTC (Provider-initiated HIV Testing & Counseling)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 15,000	
Funding Source	**Funding Amount**
GHP-State	15,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

EGPAF will support key intervention areas in the Partnership Framework through: Supporting the MOH to create an enabling environment for universal access to HTC within all health facilities; Supporting implementation of routine HTC services; Strengthening linkages and referrals; and Building provider capacity and strengthening health systems. This project will focus on HTC at primary care settings, which include clinics and PHUs, as the entry point for individuals to access HIV services. While most women are reached with HTC through ANC services, testing for men and children lag far behind. Expanding HTC to all service points, particularly STI, TB, inpatient and outpatient department (OPD) clinics, and expansion of routine screening of child and mother health cards, will significantly reduce missed opportunities for HTC and subsequent care and treatment services. This project will collaborate with the PEPFAR community HTC partner (PSI) to increase demand for routine HIV testing at every

service point within health facilities. In Year 1, the project will reach 113 health facilities; by end of Year 3, the project will support all health facilities in Swaziland. EGPAF will leverage partnerships with USAID, ViiV, and PSI (new recipient of community-based HTC project) and URC lab infrastructure project to coordinate activities, maximize results, and leverage funding. EGPAF will also engage with the relevant departments in the MOH, as well as with the National Emergency Response Council on HIV and AIDS (NERCHA) and PSI and other partners, to facilitate implementation of the HTC communication strategy and the development of necessary HTC job aids and promotional materials/messages, avoiding duplication of efforts and waste.

Cross-Cutting Budget Attribution(s)

Construction	15,000
Human Resources for Health	15,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Child Survival Activities
TB

Budget Code Information

Mechanism ID:	**13738**
Mechanism Name:	**EGPAF-PIHTC (Provider-initiated HIV Testing & Counseling)**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	0	0

Narrative:

EGPAF will support the MOH to firmly establish linkage to appropriate care and support services following provider-initiated HIV testing in all 4 regions of Swaziland. EGPAF will build on the successful pilot of the Patient Follow Up Standard Operating Procedures, which focuses on linkage to care, retention in care and defaulter tracing. EGPAF will pilot the use of expert clients as additional post-test counselors for newly diagnosed HIV patients in facility-based setting HTC settings. They also will develop and utilize new IEC materials to create demand for linkage to care. To assist in monitoring their efforts, they will develop/improve existing referrals forms, registers and monitoring systems. This effort will tie in closely with the full roll out of pre-ART as part of the HIV Comprehensive Package of Care, strengthened adherence and psychosocial support (APS) and PwP, the Expert Client initiative, clinical mentoring and supportive supervision, as well as the community linkages program—much of which is primarily supported by ICAP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	15,000	0

Narrative:

EGPAF's HTC activities will be aligned with national health sector response to HIV and AIDS (2009-2014) and the national policy guidelines for TB/HIV collaborative (2007). EGPAF will collaborate with PSI and URC to increase demand for routine HIV testing in tuberculosis (TB) clinical settings, both outpatient and inpatient wards. HTC in these settings can yield high numbers of HIV-positive clients in need of treatment.

EGPAF will collaborate with other care and treatment partners to further decentralize HIV services so lower-level health facilities can better deliver these services to newly-diagnosed clients. Clinics will serve as platforms to access communities with HTC services through outreach, while the clinics themselves will be connected to secondary and tertiary health facilities through a strengthened referral network to ensure provision of care and treatment services.
EGPAF will advocate for and promote national efforts on task sharing and shifting to extend ART provision, starting with the MOH?s proposed special authority for nurses to initiate ART for pregnant women and TB clients as high priority groups.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

EGPAF will support the GKOS to achieve its goal of increasing the percentage of the population undergoing HIV testing each year to 50% of women and 40% of men by 2013 through strengthening health facility based Provider Initiated HIV Testing and Counseling (PITC) services. *EGPAF will continue to participate in the national HTC core team and support the MOH/SNAP to finalize the national policy on routine HTC; national HTC scale up plan and development/adaptation of PIHT SOPs and job-aides. EGPAF will also build capacity health workers through training and mentorship on PITC including on couple HTC and pediatric PITC.* *EGPAF will rollout PITC to all settings and service points including inpatient and outpatient facilities, TB clinics, STI services, ANC, family planning, child welfare units, and male circumcision sites using the national HIV testing algorithm. The facility-based PITC services support will take place in a phased manner, beginning in Year 1 (2011) with support to 113 health facilities, reaching all health facilities by Year 3. EGPAF's support will be tailored into 2 categories of health facilities. Category one health facilities which include largely the PHUs and clinics will receive the standard support which includes trainings, on-site mentorship, support supervision, quality improvement and quality assurance activities, ensuring uninterrupted supply chain for HTC. Category two health facilities which include 5 hospitals and 5 health centers will receive the standard support as described under category one plus intensive support to implement PITC which includes placing lay counselors in TB units and OPD, renovation or upgrading the infrastructure to create space for PITC at OPDs, improve the client flow to facilitate linkages to care according to the national PITC SOP, Billboards to increase demand of HTC services and working with inpatient wards staff including doctors and the nursing staff to implement routine PITC as standard care in the inpatient wards. Moreover these category two sites will receive an intensive on-site mentorship once every month.*

Implementing Mechanism Details

Mechanism ID: 13742	**Mechanism Name: C-BLD (Capacity Building and Livelihoods Development)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 820,000	

Funding Source	Funding Amount
GHP-State	820,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The C-BLD project has three primary objectives: (1) to improve the livelihood capabilities of women and youth; (2) to strengthen the capacity of organizations to provide economic strengthening (ES), livelihoods and social support services to women and children; and (3) to create a positive enabling environment for women and children and protect their rights. The project's approach includes direct implementation of activities with beneficiaries and technical assistance (TA) to organizations to enhance their capacity to deliver effective services and support each other. The project's approach will emphasize partnerships, linkages and referral networks to maximize impact and improve the access of vulnerable households to relevant services. C-BLD will collaborate with GOKS and other partners at the national level to develop and support strategies promoting a stronger enabling environment for women and children. C-BLD will also provide TA to PEPFAR partners and others in designing, implementing and monitoring ES, gender and OVC programming. At the community level, C-BLD will collaborate with community members and institutions to develop an integrated approach, combining direct implementation, TA and advocacy to deliver against project objectives. The project will also collaborate with community structures to implement a referral system linking clients and beneficiaries to multiple services. C-BLD intends to contribute to the knowledge base within Swaziland. Through rigorous monitoring and evaluation and case studies, C-BLD aims to develop evidence-based approaches that can be scaled up across the country. Where possible, C-BLD will integrate its own project strategy with existing national strategies, including those developed by NERCHA, NCCU and UNICEF.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	390,000
Gender: GBV	280,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**13742**
Mechanism Name:	**C-BLD (Capacity Building and Livelihoods Development)**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	820,000	0

Narrative:

The C-BLD project has three primary objectives: (1) to improve the livelihood capabilities of women and youth; (2) to strengthen the capacity of organizations to provide economic strengthening (ES), livelihoods and social support services to women and children; and (3) to create a positive enabling environment for women and children and protect their rights. The project's approach includes direct implementation of activities with beneficiaries and technical assistance (TA) to organizations to enhance their capacity to deliver effective services and support each other. The project's approach will emphasize partnerships, linkages and referral networks to maximize impact and improve the access of vulnerable households to relevant services. C-BLD will collaborate with GOKS and other partners at the national level to develop and support strategies promoting a stronger enabling environment for women and children. C-BLD will also provide TA to PEPFAR partners and others in designing, implementing and monitoring ES, gender and OVC programming. At the community level, C-BLD will collaborate with community members and institutions to develop an integrated approach, combining direct implementation, TA and advocacy to deliver against project objectives. The project will also collaborate with community structures to implement a referral system linking clients and beneficiaries to multiple services. C-BLD intends to contribute to the knowledge base within Swaziland. Through rigorous monitoring and evaluation and case studies, C-BLD aims to develop evidence-based approaches that can be scaled up across the country. Where possible, C-BLD will integrate its own project strategy with existing national strategies, including those developed by NERCHA, NCCU and UNICEF.

Implementing Mechanism Details

Mechanism ID: 13743	Mechanism Name: ECSA-HRAA
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Eastern, Central and Southern African Health Community Secretariat	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Abt Associates	JHPIEGO	

Overview Narrative

In COP12/13, HRAA will focus on human and capacity development to address the workforce shortages in social welfare informed by the pre-service strategy that will be developed in FY 12. Further, looking at how the in-service should be structured for on-going training is important in building the capacity of staff at the Department of Social Welfare (DSW) who do not have a social work background. Immediate TA support is needed by UNISWA to develop a degree program in Social Work responding to the DSW request for this program to be offered. Currently, UNISWA offers social work elective courses and students do not major in social work but in other disciplines i.e. Bachelors in Social Science, Public Administration, Sociology because there is no major in Social Work. These graduates are employed as professional social workers but in reality do not have the requisite educational background to qualify as social workers. The streamlining of the Para-professional (auxiliary) cadres is another area that will be supported in addressing workforce needs in this sector. Programs like the ODL program offered by UNISWA in Psychosocial Support offered through Distance Learning Program, and the Institute of Development Management (IDM) certificate and diploma programs are important to inform what is available on the ground. In the broader OHSS support, the Swaziland Clilnical Nursing Hub is being created to compliment the ICAP program's pre-service training. This Clinical Hub will be the model practice lab for faculty to teach practical skills that have been identified as a major gap in clinical practice for graduates that are being produced in the three nursing institutions.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13743		
Mechanism Name:	ECSA-HRAA		
Prime Partner Name:	Eastern, Central and Southern African Health Community Secretariat		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0

Narrative:

Currently, UNISWA does not offer a degree in social work but elective courses that students studying in the following disciplines i.e. Bachelors in Social Science, Public Administration, Sociology can select to take and get a double major. There is a growing need to train professinal social workers has been ensodrsed by the DSW under the Deputy Prime Minsiters Office and the Technical Comiitee that that representition from a multiple stakeholer group (DSW, key line ministries, UNICEF, PEPFAR, and UNISWA). UNISWA has developed a draft curriculum and has requested PEPFAR to provide techncial support to finalise this workign with the stakeholders. PEPFAR has also commtted in streamlining the para-professional cadres that work at community level so that the training is uniform and addresses the needs of the country. All of this traingin needs to be guided by teh pre-service strategy that Jhiego is developing to inform: the numbers to be trained with projections in the short term, medium term, and long term; teh key competencies for trainign at each level; defining the different entry and exit points depending on the academic and experience of the learners; and the acreditation and licensing of professional including a code of conduct that will be monitored by a statutory body, a Social Work Council that will be

established.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The Swaziland Clinical Nursing Hub is envisioned to be the model clinical practice hub being created to complement the ICAP/INCI program in pre-service education, PEPFAR infrastructure investment in the three nursing schools (refer to Governance and Systems TAN). The foucs is to improve the quality of clinical education, facilitate link between academic and clinical agencies, ensure that clinical educators maintain clinical competencies and teaching competency. Jhiego will develop a vision for the Clinical Hub. This will include: how this hub can be used a Simulation center for formative skills practice, and provide Clinical assessment of students as part of registration, using the hub to be for Competency maintenance – a component of CPD, and creating the links between the preceptor ship and mentorship roles. The implementation of the Clinical Hub will be a multi stakeholder activity including i.e. MOH, Nursing Council, traingin schools, donors inlcuding PEPFAR and World Bank. The implementation will take into consideration:

• Develop a monitoring and evaluation plan – indicators of success, plan for sustainability
• Develop a quality improvement strategy to be implemented in each facility providing clinical education
• Establish set of core competencies – What are nurses expected to do effectively immediately upon graduation
• Map each competency to associated knowledge, skills and attitudes
• Map clinical skills to most appropriate facilities and health workers
• Prepare facilities for clinical education – ensure that infrastructure, equipment and supplies can accommodate education. Determine appropriate student volume for different sites
• Prepare health workers for their role as clinical educators (preceptors)
• Provide supportive supervision of clinical educators
Note: This activity is funded from ECSA pipeline.

Implementing Mechanism Details

Mechanism ID: 13772	**Mechanism Name: MSH-BLC (Building Local Capacity)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

MSH links to the following PFIP objectives: "Improve the human and institutional capacity of the MoH and NGOs to respond to the HIV epidemic" and "HIV and AIDS health systems strengthened and integrated to improve health outcomes and developmental action in Swaziland". The BLC project works to build the capacity of local institutions in the delivery of HIV/AIDS services in the region. With BLC support, such institutions will progress to the point where they are able to attract and effectively manage funding received directly from the US government and other donors. Through MSH, PEPFAR will continue to provide USG's in-kind contribution to the CCM, in addition to providing necessary program management, technical assistance and tools. MSH will also provide necessary technical assistance and tools to help the Advisor improve grant alignment and leveraging of Global Fund grants with HIV donor activities, in particular PEPFAR resources. BLC will support other training and coordination activities as determined in consultation with the CCM and NERCHA. For the capacity-building activities described above, MSH will not receive additional funding inputs from other donors, host government and/or civil society - these activities are funded entirely by PEPFAR.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13772**
Mechanism Name:	**MSH-BLC (Building Local Capacity)**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The ESI project will provide a broad program of technical assistance and other targeted project support to improve the quality, availability and use of Strategic Information (SI) under the MoH's Strategic Information Department (SID). The SI activity will contribute to strengthening programs, improving accountability and reporting, and information sharing within PEPFAR partners. IHM will implement an integrated data review and information products generation strategy to address this activity. Data reviews are collaborative exercises whereby M&E officers in the SID will work collaboratively with IHM to implement a strategy of engaging health program management teams (i.e. program managers and technical leads) within the programs in manipulating and preparing health data to be presented in targeted fora in the format of technical and professional presentations and monthly or quarterly review reports demonstrating program development and growth or attainment of program milestones or targets. A key output of these review sessions will be a publishable presentation or technical report documenting the processes undertaken. IHM will provide mentorship support in structuring, facilitating and documenting these processes. IHM will support and mentor the SID to institutionalize a standard process for generating information products. IHM worked with the SID in 2010 to develop an evaluation capacity development strategy that was included in the MoH M&E framework. The strategy calls for the establishment of an Office of Evaluations and Operations Research within the SID. IHM will provide technical support in the form of a senior technical advisor to: (i) establish collaborative partnerships with targeted centers for excellence within the region and abroad to enable SID to access already established evaluative expertise, (ii) mentor at least two officers assigned by SID to understudy the senior technical advisor as part of ensuring sustainability, and (iii) institutionalize a culture of self-examination, experimentation and driving program improvement based on evaluative evidence through the implementation of at least one evaluation study and one operations research activity within the first year of establishing the office.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	OHSS	0	0

Narrative:

MSH is working with Swaziland's CCM and with NERCHA as a Global Fund Principle Recipient. To maintain cost-effectiveness and streamline operations, MSH corporate policy requires that, to the extent practicable, all projects in any country are co-located in the same offices and are supported by a common operational platform. While the Building Local Capacity Project does not have permanent staff in Swaziland, operations are supported by MSH's Strengthening Pharmaceutical Systems (SPS) Project with offices in Mbabane. The work with the CCM and NERCHA anticipates a higher level of technical assistance and other resource inputs in the first two to three years, with such support tapering off in the out years. Performance benchmarks include: i) development of HR plans for the adequate staffing of the CCM secretariat and NERCHA Global Fund management unit (GMU); and ii) orientation and training of staff from NERCHA's GMU, including sub-recipients and other implementing partners, on Global Fund systems, processes and reporting.

Implementing Mechanism Details

Mechanism ID: 13791	**Mechanism Name: PSI-CIHTC (Client-initiated HIV Testing & Counseling)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 180,000	
Funding Source	**Funding Amount**
GHP-State	180,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PSI strives to tailor its HIV counseling and testing services appropriately for men and women, and to promote men and women (or men and men and women and women) to be counseled together as couples as a means to ensure gender equity. PSI will continue its efforts to encourage testing among men as a population with fewer regular encounters with the health care system and as leaders in their communities./families to set a positive example by knowing their HIV status. PSI will continue its work with MARPs including sex workers, MSM and mobile populations to increase HIV testing and subsequent HIV prevention and care/treatment seeking behaviors among these groups. Through PSI's Corporate AIDS Program, PSI will continue to expand the availability and accessibility of HTC services in the workplace.

The content of PSI's HIV counseling and testing work addresses a comprehensive set of counseling messages that covers prevention strategies, linkages to care and treatment as well as family planning messages and TB screening and subsequent referral. Counseling messages on these topics are tailored to the individual based on needs that emerge during the one-on-one counseling interaction. All counselors are trained to promote and discuss family planning when appropriate and to make referrals for family planning products and services. All counselors incorporate the TB screening tool into the counseling session and also discuss TB diagnosis and treatment and make referrals as appropriate.

Cross-Cutting Budget Attribution(s)

Key Populations: FSW	150,000
Key Populations: MSM and TG	30,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	13791		
Mechanism Name:	PSI-CIHTC (Client-initiated HIV Testing & Counseling)		
Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

PSI will support the MOH to firmly establish linkage to appropriate care and support services following community-based HIV testing in all 4 regions of Swaziland. PSI will build on the successful pilot of the Patient Follow Up Standard Operating Procedures, which focuses on linkage to care, retention in care and defaulter tracing. PSI will expand the use of expert clients as additional post-test counselors for newly diagnosed HIV patients to other key community-based HTC settings. They also will develop and utilize new IEC materials to create demand for linkage to care. To assist in monitoring their efforts, they will develop/improve existing referrals forms, registers and monitoring systems. This effort will tie in closely with the full roll out of pre-ART as part of the HIV Comprehensive Package of Care, strengthened adherence and psychosocial support (APS) and PwP, the Expert Client initiative, clinical mentoring and supportive supervision, as well as the community linkages program—much of which is primarily supported by ICAP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	0	0

Narrative:

The PEPFAR Swaziland Pediatric HIIV care and support covers a target population of 0-15yrs. PEPFAR Swaziland supports family-centered approach to HIV care and treatment which includes family testing strategies at health care facilities (DBS for infants 0-18months and rapid test thereafter) as well as during home-based HTC. Children are tested as part of the family during home-based testing and are referred for care and support services similar to standard protocols for adult care and support. At health facilities, a family tree approach is used to identify all children in the family who need to be tested, using the parent as an index case at pre-ART and ART care points. There is an efficient system in place at health facilities to identify exposed infants for DBS. More than 95% of exposed infants currently receive DBS. The far majority (79%) of exposed infants are initiated on co-trimoxazole and over 95% are initiated on extended Nevirapine. The main challenge is tracking exposed infants to know what happens to them. PEPFAR Swaziland is currently working with the national strategic information department to set up a surveillance system to follow up exposed infants. PEPFAR supports adolescent clubs to provide peer support for adolescents living with HIV. These clubs meet regularly to discuss adherence issues, and how to live positively. Efforts are in place to strengthen adolescent care and support through special clinics where adolescents will receive more attention to issues specific to adolescents and to ensure smooth transition into the adult care and support programme to minimize lose to follow up. An adolescent TWG has recently been formed at the national

level. This TWG which is a sub-committee of the Pediatric TWG will focus of adolescent specific issues to ensure that their issues are not lost between the adult and pediatric TWG discussions. PEPFAR Swaziland partners will participate in these meetings to provide technical support for both pediatric and adolescent issues. PEPFAR will support job aides and IEC materials that are kid friendly to support psychosocial and adherence counseling. PEPFAR Swaziland is supporting efforts to improve early enrollment of infants testing positive from DNA-PCR into care and treatment. Nurses are being trained both in didactic trainings and clinical attachments through a sub-award to Baylor Center of Excellence to acquire more knowledge and skills in diagnosis and management of pediatric opportunistic infection, pediatric phlebotomy as well as psychosocial and adherence needs of pediatrics. Starting from FY 13 through FY 14, the pediatric guidelines will be revised in line with current evidence to improve pediatric HIV care and support. World Food Programme has a food for prescription programme for children from 5yrs and above. PEPFAR partners support the implementation of this program by training healthcare workers on how to identify malnourished children using MUAC and/or BMI.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	

Narrative:

PSI will primarily provide technical support in strategic information to ensure that all community-based HTC partners have MIS and M&E systems that are in line with national, international and PEPFAR guidelines. PSI will help with the integration of the national HTC register and other relevant M&E forms for all partners/sites. PSI will help ensure that these organizations/sites are reporting into the MOH and will ensure that MIS systems are integrated and capacitated to support track key HTC indicators.

PSI will also help capacitate the Ministry of Health to collect, manage and use key program data to make evidence based decisions to ensure HTC program coverage. For example, PSI will provide technical support to the Ministry of Health to establish and maintain the health services tracking map. PSI will work through the HTC Core Team to ensure quarterly meetings to review the map and make decisions about the geographic location of services including HBHTC efforts. As part of quality improvement, PSI will lead mentorship sessions at HBHTC data collection level to ensure that the quality gaps are monitored and addressed. PSI will also help transition the database of lay counselors to the Ministry of Health and provide technical support to ensure this database is updated on a regular basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	

Narrative:

PSI will support human resources for health by seconding a person to the Ministry of Health to work closely with the National HTC Coordinator. This person will be focused on community based HTC outreach and will help coordinate all PSI and partner activities to ensure broad geographic reach of this HTC approach. A quarterly meeting with all community based HTC implementers will be held to share best practices and assist in capacitating CBO's. He will also help to coordinate HBHTC. He will establish a national HTC outreach protocol that can guide future community based HTC efforts. This National HTC Outreach Coordinator will be funded fully by PEPFAR for two years. Subsequently, integration options will be explored for the position with the Ministry of Health and/or to integrate the responsibilities with the existing responsibilities of the position seconded by EGPAF.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	180,000	0

Narrative:

PSI grant activities will focus on providing HTC to the general population – adults aged 15-49- through community-based HTC. In pursuit of the national strategic framework objectives to reach 196,000 people with HTC on an annual basis and to increase the proportion of men tested to 40% and of women to 50%, PSI will design and focus its activities to be appealing to both men (e.g. dip tanks) and women (e.g. VCT). PSI will also focus on reaching MARPs including sex workers, MSM and transport operators. The Luke Commission will help ensure that HTC reaches the most rural areas as well as the older age segments of the general population. PSI will collaborate with existing partners to provide HTC services in the workplace. Activities will be focused nation wide and will take place in a variety of settings. Outreach activities aim to take HTC services deep into the communities at community events, dip tanks, medical outreach camps, mobile circumcision services, targeted HTC campaign events, workplace and other innovative strategies. PSI will also continue to provide HTC in VCT settings through its New Start franchise network. PSI will conduct HBHTC to help fill in gaps in HTC geographic coverage. PSI will map all CB-HTC activities in the country and door to door HTC will be conducted as a 'fill-in-the-gap' activity. PSI will work with EGPAF to ensure that there is synergy between facility based and community based HTC activities. PSI will continue to work with the Ministry of Health to refine, test and finalize the national referrals and linkage system. PSI will use its TRaC surveys to assess HTC uptake and to behavioral determinants that are correlated with HTC service utilization that will inform the design of communications activities to promote HTC and to normalize testing. PSI will assist MOH to develop an accurate and reliable M&E system that also harmonizes HTC and care and treatment data. PSI will support MOH to establish an HTC health services map using GPS coordinates. To help ensure harmonized messages on HTC across all HTC entry points, PSI will conduct a DELTA Marketing Planning for stakeholders to develop one national communication plan.

Implementing Mechanism Details

Mechanism ID: 14201	Mechanism Name: M2M (Mothers 2 Mothers)

Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Mothers 2 Mothers	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The m2m program is closely aligned with PFIP goals and principles, particularly the key intervention area of decentralized and improved quality of care and treatment services. The m2m program is offered at existing PMTCT services in public health facilities and aims to contribute to reducing new HIV infections by supporting pregnant women and new mothers to utilize PMTCT services from antenatal to postpartum period in order to prevent mother-to-child-transmission of HIV. In line with the PF, m2m contributes to effective task-shifting by employing mothers living with HIV to provide critical education and support services to clients at understaffed health facilities. m2m will closely collaborate with the MoH, EGPAF, the Swaziland Infant Nutrition Action Network (SINAN) and the Family Life Association of Swaziland. Currently m2m provides services at 60 public health facilities which are evenly distributed across the 4 regions of the country. m2m's target populations are HIV-positive pregnant women, new mothers and their partners. The m2m model is unique, cost-effective, easily replicable, scalable and adaptable to any culture and needs of. The cost effectiveness of this model is based on the lifetime skills and economical empowerment and human development of women contributing to HIV prevention. To ensure cost efficiency and sustainability, m2m will explore alternative service delivery models, such as technical assistance to government and indigenous organizations. However, the current economic challenges being faced by the GOKS might limit the implementation of this model.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Child Survival Activities

Safe Motherhood

Family Planning

Budget Code Information

Mechanism ID:	14201		
Mechanism Name:	M2M (Mothers 2 Mothers)		
Prime Partner Name:	Mothers 2 Mothers		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	0	0

Narrative:

Currently m2m is operating at 60 sites and will be opening and functional in 5 more sites by November 2012. This expansion is aimed at contributing to the improvement of PMTCT outcomes at priority sites in the country. m2m activities are guided by the Ministry of Health PMTCT Elimination Strategic Framework and the current EPAS initiative focusing on quality service delivery, scale up and monitoring and evaluation of activities. Focus will be towards greater male involvement (couple HIV counseling and testing services, medical male circumcision) and improving client retention in the PMTCT cascade. In order to meet program goals and objectives, m2m will work collaboratively with other partners and government to maximize on opportunities and synergies. Mentor mothers' skills will be developed through trainings and on the job mentorship.

Implementing Mechanism Details

Mechanism ID: 14374	**Mechanism Name: APHL**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Association of Public Health Laboratories (APHL) is a laboratory partner of the Centers for Disease Control and Prevention (CDC), Global AIDS Program in Swaziland, in support of the US President's Emergency Program for AIDS Relief (PEPFAR). APHL is assisting the Swaziland Ministry of Health (MOH) to implement a national laboratory information system in all MOH laboratories. In the first phase of this implementation, 6 laboratories will have electronic Laboratory Information Systems (LIS) installed. The scope of the project includes: 1) contracting with a vendor to supply electronic LIS software and system support; 2) contracting with a vendor to provide hardware i.e. install computer hardware - PCs, networking cables and related items; 3) contracting with a vendor to provide basic Windows computer training; 4) ensuring that any physical renovation needed at Phase I sites is completed and support is provided as necessary; 5) overseeing the installation of the LIS software and training of users in LIS application; and 6) overseeing the maintenance of the LIS operating system. Contract vendors will be responsible to deliver, install, conduct all training and provide on-site support services necessary for the successful implementation of this project.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)

Military Population

Budget Code Information

Mechanism ID:	14374		
Mechanism Name:	APHL		
Prime Partner Name:	Association of Public Health Laboratories		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	0	0

Narrative:

APHL will continue to assist CDC/Swaziland and MOH in the planning, design and implementation of a laboratory information system (LIS) to support HIV/AIDS care and treatment. Using the APHL methodology described in the "Guidebook for Implementation of Laboratory Information Systems", APHL will collaborate with CDC Swaziland and MOH to develop the scope of work (SOW) and assess selected laboratory sites to identify paper based strengthening activities and high level functional requirements for a pilot LIS. Assist with the formation of an LIS Working Group with representation from CDC, MOH and other stakeholders in Swaziland. In consultation with CDC and MOH, Award a contract to an appropriate LIS provider for the pilot LIS and manage implementation of the system. APHL will work with the selected vendor to implement the laboratory information system at the national laboratory and at least 2 district laboratories (2nd tier laboratories) by the end of the fiscal year.

Implementing Mechanism Details

Mechanism ID: 14437	**Mechanism Name: WHO-OHSS**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: World Health Organization	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

WHO country office plays a key advisory role in the MOH and supports all aspects of HSS. PEPFAR has a good working relationship with the country office and has funded a grant to develop the Task Shifting Framework document that is a national priority. PEPFAR funding under COP 12 is strategically building on this relationship to fund WHO to provide technical support to the MOH HR Unit to build its capacity and model a prototype HR unit and institutionalize the key documents i.e. HR Policy, HRH Strategic, EHCP staffing norms that is a national priority. Further, WHO is best positioned to provide technical support to the newly established multi-sectoral HRH TWG/Observatory. This is critical because of the capacity issues in the MOH/HR Unit and that this is an area that WHO focuses on in Swaziland and has political influence to complement PEPFAR technical support through HRAA.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14437**		
Mechanism Name:	**WHO-OHSS**		
Prime Partner Name:	**World Health Organization**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0

Narrative:

WHO will be funded to build the capcity in the MOH/HR Unit in the following key areas:
1. Build the capacity of the MOH Multi-sectoral HRH Technical Working Group and strengthen the HRH Observatory. It is critical in the first two years to build capacity for the MOH to manage, and have a vision for the national HRH agenda, ensuring coordination amongst key stakeholders that support HRH activities in the country. This will include:
a) Working closely with the MOH to set the agendas for the meeting and co-chairing the meetings with MOH.
b) Working with HRAA Country Director establish a system and meeting scheduling for the meetings including timely documentations of minutes, follow-up on action points and providing clarity on issues where needed.
c) Organize a field trip to Lesotho that has a functioning HRH TWG to learn how this is run and managed
Modeling a prototype HR Unit
2. Develop a the prototype model HR Unit that will take into consideration required technical skills and the appropriate staffing level informed by the current existing positions to implement the approved new structure by cabinet. a) The focus will be to define an approprite prototype model structure for the unit that will engage Management Services Department in the Ministry of Public Service working with the HRAA Country Director.
b) Defining the skills and profiles required to staff the unit.
c) Facilitating an study tour in a country that has a functioning HR Unit
3. Develop a capacity development plan for the prototype HR unit informed by the above
a) The plan will take into consideration the key documents i.e. HR Policy, HRH Strategic Plan, EHCP staffing norms a priority focus for HRAA in year one of implementation that need to be instituionalised at MOH/HR Unit
b) Developing the HR capacity for the various WHO tools i.e. WISN to assess staff training requirements at National, Regional and facility level.
c) Identifying relevant training and TA for the MOH HR Unit

This work will complement HRAA's year one activities and the placement of the HR Advisor.

Implementing Mechanism Details

Mechanism ID: 14842	**Mechanism Name: Public Diplomacy**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: USG Core
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

U.S. Embassy Mbabane's Public Diplomacy section is an integral part of the PEPFAR team. Beyond local and international media relations and public diplomacy activities undertaken as a core function of the PD section, the PEPFAR team develops high visibility PD activities to cultivate leaders in the arts as spokespeople for PEPFAR prevention messaging and to raise awareness of the PEPFAR Swaziland program.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	14842		
Mechanism Name:	Public Diplomacy		
Prime Partner Name:	U.S. Department of State		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	0	0

Narrative:

1. Arts Outreach Program- collaboration between local arts organization and rural school children to work on youth empowerment through the arts. Workshops to take place in rural schools that center around telling the story of the impact of HIV/AIDS through the eyes of children to be followed by an arts exhibition in Mbabane, attended by government officials, religious leaders, NGOs working on HIV/AIDS prevention, care and treatment.

2. Spoken word poetry training and national competition-grant to poetry association to train young Swazis to express themselves through poetry and then participate in a national competition of spoken word poets in the capital city. Youth Empowerment as a way to protect yourself against HIV/AIDS.

Implementing Mechanism Details

Mechanism ID: 16760	**Mechanism Name: URC-ASSIST**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 350,000	
Funding Source	**Funding Amount**
GHP-State	350,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY13, ASSIST will continue to: 1) Scale up and strengthen provision of integrated TB/HIV including MDR-TB care and treatment services to PHC clinics and communities; 2) Institutionalize Quality Improvement/Quality Assurance for TB/HIV services; 3) Strengthen the capacity of MOH Tuberculosis Control and AIDS programs to lead and manage roll out of TB/HIV care and treatment services; 4) Contribute to health systems strengthening; 5) Conduct operational research to inform current practices; 6) Strengthen community participation in the provision of TB/HIV and MDR-TB care and treatment; and 7) Knowledge management, monitoring and evaluation and project administration. The project will work in all four regions to support 30 more TB diagnostic units and 60 primary health clinics initiating TB treatment integrated with HIV care. The project will work with the following target populations: general population at risk for TB and HIV; people living with HIV; pediatric TB and HIV patients; members of the military and armed services; inmates and prison service members in 4 main prisons (one per region); and employees of large scale corporate organizations at risk for TB/HIV co-infections. In a bid to increase efficiency, the project will reallocate workloads and technical support from focusing on specific technical areas to provide support in all technical areas to reduce redundancy to ensure maximum output and accountability. ASSIST will continue to work collaboratively with PEPFAR and other donors to maximize technical support, increase efficiency and reduce cost from duplication. ASSISTsupports the MOH to develop and use evidence-based policy guidelines and capacity building strategies that promote ownership.

Cross-Cutting Budget Attribution(s)

Renovation	350,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Military Population
Mobile Population
TB
Workplace Programs
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**16760**
Mechanism Name:	**URC-ASSIST**
Prime Partner Name:	**University Research Corporation, LLC**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	350,000	0

Narrative:

" ASSIST's primary target populations include adults, children, PLHIV and high risk groups for MDR-TB. ASSISTalso covers health care workers, the general public and policy makers. ASSIST will build on its successes in order to address gaps/bottlenecks for achievement of national and PEPFAR targets, and implement new activities that address new national and international priorities. In FY13 ASSIST aims to: scale up and strengthen provision of integrated TB/HIV including MDR-TB care and treatment services to PHC clinics and communities; institutionalize Quality Improvement/Quality Assurance for TB/HIV services at national and health facility levels; strengthen the capacity of MOH Tuberculosis Control and AIDS programs to lead and manage roll out of TB/HIV care and treatment services; contribute to health systems strengthening; conduct operational research to inform current practices; strengthen the programmatic and clinical MDR-TB management; and improve TB/HIV knowledge management, monitoring and evaluation. ASSIST will continue to: strengthen TB screening and diagnosis in all HIV clinics as well as the military and correctional services; engage CBOs to advocate and/or provide TB/HIV care like patient support, provision of community DOTs both for drug sensitive and drug resistant TB; collaborate with CMS, MSH and CHAI in forecasting and quantification of both 1st and 2nd line anti-TB drugs; scale up the provision of TB diagnostic and treatment services in primary health clinics in the regions supported; and collaborate with business societies and the public service commission to continue providing resources for information dissemination and education among their employees.
"

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

n a more recent report by Abt Associates, an assessment of the MOH/HR Unit was conducted to ascertain the skills required to implement the HRH Strategic Plan. The Training Office is one of the functional areas within the MOH/HR that was assessed in terms of functions and responsibilities. Currently, a Training Officer (TO) second by the MOPS and a nurse are responsible who has been seconded to the unit are managing the training function for the entire MOH to address in-service training needs for a workforce of about 3,000+ health workers . Swaziland is a high prevalence HIV/AIDS and the TB/HIV co-infection rate very high. This scenario poses challenges for the Training Office because of the varied needs of the health workers with the complexities with TB/HIV co-infection. The report has identified these areas of support for the Training Office: strengthening coordination of in-service trainings; developing evidence informed and needs based training plan; ensuring quality of in-service trainings. These 3 areas are technical and broad and require expertise in training and development in the health.

The current barriers in IST that contribute to it not function include are largely related to poor coordination amongst providers a fragmented training system with MOPS responsible in defining training priorities for the entire civil service and MOH not having a role in influencing this process, duplication of training, poor quality training because there is not system currently to evaluate training courses offered, and poor linkages between IST, on-the-job-training and supportive supervision. There is no follow-up system once an individual has completed training and no training database and selection of trainees.

PEPFAR partners are also contributing largely to these barriers where partners are targeting the same health care workers from facilities for different training that maybe overlapping in content; the training is not informed by any needs assessment but project driven to address technical skills that are not vetoed by the TO because the is no technical capacity to assess the training; training has become an easy way to increase the burn rate by partners; the same type of training by each partner without an evaluation of the use by the participants in improving health care delivery; there is no accreditation system in Swaziland to evaluate training and partners are making the determination on who and what they train.

Through URC/ASSIST, technical support will be provided to the TO in developing systems for managing IST in the MOH that will include a framework for all training programs that will offered and also provide guidance to in-service training program providers and the MOH TO in defining key practices, training program’s structure, processes and outcomes. This framework will help focal persons and departmental

heads to plan and improve coordination in terms of format, training approaches, participant selection, engaging supervisors and managers in defining their departmental training needs, defining the relevant learning methods and approaches to enhance the skills of the health workforce, and follow-up after the training to assess impact.

Implementing Mechanism Details

Mechanism ID: 16812	**Mechanism Name: ASLM**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Society for Laboratory Medicine	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 20,000	
Funding Source	**Funding Amount**
GAP	11,991
GHP-State	8,009

Sub Partner Name(s)

(No data provided.)

Overview Narrative

African Society for Laboratory Medicine (ASLM) will organize a Stepwise Laboratory Improvement. Process Towards Accreditation (SLIPTA) Auditors training course in Mbabane, Swaziland. ASLM will use standardized curriculum to train 5 participants. Those successful (70% score in the final examination) in completing the SLIPTA auditors training will conduct auditing and provide technical assistance and guidance to medical laboratories in the country. The first three days will be for didactic and the other two days are for mock assessment and feedback provision. Those successful participants will also conduct post training audit practicum to become an independent auditor. ASLM will also link Swaziland to ASLM collaborating centers and internationally to organizations like ASCP, APHL and others to learn best practices on quality laboratory management systems, capacity building of the laboratory workforce and other relevant developments in laboratory medicine.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**16812**
Mechanism Name:	**ASLM**
Prime Partner Name:	**African Society for Laboratory Medicine**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	20,000	0

Narrative:

ASLM will:

1. Provide Technical Assistance in setting up a Medical Laboratory Council to handle and prescribe credentials for Laboratory Professionals registration and Professional conduct
2..Support the set-up and the functions and affiliations of the Laboratory Professional body
3.Provide Technical Assistance in setting up standards for Laboratory Accreditation through SLMTA by providing assessors . This assistance is expected to further professionalize laboratory services in Swaziland.

Implementing Mechanism Details

Mechanism ID: 16815	Mechanism Name: Health Finance & Governance Project (HFG)
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,315,000	
Funding Source	**Funding Amount**
GHP-State	1,316,000
GHP-USAID	999,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Abt HFG mechanism will focus on HICD, targeting key government ministries and NGOs to strengthen organizational systems and structures that promote their sustainability. The national strategies for HRH and SW in line with the PFIP Pillar 5 objectives will be prioritized. The emphasis is supporting the scaling up the HIV response and enhancing the sustainability of priority HR interventions. Synergy with the four pillars is critical to complement the efforts of other USG projects and other donors in line with national priorities. The HRH and SW Technical Working Groups will be the primary forums to coordinate these efforts in which development partners and in-country stakeholders will develop and contribute towards long term HRH and SW objectives. HFG will systematically seek to strengthen existing in-county systems and networks and focus on building the capacity of local institutions and individuals, thus minimizing the costs associated with supporting international systems and TA. Technical advisors will be placed at MOH and DSW to drive the support. Priority for the project is advocating for the transition of donor-funded positions to the government. Local stakeholders have been involved in the development of the HRH and SW Strategic Plans to ensure a long-term vision in implanting the plans by the local staff, strengthening coordination systems and capacity building of local entities to manage the systems. This will lead to country-owned interventions and M&E systems to evaluate progress. Supporting the HRIS in ensuring that reliable workforce planning data is critical and leverages PEPFAR TA support with defining staffing levels in facilities and the review of the Health Information Systems.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,000,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	16815		
Mechanism Name:	Health Finance & Governance Project (HFG)		
Prime Partner Name:	Abt Associates		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	585,000	0

Narrative:

The objectives of the project's OVC component in Swaziland will be to 1) strengthen the delivery of social welfare services to vulnerable children and families 2) develop a national framework for social protection for vulnerable children. These objectives fit into PEPFAR's OVC priorities for strengthening systems as per the CARE TAN, namely 1) strengthening and decentralization of the Department of Social Welfare, 2) strengthening the child protection system and 3) enhanced M&E for impact mitigation. Target populations will be vulnerable children and families which will benefit from improved social services and child and social protection. The strategies to achieve these objectives are in line with global evidence-based OVC guidance, namely strengthening the social welfare workforce and its systems and policies that address the unique needs of children in Swaziland's epidemic.

Abt HFG mechanism will provide technical assistance to the Directorate of Social Welfare (DSW) to upgrade the skills of its social workers many of whom lack adequate training, and will review key

practices and systems in the Directorate to enable improved case management and child protection, with emphasis on decentralization of DSW. The mechanism will also support the University of Swaziland to set up a degree course for social work, including the development of a curriculum. Pending government approval of a proposed new DSW structure including a cadre of auxiliary social workers, a pre-service training program for parasocial workers will be developed.
Another area of support through Abt will be a review of the various social assistance programs that benefit OVC's i.e: free primary education which currently extend to Grade 5;school-feeding for primary schools and for community facilities called Neighbourhood Care Points; a bursary scheme for eligible secondary school students; and grants to the elderly, many of whom take care of OVC's. A cash transfer program to OVC will be piloted by the World Bank. However, the system is fragmented and sustainability as well as functionality of these and other social protection components is weak. Activities will include a series of consultations and tailored training to develop consensus on national social protection priorities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,730,000	0

Narrative:

The five-year PFIP 2009-2013 seeks to address the spread of HIV not only by supporting the scaling up behavioral and biomedical interventions, but also by strengthening public health and community systems to foster a sustained response. As such, cross-cutting efforts to strengthen local capacity focus on building a human and institutional base to allow for expanded and extended service delivery. Over the length of the PFIP, the partnership expects to shift further toward capacity building and financial sustainability as USG gradually takes on a supportive role more focused on technical rather than financial assistance.

The HICD pillar in the PFIP addresses workforce imbalances and barriers that impact programs supported by PEPFAR across the 5 pillars, ensuring effective and efficient healthcare and social welfare service delivery systems. As highlighted in the HRH Strategic Plan (SP), HR functions overlap across various ministries and fragmentation in workforce planning, development, and management present a challenge that impacts the function of this pillar. Several assessments have highlighted a glaring lack of capacity in the MOH/HR that challenges the ability of the MOH to manage HRH and to effectively implement the HRH SP. Swaziland is also undergoing a number of strategic changes in the Social Welfare sector. The delivery of social welfare services is being reassessed, including a restructuring of the DSW and the adoption of strategies to foster a greater impact of Social Welfare services.

In light of the above challenges, the Abt-led Health Finance and Governance project (HFG) was selected

by the USG team in Swaziland to strategically address gaps evident in USG-supported health and social welfare programs in Swaziland. Abt was the lead implementer of the HS 20/20 award, is a vendor under the ECSA-led HRAA program, and has worked in Swaziland conducting costing work including the HRH Strategic Plan and the MOH restructuring. The USG program can leverage this global expertise to strengthen support to all the PFIP pillars, consistently weak with SAHCD and HRAA. Further, health financing is garnering increased attention in Swaziland and the need for a strong partner in this area is essential. To achieve this Abt will need a presence in Swaziland.

PEPFAR has supported the development of several critical national-level documents i.e.: HRH Strategic Plan approved by cabinet, Development of the Staffing Norms to implement the Essential Health Care Package in line with decentralization of health services, Restructuring of the SWD. HFG support will follow and complement this work, and impact our support decentralization of ART and social welfare services and PMTCT Plus scale-up.

There is a growing interest to support HICD with the new World Bank/ EU HSS project, GF HSS grant and PEPFAR partners being encouraged to address HSS more holistically. Through PEPFAR, Pact Swaziland is building CANGO's capacity to be a UGM for smaller civil society organizations that do not receive GF and PEPFAR funding. PEPFAR is funding WHO directly and leveraging the relationship they have with the MOH to improve coordination of HR at a national level. This presents a prime opportunity for HFG to support WHO in strengthening the governance mechanisms of the multi-ministerial forums responsible for HR and SW to address key technical and policy implementation issues.

Implementing Mechanism Details

Mechanism ID: 16821	**Mechanism Name: Health Communication Capacity Collaborative (HC3)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 320,000	
Funding Source	**Funding Amount**

GHP-State	0
GHP-USAID	320,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of the JHU HC3 activity is to strengthen community systems and capacitate stakeholders to lead an effective HIV response including addressing the socio-cultural and gender norms that create barriers to service uptake and increase vulnerability. The primary focus of the community engagement will be to scale up all four prongs of PMTCT through a community lead process. This process will become the foundation for communities to address all aspects of the HIV response especially sexual prevention. Furthermore, addressing the norms, beliefs, and practices for PMTCT will result in reduced stigma and vulnerability for HIV in general. HC3 is aligned with the GOKS NSF extension 2014-2017 and falls squarely within the guiding principles and the core priority prevention strategies for Community engagement and ownership of HIV interventions. It will contribute to prevention outcomes including reduced exposure to HIV infection. HC3 will build on the existing decentralized coordination structure through the MTAD, reinforce CBO efforts, and actively link with other partners. The objectives are: 1)to create an enabling environment for PMTCT and sexual prevention by strengthening community capacity to use local and national information for community-based planning and monitoring of their HIV response; supporting a community process to maximize their assets and address barriers to prevention; and supporting a rights-based community approach to stigma reduction and norm change; 2)to improve access to and uptake of PMTCT and HIV prevention services by empowering communities to lead social and behavior change communication; strengthening the community based cadres; and strengthening linkages with CBOs and FBOs to promote uptake of services and healthier behaviors.

Cross-Cutting Budget Attribution(s)

Gender: GBV	200,000
Gender: Gender Equality	200,000
Key Populations: FSW	300,000
Key Populations: MSM and TG	172,500

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Family Planning

Budget Code Information

Mechanism ID:	**16821**		
Mechanism Name:	**Health Communication Capacity Collaborative (HC3)**		
Prime Partner Name:	**Johns Hopkins University Bloomberg School of Public Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	50,000	0

Narrative:

1) The Health Communication Capacity Collaborative (HC3), is a globally competed cooperative agreement led by the Johns Hopkins University Center for Communication Programs (JHU-CCP), with a consortium of partners including MSH, NetHope, Ogilvy Public Relations, PSI, and Internews. HC3 will focus on strengthening in-country capacity to implement state-of-the art health communication and social change. The project will provide tailored, multi-level capacity strengthening to a range of indigenous implementers, as well as technical leadership in health communication.
2) The portfolio review identified a number of weaknesses in the sexual prevention program, including the need for greater focus on special vulnerabilities of and sexual reproductive health for youth, and more substantial engagement of communities to address the social, gender and cultural norms that create vulnerability to HIV infection including early sexual debut, intergenerational sex, multiple partnerships, SGBV sexual abuse and coerced sex, inconsistent condom use, lack of knowledge of status, and stigma around treatment.
3) OP and AB funds are combined for comprehensive sexual prevention programming. The purpose of the AB component is to strengthen community systems and capacitate stakeholders to lead an effective HIV response including addressing the socio-cultural and gender norms that increase vulnerability and create barriers to service uptake with particular attention to youth interventions. The objectives are : 1) to

strengthen the capacity of communities to assess the current context, implement actions to address vulnerabilities and barriers to HIV services, and monitor progress; 2) empower communities to lead social and behavior change communication to address norms and promote service uptake; 3) in concert with other partners, strengthen the capacity of existing community cadres to address norms, stigma, and promote up-take of services; and strengthen linkages with community, FBOs, and HIV prevention treatment and care service providers.
- The strategies to achieve these objectives are in line with OGAC prevention guidance, , the HIV and AIDS coordination framework for the Ministry of Tinkhundla Administration and Development (MTAD), and the Swaziland National Strategic Framework. HC3 will focus their efforts in select chiefdoms working at the grass roots level through MTAD structures including the Chiefdom multi-sectoral HIV and AIDS Coordinating Committees (CHIMSHACC) that have the mandate to assure a coordinated and effective community led response. The CHIMSHACC include community representatives from the churches, health care providers, police, traditional healers, schools, agriculture extension workers, male, female and youth leaders etc. HC3 will provide technical assistance and support to the CHIMSHACCs and youth leaders to plan, implement and monitor interventions that will address the norms, vulnerabilities and barriers to service use, finding creative solutions and using local means to address gender norms, HIV related stigma and other barriers through community-led communication, peer support, and mobilization. HC3 will support community-based monitoring through participative approaches. Monitoring information will be used by the community for continuous program improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	270,000	0

Narrative:

1) The Health Communication Capacity Collaborative (HC3), is a globally competed cooperative agreement led by the Johns Hopkins University Center for Communication Programs (JHU-CCP), with a consortium of partners including MSH, NetHope, Ogilvy Public Relations, PSI, and Internews. HC3 will focus on strengthening in-country capacity to implement state-of-the art health communication and social change. The project will provide tailored, multi-level capacity strengthening to a range of indigenous implementers, as well as technical leadership in health communication.
2) The portfolio review identified a number of weaknesses in the sexual prevention program, including the need for greater focus on special vulnerabilities of and sexual reproductive health for youth, targeted package of interventions for MARPS, and more substantial engagement of communities to address the social, gender and cultural norms that create vulnerability to HIV infection including intergenerational sex, multiple partnerships, SGBV sexual abuse and coerced sex, inconsistent condom use, lack of knowledge of status, and stigma around treatment.

3) OP and AB funds are combined for comprehensive sexual prevention programming. The purpose of the OP component is to strengthen community systems and capacitate stakeholders to lead an effective HIV response including addressing the socio-cultural and gender norms that increase vulnerability and create barriers to service uptake with particular attention to youth interventions and sex worker and LGBTI communities. The objectives are : 1) to strengthen the capacity of communities to assess the current context, implement actions to address vulnerabilities and barriers to HIV services, and monitor progress; 2) empower communities to lead social and behavior change communication to address norms and promote service uptake; 3) in concert with other partners, strengthen the capacity of existing community cadres to address norms, stigma, and promote up-take of services; and strengthen linkages with community, FBOs, and HIV prevention treatment and care service providers.
- The strategies to achieve these objectives are in line with OGAC prevention guidance, , the HIV and AIDS coordination framework for the Ministry of Tinkhundla Administration and Development (MTAD), and the Swaziland National Strategic Framework. HC3 will focus their efforts with two types of communities: 1) select chiefdoms: working at the grass roots level through MTAD structures including the Chiefdom multi-sectoral HIV and AIDS Coordinating Committees (CHIMSHACC) that have the mandate to assure a coordinated and effective community led response. The CHIMSHACC include community representatives from the churches, health care providers, police, traditional healers, schools, agriculture extension workers, male, female and youth leaders etc. 2) the LGBTI and sex worker communities. HC3 will provide technical assistance and support to the CHIMSHACCs and LGBTI/SW to plan, implement and monitor interventions that will address the norms, vulnerabilities and barriers to service use, finding creative solutions and using local means to address gender norms, HIV related stigma and other barriers through community-led communication, peer support, and mobilization.
- HC3 will support community-based monitoring through participative approaches. Monitoring information will be used by the community for continuous program improvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

1) The Health Communication Capacity Collaborative (HC3), is a globally competed cooperative agreement led by the Johns Hopkins University Center for Communication Programs (JHU-CCP), with a consortium of partners including Management Sciences for Health (MSH), NetHope, Ogilvy Public Relations, PSI, and Internews. HC3 will focus on strengthening in-country capacity to implement state-of-the art health communication and social change. The project will provide tailored, multi-level capacity strengthening to a range of indigenous implementers, as well as technical leadership in health communication The project will be characterized by a strong focus on implementation science, emphasizing rigorous evaluation, documentation, and diffusion

of effective practices.
2) The portfolio review identified a number of weaknesses in the Swaziland PMTCT program, including: low EID result pick-up rate for exposed infants; low uptake of ART among eligible women; low partner testing and involvement in PMTCT; poor re-testing rates among clients who initially test negative for HIV; high rates of transmission in children between 6 weeks and 2 years of age; and Weak referral linkages and follow up system & weak defaulter tracing mechanisms. Furthermore, the portfolio review identified community, cultural, and gender norms as key reasons for these weaknesses in the program.

The overall purpose of the PMTCT component in Swaziland is to strengthen the capacity of regional coordination committees and communities to increase the uptake of PMTCT in their areas through a community-led and owned process.

The objectives are : 1) to strengthen the capacity of communities to assess the current context, implement actions to address barriers to PMTCT ,and monitor progress; 2) empower communities to lead social and behavior change communication around PMTCT ; 3) in concert with other partners, strengthen the capacity of existing community cadres to address all 4 PMTCT prongs and promote up-take of services and strengthen linkages with community, FBOs, and PMTCT service providers.
3) The strategies to achieve these objectives are in line with OGAC prevention guidance, PMTCT guidance, the Swaziland National PMTCT acceleration plan, and the Global plan towards eliminating MTCT. It also builds on the UNAIDS promising practices in community engagement for the elimination of new infections. Most important these strategies will fill an important gap in PMTCT efforts in Swaziland.
- HC3 will provide technical assistance and support to the Ministry of Tinkhundla Administration and Development to strengthen the capacity of the region to coordinate regional and chiefdom level multisector response to HIV including PMTCT
- Provide technical assistance to key community leaders in the design and planning of interventions that will address the main barriers to PMTCT and follow-up. This will include finding creative solutions and using local means to address gender norms, HIV related stigma and other barriers through community-led communication, peer support, and mobilization.
- Supporting community-based monitoring through participative approaches that engage the community early and in all phases of the process. Monitoring information will be used by the community for continuous program improvement.

Implementing Mechanism Details

Mechanism ID: 17048	**Mechanism Name: USAID/Southern Africa Evaluations Indefinite Quantity Contracts (IQCs)**

Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: U.S. Agency for International Development (USAID)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 185,000	
Funding Source	**Funding Amount**
GHP-USAID	185,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Local Evaluation Services Indefinite Quantity Contract (IQC). The IQC was awarded to the following six South African firms in July 2012 without a leader organization:

1. *Khulisa Management Services,*
2. *DNA,*
3. *Southern Hermisphere,*
4. *University Research South Africa,*
5. *Grant Thornthon, and*
6. *Manto Management*

This is a mechanism created to evaluate USAID/SA programs and help the mission comply with the agency evaluation policy. The IQC provides evaluation services for the Health Office , Regional Economic Growth Office (REGO), Regional General Development Office (RGDO), Regional

HIV/AIDs Program Office (RHAP - including Lesotho and Swaziland), and Botswana Office.

All new evaluation services under USAID/SA will be provided through this mechanism provided the service required matches the IQC Scope of Work. In line with the Evaluation Policy, evaluations are managed by the Regional Program Office. The Program Office is finalizing clear guidance on evaluations on the Mission Order for evaluations to be released soon. The new guidance will explain the steps necessary to initiate an evaluation under this IQC. Until that time, CORs are requested to schedule a meeting with me or Erik Pacific or Lisa Campbell at least 5 months before the desired start date of your evaluation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**17048**
Mechanism Name:	**USAID/Southern Africa Evaluations Indefinite Quantity Contracts (IQCs)**
Prime Partner Name:	**U.S. Agency for International Development (USAID)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	185,000	0

Systems			

Narrative:

USAID/Southern Africa Evaluations Indefinite Quantity Contracts (IQCs) creates solutions for client missions that seek innovative approaches to address evaluation, assessment, and performance monitoring needs. The IQC will help missions comply with the new USAID Agency evaluation policy. The IQCs ensurs that evaluations conducted under these mechanism will serve two primary purposes: 1) providing accountability to stakeholders and 2) learning to improve aid effectiveness. All evaluations conducted under the Southern Africa Evaluation IQCs will be unbiased in measurement and reporting; relevant in terms of linking evaluation questions to specific future decision to be made by USAID leadership, partner governments, and other key stakeholders; based on best practices; oriented toward building local capacity; and transparent with a commitment to full and open disclosure of findings.
The objective of the regional IQCs is to strengthen the region's evaluation system to
1. Provide evaluation services for USAID/Southern Africa, which includes the USAID's Bilateral and Regional Programs; the Botswana, Lesotho, and Swaziland PEPFAR-funded programs in a manner that permits timely access to appropriate evaluation expertise.
2. Support client missions in above-mentioned countries with an accessible evaluation mechanism.

South Africa has a large pool of well-trained and technically competent organizations that are capable of delivering the services required under the Regional Evaluations IQCs. In the past, USAID/Southern Africa has contracted with a number of local organizations and has received quality products and services. Additionally, utilizing local organizations may reduce language and culture related evaluation data quality problems which can bias the results. In addition to the above benefits, the use of local organizations are 1) consistent with USAID Forward reforms to engage local organizations, 2) more efficient in terms of time, administration and resource utilization and 3) can be more cost effective. USAID Swaziland will buy into this mechanism to conduct a number of project evaluations over COP 13 including PACT.

Implementing Mechanism Details

Mechanism ID: 17096	**Mechanism Name: Together for Girls (MCH Umbrella Grant)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Children's Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Together for Girls Initiative will address three of the most pressing issues: 1. Establishing a system for post rape care for children: Coordinated by the NCCU, GOKS is in the process of setting up a One-Stop Center aimed at addressing the medical, psychosocial and legal needs of victims of sexual violence. Space has been identified and partially refurbished and equipped, and HCW from the have been identified to staff the facility. Anticipated outcomes include a well functioning One-Stop Center that provides comprehensive services to children who have been sexually abused and a plan for adapting and/or expanding the model to one or more additional regions. 2. Improving quality of post rape care services: In 2010 UNICEF and WHO supported the Ministry of Health to develop guidelines for post-rape care, which are now in the process of being finalized. The guidelines cover post rape care for adults and children, and address the management and referral of sexual violence cases to health services, police, psychosocial and other providers. The anticipated outcome is improved quality of care of children who have been sexually abused at the One Stop Center and selected health facilities nationwide. 3. Strengthening intersectoral action planning for the prevention and mitigation of child sexual abuse to result in a more coordinated and effective response with active participation of all key sectors, a research report that clarifies the factors and drivers associated with the sexual abuse of children in Swaziland, and a National Strategy on Preventing and Responding to Violence Against Children drafted.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**17096**
Mechanism Name:	**Together for Girls (MCH Umbrella Grant)**
Prime Partner Name:	**United Nations Children's Fund**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

USAID will build on an existing agreement with UNICEF to implement the Swaziland Together for Girls Partnership. The Partnership will move evidence to action, using the results of the 2007 Child Violence Survey, lessons learned from multiple years of investment in community child protection efforts, results of a child protection systems mapping exercise and opportunities identified in the PEPFAR Swaziland Gender Strategy to launch a program that will model effective interventions to prevent and respond to sexual violence. Regional best practices that have demonstrated results will be drawn on to develop a detailed concept paper that will be used an advocacy and resource mobilization tool. The Partnership will leverage resources from other donors, harness local civil society and Government stakeholder involvement and coordinate closely with ongoing PEPFAR funded activities in order to realize synergies and achieve maximum impact against USG's investment. Pipeline funds from previous UNICEF mechanism will be reprogrammed to supplement Central funding for this activity.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing			61,464	61,464
ICASS			670,364	670,364
Management Meetings/Professional Developement			12,500	12,500
Non-ICASS Administrative Costs			200,000	200,000
Staff Program Travel			55,000	55,000
USG Staff Salaries and Benefits		0	1,067,643	1,067,643
Total	**0**	**0**	**2,066,971**	**2,066,971**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-USAID		61,464
ICASS		GHP-USAID		670,364
Management Meetings/Professional Developement		GHP-USAID		12,500
Non-ICASS	equipment and	GHP-USAID	housing upgrades,	200,000

Administrative Costs	furniture		furniture equipment 125000; transport of furn and equip	

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		500,000		500,000
Staff Program Travel		78,000		78,000
USG Staff Salaries and Benefits	608,312	1,412,352		2,020,664
Total	**608,312**	**1,990,352**	**0**	**2,598,664**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		500,000

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		172,963		172,963
USG Staff Salaries and Benefits		123,402		123,402
Total	**0**	**296,365**	**0**	**296,365**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		172,963

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Peace Corps Volunteer Costs		950,000		950,000
USG Staff Salaries and Benefits		0		0
Total	**0**	**950,000**	**0**	**950,000**

U.S. Peace Corps Other Costs Details