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Swaziland

Country Operational Plan

FY 2014

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

I. Country Context

Epidemiology: The HIV prevalence in Swaziland among adults aged 18-49 years is 31% (women: 38%; men: 23%) (1). The prevalence peaks at 54% among women aged 30-34 years and at 47% among men aged 35-39 years. Incidence in this population is 2.4/100 person-years (women: 3.1/100p-y; men: 1.7/100p-y) (1). For women, incidence is higher among those who are not married or living with a partner, those with 2 or more partners, and those reporting pregnancy. Higher incidence is observed among men who reported inconsistent condom use, have 2 or more partners, and were uncircumcised. Among HIV positive people, 63% were already aware of their HIV status (women: 68%, men: 50%)¹. Prevalence estimates for girls are: 4.8% for age group 2-4 years; 3.6% for 5-9 years; 3.3% for 10-14 years; and 10.1% for 15-19 years. For boys, prevalence estimates are: 5.5% for age group 2-4 years; 4.8% for 5-9 years; 1.9% for 10-14 years; and 1.9% for 15-19 years (11). In 2014, 1,339 new HIV infections among children and 1,043 new infections among infants are expected (1). The number of PLHIV will be 210,984 (195,752 adults and 15,323 children) in 2014³. About 77% of TB patients are also infected with HIV. In 2012, 89% of all pregnant women have been tested for HIV, and 86% of HIV positive pregnant women received ARV prophylaxis².

In 2010 self-reported circumcision was 19.1%². WHO reported that 24% of men were circumcised by 2012. Among uncircumcised men, the reasons for not being circumcised were fear/pain (39.0%), tradition/religion (13.5%), and other (41.0%). However, 81.4% of men reported that they would circumcise their son. More men in urban areas are circumcised compared to the rural areas (26% vs. 16%)⁴. The HIV prevalence among female factory workers and male cane cutters are 49.7% and 28.0%, respectively². Knowledge of condom use is high but actual condom use is low in both populations. Among in-school youths, 26.7% reported ever having sex. Twenty five percent of respondents from one survey reported that mosquito bites can transmit HIV, and 31% reported that they do not know anyone who is infected or have died of AIDS. The majority of youth in-school (76% females and 67% males) do not use a condom during their first sexual encounter⁶.

In 2011 PEPFAR supported the MOH to conduct a Bio-Behavioral Surveillance Study that examined the social and structural factors associated with HIV risk behaviors and prevalence among FSW and MSM. HIV prevalence was found to be 70% among FSWs and 18% for MSM. Both groups reported high rates of abuse and human rights. Though FSWs reported high condom use with new clients, usage drops with regular clients and non-commercial sexual partners. Just half of MSM reported always using a condom with regular partners. The country does not have any reliable information on the size of MSM and FSW



populations, however a size estimation exercise is planned for FY14 as part of the KPCF. COP FY2014 investments aim to address these epidemiological and programmatic statistics, and the broader social, cultural and gender dynamics of the HIV/AIDS epidemic in Swaziland. All activities proposed were designed in consultation with GOKS (various sectors), civil society organizations (including FBOs) and key populations groups. COP FY2014 activities align with the extended Swaziland National Strategic Plan (eNSF) for HIV and AIDS (2014-2018).

Status of the national response

The national HIV response in Swaziland has promise, but faces some consistent challenges. HIV and TB clinical and care and treatment interventions are solidly supported and PEPFAR assistance is generally well-leveraged. At the end of 2012, ART coverage was estimated at 91% using an eligibility criterion of CD = 350 with a 12-month retention rate of 85%. Swaziland has adopted the new WHO 2013 guidelines and revision of the national guideline is underway with plans to complete and have it published by June 2014. PMTCT and HTC coverage is similarly strong. As noted elsewhere, the GKOS is committed to procuring its own medicines and laboratory commodities, although the supply chain continues to face challenges and needs ongoing support. Leadership for HRH, prevention and impact mitigation activities, however, is fragmented and responsibility rests within multiple ministries. As a result, PEPFAR has been required to invest a great deal of energy into supporting coordination efforts and building capacity for leadership and successes, which while significant may not be sustainable.

How USG fits in: PEPFAR is a key partner in the national response, as the largest donor second only to the Global Fund. USG works closely with NERCHA, UN Agencies and civil society umbrella organizations to prioritize and coordinate support. A continued focus of PEPFAR is to promote greater accountability and transparency. PEPFAR liaises not only with NERCHA and UNAIDS, but also with the Ministries of Education, Finance, Economic Planning and Development and Public Service and the Deputy Prime Minister's office. Greater engagement with these non-health sectors with regard to PEPFAR investments has improved the overall transparency for planning and budgeting.

PEPFAR is a key partner in the GF processes in country. In addition to providing technical support towards the CCM and PR readiness for the New Funding Model, PEPFAR technical personnel and implementing partners provide programmatic technical assistance to support implementation of the grants. PEPFAR is also providing key support in the drafting of the HIV/TB integrated concept note.

To improve donor coordination, the USG, in collaboration with UNAIDS, will support NERCHA to convene a national health partners' donor working group to ensure that development partners are appropriately leveraging their HIV and health investments. This forum is long overdue and will also provide an opportunity to leverage non-HIV specific resources.



To operationalize USG program coordination with key national stakeholders, the USG/PEPFAR interagency management team holds monthly PEPFAR monitoring meetings with the directorates of MOH and NERCHA; and quarterly meetings with the DPM's Office, WHO and UNICEF. Routine meetings with UNFPA have recently been established. These fora are important to monitoring accountability against mutual commitments, including those set forth in the PF. In 2014, USG will begin periodic meetings with other sectors (mentioned above, and guided by the PF Review) to update on key implementation issues as appropriate.

Other donors: 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, Medecins sans Frontiers (MSF), the Clinton Health Access Initiative (CHAI) and several international NGOs – are, on balance, supporting national systems rather than setting up parallel vertical programs. In the GKOS recently released budget speech, GKOS committed over \$30 million for ARV drugs, citing the change in CD4 count threshold from 350 to 500. This represents an increase over the prior year allocation by approximately 25%. GKOS budget also commits to upgrades for the existing TB hospital, and HCW housing. However, these budget commitments are accompanied by some uncertainties due to ongoing challenges with supply chain and financial management capacity.

As all active GF grants end in 2014, the country has been working intensively towards readiness for Concept Note submission in August 2014.

Contextual factors - 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. Beyond HIV/AIDS Swaziland's development continues to be adversely affected by increasing levels of poverty and negative economic growth, political repression, and a burgeoning youth population ill-prepared to address the country's future challenges. The human, social, and economic costs of the HIV/AIDS crisis, coupled with poor governance, weak democratic institutions, and an unattractive investment climate, exacerbate the overall development challenges in Swaziland. Economically, Swaziland is closely tied to South Africa, from which it receives 90 percent of its imports and more than 60% of its public sector financing through the Southern African Customs Union (SACU). Compounding the health and social strains of the Kingdom was a precipitous fall in revenue resulting from a two-thirds cut of SACU customs receipts in 2011. Since then revenues have rebounded. However, Swaziland has not instituted the structural changes (as recommended by the IMF) required for economic stability and growth and the country remains dangerously dependent on SACU shares and their fluctuation.



As noted in the epidemiology summary, there is a strong gender dimension to the HIV epidemic in Swaziland. Gender norms underlie sexual behaviors and men's exertion of control in sexual relationships. The Child Protection Welfare Act was enacted in 2012. After years of debate, the Sexual Offences and Domestic Violence Act finally was passed by the second house of parliament in 2013, just prior to the disbanding of parliament for the election period. However it has not yet been signed into law by the King, and there is speculation that it will need to be reviewed by the new parliament and re-submitted to the King before actual enactment will occur. These pieces of legislation provide a basic policy environment for protection of women and children, however much work is required to see these laws effectively implemented.

Since COP FY2012, PEPFAR has worked systematically to address pipeline. All COP FY2014 allocations have factored in existing pipelines and projected outlays. PEPFAR coordinated with NERCHA, GF, the MOH and other funders to ensure PEPFAR proposed investments would not be duplicative. Preliminary EA findings were made available to and assessed by the PEPFAR team in February 2014; this timing did not allow for extensive use of this data during COP planning. Once final reports are available, PEPFAR will use the data to identify and maximize efficiencies.

II. PEPFAR Focus in FY2014:

Program Overview

The PEPFAR portfolio will undergo a major transition in COP FY2014 across all program areas, as many five-year agreements end in early 2015. As a result, nearly 45% of the program budget is allocated to new procurements. The team has used this opportunity to implement strategic shifts in programming to achieve an HIV-free generation, reflect GKOS priorities in the HIV response, maximize efficiencies, and implement recommendations made by various HQ reviews and assessments to strengthen the continuum of the response.

PEPFAR has supported different components of the continuum of HIV and TB clinical services through different partners working in the same health facilities since 2007. This approach was successful in rapidly scaling up HIV and TB services, however, the vertical nature resulted in inefficiencies. In COP FY2014, we will move towards a hybrid approach. We will maintain the efficiency of having one partner working at the national level in each of three key vertical areas—PMTCT/MNCH, HIV, and TB. But we will assign each of these three partners to work on the entire HIV/TB continuum of care within one of the three regions that PEPFAR supports. The goal of this new, regionalized approach is to support the MOH to integrate the entire continuum of clinical HIV and TB services for pediatrics, adolescents and adults (including pregnant women, and key populations) into an overall improved and decentralized health care system. Each of the three TBDs will also work closely with their assigned Regional Health Management Team. The intention is to provide support to improve the RHMT's coordination, management and



oversight responsibilities for quality management of all clinical services as a strategy for sustainability and transition over time. (Of note, some critical vertical and cross-cutting clinical activities will remain under partners working at a national level, including male circumcision, supply chain, HMIS, and laboratory.)

Key priorities in COP FY2014, listed in no specific order, are as follows: 1) strengthen integration and coordination of HIV and TB clinical care services to improve access and quality in line with newly adopted national guidelines that expand ART eligibility criteria (eg, CD4 <500, all pregnant women, all TB patients, all children <5 yrs old); 2) strengthen SBCC coverage, quality and dose across the continuum of the response to increase uptake of high impact services; 3) implementation of targeted combination prevention programming (ages and stages); and 4) health systems strengthening (including quality management, HMIS systems, targeted support for HRH, social welfare, and epidemiology capacity).

PEPFAR used an interagency approach for assessing resources and determining budgets by program area. The approach started with a Portfolio Review in October 2013 that included extensive analysis of pipeline, discussion of OGAC guidance, review of eNSF priorities, and in depth consultations with GKOS technical and civil society counterparts—all with the goal of shaping the programmatic areas for inclusion in COP FY2014. PEPFAR also engaged with UNAIDS, Global Fund, World Bank/EU, MSF, and CHAI to understand the available resource envelope and ensure that PEPFAR was appropriately leveraging (and not duplicating) other inputs. In addition, PEPFAR took close notice of recommendations outlined in the FY2014 funding letter, particularly in regards to moving towards Option B+ and better linking OVC programs to clinical care and prevention services.

III. Progress and Future

PFIP: The term of the PF agreement ended in September 2013. As PEPFAR and the GKOS begin to plan for the next five-year period, the importance of examining and reflecting upon progress and performance under this first PF was evident. To this end, PEPFAR, in partnership with the GKOS, commissioned a consultant to carry out a review. The review addressed PF accomplishments, weaknesses, coordination and collaboration, and monitoring as well as recommendations for the design and content of the next five-year agreement. The review found that the PF is highly valued in Swaziland because it helps to formalize the relationship between the GKOS and the USG and to harmonize and clarify the work of the USG in support of the national HIV response. Respondents largely agreed that both collaboration and coordination in the HIV response have improved under the PF.

More broadly there is a general call for earlier and more meaningful consultation with relevant stakeholders, including civil society, in both design and implementation of a follow-on Framework. There is also a call to both the GKOS and the USG for greater multisectoral engagement, including with central Ministries. The process of planning for COP14 provided an opportunity to begin such engagement. We

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explicitly worked with our GKOS and civil society counterparts with the understanding that this two year COP would form the basis of the first couple of years of a follow on PF.

Country Ownership: In COP FY2014, PEPFAR will focus on developing its Sustainability Plan – which will essentially be the follow-on to the PF 2009-2013, building on lessons learned and recommendations stemming from the PF review. Although Swaziland is categorized as a long term strategy country, the team investments are largely focused on systems and TA. As a large part of the portfolio is transitioning to new agreements, a great deal of consultation and discussion has already taken place with GKOS counterparts regarding transition of positions and support as PEPFAR increases its focus on strategic, systems and human resource strengthening investments. These shifts are consistent with the PEPFAR Blueprint's action steps of moving towards country-led, managed and implemented responses. To succeed in these endeavors, PEPFAR will continue to leverage its already strong relationships with multilateral and bilateral partners and expand its support to civil society organizations. Progress in the national HIV response will be measured through biannual forums chaired by NERCHA, with technical assistance for the forums provided by PEPFAR. These forums will be critical to following Swaziland's progress on the four dimensions of country ownership of the HIV response: political ownership and stewardship; institutional and community ownership; capabilities; and mutual accountability.

Trajectory in FY2015: In COP FY2014, PEPFAR will support 1) increased access to and quality of targeted, high impact, evidenced based combination prevention interventions, and 2) the systems such as HRH and SI that underlie them. In addition, PEPFAR is optimistic about the efficiencies that will arise from implementing a regional approach to providing TA to clinical services. While the team does not anticipate that the base budget will increase, PEPFAR intends to capitalize on being the only country in the world with a national HIV incidence baseline. This baseline, from the 2011 Swaziland HIV Incidence Measurement Survey, offers the unique opportunity to repeat an incidence/AIDS indicator survey and quantify the impact of combination prevention in a national, non-experimental, setting. To achieve this objective, PEPFAR will need to leverage a combination of OGAC, CDC and USAID HQ, and future COP funds. Nearly \$400,000 from COP FY2014 has been allocated to begin the planning process for the survey in early 2015. It is anticipated that the survey would include population measurements of incidence, viral load, and CD4 among other biological and demographic data. The survey will also provide an opportunity to test an additional 10,000-15,000+ people and link them to appropriate services. PEPFAR will need additional funding added to its base budget to support full implementation of the SHIMS follow-on, which is essential to providing evidence toward incidence reduction and progress towards an AIDS-free generation.

Details on each major program area. Please note relevant epidemiological data for each section is provided above.)



Prevention

PEPFAR is the largest donor to prevention efforts in Swaziland and collaborates closely with civil society partners, NERCHA and the MOH in the implementation of the national program. As several major prevention-focused agreements end in FY2014, this COP is an opportune time to implement strategic shifts in the prevention portfolio including a robust focus on attaining coverage of priority populations with a minimum package of interventions with specific focus on high impact services. Approximately 14.5% of the total program budget assigned to prevention budget codes (including PMTCT), is allocated to TBD mechanisms. Of note, PEPFAR will be using our new regional HIV/TB clinical TA TBDs to support Swaziland's national shift in PMTCT guidelines to put all pregnant women on ART (Option B+) as well as the ongoing push to implement routine opt-out HIV testing in clinical settings. One of these regional TBDs will also be the lead TA provider to the national MNCH/PMTCT program, helping to develop guidelines, policies, training materials, and conducting implementation science research in this area. PEPFAR will also implement a national communication strategy to promote Option B+ and community partners will strengthen linkages with facilities and support for pregnant women.

In 2013 PEPFAR conducted a review of all PEPFAR-funded SBCC programming to identify gaps and opportunities with particular aim of increasing the up-take high impact HIV services and addressing the social, cultural and gender issues that influence their access. Guided by this assessment and the eNSF priorities, PEPFAR has identified a lead partner to work with GKOS in improving the access to high impact services and communication across the continuum of the response. The partner will work closely with clinical, community-focused partners, MOH, NERCHA, and key stakeholders to assure greater standardization and coverage of the minimum package of prevention interventions. This partner will also engage closely with and build capacity of local leaders and stakeholders to take leadership roles in their communities' HIV response by setting targets and tracking the uptake of services in their own communities.

Over the past two years, PEPFAR has invested significant time and effort into improving the genuine ownership of the national voluntary medical male circumcision (VMMC) program in the country. These efforts are beginning to pay off: a new national strategy and operation plan are under development using the results of PEPFAR-supported coverage mapping and the DMPPT 2.0 model, VMMC is a cornerstone of the HIV response in the eNSF, and partners are working on improved and more cost-efficient implementation approaches. In COP14 TA and service delivery support to the GKOS national efforts will be provided by a new performance-based mechanism. Building on lessons learned and investments from ASI this activity will focus on: 1) increased coverage and demand for high quality adolescent VMMC services, 2) expanded early infant male circumcision (EIMC), and 3) TA to the national VMMC/EIMC program. PEPFAR also intends to provide direct funding to a local partner to provide VMMC services.

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As a PEPFAR sub-partner in the past few years, this partner has demonstrated strong capacity to deliver results. The partner offers a range of non-HIV services – and hence draws large numbers of VMMC clients and future champions when services are offered via their mobile clinic. The VMMC program will also focus on mobile and outreach services for key populations.

Care:

New mechanisms funded through the care budget codes represent approximately 12.5% of the total program budget. Swaziland's Care program has made significant strides in improving strategic information and the overall quality of TB/HIV integrated care and services provided to HIV positive individuals. HIV clinical care services are defined by the national program and are being scaled up to include prevention and treatment of OIs like cervical cancer and cryptococcal infection. Priorities and key interventions outlined in the TAN are informed by the review of the care and treatment portfolio in early 2013.

One of the new TBD regional partners will be the PEPFAR technical lead for TB, providing TA to the NTCP in establishing and monitoring performance standards for TB, MDR-TB and IPC services, helping to develop guidelines, policies, training materials, and conducting implementation science research. Another regional TBD will be the lead PEPFAR technical partner for HIV care, including cotrimoxazole prophylaxis; screening and prevention/early treatment of TB, cervical cancer, and cryptococcal infection; PHPD, NACS, integrated family planning, pain/symptom management, PLHIV support groups, end of life care, and social services. As noted above, while each of the three TBD regional partners will provide specialized support at the national level, each will provide support to the implementation of the entire continuum of care at the facility level.

Although PEPFAR does not have accurate data regarding the size of MSM and FSW population, there is enough evidence with regard to prevalence in these key populations to warrant targeted interventions. Key population care activities will focus on a comprehensive package of interventions which includes HTC, risk counseling and referrals to services that are sensitive to the needs of key populations.

Given the enormity and complexity of the needs of the OVC population in Swaziland (45% or 229,000 of children are classified as OVC). PEPFAR has made strategic investments to balance the need for long-term, sustainable systems strengthening support and service delivery to OVC. There is one new mechanism funded through the OVC program (HKID and other budget codes), comprising approximately 6% of the total program budget. The design of this new activity was informed by the end of program evaluation of the current lead partner (PACT), as well as the SBCC review conducted in 2013. This activity will have a specific focus on prevention interventions that target those most vulnerable to

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acquiring HIV, including adolescent girls. The TBD will focus on 1) evidence-based interventions, supporting integrated HIV prevention and OVC interventions (with linkages to testing, care and treatment) targeting adolescents, and 2) organizational development and capacity building of civil society organizations with the comparative advantage to deliver these services in Swaziland.

Swaziland's legal and policy framework for child protection is quite good, with key legislation having been passed into law in 2012. However, implementation is limited to non-existent due to inadequate leadership and coordination of ministries with statutory responsibilities to implement the Act, and extremely weak human resource capacity of the Department of Social Welfare. COP FY2014 will focus on strengthening social service delivery through existing DSW cadres and strengthening coordination with key line ministries and NGOs supporting OVC.

Treatment:

Approximately 11% of the total program budget allocated to treatment budget codes is allocated to TBD mechanisms.

Swaziland has adopted the WHO 2013 guidelines and will soon implement an ART eligibility requirement of CD4 \leq 500. Once the new guidelines are implemented ART coverage will drop to less than 50% as the population for those in need of ART will nearly double. To build Swaziland's coverage rate back up to the current 90%, PEPFAR will support an increase in targeted provider-initiated and community-based testing, accompanied by aggressive implementation of standard linkage to care procedures that were introduced in 2012. At the facility level, the Nurse-led ART Initiation in Swaziland (NARTIS) curriculum has been revised and nurses will be trained in time to support the implementation of the new guidelines. A key focus in COP FY2014 is to reach 90% pediatrics coverage by 2015 (current coverage is 70%). Activities will focus strengthening case finding, communications strategies and interventions to improve ART uptake (in collaboration with the lead SBCC partner), building nurse capacity for phlebotomy on infants, and strengthening adolescent adherence and retention. Regarding key populations, PEPFAR will also increase its emphasis and targeting of counseling and testing to FSW and MSM, to increase uptake and referral to care and treatment.

In COP FY2014 PEPFAR is adopting a regionalized approach to clinical services to maximize efficiencies and strengthen integration across the continuum of the response. A new TBD partner will be the PEPFAR technical lead for Care and Treatment, providing TA to the National AIDS Program. This partner will to establish and monitor performance standards for HIV care and treatment services, develop guidelines, policies, training materials, and conduct implementation science research. (Note- this is the same partner noted above in the Care section.) This partner will be the prime TA partner to one of the Regional Health Management Teams and the facilities within that region, all with the goal of improving access to and

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quality of services.

PEPFAR will also provide TA to the national supply chain management systems. It is important to note that GKOS funds 100% of the country's ARVs and lab commodities. TA in supply chain will focus on strengthening systems and building HR capacity as well as advocating for new legislation that will lead to a Medicines and Regulatory Authority and licensing of pharmacy professionals.

Regarding the laboratory, a new partner will lead on strengthening QM systems, human resources capacity and implementing a strategic plan that will improve access and quality, particularly of key diagnostic and monitoring tests like HIV rapid test, Gene Xpert, CD4 and viral load. All laboratories in Swaziland will be enrolled in SLMTA and our TBD lab partner will support their path towards accreditation.

Health Systems Strengthening

PEPFAR has embraced the GHI principle of "Building Sustainability through Health Systems Strengthening" as critical in its approach to addressing HIV/AIDS prevention, care, and treatment. USG works closely with its partners and the GKOS to ensure that all components of a comprehensive health system - service delivery, supply chain, laboratory, information, governance, human resources, and finances - are strengthened and coordinated to more effectively deliver a sustainable national response to HIV and AIDS and other basic health services. PEPFAR support in COP FY2014 will support all but the last of these building blocks. (CHAI is providing extensive support to health financing, and while PEPFAR is represented on the financing TWG, we are not actively making investments in this area.) PEPFAR support to service delivery, supply chain, and laboratory are described above, the others will be described below.

SI: Strengthening Strategic Information (SI) systems and contributing to one national M&E system is an important focus of MOH and PEPFAR. Approximately 7.5% of the PEPFAR program budget is allocated to the strategic information budget code. All implementing mechanisms in COP FY2014 have dedicated resources for monitoring and data quality assurance.

The hallmark of PEPFAR's support to the ongoing implementation of the national HMIS strategy with technical assistance and capacity building. The partner is TBD--though a well-established local partner is currently implementing as a sub-partner and is expected to continue in a direct funding capacity. This partner will strengthen the national M&E infrastructure, by supporting implementation of electronic patient information systems, facilitating data quality improvement exercises, and establishing a patient unique identifier (PUID). To leverage the PEPFAR resources and ensure sustainability, the MOH and the TBD partner will continue to work closely with the Ministries of Public Service, Technology and Home Affairs.

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While one SI TBD partner works on HMIS and M&E, another SI TBD partner will focus on building epidemiology, surveillance and health research capacity locally. The goal of the TBD is to establish a cadre of local stakeholders who can create and use evidence for programming and policy purposes. This TBD partner will also be responsible for the planning of the AIDS Indicator Survey, and if funding is available, for the implementation as well.

Governance: In COP FY2014 a new TBD G2G mechanism with the MOH will be dedicated to improving leadership and governance through the introduction of quality management systems.

The CoAg will accomplish this objective by providing support to MOH to finalize the mentoring and supervision framework, clearly define performance indicators and targets for treatment, care, and support, and fully implement the two documents noted above. Currently, PEPFAR partners support quality management activities at the facility level through regular mentoring and supportive supervision to health facilities. Facilities are supported to have regular multidisciplinary team meetings where their performance data is reviewed, gaps identified, and QI plans are developed and reviewed. At the national and regional levels, PEPFAR will continue to support the successful practice of working with the MOH to organize semi-annual data and performance review meetings where high performing facilities and best practices are recognized. PEPFAR has also instituted interagency site supervision visits that are conducted in close partnership with the MOH. It is expected that, through the TBD G2G mechanism, the MOH will institutionalize the site visits into their own QM structure.

HICD: In COP FY2014 there will be one lead HRH partner (Abt HFG). HFG will focus on human and institutional capacity development (HICD), targeting MOH and the Department of Social Welfare in an effort to strengthen organizational systems that promote expanded services and sustainability. HFG will build off a successful recent discussion between PEPFAR and the GKOS regarding transition of salary support from donors to government. As a result of the discussions, nearly half of over 800 positions that were donor-supported in 2013 will be absorbed by the GKOS. HFG will take on the next tasks of addressing skills shortages, improving recruitment, retention, and training of the health and social welfare workforce (formal and informal). An important aspect of this work is the continuing effort to strengthen Swaziland's Medical and Dental Council and Nursing Council, building its capacity to provide regulatory oversight and formalizing a regulatory system for allied health workers. On a smaller level, a second partner (URC ASSIST) will focus on coordinating in-service training activities across all partners – minimizing the risk of duplication.

V. GHI Program Integration, Central Initiatives and other considerations

a) GHI - Swaziland's USG interagency team has been focused on implementation of the GHI since the

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team finalized its strategy in 2011. GHI built upon the GKOS-PEPFAR PF 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: 1) strengthening USG-GKOS partnership and GKOS ownership; 2) intensifying efforts to address cross-cutting areas of Gender and Health Systems Strengthening; 3) increasing efforts to integrate PMTCT and MNCH; 4) promoting research and innovation; 5) building more sustainable systems; and 6) strengthening donor coordination.

b. GF/Multilateral Engagement: PEPFAR collaborates closely with all GF stakeholders in Swaziland. Regular engagement with the Fund Portfolio Manager, the CCM Secretariat, the Local Fund Agent, NERCHA, and the MOH continues in the management of current grant issues. More intense engagement is taking place (i.e. coordinating TA with UNAIDS, PEPFAR HQ-funded TA to support CCM eligibility requirements) as the country prepares for a concept note submission in October 2014.

c. Central Initiatives: PEPFAR has utilized several central initiatives to further bolster the approach of aligning its program with GHI principles:

KPCF: With funding provided through the KPCF (\$1,965,000), and PEPFAR's contribution of \$902,500 over three years, programming will focus on improving access to services for marginalized FSW and MSM/LGBTI. 85% of the KPCF is focused on services for key populations (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).

OVC: The OVC Special Initiative Funds (\$3 million over 3 years) will focus on the youngest of OVC through an integrated evaluation of whether there are differences in HIV-related health outcomes for children whose mothers have participated in parent education program compared with children whose mothers have not. This initiative will complement COP FY2014 HKID investments which are geared towards strategic integrated programming across ages and stages.

WCF/SCMS: PEPFAR will use \$224,000 in central funding to fill a critical gap in supplies and commodities for VMMC activities. Items to be procured include VMMC kits, pharmaceuticals, commodities and supplies.

PMTCT plus up: These additional funds (\$1 million) will target once-off high impact investments to bolster the country's transition to Option B+. Options proposed, which still need discussion with stakeholders

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and the MOH include: pre-service training for NARTIS, , scale up of the new electronic medical record/CMIS, support to the laboratory information system , and support to the National Laboratory Transportation System.

Data Sources:

1. Swaziland HIV Incidence Measurement Survey (SHIMS) First Finding Report, November 2012
2. Swaziland Demographic and Health Survey, 2006-2007
3. Swaziland HIV Estimates and Projections Report, 2010
4. PMTCT Annual Program Report, 2012
5. Multiple Indicator Cluster Survey, 2010
6. Swaziland Behavioral and Surveillance Survey, 2010 (draft)

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