United States Department of State

Washington, D.C. 20520

January 16, 2019

INFORMATION MEMO FOR AMBASSADOR LISA PETERSON, ESWATINI

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

Subject to COP Development and Approval

We are grateful to you, Ambassador Peterson, and your Deputy Chief of Mission, Michael Lombardo, for your engagement in planning, review and implementation of the PEPFAR program, and with the community and Government to enhance PEPFAR program impact. You are commended for your attention to core policy adoption and holding partners to account for performance to improve outcomes and achieve greater impact. We appreciate your PEPFAR staff in country, who work tirelessly across agencies to ensure the most effective and efficient use of taxpayer dollars.

The U.S. government, through PEPFAR, is proud to partner with the people and Government of Eswatini in accelerating Eswatini's progress towards achieving HIV/AIDS epidemic control. From FY 2007 – 2019, the U.S. government through PEPFAR has invested $437,356,392. In FY 2018, PEPFAR supported 175,912 people receiving antiretroviral treatment (ART), and, in prevention, 13,636 voluntary medical male circumcisions (VMMC). Additionally, in FY 2018, targeted HIV testing services for 407,574 people were provided, and 34,180 Orphans and Vulnerable Children and their caregivers received supportive services. While the PEPFAR program experienced some challenges in FY 2018 in identifying new HIV positive persons, partners had a clear focus on improving the quality of the index client testing modality, which resulted in a higher HIV positive yield than realized in the previous year, with high overall linkage rates to treatment services and adult viral load suppressions rates of over 90%. Policy and programmatic achievements include full implementation of the government endorsed Test and Start policy, roll-out of Differentiated Service Delivery models of care nationwide, introduction of a new ART regimen – TLD; implementation of index client testing and self-testing, full adoption of TB preventive therapy policy for PLHIV, and nationwide roll-out of national ID cards (i.e., unique identifiers).

While the overall PEPFAR Eswatini focus in 2018 has been on a targeted approach to testing and treatment quality strategies, near term and COP 2019 efforts must be directed at implementing a case finding approach to HIV testing and access to quality services across the cascade. Eswatini has achieved high treatment coverage rates and the PEPFAR response must align with this success to ensure the most effective approaches to index client testing, linkage, retention and viral load suppression are afforded to people in Eswatini. Specifically, PEPFAR Eswatini should:

- Eliminate non-targeted HIV testing and scale volume of index client testing, including use of recency and self-testing, and respond to patterns of positive case finding.
- Focus on men 20-29 years of age for targeted testing and treatment, and VMMC services.
- Implement systematic lab quality improvement activities and ensure access to viral load is equally high in all provinces.
- Invest in data systems and data quality measures to build accuracy and confidence in results reporting and the country's ability to attain and verify reaching epidemic control.

As results from the SHIMS2 indicate that Eswatini will achieve epidemic control in the COP 2018 implementation period, PEPFAR Eswatini should place emphasis on supporting the host country government to sustain this control. PEPFAR Eswatini can sustain epidemic control through the above approaches and others identified later in this letter. However, sustained epidemic control will require review of the PEPFAR portfolio to optimize this shift in support.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Eswatini for the 2019 Country Operational Plan (COP 2019) is **$70,000,000**, inclusive of all new funding accounts and applied pipeline.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair, Julia Martin, and PEPFAR Program Manager, Stephanie Weber. My office is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Eswatini.

APPENDICES:

1. **COP 2019 PLANNING LEVEL**
2. **COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **COP 2019 DIRECTIVES**

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APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget

Eswatini TOTAL COP 2019 PLANNING LEVEL: $70,000,000		
Total Base Budget for COP 2019 Implementation		**$70,000,000**
Total COP 2019 New Funding	$59,721,145	
*of which, VMMC**	$5,168,952	
of which, DREAMS	$5,009,695	
Total Applied Pipeline**	$10,278,855	
Total Faith Based Organization Initiative Funding (FY 18 Funds)		**$8,000,000**
*VMMC total can include pipeline from existing partners.		
**Applied pipeline by agency is provided in chart below		

Table 2. COP 2019 Applied Pipeline by Agency**

Eswatini COP 2019 APPLIED PIPELINE BY AGENCY	
TOTAL APPLIED PIPELINE	**$10,278,855**
HHS/CDC	$4,984,789
DOD	$320,710
PC	$412,756
State	$354,594
State/AF	$40,571
USAID	$4,165,435

**Based on agency reported available pipeline from EOFY

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of $70,000,000.

Central Funding

Eswatini is also receiving $8,000,000 in Central Funds as a part of the FBO Initiative. These FY 2018 funds are being notified to you via this letter, and these funds are being released immediately, ahead of the release of the bilateral COP 2019 funds. Central Funds for the FBO

Initiative should be used as soon as possible after receipt, during the current implementation cycle of COP 2018/FY 2019. Part of the funds are to restore cuts made specifically and uniquely to FBOs during the COP18 cycle and need to be immediately restored and continued at the increased level within COP19 planning. Part of the funds are for new activities as noted in the Appendix 4 which provides further guidance on use of these funds and the budget breakdown by agency. Each country team should specify the purpose and use of these funds (based the data and analysis from the recent FBO TDYs) as part of the SDS.

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

Eswatini COP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T)	**$31,652,207**
% of base funds allocated to C&T	53%
HKID	**$6,569,326**
Gender Based Violence (GBV)	**$1,140,888**
Water	**$150,000**

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Eswatini's minimum requirement for the care and treatment earmark is reflected in the chart above. The care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that Eswatini program a minimum of 53% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: Eswatini's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above and is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below $6,569,326.

Gender Based Violence (GBV): Eswatini's COP 2019 minimum requirement for the GBV earmark is $1,140,888. Eswatini's GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code and derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below $1,140,888.

Water: Eswatini's COP 2019 minimum requirement for the water earmark is $150,000. Eswatini's water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code and is derived by using the final COP 2018 water

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earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below $150,000.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each Eswatini agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Eswatini should hold a 3-month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $10,278,855 given by S/GAC as a part of the COP 2019 planning level was calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Eswatini must apply as pipeline in the COP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 3 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

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APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget **

	Sum of Approved COP17 Planning Level	Sum of Total FY2018 Outlays	Sum of Over/Under Outlays
Eswatini	**$68,809,695**	**$51,396,749**	**($17,412,946)**
DOD	$717,776	$194,023	($523,753)
HHS/CDC	$22,064,107	$18,499,574	($3,564,533)
PC	$1,120,000	$926,188	($193,812)
State + State AF	$1,039,110	($2,361,249)	($3,400,359)
USAID	$43,868,702	$34,138,214	($9,730,488)

**State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.

Eswatini's total FY 2018 outlay level of **$51,396,749** is **under** the approved COP17 planning level of **$68,809,695**. Within this total outlay level, all agencies spent below their approved FY 2018 planning level. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP 2017 approved planning level.

Table 5. Implementing Partner FY18 Outlays *

**This table was based off the FY18 EOFY submissions, but edited to reflect OPU's as of January 15, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level.*

OU	Mech ID	Mechanism Name	Prime Partner	Funding Agency	Adjusted Excess Pipeline	COP17/FY18 Budget (New funding + Pipeline)	Actual FY18 Outlays ($)	Actual FY18 Outlays as % of COP17/FY18 Budget	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
Swaziland	N/A	N/A - M&O Mechanism	N/A	DOD	$ 61,990	$ 147,412	$ 187,506	127%	$ 40,094
Swaziland	17463	ICAP-Manzini	International Center for AIDS Care and Treatment Programs, Columbia University	HHS/CDC	$ 596,454	$ 4,686,818	$ 6,366,495	136%	$ 1,679,677

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Table 6. COP 2017/ FY 2018 Results versus Targets*

** Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.*

Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	190,108	218,024	114.68%	HTS	$4,699,148	78%
	HTS_TST_POS	23,117	15,626	67.60%			
	TX_NEW	21,744	11,216	51.58%	C&T	$6,050,931	42%
	TX_CURR	97,972	97,374	99.39%			
					Above Site Programs	$3,155,931	
					Program Management	$5,151,430	
DOD	HTS_TST	4,348	1,840	42.32%	HTS	$18,508	19%
	HTS_TST_POS	910	298	32.75%			
	TX_NEW	1,177	320	27.19%	C&T	$178,147	43%
	TX_CURR	3,427	1,915	55.88%			
	VMMC_CIRC	812	N/A		PREV:CIRC	$16,607	100%
					Above Site Programs	$51,157	
					Program Management	$88,163	
PC	OVC_SERV	5,037	2,895	57.47%	SE for OVC	$65,829	100%
					Above Site Programs	$0	
					Program Management	$250	
USAID	HTS_TST	151,168	188,177	124.88%	HTS	$2,544,349	72%
	HTS_TST_POS	12,111	8,259	68.19%			
	TX_NEW	12,184	6,559	53.83%	C&T	$8,875,671	79
	TX_CURR	70,943	76,623	108.01%			
	VMMC_CIRC	21,239	13,636	64.20%	PREV:CIRC	$2,936,626	96%
	OVC_SERV	47,766	31,285	65.50%	SE for OVC	$4,228,018	91%
					Above Site Programs	$4,991,719	
					Program Management	$6,135,102	

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COP 2017/ FY 2018 Performance

- **First 90:** Overall, case finding was a challenge for PEPFAR Eswatini in FY18. Of 408,641 tests performed, only 24,183 tested positive (yield = 5.9%) within a context of 30-40% adult prevalence in many age groups. By modality, the highest volume of tests was performed under "Other PITC" (195,520 tests), with a very low yield (9,484 or 4.9%). Index testing showed the most promise as a modality – yield was 15.7% -- but the number of tests performed was inappropriately small (10,912 tests). For mobile testing, 43,505 tests were performed with a yield of 8.6% - showing no promise in light of Eswatini's prevalence. John Snow, Inc (JSI), Population Health Services (PSI) and University Research Corporation (URC) experienced serious performance issues with a range of 43% to 69% results over targets achieved and must be addressed.
- **Second and Third 90:** PEPFAR Eswatini met its targets for TX_CURR in FY18, but with uncertainty in the confidence of data quality. With underperformance of new HIV positives identified, linkage rates were also low, ranging from 60% to 80% (with the exception of the military which was >100%). PEPFAR Eswatini did not meet the targets for new on treatment. TX_NEW achievement was low for all partners in all regions. Low linkage and underachievement in TX_NEW suggest data quality issues in TX_CURR, owing potentially to returning clients recorded as new. Viral suppression rates are

consistently high among adults; access to viral load is uneven with improvements needed in all provinces.

- **Data Quality Issues:** PEPFAR Eswatini has been forthcoming about its concerns regarding the reported TX-CURR in FY18. The team believes the reported FY18 Q4 TX_CURR is inflated. In FY19 Q1, the MOH and PEPFAR developed a protocol to conduct a TX_CURR census across all the regions. In addition, the team is investigating data inconsistencies in the TX_NET_NEW. The PEPFAR team is working to resolve the data issues by January 25, 2019 to validate the treatment program numbers and develop targets for COP19.
- **VMMC:** The VMMC program in Eswatini underperformed in FY18. Results achieved were 62% overall with an absolute number of 13,636 VMMCs performed – well below the target of 22,051. FY18 is the second consecutive year the program missed achieving its targets for VMMC. The Centre for HIV and AIDS Prevention Studies is the partner responsible for the majority of targets with the lowest achievements. The government recently developed a revised approach to the VMMC program with the support of PEPFAR. The revised approach focuses on fixed VMMC sites, new demand generation strategies, a switch to reusable versus disposable kits, and involvement of a greater number of implementing partners. With limited details on the demand creation strategy and anticipated time required to re-organize the VMMC program, the risk of ongoing underperformance persists in the current implementation year.
- **Key Populations:** Testing among female sex workers (FSW) had a yield of 13%, though absolute numbers were low (344 positives). Testing among men-who-have-sex-with-men (MSM) had a yield of 5%, and absolute numbers were very low (50 positives). Target achievement for KP_PREV was 86%, and linkage was very low at only 52%. FHI 360 is the key population partner.
- **OVC:** In FY18, the OVC portfolio underperformed, achieving only 71% of the OVC_SERV target for all ages and 54% for children under age 18. In addition, there is no HIV testing data for 25% of <18 OVC beneficiaries. There are several OVC partners with small targets that were not achieved; PACT had the largest target, and achieved 87% of the OVC_SERV target.
- **DREAMS:** In FY18, the DREAMS program enrolled 15,239 adolescent girls and young women (69% of target), of which 10,426 are girls between the ages of 10-19 years. 66% of adolescent girls enrolled in DREAMS are also OVC. PrEP was piloted in FY18 with a focus on women over the age of 24 years. The DREAMS program now uses a national identification, rather than the project-generated ID.

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APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for Eswatini:

Indicator	Pediatric (<15) Treatment Target	Adult Women (15+) Treatment Target	Adult Men (15+) Treatment Target	Treatment Target Total[a]
	COP 18 (FY 19 Targets)			
TX_NEW (New on Treatment)	1,930	5,755	8,202	15,887
TX_CURR (Current on Treatment)	11,260	108,083	68,957	188,300
TB_PREV	N/A	N/A	N/A	88,262
VMMC_CIRC	N/A	N/A	N/A	31,092
	COP 19 (FY 20 Targets)			
TX_NEW (New on Treatment)	741	14,800	5,400	20,941
TX_CURR (Current on Treatment)	11,438	117,478	70,909	199,826
TB_PREV	N/A	N/A	N/A	43,678
VMMC_CIRC	N/A	N/A	16,500 (minimum)	30,000
	National Treatment Coverage			
Treatment Coverage	90%	90%	90%	90%

[a]Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Eswatini should consider, as it move to Epidemic Control, how Eswatini could exceed these minimum requirements.
- TX_CURR: TX_CURR targets were generated to move Eswatini to 95-95-95 at the country-level based on preliminary UNAIDS 2018 PLHIV and ART coverage estimates. To achieve this target, PEPFAR Eswatini needs accurate reporting and minimization of loss and mortality.
- TB_PREV: Targets for TB_PREV were calculated utilizing (among other considerations) estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms; the proportion likely to be ineligible for clinical reasons; the estimated number who would have already received TPT by the start of COP 2019; and projected enrollment and completion rates.
- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

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Given the results from the SHIMS2, Eswatini will achieve epidemic control in the COP 2018 implementation period. PEPFAR's investment will need to place emphasis on supporting the host country government to sustain its control of the epidemic. PEPFAR Eswatini should prioritize refinement of testing strategies, deployment of case-based surveillance, and increasing use of unique identifiers among the patient population. PEPFAR Eswatini will need to optimize its portfolio to best support this shift in support to the Government of Eswatini.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Eswatini budget.

Table 8. Minimum Requirements

Minimum Requirement	OU Specific Guidance
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Eswatini adopted a Test & Start policy on October 1, 2016. This policy has been implemented nationwide. There is focus on same day and rapid ART initiation within two weeks of diagnosis. Implementation of Test and Start built on Option B+ implementation, which was implemented in 2015. However, Eswatini needs to improve fidelity to this policy to achieve TX_NEW targets. In addition, linkage rates from testing among key populations are low.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	The DSD models implemented countrywide are still limited and consist mainly of MMS and fast track services for stable patients in facilities. To improve retention and maintain high viral suppression rates, Eswatini must scale up DSD models across the country and increase its focus on men 24-35 years old.

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3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.	The country has adopted a phased approach to the TLD transition. Phase 1 commenced October 2018 and extends to March 2019 and includes all new initiations and those already on ART (who fall within the following populations and are virally suppressed): men >20yrs; adolescent boys (10-19 yrs); women (50+yrs); those with EFV toxicity. Phase 2 will commence in April 2019 to include all new initiations, those already on other first line ART regimen for ≥ 6months with evidence of undetectable VL results within 3 months, and women of child-bearing age. There is not an explicit policy of TLD for pediatrics.
4. Scale up index client testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	*Index client testing*: Has been adopted as a targeted approach and a high yield strategy in the country as articulated in the 2018 HIV Management Guidelines. Index client testing is implemented at both facility and community levels. The national HIV testing program, with support from PEPFAR and partners, developed an index testing register, procedures and incorporated the indicators in the electronic client record systems ('CMIS'). Trainings on index client testing are ongoing. *Self-testing*: The 2018 HIV Management Guidelines incorporate HIV self-testing as a strategy that provides an opportunity for people to test themselves discreetly and conveniently and may provide an opportunity to reach people who are not currently reached by existing HIV testing and counselling services. Priority populations for HIV self-testing in Eswatini are men, adolescents and key populations. Models for distribution include facility and community. Both models use unassisted and assisted approaches to testing. The national self-testing program and partners have developed tools, standard procedures and have a draft distribution strategy.

5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	The policy to provide TPT has been fully adopted for PLHIV. However, gaps persist in initiating children living with HIV, children with contact with TB patients, newly diagnosed PLHIV, and healthcare workers. Clinicians fear adverse events and there are negative perceptions about TPT due to historical INH/Pyridoxine stock outs. Systems for monitoring and pharmacovigilance are inadequate and need to be strengthened.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The 2018 HIV Management Guidelines recommend linkage to treatment or HIV prevention after HIV testing services. For newly diagnosed clients, the Guidelines recommend early ART initiation (Test and Start). A Linkage Case Management model (LCM) was introduced in Eswatini, which entails providing individualized client services (face-to-face counseling, call reminders, etc.), navigation services (escort client on first appointment to facilitate enrollment), and acceptance of index client testing. The LCM approach is delivered by expert clients and is currently delivered in high volume facilities in the country. The National HIV Program developed LCM procedures, and trainings are ongoing. To improve linkage rates, PEPFAR partners have deployed extra counselors and expert clients in selected high volume areas. COP19 partner work plans must reflect fidelity to this minimum requirement.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	Prohibition of user fees mainly covers care and treatment needs (TB diagnosis and TB treatment, ART provision, prophylaxis of opportunistic infections and laboratory monitoring), but does not cover costs for radiography. Chest X-Ray and ultrasound scan services require payment of subsidized user fees applicable to patients, regardless of HIV status. As part of an increased focus on TB prevention and treatment among HIV

	positive persons, dialogue with the government to plan for removing barriers to access to radiology should be initiated.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	VL access lags in all provinces. A headquarters support visit in December 2018 made recommendations to the team about how to strengthen the VL sample transport system. The team will implement these recommendations in support of the TLD transition and to meet this minimum requirement. Additionally, increase to >85% VL access in all provinces should be prioritized in FY19 implementation and COP 19 planning.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	The Eswatini government has supported the roll-out of a standardized electronic patient record system. Approximately 50% of facilities and clients on ART are in the e-system. This system will become the backbone for client monitoring data and should be used to report on morbidity and mortality outcomes and reporting on TX_ML.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	While improvements in performance are required in the OVC portfolio during the remainder of FY19, for COP19 submission, the team should outline in the SDS the plan to ensure targets are achieved in FY20, especially among <18. In addition, ensure all <18 OVC are assessed for HIV testing and all HIV+ OVC are linked to treatment.
11. Evidence of resource commitments by host governments with year after year increases.	The Eswatini government provides budget support for ARVs and for health care worker staff. Recent and persistent economic challenges and local currency devaluations have created risks for the government in not fulfilling its commitments. To date, commitments have been fulfilled, but close monitoring with new government leadership on the continuance of budget support for the HIV response will be necessary.

12. Clear evidence of agency progress toward local, indigenous partner prime funding.	The number of active local, indigenous partners is limited in Eswatini. Careful review of options for local partners must be laid out with a pathway to increasing utilization of these partners.
13. Scale up of unique identifier for patients across all sites.	In theory, all citizens have national identity cards. Nonetheless, some clients do not bring their national IDs to the health facility. Hence, a series of activities are being undertaken to ensure that clients appreciate the need to bring their IDs to the facility.

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COP 2019 Technical Priorities

Tuberculosis

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in Eswatini is 43,678, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. To ensure successful programming, it is expected that, at a minimum, $244,596.80 will be budgeted for TPT commodities.

DREAMS

Eswatini is allocated **$5,009,695** funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which, $995,555 of your COP 2019 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within the COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

Specifically, the Eswatini team should:

- Accelerate and finalize a tracking system for intervention layering. Include a timeline for standing up the system and a date by when the team will be able to report on AGYW_PREV in the COP submission.
- Institute use of mentors and peer leaders within the DREAMS program to help recruit and retain AGYW. Give attention to pathways for promotion from a DREAMS beneficiary to mentor and DREAMS Ambassador/peer leader.
- Focus on scaling up demand for and distribution of PrEP.
- Focus on reaching more 19-24 year-olds.

VMMC

Eswatini is allocated **$5,168,952** for VMMC. Eswatini's total COP 2019 allocation to the CIRC budget code is included in the COP funding determined in this letter. Eswatini must use VMMC funding exclusively to support the implementation of VMMC programs in males 10 years and older, pursuant to the CIRC budget code guidance. This implementation includes the minimum package of clinical and prevention services – which must be included at every VMMC delivery point – circumcision supplies and commodities; communication and demand creation; training; and case finding and linkage for high-risk men.

Eswatini's VMMC target for COP 2019 is 30,000 and a minimum of 16,500 circumcisions should be done in men over age 14.

	COP19					
	Target	**Budget**	**VMMC coverage 15-24**	**VMMC coverage 15-49**	Minimum % 15+	Minimum VMMC in 15+
Eswatini	**30,000**	$5,168,952	**5%**	**8%**	**55%**	**16,500**

The PEPFAR team has been directed to convene an interagency VMMC headquarter technical support trip in FY19 Q2 to inform the remainder of FY19 implementation and COP19 planning. COP19 planning must clearly outline any changes in the VMMC cost structure as a result of the new VMMC strategy that now includes multiple partners and fixed service delivery sites.

Cervical Cancer Screening and Treatment:

Alongside COP 2018, PEPFAR Eswatini is allocated a total of **$3,700,000** in two-year Central Funds for Cervical Cancer Screening and Treatment programming. These Central Funds were provided to reduce morbidity and mortality of women on ART in Eswatini by increasing the screening of HIV positive women for cervical cancer and the treatment for pre-invasive cervical lesions. The COP 2019 target for screening HIV positive women for cervical cancer is 39,943 –

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calculated as 50% of women 25-49 on treatment per the number of women on ART for the 25-49 year old age band in Eswatini at the end of COP 2017 / FY 2018 implementation period. A detailed description of implementation status and scale-up plans is requested within the Strategic Direction Summary for COP 2019.

Addressing Gaps in Epidemic Control, including by Enhancing Engagement with Faith Communities

Eswatini FAITH BASED ORGANIZATION INITIATIVE FUNDING: $8,000,000	
HHS/CDC	**$3,947,250**
DOD	**$500,000**
USAID	**$3,552,750**
of which, Catholic Relief Services	$234,933
of which, Luke Commission	$2,023,204

PEPFAR Eswatini is allocated **$8,000,000** central support through the FBO and Community Initiative to accomplish priority activities, as identified per the FBO TDY visits. Of this total, 50% should support case finding for young adult men, adolescents, and children living with HIV and 50% should support primary prevention of sexual violence and HIV among children ages 9-14 years old, as explained below.

As one of the countries that participated in the FBO Mapping and Gap Analysis TDYs and that posted a reduction between COP17 and COP18 of $2,258,137 in support for FBO partners, PEPFAR Eswatini will receive $2,258,137 (part of $8,000,000) to restore funding in COP18 execution to Catholic Relief Services and Luke Commission in the amounts indicated above and these partners must receive full funding for all services provided in COP19 remembering that many FBO clinics are often not subsidized to the same extend as public sector clinics.

USAID should program $234,933 to Catholic Relief Services to address gaps in funding from the previous year to support the primary prevention of sexual violence and HIV among children ages 9-14. USAID should program $2,023,204 to the Luke Commission, with $1,269,074 to support the case-finding priorities and $754,130 to support the primary prevention of sexual violence and HIV among children ages 9-14.

PEPFAR Eswatini will receive additional central support through the FBO and Community Initiative, with an additional $1,294,613 to USAID (combined with the above, totals $3,552,750 for USAID), $3,947,250 to CDC, and $500,000 to DOD. These funds should engage those who work in high burden areas (including informal settlements) with faith communities, such as local faith-based and traditional networks, local faith-based and traditional organizations, as well faith and traditional leaders.

Case-finding investments should include:

- Development and/or adaptation and dissemination of new messaging about HIV testing, linkage, and retention (e.g., Test & Start, U=U)

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- Capacity building among local faith leaders and faith organizations to create demand for and use of HIV self-tests
- Targeted distribution of HIV self-tests
- Engaging champions in faith communities to strengthen linkage and adherence support
- Programming on basic HIV education and stigma reduction
- Convening key stakeholders to facilitate sharing solutions

Investments in primary prevention of sexual violence and HIV should include:
- Raising awareness among faith and traditional leadership about sexual violence and HIV risk faced by 9-14 year olds
- Use of national-to-local infrastructures to train faith leaders in targeted implementation of evidence-based approaches within faith community infrastructures, including youth, parenting, and men's religious programing, with a focus on community mobilization, changing norms and parenting/caregiver programs (these programs include *Families Matter, Parenting for Lifelong Health, Real Fathers, Coaching Boys Into Men, and SASA! Faith)*
- Engaging in child safeguarding policy development and implementation through faith and traditional community structures, assuring inclusion of the contextualized process for accessing health, legal, and social protection referrals

Some Faith and Community partners support both HIV case-finding/linkage/retention and prevention of sexual violence and HIV risk among ages 9-14 years. In these cases, it may be possible to engage in comprehensive prevention and care by supporting both key FBO priorities.

Other Technical and Programmatic Priorities for Eswatini

- **First 90**: During the remainder of FY19 and moving into COP19 planning, PEPFAR Eswatini should focus and substantially scale with fidelity implementation of index testing; conduct optimized PITC; and significantly reduce or eliminate mobile testing, home-based testing, and testing campaigns. Three partners (JSI, URC, PSI) had poor results against targets in FY18, but all over-expended their budget allocation for testing. In FY19 implementation, these partners must manage their testing program expenditures and achieve their HIV test positive targets through elimination of low yield and inefficient testing as well as scale up of targeted case finding. Performance plans and monitoring should be established. Additionally, careful attention should be paid to 24-35 year-old men and increasing targeted testing and linkage to treatment. Men in this age group are notably underrepresented in positive tests results and TX_CURR.
- **Second and Third 90**: During the remainder of FY19 and moving into COP19 planning, PEPFAR Eswatini should:
  - Closely monitor the performance of JSI, URC and ICAP for marked improvements in TX_NEW given the underperformance in FY18 of 36% to 69% target achievement paying close attention to improvements in linkage strategies;
  - Close the gap on access to viral load in all provinces.

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- **VMMC**: The PEPFAR team has been directed to convene an interagency VMMC TDY in FY19 Q2 to inform the remainder of FY19 implementation and COP19 planning. The current VMMC partner – CHAPS – should be required to provide rationale for full expenditure of COP18 budget with only 62% of targets achieved.
- **Key Populations**: During the remainder of FY19 and moving into COP19 planning, PEPFAR Eswatini should develop a partner performance improvement plan for FHI360/Linkages. Should performance continue to be low (absolute volume of HIV tests done and lower than expected yields), evaluation of the program strategy, budget and continuance will be done prior to the COP19 funds transfer.
- **OVC**: During the remainder of FY19 and moving into COP19 planning, PEPFAR Eswatini should better understand any under-reporting from partners, and pay careful attention to target setting by partner. Should performance continue to be low, evaluation of the program strategy, budget and continuance will be done prior to the FY19 Q4 POART.
- **Patient monitoring data and quality:** Given the uncertainty of the TX_CURR achievement in FY18 and the discordance with TX_NEW and the linkage rate, the PEPFAR team is requested to proceed at pace with the data quality audit of the TX_CURR number to build confidence in understanding how close the country is to reaching epidemic control. As part of this effort, COP19 should prioritize support for continued roll-out of the patient monitoring system and rigorous data migration.

COP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

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In March and April 2019, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Washington, DC where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).

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