SWAZILAND Country Operational Plan (COP) 2018

Strategic Direction Summary

March 29, 2018

Acronym and Word List

A	Adolescents
AE	Adverse Event
AG	Adolescent Girls
AGYW	Adolescent Girls and Young Women
ALHIV	Adolescents Living with HIV
ANC	Antenatal Clinic
APR	Annual Program Results
ARROWS	ART Referral, Retention, and Ongoing Wellness Support
ARV	Antiretroviral
ART	Antiretroviral Therapy
ASLM	African Society for Laboratory Medicine
C	Children
C/A	Children/Adolescents
CAG	Community Adherence Group
CANGO	Coordinating Assembly of Non-Governmental Organizations
CCM	Country Coordinating Mechanism
CEE	Core Essential Element
CHAI	Clinton Health Access Initiative
CIHTC	Community-Initiated HIV Testing and Counseling
CMIS	Client Management Information System
CMS	Central Medical Stores
CoAg	Cooperative Agreement
CQI	Continuous Quality Improvement
CS(O)	Civil Society (Organizations)
DBS	Dried Blood Spot
DQA	Data Quality Assessment
DSD	Direct Service Delivery
E	Swazi Emalangeni (1 lilangeni equals 1 rand)
ECD	Early Childhood Development
EID	Early Infant Diagnosis
eNSF	extended National Multi-Sectoral Strategic Framework for HIV & AIDS
EQA	External Quality Assessment
DMPPT	Decision Makers Program Planning Toolkit
EU	European Union
FDC	Fixed dose combination
FDI	Foreign Direct Investment
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GHSP	Global Health Services Partnership
GKoS	Government of the Kingdom of Swaziland
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
HC4	HIV Response Coordination, Community Capacity and Communication

HCW	Health Care Worker
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IEC	Information, Education and Communication
IM	Implementing Mechanism
KP	Key Population
LES	Locally Employed Staff
LGBTIQ	Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex, Queer
LTFU	Lost to Follow Up
LIS	Laboratory Information System
MBP	Mother-Baby-Pair
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Reporting
MEPD	Ministry of Economic Planning and Development
MICS	Multi Indicator Cluster Survey
MNCH	Maternal Newborn and Child Health
MoET	Ministry of Education and Training
MoF	Ministry of Finance
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
MTC	Matshapa Town Council
NACS	Nutritional Assessment, Counseling, Support
NARTIS	Nurse-led ART initiation in Swaziland
NERCHA	National Emergency Response Council on HIV and AIDS
NCP	Neighborhood Care Points
NTCP	National TB Control Program
ODA	Overseas Development Assistance
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PCV	Peace Corps Volunteer
PEP	Post Exposure Prophylaxis
PEPFAR/S	Presidents Emergency Plan for AIDS Relief/Swaziland
PFSCM/SCMS	Partnership for Supply Chain Management/Supply Chain Management System
PHC	Primary Health Care
PHU	Public Health Unit
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
PNC	Post Natal Clinic
POART	PEPFAR Oversight and Accountability Response Teams
POC	Point of Care
POCT	Point of Care Testing

PP	Priority Populations
PPP	Public Private Partnership
PrEP	Pre-exposure Prophylaxis
PSNU	Priority Sub-National Unit
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
QMS	Quality Management System
RA	Regional Administrator
RASTA	Region Age Sex Testing/Treatment Attribution
RHM	Rural Health Motivator
RHMT	Regional Health Management Team
RPM	Regional Planning Meeting
RTK	Rapid Test Kit
SAPR	Semi-Annual Program Report
SGBV	Sexual and Gender Based Violence
SHIMS	Swaziland HIV Incidence Measurement Survey
SI	Strategic Information
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SOP	Standard Operating Procedures
SNAP	Swaziland National AIDS Program
SNU	Sub-National Unit
SRH	Sexual Reproductive Health
SRHU	Sexual Reproductive Health Unit
SWABCHA	Swaziland Business Coalition on HIV/AIDS
SWAGAA	Swaziland Action Group Against Abuse
SWAMMIWA	Swaziland Migrant Mineworkers Association
SWANNEPA	Swaziland National Network of People Living with HIV/AIDS
TA	Technical Assistance
TB	Tuberculosis
Tinkhundla	Government Administrative Unit (Below Regional Level)
T&S	Test and Start
TPT	TB Preventive Therapy
TSP	Technical Support for PEPFAR Programs
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
USDF	Umbutfo Swaziland Defence Force
USG	United States Government
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WAD	World AIDS Day
WHO	World Health Organization
WMIS	Warehouse Management Information System

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1.0 Goal Statement

1.0 Goal Statement

The overarching goal of the PEPFAR/Swaziland (PEPFAR/S) program is to support the Government of the Kingdom of Swaziland (GKoS) to achieve the HIV epidemic control and reverse the impact of HIV on the people of Swaziland. PEPFAR/S activities are guided by the new National Multi-Sectoral Strategic Framework for HIV and AIDS (NSF) 2018-2022 (see Appendix D Documents Library) to:

1. Find 95% of people living with HIV (PLHIV) and make them aware of their status, intensify same-day ART initiation and implement differentiated care models to target groups of missing populations;
2. Provide primary and combination prevention services to priority and key populations to prevent HIV transmission and acquisition to reduce new infections;
3. Address HIV related stigma and discrimination and ensure the right to access HIV services for all; and
4. Reduce the vulnerability of orphaned and vulnerable children (OVC) and address sexual and gender-based violence (SGBV).

PEPFAR/S will work with GKoS to intensify program implementation in all four regions of this small high-prevalence country. The ambitious timeline to reach "attained" status for all age bands, sexes, and risk groups by the end of Country Operation Plan 2018 (COP18) through support for testing 242,488 people, initiating 15,918 people on treatment, is achievable. All four regions are classified as scale-up-to-saturation. In COP18, PEPFAR/S will scale up index case testing and HIV self-testing (HIVST) to find those who are unaware of their status and those who are aware of their status but not on treatment, particularly men, ages 20-39 and women ages 15-34. In COP18, approximately 36% of all PLHIV will be identified through index case testing and HIVST with a focus on males ages 25-34. Linkage to care and prevention services will be strengthened through the implementation of custom indicators.

Priority populations (PPs) and key populations (KPs) will have access to comprehensive packages of health and social services in COP18. In order to ensure that those who are negative do not acquire HIV and those who are positive do not transmit, combination prevention interventions will be offered to men, ages 15-39, and traditional leaders will help link community members with interventions, testing and HIV services as well as addressing SGBV. The DREAMS package will focus on adolescent girls and young women (AGYW) ages 15-29 and orphans and vulnerable children (OVC), strengthening risk avoidance for 9-14 year olds. PEPFAR/S will scale-up demand for and provision of condoms and lubricants for all PP and KP, Pre-exposure prophylaxis (PrEP) for those at greatest risk and voluntary medical male circumcision (VMMC) focusing on men ages 15-29. Reducing SGBV, stigma and discrimination also continue to be a priority.

PEPFAR/S will decongest facilities and increase access to ART refills through innovative mobile and community models for PPs and KPs as well as increase multi-month prescriptions. To minimize adverse drug reactions and lower the cost of treatment, Swaziland will transition to the use of a dolutegravir-based first-line regimen. PEPFAR/S, in conjunction with the Ministry of Health (MoH), will ensure that viral load (VL) and early infant diagnosis (EID) testing is readily available.

PEPFAR/S will continue to monitor implementing partners' performance and expenditures on a monthly/quarterly basis to immediately address performance issues. Weekly updates will be required of testing and under-performing partners. Program implementation will be monitored via quarterly performance reviews and regular SIMS visits. Partners will be required to report their quarterly outlays against their approved COP18 levels, achievements and targets.

GKoS and PEPFAR/S are confident that these goals are achievable in COP18 and are motivated to control the HIV epidemic in this small country so unduly burdened.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

In 2017, the Swaziland National Population and Housing Census counted 1,093,028 people in the population; 36% are 15+ years old and 56% are <25 years old, indicating a youth bulge in the population. The annual growth rate is 0.7% (Hhohho 1.3%; Manzini 1.1%; Shiselweni -0.2%, and Lubombo 0.2%), and 76% of the population live in the rural areas.

Figure 2.1.1 shows the population count per inkhundla (district). By region, Manzini (the economic capital) has the highest population (355,945), followed by Hhohho (the national capital) (320, 651), Lubombo (212,531), and Shiselweni (204,111).

Figure 2.1.1. Population by inkhundla, Swaziland National Population and Housing Census, 2017

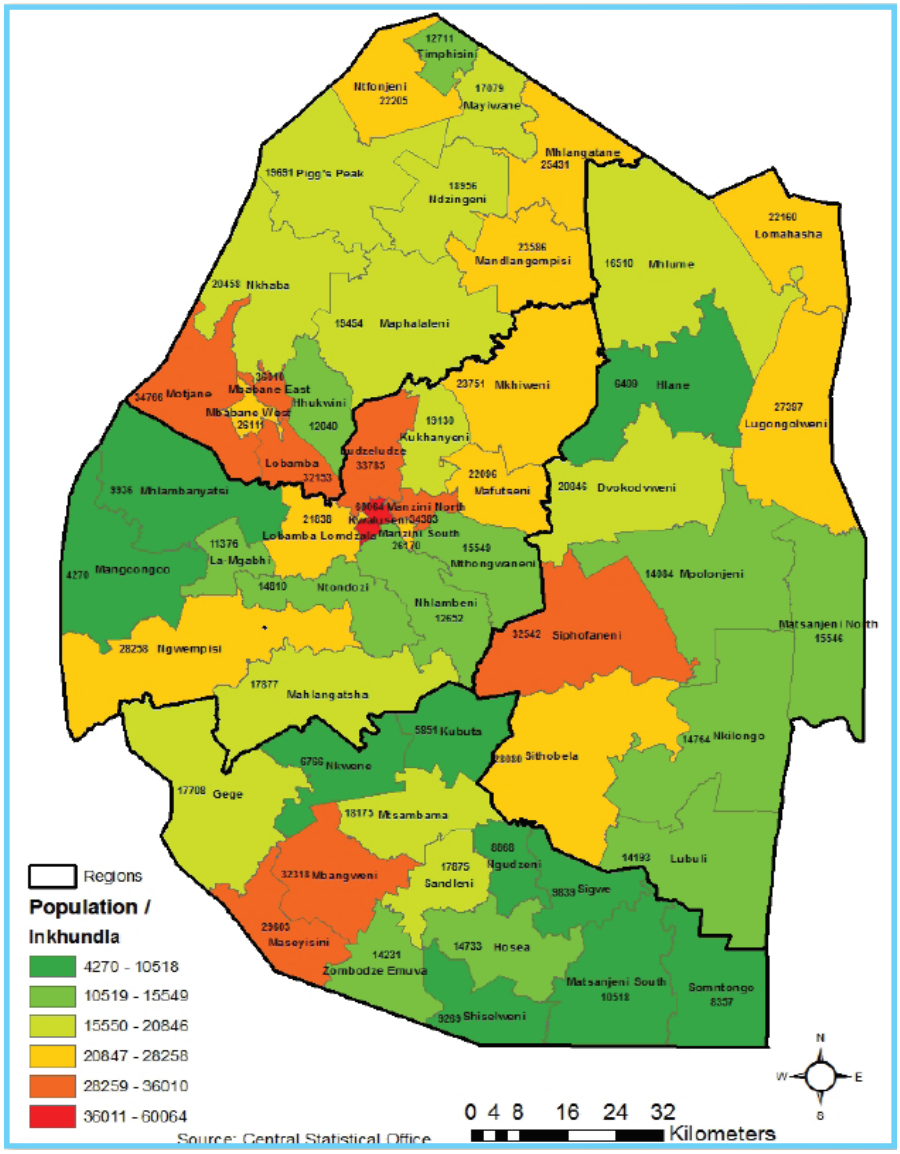


Figure 2.1.2 shows two tinkhundla in Lubombo with high male to female ratio: Mhlume inkhundla (143 males/100 females) and Nkilongo inkhundla (130 males/100 females), and the ratio is consistently higher along the western border to South Africa in Hhohho region. These areas are locations of male-dominated industries such as sugarcane and wood pulp plantations, and have programmatic implications in the context of COP18 strategic direction to identify and link more male PLHIV into treatment. The figure needs to be triangulated with the population count (Figure 2.1.1), population density (Figure 2.1.3), male population count (figure 4.2.3) and other data to determine the appropriate locations and approaches to find and link men to treatment or prevention. Swaziland also has substantial movement through both formal and informal borders, which has implications for programming, including major trucking routes east to west and to the south with well-established hot-spots. Figure 2.1.2 shows some of these areas with a more equal male to female ratio, but also needs to be triangulated with other data including hot-spot mapping.

Figure 2.1.2. Sex ratio of all ages by inkhundla, Swaziland National Population and Housing Census, 2017

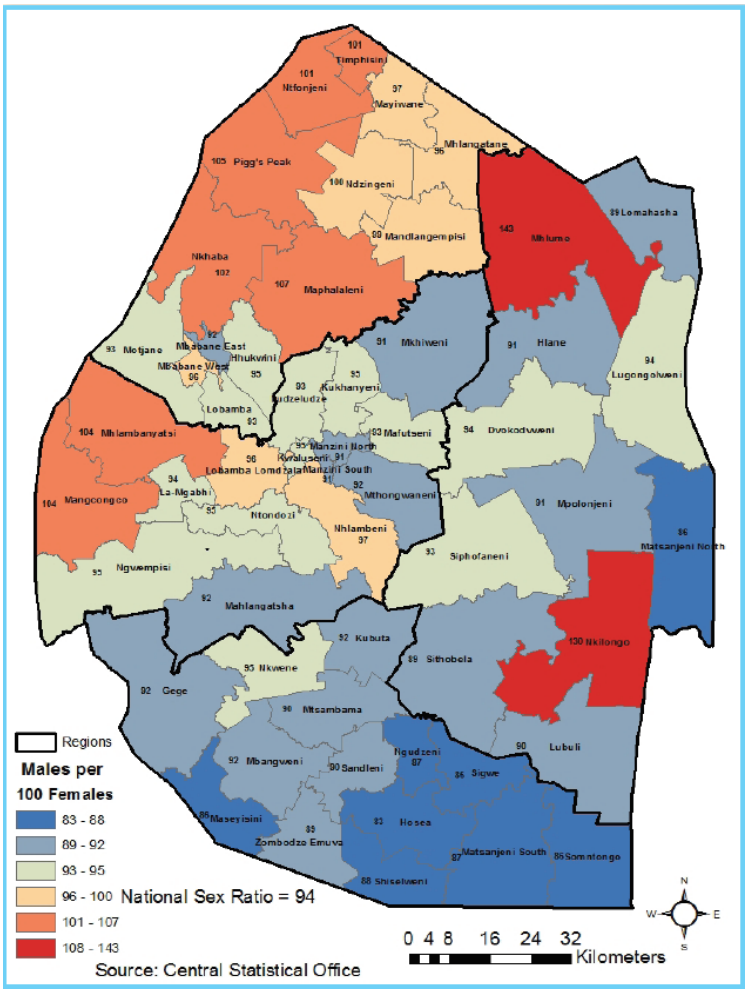
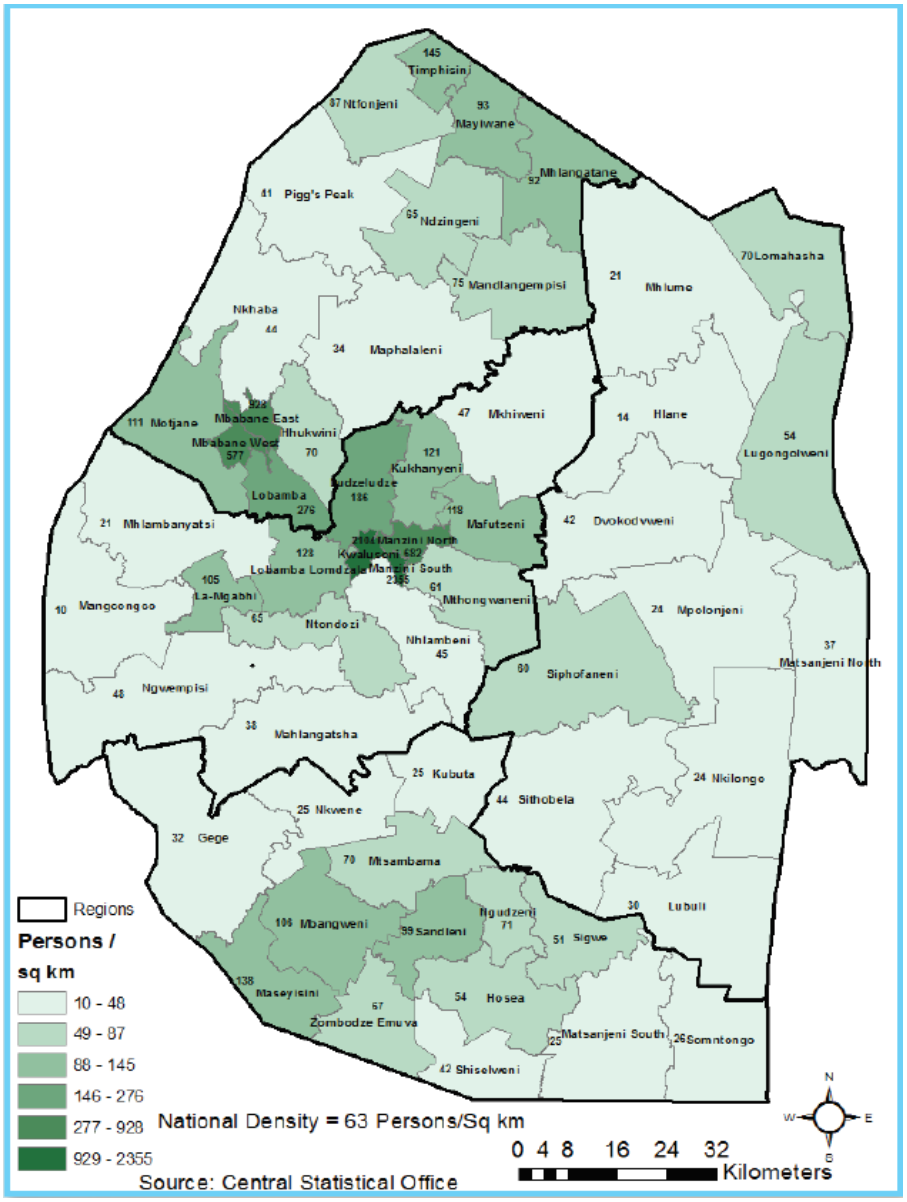


Figure 2.1.3 shows that population density is highest in the two tinkhundla in Manzini region: Kwaluseni (2,104 persons/km²) and Manzini South (2,355 persons/km²). Overall, population density ranks as follows: national (63 persons/km²); Hhohho (89 persons/km²); Manzini (87 persons/km²); Shiselweni (54 persons/km²); and Lubombo (36 persons/km²). The higher density areas on the map are known as the Manzini-Mbabane corridor, connecting the economic and industrial hubs, Manzini and Matshapa in Manzini region to Mbabane, the administrative capital, through Motjane to the main border, Oshoek, in the Hhohho region.

Figure 2.1.3. Population density by inkhundla, Swaziland National Population and Housing Census, 2017

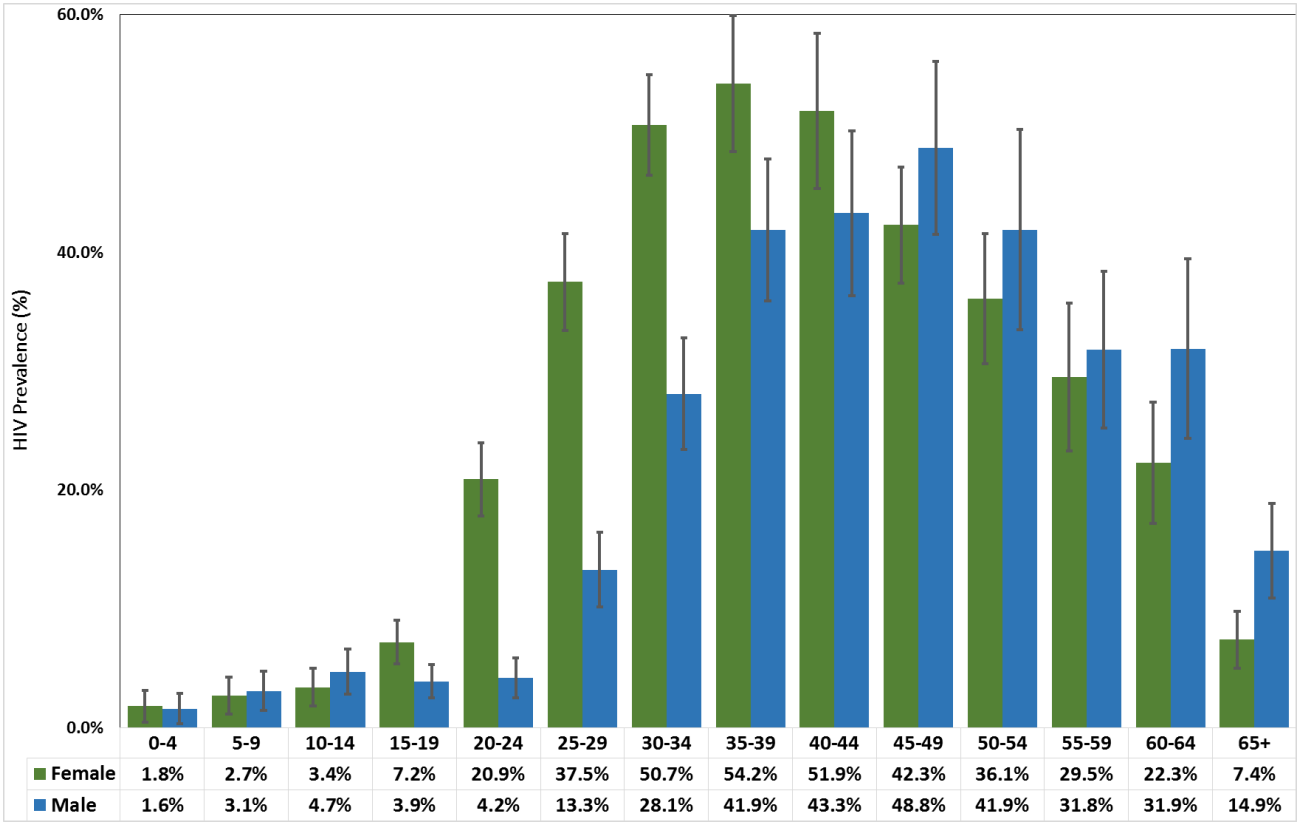


The GDP at market prices was $3.73 billion and GNI per capita was $2,960 in 2016. About 20% of children ages 0-17 are orphans, and 71% are either orphans or vulnerable.

The Swaziland HIV Incidence Measurement Survey (SHIMS) 2, 2016-17 estimated HIV prevalence among adults ages 15 and older is 27% in 2017. HIV prevalence is 13.9% among females ages 15-24 and 4.1% among males of the same age group. Among those ages 25 years and older, HIV prevalence is 41.2% among females and 29.9% among males.

Figure 2.1.4 shows that the prevalence among women is five times higher than for men ages 20-24 years (20.9% vs. 4.2%), three times higher among ages 25-29 (37.5% vs. 13.3%), and almost twice for ages 30-34 years (50.7% vs 28.1%). At least 50% of all women ages 30-44 are HIV positive.

Figure 2.1.4. HIV prevalence by age and sex, Swaziland HIV Incidence Measurement Survey (SHIMS) 2, 2016-17

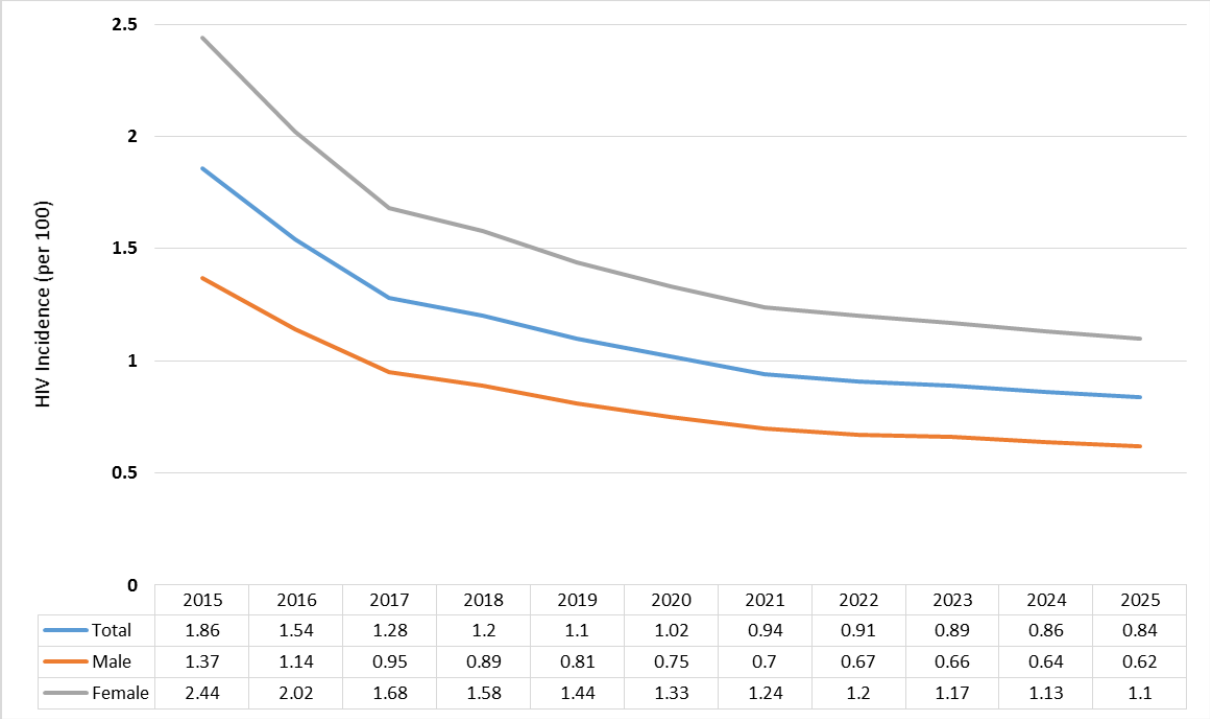


	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Female	1.8%	2.7%	3.4%	7.2%	20.9%	37.5%	50.7%	54.2%	51.9%	42.3%	36.1%	29.5%	22.3%	7.4%
Male	1.6%	3.1%	4.7%	3.9%	4.2%	13.3%	28.1%	41.9%	43.3%	48.8%	41.9%	31.8%	31.9%	14.9%

Annual HIV incidence among adults 15-49 years is 1.48 per 100 (female: 1.99; males: 0.99). From 2011 to 2016, the HIV incidence among adults ages 18-49 dropped from 2.5 per 100 to 1.4 per 100, marking a decrease by 44% in five years. In the same period, population viral load suppression among all PLHIV regardless of awareness or treatment status increased from 34.8% among all PLHIV to 71.3%.

Figure 2.1.5 shows Spectrum-estimated trajectory of HIV incidence decline, which will reach 0.84 per 100 in 2025.

Figure 2.1.5. Trends in estimated HIV incidence in adults ages 15-49, Swaziland (2015–2025)

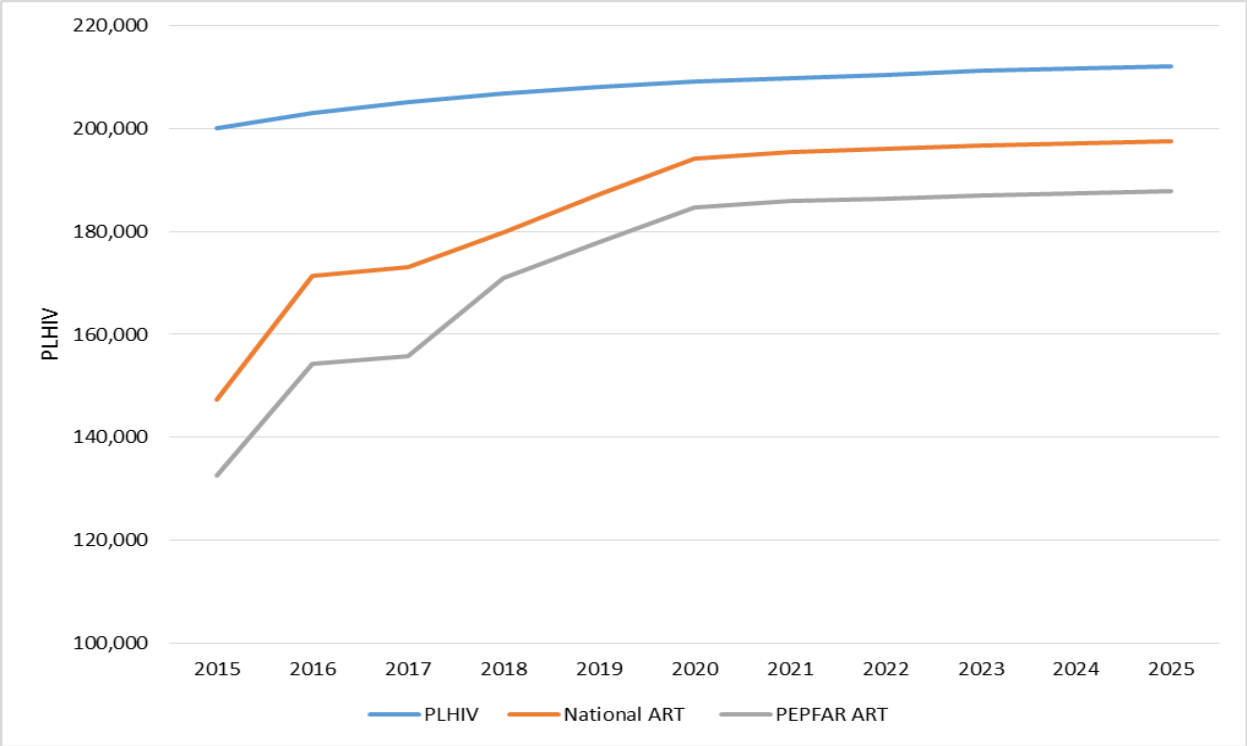


	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total	1.86	1.54	1.28	1.2	1.1	1.02	0.94	0.91	0.89	0.86	0.84
Male	1.37	1.14	0.95	0.89	0.81	0.75	0.7	0.67	0.66	0.64	0.62
Female	2.44	2.02	1.68	1.58	1.44	1.33	1.24	1.2	1.17	1.13	1.1

The most recent Spectrum modeling estimated in 2019 there will be 208,100 PLHIV, 3,189 AIDS-related deaths, and 5,877 new infections. Females ages 15-24 years comprise 29.4% of all new infections, while males of the same age group comprise of 4.3%. Among all new infections, 33.1% will be among males ages 25 and older, and 22.5% will be among their female counterparts (Table 2.1.5).

Figure 2.1.6 shows the trends for PLHIV, national on ART number, and PEPFAR ART number as a subset of national.

Figure 2.1.6. National and PEPFAR trends and targets for PLHIV on treatment, Swaziland 2015-2025



To assess national status on the 95-95-95 pillars, clinical cascades, national pyramid, and RASTA tables were developed. The national Spectrum file was updated to include the 2017 National Housing and Population Census, SHIMS 2 incidence, and programmatic data. This Spectrum file produces the projected population and number of PLHIV for 2019 which were used as the basis for cascades, pyramid, and RASTA tables.

To determine the number of PLHIV who are aware of their status, on ART, and virally suppressed, Swaziland HIV Incidence Measurement Survey (SHIMS 2) proportions were used and applied to the denominator. In addition to self-reported awareness of status and on treatment status, SHIMS 2 also confirmed these self-report with ARV metabolite testing for all sero-positive participants, and the self-report proportions were adjusted based on presence of ARV metabolites.

SHIMS 2 was a nationally representative Population-based HIV Assessment (PHIA) survey and was designed to estimate HIV incidence and prevalence among adults ages 15 years and older. As such, even though the survey included children 0-14, it was not powered to estimate age- and sex- specific pediatric indicators. Furthermore, the survey was not powered to estimate region level (SNU) estimates needed to calculate region-specific cascades and pyramids.

Two types of cascades were produced:

1) **Unconditional or overall cascades**: uses the PLHIV as a common denominator for all three 95-95-95 pillars and shows the achievement of awareness of status, on ART (treatment coverage), and community viral suppression for all PLHIV. The target for the 1st 95 is 95%, for the 2nd 95 is 90% (0.95 x 0.95), and for the 3rd 95 is 86% (0.95 x 0.95 x 0.95).

Unconditional 1st 95 = $\frac{PLHIV\ who\ are\ aware\ of\ their\ status}{All\ PLHIV}$

Unconditional 2nd 95 = $\frac{PLHIV\ who\ are\ on\ ART}{All\ PLHIV}$ (i.e. treatment coverage)

Unconditional 3rd 95 = $\frac{PLHIV\ who\ are\ virally\ suppressed}{All\ PLHIV}$ (i.e. community viral suppression)

2) **Conditional cascades**: uses different denominator for each 95-95-95 pillar depending on the indicator. The 1st 95 is the same as the unconditional cascade since it also measures the proportion of PLHIV who are aware of their status. The 2nd 95 measures ART uptake among PLHIV who are aware of their status. This is a proxy for linkage to treatment. The 3rd 95 measures virally load suppression only among PLHIV who are on ART. A high value in this pillar is a proxy for treatment success, treatment adherence, low transmission probability among PLHIV on ART, and low probability of HIV drug resistance. The target for all three pillars is 95%.

Conditional 1st 95 = $\frac{PLHIV\ who\ are\ aware\ of\ their\ status}{All\ PLHIV}$

Conditional 2nd 95 = $\frac{PLHIV\ who\ are\ on\ ART}{PLHIV\ who\ are\ aware\ of\ their\ status}$ (i.e. linkage and treatment uptake)

Conditional 3rd 95 = $\frac{PLHIV\ who\ are\ on\ ART\ and\ are\ virally\ supressed}{PLHIV\ who\ are\ on\ ART}$ (i.e. treatment adherence)

The population pyramid shown in Figure 2.1.9 below uses the conditional calculations.

Figure 2.1.7. National unconditional clinical cascade, COP18, Swaziland

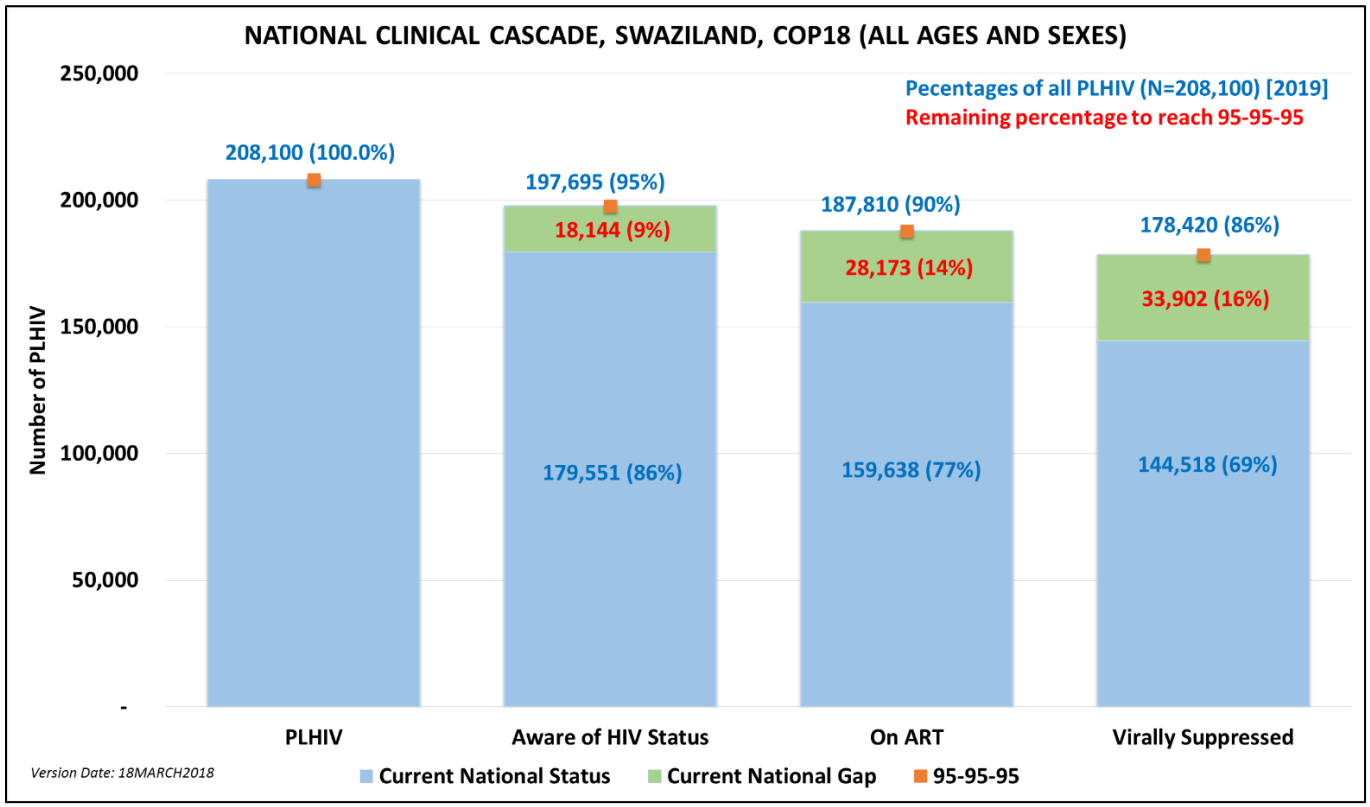


Figure 2.1.7 shows the national unconditional or overall clinical cascade. Nationally, 86% of PLHIV know their status, 77% of all PLHIV are on ART, and 69% of all PLHIV are virally suppressed.

In contrast, the conditional 95-95-95 cascades in Figure 2.1.8 shows the achievement of awareness among all PLHIV, on ART among those who are aware, and viral load suppression among PLHIV on ART.

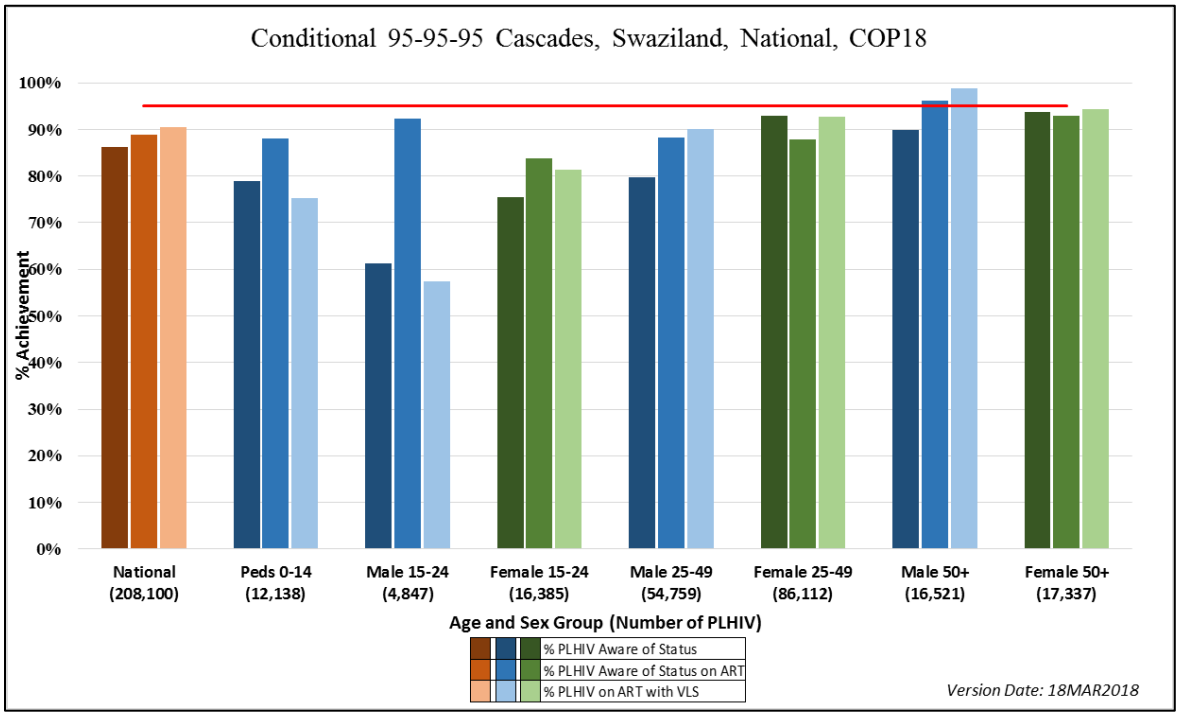
Numbers in parentheses are number of PLHIV for that particular group for volume comparison. This is conditional cascade, so "Aware" is among all PLHIV, "On ART" is among those PLHIV who are aware, and "VLS" is among those PLHIV who are on ART. The red target line is set at 95%, reflecting the 95-95-95 concept.

Nationally, 86% of all PLHIV are aware of their status, 89% of PLHIV who are aware are on ART (representing the linkage rate), and 91% of PLHIV on ART are virally suppressed. This means that once PLHIV are on ART, the vast majority of them are virally suppressed, indicating treatment success and high adherence. Awareness is lowest among males 15-24 (61%), and highest among females 50+ (94%).

"On ART" reflects linkage to treatment among those who are aware of their status. Overall, all groups have at least 80% linkage to treatment, although females 15-24 (84%), and males and females 25-49 (88%) need additional effort to get linked to treatment once they are aware of their status.

"VLS" reflects on how well treatment is working once PLHIV are on ART. High conditional VLS percentages is a proxy for good adherence, low transmissibility, and low potential to develop drug resistance. Among PLHIV ages 25+ who are on ART, at least 90% are virally suppressed. Additional effort is needed to increase viral suppression for children 0-14 (75%) and males and females 15-24 (57% and 81%).

Figure 2.1.8. National conditional 95-95-95 cascade, COP18, Swaziland



Figures 2.1.9 describes the national demographic, disease burden, awareness of status, ART coverage, and viral load suppression by five-year age groups, sex, and region. Using the 2019 projected number of PLHIV from Spectrum, there are approximately 48,462 PLHIV not on treatment, 28,549 (60%) of whom are not aware of their status. The red areas illustrate those who are not aware of status, notable are females 15-34, and males 20-44. National average for aware of status is 87%.

The orange areas denote those who are aware but not on treatment. Women 20-39 have notable gaps for aware but not on treatment.

Yellow represent those on treatment but not virally suppressed, these are small, reflecting the national average of VLS among those on treatment of 91%.

Figure 2.1.9 illustrates the current programmatic gaps which will be addressed in COP18: Finding PLHIV who do not know their status and linking them to treatment, linking those who know their status but currently not on treatment, and maintaining the high viral load suppression among PLHIV who are already on treatment.

Figure 2.1.9. Swaziland national population, COP18, PLHIV & TX_CURR pyramid

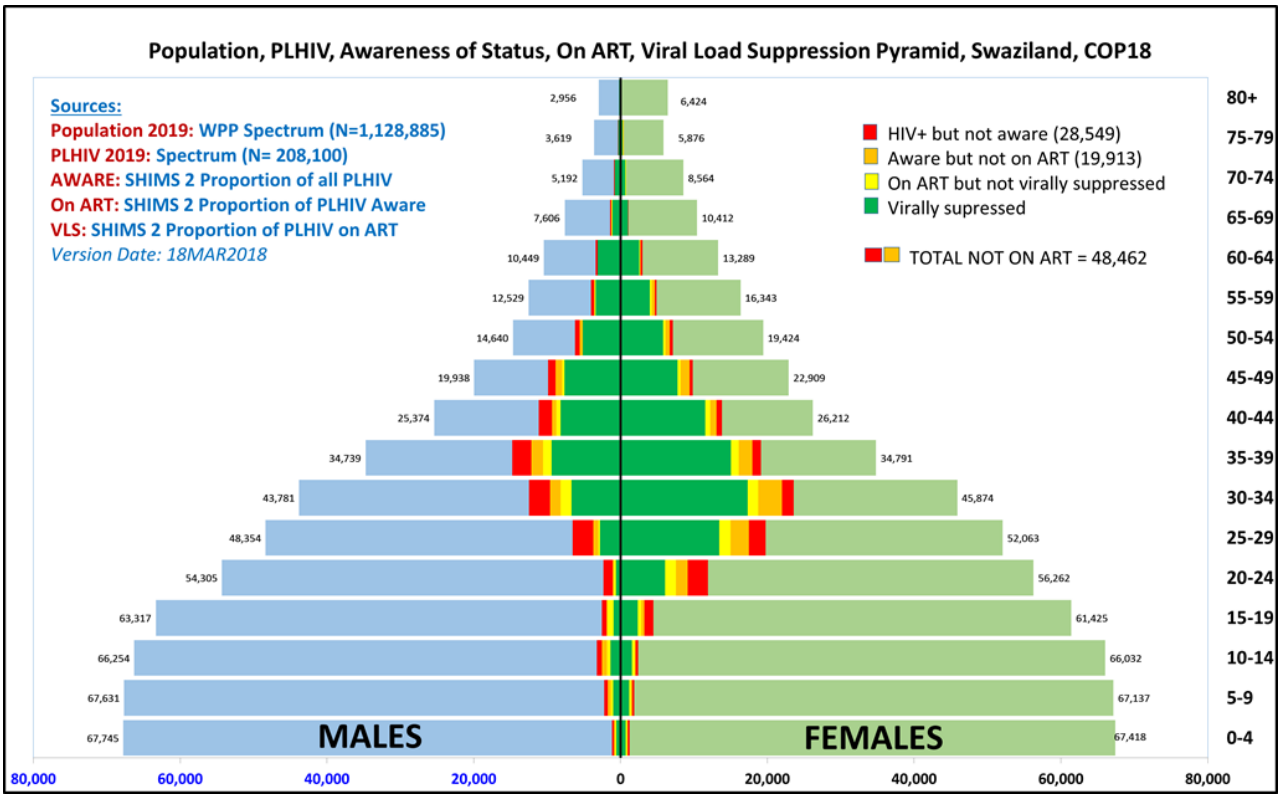


Table 2.1.1. Host country government results, COP18, Swaziland

	Total		<15				15-24				25+				
			F<15		M<15		F15-24		M15-24		F25+		M25+		*Source,*
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	*Year*
Total Population (proj. 2019)	1,128,885	100	200,588	17.8	201,630	17.9	117,688	10.4	117,622	10.4	262,181	23.2	229,177	20.3	A, 2018
HIV Prevalence (%)		27.0*		2.6		3.0		13.9		4.1		41.2		29.9	B, 2017
AIDS Deaths (proj. 2019)	3,180	100	184	5.8	193	6.1	161	5.1	84	2.6	1,268	39.9	1289	40.5	A, 2018
# PLHIV (proj. 2019)	208,100	100	5,540	2.7	6,598	3.2	16,385	7.9	4,847	2.3	103,449	49.7	71,281	34.3	A, 2018
Incidence Rate (per 100)		1.36*						1.87		0.79		1.84‡		1.50‡	B, 2017
New Infections (proj. 2019)	5,877	100	309	5.3	318	5.4	1,728	29.4	252	4.3	1,325	22.5	1,945	33.1	A, 2018
Annual births	26,238	100	12,989	50.5	13,249	49.5									F, 2017
% of Pregnant Women with at least one ANC visit		98.5													E, 2014
Pregnant women needing ARVs (proj. 2019)	9,563														A, 2018
Orphans (maternal, paternal, double)	66,635		9,360[a]		9,790[a]		12,708[b]		13,173[b]		10,783[c]		10,821[c]		A, 2018 E, 2014
Notified TB cases (Yr)	3,806														G, 2017
% of TB cases that are HIV+		70													G, 2017
% of Males Circumcised	125,803	35.1			20495	36			43730	37.6			61,578	28.8	D, 2018
Estimated Pop of MSM*	5,084														C, 2015
MSM HIV Prevalence		17.7													C, 2015
Est. Pop of FSW	12,274														C, 2015
FSW HIV Prevalence		70.3													C, 2015
Est. Pop Females 15-29 years	169,751														A, 2018
Est. HIV Prev. Females 15-29 years		21.2													B, 2017
Est. Pop Males 20-39 years	181,179														A, 2018
Est. HIV Prev. Males 20-39 years		39.0													B, 2017
	**Age 15+* ‡*Age 25-34* [a]*Age0-9* [b]*Age10-14* [c]*Age15-17*														

A. Swaziland Spectrum File (February 21, 2018)	D. Decision-Maker's Program Planning Tool (DMPPT), 2018 end of FY17(the total percentage is for 10-29 years old while the absolute number is for 10-49 years old; the >25 percentage is for 25-29 years old while the absolute number is for 25-49 years old)
B: Swaziland HIV Incidence Measurement Survey 2, 2016-17	E. Swaziland Multiple Indicator Cluster Survey 2014
C. HC3. Characterizing the HIV prevention and treatment needs among key populations, including men who have sex with men and female sex workers in Swaziland: from evidence to action. HC3; 2015 June	F. CIA Fact Book, Swaziland National Population and Housing Census 2017

Table 2.1.2. National 95-95-95 cascade: HIV diagnosis, treatment and viral load suppression, COP18, Swaziland

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate 2019 (#)	HIV Prevalence (%)	Estimated Total PLHIV 2019 (#)	PLHIV diagnosed (#)	On ART as of Dec 2017 (#)	Unconditional ART Coverage (Denominator = All PLHIV) (%)	Unconditional Viral Suppression (Denominator = All PLHV) (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total	1,128,885	27*	208,100	179,551	164,697	77	69	569,239	32,645	23,267
<15 years	396,606	3	12,138	9,572	8,437	70	52	121,602	1,308	1,348
15-24 years	234,598	9	21,232	15,323	13,872	65	47	187,443	7,576	4,245
25+ years	497,679	35	174,730	154,656	142,388	81	73	260,194	23,764	17,323
MSM	5,084[1]	18[2]	900[2]	n/a	n/a	n/a	n/a	1,001[3]	41[3]	31[3]
FSW	12,274[1]	70[2]	8,628[2]	n/a	n/a	n/a	n/a	2,240[3]	200[3]	189[3]
PWID	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Females 15-29	169,751	21[4]	36,529	29,837	26,697	73	60	n/a	n/a	n/a
Males 20-39	181,179	18[4]	36,282	26,477	20,703	57	54	n/a	n/a	n/a
OVC 10-17	188,820[5]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Military	5,000	27	1,350	520	401	29.7	83	1,755	189	198

Age 15+

[1] HC3. Characterizing the HIV prevention and treatment needs among key populations, including men who have sex with men and female sex workers in Swaziland: from evidence to action. 2015.
[2] Swaziland HIV Integrated Bio-Behavioral Surveillance Study (IBBSS), 2010
[3] PEPFAR DATIM Reporting Jan-Dec 2017
[4]Swaziland HIV Incidence Measurement Survey (SHIMS) 2, 2016-17
[5]Swaziland National Population and Housing Census 2017; Swaziland Multiple Cluster Indicator Survey, 2014

2.2 Investment Profile

Funding Landscape: Despite Swaziland's classification as a lower middle-income country, indicators (such as a weak business climate and low foreign investment) reflect a low-income country status that has a high income disparity with 63% of Swaziland's population living below the poverty line. Inequality is very high with a Gini coefficient of 49.5. Over the past year, economic growth has continued to slow down due in part to provisions for drought recovery and a sharp decrease in Southern African Customs Union (SACU) revenues that resulted in price increases for products imported from outside the currency zone. The high HIV and TB prevalence and OVC burden remain major health and social concerns.

Swaziland received approximately US$898.40 million in Overseas Development Assistance between 2011/12 and 2015/16, averaging US$149.74 million annually. The health sector has been the largest beneficiary of external assistance; the HIV/AIDS and tuberculosis (TB) epidemics have received a significant response from global development partners and donors.

Donors support critical areas in HIV/TB care, treatment, and prevention, including direct service delivery, technical assistance (TA), commodities, and human resources (HR). Nonetheless, laboratory support for patient monitoring and the complete rollout of the Client Management Information System (CMIS) require additional funding.

PEPFAR is the largest contributor to the HIV response, followed by GKoS, and then the Global Fund (GF). PEPFAR and GF continue to provide stop-gap support and provision of specific commodities that are difficult for GKoS to procure at the smaller volumes required by the country given that PEPFAR/S and GF are major procurers of reagents and testing equipment at the global level. In COP18, PEPFAR/S will support pediatric ARVs and initial supplies of TLD. GKoS will support all first line ARVs. GF will support all viral load reagents and rapid test kits. At GKoS's 2015 request, PEPFAR/S agreed to supply all the public sector, free and socially marketed condoms for health programs in country. PEPFAR/S is also the main supporter of HIV prevention programming including VMMC, oral PrEP, and comprehensive interventions and services for adolescent girls and young women (AGYW), OVC and key populations.

PEPFAR/S provides support for above site activities to build the capacity of GKoS to collect, analyse and use data for HIV/TB program decision-making. PEPFAR/S investments also include HRH support and development and systems strengthening (CMIS, Laboratory Information System (LIS), Warehouse Management Information System (WMIS), etc.) Please see Section 6.0 and Appendix C. Table 6 for more information on PEPFAR/S support to above site activities.

Table 2.2.1 Annual Investment Profile by Program Area – FY 17
[REDACTED]

Table 2.2.2 Annual Procurement Profile for Key Commodities – FY 17
[REDACTED]

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resource**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding**	**Objectives**
USAID MCH	$0	$0	0	$0	N/A
USAID TB	$0	$0	0	$0	N/A
USAID Malaria	$0	$0	0	$0	N/A
Family Planning	$0	$0	0	$0	N/A
NIH	$3,690,004	$0	0	$0	NIH is conducting four studies in Swaziland: the HIV Prevention clinical trial, Link4Health study, Link4Health HEART sub-study and the Safe Generation Plus study.
CDC NCD	$0	$0	0	$0	N/A
Peace Corps	$1,236,153	$0	0	$0	Volunteer Support
DOD Ebola	$0	$0	0	$0	N/A
MCC	$0	$0	0	$0	N/A
Total	**$4,926,157**	**$0**	**0**	**$0**	**N/A**

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation						
VMMC					$1,304,284	Support VMMC programs for males 10 years and older, including the minimum package of clinical and prevention services
Cervical Cancer – Central Funds					$3,700,000	Provide cervical cancer screening for HIV+ women – the target is 25,000 women annually
Other PEPFAR Central Initiatives						
HIV Drug Resistance Study Dissemination		$20,000				These are HOP16 funds, going into a CDC cooperative agreement in April 2018. These funds will be used for the HIV Drug Resistance analysis and dissemination activities
Comm-Link Evaluation		$211,489				These are HOP16 funds going into a CDC cooperative agreement in April 2018. These funds will complete Commlink (Community-based Mobile HIV-care and Peer-delivered Linkage Case Management Project) evaluation
Peace Corps (GHSP – Central)	$240,236					These are COP17 funds that will be used for Global Health Services Partnership (GHSP) volunteer support
Public Private Partnership		$2,000,000		0	$1,500,000	The objective is to reach 70% of the vulnerable adult population in Matsapha with high impact interventions to improve their health and productivity. The project seeks to increase access to critical prevention, treatment and care services, provide effective information and support for behavior change to reduce risk and vulnerability to HIV/TB; and effectively engage other private sector companies in the HIV response and to increase access to critical prevention, treatment and care services. Funding here represents the life of the 5 year project.
Total	**$240,236**	**$2,231,489**		**-**	**$6,504,284**	

2.3 National Sustainability Profile Update

SID Process:
PEPFAR/Swaziland, UNAIDS, MoH and National Emergency Response Council on HIV and AIDS (NERCHA) jointly convened a one-day Sustainability Index Dashboard (SID) workshop on November 7, 2017. Participants were from the MoH, Ministry of Economic Planning and Development (MEPD), USG agencies, Global Fund supported Country Coordinating Mechanism (CCM) and Principal Recipients, civil society, people living with HIV/AIDS (PLHIV) and private sector representatives, bilateral and multilateral stakeholders, implementing partners and other development partners. Following the review of the sustainability index measurement process, participants broke into four domain subgroups to discuss and complete the SID tool. Representatives from the MoH, MEPD, and NERCHA facilitated each subgroup. PEPFAR/S staff participated in each subgroup. Together, subgroup members agreed on responses, recorded data sources, and documented points of clarification and context. The full group reconvened at the end of the day to review the completed tool, discuss the findings and identify priorities moving forward.

Sustainability Strengths:
Element 1: Planning and Coordination (8.02, light green): NERCHA and the Prime Minister's Office effectively lead the HIV response in Swaziland. Nonetheless, participants agreed that additional efforts are needed to address duplication and gaps among partners. Furthermore, the coordination of the multi-sectoral and community-led response could also be strengthened.

Element 12: Technical and Allocative Efficiencies (8.16, light green): The GKoS effectively analyzes and applies/utilizes relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions.

Sustainability Vulnerabilities:
Element 13: Epidemiological and Health Data (3.96, yellow): Additional capacity is still required for ongoing epidemiologic and monitoring and evaluation (M&E) activities and additional support is needed to continue the roll-out of the CMIS and the use of unique identifiers to track individuals through the prevention and treatment cascades. There is also a lack of a system to standardize reporting for viral load testing at clinics. Results of community-level activities and interventions are not being adequately captured and reported.

Element 10: Laboratory (5.17, yellow): The monitoring of point of care testing (POCT), quality assurance (QA) and quality improvement (QI) needs to be strengthened, particularly at the community level.

Element 7: Human Resources for Health (5.51, yellow): Some cadres that are critical for the attainment of 95-95-95 are still almost entirely donor-funded (such as phlebotomists), which is less sustainable than government-funded positions. There is also a need to continue to rationalize HR numbers and skillsets with client volume at facilities.

Element 8: Commodity Security and Supply Chain (6.90, yellow): Commodity management, especially between hub and spoke facilities, remains weak and, with the rollout of CommART, additional support is needed from PEPFAR this year. PEPFAR will continue to assist GKoS in forecasting and supply planning. In addition, PEPFAR will continue to strengthen government capacity in contracting and financing.

Table 2.3.1. Sustainability Index Dashboard (SID) Vulnerabilities, COP18, Swaziland

Sustainability Vulnerability prioritized in COP18	**Donors Supporting Area**	**Notes**
Epidemiological and Health Data	PEPFAR, UN Agencies	The GKoS, through the MoH and the Central Statistics Office, leads the administration of epidemiological and health surveys and the MoH has complete ownership of some surveillance systems. Nonetheless, PEPFAR and UN Agencies have supported the MoH in conducting various surveys and some of the surveillance systems still rely on donor funding.
Laboratory	PEPFAR, Global Fund, MSF	PEPFAR and the Global Fund support the MoH laboratory though HR support, support for the implementation of a laboratory information system as well as for the procurement of laboratory commodities, and with the sample transportation system. Médecins Sans Frontières (MSF) has scaled back its laboratory support as part of the organization's exit strategy but MSF supports laboratories in the Shiselweni and Manzini regions will end during COP18.
Human Resources for Health	PEPFAR, Global Fund, UN Agencies, CHAI, MSF	Donors provide support in this area with seconding staff to the MoH, offering direct HR support to various levels of the health system, and supporting the pre- and in-service training of health care workers.
Commodity Security and Supply Chain	PEPFAR, Global Fund, CHAI	The donors support the MoH in strengthening supply chain systems including providing technical assistance for the development and implementation of supply chain management information systems to procure ARVs and opportunistic infection (OI) medicines.

Military SID

The Military completed a Military SID (MilSID) in December 2017. The MilSID was conducted over two days at the Army headquarters under the supervision of the Head of the Medical Corp. Senior military and medical program officials participated.

Sustainability Strengths:
Element 3: Planning and Coordination (8.00, light green): The military of Swaziland (Umbutfo Swaziland Defence Force (USDF)) coordinates all HIV/AIDS activities; the central military program is responsible for service delivery at the decentralized unit level.

Sustainability Vulnerabilities:
Element 6: Commodity Security and Supply Chain (MilSID 1.8, red): There is no plan or annually reviewed supply chain standard operating procedure. There is no system within the military to assess quality within the military supply chain.

Element 7: Quality Management (MilSID 0.28, red): USDF does not have any structures or resources to support site level quality improvement (QI). There is no HIV quality management (QM)/QI strategy and no training to build the USDF health workforce competency in QI.

Element 8: Laboratory (8MilSID 2.2, red): There is no military laboratory strategic plan or set of regulations to monitor quality of laboratory services and POCT sites are only partially implemented.

Element 10: Technical and Allocative Efficiencies (MilSID 2.2, red): Information is not available on the process and amount of resource allocation for military health services; most resources (70-80%) are allocated to one site. There is also no system for funding cycle reprogramming; the partner does not use expenditure data or cost analysis to estimate unit costs.

Element 11: Epidemiological and Health Data (MilSID 2.24, red): No HIV/AIDS military surveys or surveillance have been done in the past nine years. No structures, processes or policies are in place to assure that surveillance or survey data quality exist or can be documented.

Element 12: Financial/Expenditure Data (MilSID 1.88, red): No tracking of military expenditure has been done in the past five years. HIV/AIDS expenditure data are not systematically tracked.

2.3.4 Stigma, discrimination, violence and human rights

The PLHIV Stigma Index for Swaziland was published in June 2011. Though there are currently no plans to conduct a PLHIV Stigma Index in COP18, PEPFAR/S remains committed to ending stigma, discrimination and violence for PLHIV in Swaziland. All PEPFAR/S programs include activities to reduce stigma and discrimination to increase access to HIV prevention, treatment and care services for all populations – especially those who are most vulnerable and marginalized, including OVC, AGYW, female sex workers (FSW), and men who have sex with men (MSM) and transgender people. Some of PEPFAR/S programmatic elements that address stigma, sexual and gender-based violence and human rights include:

- Supporting CANGO and its CSO consortium to develop and implement advocacy plans to ensure stigma-free access to services for children and adolescents
- Establishing and supporting a model child-friendly court so that rape and abuse cases can be adjudicated quickly while minimizing secondary trauma to the survivor
- Strengthening community-led initiatives to address deeply rooted social, cultural and gender norms as well as stigma that create barriers to the uptake of HIV services
- Engaging men and traditional leaders including adolescent male mentoring camps (*Lihawu*) to promote positive masculinity and health seeking behaviors. These initiatives are also critical in addressing SGBV, supporting risk avoidance among the 9-14 year old girls and creating a protective environment for AGYW.
- Changing health care workers (HCW) attitudes through transformative sensitization activities during which KP 'ambassadors' and facility staff openly discuss their feelings and experiences regarding stigma and discrimination
- Addressing human rights and stigma with the Royal Swazi Police Force from the national level to field officers to facilitate a comprehensive understanding of KP issues and their human rights. The seminars provide practical ways for police to be aware of stigma and address violence against KPs. Regional and field offices of the Royal Swazi Police have designated a 'KP friendly' officer. These officers can assist KPs when they access police services OR when they engage with police. Additional more targeted KP friendly officer trainings will be conducted in May at 36 top priority stations.

The PEPFAR/S interagency team is actively working to support a sustainable enabling environment for individuals accessing HIV and sexual reproductive health (SRH) services by:

- Developing a plan and timeline to measure, document and mitigate stigma, discrimination and violence in collaboration with relevant sections of the US Embassy in FY18;
- Designating an interagency point of contact to monitor that all PEPFAR/S implementing partners have participated in the Non-Discrimination and Gender & Sexual Diversity Training, which is mandatory; and
- Participating in the inter-agency Gender Equity Working Group at the US Embassy that meets every two weeks and helps raise awareness about gender issues.

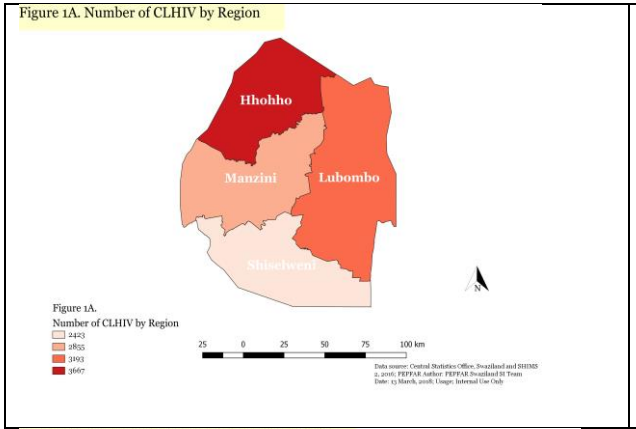
2.3.5 Coordination among US Government Agencies

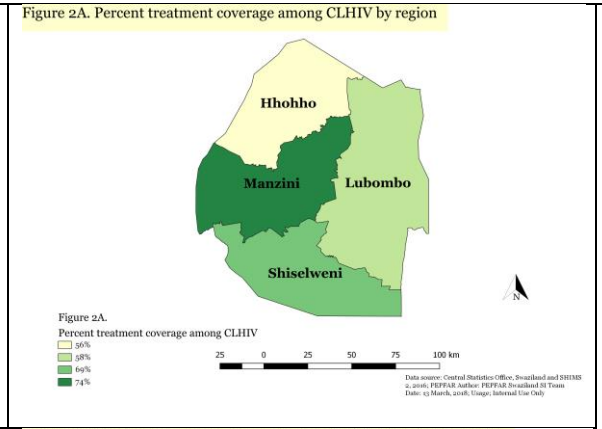
Ambassador Peterson and DCM Lombardo are strong proponents of the whole of government approach to addressing stigma, discrimination, violence, and human rights. The Ambassador and DCM ensure active collaboration between PEPFAR and other USG offices in this regard. In addition, they are actively engaged with the PEPFAR team and they meet with agency heads weekly. As PEPFAR/S is a small team, interagency coordination within PEPFAR/S is facilitated by the close proximity of the team, as everyone sits together in one space within the US Embassy with the exception of Peace Corps. The entire PEPFAR/S team also discusses relevant programmatic updates related to stigma, discrimination, violence, and human rights at their weekly staff meetings.

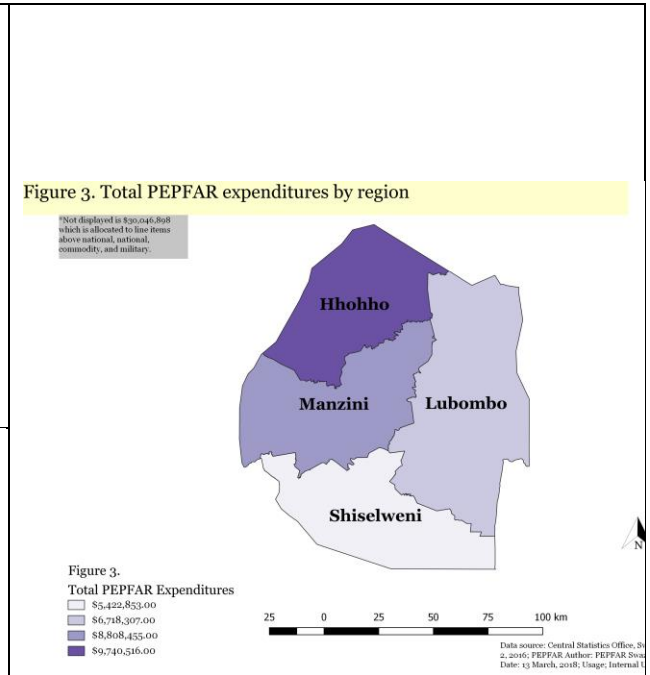
2.4 Alignment of PEPFAR investments geographically to disease burden

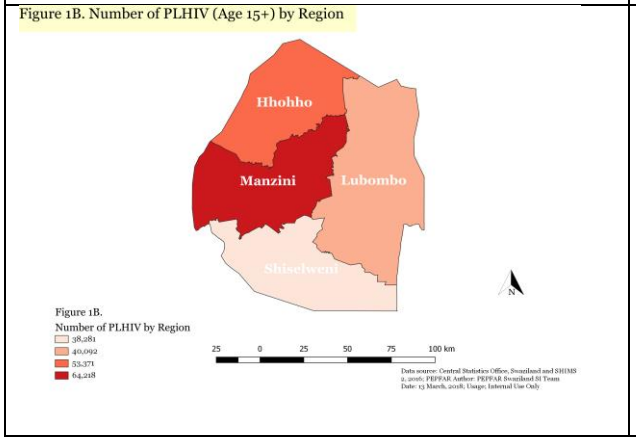
Swaziland has four SNUs. The numbers of PLHIV are consistent with the population distribution and density. Manzini has the highest total disease burden (67,885 CLHIV and PHLIV ages 15 and above) and the highest population; it has the second lowest CLHIV (2,855) and the highest adult PLHIV 15+ (64,218). Manzini is the economic capital and industrial hub and tends to draw the young adult populations with highest incidence. Hhohho follows as the region with the second highest population and the second highest number of PLHIV 15+ (57,038 PLHIV), however it has the highest number of CLHIV (3,667). Lubombo has the third highest populations and third highest burden with 40,092 PLHIV. Shiselweni, the least populated region, has 38,281 PLHIV. Among PLHIV 15+ Hhohho has the highest treatment coverage at 85% followed by Manzini, Shiselweni, and Lubombo with *1%, 77%, and 69% treatment coverage respectively. For CLHIV, Manzini has the highest treatment coverage at 74% while Hhohho had the lowest CLHIV treatment coverage at 56%. The expenditures per region suggest the highest expenditures in Hhohho, the administrative capital, followed by Manzini and Lubombo with Shiselweni having the lowest (MSF supports the most populated cluster in Shiselweni).

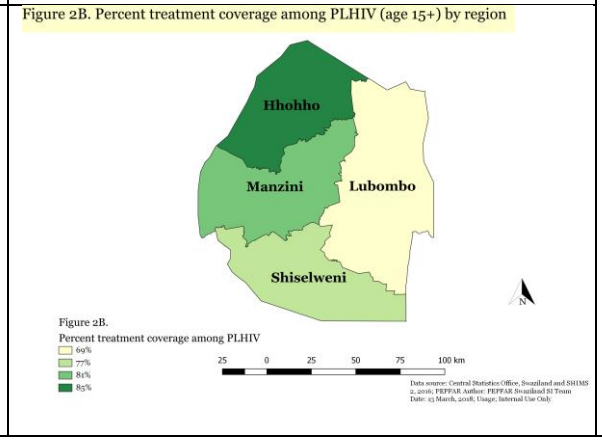
Figure 2.4.1.Map of PLHIV by region, treatment coverage by region, and PEPFAR expenditure by region, 2017, Swaziland











2.5 Stakeholder Engagement

Host country government: PEPFAR/S continues to meet with the Secretary to Cabinet and the Principal Secretary to the Prime Minister on a quarterly basis; and with the Principal Secretaries' Forum representing all Ministries at least once annually to provide a high-level briefing on the overall program and results. In addition, PEPFAR/S holds monthly meetings with the MoH and NERCHA to discuss program priorities and program progress. These meetings are used to present the POART results, COP Guidance, the data pack and targets. PEPFAR/S also met with MoH and NERCHA technical leads to discuss and agree on PEPFAR-supported targets for COP18.

External development partners: PEPFAR/S was actively involved in the GF TB/HIV funding request development in the past year and is continuously engaged with GF to address areas of shared interest, such as commodities, CMIS, supply chain management, AGYW and key populations to avoid potential duplication. Consultations with the Fund Portfolio Manager are ongoing. The Swaziland TB/HIV funding application was submitted to GF in August 2017. Final grant making documents were submitted February 28, 2018. It is important to note that the new GF grant is $20 million less than the current grant. PEPFAR/S is a member of the CCM and a member of the CCM Oversight Committee and shares financial and programmatic information with the GF and CCM members. CHAI, MSF and the United Nations (UN) family are also key PEFPAR/S partners. For example, UNAIDS assisted in convening the SID stakeholders meeting in November 2017 and feedback meetings on COP with the UN family.

Civil Society (CS)/community engagement: PEPFAR/S convened several meetings with Coordinating Assembly of Non-Governmental Organizations (CANGO), the Civil Society umbrella coordination group, to provide updates on the quarterly POART results. Large stakeholder meetings that included civil society (CS) were held in December 2017 and January 2018 to gather input for COP18. PEPFAR/S broadly shared information with CS about the COP18 strategic direction prior to and after the Johannesburg Regional Planning Meeting. Drafts of the Strategic Direction Summary (SDS) were also shared to gain valuable feedback and input from CS.

Private sector: PEPFAR/S currently collaborates with Swaziland Business Coalition on HIV/AIDS (SWABCHA), Swaziland Migrant Mineworkers Association (SWAMMIWA), and companies with male-dominated workplaces (e.g., construction companies, plantations, lumber companies, and mines). PEPFAR/S also has a public private partnership (PPP) with Coca Cola and the Matsapha Town Council (see description below) that could potentially serve as a model to be replicated with other companies in the private sector. PEPFAR/S has had initial discussions with the Royal Swaziland Sugar Corporation to explore potential for future collaborative efforts. PEPFAR/S anticipates expanding existing and new relationships with the private sector in COP18.

PPP between PEPFAR/S through USAID (PSI), Coca Cola and Matsapha Town Council
PEPFAR through USAID (implemented by PSI), has a PPP with Coca Cola and the Matsapha Town Council in Swaziland's industrial hub to increase access to and the use of comprehensive sexual reproductive and HIV/TB services and garner greater engagement of the private sector in

supporting a healthy workforce. Greater Matshapa, with a population of about 70,000, is a magnet for high risk young women and men who are seeking employment in the textile factories and other industries. The PPP operates a mobile clinic and outreach services mostly during evening hours and weekends bringing services close to those with difficult access. Clients that chose HIVST can either receive assistance from staff onsite, complete the test without assistance at the mobile site, or perform the test at home. The nurse or counselor at the mobile unit then confirms test results. Index case testing will be an increased focus for this PPP in COP18.

The following table (Table 2.5.1) outlines PEPFAR/S engagement with CSO and other stakeholders prior to COP18 submission.

TABLE 2.5.1. PEPFAR Engagement with Civil Society Organizations for COP18 and beyond

DATE	Meeting/Communication	Objectives
December 13, 2017	Pre-Regional Planning Meeting (RPM)	• Shared the COP process and timelines • Developed initial strategies (e.g., gender/age pivots, reaching men, and plans for reaching 95-95-95)
January 31, 2018	Pre-Regional Planning Meeting	• Shared the COP process and timelines, final tools and guidance • Reviewed priority population strategies, e.g., AGYW, reaching men, as well as plans for reaching 95-95-95
February 28, 2018	Post-RPM in Johannesburg	• Meeting with MoH, NERCHA and implementing partners to share RPM out brief and to discuss the Disaggregate Tool process • Key findings were sent to all stakeholders via email with the out brief presentation, AMB Birx plenary presentation, and the presentation from feedback meeting for those who could not attend • The on-going timeline for COP18 was included with a request to review the SDS prior to submission.
March 9, 2018	Pre-COP Submission and before DC Approval meeting	Share draft SDS with Stakeholders for review and feedback
TBD	Post-DC Approval meeting	Communicate the outcome of the COP submission
On-going	Quarterly POART meetings	POART feedback

3.0 Geographic and Population Prioritization

Table 3.1 Current Status of ART saturation, December 2017				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP18**	**# Current on ART (FY17)**	**# of SNU COP17 (FY18)**	**# of SNU COP18 (FY19)**
Attained	n/a	n/a	n/a	n/a
Scale-up Saturation	208,100	164,697	4	4
Scale-up Aggressive	n/a	n/a	n/a	n/a
Sustained	n/a	n/a	n/a	n/a
Central Support	n/a	n/a	n/a	n/a
TOTAL	208,200	164,697	4	4

Table 3.2. National conditional 95-95-95 RASTA, Swaziland

	Aware		On ART		VLS	
	Male	Female	Male	Female	Male	Female
0-4	79		88		75	
5-9						
10-14						
15-19	76	72	93	87	54	83
20-24	45	77	91	83	63	81
25-29	57	88	82	86	93	90
30-34	77	93	85	85	82	92
35-39	82	94	87	90	89	93
40-44	84	95	94	93	93	95
45-49	90	96	90	87	96	95
50+	90	94	90	88	99	94
Total	**80**	**91**	**90**	**88**	**91**	**92**
*SHIMS2 not powered for age-sex disaggregated estimates						
GREEN	≥95%	YELLOW	75-94%	ORANGE	50-74%	RED

Table 3.3. Unconditional Treatment RASTA by age, sex and region, Swaziland

	Manzini		Hhohho		Lubombo		Shiselweni		National		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
0-4									70		
5-9											
10-14											
15-19	52	75	73	48	72	82	74	64	64	64	64
20-24	43	64	40	82	32	55	95	58	48	65	62
25-29	36	75	54	80	38	75	81	71	46	76	69
30-34	63	78	57	95	37	66	60	78	55	82	73
35-39	70	97	69	95	49	85	52	76	62	92	79
40-44	75	96	98	95	58	82	66	91	75	92	84
45-49	75	96	66	92	50	92	71	90	66	93	80
50+	85	99	86	99	75	93	85	89	83	95	91
Total	**68**	**86**	**70**	**92**	**52**	**78**	**71**	**77**	**65**	**84**	**77**

SHIMS 2 not powered for regional, age, sex specific estimates

GREEN	≥95%	YELLOW	75-94%	ORANGE	50-74%	RED	<50%

Source: SHIMS 2 Proportions, 2016-2017

Overall, none of the regions have been saturated with ART. Similarly, VMMC coverage for males ages 15-29 is not yet at saturation. Please see population pyramid above, RASTA tables, maps, and clinical cascade in Section 2.

VMMC coverage of males all ages at the end of FY17 is 46%. Geographically, from SHIMS2 data, men 15+ is highest in Manzini at 29%, followed by Hhohho and Lubombo at 26.6% and 25.7% coverage, respectively, with Shiselweni having the lowest coverage at 22.9%. Among the target age bands 15-29, SHIMS2 self-reported data show that 29% of males ages 15-24 and 17% of >25 year olds have been circumcised.

A. Analysis of SNU performance and need

The PEPFAR/S SNUs are the four regions: Manzini, Hhohho, Lubombo and Shiselweni. Lubombo and Shiselweni are predominantly rural regions, whereas Manzini and Hhohho have higher population density and are more urban.

Manzini

Manzini has the highest population with the most densely populated areas of the country in the Manzini/Matshapa economic and industrial areas. It also has the highest number of PLHIV 15 years or older. As noted previously, the industrial areas draw many young men and women from other regions as they seek employment. These areas are also known hot-spots for sex workers and MSM. Other areas in Manzini Region have lumber and mining activities that attract men for employment, and subsequently the women who follow them. Services with extended hours and specific activities to engage men cater to those employed in factories or male-dominated jobs in this region. Active

promotion among men for testing, HIV services and outreach for testing and linkages (ARROWS Project) as well as accelerated KP case finding is prioritized in this region.

Hhohho

The Hhohho region is the second most densely populated region, with the second highest number of PLHIV 15+ and the highest number of CLHIV. While the adult treatment coverage is high at 85%, the treatment coverage among children is low (56%). The northern and western areas of Hhohho are dominated by logging, citrus farming and small scale industries that attract men. The main border crossing at Oshoek is a large truck stop with transient men and women. There are also a number of known hotspots in Piggs Peak as well as along the Mbabane-Manzini corridor. Finding the missing, linking them to treatment and retaining them in care will be reinforced through intensive community and male engagement (HC4). Extended hours, leveraging the DREAMS/OVC platforms and active case finding and outreach with KP groups.

Lubombo

As a primarily rural region, Lubombo has less population density and greater levels of poverty, food insecurity, a higher burden of OVC and female-headed households and where access to services and transportation are difficult. As a reflection of need, only 52% of the population in this region has access to safe water compared to the urban regions who have closer to 80%. This level of poverty impacts people's ability to seek health services at facilities and thus there is a greater reliance on mobile services reaching the hardest to reach (TLC) and through community engagement and outreach. Lubombo has the lowest percentage of PLHIV on ART, so community testing and linkage (ARROWS Program) and differentiated models of community ART (CommART) are prioritized in this region.

Shiselweni

Shiselweni is the poorest region in Swaziland and it is a primarily rural area similar to Lubombo. Like Lubombo, Shiselweni has a high burden of food and water insecurity. Much of the population in Shiselweni have very difficult access (deep rural and poor), however other areas have concentrations of high risk populations including recent growth of textile factories that attract women seeking work, and the main truck route to the Durban Port and its border crossing, at Lavumisa, is a hot-spot and has dynamic and a transient population. Mobile services and outreach to the poorest populations with limited access to testing and linking them to treatment along with focused programming with extended hours in new industrial and hotspot zones will be prioritized as well as leveraging the OVC and DREAMS efforts to link these priority populations to testing, treatment, and social services.

DREAMS

The 19 DREAMS tinkhundla cut across all regions and include deep rural areas, seasonal plantations and wood pulp factories, and textile and industrial areas. DREAMS provides an important platform for preventing new infections and reaching 95-95-95 by reaching OVC and AGYW with a comprehensive package of services including SRH and HIV testing and referrals for both treatment for PLHIV and to prevention services for negatives. A number of other ongoing outreach and mobile service delivery mechanisms can be effectively leveraged to find the hard to reach, link the missing to treatment as well as to high impact prevention services in COP18. In 25 tinkhundla, inclusive of the 19 DREAMS tinkhundla, men ages 15-39 will be reached with a package of evidence-based interventions and actively linked to testing and HIV services, including treatment for PLHIV and VMMC for HIV negative. Traditional leaders will be engaged to encourage men to access testing, treatment and prevention services.

B. *Population Analysis*

PEPFAR/S uses a population and location-based approach to respond to the different needs of the people at risk, and through their communities empower them to make informed choices about different prevention options at different stages during their life. HIV testing is an important gateway to accessing critical HIV prevention services as well as treatment. The PEPFAR/S program's priority populations (PPs) for prevention: AGYW ages 9-29, men ages 15-39 and OVC along with KP (MSM, FSW and transgender people) have been identified as those populations most vulnerable to HIV infection based on epidemiologic, socio-economic and contextual factors. The population pyramid (Figure 2.1.9) demonstrates by age band and sex those who are currently negative and require a tailored package of services and interventions to keep them negative[4], and PLHIV not on treatment and need to be linked to treatment.

Priority populations will access HIV testing, treatment and prevention services, such as same-day treatment through DREAMS, OVC programming KP, community and male engagement interventions, and community mentor mothers.

Coverage of VMMC remains low and men are lagging behind women in treatment primarily due to low uptake of health services. In all regions, less than half of the men who are HIV infected between the ages of 20-25 years know their status. Additionally, men lag behind women in knowing their status in each age band.

Analyses of the above data, population pyramid and RASTA tables identified two focus populations to achieve 95-95-95: females ages 15-39, and men greater than 20 years old. Sixty two point five (62.5%) of all new infections are from females ages 15-24 (29.4%) and males >25 years old (33.1%). These populations, along with OVC, must be targeted with comprehensive HIV prevention and treatment services. AGYW, ages 15-24, have low ART coverage (68.3%) and viral load suppression (47.1%). There are a significant number of women over the age of 20 years that know their status

[4] See section 4.2 for description of the age sex segmented packages of services

but are not linked to treatment. There are several possible reasons why some women may know their status but are not on treatment. These include: some were likely above the CD4 threshold for ART initiation when the country was still implementing Option A for PMTCT before Test and Start was implemented nationally; poor information regarding treatment availability irrespective of CD4; stigma; and limited access to health care. The majority of those over 50 years are aware of their status, on ART and virally suppressed. Similarly, high ART coverage is observed for men over 50 years.

To continuously improve the effectiveness of community-based programming in COP18, PEPFAR/S will routinely analyze epidemic patterns by age, sex and, where possible, by location, as well as the primary modes of transmission and underlying behavioral and structural factors among sub-populations. Engagement with local government, traditional, and religious leaders is important to support and coordinate effective interventions and services for priority populations and it remains a pillar of the PEPFAR/S program for a sustainable HIV response.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

Table 4.0.1. Summary of national policy and guideline changes, FY18, Swaziland

Policy/Guideline	Status	Comments
Test and Start	Adopted and implemented in 2015	Same day initiation is now offered to all patients testing HIV positive.
PrEP Framework	Three demonstration projects are underway	PrEP will be scaled up and integrated into other clinical services in COP18, targeting broader populations than those covered by the demonstration projects.
Multi-month prescriptions	Three month prescriptions have been implemented for stable patients in many facilities. Scale up nation-wide should be complete by the end of 2018.	Clinicians can prescribe medications for a maximum of six months but dispensing is still limited to three months as the MoH is reviewing the feasibility and systems barriers to multi-month dispensing of greater than three months. Other interventions include community adherence groups (CAGs), community distribution points and fast-track visits (pharmacy-only visits for those who need ARV refills) for stable patients at health facilities.
TLD transition	The final TLD transition plan will be approved in April 2018.	The nationwide transition to TLD will occur in two phases. A phased approach was decided upon to allow for clear communication with healthcare workers, development of in-country learnings, and commodity availability security.
Core Package for HIV Prevention: Guidelines for Implementers	The guidelines were launched on WAD 2017	The Core Package for HIV Prevention Guidelines provide normative guidance for age sex specific prevention interventions and services. They are the basis for the design, implementation and monitoring of the coverage of combination HIV prevention interventions for priority and key populations.
2018 Integrated HIV Management Guidelines	The guidelines have been finalized and are being printed for launch and dissemination in April 2018.	The updated guidelines provide new guidance on HIVST, PrEP, and the package of care for late presenters. The guidelines also highlight the country's decision to include dolutegravir as part of ART. Further, the integrated guidelines now include non-communicable disease management and the prevention component.

4.1 Finding the missing, getting them on treatment, and retaining them

This section addresses overarching testing and treatment and care interventions including TB/HIV. The main program objective in COP18 is to find the missing, link them to treatment, ensure they are retained in treatment, and are virally suppressed. The missing are defined as those PLHIV who are not aware of their status and must be identified through targeted testing strategies and those who are aware of their status but are not on ART. The latter will require a different approach to get PLHIV who are aware of their status but are not on ART to be retained in treatment services.

I. Present Situation

Figure 4.1.1. National unconditional cascade, all ages and sexes, COP18, Swaziland

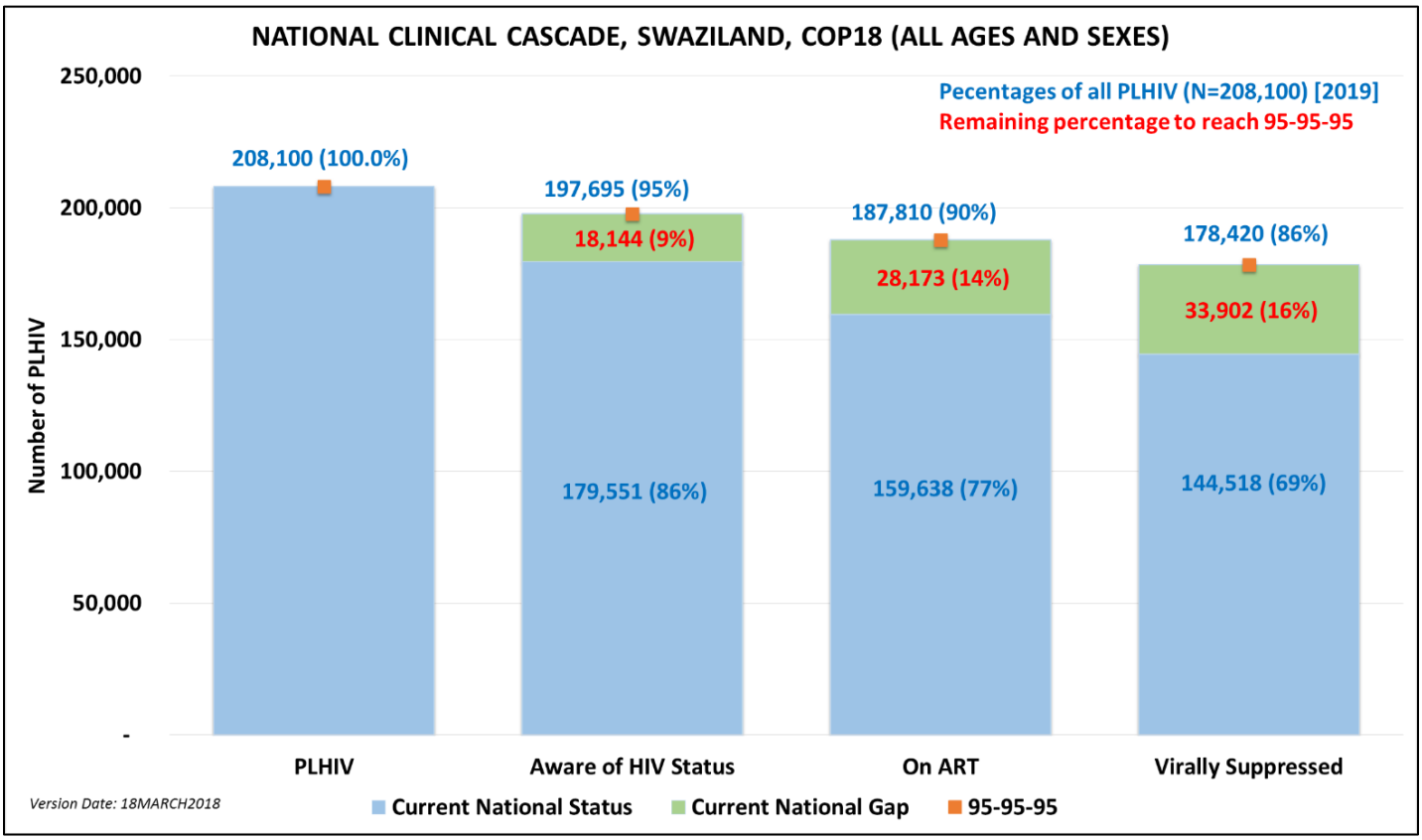
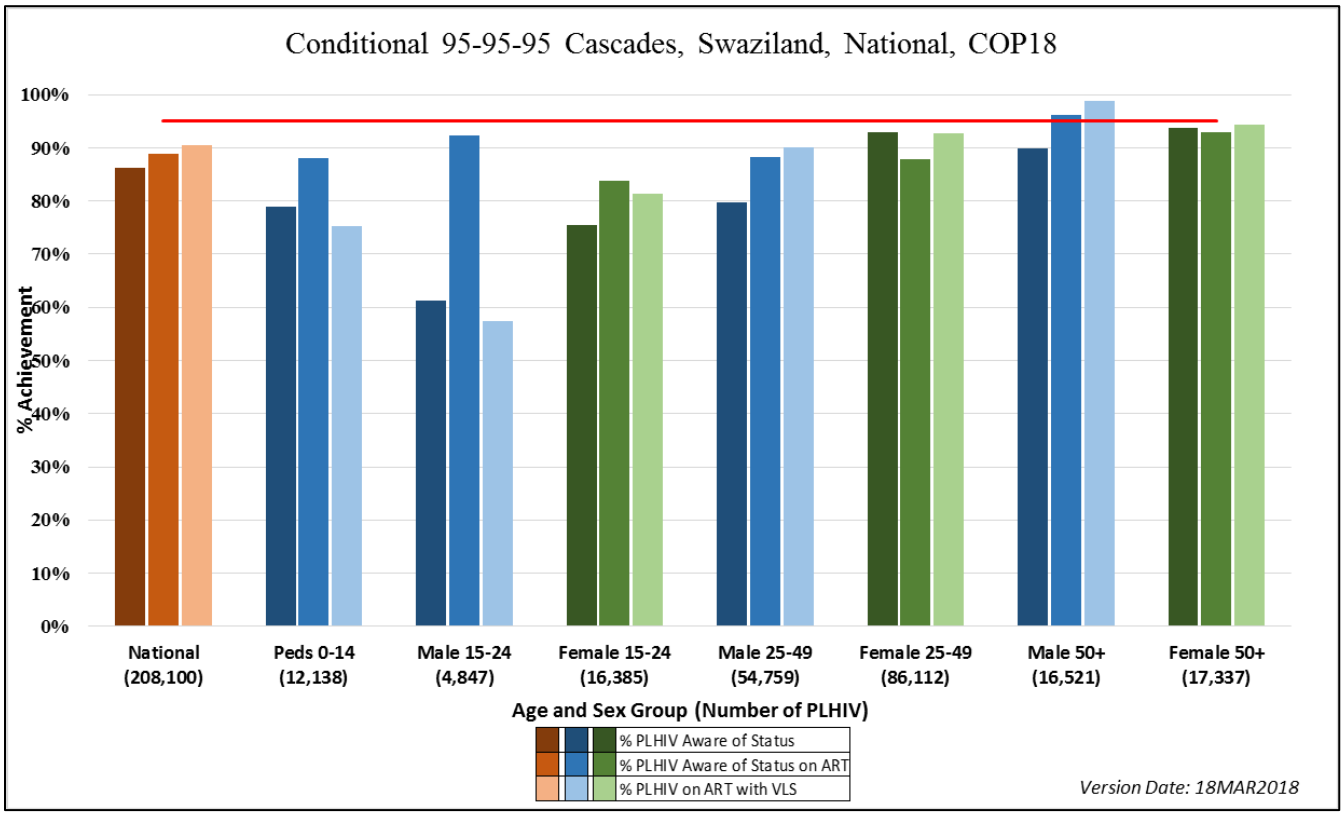


Figure 4.1.2. National conditional cascade, all ages and sexes, Swaziland



II. Approaches

A. Testing

Table 4.1.1. Summary of age and sex-specific HIV testing interventions, COP18, Swaziland

Targeted Population	Testing Approaches
Children (≤ 14 years)	• Testing of children as part of index case testing – to identify children older than two years (From all entry points) • EID at six weeks (95% coverage), 12 and 18 months • Under five Clinics including malnutrition bays in health centers and hospitals • Pediatric inpatient and outpatient departments • Prevention of Mother to Child Transmission (PMTCT) services • HIV risk screening and HTS referral through the OVC program
AGYW (15 -29 years)	• Mobile testing in the DREAMS and OVC platforms (DREAMS on Wheels) provided in combination with comprehensive SRH and family planning services • ANC, PNC and family planning clinics • Index case testing of male PLHIV 20-35 years (PLACE Study)* • Unassisted and assisted HIVST through the peers DREAMS platform • Index case testing of ART patients with high viral loads • Testing in tertiary institutions
Young Males (15-24 years)	• Peer driven testing using the index case platform • Testing at TB clinics – as a lot of males present late and are diagnosed in these clinics • Testing of presumptive TB clients (Male: female ratio is 2:1) • Distribution of HIVST kits by active case finders (ACFs) in the community to all presumptive TB clients • HIVST distribution through AGYW tested in DREAMS and other platforms (e.g., VMMC) • Index case testing of ART patients (high priority for clients with high viral load)
Adult Females (30 -49 years)	• Index case testing of male PLHIV diagnosed in OPD, TB clinics, standalone VCT and mobile sites. • HIVST distributed via the index case testing platform • Family planning clinics • Index case testing of ART patients (high priority for clients with high viral load) • Referrals for HTS for female OVC caregivers through the OVC program
Adult Males (25 -49 years)	• Index case testing of female PLHIV attending ANC, PNC and family planning clinics • HIVST distributed via the index case testing platform • Testing of presumptive TB clients (male: female ratio is 2:1) • Distribution of HIVST kits by ACFs in the community • HIVST distribution through AGYW tested in DREAMS and other platforms (e.g., VMMC) • Index case testing of ART patients (high priority for clients with high viral load)
Key Populations (FSW, MSM)	• Index testing through Enhanced Peer Outreach Approach • HIVST through Mobile and Outreach • HTS at venue-based pop-up service delivery sites (e.g., Hotels, Bars) • HTS at venue-based KP-friendly drop-in centers • Community-based HTS

**PLACE Study: https://www.measureevaluation.org/resources/publications/tr-17-168*

Figure 4.1.3. Entry points and modalities by sex, APR 17, Swaziland

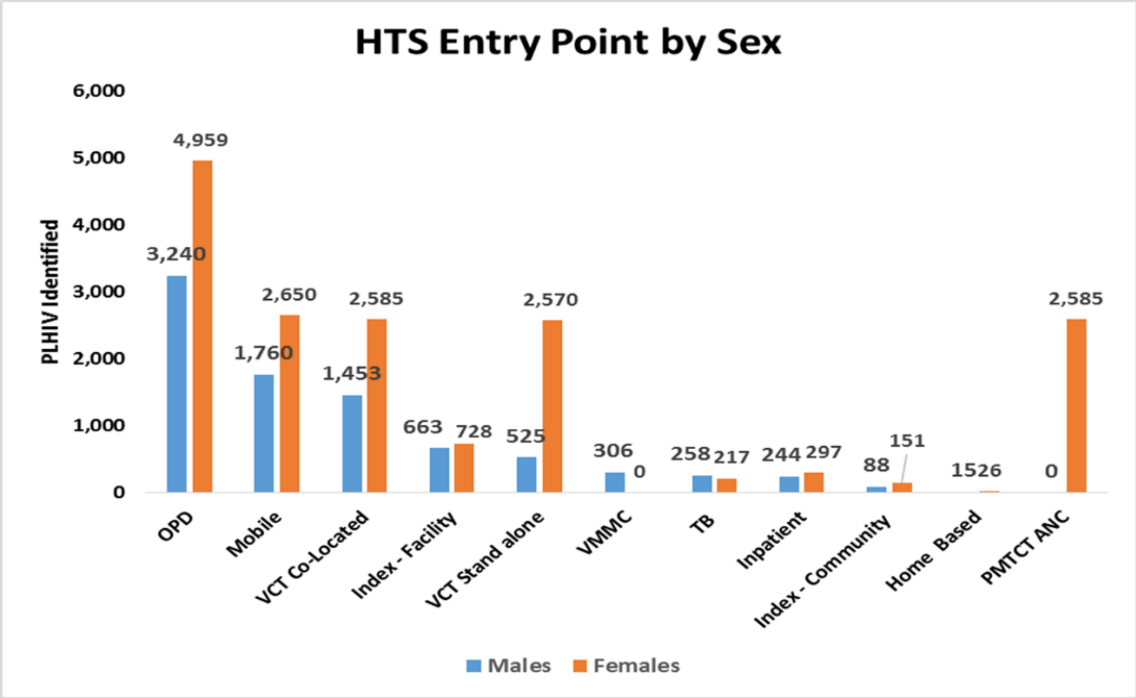
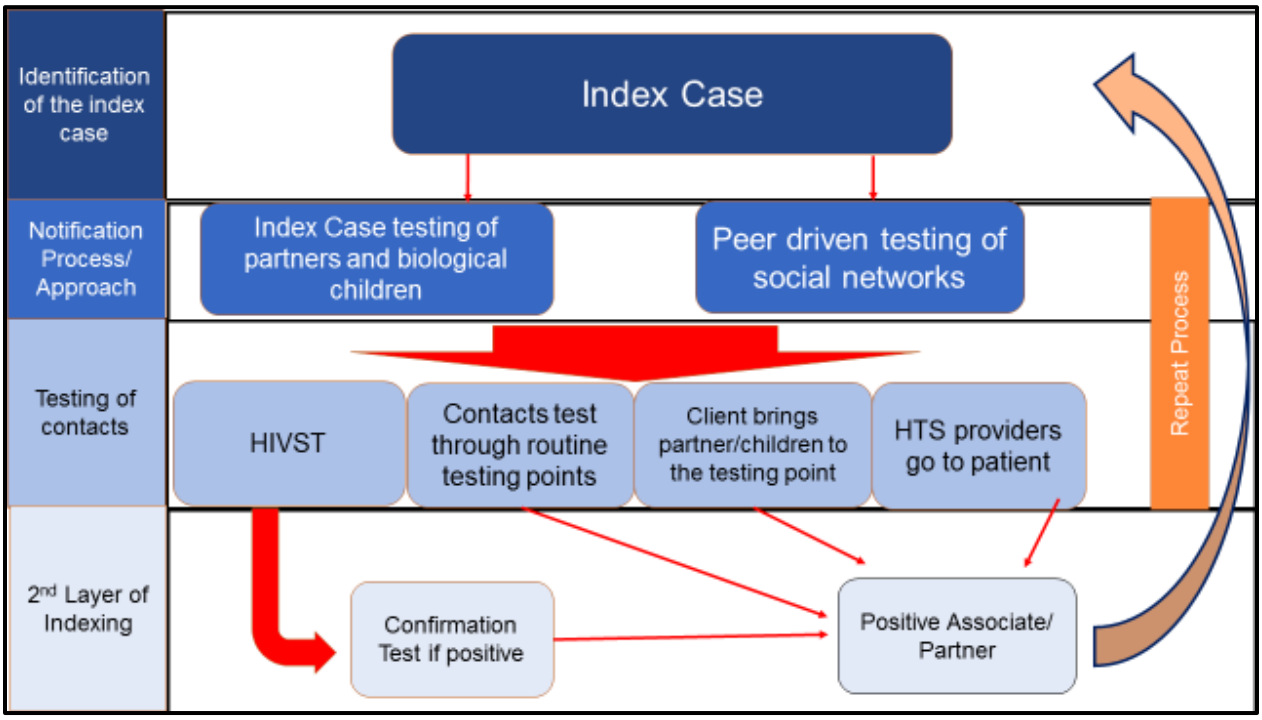


Figure 4.1.3, above, shows that index case testing in the facility and community entry points at the end of COP16. Standalone VCT appears to appeal to women as an entry point and PEPFAR/S is continuing to evaluate innovative ways to expand this modality.

Key targeted testing approaches, which will continue to be implemented in COP18, are shown above in Table 4.1.1. Index case testing and HIVST are integrated into existing testing modalities that have consistently been effective at HIV case identification. These newer approaches will improve the case finding among males, children, young people and key populations who are not reached by current testing approaches. Index case testing is currently being scaled up in COP17.

Figure 4.1.4. Approach to index and peer-driven testing to find the missing, Swaziland



In COP17 Q1, index case testing accounted for approximately 1% of all HIV tests. Index case testing identified 5% of PLHIV with a positivity rate (HTS_TST_POS yield) of 17%. In COP18, with the scale up of index case testing, approximately 36% of all PLHIV will be identified through index case testing. This will ensure that males make up at least 55% of all PLHIV identified in Swaziland. As the majority of PLHIV on ART (66%) and the majority of PLHIV identified through standard testing approaches (60%) are females, index case testing of their partners should identify more male PLHIV. For males who were identified as index cases in the CommLink project in Swaziland, it was shown that using a peer-driven approach to reach their social contacts had high yields of case finding, so PEPFAR/S will leverage this platform to identify more males and report them under community-based and mobile HIV testing modalities. Those clients who are identified as HIV negative via all testing approaches will be linked to appropriate prevention services. Prevention services include VMMC for HIV negative males and PrEP for HIV negative clients at significant risk, including those in sero-discordant relationships.

1. **HIV Self testing (HIVST)**
   HIVST is an approach that was piloted through support from UNITAID in COP16 and 17. Scale up will be begin in COP17 and be completed in COP18. It will be a key strategy in the testing of hard-to-reach populations and is a powerful tool for exploring sexual and social networks (using peer driven approaches to distribute self-test kits). HIVST remains a screening test and all positives will be confirmed using the national rapid testing algorithm. Swaziland will use both assisted and unassisted HIV self-testing approaches. HIVST will be used in index case testing to reach sexual networks and social networks, in testing of key populations employing a peer

driven approach and will also be distributed to specific populations to improve case finding, for example, the partners of pregnant women and AGYW, through male dominated industries, as well as the uniformed services. HIV self-testing (HIVST) has the potential to increase access to HIV testing, especially for young people, men and key populations. HIVST is particularly appropriate and acceptable for AGYW and has been shown to increase the uptake of HIV testing among adolescent females and males.

2. Innovative New Testing Approaches

a. Guided Peer Network Referral

Identification of young people infected with HIV who do not know their HIV status or who have dropped out of care is a particularly compelling public health challenge in Swaziland. Epidemic control will not occur without successful reduction in HIV incidence among young people. To access youth and particularly young men we will use voluntary partner referral and peer network referral to identify young men/youth who are infected but do not know their status or who are not yet in treatment. According to the recent PLACE study in Swaziland, only 18% of young men and women with a sexual partnership in the past 12 months were living with the sex partner. Consequently, it may be unlikely that standard partner referral among young people in Swaziland would reveal a large proportion of sexual partners. Disclosure of HIV status is more difficult among adolescents and their partners and makes their heightened vulnerability and powerlessness a greater safety concern. Over 20% of adolescent girls and over 40% of young women in the PLACE survey reported that their male partner was five or more years older.

To increase access to HIV infected youth and particularly young men, we will use peer recruitment from risk networks. The proportion of new infections among young people is likely to be higher than among older people, consequently the peer networks of young people infected with HIV may offer a strategic opportunity to identify people who do not know they are infected. Those identified as having a recent infection through the use of the recency assay will be prioritized.

Adolescents and young men in the target age range who are HIV infected or who report a large number of sexual partners will be offered education about HIV and risk behaviors and asked to recruit their at risk peers. Each of the "seeds" will be provided with coupons for recruiting 4 of their peers. They will be given the option to recruit the person themselves or have a member of an implementing partner assist in recruitment. The options for the level of incentive provided to each recruiter will be explored. Respondent driven sampling usually provides an incentive at the level of the cost of a lunch. By engaging young people who are infected as well as young people who are not infected, we hope to allay stigma of being associated with participation.

WHO recommends HIV testing by trained lay providers or peers. Providing linkage to counseling and treatment services are considered as part of HIV testing services, as adolescents may find it more difficult to handle an HIV-positive diagnosis, disclose to

partners and may need more assistance in accessing and adhering to treatment. Linkage to effective prevention services for AGYW who test HIV negative will ensure they remain uninfected. Adolescent boys and young men who test negative will be linked to VMMC services. HIV testing services integration with SRH services will be strengthened, as those services are an important way to reach young women and men with HIV testing services.

b. "Pop-Up" VCT

"Pop-up" VCT will provide semi-static VCT services for a period of approximately 1-3 months in an attempt to saturate the area. These semi-static sites will be located near commercial centers, pharmacies or private facilities with high traffic. Pop-up VCT will be chosen based on where high density of adults in the target age ranges. Each "Pop-up" will remain at a site for as long as client uptake remains at least 3 HIV positive newly diagnosed tests per day or an average weekly yield of over 10%, but not exceeding three months. Three of the five mobile units branded New Start will be dedicated for ''pop-up'' outreach. The staff of the Pop-ups will work closely with the local community councilmen and other opinion leaders to encourage testing. The strategy will reach men and women who might not go to facilities for an HIV test. All regions of the country will be targeted for the intervention, but initial work in FY18 will start in Lubombo and Shiselweni. Two counselors will be placed in each Pop up unit to conduct HTS. Expert clients will be required to link clients who test HIV positive to treatment in health facilities. Data from the ''pop-up'' outreach intervention will be monitored closely to facilitate a move to another location when saturation has been reached within stations. The counselors will conduct proactive outreach in the community. A permanent VCT site may be established at stations where the number of positives are high consistently during the ''pop-up'' period. The ''pop-up'' sites will remain open late to individuals who may otherwise not go to a public sector sites.

B. Linkage Approaches

Figure 4.1.5. National PLHIV not on ART, Swaziland

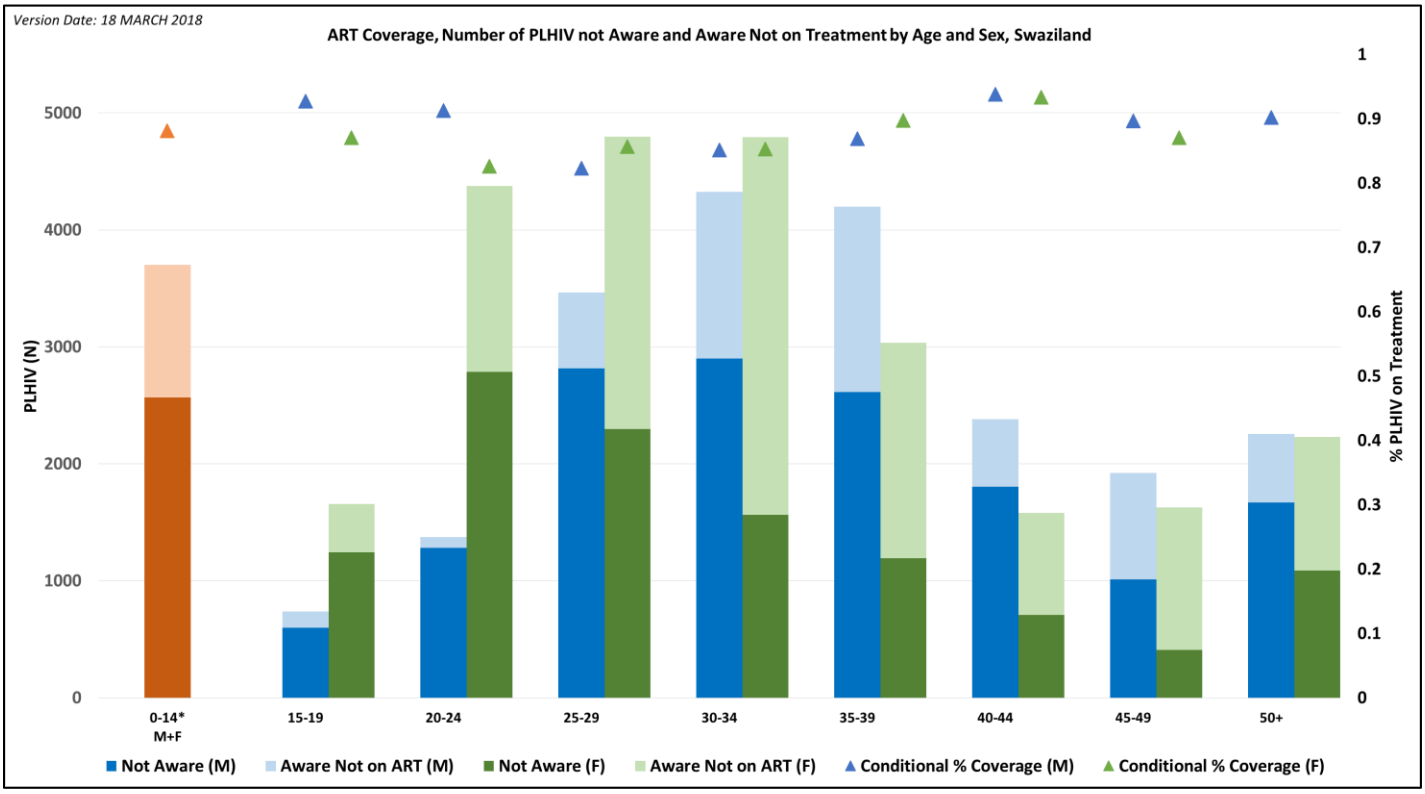


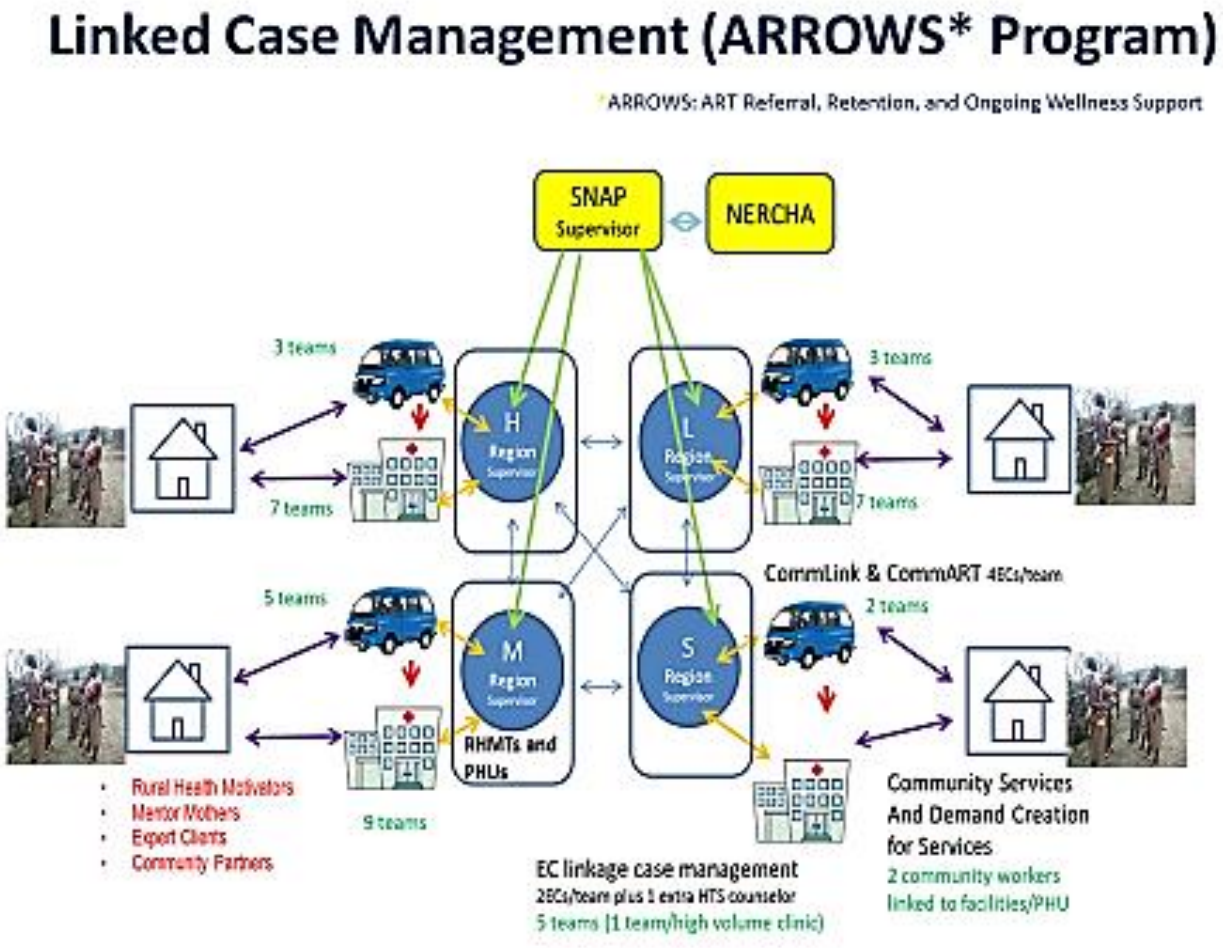
Table 4.1.2. National PLHIV, not on ART, Swaziland

	Not Aware (M)	Aware Not on ART (M)	Not Aware (F)	Aware Not on ART (F)	Conditional % Coverage (M)	Conditional % Coverage (F)
0-14*	2,566	1,135			88%	
15-19	600	139	1,242	417	93%	87%
20-24	1,281	92	2,787	1,590	91%	83%
25-29	2,814	652	2,297	2,500	82%	86%
30-34	2,898	1,427	1,565	3,228	85%	85%
35-39	2,615	1,586	1,192	1,843	87%	90%
40-44	1,805	577	710	872	94%	93%
45-49	1,011	911	408	1,219	90%	87%
50+	1,669	584	1,089	1,142	90%	88%
Total	17,259	7,103	11,290	12,811		

Figure 4.1.5 above shows the missing by sex and age bands. The dark blue and green shade represents those that are not aware of their HIV status and will be found through targeted HIV testing interventions while the lighter shades represent those who are aware of their HIV status but are not on ART and these will be reached through communication interventions and community based mobilization strategies.

1. **Scale-Up and Expansion of CommLink-ARROWS Program**
   In COP18, PEPFAR/S will continue to roll-out the ARROWS (ART Referral, Retention, and Ongoing Wellness Support) program that was an innovation in COP17. ARROWS is an expanded and adapted version of the successful CommLink program (See Appendix E for details).

Figure 4.1.6. ARROWS schematic, Swaziland



The program engages the MoH, GKoS Regional Health Management Teams (RHMTs), PEPFAR clinical and community partners and PSI. The Clinical Partners' role is to optimize linkages with the health facilities (e.g. outpatient departments to ART clinic), assure that no opportunity for testing the appropriate client is lost, and through expert clients provide the support needed for ART

initiation, retention and index testing. PSI's role in ARROWS is to provide quality CBHTS services across the four regions of Swaziland, using targeted, community-based approaches to identify HIV-positive individuals and expanding CommLink services to ensure identified clients successfully initiate ART and are retained in facilities. The ARROWS program adopts and integrates the most impactful interventions of the CommLink program for linkages to treatment, particularly the use of expert clients to ensure linkage and client support strategies. Implementing CommLink for over three years, we know that expert clients are most effective in improving linkages from community to health facility; expert clients assist newly diagnosed clients to navigate the health system; act as models of care for all newly diagnosed clients; and support them for a period of up to 90 days after diagnoses. This process enables clients to attend their appointments in facilities without being stigmatized. The relationships and trust they build with the client is crucial for retention but also builds trust for assistance with index testing.

Both the MoH and PSI work with the Regional Health Management Teams (RHMTs) to ensure ownership and locally relevant decision making for HIV programming. ARROWS' success is based on the idea that strong linkages between the community, facilities, and regional authorities is critical in ensuring epidemic control. ARROWS also maintains an emphasis on linkages to prevention, through actively linking men who test negative to link to medical male circumcision (VMMC) services.

In Year One of the program, we learned that:

1. The best way to find undiagnosed HIV positive individuals is through recently diagnosed HIV positive people.
2. For community-based HIV testing and counseling (CBHTC), stand-alone sites have high yield and clients utilize services more when ART services are provided within the same location.
3. HTS outreach teams need to update their strategies weekly to find more PLHIV.
4. For CBHTC, afternoon and evening hours are the best times to find undiagnosed PLHIV, but the hardest times to link effectively to ART – hence the value of the Matsapha New Start clinic with its later hours.
5. Having expert clients available to support newly diagnosed clients increases linkage. However, tracking linkage still requires considerable coordination between the community-based and facility-based partners.
6. Completing the enrollment process immediately upon diagnosis facilitates linkages to treatment.

Based on the above lessons, we will make the following strategic shifts in COP18:

1. Intensify collaboration with various community, regional and national stakeholders and partners. We will work closely with RHMTs to identify HTS service gaps and ensure complementarity of efforts and active linkages between community based and facility-based services.

2. The following will be done to improve index testing approach:
    a. Advance partner notification skills: This will be done through ECs who will pair with counselors to follow up all clients who have been diagnosed positive in the communities. ECs are expected to build rapport with clients and introduce partner testing in face-to-face session with the seed client. Partners will eventually be tested by counselors and HIV positive individuals referred back to ECs.
    b. Rapidly experiment with social media-based case-finding strategies. This will allow newly diagnosed PLHIV to communicate with counselors more privately using social media tools like WhatsApp and Viber.
    c. Integrate 'associate notification' which has proven successful in the CommLink index testing and empower index counselors to trace and record 'network-trees' from seed clients. Associates are affiliates, friends, and colleagues of seed clients.
    d. Different index approaches will be used to identify partner(s), family members and associates. Index testing is **NOT** going to be a one-time event but will be offered continually.
3. Explore different strategies to increase number of people testing HIV positive through free-standing sites. This will include implementing 'pop-up' testing co-located with pharmacies, private facilities and other elements of the health system.
4. Use programmatic data, as well as SHIMS2 findings when availed and other data sources, to identify the populations who are not testing and who are not linking to treatment. This data will be analysed by region, age, and sex demographics to guide mobile testing teams.
5. To reach older women, HTS will be offered at workplaces such as markets, hair salons and factories. Services in the evenings to increase access for those who might not test during the day. HIV self-testing will also be integrated within the three major testing modalities (VCT, Mobile and Index) to reach older women nationally.

C. Treatment gaps and solutions

With the rollout of Test and Start in Q1 of COP16, there was an increase in the TX_NEW numbers across all SNUs. However, the OU only achieved 72% of the annual TX_NEW target overall. This was mostly due to a contribution from the pre-ART pool that was lower than expected. In addition to challenges in case-finding for certain populations (males and young people), other challenges that led to low achievement of this target were limited access to treatment, especially for working males, and lack of communication regarding the benefits of ART, as there were fears of overwhelming facilities with a sudden influx of patients.

In order to improve ART uptake and performance on the TX_NEW indicator, the following strategies are being employed in COP17 and they will be sustained in COP18:

- Extend working hours for selected clinics to improve access to treatment services, especially for those who are employed and are unable to access facilities during working hours;

- Roll-out of ART initiation in the community through mobile units (e.g., CommLink, PPP, TLC) to improve access to treatment services in hard-to-reach localities and for clients that cannot afford transportation costs to access health facilities;
- Expand provision of refills and VL testing for ALHIV during teen club meetings on weekends;
- Increase focus on same-day ART and implementation of a package of care for clients that do not initiate treatment within the same week they are diagnosed; and
- Increase ART uptake among TB patients to >95% through appropriate messaging, training and mentorship.

Linkage to treatment with custom indicators:

PEPFAR/S has rolled out active linkage case management using peer navigators (expert clients in facilities and communities) to help newly diagnosed HIV-positive clients link to facilities and navigate the various processes at HIV service delivery sites. This method of case management will strengthen linkages from the community to the facility, as well as intra-facility linkages. PEPFAR/S partners will report cohort data at monthly intervals for consistent project management. Custom indicators will be used to track the scale and fidelity of implementation of this intervention.

Community to Facility Linkage Indicators:

- Number of PLHIV identified in the community referred for treatment by facility
- Percent verified by the facility partner to be:
  - In the chronic care register in the facility
  - Newly identified PLHIV (After APMR and CMIS search)
- Number of unlinked clients who are tracked and brought back to care

Intra-facility Linkage Indicators:

- Number of PLHIV identified and initiated on ART by facility that have:
  - Been referred to another facility
  - Been lost to follow-up
  - Died
- Number of PLHIV identified at community the level and initiated on ART that have:
  - Been referred to a facility
  - Been lost to follow-up
  - Died

D. Viral load (VL) testing coverage and viral suppression

Swaziland has achieved the third 90 at the population level with 73% of all PLHIV virally suppressed and for patients on ART the VLS rate is 92% (SHIMS2). However viral load testing coverage was at 49% at APR17. This was due to the late roll out of routine viral load monitoring (RVLM), which was officially rolled out on the 1st of April 2017 representing six months of implementation. Reporting of VLS and its impact on HIV transmission at the population level is negatively impacted by poor retention in care. Retention in care is critical for the country to achieve the last 95 across all sex and age disaggregates. Swaziland faced a number of challenges related to retention in care.

Swaziland's TX_CURR performance decreased in Q1 FY17 following a DQA exercise carried out across the country to verify the number of patients on ART in all facilities. This was necessary to manage duplications that occurred as the country transitioned from the Antiretroviral Therapy Patient Monitoring and Reporting system to CMIS. Other data quality challenges the country experienced were related to the current data flow from clinics to hubs, from hubs to the region, and from the regions to the national level.

To improve retention, Differentiated Service Delivery (DSD) models have been rolled out with a focus on community adherence groups (CAGs), community ART distribution points, outreach services through public health units that have been modified to include HIV testing and ART refills, and multi-month scripting. Viral load suppression is particularly low for men 15 – 24 years (57%). For these men a particular focus will be on community ART distribution points and multi-month scripting.

Laboratory systems capacity has also been improved to provide VL testing for all PLHIV on treatment. Testing coverage after routine VL monitoring was rolled out on April 1, 2017 (implementation period of two quarters in FY17) was over 55% across all SNUs by APR17 with a viral load suppression rate of 90%.

Improved adherence counseling tools and trainings have been rolled out. These tools are implemented with site-level high VL registers to track clients with high viral loads and ensure they get the appropriate support to maximize the likelihood of adherence and re-suppress or definitively decide if they are failing treatment and facilitate a switch in their regimen.

E. TB/HIV Co-infection

TB case notifications peaked at almost 11,000 cases in 2010 and has declined since then with a case notification rate of 3,806 cases reported in 2017 (See Figure 4.1.7 below). Swaziland has a high TB/HIV co-infection rate (71%) and this decline in case notification has matched the decentralization of ART provision across the country and the subsequent increase in ART coverage (currently at 74%). WHO estimates of Swaziland's TB burden, however, have

remained high and show a case detection rate of 60% when compared to the case notification rate. To resolve this discrepancy, the National TB Control Program (NTCP) is conducting a prevalence survey to determine the true burden of TB in the country which should be complete by the end of Q2 FY19. This survey will include HIV testing of participants with linkage to care for all PLHIV identified, which is a key element of COP18. The adoption of better diagnostic tests (GeneXpert Ultra) will be key to improving TB case detection. PEPFAR/S will continue to work with NCTP to accelerate implementation of TB/HIV collaborative activities to ensure prevention of transmission, and rapid diagnosis and successful treatment of both diseases. Survey findings will be used to refine strategies.

Figure 4.1.7. Decline in TB case notifications over time and by region, Swaziland

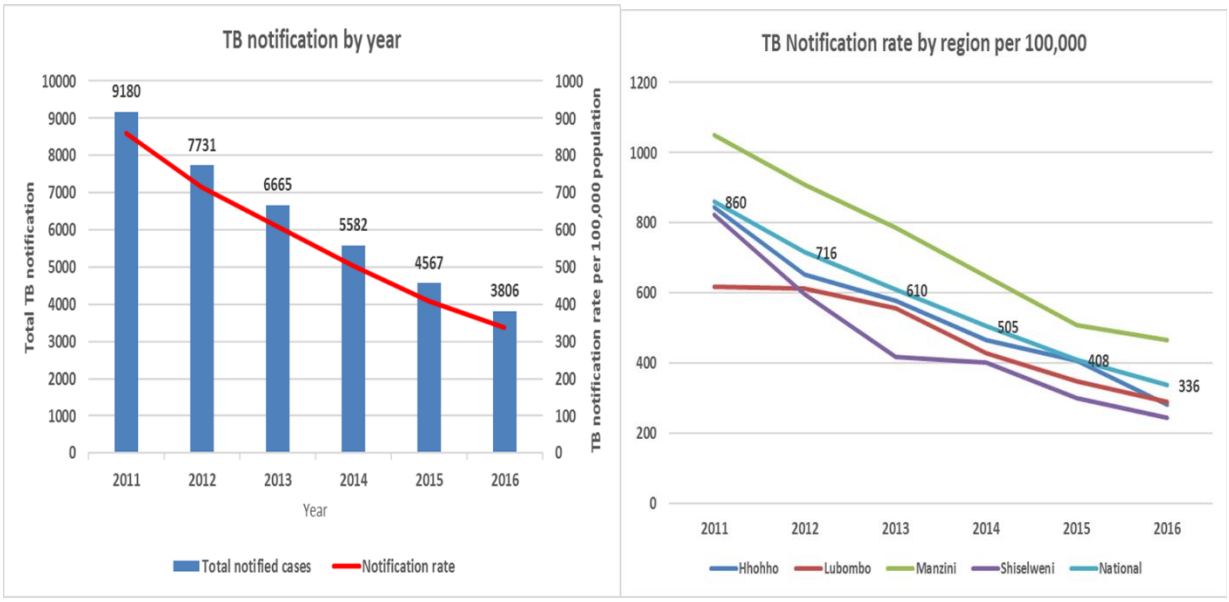
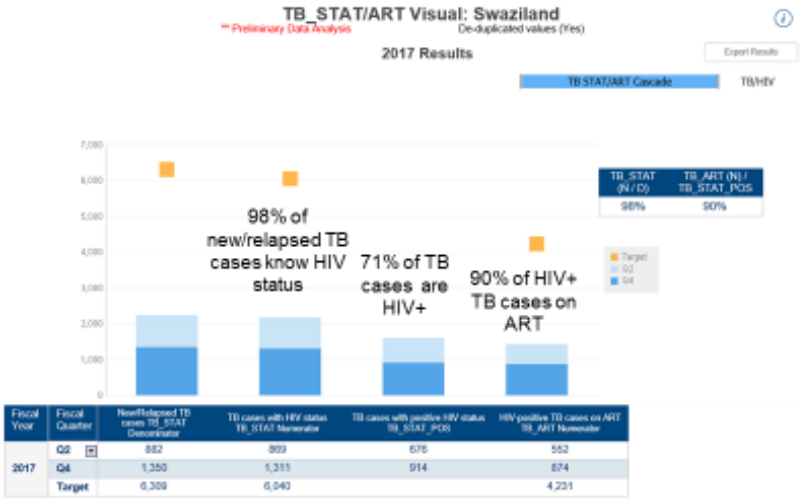


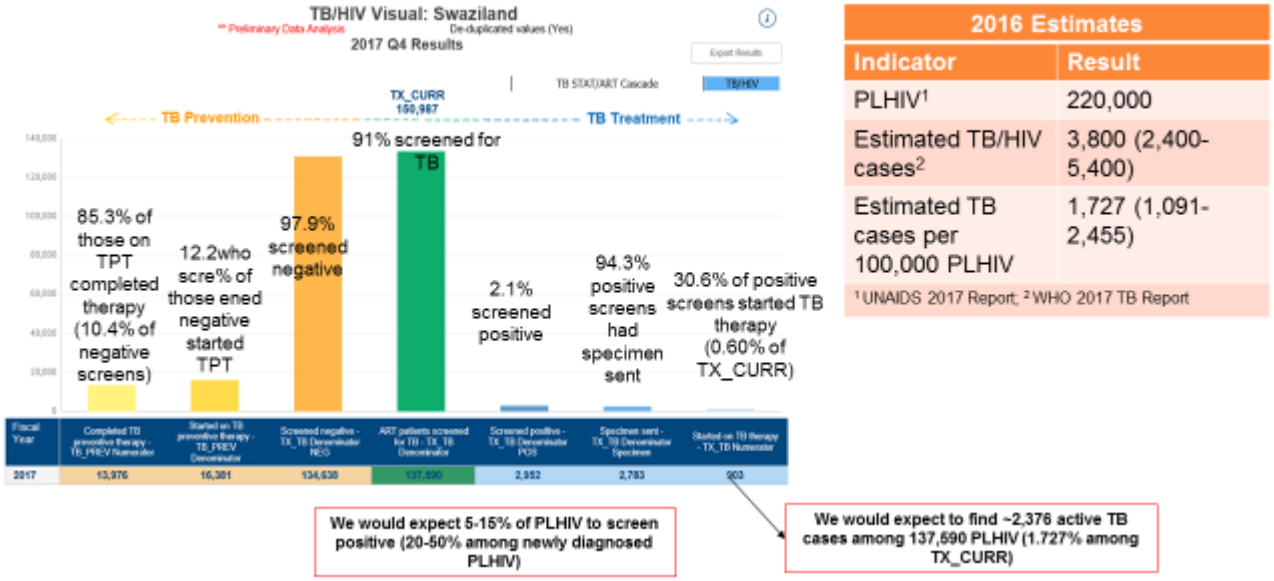
Figure 4.1.8. TB/HIV results, Q2 & Q4 2017, Swaziland



WHO 2016 Data	
Indicator	Value, n (%)
New/Relapse TB Cases	3,567 (100)
TB cases with known HIV status	3,774 (106)
TB cases with known status who are HIV+	2,649 (70)
TB cases with known status who are HIV+ and on ART	2,482 (94)

Figure 4.1.8 shows the Swaziland TB cascade starting with the total number of TB cases cascading down to the proportion tested for HIV, proportion who are HIV positive and finally those who are put on ART during the reporting period. These represent data from PEPFAR-supported sites. The orange box represents WHO data. To date, Swaziland has performed well on the TB_TST and TB_ART indicators, as 98% of all TB cases were aware of their HIV status. This percentage includes those who were aware of their HIV status at TB diagnosis and those tested for HIV after TB diagnosis. In COP18, there is room to improve ART uptake among TB patients testing positive for HIV with the current coverage at 90%.

Figure 4.1.9. TB/HIV results, April 2017, Swaziland.



2016 Estimates	
Indicator	**Result**
PLHIV[1]	220,000
Estimated TB/HIV cases[2]	3,800 (2,400-5,400)
Estimated TB cases per 100,000 PLHIV	1,727 (1,091-2,455)

[1] UNAIDS 2017 Report; [2] WHO 2017 TB Report

Figure 4.1.9 shows two cascades: the TB prevention cascade to the left of the green bar and the TB treatment cascade to the right (as of April 2017). The orange box represents data from WHO reports and UNAIDS estimates.

Swaziland is successfully screening all PLHIV using a four-symptom screening tool with 98% of clients screening negative. However, only 12% of these start TB Preventive Therapy (TPT) with an 85% completion rate. Two percent screen positive for TB and 94% of those who screen positive receive a confirmatory test for TB using Xpert MTB/RIF. Only 0.6% of all PLHIV are diagnosed with TB and put on treatment. This is lower than expected, based on WHO estimates of Swaziland's TB burden (discussed above) where at least 1.7% of PLHIV are expected to have TB.

Strategies to reach epidemic control for TB/HIV:

PEPFAR/S has provided support to GKoS to implement the provision of TPT through the following activities that will continue in COP18:

- Introduction of the Cotrimoxazole/Isomazid/VitaminB6 FDC (included in new guidelines) to reduce pill burden and improve uptake of TPT and completion rates;
- Finalization, testing, printing and distribution of TPT information, education and communication (IEC) materials in partnership with SNAP and MoH health promotion unit:
    - This should be complete by end of FY18 Q2 and will create demand for TPT at the community level, which has been lacking in the implantation of TPT to date.
- Printing and distribution of TPT Tools to capture and report TPT data;
- Incorporation of a TPT module in the CMIS version 2.0;
- Continuous training of HCWs on the advantages of TPT to improve healthcare worker buy in and appreciation of the benefits of TPT; and
- Support TPT stock forecasting and procurement to minimize stock outs.
- Late presenters package includes urine TB Lam testing for rapid diagnosis and treatment of TB.

Improved case management of TB/HIV cases to reduce mortality

Mortality among TB/HIV co-infected patients is high at 14% compared to mortality for HIV-negative TB patients (4%) and 12% overall. This trend has been consistent over the last four years despite marked improvement in ART coverage and a decline in overall mortality among PLHIV. Decreasing TB-related mortality will improve overall retention in HIV treatment as TB is the leading cause of death among PLHIV.

- The introduction of routine mortality reviews, started in COP17 and will be sustained through COP18. Mortality reviews have not been part of routine patient care in Swaziland in the past and have only been included as part of maternal mortality audits at the national level. These reviews will identify gaps in the clinical management of patients to inform related quality improvement projects that will improve patient outcomes.
- Clinical mentorship will strengthen clinical management of TB/HIV cases to improve patient outcomes. PEPFAR/S will use an approach that has already been employed for the review of complicated MDR-TB cases that require use of newer DR-TB drugs (bedaquiline and delamanid).
- Importantly, Swaziland recently completed a TB Drug Resistance Survey (DRS) and this data will be used to improve program performance and patient outcomes.

Improve TB case identification

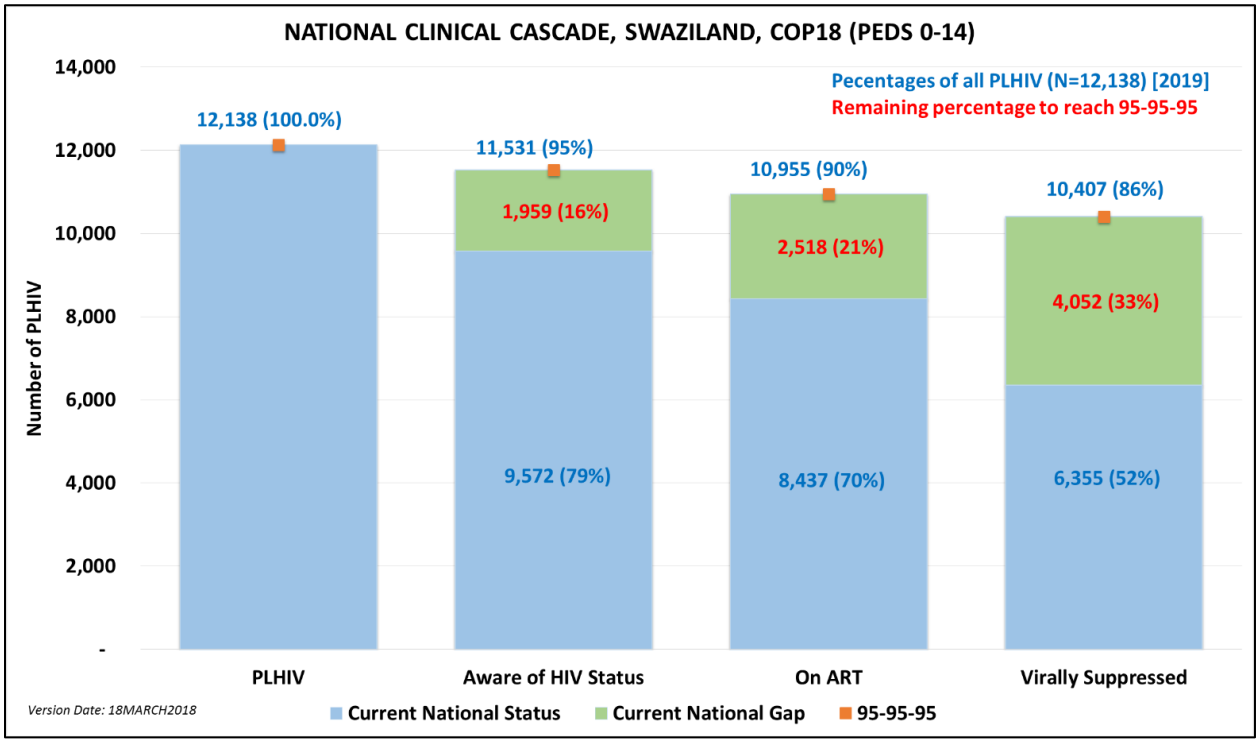
As noted above, the TB case notification rate has continued to decline even though WHO estimates of Swaziland's TB burden have remained relatively high and Swaziland's case detection rate has remained constant at 60%.

- To close this gap, the NTCP, through support of GF, will continue to employ community-based active case finders to target high-risk communities and localities for TB screening and investigation to improve TB case detection in COP18.
- The ongoing TB prevalence survey will provide timely data in FY18 Q2 on Swaziland's TB burden and case detection rate to better inform COP18 activities.
- Maximize case detection through implementation of household contact tracing, including PLHIV, children, pregnant and lactating women, and elderly
- Integrate or twin TB household contact tracing with HIV index case testing in TB setting to maximize resource utilization
- Utilize the TB screening tool as an effective way to identify people who are unlikely to have TB but it can be ruled out, hence, other screening considerations may be needed to identify TB cases. Unpublished Swaziland data unpublished for TB screening in pregnant and lactating women indicates failure of the four symptom tool to identify TB cases.
- Identify best screening methodology in the context of Swaziland by analyzing routine data and existing data from research findings

III. Specific Populations

A. Children (≤ 14 years)

Figure 4.1.10. Pediatric unconditional national cascade, COP18, Swaziland



Finding the missing CLHIV (1st 95)

As demonstrated by the pediatric cascade (Figure 4.1.10), there is high awareness of HIV status among children living with HIV (CLHIV). Based on the recommendations of the upcoming laboratory headquarters technical assistance (TA), the Swaziland program is planning to leverage and optimize the existing GeneXpert and Alere-Q machines to roll-out EID POC testing for CLHIV. In COP18, PEPFAR/S will continue activities to strengthen post-natal follow-up of HIV-exposed children by supporting both the facility and community mother-baby-pair initiatives across all four regions. The program will also increase pediatric case finding through index case testing of children of HIV clients who are identified through high volume and high yield entry points. In addition, the programs will scale-up index case testing of all children of HIV positive mothers seeking MNCH services.

The OVC program aims to ensure that the HIV status of 90% of beneficiaries <18 is known to their caregivers (OVC_HIVSTAT). OVC home visitors conduct monthly household visits to build trust with children and caregivers for HIV risk screening and to ensure that HTS referrals are completed.

Getting CLHIV on treatment (2nd 95)

In an effort to increase ART uptake among pediatric clients, PEPFAR/S will continue to strengthen the training of clinic nurses on pediatric ART, including attachment of nurses at health facilities with doctors with experience in pediatric case management. The program will also continue training more nurses in Nurse-Led ART initiation in Swaziland (NARTIS) in an effort to reduce missed opportunities for ART initiation. In COP18, PEPFAR/S will collaborate with social workers to assist in situations where mothers or caregivers are not ready to put their child on treatment. In addition, the program will put in a concerted effort to ensure that the family unit is fully involved in the child's treatment and care needs.

OVC home visitors will conduct follow-up with caregivers to ensure that CLHIV identified through the OVC program are initiated on treatment. In FY 17, all 89 C/ALHIV newly identified through the HIV program were successfully put on ART.

Retaining CLHIV in care and achieving viral suppression (3rd 95)

In an effort to increase viral load coverage among pediatric clients, PEPFAR/S will continue to build the capacity of nurses in pediatric phlebotomy and will provide ongoing clinical mentorship to strengthen the identification and management of children failing or defaulting on their ART regimens. The program will also continue actively tracking children defaulting on treatment through facility and community lay cadres. In COP18, the Swaziland program will continue to support the implementation of viral load monitoring using DBS samples. The program will also expand differentiated care models for children, which in the past have primarily focused on treatment clubs (such as support groups/teen clubs), to also include multi-month prescriptions and other emerging and PEPFAR-supported differentiated models of care. Adolescents over 30 kilograms will also be prioritized for transitioning to more robust regiments containing DTG.

Clinical and OVC partners will collaborate to strengthen quality of services provided through facility based teen clubs where C/ALHIV receive psycho-social and peer support for adherence. Viral load testing during teen club sessions that take place at weekends will be rolled out.

B. AGYW and Adult Women

Figure 4.1.11. National unconditional cascade for females ages 15 - 29, COP18, Swaziland

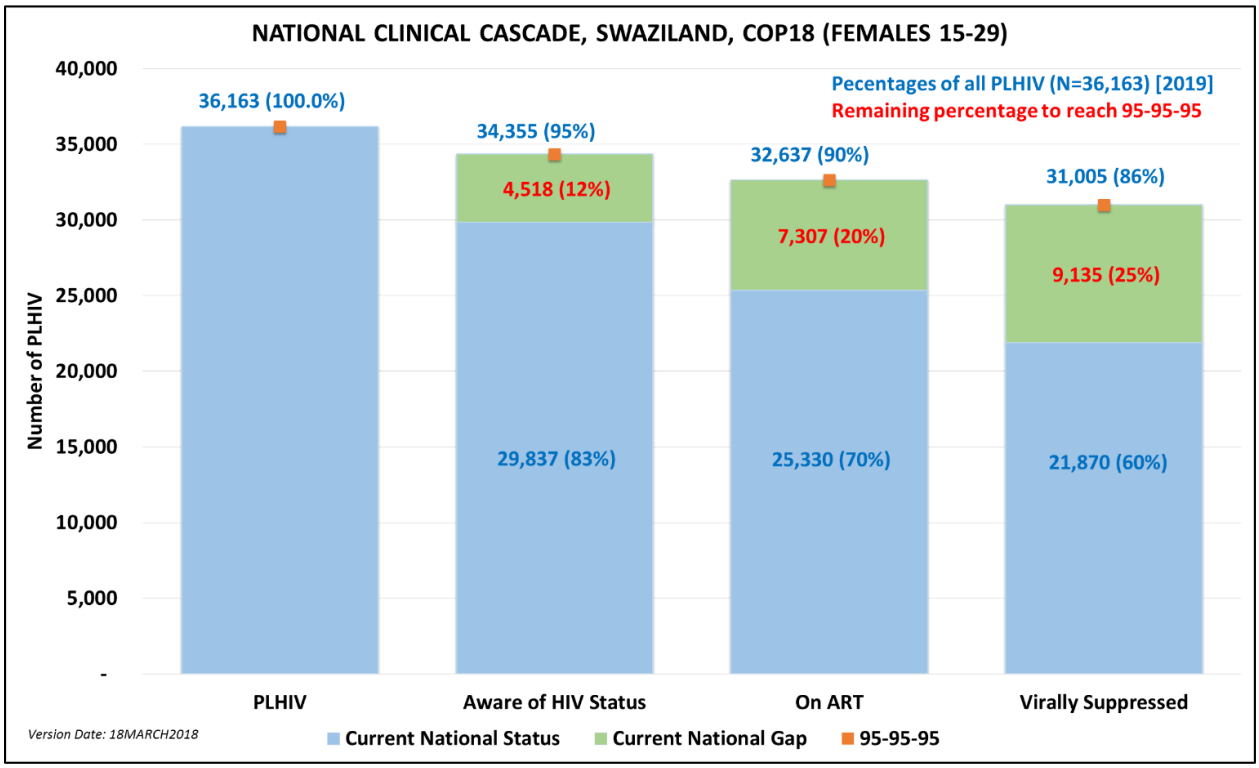
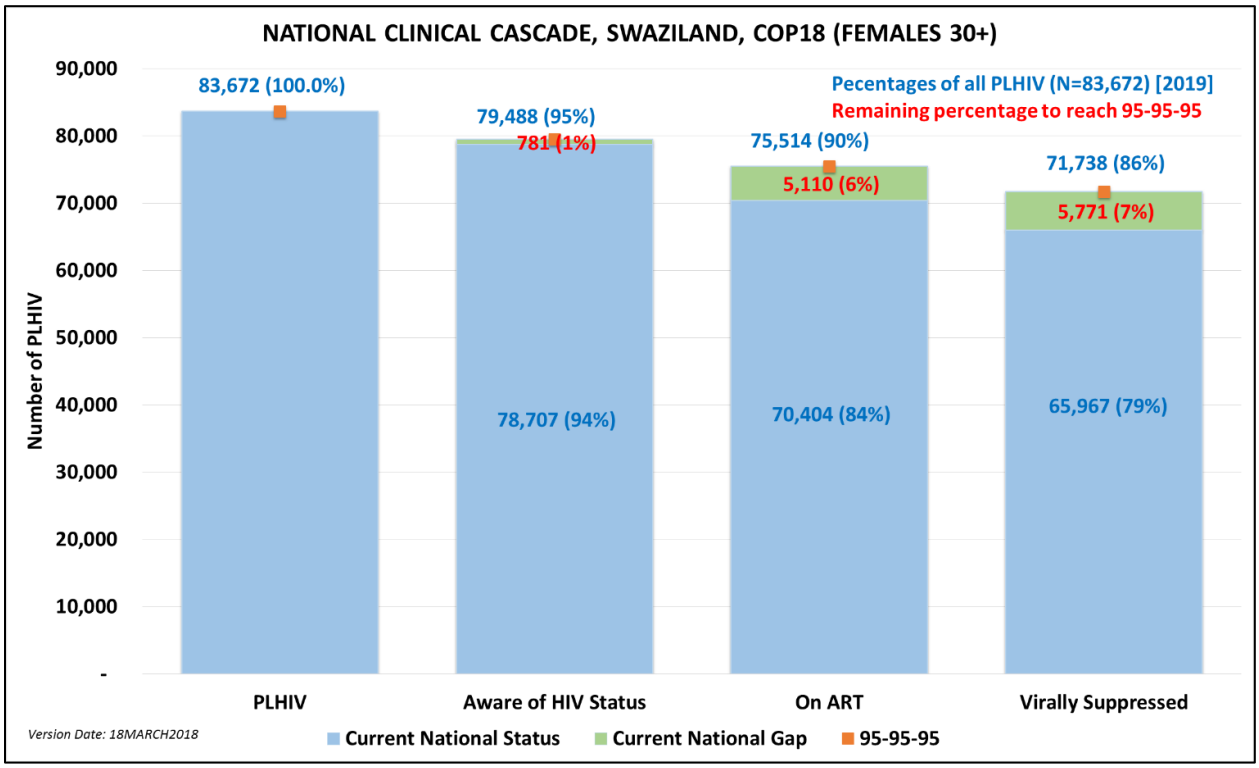
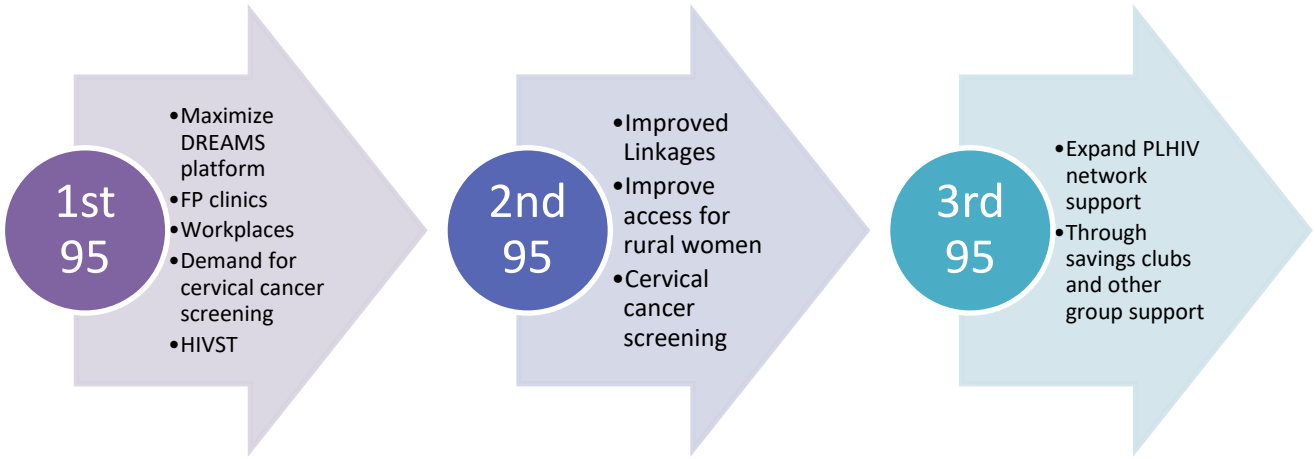


Figure 4.1.12. National unconditional cascade for females 30+, COP18, Swaziland



Figures 4.11 and 4.12 show the national unconditional cascades for females, demonstrating the difference in coverage of testing, treatment and viral suppression between AGYW and older women. The need to focus on AGYW is apparent.

Figure 4.1.13. Summary of approaches to reach 95-95-95 for adult females, Swaziland



The DREAMS platform already provides a non-stigmatizing entry point for reaching AGYW. DREAMS approaches and tools will be strengthened to be inclusive of HIV negative and positive AGYW, aiming to attract especially YW ages 20-29 who present significant gaps in the pyramid to reach the 95-95-95 goals. Program strategies will focus on getting YW to know their status and on getting known positives on treatment. The comparative advantage of the DREAMS package is that interventions continue over several months and build trust between beneficiaries through individual and small group mentoring. Both, trust to overcome stigma and clear messaging on the benefits of knowing one's status and treatment will be crucial to get AGYW to test and take up treatment. Along with community level DREAMS empowerment approaches, DREAMS branded clinical services (DREAMS on Wheels) will cater to HIV prevention, family planning and SRH needs to both negative and positive AGYW. They will provide HTS and assisted and non-assisted HIVST, and provide ART initiation and referrals.

PEPFAR/S is close to achieving the 95-95-95 goals for HIV infected women over 30 years with 93% already identified and 91% on treatment. Additionally, women over 25 years fare well across the clinical cascade. For the 1st 95, over 90% of women over 25 years are aware of their HIV status in all regions; this may be due to high access to HIV testing in ANC clinics. Similarly, over 90% of women in this age group are also on ART in the urban regions of Manzini and Hhohho. In the rural regions of Lubombo and Shiselweni, fewer women are on ART with just over 80% coverage in both regions (Lubombo = 4,800 and Shiselweni= 5,000). There are several possible reasons why some women may know their status but are not on treatment. These include: some were likely above the CD4 threshold for ART initiation when the country was still implementing Option A for PMTCT before Test and Start was implemented nationally; poor information regarding treatment availability irrespective of CD4; stigma; and limited access to health care.

These women who know their status but are not on treatment are less likely to get pregnant and PEFPAR/S must identify new approaches to bring them to care (as seen in Figure 4.1.13). These approaches include: use of facility records to track them in the community and link them to treatment using the community outreach workers; a campaign "If you know, You must go" that will stress the benefits of treatment and the need for cervical cancer screening for female PLHIV through media, community outreach and church groups; outreach for index case testing; services for GBV care; and CommART (community treatment activities). Across all regions, most HIV infected women over 50 years are aware of their status, on ART and virally suppressed (94%, 96%, and 86% respectively). Programming for women in this age group is ongoing in COP18 to reach epidemic control for women over 50 years. Through the community-based OVC lay cadres, HIV positive mothers and caregivers of OVC not on treatment will receive clear messaging on the benefits of treatment. In an effort to address the gap of low utilization of index and partner testing using the MNCH platform, the Swaziland program will also roll-out index case testing and HIVST to reach male partners of all pregnant women.

Targeted outreach, guided peer network referrals, and HIV testing services integration with SRH services will be strengthened, as those services are an important way to reach young women with HIV testing services. DREAMS platforms will be maximized to reach those with greatest need.

C. Young and Adult Men

According to SHIMS 2 (2016), 77.5 % of male PLHIV in Swaziland were aware of their HIV status. Eleven percent of those who were aware of their status were not on ART. Younger males 15-19 years and 20-24 years have lower levels of awareness compared to their older counterparts at 51.5% and 65.7%, respectively. Those not aware of their status and those that are aware but not on ART represent the missing among males and will require different interventions to identify them and link them to treatment. Overall, ART uptake among males who were aware of their status was high at 88.6%.

With regards to HTS in Swaziland, men are able to access these services at either the community or facility levels. At the community level, implementing partners reach men through outreach events to encourage them to utilize HIV testing services either in the community or at a facility. Men who test positive for HIV, at either the community or facility level, are then referred to care and treatment as part of the 95-95-95 goals. Case finding and linking individuals to care that have tested positive continue to be challenges for the PEPFAR/S program, which will be addressed through planned COP18 activities. Services that include HTS at the community level, in places and at times that are convenient for men, has been shown to be effective in increasing testing and linkages to treatment. Engaging traditional and community leaders is critical for coordination of services, ownership and sustainability.

Figure 4.1.14. National unconditional cascade for males, ages 25+, Swaziland

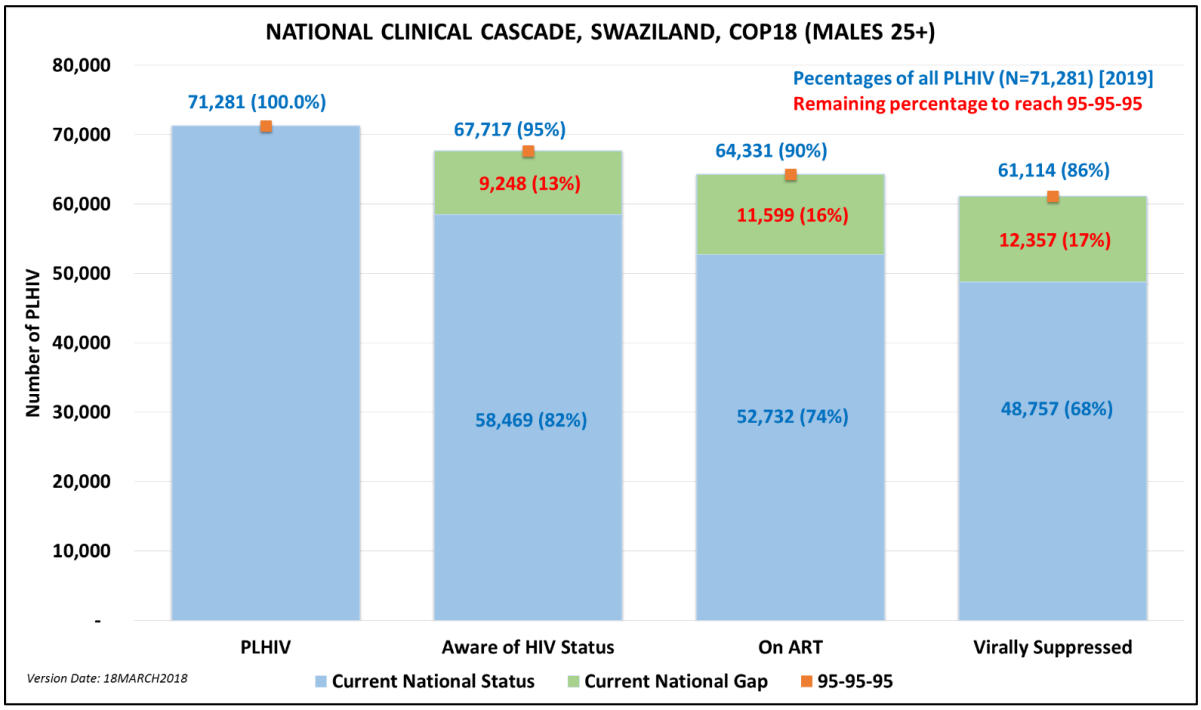


Figure 4.1.14, the clinical cascade for adult males 25+ years at the population level (all male PLHIV ages 25+ years regardless of ART status), shows the gap between current case identification, ART coverage and viral load suppression compared to 95-95-95 targets.

Figure 4.1.15. National unconditional cascade for males, ages 15-24, Swaziland

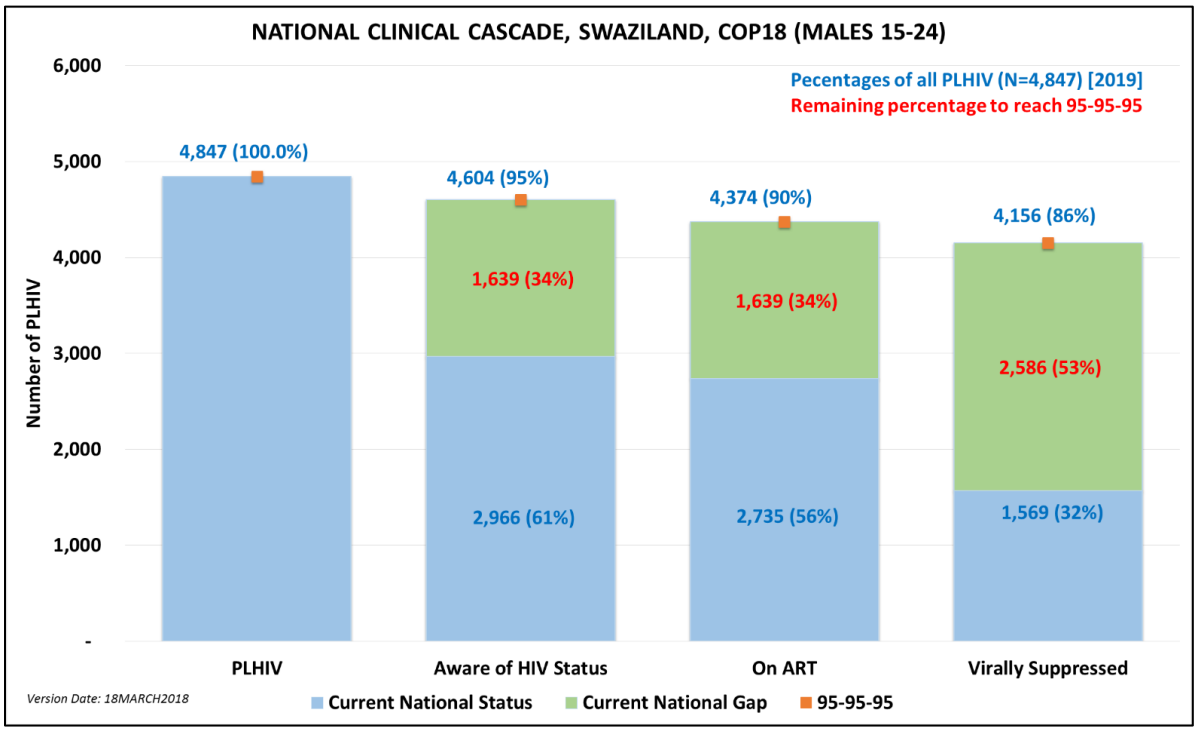


Figure 4.1.15, the clinical cascade for males ages 15-24 years at the population level (all male PLHIV ages 15-24 years regardless of ART status), shows the gap between current case identification, ART coverage and viral load suppression compared to 95-95-95 targets. The lower levels of awareness and viral suppression compared to males 25+ are noted.

Figure 4.1.16. National conditional 95-95-95 cascades, by age and sex, COP18, Swaziland

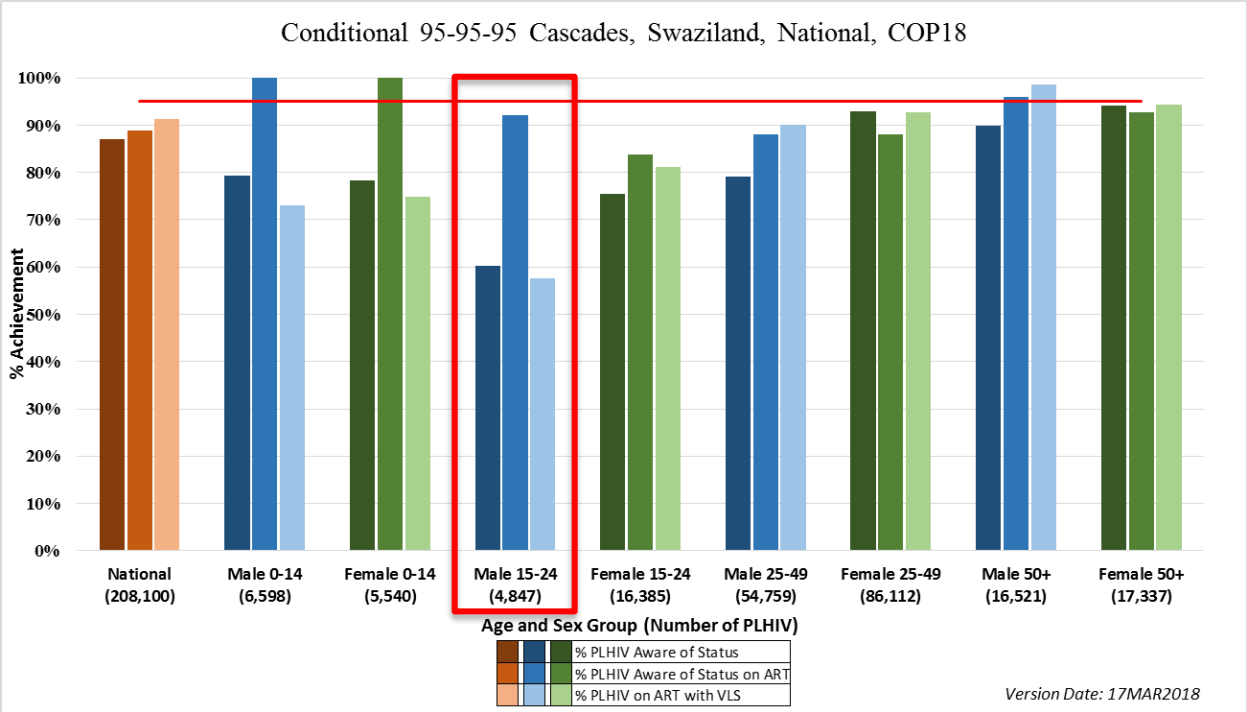


Figure 4.1.16 is the conditional cascade showing the gap between current case identification, ART coverage and viral load suppression compared to 95-95-95 targets. The lower levels of awareness and viral suppression amongst males ages 15-24 years are highlighted in this figure.

Both figure 4.1.15 and 4.1.16 above highlight the lower levels of HIV status awareness and viral suppression rates amongst males ages 15 -24 years. This highlights the challenges in HIV testing for this population as they are either in school or working and are not reached by the routine approached to testing. ART uptake appears to be good in this group, probably due to the fact that they tend to present late when they are unwell (found in OPDs and TB clinics) and there for are willing to take up treatment, but they may have challenges with viral suppression due to co-morbid conditions (poor health and pill burden) and lifestyles that may make adherence difficult.

Figure 4.1.17. Linkage to treatment by sex and five-year age bands, Swaziland

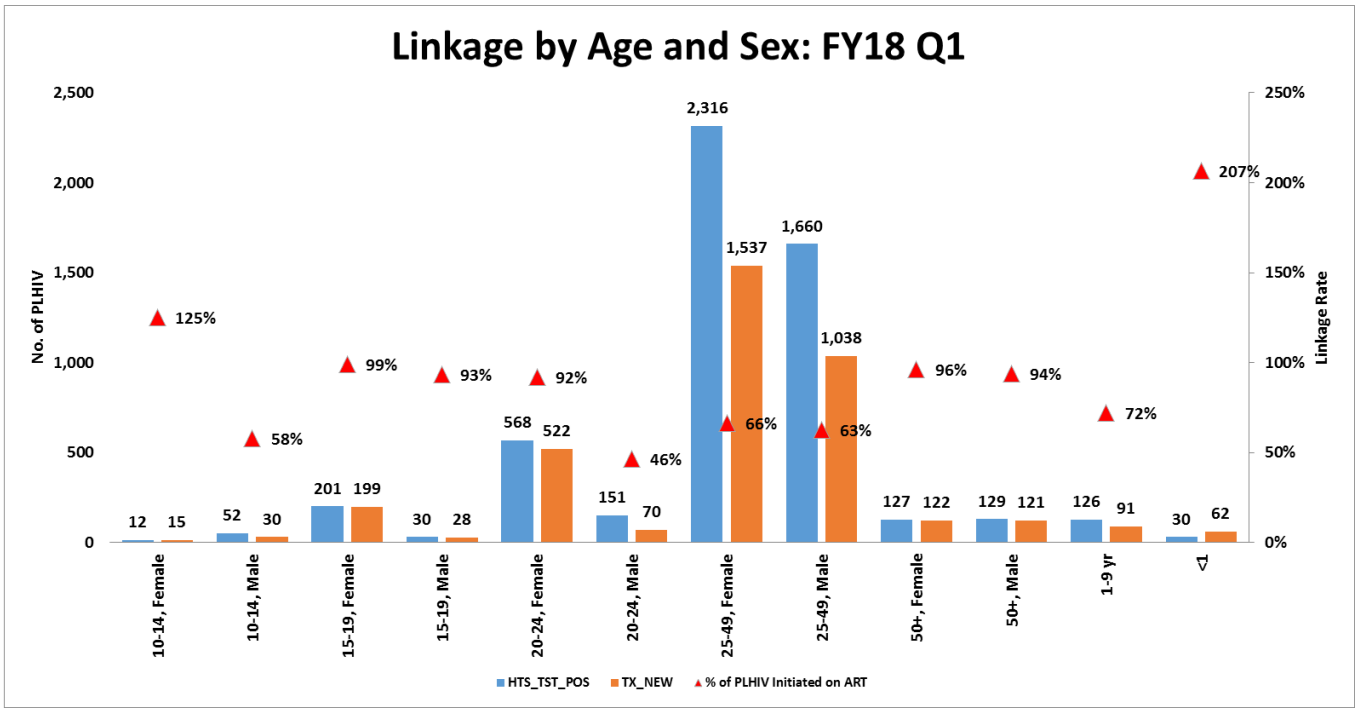


Figure 4.1.17 highlights low linkage to ART for males 20-24 years (46%) and males 25 – 49 years (63%). It is clear that much still needs to be done to consistently link males to treatment in Swaziland. The average linkage rate for males was 64% in Q1 FY18. The shift of national ART guidelines to Test and Start, combined with an increased focus on same-day ART initiation and rapid ART initiation within the first week of diagnosis will strengthen linkages to treatment.

Figure 4.1.18. Summary of approaches to reach attained for males age 15-49 years, Swaziland

Index case testing with custom indicators to find males (15-49 years)
Notification of male partners of females already on ART – and prioritizing those with high viral loads (>10,000cp/mL) – and those that are newly identified will be scaled up in COP18 specifically targeting male partners of female PLHIV in ART clinics, antenatal clinics (ANC), post-natal clinics (PNC) and family planning clinics.

Index case testing and partner notification platforms will be used to reach associates (male friends and social contacts) of male PLHIV in a peer-driven testing approach (Table 4.1.1). This approach has shown great promise in the CommLink study with a high yield. PEPFAR/S will be targeting associates of male PLHIV based on the assumption that there will be a high yield because they have similar behavior to the HIV-positive index cases. Males are also likely to have a stronger influence on their peers to warrant this type of testing strategy.

Custom indicators will be used to track IP implementation of index case testing, collect data on populations reached through this modality, and encourage closer collaboration between community- and facility-based partners. Both conventional testing and HIVST modalities will be available. The below indicators will track the scale and fidelity of implementation among this group. A carbon copy form for partner notification will be introduced to replace the current partner notification letter. This will facilitate better tracking of the implementation of index case testing.
Custom indicators include:

- Number of new PLHIV identified by facility, sex and age;
- Number of partner and associate notifications sent out by facility, sex and age ; and
- Number of HIVST kits distributed by facility, sex and age.

HIV self-testing (HIVST) to identify male PLHIV (15-24 years)
HIVST is a new testing modality for Swaziland that has been piloted through UNITAID support, this pilot will conclude in March 2018. HIVST policies and guidelines will be developed and HIVST will be more fully rolled out. HIVST will be brought to scale in COP18. HIVST will be used to reach sexual networks of PLHIV. To target males, females attending ANC, PNC and family planning clinics will receive HIVST kits. To identify younger females, the program will target males (25-34 years) with HIVST kits through index case testing. HIVST will also be used to assist in cases where the client feels it would be easier to share an HIVST rather than a partner notification slip.

Male Tuberculosis (TB) and presumptive TB patients:
HTS of TB and presumptive TB patients will be an important approach to identify male PLHIV (15-49 years) that are currently missing. There are at least ten times more presumptive TB cases than actual TB cases in Swaziland and testing of these cases has been shown to have a high yield in past studies. The male: female ratio is 2:1 and presumptive cases have been demonstrated to have a high yield; the Swaziland National AIDS Program (SNAP) reported 43% yield among presumptive TB cases. Testing will done through TB Active Case Finders (ACF) who work in the community through support from GF. Two approaches will be used: 1) referrals for HTS at either facility or community-

based testing partner; and 2) distribution of HIV self-test kits by ACF. The patient flows in most facilities are designed to start with HTS before TB screening and this protocol has led to high testing coverage of presumptive TB cases within health facilities as they are routinely tested through provider-initiated testing and counseling (PITC).

PEPFAR/S will ensure that all presumptive TB cases are tested for HIV, including those identified through active case finding in the community level. Contacts of HIV-positive TB cases will be tested as part of index case testing and contact tracing for TB programming.

Male-dominated industries:
PEPFAR/S will target male dominated industries for HIV testing in COP18 to find the missing men who aren't aware of their status or are aware of their status but not on treatment. These include the sugar and forestry plantations. Many of these companies employ casual workers and migrant workers from other regions who may have limited access to conventional testing and treatment services because of their living arrangements, income level, and other factors. Settlements provided by these companies may be far from conventional health services with limited transportation services. Use of "Pop-up" mobile testing services will help improve access in these localities.

Figure 4.1.19. Map of male-dominated industries, Swaziland

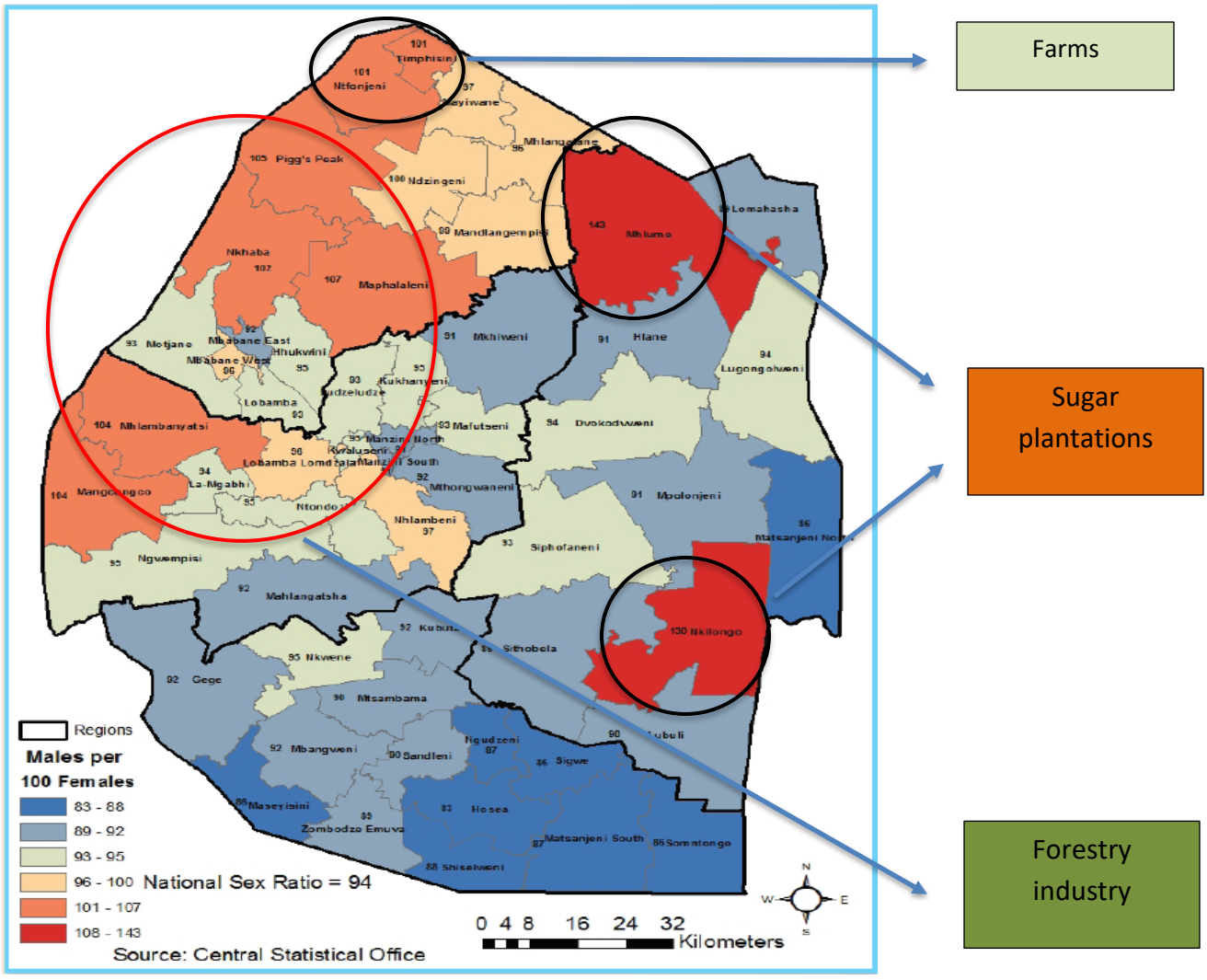


Figure 4.1.19 above shows the tinkhundla that have a higher proportion of males compared to females. These are aligned to where there are male dominated industries like sugar plantations, forestry and citrus farms. Females dominate the textile industries as seen in Matsapha and Nhlangano.

Swaziland Military

The Swaziland military (Umbutfo Swaziland Defence Force, USDF) consists of a highly mobile priority population group with a higher HIV prevalence than the general population (SABERS 2009). A number of gaps in HIV programming have been identified through the quarterly reviews, MILSID, SIMS and site assessments. In COP18:

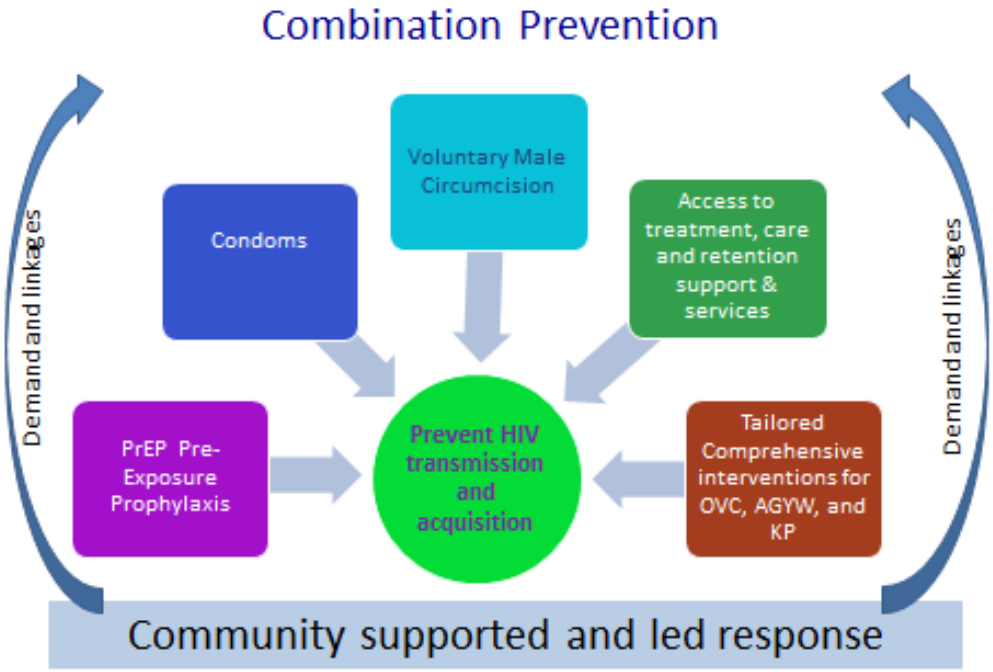
- A SABERS integrated bio-behavioral survey will be done to obtain current population-specific data to assist in programming;
- The USDF HIV Wellness Policy will be reviewed to align current clinical and prevention activities with military requirements so that prevention and clinical activities can be implemented with full USDF support;
- An implementing partner will scale up clinical and prevention services to improve the quality of care in military clinics;
- Established (but underperforming) military clinics will be upgraded and staffed as effective NARTIS sites that will offer Test and Start, introduce index case testing and provide HIVST kits to improve HIV test positive yield, and offer GBV and prevention services;
- The VMMC program will be re-launched; a service provider will be identified for rapid scale-up of VMMC activities and for capacity building for program sustainability; and
- An assessment of the laboratory services and activities will be completed to optimize the existing equipment and current staff performance Assistance will be provided to all supported sites to improve the quality of laboratory or POC services provided.

4.2 Prevention, specifically detailing programs for priority programming:

Overview

As Swaziland nears the attainment of the 95-95-95 goals, the PEPFAR/S program must shift focus and resources towards preventing new infections while continuing to prioritize the maintenance of treatment and retention coverage. With Swaziland's substantial youth bulge, persistent high incidence among AGYW, elevated rates of sexual and gender-based violence, and high rates of unemployment and mobility, a concerted effort will be needed to reach priority and key populations with effective combination HIV prevention interventions and provide them with access to services at scale and access to HIV information, services and referrals (Figure 4.2.1).

Figure 4.2.1. Combination prevention and community HIV services, Swaziland



Policies/Guidelines

The GKoS is fully committed at all levels to accelerate HIV prevention and support towards a sustainable community-led HIV and TB prevention response. As such, Swaziland has developed a number of key plans and guidelines that provide a robust underpinning to the PEPFAR/S HIV prevention program. These include: the 100-day plan in line with the Global Accelerated HIV Prevention 2020 Road Map, National HIV Prevention Core Packages: Guidelines for Prevention Interventions, the National Prevention Coordination Framework and the draft National Strategic Framework 2018-2022.

In October 2017 Swaziland adopted the **UNAIDS HIV Prevention 2020 Road Map**, and launched its 100-day catalytic prevention plan on December 1st, World AIDS Day (WAD). The goal of the Road Map, is to reduce new HIV infections by 75%, will require an intensive focus on combination HIV prevention complemented by the scale-up of HIV testing and treatment. The Swaziland Road Map 2020 Prevention Plan uses a location and population-based approach to ensure effective and efficient planning and programming, as well as a people-centered approach that responds to the needs of people at higher risk of HIV infection.

The 10 point plan outlines the critical strategies required to accelerate HIV prevention country wide including: enhanced leadership oversight and management; revised national targets; a national operation plan for HIV prevention; national guidance for prevention intervention packages; and strengthening and standardizing prevention monitoring systems. The Framework also provides coverage targets for the five prevention pillars in the Road Map (see Figure 4.2.1).

The National HIV Prevention Core Packages is based on the biomedical, behavioral and structural determinates that influence HIV acquisition and transmission in Swaziland. It has outcome-oriented packages and is age and sex disaggregated. The guidelines provide a foundation for the development of standard operating procedures for facility and community programs as well as for the development of age and sex disaggregated coverage and outcome targets at the national, regional and tinkhundla level.

Finally, the evaluation of the 2014-2018 extended National HIV Strategic Framework (eNSF) found that the national HIV response was fragmented due to weak multi-sector and partner coordination structures. NERCHA has developed a **National Coordination Framework** that revisits coordination platforms and accountability among sectors and implementing partners at all levels.

Program Direction

In COP16 PEPFAR/S identified the need for more flexible interventions and adaptable person-centered approaches for specific DREAMS and male sub-populations including out-of-school/work and mobile populations. HIV prevention programming is too often focused on the intervention and/or curricula rather than people's specific needs and lifestyles. As a result, interventions in COP17 are more person-centered and adaptable to address the needs of different sub-populations and improve their access to HIV prevention services.

POART findings and program data also demonstrated shortcomings in assuring and tracking linkages to HIV testing, after having successfully reached and mobilized men. For example, in COP16, HC3 reached 48,002 men, ages 20-49, with comprehensive interventions and generated demand for HIV services, yet only 11% of those males were tested. One of the main reasons cited by the beneficiaries was the lack of access to convenient male friendly testing services. ARROWS and HC4 will collaborate closely in COP18 to ensure access to HTS and linkage to treatment and prevention for these mobilized men. In addition, PEPFAR/S missed the opportunity with the over 100,000 men who tested HIV negative men in FY17 to link them to VMMC and other prevention services.

To a lesser degree, AGYW DREAMS programming had similar linkage concerns. For DREAMS/OVC, combining mobile clinical and community-based interventions resolves the linkage issues (Triple R). PEPFAR/S is course-correcting in COP17, by improving coordination and strengthening linkages and referrals between and among partners working in communities and with partners supporting mobile testing and other services (e.g., VMMC, DREAMS, SRH, ARROWS, etc.), as well as building more robust bi-directional collaboration between community and facility partners. In addition, use of unique identifiers at the community level will assist in tracking individuals through both the prevention and treatment cascades from the community to services and to retention in care. The establishment of a community CMIS will begin in COP18.

While there were implementing partner coordination challenges linking mobilized men to testing and services, the HC3 program data and effectiveness assessment, which included findings from interviews with over 100 beneficiaries, showed individual male behavior change and demonstrated

the power of community and male engagement to transform gender norms to create a safer environment for AGYW and address issues of SGBV and stigma.

Below, one of the quotes from the HC3 assessment indicates that chiefs and their local government structures are making changes to protect AGYW from HIV and SGBV:

"No marriage with young girls is allowed here"

Chief Michael Magongo,
Bhadzeni I chiefdom, Ngwempisi inkhundla

Following workshops with chiefs, their wives and the inner council…"We took a decision to disallow sexual relationships and marriages with children under the age of 16 years."

Communication and knowledge gaps were also identified during POART and portfolio reviews. The 2014 Multiple Indicator Survey shows a dramatic decrease in knowledge of HIV transmission among youth. Implementing Partners have noted challenges in explaining test and start and viral load. Chiefs, community leaders and adult men were surprised to learn that among the reasons why AGYW have a much higher burden of HIV is related to their biologic vulnerabilities. Swaziland is an oral society; effective methods for transmitting key HIV messages are through leaders, peers and community groups. Social media is also accessible and an effective channel of communication for youth and KP. In COP18, HC4 Breakthrough Action will host listening groups with a variety priority populations and sub-populations to determine key messages that resonate well with that population and which channels would be effective for delivery. Implementing partners and other stakeholders will be able to take the messages and utilize them with their constituencies through their channels.

Partner Management

In COP18, PEPFAR/S will institute a number of measures to improve prevention partner performance and improve coordination and synergies among all partners across prevention, care, and treatment activities as follows:

1. Establish common custom indicators and strengthen local and regional government structures to set and track prevention targets;
2. Convene monthly joint and individual partner meetings and report-out on achievements including concrete evidence of coordination; and

3. Hold implementing partners accountable by establishing and enforcing joint partner accountability measures.

Innovations

In COP18, PEPFAR/S will continue to scale up the COP16 Game Changer "engaging men and chiefdom structures for epidemic control" from 6 to 25 tinkhundla including all DREAMS focus areas (See Figure 4.2.3) reaching 43,000, men ages 15-39, and linking them to core HIV prevention or treatment services, and reaching over 700 local government, traditional, and church leaders. The increase in uptake of VMMC and treatment from the 6 months of the Game Changer intervention are promising as seen in the graph below (See figure 4.2.2). This intervention will also operationalize the accelerated HIV Prevention Road Map 2020 at the community level by building local ownership, standardizing intervention packages and monitoring tools, and promoting the five pillars of prevention among the priority populations.

Through HC4 Breakthrough Action, leaders in Chiefdoms and Municipalities in the 25 tinkhundla will analyze national and local epidemiologic and contextual data to establish baselines and develop their HIV action plans with measurable targets. With PEPFAR support, local structures with improved governance and accountability and empowered leaders, will coordinate and track the uptake of HIV services across all sectors. It is anticipated that through this process community leaders will participate in the creation of an enabling environment to reduce SGBV, improve access to services and mobilize populations to use the services for a sustainable HIV response and epidemic control.

Figure 4.2.2. 'Community engagement game changer' FY16 and FY17 results, Swaziland

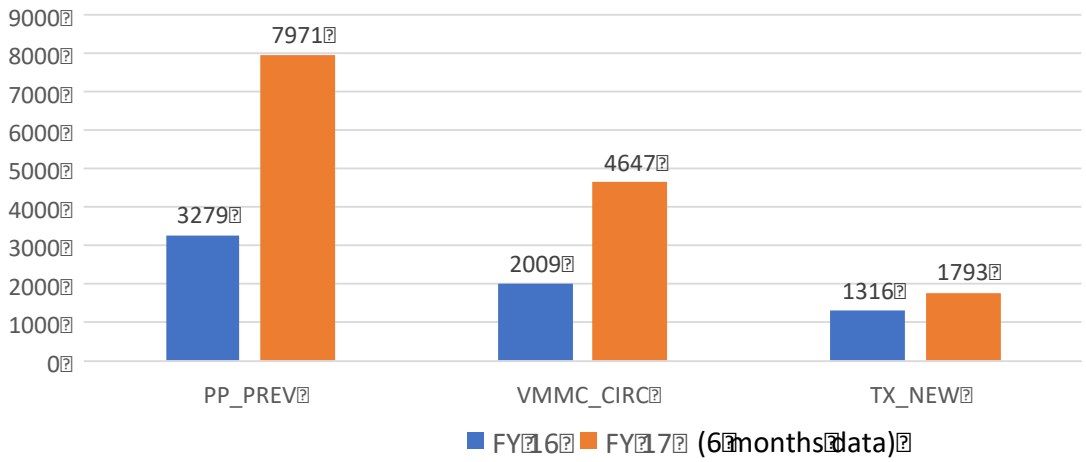
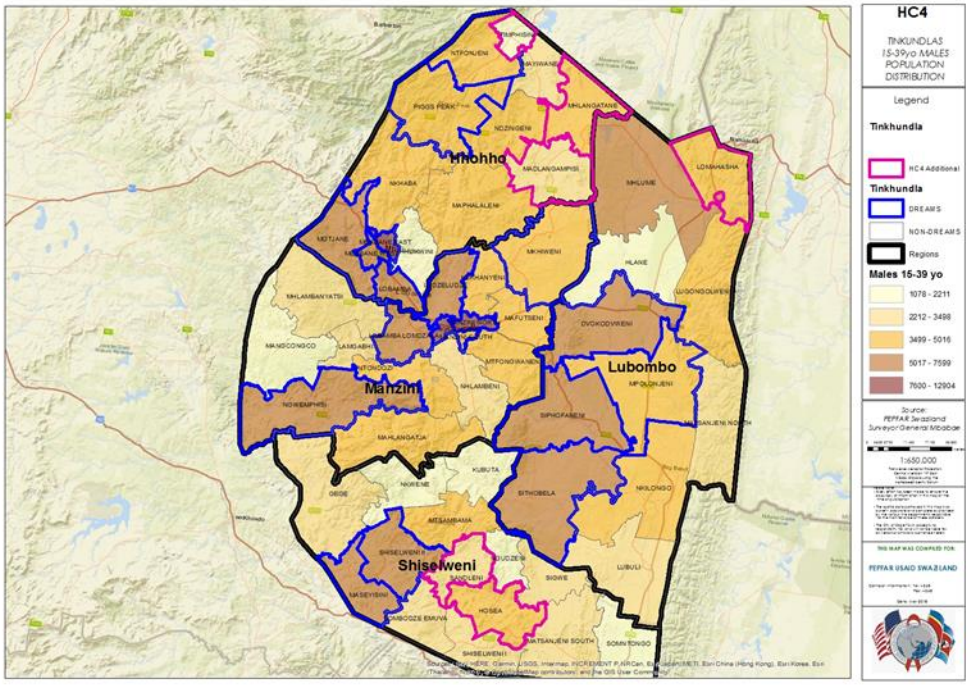


Figure 4.2.2 shows the increased uptake of services after 6 months in 6 'Game Changer" tinkhundla in FY17 compared to FY16.

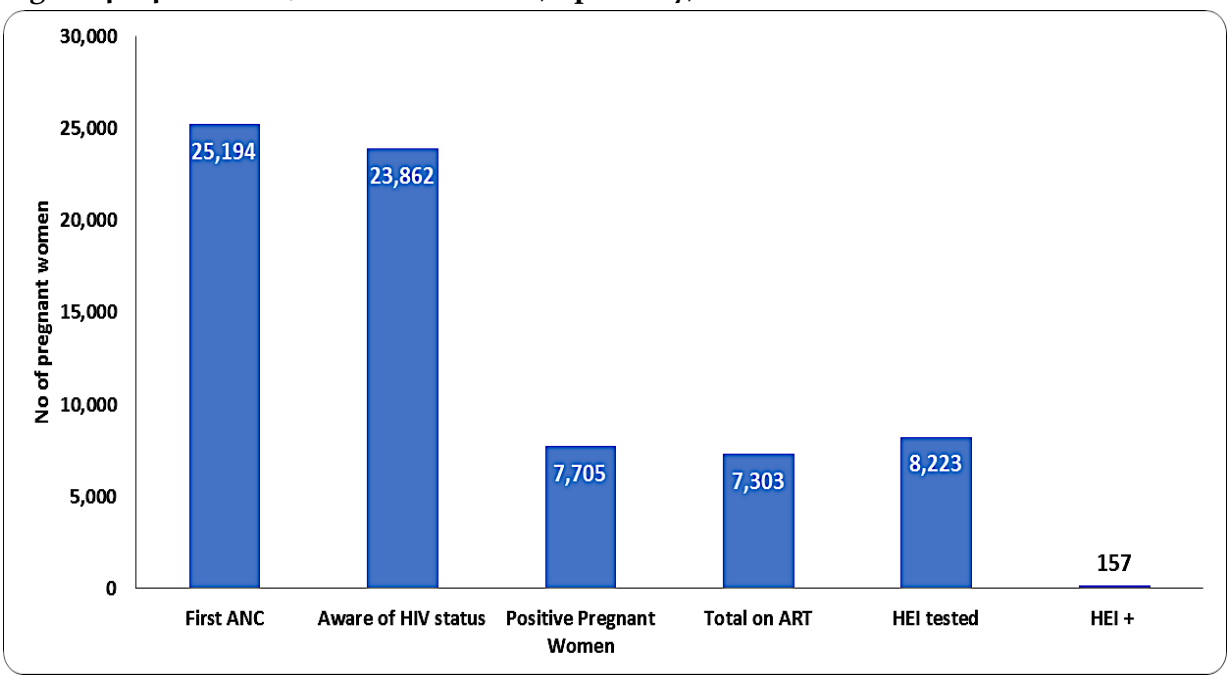
Figure 4.2.3. Map of HC4, Breakthrough Action activities by inkhundla and men, ages 15-39, Swaziland



Priority and key populations packages of services and interventions

a. Children/PMTCT

Figure 4.2.4. PEPFAR/S PMTCT cascade, April 2017, Swaziland



The Swaziland PMTCT program has successfully accomplished high HIV testing coverage among pregnant women; high treatment coverage among HIV-positive pregnant women; and high EID coverage of HIV-exposed infants. In an effort to maintain the high testing, treatment, and EID uptake, PEPFAR/S will continue to strengthen the capacity of HCWs in PMTCT skills through trainings and ongoing clinical mentorship. Working through the mentor-mother program, PEPFAR/S will also strengthen peer-to-peer education and counseling of pregnant and breastfeeding women. In addition, PEPFAR/S will support the regular review of PMTCT data at the facility level to identify program gaps and implement appropriate course corrective measures.

Despite PMTCT program successes, the program is still faced with the challenges of high loss to follow-up of HIV-exposed infants as measured at 18 months. The Swaziland program will continue strengthening post-natal follow-up of HIV-exposed children through the facility-based mother-baby-pair initiative across all four regions. In addition, PEPFAR/S will scale-up the community mother-baby-pair intervention through the various existing community lay cadres such as mentor-mothers, expert clients, and OVC home visitors.

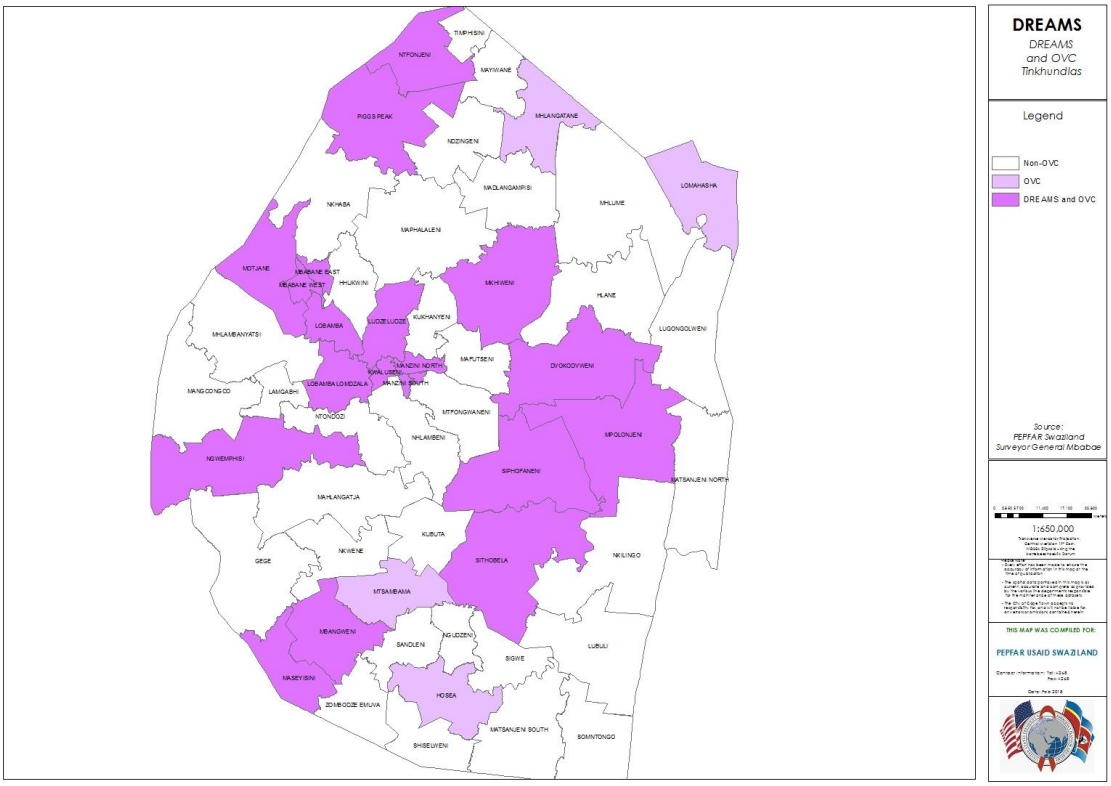
b. HIV prevention and risk avoidance for AGYW and OVC

PEPFAR/S priority populations for HIV prevention are adolescent girls (AG) ages 9-19, young women (YW) ages 20-29 and male and female OVC ages 0 – 17. HIV prevention programming for AGYW and OVC is integrated programmatically and geographically into PEPFAR/S activities to ensure that AG who are also OVC receive the most intensive/comprehensive combination of services from DREAMS and OVC packages.

In COP16, DREAMS programming for AG covered the 14 mostly rural 15+, and is expanding to the five urban tinkhundla in COP17. Also in COP17, YW programming will expand from 17 to all 19 DREAMS tinkhundla and will include YW up to age 29. In COP18, AGYW programming will continue to operate for all target groups in all 19 tinkhundla that were identified as DREAMS sites based on demographic and socioeconomic characteristics.

In line with DREAMS programming for AG, the OVC program is expanding to the urban tinkhundla in the current fiscal year. In COP18, OVC interventions will continue to target the DREAMS tinkhundla and key sites in five additional tinkhundla (total of 24 tinkhundla). In addition, PEPFAR/S will be implementing in a number of additional non-DREAMS tinkhundla, through Peace Corps Volunteers.

Figure 4.2.5. DREAMS and OVC by inkhundla, Swaziland



The table below (Table 4.2.1) presents a summary of AGYW and OVC programming by target group, enrollment strategies and service packages.

Table 4.2.1. Summary of AGYW and OVC program services by age and sex, Swaziland

Priority groups	Identification strategies / entry points	Priority interventions
AG 9-14: **AG in school, but overaged for grade; AG not living with biological mother; AG survivors of/at risk of abuse**	**Rural:** Household level identification through door-to-door enrollment & vulnerability assessment; schools; traditional leaders; community lay cadres (RHMs, LLs, KaGogo Centre managers) **Urban:** Schools; markets and other gathering places	**Tailored DREAMS package of services,** including mentorship focusing on HIV risk avoidance, physical & emotional changes in puberty, healthy friendships, gender norms, decision-making, self-esteem, awareness of GBV, and staying in school. Needs-based education support; support to caregivers on parenting skills
AG 15-19: **AG not in school; sexually active AG; pregnant AG & young mothers; AG at risk of**	**Rural:** Household level identification through door-to-door enrollment & vulnerability assessment; engagement with schools to identify drop-outs;	**Tailored DREAMS package of services** and mentoring, risk assessment, mentorship focusing on HIV risk reduction and HIV prevention life skills, partner

engaging in transactional sex	traditional leaders; youth leaders, community lay cadres **Urban:** Targeted enrollment in high vulnerability urban areas; DREAMS on Wheels mobiles; snowballing techniques; ANC clinics	communication, prevention of transactional sex, employability skills, ANC referrals and ECD support for pregnant AG/mothers; needs-based education support. **Comprehensive SRH services** through DREAMS on Wheels plus referrals (FP, condoms, HTS based on risk assessment)
YW 20-29: Unemployed YW; YW in low income employment; YW without local family support; YW unaware of their HIV status; YW survivors of abuse	**Rural:** Household level identification via OVC enrollment; engagement with traditional leaders; DREAMS on Wheels mobiles **Urban:** Outreach and snowballing techniques at informal markets, local events, transport hubs, informal day care centers, education upgrading centers, factories, tertiary institutions, ANC clinics, and churches; DREAMS on Wheels mobiles	**DREAMS package of services** and mentoring, flexible livelihoods and employability support tailored to vulnerability; HIV awareness and risk reduction; ANC referrals and early childhood development support for pregnant YW/mothers **Comprehensive SRH services** through DREAMS on Wheels plus referrals (FP, condoms, HTS, PrEP)
OVC 0-17: C/A who have lost one or both parents; C/A dropped out of school; C/A of PLHIV caregivers; Children of FSW; C/A who have been neglected or abused; C in child-headed households; Pregnant girls/teen mothers; HIV exposed infants; Children/Adolescents Living with HIV (C/ALHIV); children/adolescents (C/A) in families not able to cover their education or health expenses	**Rural**: Door-to-door enrollment through OVC vulnerability assessment; informal day care centers, Neighborhood Care Points (NCPs), schools, community lay cadres (RHMs, LLs, KaGogo center managers), ART clinics & teen clubs, social workers **Urban:** Outreach to secondary schools to identify drop-outs, gathering places including markets, shopping centers, DREAMS on Wheels mobiles; social workers; KP peer networks (for children of FSW); ART clinics & teen clubs	Comprehensive age-segmented package of OVC care and HIV prevention to ensure health, schooling, stability and safety. Individual case management with family care plans and regular home visits; tracking of school attendance and progression; savings groups with business skills for caregivers; parenting skills; adherence and disclosure support to ALHIV including teen clubs; referral for VMMC and male mentoring camps for adolescent boys. *[Refer to Table4.2.2 for OVC packages by outcome, age and sex]* ***AG ages 9-17 who are OVC receive age-appropriate DREAMS packages above plus the additional OVC interventions.***

Adjustment to the focus of AGYW programming:
Based on program performance in COP16 and COP17, and on COP18 guidance, AGYW programming will continue to ensure that AG, including female OVC, and YW receive age-appropriate and evidence-based HIV risk avoidance and risk reduction services as per the DREAMS core package.

The following adjustments in COP18 represent the fine-tuning of approaches based on AGYW program experiences and efficiency considerations for PEPFAR/S:

- DREAMS programming already includes 10-14 year olds, so 9 year olds will be included in DREAMS programming in COP18. Services for the younger age group will be focused on sexual risk avoidance and delay of sexual onset.
- The implementation of HIV programming for AG in schools through external youth facilitators with extra-curricular modules, such as Stepping Stones, has not been feasible due to time requirements for Ministry of Education and Training (MoET) approval procedures, as well as sensitivities regarding content regarded as too sexually explicit. While PEPFAR investments will continue to focus on providing medically accurate and developmentally appropriate HIV/AIDS and sex education to AG in community settings, we aim to engage the MoH's School Health Program to strengthen HIV content in its outreach activities in schools, including HIV and GBV prevention and demand creation for HTS and SRH services. The inclusion of HIV content in the School Health Program will complement both the primary school HIV life skills curriculum currently under development with support from GF, as well as the secondary school (high school) Guidance and Counseling curriculum which already has HIV prevention components and has been rolled out to all secondary schools with PEPFAR support.
- Program tools and training content for mentors and facilitators will be reviewed to ensure AG ages 9-14 adequately understand violence and HIV risk avoidance, as well as how to prevent sexual violence.
- GBV screening and support for survivors of sexual abuse, currently provided to AG/OVC, will be expanded to YW through PEPFAR programming.
- HIVST will be rolled out during COP18, DREAMS SRH mobile services will include provision of self-test kits to AGYW to reach their peer networks and their sexual partners.
- Program experiences have shown that retention of vulnerable YW in group-based HIV prevention activities is challenging, due to the high mobility of this age group and the reality that interventions extending over several months, such as savings groups, do not adequately meet the needs and aspirations of this group. Approaches to YW programming will be modified to an individual- or social network-based mentoring model targeting highly vulnerable AGYW. Mentoring will combine social asset building, such as self-esteem and problem solving abilities, with flexible economic strengthening support focusing on employability, financial literacy and small business development to more directly meet the needs of this group.

- Oral PrEP is currently offered through demonstration projects at 21 sites, 4 of which are PEPFAR-supported. Of the 21 clinics, 12 sites are located in 8 DREAMS tinkhundla, where nearby residents are referred for PrEP and AGYW above age 18 are at the greatest risk for HIV. In these tinkhundla, AGYW may be able to access PrEP services. Expansion of PrEP provision to additional sites in COP18 will be contingent on GKoS plans to roll out PrEP to additional sites.
- POART reviews to date indicate that both the AGYW program and the broader prevention program have a clear need for custom indicators that capture outputs and outcomes for interventions related to HIV prevention, gender, and GBV in a more nuanced way than the MER indicators. Custom indicators must also be harmonized across partners in order to better capture program performance, measure linkages to services and layering of services, and track the completion of referrals.
- To reach out of school AGYW, Peace Corps Volunteers will shift their programmatic direction in FY19. This includes shifting Volunteer work to report on prevention. Volunteers will target 15-24 year old females, particularly those not in school. This also includes the scaling up of the "clubs to camps" model (GLOW Clubs) and includes the creation of strategic partnerships designed to engage community partners (traditional leaders, KaGogo centers, youth leaders, local clinics and school staff) in the implementation and monitoring of evidence-based community prevention interventions. This will also include extending programmatic focus across the country, including several non-DREAMS tinkhundla.

Adjustments to the focus of OVC programming

The OVC program through PEPFAR/S will continue to focus on direct service delivery of comprehensive age-segmented family-based HIV prevention and risk assessment packages to the following groups: adolescents ages 9-17 and other co-resident vulnerable children; HIV-exposed infants; and children of teenage mothers. Home visitors who directly work with caregivers will support case management of OVCs. Home visitors will also work with OVC to develop tailored family care plans outlining action points for the caregiver and each child. The OVC service packages are in line with the PEPFAR OVC outcomes: *Healthy, Stable, Safe and Schooled*. HIV prevention and HIV risk assessment are an integral part of the OVC packages, summarized in the table (Table 4.2.2) below by age and sex bands.

Peace Corps Swaziland will shift programmatic direction in FY19 in order to strengthen the alignment of Volunteer work with PEPFAR priority programming areas. Peace Corps Volunteers (PCVs) will be based in rural communities and partnering with health facilities to improve the supply chain processes to deliver and manage commodities for HIV/AIDS. Volunteers will also partner with KaGogo Centers and community based workers to promote HIV prevention and demand creation of services among AGYW and young men and boys ages 15-24 and to provide comprehensive services to and monitoring of OVCs. Volunteers will also partner with health facilities to either establish or strengthen existing support groups for youth living with HIV and AIDS in order to promote their care, treatment, and overall wellbeing.

Table 4.2.2. PEPFAR OVC packages by age and sex bands, Swaziland

		0-5 years	9-14		15-17		18-19	ALHIV	
	Component		F	M	F	M	F in school	F	M
Service Delivery	**CASE MANAGEMENT**								
	Family care plan	✓	✓	✓	✓	✓	✓	✓	✓
	Home visiting	✓	✓	✓	✓	✓	✓	✓	✓
	HEALTH								
	HIV prevention education & risk assessment	✓	✓	✓	✓	✓	✓		
	Facilitating uptake of HIV testing (children)	✓	✓	✓	✓	✓	✓		
	Promoting access to HIV testing (caregivers)	✓	✓	✓	✓	✓	✓	✓	✓
	Adherence and disclosure support/teen clubs							✓	✓
	ECD support (caregivers)	✓							
	SCHOOLING								
	Monitoring of school attendance and progress		✓	✓	✓	✓	✓	✓	✓
	Needs-based education subsidies		✓	✓	✓	✓	✓	✓	✓
	School block grants		✓		✓		✓	✓	
	Remedial teaching		✓	✓	✓	✓	✓	✓	✓
	STABILITY								
	Parenting skills (caregivers)	✓	✓	✓	✓	✓	✓	✓	✓
	Saving groups/financial literacy (caregivers)	✓	✓	✓	✓	✓	✓	✓	✓
Demand Creation	**HEALTH**								
	Facilitating access to VMMC			✓		✓			
	SCHOOLING								
	Facilitating access to GOKS OVC education grant		✓	✓	✓	✓	✓	✓	✓
	SAFETY								
	Facilitating access to national identity documentation	✓	✓	✓	✓	✓	✓	✓	✓
	Support to child survivors of abuse to access health, social and legal services	✓	✓	✓	✓	✓	✓	✓	✓
TA for Service Delivery	**SAFETY**								
	Strengthen community capacity to respond to cases of violence, neglect and abuse of children	✓	✓	✓	✓	✓	✓	✓	✓

Based on ongoing/routine program review, POART findings, and COP18 guidance, the following activities will be undertaken in COP18:

- In FY18, an analysis of the current OVC beneficiary composition by OVC sub-population showed that some groups of the most vulnerable OVC might be underrepresented in the current program caseload, such as children of PLHIV and out-of-school adolescents. In COP18, size estimations for subpopulations in target tinkhundla will be conducted to set targets for specific OVC subpopulations that the OVC program will aim to reach.
- PEPFAR/S demonstrated progress on results for OVC_HIVSTAT where indicator reporting increased from 29% at SAPR to 81% at APR17, showing that HIV status information was available for 81% of OVC beneficiaries > age 18. In COP18, the program will increase efforts to ensure that OVC caregivers are aware of their own HIV risk and HIV status, and promote ART uptake for caregivers who know they are HIV positive and are not yet on treatment.
- While overall OVC_SERV targets were fully met in all sites, disaggregated results for females – which had a higher target than males – were just over 82%. Program activities in COP18 will ensure that targets for both sexes will be achieved above 85%.
- FY18 Q4 POART demonstrated successful referrals of male adolescent OVC and co-resident males for VMMC, increasing circumcision prevalence from 18% at baseline to 40% at reassessment 15-18 months later. The OVC program will continue referrals for VMMC services and the partner will set targets for completed VMMC referrals in COP18.
- School block grants, an innovative intervention designed to address barriers to education, especially the transition to and completion of secondary education for female adolescent OVC, will be scaled up in COP18. School block grants were piloted in collaboration with the MoET in COP16-17 in two schools per inkhundla. In this model, in-kind support is provided to schools benefits all students through the purchase of supplies (e.g., computers, desks, science equipment) in exchange for school fees being waived for selected OVC. Results from the pilot show that retention of girls benefitting from block grants equals that of girls receiving the traditional individual school subsidies (e.g., school fees, school uniforms), and that it has the potential to generate efficiency gains. This model is more suitable for implementation in rural areas, as schools in urban areas tend to be better resourced.

Partner management:

In FY18 Q3, all direct service delivery through AGYW and OVC programming in Swaziland will be consolidated under one implementer who will work in all DREAMS and OVC sites. This partner will provide comprehensive packages of services, including mobile clinical SRH services with HTS and family planning (DREAMS on Wheels). This consolidation of implementers is expected to facilitate partner management and coordination, and allow for easier tracking of layered OVC and DREAMS services to individual beneficiaries through an integrated monitoring system and database.

d. Key Populations

PEPFAR/S provides a comprehensive package of services and interventions (see Table 4.2.3) for Key Populations (KP) including FSW; MSM comprising of gay men, sex workers, and other men who have sex with men; transgender people including transgender sex workers; and people who inject drugs. In COP18, PEPFAR/S will expand coverage and increase access to comprehensive services to current and new hotspots and beneficiaries including hard to reach KPs, such as older MSM, and young FSW. PEPFAR/S will utilize new testing modalities and treatment options including self-testing , test and start through initiation in mobile and other sites, community refills (CommART), and PrEP. Children of KP will be reached through the OVC program.

New MoH guidelines for ART initiation through mobile and venue-based 'pop-up' sites, CommART for KP PLHIV groups; and expansion of HIVST and PrEP will increase the number of KPs that know their status, are linked and retained in care, and for HIV negative KP, are linked to PrEP.

Expanded coverage to the hardest to reach KPs will be improved through tailored programming including different testing and linkage modalities and through targeted Enhanced Peer Outreach Approaches that target KPs that are at the highest risk, and those who currently do not access services. The program will also offer add on programming for economic empowerment such as savings groups, improved referrals to social protection; and legal, educational, substance abuse, and other support services.

PEPFAR/S has improved its tracking of individual KPs through the cascade, however linkage to care remains an important gap (Figures 4.2.6 & 4.2.7). It is anticipated that ART initiation through mobile and KP friendly venue-based services, and improved testing and linkage modalities, as noted above, along with improvements in establishing KP friendly services in select public health facilities, will close this gap.

Stigma, discrimination and human rights violations continue to be substantial barriers to services and increase risks for KPs and their children. Over the past several years, working closely with MoH, health care providers, the Royal Swazi Police (RSP) and human rights lawyers, PEPFAR/S has made progress towards breaking down these barriers, and increasing access to social and legal protection, but much remains to be done. In COP18, the program will continue programs to improve KP friendly services at facilities through training, use of KP champions, and follow-up through mentorship at health facilities and provision of support for the champions. The MoH intends to work towards establishing centers of excellence that provide documented KP friendly services in each Region. PEPFAR/S will continue to provide training and mentoring with the RSP, including establishing KP point of contact at key police stations and within the domestic violence units; and will continue to work with the human rights lawyers.

PEPFAR/S continues to strengthen and capacitate local/indigenous KP/Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex, Queer (LGBTIQ) Community-Based Organizations (CBOs) and non-governmental organizations (NGOs). Support includes training of their peer outreach workers, organizational capacity building and support, advocacy skills building and small grants.

Table 4.2.3. KP package of comprehensive services, FY17 and FY18, Swaziland

Service Package	Female Sex Workers (FSWs)	Men who have Sex with Men (MSM)
Core Services	• Targeted Risk education and counseling (HIV transmission dynamics and different sexual practices) • HIV Testing and Counseling (HTC) • GBV Screening, post-exposure prophylaxis (PEP) services, and referral to GBV support and/or legal aid services • Family planning: education, counseling, pregnancy testing, provision of short, and select long acting reversable methods and referral for othe long-acting permanent methods • Promotion of partner / client HTC • Promotion of condom / lubricant use and distribution • STI syndromic screening and treatment/referral • Peer Education • Psycho-social support, human rights support, stigma SGBV reduction • Social cohesion and community building • Self efficacy	• Targeted Risk education and counseling (HIV transmission dynamics and different sexual practices) • HIV Testing and Counseling (HTC) • GBV Screening, post-exposure prophylaxis (PEP) services, and referral to GBV support and/or legal aid services • Promotion of partner / client HTC • Promotion of condom / lubricant use and distribution • STI syndromic screening and treatment and or referral • Peer Education • Psycho-social support, human rights support, stigma and SGBV reduction • Social cohesion and community building • Self efficacy
Expanded Sero-Negative	• All Core Services • Quarterly HTC and STI screening • Repeated and regular risk-reduction counseling, PrEP	• All Core Services • Quarterly HTC and STI screening • Repeated and regular risk-reduction counseling, PrEP
Seropositive Not Yet on Treatment	• All Core Services - except HTC • Measurable linkage to care and treatment services, referral, outreach workers at mobiles and health facilities • TB Screening and referral for treatment • Enrolment in care, CD4 testing • For FSWs who are pregnant: referral for PMTCT • Promotion of community-based HTC to partners & children of sex workers • Assessment of STI and other opportunistic infections	• All Core Services - except HTC • Measurable linkage to care and treatment services, referral, outreach workers at mobiles and health facilities • TB Screening and referral for treatment • Enrolment in care, CD4 testing • Promotion of community-based HTC to partners & children of sex workers • Assessment of STI and other opportunistic infections
Seropositive on ART	• All Core Services - except HTC • All expanded services for seropositive not yet on ART • Initiation on ART • PLHIV support groups to access treatment and increase adherence	• All Core Services - except HTC • All expanded services for seropositive not yet on ART • Initiation on ART • PLHIV support groups to access treatment and increase adherence
Additional Services	Screening for: blood glucose, blood pressure, anal cancer, pregnancy, cervical cancer screening, breast cancer examination; financial literacy, savings clubs, social protection support for children	Screening for: blood glucose, blood pressure, anal cancer; financial literacy

Figure 4.2.6. FSW cascade, Swaziland

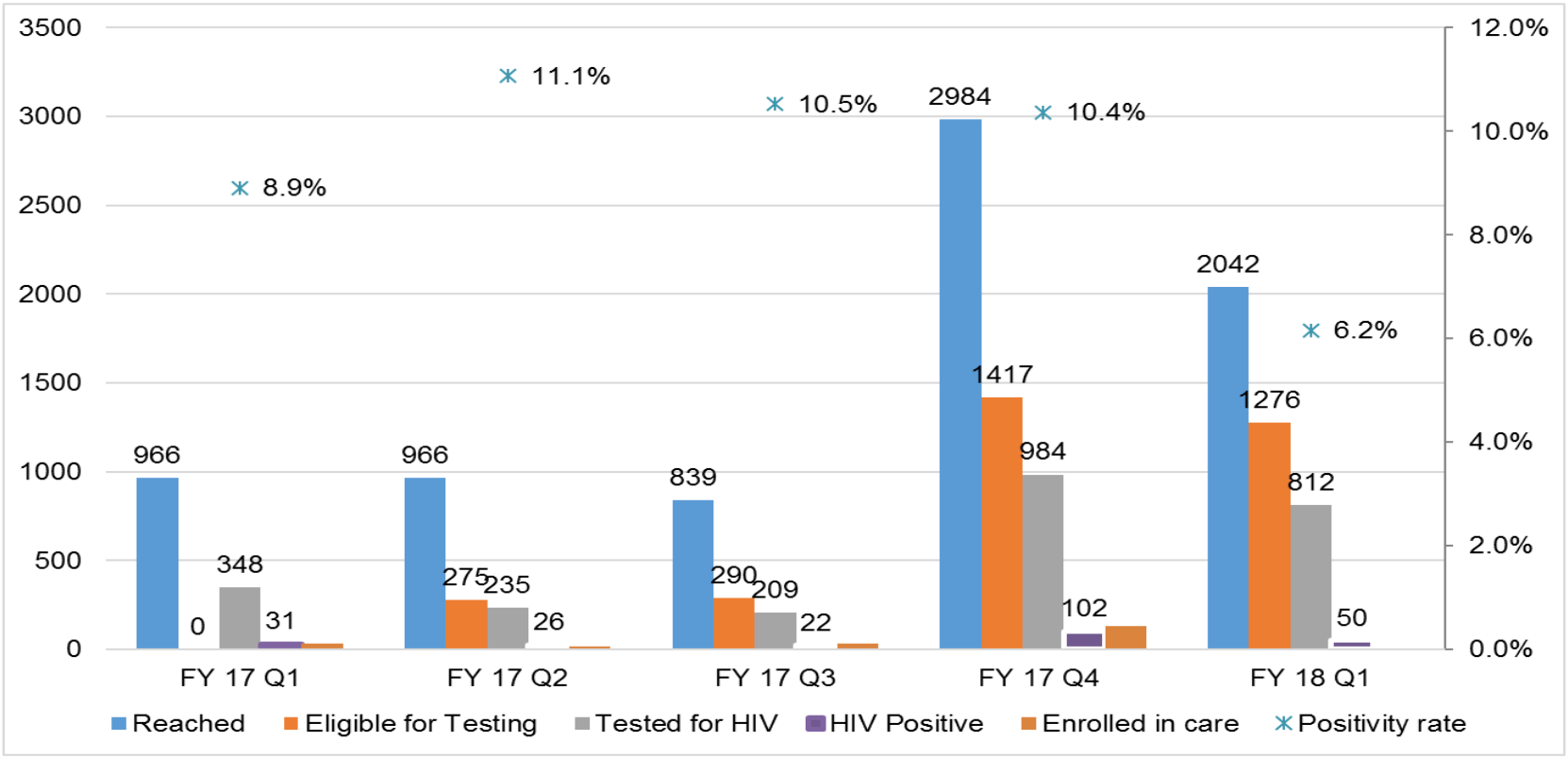
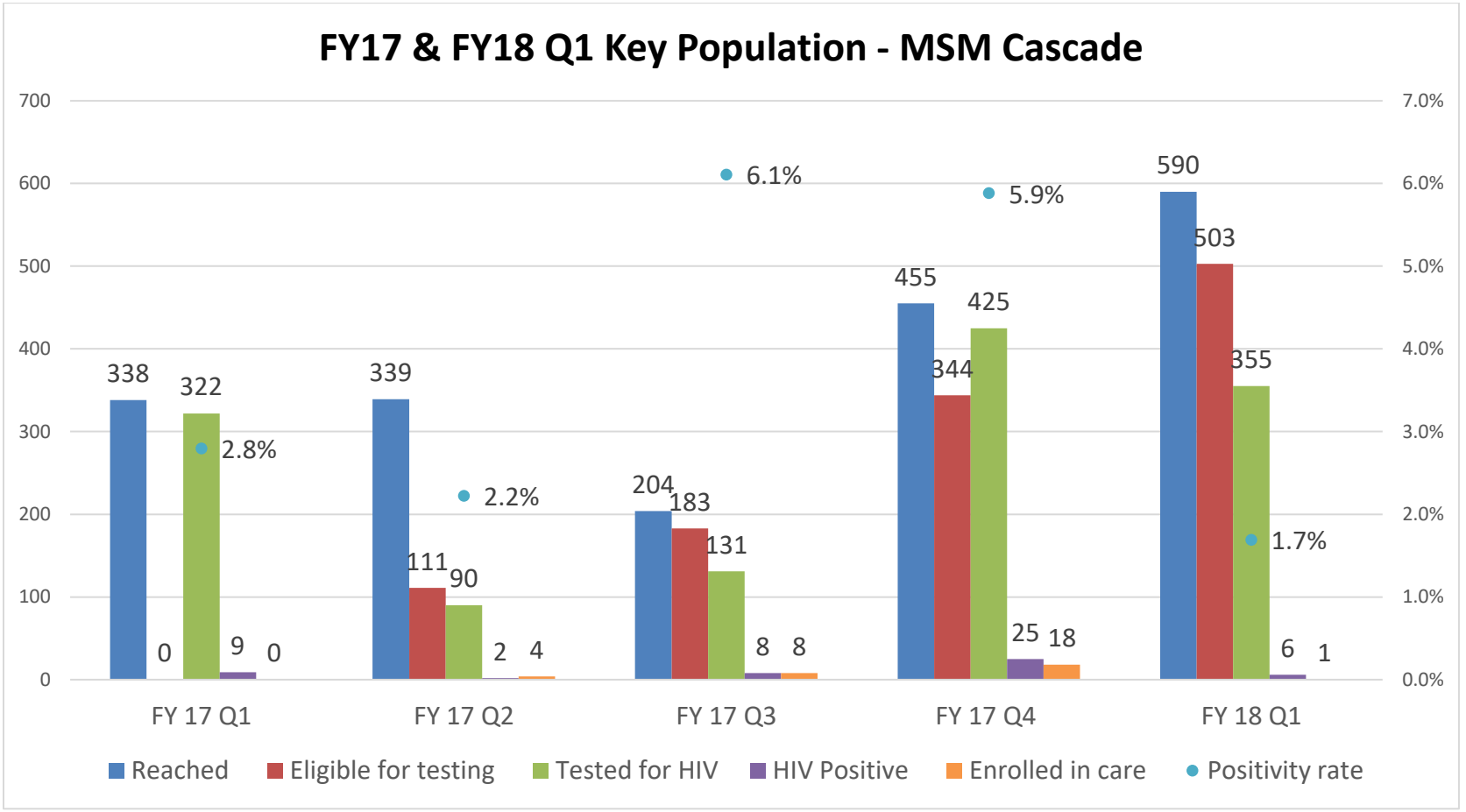


Figure 4.2.7. MSM cascade, Swaziland



e. Prevention services for men

Males 15-39 are a priority population for PEPFAR/S with a focus to reduce transmission by getting HIV positive males tested and linked to early treatment; to prevent new infections through high impact prevention services including VMMC and PrEP, and consistent correct condom use; and to engage men in addressing gender inequities, harmful gender norms and especially sexual and gender-based violence. Swaziland is a patriarchal society and thus men are the gateway to their families and community's health and wellbeing. Supporting local government and traditional and faith leaders, most of whom are men, are important for shaping social/gender norms and perceptions and they are critical for a sustainable HIV response

While HIV incidence is low among adolescent boys and young men it increases with age. Males 15-24 represent 4.3% of all new infections while males 25+ represent 33.1% of all new infections. By age 15 only 2.8% of adolescent boys reported having had sex but by the age 18 one in three males reported having had sex (MICS 2014),

Males are a foundational population that must be reached with a comprehensive package of male-centered prevention interventions and approaches that will increase their uptake of testing, circumcision, PrEP for high risk males (including newly sero-discordant couples), and correct and consistent condom use. In addition interventions must address deeply entrenched and harmful gender norms, SGBV, create a safe environment for AGYW and address gender equity.

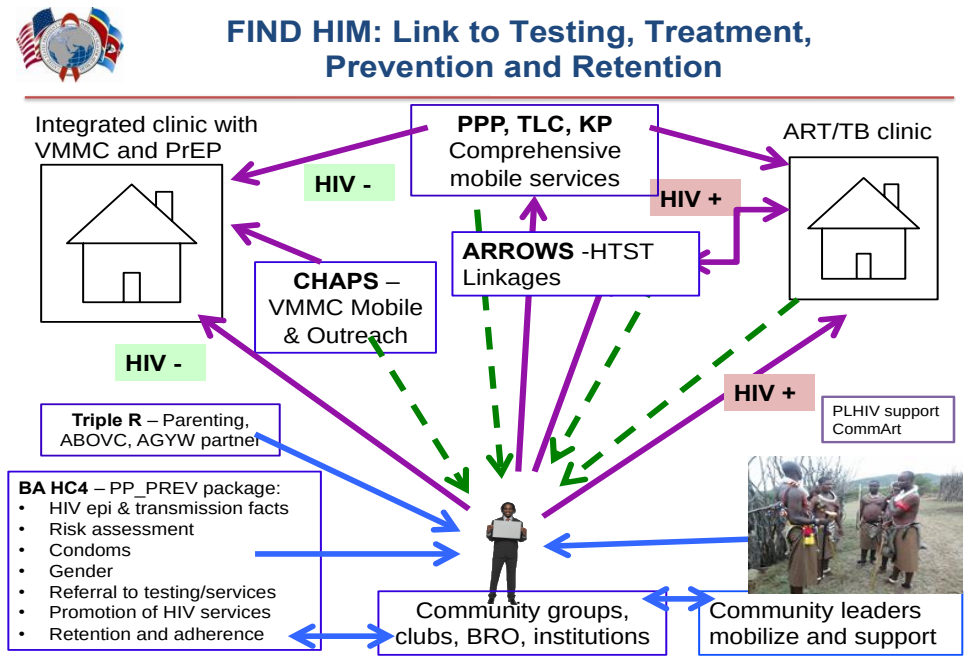
PEPFAR/S will scale up its comprehensive male and community engagement program reaching 48,000 males and traditional and faith leaders in 25 tinkhundla (inclusive of the 19 DREAMS tinkhundla). Males will be reached through multiple approaches and platforms, including male mentoring camps, the workplace (SWABCHA), CBOs, small group sessions, male regimens and through interpersonal communication and social media. In these communities HC4 will work in collaboration with OVC and DREAMS programs to support reduction in SGBV and to support risk avoidance especially among the 9-14 year olds. To increase access to and up-take of services, HC4 will collaborate with facility-based services and VMMC partners as well as with ARROWS and other mobile services for testing and linkage to treatment and/or prevention.

Table 4.2.4. Prevention services for men, COP18, Swaziland

	Component	Community	Facility
Service Delivery	HIV transmission and acquisition, determinants including for AGYW (biologic, behavioral and structural), sexual practices, and gender dynamics	✓	
	Tailored HIV risk assessment/education	✓	✓
	Delayed sexual debut (age appropriate)	✓	
	Gender norms, positive masculinity, SGBV prevention, rape/coercion, safety for AG	✓	
	Financial literacy, economic empowerment	✓	
	Substance abuse information and referral	✓	
	Condom and lubricant skills and distribution	✓	✓
	Social protection referrals	✓	
	Importance of national ID and registration with CMIS	✓	✓
	HIV testing (including self testing)	✓	✓
	ART initiation		✓
	ART refill (ComART), PLHIV support	✓	✓
	PrEP		✓*
	STI screening and treatment		✓
	TB screening and referral		✓
	VMMC Procedure		✓
	Individual commitment and HIV and GBV prevention plan		✓
Demand	IPC - Peers, outreach workers, facilitated sessions, 'champions', traditional, religious leaders	✓	
	Small/mass media - radio, social media, IEC materials, TV, community events	✓	
	Facilitating access to core services	✓	✓

* PrEP is currently available only at sites with ongoing PrEP demonstration projects

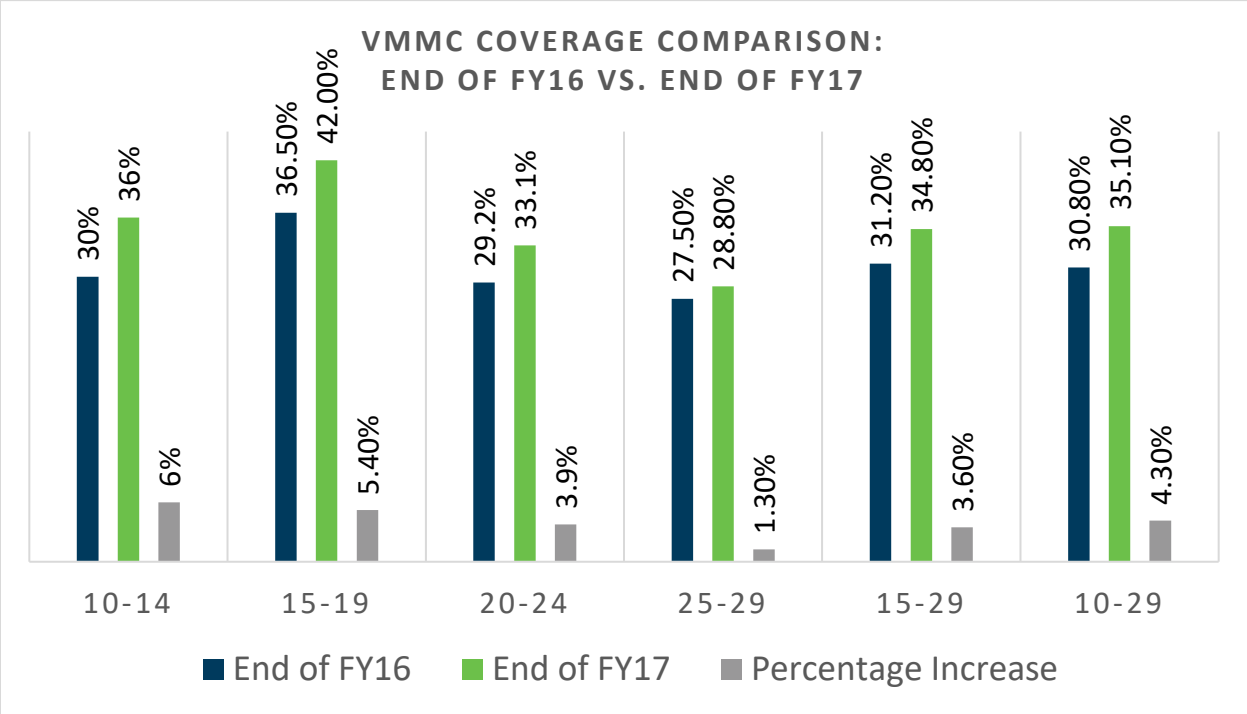
Figure 4.2.8. Community linkage for men



1. **VMMC**

Swaziland's VMMC program contributed to an increase in male circumcision coverage from 8% in 2008 to 35.1% among 10-29 years old by the end of FY17. In COP16 alone, the program increased coverage by by 4.3% among 10-29 years old. However, there is still substantial unmet need. With an increase in target from COP17 (22,051) to COP18 (30,689), the VMMC program will focus on increasing access, and ensuring effective utilization and up-take of services with a focus on the most at risk men ages 15-29 years.

Figure 4.2.9. VMMC coverage, Swaziland



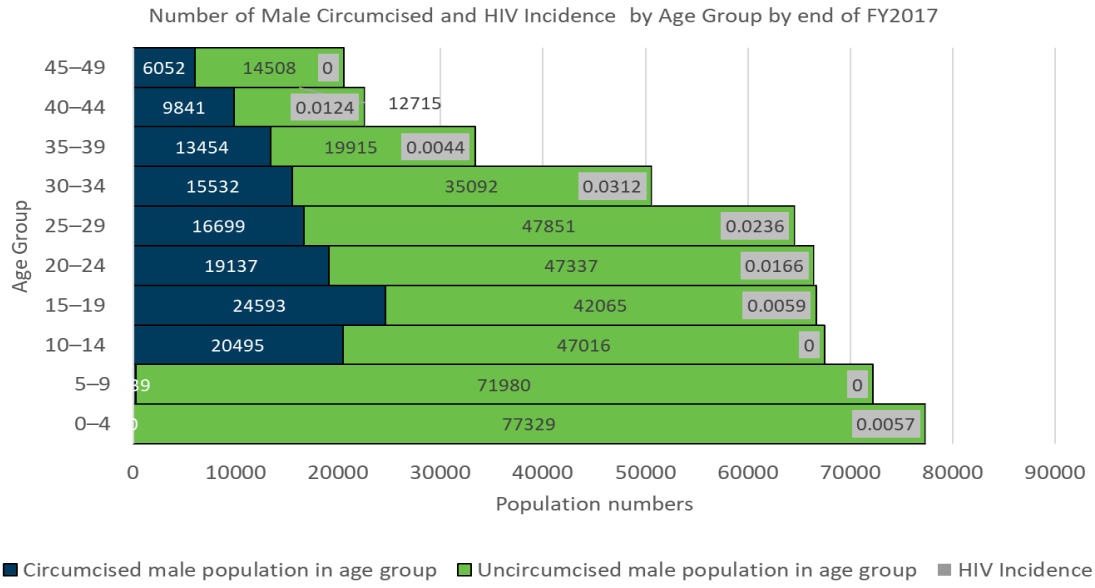
In an effort to increase access to VMMC services, the MoH has identified twelve public health facilities where VMMC services will be offered. Furthermore, planning and monitoring of site performance will aim to increase site utilization rates to above 80%. To address uptake of services among most at risk men ages 15-29 years, the Swaziland VMMC programs will draw lessons learned from the Mozambican model where the program in Manica and Tete Provinces increased the site utilization rates from 29% to an average of 85% and maintain these levels through FY17.

Based on lessons learned from the Mozambique VMMC program, the Swaziland program will strengthen collaboration among partners targeting men as well as scaling up linkages to

VMMC and other HIV prevention services, particularly among men ages between 15 and 29, through the following quick wins:

- Planning and motoring program performance at site level: use of improve monitoring tools and the Site Capacity Productivity Tool to plan and monitor site level performance with the aim of increasing and maintaining a site utilization rate of at least 80%;
- Establishing linkages between the HTS program and the VMMC program in an effort to ensure that HIV negative men are referred for prevention services including VMMC, PrEP and condoms; and
- Creating demand for prevention and VMMC services at the community level, through men's corners, workplace programs, and community outreach activities.

Figure 4.2.10. Male circumcision and HIV incidence pyramid, Swaziland



f. PrEP

During COP17, the MoH approved the PrEP framework and began three PrEP demonstration projects to assess the various integrated service delivery models and local acceptability of PrEP for HIV prevention among those at substantial risk of infection and very vulnerable HIV negative populations, including those with incidence rates exceeding 3 per 100, recently diagnosed sero-discordant couples, HIV-negative sex workers and MSM, and the most vulnerable AGYW. The demonstrations are currently being conducted in 21 sites as of April 2018, with four clinics receiving technical support from PEPFAR. During COP18, PEPFAR is also supporting PrEP readiness by supporting MoH in the development of implementation guidelines, SOPs, job-aids, training materials, communication materials, demand creation strategies and monitoring tools.

PEPFAR will also support HCW capacity through trainings, ongoing clinical mentorship and job aids to ensure integration of PrEP services at facilities. In COP18, PEPFAR/Swaziland will support the integration of PrEP with other services.

g. Condoms

The GKoS developed and adopted a national condom strategy in early FY17. The strategy reflects an important shift toward a more sustainable, equitable and market-based approach that will improve access to male and female condoms and lubricants for key and priority populations, especially youth and males. The strategy highlights stronger coordination, increased commodity security, increased demand, access, and correct and consistent utilization of condoms. This strategy includes an analysis of evidence-based solutions for condom markets in the region and total market assessments conducted in 2016-17 through USAID and UNFPA. The strategy emphasizes a total market approach showing the need for enhanced understanding and monitoring of the current condom market (e.g., use, preference, availability).

PEPFAR/S will continue to work closely with the GKoS and civil society on forecasting and distribution and promotion strategies. In COP17, PEPFAR strategies in support of the national program include the following activities, which will continue in COP18:

- Promotion and expansion of the successful category brand *"Got it? Get it"* for youth;
- Supporting a Market Development Approach to optimize the targeted provision of free condoms and lubricants, and encourage private and commercial sectors to begin planning, procuring, marketing and distributing condoms and lubricants as well as developing innovative solutions to increasing condom use; and
- Prioritizing demand creation by developing a better understanding of current condom use, demand, perceived availability, and preference among consumers.

4.3 Additional country-specific priorities listed in the planning level letter

Table 4.3.1. Country Specific Priorities, Swaziland, COP18

Country Specific Priorities		
Priorities	**Implementation Timeframe**	**What are we doing differently in COP18**
IP management to ensure alignment	Ongoing	PEPFAR/S holds joint partner meetings to review data and progress towards targets and to identify innovative strategies that can be implemented throughout Swaziland. PEPFAR/S staff review weekly updates from poor/weak performing partners. Monthly review of data and financial outlays and obligations are conducted to identify problems early and implement corrective actions to address them. For HTS, these reviews have helped identify entry points that have good yield and volumes and ensure that the correct strategies for case identification are employed. Regular partner meetings are convened to share best practices. Weekly data reviews with testing partners has resulted in more efficient and cost-effective testing with increased yield. Regular SIMS visits, quarterly preparation for POART calls also strengthen IP management.
CMIS	Ongoing	The Swaziland MoH, with support from PEPFAR/S and GF, is implementing a project aimed at transforming the overall health management information system (HMIS). An electronic based client management information system (CMIS) is at the centre of this transformation. It is a complete migration of the patient registration systems into one modular database that will usher in the electronic collection of patient-level data. CMIS is patient-centered and patient healthcare outcomes driven. Currently the system is operating in over 110 facilities in all four regions of Swaziland. CMIS uses the national identification number to uniquely identify a patient, thus ensuring that each patient has one consolidated medical record. The system is designed to be integrated with other specialized ancillary clinical systems (laboratory information systems, supply chain software, etc.). It will also be linked to a Data Warehouse, which will bring in monthly data to inform the data and reporting needs of health stakeholders within Swaziland. In COP18, PEPFAR will provide financial and technical resources to complete the scale up of CMIS to all 172 HIV care and treatment sites in the country, thus allowing for better and integrated patient management across the continuum of care.

TLD Planning and Transition		In October 2017, Swaziland made the decision to adopt a new antiretroviral (ARV) drug, dolutegravir (DTG). With this decision came the commitment to transition the country's first-line ARV population to the new fixed-dose combination (FDC) of TLD (tenofovir, lamivudine and dolutegravir) and include dolutegravir as part of third-line regimens. The benefits associated with TLD are significant. Currently, there are around 168,000 adult (15 years and older) ARV patients in Swaziland (Spectrum Estimates, 2018) and over 70% of these patients are currently receiving TLE (tenofovir, lamivudine and efavirenz). With the introduction of, and transition to, TLD, the Swaziland government expects several main outcomes: a large savings in the cost of first-line ARVs each year, improved adherence and patient outcomes, and a reduced rate of migration from first-line to second-line. The goal of the existing draft transition plan is to guide the transition of Swaziland's ARV population from current first-line regimens to a dolutegravir-based regimen by projecting adequate TLD stock to support the transition and to ensure that there is no interruption or expiration of the national TLE stock. The nationwide transition to TLD will occur in two phases. A phased approach was decided upon to allow for clear communication with healthcare workers, development of in-country training, and appropriate stock management. The final transition plan is expected to be approved by the MoH by end of April 2018.
HIV Recency Survey		With the expectation of reaching 90-90-90 by the end of 2018 and striving for 95-95-95 by the end FY19 Q3, the approach to identify the remaining PLHIV and linking them to treatment will pivot from "HIV screening" to "HIV case finding." Finding these individuals will require active and targeted case finding activities in the community since these individuals are not likely to be aware of their status. In addition, identifying PLHIV who have been recently infected will also be pivotal because of the potential to identify additional PLHIV within an index person's network. With this background, starting October 2018, CDC Swaziland will support GKoS to implement a national case-based HIV surveillance system for children and adults, with the inclusion of HIV recency testing.

4.4 Commodities

Table 4.4. Commodity analysis between COP16-COP18, Swaziland.

	COP16 (FY 17)			COP17 (FY 18)			COP18 (FY 19)
	Approved (targets or budgets)	Achieved (expended or results)	% Achieved / Approved	Approved (targets or budgets)	Achieved (FY18 Q1 outlays* or results)	% Achieved / Approved	Planned (targets or budgets)
ARV budget	6,466,486	7,523,246	116 %	5,414,810	37,099	0.1 %	1,306,218
of which, adults	*4,193,548*			*4,505,415*			*359,340*
of which, pediatrics	*1,380,437*			*1,000,395*			*946,878*
TX_NEW	30,452	22,900	75%	34,086	3,835	11%	16,328
of which, adults	*28,383*	*22,405*	*79%*	*31,842*	*3,699*	*12%*	*14,353*
of which, pediatrics	*2,069*	*495*	*24%*	*2,244*	*136*	*6%*	*1,975*
TX_CURR	152,566	150,500	97%	170,923	149,357	87%	178,334
of which, adults	*142,494*	*142,682*	*100%*	*160,363*	*140,599*	*88%*	*166,464*
of which, pediatrics	*10,072*	*7,818*	*78%*	*10,560*	*8,758*	*83%*	*11,870*
RTK budget				175,000			175,000
HTS_TST	237,130	444,826	188%	345,624	107,524	31%	196,566
IO budget							
All other commodities budget				441,000			552,294

Stock-outs of ARVs including TLD, rapid test kits or EID, viral load, VMMC and TB commodities are not anticipated through COP17 and COP18, due to donor financing for pediatric ARVs, TB treatment, VMMC commodities and rapid test kits (GF, PEPFAR) and GKoS financing for adult ARVs. The USG is the primary donor for public sector condom financing through the USAID condom funds. COP17 funds will procure 17 million male condoms and 21 million in COP18.

To increase efficiencies in the use of resources for lab commodities, PEPFAR has worked with GF to divide roles in supporting the laboratory commodity supply, to ensure that there are no testing interruptions due to reagent unavailability.

In October 2017, Swaziland made the decision to adopt a new first-line ARV, dolutegravir (DTG). With this decision came the commitment to transition the country's first-line ARV population to the new fixed-dose combination (FDC) of TLD (tenofovir, lamivudine and dolutegravir) and include dolutegravir as part of third-line regimens. The benefits associated with TLD are significant. Currently, there are around 168,000 adult (15 years and older) ARV patients in Swaziland (Spectrum Estimates, 2018) and over 70% of these patients are currently receiving TLE (tenofovir, lamivudine and efavirenz). With the introduction of, and transition to, TLD, the Swaziland government expects several main outcomes: a large savings in the cost of first-line ARVs each year, improved adherence and patient outcomes, and a reduced rate of migration from first-line to second-line. The goal of the existing draft TLD plan is to guide the transition of Swaziland's ARV population from current first-line regimens to a dolutegravir-based regimen by projecting adequate TLD stock to support the transition and to ensure that there is no interruption or expiration of the national TLE stock.

The nationwide transition to TLD will occur in two phases. A phased approach was decided upon to allow for clear communication with healthcare workers, development of in-country learnings, and appropriate stock management. The final transition plan is expected to be approved by the MoH by end of April 2018.

Peace Corps Volunteers will work within health facilities in rural areas to support the management of supply chain processes in Swaziland. Volunteers will be trained by the MoH and Technical Support for PEPFAR Programs (TSP), which is the national partner for supply chain management. Volunteers will help improve the following areas: inventory management and logistics management information system (LMIS) reporting tools.

4.5 Collaboration, Integration and Monitoring

a. *PEPFAR/S participates in a number of forums that improve collaboration and coordination between MoH, GF and other external stakeholders.* These include but are not limited to:
   - CCM: The CCM coordinates all GF activities in the country, and includes representatives from PEPFAR, MoH, UNAIDS, WHO, civil society and other stakeholders.
   - TWGs: The TWGs, chaired primarily by the MoH and NERCHA, are designed to coordinate ongoing activities within the different program areas across all donors/partners. PEPFAR/S participates as members of these TWGs.
   - Commodity Planning: PEPFAR also regularly engages directly with MoH and GF around issues related to commodities and programming.

   The above regular engagements ensure that there is collaboration and no duplication in implementation or procurement across donors/partners. In addition, the early involvement of MoH and GF in the COP18 Regional Planning Meeting provided another opportunity to further streamline and strategically plan for COP18 HIV/AIDS activities in Swaziland.

b. Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods

PEPFAR/S regularly holds joint partner meetings to review data, measure progress towards targets and identify innovative strategies that can be implemented throughout HIV/AIDS programs in Swaziland. Regular SIMS visits and quarterly preparation for POART calls also strengthen IP management through standard reporting mechanisms. In COP17, weekly meetings with testing partners are being conducted to review data resulted in more efficient and cost-effective testing with increased yields at numerous facilities. For all partners, monthly reviews of data, financial outlays and obligations are conducted to identify problems early and implement corrective actions to address them. These monthly reviews of HTS activities/programs have identified additional entry points that demonstrate high yield and have ensured that the correct strategies for case identification are employed. Regular partner meetings are convened to share best practices and lessons learned. As necessary, PEPFAR/S staff review weekly updates from poor or underperforming partners to monitor progress

towards targets. Monthly and quarterly partner SI meetings are conducted to review results and reporting requirements and to provide guidance.

c. *Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade*

In COP17, above site activities focused on the development and integration of key health systems and interventions to better support the national HIV response:

1. **Human Resources (HR):** Inadequate numbers and capacity of human resources for health remains one of the key barriers to sustainable epidemic control in Swaziland. To address this barrier, PEPFAR/S has supported the development of staffing norms that define the staff composition required at each service delivery level. PEPFAR also supported a state of the art electronic HR information system (HRIS) that tracks actual staff numbers versus the staffing norms and the Ministry of Public Service wage bill (the MoH allocated amount for salaries). The HRIS allows MoH to track HRH indicators and staff levels on a quarterly basis to inform the recruitment and deployment of staff in facilities. This has been prioritized in the HRH Strategic Plan 2018-2022 to address ongoing staffing barriers and challenges.

   One of the most important staffing gaps that has been identified in COP17 and 18 is the hiring of new graduates in Pharmacy Tech and Lab Tech to support scale up of treatment and viral load services. PEPFAR has supported pre-service training for the Lab and Pharmacy tech programs and continues to track the absorption/deployment of these graduates. Further, frequent staff rotations of nurse-led ART initiated service (NARTIS)-trained nurses negatively impacts PEPFAR-supported sites because training of new nurses posted in those sites is constantly required. PEPFAR continues to support in-service training for the NARTIS.

   Another important issue remains the transition of key national, regional and facility staff, who are in the government establishment register, currently supported and deployed by PEPFAR to MoH. These staff are tracked by the HRH-CURR and the HRH- Staff (government) in facilities reported by PEPFAR partners. In COP18, PEPFAR/S will begin discussions with GKoS to develop a transition plan. A PEPFAR/S specific HR for health policy will be developed to ensure any PEPFAR recruitment and pay packages are in line with the government pay scale and job functions. A formal engagement process with the government has been prioritized and in COP18, PEPFAR will transfer select cadre, including phlebotomists and national level staff to the MoH Cooperative Agreement to increase country ownership.

2. **Laboratory Systems:** Since the laboratory plays a major role towards the achievement of the 3rd 95 of the clinical cascade, in FY18, the lab will continue scaling up VL testing, EID and TB diagnoses to ensure that every eligible PLHIV has access to testing regardless of sex, age or geographic location. Having completed a laboratory instrument mapping and optimization in COP17, the laboratory TWG, working with SNAP, will determine where to place laboratory instruments at different sites to increase VL testing capacity and map out

efficient work flow through integration of laboratory tests to available instruments. EID testing will be decentralized by integrating testing to existing WHO qualified platforms which are near-point of care and at point of care.

During COP18, there is a plan to rollout Dried Blood Spot (DBS) VL testing after sites have been mapped out and the national transport sample transport system has been re-configured. There is a plan to replace the platform for VL testing in the Shiselweni region since the partner currently supporting VL testing in this region is transitioning out as of October 2018. PEPFAR will support VL testing in this region and the current platform will be replaced because it is not WHO approved. In order to minimize chances of creating back log in VL testing, additional lab HR are needed to maintain the shift system.

To increase efficiencies in the use of resources, PEPFAR has worked with GF to divide roles in supporting the laboratory system, primarily around commodity support to ensure that there are no testing interruptions due to reagents unavailability. The role of other stakeholder, especially community and civil society is to promote demand creation among PLHIV for VL testing. Most PLHIV are used to CD4 testing, therefore, there is need to educate them about the importance of VL monitoring.

COP18 above site activities will continue to build on COP17 activities by implementing the following health system interventions:

- The laboratory shift system, which will increase the capacity of doing VL testing and decreases the chance of backlogs;
- The Laboratory Information System (LIS), which will improve reporting turnaround time, decrease the usage of paper forms and reduce transcription errors;
- The HRIS, which allows the government to analyze staffing norms to identify gaps and utilize these data for programmatic decision-making;
- CMIS, which will be fully rolled out to all identified sites (~172 sites) to enable better tracking of clients across the clinical cascade between facilities and regions; and
- Prioritizing supply chain strengthening, including the use of the Warehouse Management Information System (WMIS)

d. Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites

Swaziland has rolled out differentiated models of care in order to:

- Define service delivery for stable and unstable patients on ART;
- Improve the efficiency of service delivery for patients on ART;
- Improve adherence to treatment and the likelihood of viral suppression for patients on ART by streamlining HIV services and improving support structures for the patients, both at the community and facility levels; and

- Enhance the quality of clinical care in patients likely to die (hence improve retention & quality of life) by implementing care package for patients coinfected with TB and cryptococcal disease/meningitis.

Pasipamire et al. analyzed the looked at implementation of combination ART refills models in rural Swaziland and found high retention in care (96% for facility based treatment clubs and community adherence clubs and 77% for comprehensive outreach care). There is a clear need to understand the limitations of these models of care as we continue to roll them out in COP18.

e. *Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control*

COP18 above service delivery activities are mapped to key barriers, such as, inadequate HIV transmission and low demand for HIV and SRH services (e.g., VMMC, PrEP, condoms, and family planning for AGYW). In addition, COP18 activities specifically address barriers for increasing men's up-take of testing, linkage to early treatment for PLHIV and to VMMC or PrEP for HIV negative men. Above service delivery activities also address SGBV, stigma, and harmful gender norms to create a protective environment for AGYW and reduce the barrier to services and support. The above service activities are clearly documented in Table 6 with measurable outcomes that will be necessary to reach epidemic control.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts, Swaziland

Entry Streams for ART Enrollment	Tested for HIV (APR FY19) *HTS_TST*	Newly Identified Positive (APR FY19) *HTS_TST_POS*	Newly Initiated on ART (APR FY19) *TX_NEW*
Total Men	84,282	7,333	8,223
Total Women	58,230	5,095	5,714
Total Children (15+)	99,976	2,015	1,976
Adults			
TB Patients	1,619	520	1,341
Pregnant Women	18,629	2,236	3,555
VMMC clients	30,683	867	693
Key Populations	3,167	316	284
Priority Populations			
Other Testing	188,390	10,505	7,925
Previously diagnosed and/or in care			2,116
Pediatrics (15+)			
HIV Exposed Infants	7,665	178	161
Other pediatric testing	92,311	1,714	1,543
Previously diagnosed and/or in care			272

Table 4.6.2. VMMC Coverage and Targets by Age Bracket in Scale-up Districts, Swaziland					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY18)**	**Expected Coverage (in FY19)**
Manzini	15-29 years	**48,754**	**40%**	**3,473**	**54%**
Hhohho	15-29 years	**28,700**	**67%**	**4,588**	**88%**
Lubombo	15-29 years	**29,533**	**50%**	**2,394**	**58%**
Shiselweni	[15-29 years	**52,799**	**24%**	**2,291**	**30%**
	Total/Average	**159,786**		**12,746**	

Table 4.6.3. Target Populations for Prevention Interventions to Facilitate Epidemic Control, Swaziland			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY18)**	**FY19 Target**
KP_MSM	**5,754**	**60%**	**4,027**
KP_FSW	**14,581**	**50%**	**8,749**
PP_PREV_AGYW_15-29	**119,216**	**50%**	**61,014**
PP_PREV_Men 15-39	**100,454**	**50%**	**57,542**
TOTAL	**240,005**		**131,332**

Table 4.6.4. Targets for OVC and Linkages to HIV Services, Swaziland			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC***
Manzini	107,818	21,006	16,805
Hhohho	101,483	18,841	15,073
Lubombo	73,350	17,896	14,317
Shiselweni	72,698	11,739	9,391
TOTAL	**355,349**	**69,483**	**55,586**

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

Swaziland has not yet reached "Attained or Sustained" in any SNU.

5.1 COP18 Programmatic Priorities

Program approaches and activities to meet COP18 priorities do not differ from those described in sections 4.1-4.4.

5.2 Targets for attained and sustained locations and populations

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing (all populations)	*HTS_TST*	345,624	**242,488**
HIV positives (all populations)	*HTS_TST_POS*	36,190	13,139
Treatment new	*TX_NEW*	34,086	15,918
Current on ART	*TX_CURR*	170,923	177,944
OVC	*OVC_SERV*	63,757	69,483
Key populations	*KP_PREV*	10,777	12,776

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the Attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing in PMTCT sites	*PMTCT_STAT*	**27,059**	**24,462**
HTS (only sustained ART sites in FY17)	*HTS_TST/HTS_TST_POS*	**345,624/36,190**	**242,488/13139**
Current on ART	*TX_CURR*	**170,923**	**177,944**
OVC	*OVC_SERV*	**63,757**	**69,483**

5.3 Establishing service packages to meet targets in attained and sustained districts

Swaziland has not yet reached "Attained or Sustained" in any SNU.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Please see Appendix C for Table Six.

In COP18, the activities listed in Table 6 will address key gaps at the above site level that were highlighted in SID 3.0. Above site activities support three areas: Care and Treatment (C&T), Health Systems Strengthening (HSS), and Prevention.

In COP17, above site activities were focused on improving the quality of service delivery within certain lab facilities, addressing inadequate and irregular supplies of drugs, reagents and test kits, implementing Test and Start, supporting HRH staffing norms and critical staffing needs (lab techs, pharm techs and NARTIS trained nurses), strengthening NERCHA and local government and traditional structures to lead and coordinate the multi-sector HIV response. There has been some progress in these areas to date and further progress is expected to occur in the remainder of COP17.

Progress was made in COP17 with regards to supporting laboratory infrastructure. In COP17, activities were supported to improve quality assurance/quality management activities and enroll laboratories in strengthening laboratory management toward accreditation (SLMTA). All laboratories have been enrolled in SLMTA, a checklist has been developed for mini-labs and baseline audits have been conducted. In addition, Quality Officers in all labs have been trained on SLMTA and work is ongoing to fast track QM activities and monitor progress towards accreditation. COP18 will support the establishment of a regional Quality Control corps to conduct external quality assessment (EQA) trouble-shooting at all levels.

In COP18, Swaziland will also move towards the national transition to TLD, complete the rollout of CMIS to the remaining ART facilities in partnership with GF, and ensure CMIS is operational to provide better tracking of patients between facilities and regions at all sites.

In the area of HRH, during COP16 and 17, PEPFAR supported the government in establishing staffing norms, assessing the number and skill sets required at each level, strengthening the pre-service program for nursing and pharm techs. In addition, PEPFAR/S supported a training information system to strengthen the deployment and tracking of staff and the establishment of a state of the art electronic HR system that provides quarterly reports to track progress on staffing norms. The HRIS provides the MoH with critical information to report to Parliament and establish annual budgets and recruitment plans. COP18 will continue to strengthen the HR unit in the MoH and government to improve HR processes and analyze and use these data for advocacy and decision-making. In COP18, PEPFAR/S will also develop a plan for the transition of specific HR to government.

COP18 above site activities for **Care and Treatment (C&T)** and prevention will continue to strengthen capacity at the national, regional and community levels to better manage and coordinate HIV/AIDS and TB activities in Swaziland. This will provide a stronger platform for the planning, implementation and evaluation of HIV and TB activities so that the government (and PEPFAR) can make quick and informed decisions to address gaps, redundancies, and deficiencies and develop or adjust policies and programs to achieve 95-95-95 and prevent new These activities will strengthen the capacity of NERCHA, the MoH, other ministries, and local government and community structures to lead an effective and coordinated HIV/AIDS and TB response in Swaziland. Above site activities will also support demand creation for and uptake of testing, treatment, PrEP, VMMC, condoms, and sexual reproductive health services including family planning.

Additional above site activities will also help improve the health systems and the collection, analysis and use of data that can be used for monitoring and evaluating HIV and TB activities in Swaziland. Systems, such as CMIS, the LIS, the logistics information system to support commodity security, HRIS, the VMMC site productivity tool and Decision Makers Program Planning tool, and the Integrated Disease Surveillance and Response system (IDSR) will all help government gain efficiencies and provide data to guide the national HIV response.

The following are some examples of COP18 above site activities that will address critical gaps to help Swaziland reach epidemic control (see Table 6 for all above site activities):

- Build the capacity of SNAP, the Sexual Reproductive Health Unit (SRHU), and the NTCP to more effectively manage and coordinate the HIV and HIV/TB response through targeted technical assistance
- Strengthen NERCHA, Regional Administrators, and local government and traditional structures to effectively utilize data to inform their HIV/TB programming and improve the coordination of the multisector response at national, regional and community level
- Strengthen MoH Regional Health Management Teams' ability to develop the criteria and process for Health Services accreditation so that hospitals and clinics can better respond to the demand for HIV/AIDs services
- Strengthen the MoH HR Unit to effectively use the HRIS for recruitment projections, assessing staffing norms, development of job descriptions, dissemination of standard operating procedures and HRH transition and absorption plans for sustainability
- Strengthen the national IDSR system as well as support the pediatric case surveillance system and HIV drug resistance surveillance system
- Support the rollout of the CMIS system to all 172 facilities to enable better tracking of patients along the cascade between facilities, regions and communities
- Strengthen the supply chain management to ensure availability of ART, TB, lab commodities and condoms at site and community level as well as improved reporting of adverse events and complications

- Build the capacity of the Health Research Unit to transition to a self-sustaining National Data Coordination Center, serve as an Institutional Review Board, provide training for mid-career professionals who can produce and consume epidemiologic information as well as assist in implementing the National Research Agenda
- Strengthen the laboratory capacity to conduct EQA at all testing levels, roll-out near-POC platforms to increase access to EID testing, review the LIS for cost effectiveness and sustainability and improve laboratory capacity for the main military clinic
- Rollout the VMMC site capacity productivity tool at all VMMC sites and link it with the Decision Makers Program Planning Tool and GIS mapping tools
- Build capacity for pharmaceutical management at the national, regional, facility and community level
- Conduct a survey of the military population around HIV/AIDS issues to better target program activities
- Increase demand for and access to adolescent friendly sexual reproductive health and HIV services for AGYW
- Engage communities and men to create demand for testing (including the use of index case testing) and access treatment for PLHIV and prevention services for HIV negative individuals and to support adherence and retention
- Strengthen the supply chain management to ensure availability of ART, TB, lab commodities and condoms at site level as well as improved reporting of adverse events and complications.

Surveillance, Research and Evaluation Inventory

Swaziland does not have any research or evaluation projects. The inventory of surveys and surveillance projects can be found in Table 6.1 below.

Table 6.1. Inventory of surveys and surveillance projects, Swaziland

Title of Survey/Surveillance	Agency	Implementing Partner	Key Question	Population	How does this project advance COP priorities and activities?
HIV Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS)	DoD	TBD	What is the HIV prevalence and associated behavioral risk factors among military personnel in Swaziland?	Military	Allows for accurate target and program planning among military population
HIV recency testing and incidence surveillance and pediatric case reporting surveillance	HHS-CDC	TBD	What is the epidemiology and geographic distribution of recent HIV infections in Swaziland? What is the epidemiology of pediatric HIV among children ages 0-18 in Swaziland?	All persons tested positive for HIV, HIV exposed infants and children ages 0-18	Advance understanding of epidemiology and geographical distribution of new infection in country to tailor prevention and treatment services; Provide understanding of pediatric transmission and final outcome of HIV exposed and infected children, which SHIMS 2 was not powered or designed to do

7.0 Staffing Plan

7.1 Analysis of PEPFAR/S Staffing Footprint

Based on the analysis of the staffing footprint and interagency organizational structure of PEPFAR/S, the team has reviewed the interagency organizational structure and identified key positions that should be filled. The baseline Level of Effort (LOE) of current staff allows the PEPFAR/S team to effectively work together in the interagency space. The current staffing plan also encourages effective intra-agency, interagency, and implementing partner management with a balance of technical expertise and program management skills. PEPFAR/S have identified the following missing skillsets or competencies:

- The PEPFAR Coordinator (State)
- The PEPFAR Administrative Assistant (State)
- An HIV/TB focal point (CDC)
- A Community and KP Advisor (USAID)
- A Senior Policy and Program Specialist (USAID)

In order to compensate for these deficiencies and better align with the new PEPFAR business model and program priorities in Swaziland, PEPFAR/S has covered this work with existing staff, but this arrangement is neither optimal nor sustainable. These new team members will ensure that agencies are able to achieve balance between partner management, technical roles and interagency work processes, including SIMS requirements as determined by the SIMS calculator.

One of the most critical vacancies, the PEPFAR Coordinator, is essential to ensure that all coordination activities are covered. The Deputy PEPFAR Coordinator is also acting as the PEPFAR Coordinator at this time.

Beyond COP submission, PEPFAR/S would like to ensure that recently hired staff are brought onboard quickly and that progress continues for previously approved positions that are either in recruitment or have selected candidates.

7.2 Progress of Long-Term Vacant Positions

Several positions have been filled in the past year, including:

- The DOD locally employed staff (LES) agency lead positon was filled on 23 August 2017.
- The CDC LES HTS position was filled and the individual joined the team in February 2018.
- The CDC LES Administrative Support Specialist was filled and the individual joined the team in October 2017.

Additionally, there has been progress regarding some previously approved positions:

- The CDC LES TB/HIV Specialist was approved in COP14. A candidate has been selected and is pending security clearance before joining the Team.
- The USAID LES Program administrator position, approved in COP14 has been repurposed as the Senior Policy and Program Specialist, the position description has been finalized and recruitment is underway.
- The USAID LES Senior Community and KP advisor position approved in COP14, recruitment is underway.
- The PEPFAR Coordinator has been selected and has obtained her security clearance but has not joined the Team because of the hiring freeze. Mission Swaziland requested an exception for this position and is awaiting a response.

7.3 Justification for Proposed New Positions

Peace Corps is requesting a new position of Small Grants Coordinator. The position is in response to the major shift in their programming that necessitates a restructuring of staff responsibilities in order to accommodate the new intensive technical training plan. Current Programming and Training staff who were supporting the small grants administration process will now focus on designing and delivering new technical training sessions as well as developing comprehensive resource materials for volunteers (and supporting program implementation). The Small Grants Coordinator will play a critical role in streamlining the small grants process. This request is also in response to small grants administration challenges that Peace Corps reported in the most recent EA. Designating one staff person to small grants coordination (and therefore small grants training) would resolve these issues by streamlining the small grants process, coordinating the small grants committee, monitoring implementation through site visits, and strengthening and improving small grants reporting. The Small Grants Coordinator position will be a 5-year annually renewable PSC contract.

7.4 Changes to CODB

Generally, the cost of doing business has increased due to increases in ICASS costs. Additional factors include:

- CDC's CODB has risen due to the addition of permanent Change of Station costs for two direct hire staff, and costs associated with a new CDC Fellow who will be working on HIV Recency Testing and ARROWS activities.
- The increase in State's CODB is due to the cost of the LNA Coordinator position. PEPFAR/S has been without a Coordinator since December 2015. In spite of several TDYs to support this position, a full-time Coordinator who is fully engaged in the PEPFAR/S program will provide consistency and leadership for PEPFAR agencies, stakeholders and partners.
- The PEPFAR Coordination Office proposes the promotion of drivers to Driver/Clerk positions to provide additional administrative assistance. If this is not fully supported, administrative support for Coordination activities, for DOD and USAID may suffer.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1

COP	< 10 YR	10-14 yr		15-19 yr		20-24 yr		25-49 yr		50+ yr		Overall Summary
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
COP16	65%	78%	52%	61%	62%	65%	43%	81%	59%	90%	70%	72%
COP17	104%	76%	56%	112%	101%	132%	285%	77%	73%	65%	64%	82%
COP18	82%	93%	90%	85%	82%	83%	82%	86%	85%	86%	88%	86%

Note:
COP16: Denominator = APR17 Achievement; Numerator = Projected PLHIV for 2019 (208,100)
COP17: Denominator = COP17 Targets (Expected achievement); Numerator = Projected PLHIV for 2019 (208,100)
COP18: Denominator = COP18 Targets (Expected achievement); Numerator = Projected PLHIV for 2019 (208,100)
All numerators extracted from DATIM (PEPFAR results and targets)

Limitations:
1. Targets for COP16 and COP17 TX_CURR were based on estimated PLHIV of 226,920 and 233,923
2. APR17 TX_CURR reported prior to national TX_CURR data cleaning exercise in December 2017

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY18)**	**Additional patients required for 90% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY19) *TX_NEW***	**ART Coverage (APR 19)**
Attained	n/a	n/a	n/a	n/a	n/a	n/a
Scale-Up Saturation	208,100	181,611	5,679	197,693	15,918	95%
Scale-Up Aggressive	n/a	n/a	n/a	n/a	n/a	n/a
Sustained	n/a	n/a	n/a	n/a	n/a	n/a
Central Support	n/a	n/a	n/a	n/a	n/a	n/a
Commodities (if not included in previous categories)	n/a	n/a	n/a	n/a	n/a	n/a
Total	**208,100**	**181,611**	**5,679**	**197,693**	**15,918**	**95%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

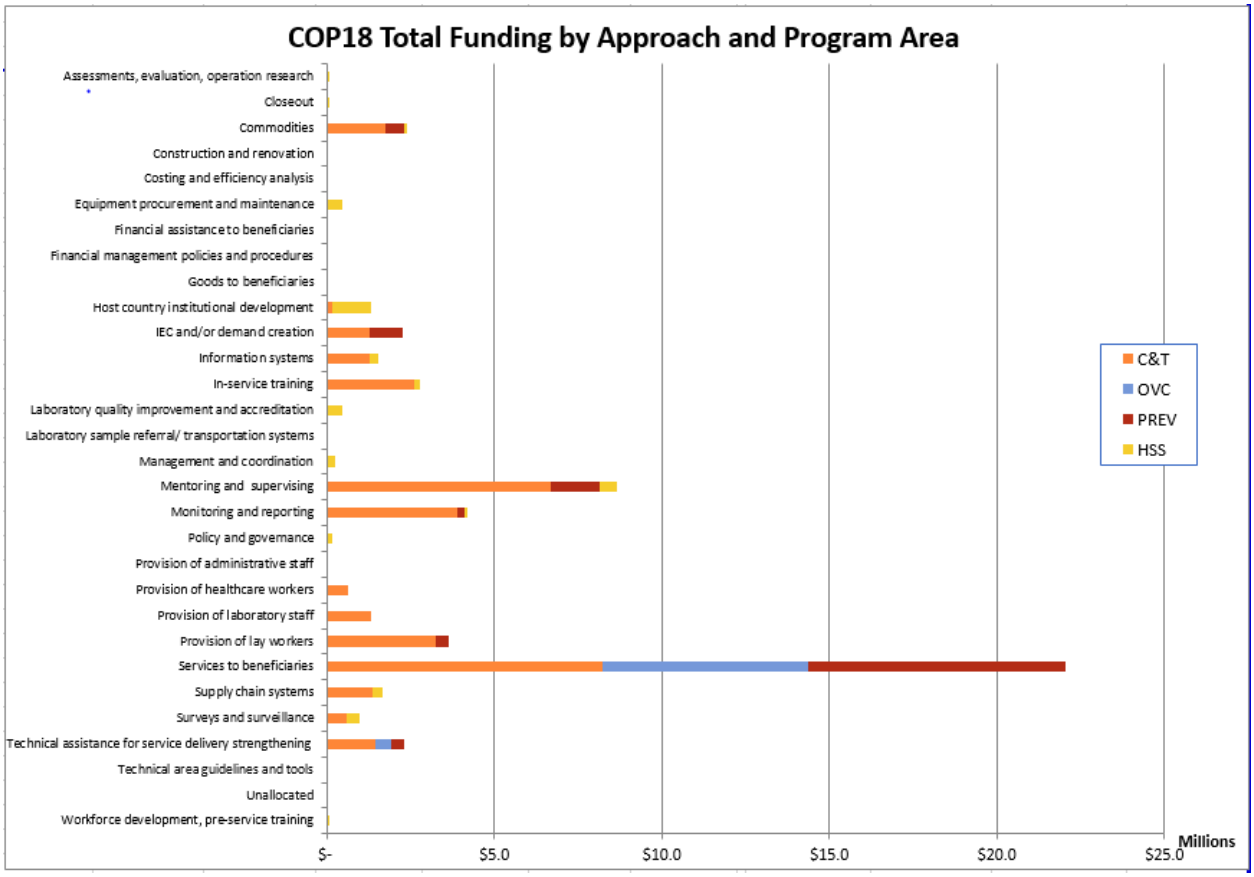


Table B.1.2 COP18 Total Planning Level

PEPFAR COP18 Resource Envelope vs Calculated Budget			
	Resource Envelope	**Calculated Budget**	**Over/(Under)**
COP18 Base Budget	**$ 66,791,784**	**$ 66,791,784**	
New	*$66,255,969*	*$ 66,255,969*	$ -
Applied Pipeline	*$535,815*	*$ 535,815*	$ -
COP18 Central	**$0**	**$ -**	$ -
COP18 Total Planning Level	**$66,791,784**	**$66,791,784**	

Table B.1.3 COP18 New funding by Budget Code

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$1,165,283
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$995,555
HVOP	Other Sexual Prevention	$3,541,108
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$6,198,377
HVCT	Counseling and Testing	$5,647,630
HBHC	Adult Care and Support	$13,465,044
PDCS	Pediatric Care and Support	$2,485,964
HKID	Orphans and Vulnerable Children	$7,024,350
HTXS	Adult Treatment	$11,933,513
HTXD	ARV Drugs	$1,370,493
PDTX	Pediatric Treatment	$747,831
HVTB	TB/HIV Care	$2,377,674
HLAB	Lab	$484,146
HVSI	Strategic Information	$3,310,322
OHSS	Health Systems Strengthening	$1,841,250
HVMS	Management and Operations	$3,667,429
TOTAL		**$66,255,969**

B.2 Resource Projections

The PEPFAR FAST was used to calculate the budget and allocate to budget codes.

APPENDIX C – Tables and Systems Investments for Section 6.0

(1) Swaziland COP18 Table 6_ 2018

APPENDIX D – NERCHA slides on eNSF 2018-2022

APPENDIX E – CommLink Results

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
1	HHS/CDC	ICAP – Epi-Research TA	HSS	Health Research Training Program (HRTP) which trains local mid-career health workers to collect, analyze, and disseminate research findings to inform HIV policy and programming.	Workforce development, pre-service training	Health Research Training Program (HRTP) which trains local mid-career health workers to collect, analyze, and disseminate research findings to inform HIV policy and programming
2	USAID	WHO/AFRO Disease Control	HSS	Strengthen MOH HR unit to effectively use the HRIS data to assess progress on the staffing norms, inform the staffing requests to MOPS to facilitate transition and absorption plans for sustainability	Policy and governance	Support to MOH to conduct quarterly and annual HRH reviews, analysis and planning; continuous review of staffing norms; develop JDs, SOPs and a transition plan for HRH
3	USAID	WHO/AFRO Disease Control	HSS	Conduct HRH assessment and analysis to inform hiring projections of new graduates critical to HIV care and treatment for sustainability of HRH.	Assessments, evaluation, operation research	Support to MOH to conduct quarterly and annual HRH reviews, analysis and planning; continuous review of staffing norms; develop JDs, SOPs and a transition plan for HRH
4	USAID	Project SOAR	HSS	Improve monitoring, tracking and evaluation of the coverage of VMMC, PrEP, FP, HTS and other HIV prevention services	Information systems	Develop VMMC site capacity productivity tool and roll out to all VMMC sites and linked with Decision Makers Program Planning Tool (DMPPT) and GIS Mapping tools; Expand the VMMC Site capacity productivity tool to address the needs to other HIV prevention and treatment services including HTS, PrEP, Condoms, Prevention intervention, Linkages, Treatment and KP
5	USAID	Strengthening Health Information Systems (SHIS)	HSS	IHM - Implement and scale up CMIS in all 172 priority HIV care and treatment facilities to track individuals through the 95-95-95 cascade	Equipment procurement and maintenance	Procure equipment to cover the Global Fund gap
6	USAID	Strengthening Health Information Systems (SHIS)	C&T	IHM - Implement and scale up CMIS in all 172 priority HIV care and treatment facilities to track individuals through the 95-95-95 cascade	Information systems	Expand the roll-out of CMIS to cover all 172 HIV care and treatment sites
7	USAID	HIV Response Coordination, Community Capacity and Communications (HC4) Breakthrough Action	HSS	Strengthen NERCHA multisector coordination and community structures to effectively utilize data for programming to prevent new infections and GBV and promote up-take of services including CommART	Host country institutional development	Build skills and capacity of Nercha and local government and traditional leaders to use their HIV program data to improve coordination and coverage of HIV prevention and care programming and track progress of achievement .

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
1	Limited local technical capacity to design, implement, analyze, and disseminate health research findings to inform HIV policy and programming	7	5.37	HRTP Cohort 6 recruited, trained, and able to conduct data analysis and dissemination in the country	1 year	Number of HRTP fellows recruited; number of relevant research proposals approved; number of abstracts and manuscripts finalized	HRTP Cohort 5 in progress, 10 fellows recruited, 100% have research proposals
2	Inadequate numbers and skill sets for different health cadres at all levels	2	7.13	% of key gaps in staffing numbers and skill sets are filled per the staffing norms	3 years	Staffing data from HRIS as compared to staffing norms	Quarterly MOH HRIS reports.
3	Inadequate numbers and skill sets for different health cadres at all levels	13	3.96	% of key gaps in staffing numbers and skill sets are filled per the staffing norms	2 years	Number of graduates recruited, tracked through HRIS, absorption plan, TIMS	HRIS, absorption plan, TIMS - Training Information Management System
4	Absence of data for decision making for SNU and site level planning and monitoring	13	3.96	Fully implemented VMMC Site Capacity Productivity Tool (SCPT); ability to monitor both community level and site level performance and productivity indicators; Excel version of the extended SCPT tool addressing the need for prevention services including HTS, PrEP, Condoms, KP.	3 years	VMMC SCPT tool available and implemented in all facilities	The VMMC SCPT tool in not in use at any facilities
5	Lack unique patient level data across sites	13	3.96	Ability track patients across HIV care and treatment continuum across regions	2 years	Number of facilities with CMIS equipment	134
6	Lack unique patient level data across sites	13	3.96	Ability track patients across HIV care and treatment continuum across regions	2 years	Number of facilities with operational CMIS platform	100
7	Limited community ownership, skills and capacity to use data to coordinate and lead the HIV response, and feed data into regional and national data systems	13	3.96	Select communities/local government have annual HIV response plans with targets and they track prevention, service up-take coverage and GBV reduction to improve programming on a quarterly basis	3 years	Number of local government/communities using data to track coverage and use for improved programming	12 of 24 local government entities have the skills and tools to collect baseline data, map communities and develop HIV plans

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP19) Annual Benchmark	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
1	HRTP Cohort 6 recruited and all will have approved research proposals		N/A		N/A	
2	1) Absorption plan is complete and establishes priorities for the absorption of PEPFAR cadres that are in the establishment register. 2) PEPFAR has established a tracking mechanism for PEPFAR supported contracts. 3) MOH and Ministry of Public Service use analysis to guide annual request for posts.		Government absorbs an agreed to % of the PEPFAR supported cadres which exist in the establishment register (i.e. Phlebotomists, Lab Techs, Pharmacy techs)		Based on Government absorption plan the % of clinical cadres in the establishment register absorbed by government (i.e., doctors, nurses, techs, etc.)	
3	MOH and Ministry of Public Service use analysis to guide annual request for posts/ recruitment		Based on Year 1 recruitment, identify the gaps in clinical cadres and request positions.		N/A	
4	VMMC SCPT tool available and implemented in all VMMC facilities		Extended SCPT available and implemented in 25% VMMC facilities		Extended SCPT tool available and implemented in all VMMC facilities	
5	Equipment for 18 additional sites		Equipment for remaining 20 facilities		N/A	
6	Increase to 134 facilities with operational CMIS platform		Increase to 172 facilities with operational CMIS platform		N/A	
7	50 % of the select local government entities have annual HIV plans with measureable targets that have been analyzed quarterly.		75 % of the select local government entities have an HIV plan and measureable targets that they have analyzed quarterly.		100 % of the select local government entities have an HIV plan and measureable targets that they have analyzed quarterly.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
8	HHS/CDC	ICAP – Epi-Research TA	HSS	Supporting the National Health Research Review Board (IRB) to be fully functional and self-sustaining, supporting the Health Research Unit to implement the National Health Research Agenda, including technical assistance to organize the National Health Research Conference. Supporting the Central Statistics Office to transition to a self-sustaining National Data Coordinating Center that will house past and future national surveillance and survey data.	Host country institutional development	Supporting the Health Research Unit to coordinate HIV incidence surveillance with clinical implementing partners
9	HHS/CDC	ICAP – Epi-Research TA	C&T	Supporting the Health Research Unit to coordinate HIV incidence surveillance with clinical implementing partners	Surveys and surveillance	Supporting the Health Research Unit to coordinate HIV incidence surveillance with clinical implementing partners
10	HHS/CDC	Strengthening MOH Leadership, Governance & Quality Management	HSS	To improve regional support for linkages, and quality of care by improving the RHMT function and effectiveness.	Host country institutional development	MOH support for four high volume hospitals/clinics accreditation process and strengthening to the health management teams to achieve 95 95 95 indicators
11	HHS/CDC	ICAP Lab	HSS	Rollout the utilization of near point of care (POC) platforms to increase access to laboratory testing	Laboratory quality improvement and accreditation	Map out sites for prioritize for scale of EID testing.
12	HHS/CDC	ICAP Lab	HSS	Strengthen EQA support to all testing levels and fast track accreditation for HIV/TB and VL Laboratories	Laboratory sample referral/ transportation systems	Establish troubleshooting guidelines, recruit QC Corps and monitor labs to ensure adherence to EQA guidelines.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
8	Nascent IRB capacity in country to review research protocols; need to migrate from paper-based review to electronic review to increase efficiency and efficacy of review process; need to enhance data use for programming and policy in country among all stakeholders, which will be fostered by national health research conference. Country ownership of national surveys continues is important to GKOS. However, the capacity to house and manage these complicated datasets in country has been limited. The CSO is the steward of all surveys in country, including health data, and need support to maintain and ensure effective use of these datasets to researchers and programmers.	13	3.96	Fully functioning and staffed NHRRB that uses electronic review system 100% of the times, efficient turn around time of reviews, well-trained board members; National Health Research Conference in 2019. Staffing and operating cost for National Data Coordinating Center will be supported by government and other non-PEPFAR mechanisms.	1 year	Turn around time of review; number of proposals received; number of trainings NHRRB members received; Attendance numbers of the National Health Research Conference 2019; numbers of abstracts submitted and presented at conference. Timeliness of data request response, number of data requests received.	1. NHRRB: Average Turnaround time is 70 days. 2. NHRRB: Number of protocols received and reviewed on quarterly basis on average is 25 protocols 3. NHRRB: A total of 10 Review board members have been trained on bio ethics 4. NHRRB: 10 Protocols submitted and reviewed through RHInnO 5. HRU: 2017 4th National Health Research Conference Held 6. HRU: 129 Abstracts were submitted for National Health Research Conference 2017. 7. CSO: Staffing and operating cost for National Data Coordinating Center supported by PEPFAR 100%.
9	Getting to 95-95-95 requires additional surveillance activities to identify location and associates of newly infected PLHIV for quick response. Currently there is limited understanding of location and epidemiology of new infections in the country.	13	3.96	HIV incidence surveillance system up and running countrywide, use of information to identify hot spots of new infection to inform response plan	2 years	Number of recent infections identified per year, quarterly analysis of place and demographics of recent infections	N/A
10	Limited capacity of MOH to achieve accreditation and strengthen health management teams	6	4.95	Increased capacity MOH to establish a process and criteria for Health Service accreditation: Four high volume hospitals/clinics will be ISO 9001 certification and accreditation which will strengthen health management teams to support improved indicators (TX_CURR, TX_New, HTS_POS, PMTCT and TB).	2 years	Hospitals will meet ISO 9001 and achieve certification in four hospitals; National health semi-annual reviews by region; TX_CURR, TX_New, HTS_POS, PMTCT and TB cascade and VL coverage and turnaround time	Current focus is on ISO certification; a pre-audit has been completed; current indicators - TX_CURR, TX_New, HTS_POS, PMTCT and TB cascade and VL coverage and turnaround time
11	HR and reagents	10	4.83	Increase EID coverage and decrease cost of viral load.	2 years	Number of sites with access to routine EID	1 Roche machine committed to EID fulltime.
12	Lack of national system to disseminate and troubleshoot EQA results	10	4.83	95% reduction in EQA failures at all levels	3 years	The percentage of sites obtaining a 100% EQA pass rate	The failure rate for participating sites is at 20%

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP19) Annual Benchmark	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP20) Annual Benchmark	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
8	1. NHRRB: Reduced average turn around review time by from 70 days to 30 days. 2. NHRRB: Number of protocols received and reviewed on quarterly basis average is 35. 3. A total of 15 Review board members are trained on bio ethics 4. NHRRB: 20 protocols submitted and reviewed by RHInnO 5. HRU: National Health Research Conference successfully held in 2019 6. HRU: 170 Abstracts are submitted for National Health Research Conference 2019. 7: CSO: Staffing and operating cost for National Data Coordinating Center supported by PEPFAR 50%.		N/A		N/A	
9	At least 80% of all HTS_POS has a recency test done; 80% completeness of data collection on recency testing tools		At least 90% of all HTS_POS has recency test done; 95% completeness of data con recency testing tools		N/A	
10	Completed final audit for accreditation and 2 hospitals/2 high volume clinics will be accredited; improved indicators		Completed final audit for accreditation and the last two high volume clinics will be accredited; improved indicators		N/A	
11	Rollout of EID near POC to 15 sites		Full rollout on all mapped sites and movement of Roche VL platform to Shiselweni lab.		N/A	
12	Establish regional QC corps and develop national guidelines for EQA troubleshooting		Implementation of an eTool for EQA monitoring at National level		Full implementation of eTools and EQA dashboard developed	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
13	HHS/CDC	ICAP Lab	HSS	Streamline running cost of LIS and work to integrate it to existing information systems (CMIS) and transition it to host government"	Information systems	Integration of LIS to existing electronic systems
14	HHS/CDC	ICAP – Epi-Research TA	HSS	The Epidemiology and Disease Control Unit (EDCU) will be fully functional with Integrated Disease Surveillance and Response (IDSR) reporting.	Surveys and surveillance	Supporting the Epidemiology and Disease Control unit to strengthen the national Integrated Disease Surveillance and Response (IDSR) system, which includes key HIV indicators; Supporting the formally HOP-funded pediatric case surveillance system, as well as implementing HIV drug resistance surveillance
15	HHS/CDC	ICAP-Manzini	HSS	Improve the capacity of MOH's NTCP programs to manage and co-ordinate the HIV/TB response	Management and coordination	Mentorship and oversight for TB activities by NTCP
16	HHS/CDC	URC - Lubombo	HSS	Improve the capacity of MOH's SNAP programs to manage and co-ordinate the HIV response	Management and coordination	Mentorship and coordination of the HIV response at SNAP
17	HHS/CDC	CIHTC Follow-on	C&T	1st 95: Improve testing coverage in the community, Scale up index case testing and strengthen linkages to treatment	Host country institutional development	Regional support for linkage to treatment
18	USAID	<Placeholder - 70330 Swaziland USAID>	HSS	TSP - Strengthen pharmaceutical governance and transparent management through legislation regulation standards and procurement planning	Supply chain systems	Build government capacity for pharmaceutical management at the national, regional, facility and community level through a diversified network of distribution channels
19	USAID	<Placeholder - 70330 Swaziland USAID>	C&T	TSP - Strengthen central and service level pharmaceutical services to achieve HIV/TB treatment outcomes.	Supply chain systems	Strengthening central level decision-making using strategic information systems and technology to improve HIV and TB treatment procurement, warehousing and logistics.
20	DOD	DOD TBD	HSS	Conduct a SABERS in the USDF to better understand HIV epidemic.	Surveys and surveillance	Conduct a survey of the military population around HIV/AIDS issues
21	DOD	DOD TBD	HSS	*Improve laboratory services to provide all essential HIV clinical monitoring services required. *Improve sites to meet NARTIS requirements	Equipment procurement and maintenance	Procure laboratory equipment for the main military clinic; this lab will perform and collate results for all tests done in military clinics

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
13	Absorption of annual license fees	10	4.83	Absorption of annual license fees by host government	3 years	No donor supported license fees	22 sites
14	Limited capacity to conduct surveillance and response to outbreaks, which also includes HIV and HIV-related conditions. IDSR will address this gap and strengthen overall surveillance capacity in the country. Limited information on pediatric epidemiology, there is a need to continue HOP-funded peds case reporting; continuous HIV DR surveillance (not survey) is needed in the era of test and start and PrEP in the country.	13	3.96	IDSR, peds case reporting, and fully functional (all sites reporting surveillance data thru IDSR system).	2 years	IDSR reporting timeliness; peds case reporting timeliness and completeness.	N/A
15	Limited capacity of NTCP to manage and coordinate the response	1	8.02	Improved management and technical leadership capacity established within NTCP that will enable them to better manage the TB response. This would include the ability to respond quickly to changes in the epidemic and policies, e.g., changes in treatment, etc.	3 years	MER and SIMS	TX_CURR
16	Limited capacity of SNAP to manage and coordinate the response	1	8.02	Reach and sustain 95 95 95 indicators. Improved management and technical leadership capacity established within SNAP that will enable them to better manage the HIV response. This would include the ability to respond quickly to changes in the HIV epidemic and policies, e.g., changes in treatment, etc.	3 years	MER and SIMS	TX_CURR
17	Limited capacity of SNAP to manage and coordinate the response	6	4.95	Achievement of a 90% linkage rate in all regions.		MER and SIMS	TX_CURR, Q1 linkage rate (71%)
18	Inadequate regular supply of commodities	8	6.9	Minimum and maximum stocks of HIV commodities maintained at all levels	3 years	Number of facilities without stock out of tracer medicines and laboratory commodities	FY 17 APR
19	Roll-out of eLMIS & CMIS to facilities; Utilization of eSystems & tools for patient services;	8	6.9	To improve the delivery and consistent use of HIV, TB and other reproductive health commodities and diagnostic and treatment services to achieve desired HIV, TB and reproductive health outcomes	3 years	Number of facilities with Nav Vision system roll out and eLMIS used	FY 17 APR
20	Lack of current data on HIV within the military population.	11	2.24	Data from survey to inform program direction.	1 year	Completed survey	Last SABERs was completed in 2009
21	Lack of adequate equipment at the site level and lack of performance management tools.	6	4.95	Equipment installed in main military site and improved data collection and reporting	1 year	Equipment installed in main site and data management tools developed	None available

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13	Finalize interoperability review		50% sites transitioned to host government support		100% sites absorbed by host government	
14	At least 95% completeness and timeliness reporting for IDSR, peds case reporting.		At least 95% completeness and timeliness reporting for IDSR, peds case reporting.		N/A	
15	Reach 95 95 95 overall, 90 90 90 for age and sex disaggregates		Reach 95 95 95 for all age and sex disaggregates		Sustaining 95 95 95	
16	Reach 95 95 95 overall, 90 90 90 for age and sex disaggregates		Reach 95 95 95 for all age and sex disaggregates		Sustaining 95 95 95	
17	Reach 95 95 95 overall, 90 90 90 for age and sex disaggregates		Reach 95 95 95 for all age and sex disaggregates		Sustaining 95 95 95	
18	Scale up the Warehouse Management System to include 1 laboratory warehouse, 5 regional hospitals, 2 specialized hospitals		Scale up the warehouse management system to 5 additional health center and 5 additional PHU.		Scale up WMS to 100 clinics	
19	Scale up the WMS to include 1 laboratory warehouse, 5 regional hospitals, 2 specialized hospitals		Scale up the warehouse management system to 5 additional health center and 5 additional PHU.		Scale up WMS to 100 clinics	
20	Completed survey with data that can be utilized for program planning and implementation.		N/A		N/A	
21	Equipment installed in main site and data management tools utilized		N/A		N/A	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
22	USAID	WHO/AFRO Disease Control	HSS	Strengthen MOH HR unit to effectively use the HRIS data to assess progress on the staffing norms, inform the staffing requests to MOPS to facilitate transition and absorption plans for sustainability	Management and coordination	Support to MOH to conduct quarterly and annual HRH reviews, analysis and planning; continuous review of staffing norms; develop JDs, SOPs and a transition plan for HRH
23	USAID	WHO/AFRO Disease Control	HSS	Strengthen MOH HR unit to effectively use the HRIS data to assess progress on the staffing norms, inform the staffing requests to MOPS to facilitate transition and absorption plans for sustainability	Workforce development, pre-service training	1) Support the implementation of the absorption plan for Lab and pharm Technologists with MOH/HRMC & MOPS 2) Support the incorporation of lab and Pharm Tech absorption into the annual staff requisition for budget process 3) Upgrade HRIS system with pre-service module for VL tracking and analytics
24	USAID	Centre for HIV and AIDS Preventions Studies Swaziland	PREV	Strengthened MOH capacity in planning, monitoring, evaluating and assuring the quality of programs for VMMC	IEC and/or demand creation	Strengthen and support demand creation programming for VMMC
25	USAID	Support for International Family Planning and Health Organization 2 (SIFPO 2)	PREV	Promotion and distribution of 20 million condoms especially targeting AGYW and men	IEC and/or demand creation	Use Total Market approach to segment audiences and development appropriate demand creation to increase up-take and use of condoms
26	USAID	HIV Response Coordination, Community Capacity and Communication (HC4) Breakthrough Action	C&T	Increase men's uptake of testing and treatment and support for improved retention through PLHIV networks and CommART.	IEC and/or demand creation	Strengthen community structures, using local data and information, to mobilize men and create demand for testing, treatment, and improved retention through PLHIV networks and CommART
27	USAID	TBD OVC, Adolescents and Girls	PREV	Triple R - Increase access to adolescent friendly SRH services, including HTS, to AGYW and OVC	IEC and/or demand creation	Increase access to and demand for comprehensive SRH services TS, FP, STI, TB and GBV screening, through mobile outreach and multiple platforms and approaches (community mobilization, small group, social media, etc.)
28	USAID	<Placeholder - 70329 Swaziland USAID>	PREV	TBD Comp. 2 - Promotion and distribution of 20 million condoms especially targeting AGYW and men	IEC and/or demand creation	Use Total Market approach to segment audiences and development appropriate demand creation to increase up-take and use of condoms among HIV - youth and men. Create demand using multiple platforms and approaches (social media, ipc, community engagement etc.)
29	USAID	<Placeholder - 70329 Swaziland USAID>	C&T	TBD Comp. 2 - Promotion and distribution of 20 million condoms especially targeting AGYW and men	IEC and/or demand creation	Use Total Market approach to segment audiences and development appropriate demand creation to increase up-take and use of condoms among HIV+ youth and men. Create demand using multiple platforms and approaches (social media, ipc, community engagement etc.)
30	USAID	<Placeholder - 70330 Swaziland USAID>	C&T	TSP - Assure availability of ART/TB, lab commodities and condoms at site level	Supply chain systems	Assure availability of ART/TB, lab commodities and condoms at site level
31	USAID	<Placeholder - 70330 Swaziland USAID>	C&T	TSP - Improve medication use and patient safety	Supply chain systems	Strengthen pharmacovigilance and reporting of adverse events and complications

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
22	Inadequate numbers and skill sets for different health cadres at all levels	7	5.37	% of key gaps in staffing numbers and skill sets are filled per the staffing norms and including	3 years	Staffing data from HRIS as compared to staffing norms	Quarterly MOH HRIS reports.
23	Various clinical support cadre graduates are not being sufficiently produced or strategically deployed, absorbed by Government and tracked	7	5.37	% of key gaps in staffing numbers and skill sets are filled per the staffing norms and including	3 years	Staffing data from HRIS as compared to staffing norms	TIMS - Training Information Management System
24	Inadequate HIV prevention information and demand creation for HIV prevention programming	6	4.95	Increased VMMC coverage to 80% especially among the 15-29 year old males	3 years	VMMC Indicators	xx% coverage
25	Inadequate HIV prevention information and demand creation for HIV prevention programming	6	4.95	Improved distribution and increased up-take of male and female condoms	3 years	condom database	17 million condoms distributed in COP 17
26	Inadequate information and demand for men's up-take of testing and treatment and retaining them in care	6	4.95	men ages 15-45 attain 95-95-95	3 years	% of males who know their status, are on ART and virally suppressed as tracked through the CMIS	xx-xx-xx (see pyramid or Rasta table)
27	Inadequate information and demand for SRH services among AGYW	6	4.95	Reduced teen pregnancy through up take of FP and linkages to appropriate services	3 years	% of AGYW accessing SRH services	43,000 AGYW reached with SRH services
28	Inadequate HIV prevention information and demand creation for HIV prevention programming	6	4.95	Improved distribution and increased up-take of male and female condoms	3 years	increased number condoms distributed through NGO/CBOs and non traditional outlets per the database	17 million condoms distributed in COP 17
29	Inadequate HIV prevention information and demand creation for HIV prevention programming	6	4.95	Improved distribution and increased up-take of male and female condoms	3 years	increased number condoms distributed through NGO/CBOs and non traditional outlets per the database	17 million condoms distributed in COP 17
30	inadequate regular supply of ART and VL commodities	8	6.9	Minimum and maximum stocks of HIV commodities maintained at all levels	3 years	Build facility and community level skills capacity to manage ART/TB lab and condoms	Inadequate regular supply of ART and VL commodities
31	Under reporting of adverse events and limitations of the pharmacovigilence system	8	6.9	Pharmacovigilance system in place and facilities reporting adverse events	3 years	Pharmacovigilance system in place and Percentage of facilities reporting adverse events accurately	FY17 APR

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22	1) Absorption plan is complete and establishes priorities for the absorption of PEPFAR cadres that are in the establishment register. 2) PEPFAR has established a tracking mechanism for PEPFAR supported contracts. 3) MOH and Ministry of Public Service use analysis to guide annual request for posts.		Government absorbs an agreed to % of the PEPFAR supported cadres which exist in the establishment register (i.e. Phlebotomists, Lab Techs, Pharmacy techs)		Based on Government absorption plan the % of clinical cadres in the establishment register absorbed by government (i.e., doctors, nurses, techs, etc.)	
23	1) Absorption plan is complete and establishes priorities for the absorption of PEPFAR cadres that are in the establishment register. 2) PEPFAR has established a tracking mechanism for PEPFAR supported contracts. 3) MOH and Ministry of Public Service use analysis to guide annual request for posts.		Work with the MOH Principal Secretary to set realistic benchmark informed by # of posts allocated in the past year. Provide assistance to the MOH in the allocation of those positions.		Work with the MOH Principal Secretary to set realistic benchmark informed by # of posts allocated in the past year. Provide assistance to the MOH in the allocation of those positions.	
24	100% of VMMC target met		100% of VMMC target met for COP 19		100 % of VMMC target met for COP 20	
25	20 million condoms distributed		22 million condoms distributed		24 million condoms distributed	
26	% HTS_TST/TST_POS, TX_NEW/CURR,TX_PVLS		% HTS_TST/TST_POS, TX_NEW/CURR,TX_PVLS		% HTS_TST/TST_POS, TX_NEW/CURR,TX_PVLS	
27	60% of AGYW in DREAMS tinkhundla reached		70% of AGYW in DREAMS tinkhundla reached		80% of AGYW in DREAMS tinkhundla reached	
28	20 million condoms distributed		22 million condoms distributed		24 million condoms distributed	
29	20 million condoms distributed		22 million condoms distributed		24 million condoms distributed	
30	9 months without stock out		12 without stock out		16 months without stock out	
31	Pharmacovigilance system in place and 5 regional hospitals and 2 specialized hospitals reporting accurately on adverse events		5 additional health center and 5 additional PHU reporting accurately adverse events		All facilities reporting accurately adverse events	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
32	HHS/CDC	CIHTC - Follow on	C&T	1st 95: Improve testing coverage in the community, Scale up index case testing and strengthen linkages to treatment	IEC and/or demand creation	Demand creation for HIV testing. Increase index case testing across Swaziland. Link positives found through increased testing to treatment.
33	USAID	Support for International Family Planning and Health Organization 2 (SIFPO 2)	C&T	Promotion and distribution of 20 million condoms especially targeting AGYW and men	IEC and/or demand creation	Use Total Market approach to segment audiences and development appropriate demand creation to increase up-take and use of condoms
34	USAID	<Placeholder - 70329 Swaziland USAID>	PREV	TBD Comp. 1 - Supporting the provision of comprehensive quality VMMC and PrEP services in two regions (Hhohho and Shiselweni)	IEC and/or demand creation	Strengthen and support demand creation programming for VMMC
35	USAID	Breakthrough Action	PREV	Community engagement and mobilization for gender and norm change to create a protective environment for AGYW	IEC and/or demand creation	Build skills and capacity of local government and traditional leaders to mobilize the community to address harmful gender norms and create a protective environment for AGYW
36	USAID	AIDSfree	HSS	Improve the capacity of MOH's SRH programs to manage and co-ordinate the PMTCT response	Management and coordination	Mentorship and oversight for PMTCT activities
37	USAID	<Placeholder - 70329 Swaziland USAID>	HSS	Improve the capacity of MOH's SRHU programs to manage and co-ordinate the PMTCT response	Management and coordination	Mentorship and oversight for PMTCT activities

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
32	Declining yield in testing	6	4.95	95% of PLHIV know their status across all age and sex disaggregates. Linkage of 90% across all regions.	2 years	MER and SIMS	TX_CURR
33	Inadequate HIV prevention information and demand creation for HIV prevention programming	6	4.95	Improved distribution and increased up-take of male and female condoms	3 years	condom database	17 million condoms distributed in COP 17
34	Inadequate HIV prevention information and demand creation for HIV prevention programming especially VMMC	6	4.95	Increased VMMC coverage to 80% especially among the 15-29 year old males	3 years	VMMC Indicators	Current VMMC Indicators
35	Inequities in gender norms	6	4.95	Adolescent girls and young women have increased access to HIV and SRH services and are protected from HIV and GBV	3 years	% of AGYW accessing HIV and SRH services; % of AGYW who seek post-violence services	FY17 APR GEN_GBV MER Indicator; 43,000 AGYW reached with SRH services
36	Limited capacity of MOH to manage and coordinate the PMTCT response	1	8.02	Improved management and technical leadership capacity established within SRHU that will enable them to better manage the PMTCT program. This would include the ability to respond quickly to changes in the epidemic and policies, e.g., changes in treatment etc.	3 years	MER and SIMS	PMTCT_STAT PMTCT_ARV PMTCT_EID
37	Limited capacity of MOH to manage and coordinate the PMTCT response	1	8.02	Improved management and technical leadership capacity established within SRH and MOH that will enable them to better manage the PMTCT response. This would include the ability to respond quickly to changes in the epidemic and policies, e.g., changes in treatment, etc.	3 years	MER and SIMS	PMTCT_STAT PMTCT_ARV PMTCT_EID

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32	Reach first 95 overall, 90 for age and sex disaggregates		Sustain first 95 for all age and sex disaggregates			
33	20 million condoms distributed		22 million condoms distributed		24 million condoms distributed	
34	100% of VMMC target met		100% of VMMC target met for COP 19		100% of VMMC target met for COP 20	
35	60% of AGYW in DREAMS tinkhundla reached		70% of AGYW in DREAMS tinkhundla reached		80% of AGYW in DREAMS tinkhundla reached	
36	achieve 95% for all indicators		maintain 95% of all indicators		maintain 95% of all indicators	
37	achieve 95% for all indicators		maintain 95% of all indicators		maintain 95% of all indicators	