Eswatini Country Operational Plan 2019

(COP19)

Strategic Direction Summary

05 April 2019

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Acronym and Word List

AE	Adverse Event
AG	Adolescent Girls
AGYW	Adolescent Girls and Young Women
ALHIV	Adolescents Living with HIV
ANC	Antenatal Clinic
ARV	Antiretroviral
ART	Antiretroviral Therapy
C/ALHIV	Children and Adolescents Living with HIV
CAGs	Community Adherence Groups
CANGO	Coordinating Assembly of Non-Governmental Organizations
CCM	Country Coordinating Mechanism
CMIS	Client Management Information System
CMS	Central Medical Stores
CoAg	Cooperative Agreement
CQI	Continuous Quality Improvement
CS	Civil Society
CSO	Civil Society Organization
DBS	Dried Blood Spot
DQA	Data Quality Assessment
DMPPT	Decision Makers Program Planning Toolkit
DREAMS	Determined, Resilient, Empowered, AIDSfree, Mentored, and Safe
DSD	Differentiated Service Delivery
DTG	Dolutegravir
EID	Early Infant Diagnosis
EQA	External Quality Assessment

ENAP	Eswatini National AIDS Program
EU	European Union
FDC	Fixed dose combination
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GKoE	Government of the Kingdom of Eswatini
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
HCWs	Health Care Workers
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HIVST	HIV self-testing
ICT	Index Case Testing
IEC	Information, Education and Communication
IM	Implementing Mechanism
Inkhundla	Government Administrative Unit (Below Regional Level)
IP	PEPFAR Implementing Partner
KP	Key Population
KPLHIV	Key Populations Living with HIV
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
MTAD	Ministry of Tinkhundla and Administration
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/E	President's Emergency Plan for AIDS Relief/Eswatini
PFSCM/SCMS	Partnership for Supply Chain Management/Supply Chain Management System

PHU	Public Health Unit
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
POART	PEPFAR Oversight and Accountability Response Teams
POC	Point of Care
PPs	Priority Populations
PPP	Public Private Partnership
PrEP	Pre-exposure Prophylaxis
QA	Quality Assurance
QI	Quality Improvement
QMS	Quality Management System
RA	Regional Administrator
RASTA	Region Age Sex Testing/Treatment Attribution
RTK	Rapid Test Kit
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
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
TA	Technical Assistance
TB	Tuberculosis
Tinkhundla	Government Administrative Units (Below Regional Level)
T&S	Test and Start
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Therapy
TSP	Technical Support for PEPFAR Programs
TWG	Technical Working Groups
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WMIS	Warehouse Management Information System

1.0 Goal Statement

Despite facing the world's highest HIV prevalence, Eswatini stands on the brink of reaching epidemic control. As we push to close the remaining gaps to achieve 95-95-95, we find that lingering unmet needs are not confined to any one region or population in the country. The overarching goal of the PEPFAR/Eswatini (PEPFAR/E) investments is to support the Government of the Kingdom of Eswatini (GKoE) to achieve epidemic control, provide high quality HIV services to people living with HIV, and continue to rapidly and sustainably reduce the number of new infections. The program activities are guided by and aligned with Eswatini's National Multi-Sectoral Strategic Framework for HIV and AIDS 2018-2022.

COP19 focuses on actively finding unidentified, untreated, or unsuppressed individuals while improving access to high quality services. The needs and approaches for finding cases vary by age, gender, and individual or family context. Strategically targeted testing will include fully scaled index testing to identify half of all new positives, scaled-up targeted self-testing, and elimination of non-targeted facility testing through full implementation of risk screening tools. Improvements in case finding increase prevention opportunities, including reaching HIV negative men with counseling on VMMC. Priority interventions include case identification for men aged 20 – 29 and youth aged 15-25, linkage to care for women aged 20-29 and men aged 25-39 who know their status but are not on treatment, and viral suppression for adolescents and young men and women. We will particularly focus on the hardest-to-reach KP subpopulations such as older MSM, younger and home-based FSW, and peri-urban marginalized mobile populations.

Striving to reach 90% of all PLHIV on ART (the second 95%) in all ages, sexes and locations, all four regions are considered scale-up for case identification and linkage to treatment. Key strategies to increase linkage are same day initiation, expert client support, peer navigation, and improved access to ART services. As we seek to strengthen our focus on retention among all subpopulations, we will be pursuing targeted and population-focused strategies such as:

- differentiated service delivery approaches for reliable and convenient ART refills for subpopulations;
- multi-month scripting and dispensing;
- key communication interventions (such as undetectable viral load means the virus is untransmittable (U=U) segmented by population; and
- effective use of outreach workers, expert clients and step-up adherence counselors.

In addition to increasing retention, a full transition to dolutegravir-based regimens, including the fixed dose combination of tenofovir/lamivudine/dolutegravir (TLD), will support the achievement of higher community viral suppression, implementation of which is made more urgent by high levels of ART resistance. This transition and implementation of revised pediatric treatment guidelines will improve the lagging viral suppression experienced by younger PLHIV. Tackling two of the most significant causes of mortality amongst PLHIV in Eswatini, COP19 will see full implementation of TB preventive therapy and cervical cancer screening and treatment.

Priority and key populations will have improved access to high impact, integrated prevention services and programs through community- and facility-based settings. We will engage PP and KP to incorporate their perspectives, needs and feedback into the design and implementation of programs. With a substantial youth bulge, tailored HIV prevention programs are critical. Targeted sub-population specific approaches, especially for males 15-30 years old, will be employed to reduce barriers to testing, treatment, condoms, VMMC and PrEP; and to increase retention. The DREAMS package will focus on adolescent girls and young women (AGYW) ages 15-29 years of age. Prevention is fully integrated into the OVC interventions. We will reinforce local government structures and traditional and faith leaders' efforts to reduce HIV and sexual and gender-based violence among 9-14 year olds and to reduce stigma and discrimination. We have re-booted VMMC programming to assure robust support for the GKoE's operational plan with a multi-pronged approach, including integrated VMMC services within facilities and men's corners, campaigns and community-based services specifically aimed at those over the age of 15 years. The VMMC program will employ targeted age segmented demand creation strategies, adapting what has worked in other countries, such as engaging local and traditional leadership, door-to-door mobilization, age-segmented services, human-centered design principles, use of incentives, and integration with other health platforms (e.g., STI clinics, ANC, etc.).

While acknowledging the successes of the national HIV program, PEPFAR is adapting investments to meet the needs as the epidemic changes. Recency testing will be implemented fully across the country, which in combination with increased investments in the national electronic medical record system will create case based surveillance systems capable of defining geographic hot spots to enable highly focused case identification. Our support to the government's laboratory optimization action plan will overturn regional discrepancies in access to viral load testing.

PEPFAR/E will continue to monitor implementing partners' performance on a monthly basis to immediately address performance issues. Weekly updates will be required of implementing partners support HIV testing given the programming shift in this area. Program implementation will be monitored via quarterly performance reviews and regular SIMS visits. Partners will be required to report their monthly outlays against their approved COP19 levels, achievements and targets.

Sustainability is of increasing importance as Eswatini edges closer to epidemic control. PEPFAR/E will continue to work with GKoE to address resource mobilization, HRH and lab optimization, commodity security, and robust data utilization systems. COP19 provides additional resources to accelerate the roll-out of the Client Management Information System (CMIS) and address data synchronization and data quality, and improve data use. COP19 shifts also include increased funding to indigenous organizations. Additionally, the GKoE's continued commitment to address the epidemic by fully funding adult ARVs and increasing domestic HIV funding are significant sustainability milestones.

Civil society (CS) and population specific input into PEPFAR remains critical in order to appropriately tailor responsive interventions and messages to achieve results. A new initiative to

work with communities of faith, traditional leaders and faith based organizations (FBOs) will leverage the unique opportunities offered by these groups' vast networks to enhance case finding and ART coverage, especially among men, and to prevent HIV and sexual violence, especially among 9-14 year olds. Continued collaboration with Global Fund and UNAIDS, through the coordination of the GKoE will ensure that the full range of PEPFAR's investments are maximized.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Though Eswatini benefits from decades of political stability, relatively low crime, fertile agricultural land, limited internal conflict, and minimal population pressures, it suffers from its high HIV burden, unemployment, food insecurity, economic and gender inequalities and the current economic crisis. The Kingdom of Eswatini is one of Africa's geographically smallest countries, with just 17,300 square kilometers of land, landlocked between neighboring South Africa and Mozambique. In 2017, the country's National Population and Housing Census had counted 1,093,028 people in the population; 36% are <15 years old and 56% are <25 years old, indicating a substantial youth bulge. The population experienced an annual growth rate of 0.7% (Hhohho 1.3%; Manzini 1.1%; Shiselweni -0.2%, and Lubombo 0.2%), between 2010 and 2017, with 76% of the population living in rural areas.

Population

Figure 2.1.1 shows the population count per inkhundla (sub-regional administrative unit). By region, Manzini has the highest population (355,945), followed by Hhohho (320, 651), Lubombo (212,531), and Shiselweni (204,111).

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

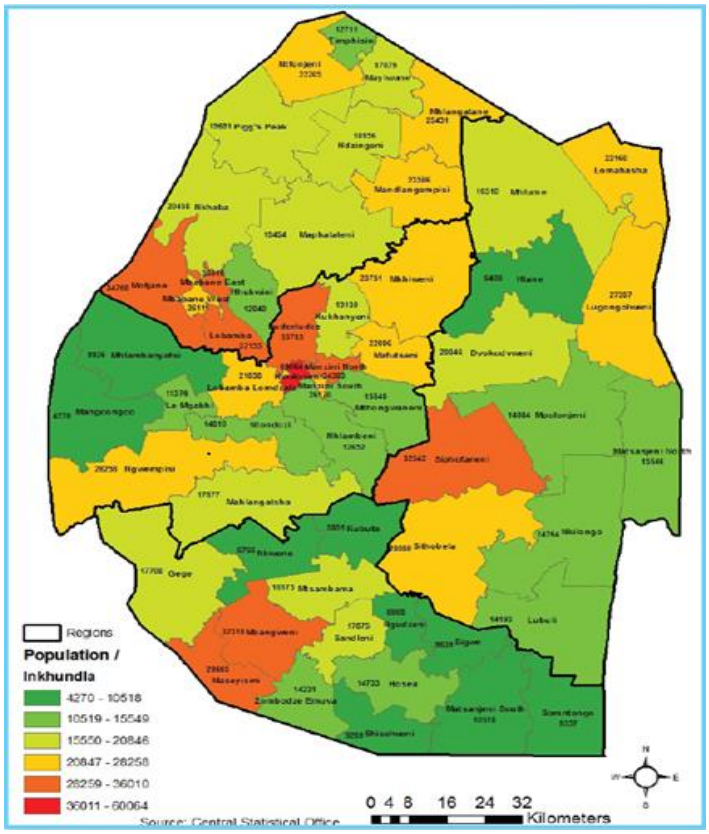


Figure 2.1.2 shows two tinkhundla (sub-regional administrative units) in Lubombo with high male to female ratio: Mhlume inkhundla (143 males/100 females) and Nkilongo inkhundla (130 males/100 females), and the ratio is consistently higher along the western border to South Africa in Hhohho region. These areas are locations of male-dominated industries such as sugarcane and wood pulp plantations that could have programmatic implications. The figure needs to be triangulated with the population count (Figure 2.1.1), population density (Figure 2.1.3) and with contextual data to determine the appropriate locations and approaches to find and link men to treatment or prevention. Additional programmatic considerations arise from Eswatini having substantial movement through both formal and informal borders, including major trucking routes east to west, and to the south with well-established hot-spots.

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

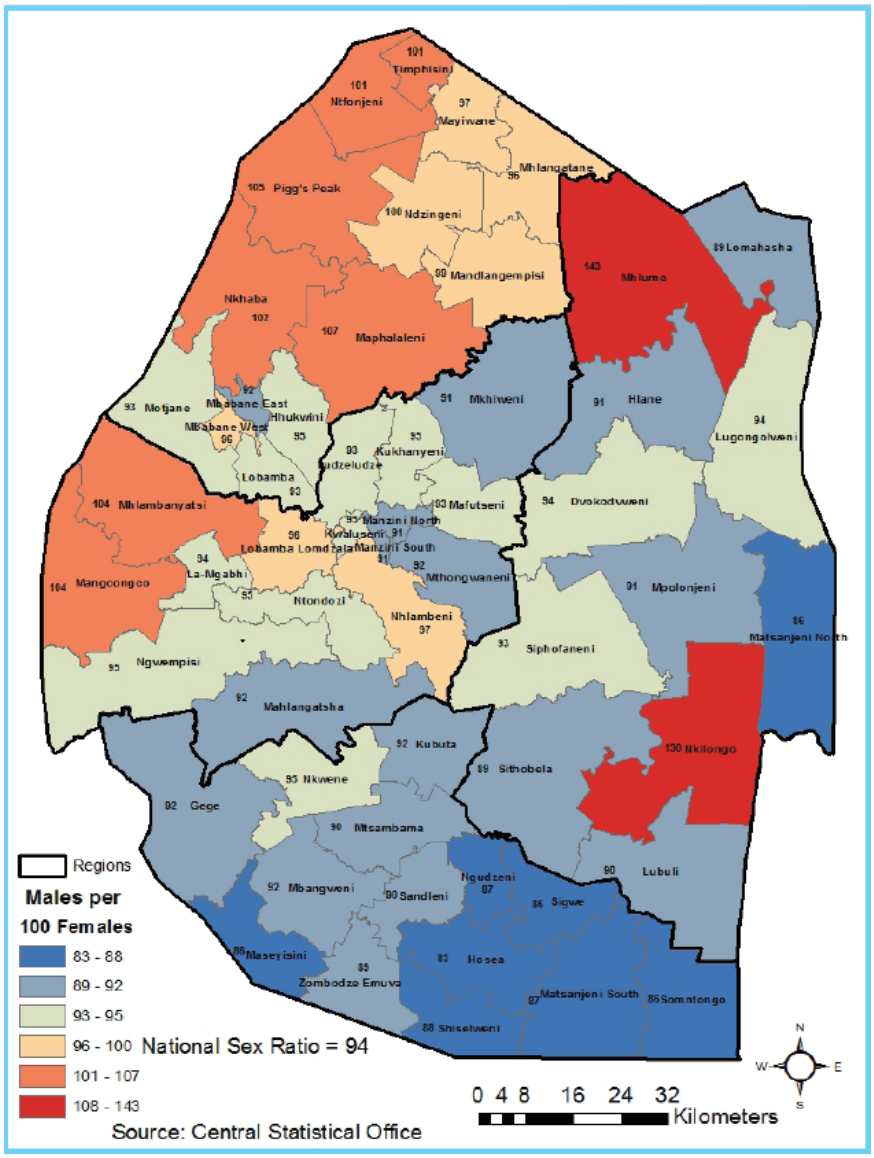
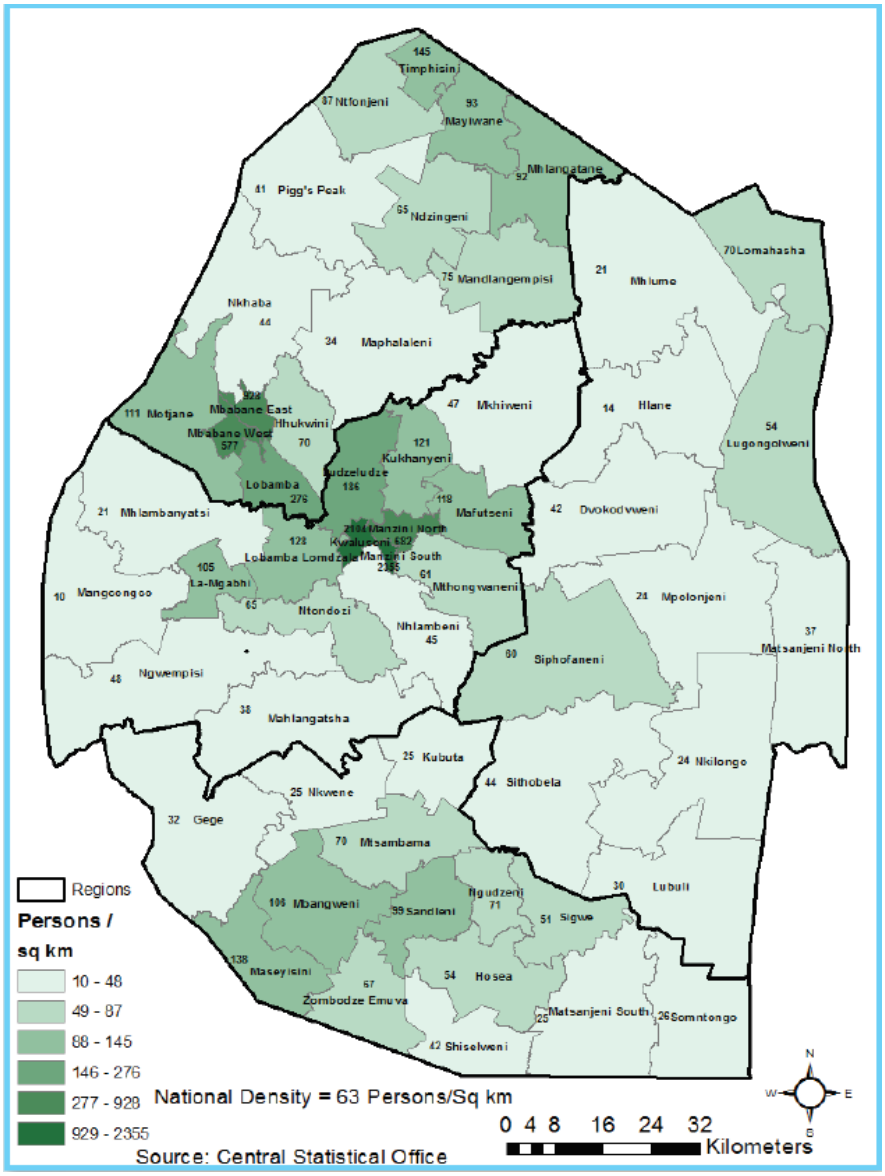


Figure 2.1.3 shows that population density is highest in the two tinkhundla in Manzini region: Kwaluseni (2,104 persons/km²) and Manzini South (2,355 persons/km²). Overall, population density ranks as follows: national (63 persons/km²); Hhohho (89 persons/km²); Manzini (87 persons/km²); Shiselweni (54 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 national capitals, Manzini in Manzini region and Mbabane in Hhohho region.

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



Small country size, ease of movement and unemployment rates all contribute to the high mobility of the population, both within and across borders. Economic migration to South Africa contributes to the country's negative net migration rate, and population movement increases the challenges in the delivery of ongoing health care services and in measuring progress in the epidemic.

Economy

The Gross Domestic Product (GDP) at market prices was $4.434 billion and Gross National Income (GNI) per capita was $2,950 in 2017 (World Bank 2017). Eswatini is classified as a lower-middle income country, however income inequality is high, with an estimated Gini coefficient of 0.49 between 2010 and 2017. Economic challenges persist, with nearly 40% of the population living under the international poverty line, rising to 62.1% when the 2011 PPP of $3.20 per person per day for lower middle-income countries is used (World Bank 2017). The unemployment rate is high at 41.8% rising to 51.6% for the youth aged between 15-24 years (Swaziland Labour Force Survey 2014). Eswatini has experienced several years of slow economic growth coupled with a regional economic downturn and a persistent domestic fiscal crisis. Real GDP growth projections for the years 2019, 2020 and 2021 remain flat at 1.09%, 1.81% and 1.45% respectively (Central Bank of Eswatini 2019). Several high profile political appointments made in the new government in late 2018 were from the private sector, focused on the task of reversing the current economic situation.

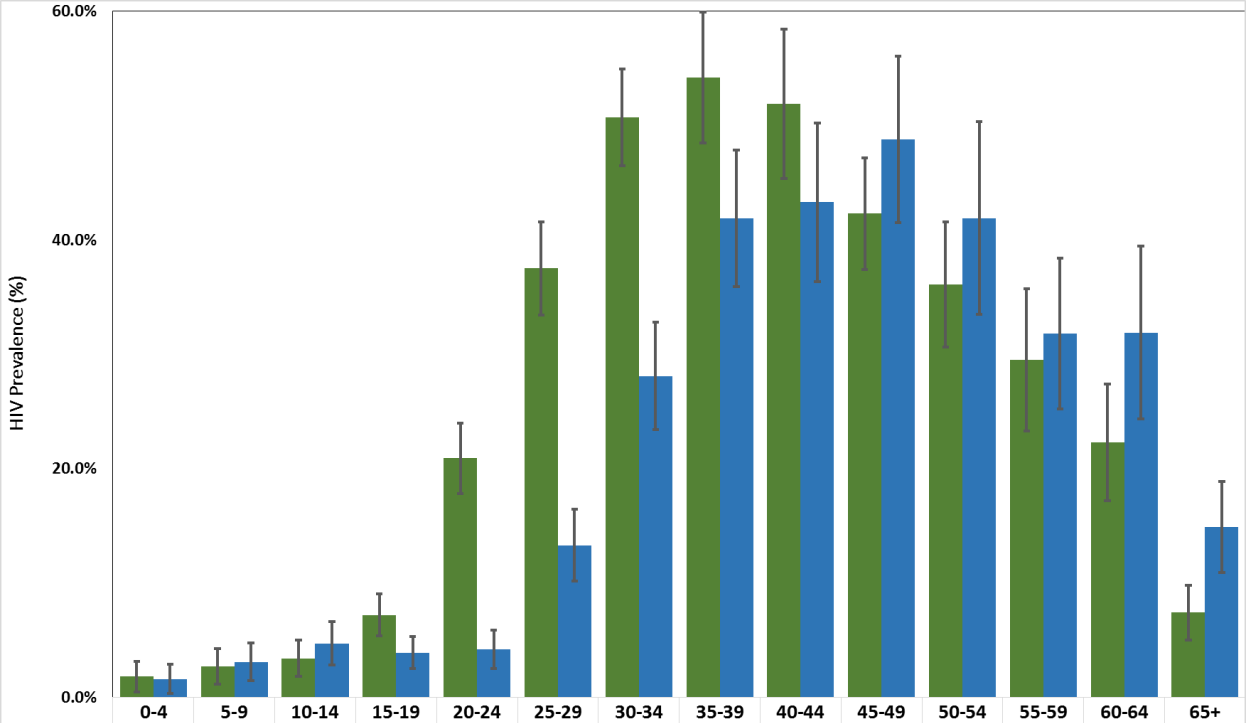
HIV

Average life expectancy in Eswatini declined sharply from 60 years in 1991, reaching a low of 46 years in 2005 (UNDP 2017), due to the intensity of the HIV and TB epidemics. The country mounted a forceful response to HIV, including the availability of life-saving ART and this has seen the life expectancy increase steadily, nearly returning the country to the pre-1991 level, with 57.7 years in 2018. The lingering effects of the epidemic's past high mortality remain; about 20% of children aged 0-17 years have been orphaned.

The Swaziland HIV Incidence Measurement Survey (SHIMS 2) in 2016-17 estimated HIV prevalence among adults aged 15 and older was 27% in 2017, the highest of any nation. It is estimated that 210,725 of the total population will be living with HIV by 2020. HIV disproportionately affects females, and infection rates are higher for them than their male counterparts until age 45. HIV prevalence was 13.9% among females aged 15-24 and 4.1% among males of the same age group. Among those aged 25 years and older, HIV prevalence was 41.2% among females and 29.9% among males.

Figure 2.1.4 shows that the prevalence among women was 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 were HIV positive.

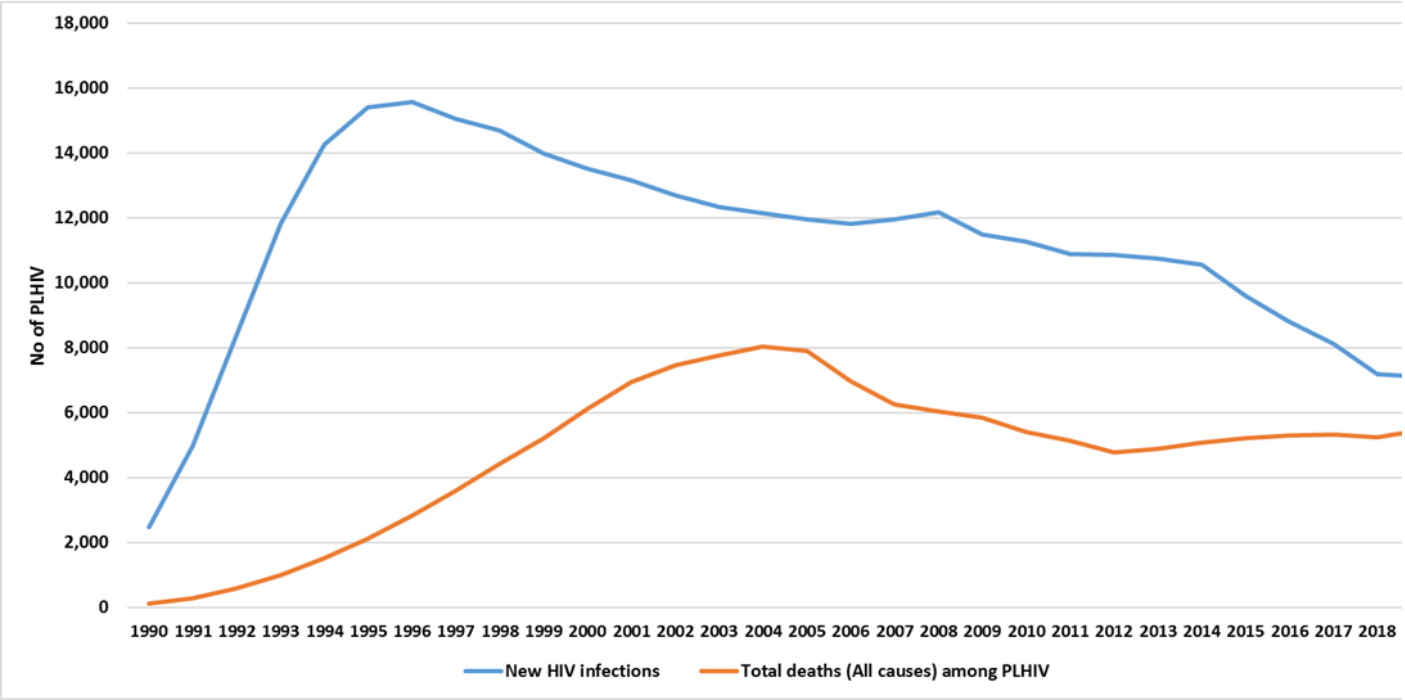
Figure 2.1.4. HIV prevalence by age and sex, Swaziland HIV Incidence Measurement Survey (SHIMS) 2, 2016-17



	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 was 1.48 per 100 (female: 1.99; males: 0.99). From 2011 to 2016, the HIV incidence among adults aged 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 (VL) suppression among all PLHIV regardless of awareness or treatment status increased from 34.8% among all PLHIV to 71.3%.

Figure 2.1.5 Trends in New infections and All-cause mortality among PLHIV



Following the initial sharp increase in the early 90's, new infections have declined. Total deaths for PLHIV have also declined (Figure 2.1.5), although according to Spectrum models more recent increases in mortality are due to non-AIDS related deaths as the population with HIV age. The most recent Spectrum modeling conducted in February 2019 estimated that in 2020 there will be 210,725 PLHIV, 2,095 AIDS-related deaths, and 6,424 new infections. Females aged 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 aged 25 and older, and 22.5% will be among their female counterparts (Figure 2.1.6).

Figure 2.1.6 2018 HIV Incidence by Age and Sex

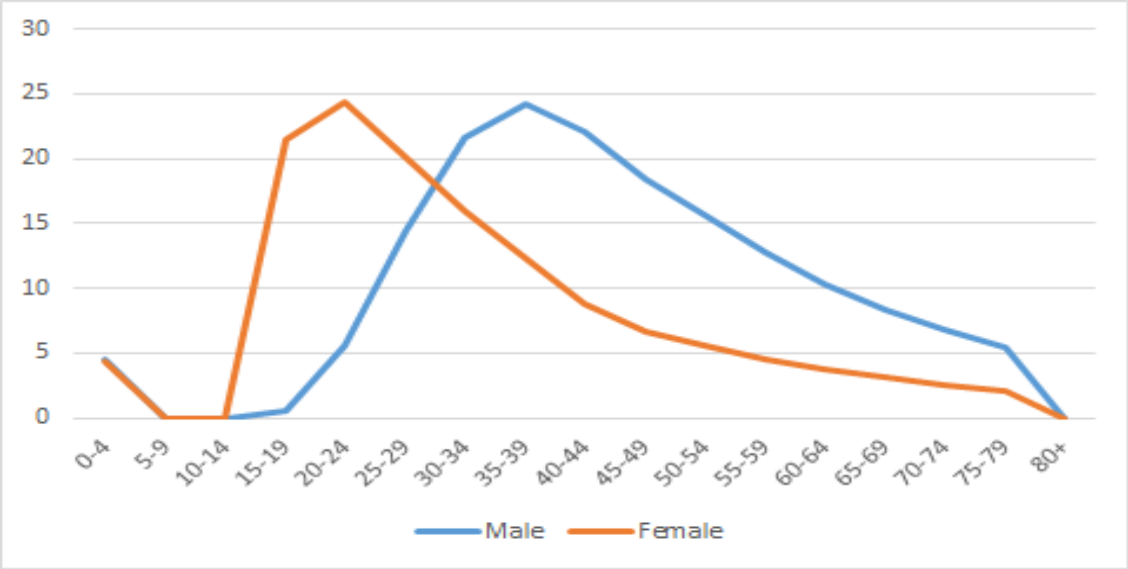


Figure 2.1.7 below shows the trend over time of total number of PLHIV compared to total on treatment and the total that are PEPFAR-supported. Over time the PEPFAR proportion of support has remained consistent while the overall proportion on treatment has increased.

Figure 2.1.7 Trends for PLHIV and number of PEPFAR-supported and national on treatment

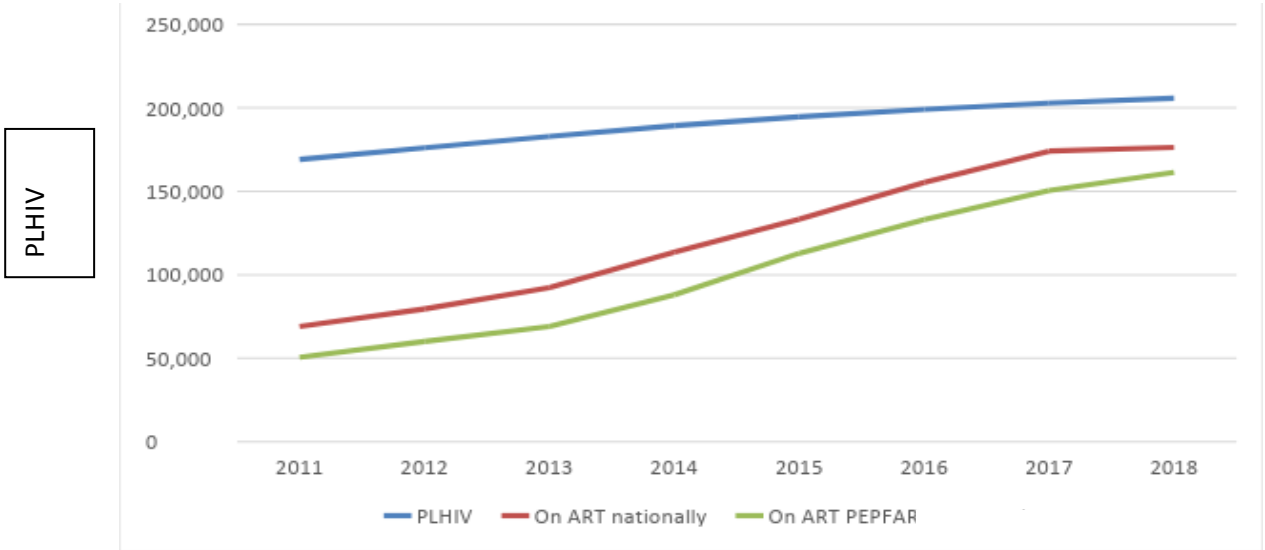


Table 2.1.1 Host Country Government Results

	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. 2018)	1,123,798	100	210,757	19	212,794	19	118,508	11	118,178	11	252,348	22	211,213	19	A, 2018
HIV Prevalence (%)		27.0*		2.6		3		14		4.1		41.2		29.9	B, 2017
AIDS Deaths (proj. 2018)	2,539	100	175	7	180	7	272	11	100	4	1,037	41	775	31	A, 2018
# PLHIV (proj. 2018)	206997	100	5904	3	6,003	3	18,541	9	3,466	2	104,232	50	68,851	33	A, 2018
Incidence Rate (per 100)		1.36*						2		0.79		1.84‡		1.50‡	B, 2017
New Infections (proj. 2018)	7,400	100	474	6	487	7	2,202	30	333	5%	1,597	22	2,308	31	A, 2018
Annual births	26,238	100	12,989	50.5	13,249	50									F, 2017
% of Pregnant Women with at least one ANC visit		98.5													E, 2014
Pregnant women needing ARVs (proj. 2019)	10,725														A, 2018
Orphans (maternal, paternal, double)	75,149														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	174,412														A, 2018

Est. HIV Prev. Females 15-29 years		21.2													B, 2017
Est. Pop Males 20-39 years	173,316														A, 2018
Est. HIV Prev. Males 20-39 years		39													B, 2017
	**Age 15+ ‡Age 25-34 [a]Age0-9 [b]Age10-14 [c]Age15-17*														

A. Draft Swaziland Spectrum File (2019)	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. Characterizing the HIV prevention and treatment needs among key populations, including men who have sex with men and female sex workers in Swaziland 2015 June	F. CIA Fact Book, Swaziland National Population and Housing Census 2017

National level statistics and projections for 2018 for the HIV epidemic in Eswatini in Table 2.1.1 show a population with 19% of the population under the age of 15, and an epidemic that heavily affects younger women compared to their male peers, as well as high prevalence among men and women over the age of 25 years. Additional statistics show high use of ANC clinics among pregnant women, disproportionate burden of TB cases among PLHIV (70% of all confirmed cases) and a male circumcision rate of 35%.

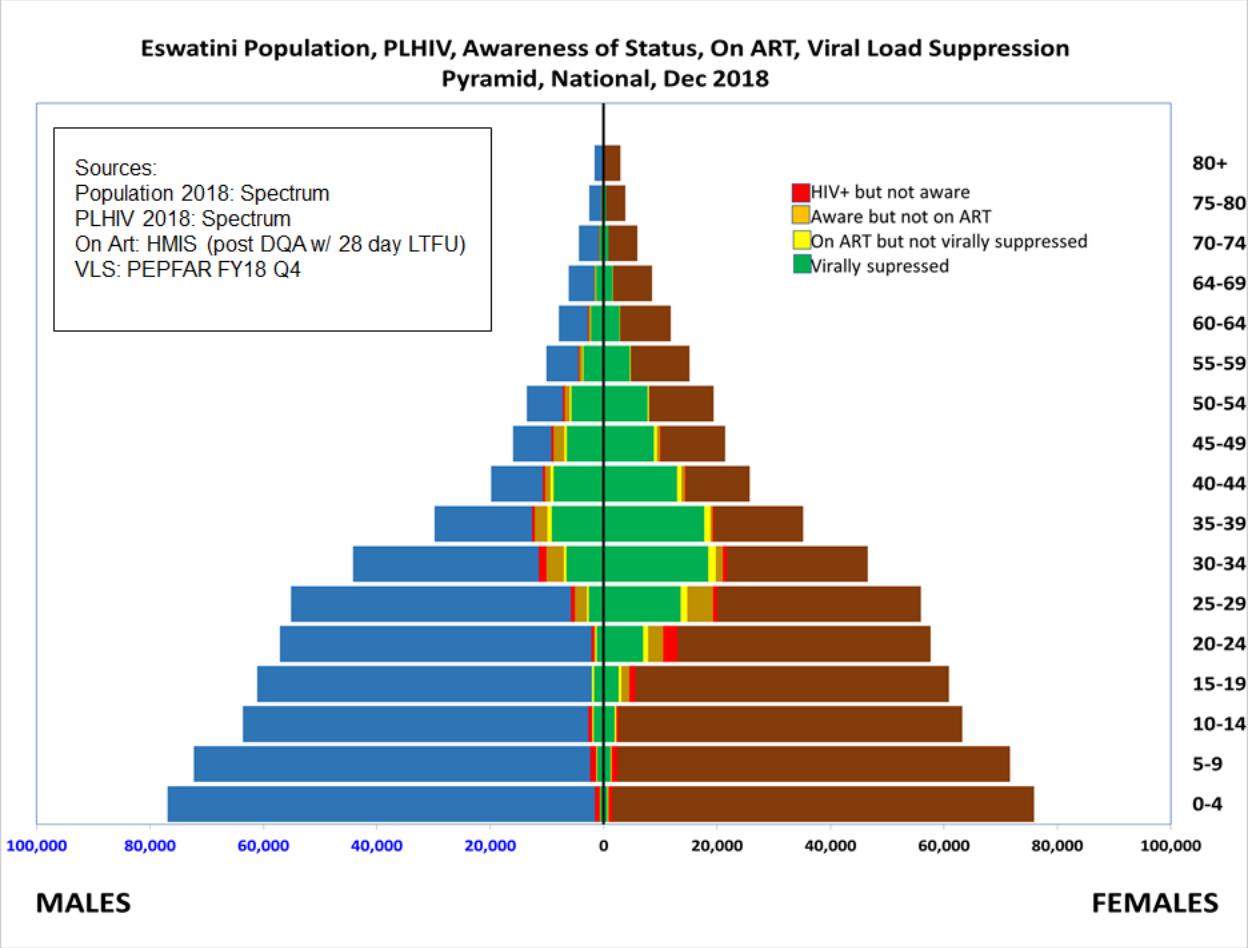
Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression in 2018

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	**1,123,798**	**27***	**206997**	**189,984**	**168,670**	**89%**	**93%**	**373,670**	**24,034**	***17,766***
Population <15 years	**423,551**	**3**	**11,908**	**unknown**	**8756**	74%	**87%**	**18,606**	**981**	***910***
Men 15-24 years	**118,178**	**9.1**	**3,466**	**3,259**	**2,346**	**72%**	**83%**	**26,550**	**808**	***457***
Men 25+ years	**211,213**	**41.2**	**67,892**	**63,129**	**54012**	**86%**	**94%**	**81,456**	**8,353**	***5,651***
Women 15-24 years	**118,508**	**13.9**	**18,541**	**15,033**	**13,574**	**90%**	**88%**	**87,357**	**4,174**	***3,141***
Women 25+ years	**252,348**	**36.3**	**104,232**	**100,243**	**95,194**	**95%**	**94%**	**128,675**	**9,865**	***7,691***

Sources: Total population and <15 are national HMIS data. Other age disaggregations represent PEPFAR-support

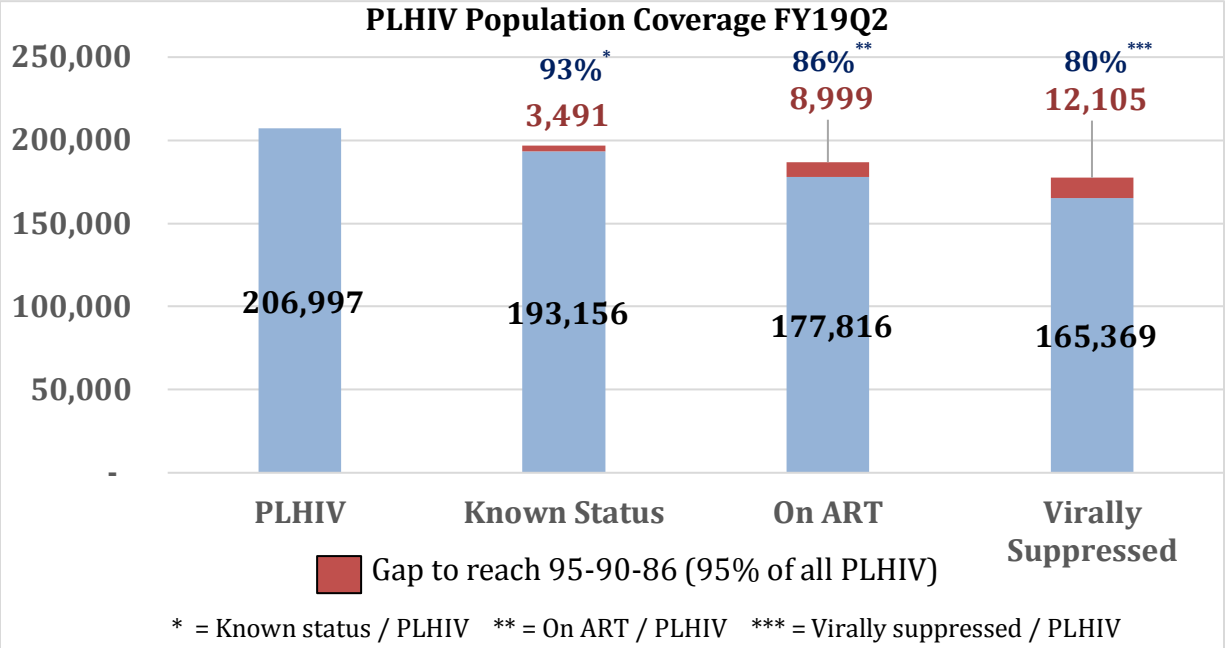
Table 2.1.2 shows 2018 progress toward the 95-95-95 goals by age group. There is no available data on the total number of PLHIV under age 15 years that know their status, but it is estimated to be close to the number on treatment. Total ART coverage is 89%, with women over the age of 25 years having the highest coverage (95%) and men aged 15-24 years having the lowest coverage (72%).

Figure 2.1.8 Eswatini Population, PLHIV, Awareness of Status on ART, VL Suppression Pyramid, National December 2018



The population pyramid for Eswatini in Figure 2.1.8 shows the predominantly HIV negative youth bulge, with increasing prevalence of HIV in the middle age range of the population. Although the far majority of those with HIV are virally suppressed, the data in the pyramid is useful for implementing age and sex specific interventions. Women age 20-24 years and men aged 30-34 years make up a large portion of those who are unaware of their HIV+ status, while women 20-29 years of age and men 30-34 years old have the highest proportions of those who know their HIV+ status but are not on treatment.

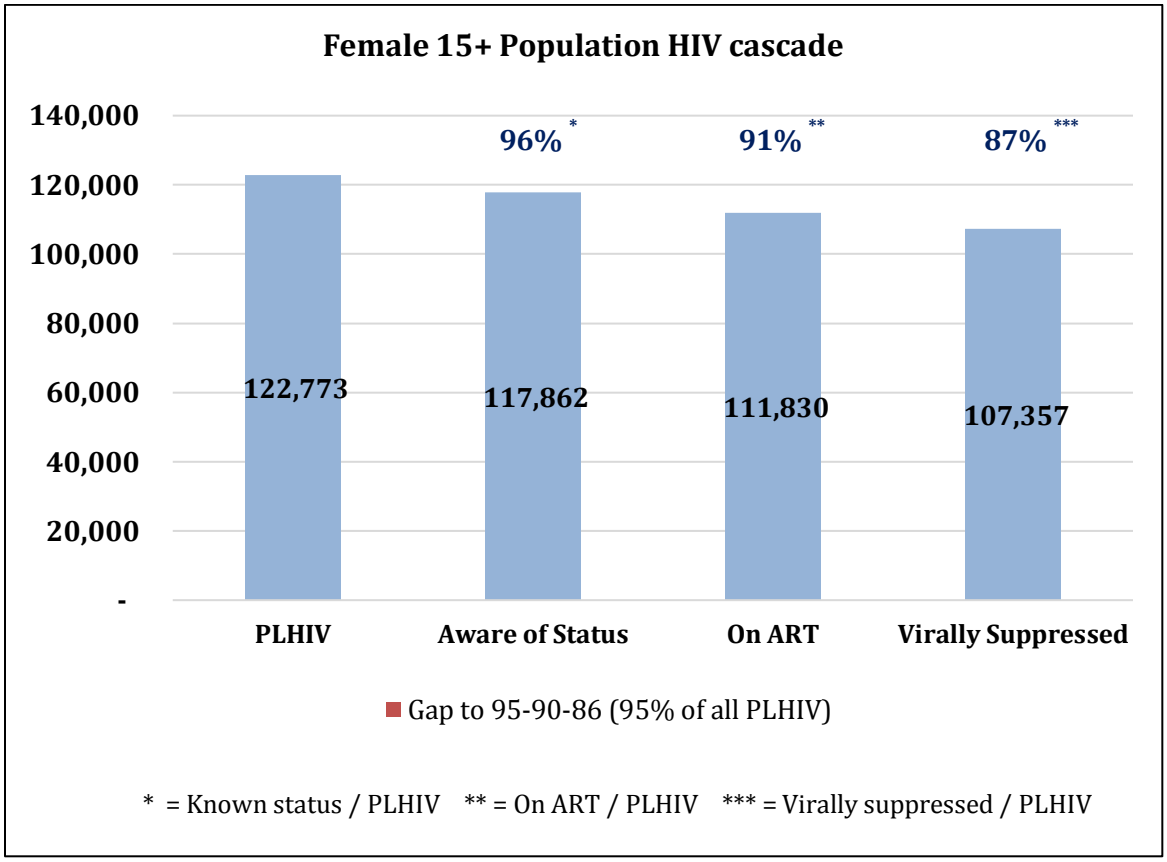
Figure 2.1.9 Eswatini National PLHIV Population Cascade, FY19Q2



Source: PLHIV=2018 estimate from 2019 Spectrum model
Aware= estimate from UNAIDS calculations
On ART= FY19Q2 HMIS program data
Virally suppressed= FY19Q2 PEPFAR program data

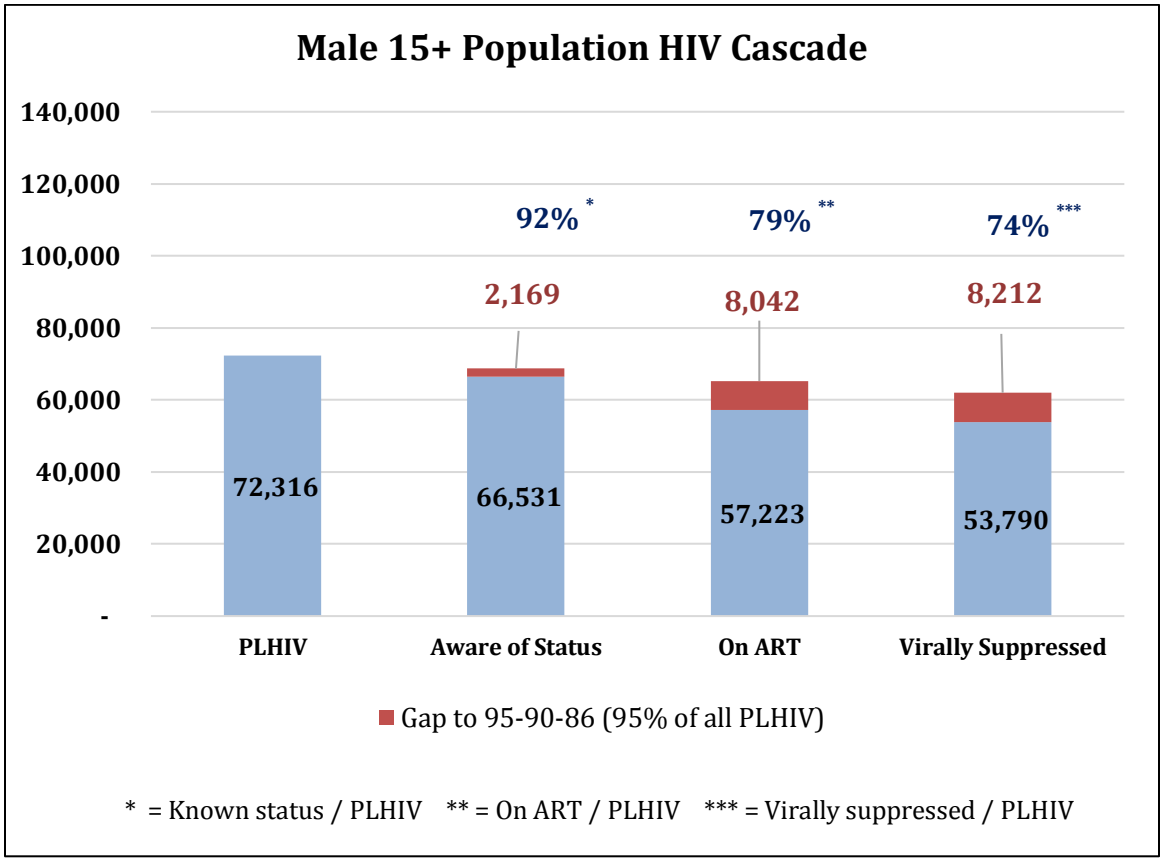
Figure 2.1.9 shows that nationally, 93% of all PLHIV know their status, 86% of PLHIV are on treatment and 80% of PLHIV are virally suppressed, which surpasses the previous 90-90-90 goals at the national level. During 2019 the Kingdom of Eswatini is expected to reach the 90-90-90 goals for males and females in all age groups, and to reach the 95-95-95 goals at a national level (meaning that 95% of all PLHIV know their status, 90% of all PLHIV are on treatment, and 86% of all PLHIV are virally suppressed).

Figure 2.1.10a Adult Female PLHIV Cascade, FY19 Q2



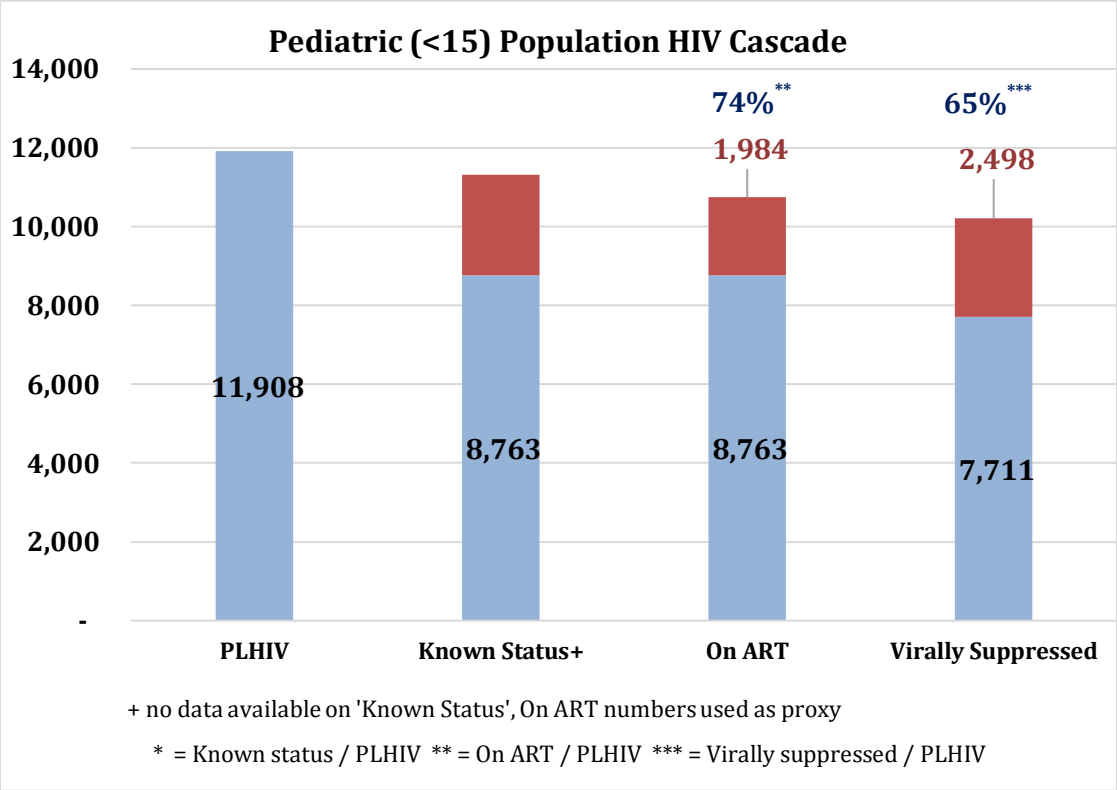
Source: PLHIV=2018 estimate from 2019 Spectrum model
Aware= estimate from UNAIDS calculations
On ART= FY19Q2 HMIS program data
Virally suppressed= FY19Q2 PEPFAR program data

Figure 2.1.10b Adult Male PLHIV Cascade, FY19Q2



Figures 2.1.10a and 2.1.10b show the disproportionate burden of HIV infections on women in the country. However, treatment coverage is significantly higher for women, leaving a larger absolute number of men with HIV who are not on treatment and not virally suppressed.

Figure 2.1.11 Pediatric PLHIV Cascade 2018



Source: PLHIV=2018 estimate from 2019 Spectrum model
Aware= estimate from UNAIDS calculations
On ART= FY19Q2 HMIS program data
Virally suppressed= FY19Q2 PEPFAR program data

The pediatric (< 15 years of age) HIV cascade in Figure 2.1.11 shows lower ART coverage and viral suppression than for adults. Population survey for the estimation of pediatric awareness or prevalence have been extremely limited due to low numbers. In the cascade above, the number on ART is used as a proxy based on programmatic knowledge that very high proportions of children diagnosed HIV positive are linked to treatment.

With regard to the fourth pillar of the cascade, viral suppression, Eswatini conducted a nationally representative HIV drug resistance (HIVDR) survey in 2016 that showed a 10.6% prevalence of pre-treatment HIV Drug Resistance (PDR) to NNRTIs (EFV and NVP) among patients initiating ART. Where nationally representative data for PDR show >10% PDR to NNRTIs, WHO recommends either changing the NNRTI backbone or providing HIV PDR testing where alternative treatment options are not feasible. PEPFAR will support Eswatini to transition all eligible patients from NNRTI based regimen to DTG based regimens in line with the revised national HIV management guidelines and to attain the 95-95-95 targets.

Eswatini has made tremendous strides towards epidemic control through a focus on key interventions in testing and treatment, coupled with strong community prevention programming. It is estimated that 92% of all PLHIV know their HIV status due to successful case identification and messaging. Early adoption of Test and Start (T&S) increased numbers of people on treatment, and strategic interventions to increase access to VL testing and to support retention have led to a viral suppression rate of 93% for those who are on ART. Prevention of Mother-to-Child Transmission (PMTCT) programming has reduced the mother-to-child transmission (MTCT) rate to 2% (based on program data). Pediatric ART coverage and viral suppression lags behind that of adults, and specific COP19 programming will address the gaps. The GKoE's early adoption and commitment to full transition to TLD will lead to further increases in viral suppression. Strong HIV prevention programming through standardized implementation of core packages of interventions including DREAMS, OVC, community and male engagement, VMMC, and condom programming have also contributed to the decline in new infections.

Table 2.1.3: Implementation of key policies/programming to address minimum program requirements - Overview

Policy/Guideline	Status	Comments
Test and Start	Adopted in 2015 and implemented fully	Same day initiation is now offered to all patients testing HIV positive.
Multi-month prescriptions	Full scale three-month prescribing and dispensing have been implemented for stable patients in all facilities since 2007. System barriers to six-month dispensing are currently being reviewed.	Three-months dispensing is the standard of care for stable patients. The GKoE will fully transition to six-months dispensing during COP 19 implementation by working through the following barriers: (i) the major barrier was financial and that is the ARVs that will be required to calibrate the GKoE minimum and maximum stock levels so that the supply chain can absorb six-months dispensing commodity requirements. During COP19 planning Eswatini was approved to receive GF technical assistance resources in the Working Capital Fund to purchase TLD to commence the transition to six month dispensing.

		(ii) Patient education on the management of higher stock levels of ARVs at home in a manner that will assure commodity quality (iii) Storeroom considerations for larger pack sizes which do not come in boxes.
TLD transition	Phased TLD transition started in October 2018 and the full transition to TLD, including women of childbearing age is expected to be completed by April 2020.	The nationwide transition to TLD is occurring in two phases to allow for clear communication with healthcare workers, development of in-country learnings, and commodity availability. The second phase started in April 2019 and the GKoE has prioritized transition to TLD of patients on NVP. The GKoE stopped outstanding orders of NVP orders and is in the process of transitioning all adults on NVP-based regimen to TLD. The TLD transition is expected to be completed by April 2020. This is to allow for: (i) the exhaustion of current 1st line ARVs stock and avoid wastages from expired stock; (ii) patients receiving VL tests according to scheduled annual VL tests (given laboratory HR and equipment capacity); and (iii) ensuring that there are no TLD stock ruptures because funding for TLD by the GKoE is based on the transition being completed in April 2020, in line with the GKoE fiscal year.
Scale up of index and self-testing	Index testing is currently being scaled up nationally	Government notified all health facilities of adoption the scale up of index testing in February 2019. Scale-up models and new approaches are being implemented to ensure that 50% of targeted newly-identified PLHIV come from index tests. Self-testing will be scaled up for targeted distribution including as part of index testing. The FBO initiative funding will target men for self-test distribution.
Scale up of TB preventive therapy	Policy for TPT in place	The MoH is working on a strategy to reboot the TPT program, including disseminating updated

		messaging. TPT coverage will reach 90% of newly enrolled on ART and 60% on ART in COP 19.
Direct and immediate (>95%) linkage of clients from testing across age, sex, and risk groups	Linkage case management is currently being implemented.	Linkage case management will be scaled up to all health facilities and the COP19 linkage rate is targeted for 95%. Lay counselors and expert client numbers will increase to facilitate this process. Enhanced patient tracking and tracing will allow a more accurate measure of linkage
Elimination of user fees	Policies are in place that ensure there are no user fees	The minimal user fees for radiography services were removed by the GKoE.
Increase access to VL testing	VL testing coverage is at 95%.	In COP 19, VL testing coverage will be increased by use of high output VL machines and turn around times improved by an interface of the laboratory information system with the CMIS so that VL results are more easily accessed and acted on by clinicians. Pediatric VL testing will increase by the use of DBS in CLHIV < 5 years of age. Requisition forms will note if the patient is a pregnant or breast feeding women (PBFW) to help prioritize notification for PBFW who are not virally suppressed.
Completion of VL/early infant diagnosis (EID) activities	Following the lab equipment optimization TDY in 2018, platform selection and reagent rental will be in place starting in May 2019.	The implementation plan for lab services and equipment optimization will be fully implemented in COP 19.
Monitoring morbidity and mortality	Morbidity and mortality monitoring will be integrated in CMIS	CMIS will integrate reporting of morbidity and mortality. CMIS will be scaled up to remaining ART sites, covering 90% of ART clients.
Alignment of OVC packages with comprehensive	OVC services are aligned with COP19 and country priorities. HIV prevention is integrated in the OVC packages and primary	The OVC program provides comprehensive needs-based services to OVC aged 0-17 employing a case management approach. HIV prevention is integrated in OVC programming. The program will

prevention and treatment services	prevention of sexual violence and HIV among 9-14 yr olds is being strengthened.	ensure that OVC with unknown HIV status are assessed for HIV testing. For HIV+ OVC, intensive support is provided to families and children to ensure linkage to treatment and retention in care including adherence and disclosure support.
Evidence of resource commitments by host governments	GKoE has a proven track record of resource commitment	GKoE funds all adult ARVs as well as other components of the HIV program. Domestic investments are set to increase for FY20. Government commitment to the HIV epidemic is strong.
Progress towards local prime partner funding	Local prime partner funding has increased in COP19	USAID and CDC increased from 4,629,822 in local partner funding in COP18 to 11,422,686 in COP19
Scale up of unique identifiers across all sites	A unique patient identifier is being scaled up nationally, currently for use in the health and education systems	Eswatini has adopted the use of the national ID number as unique patient identifier (UPID) in the CMIS. 86% of ART clients registered in CMIS had a UPID. GKoE is supporting efforts to increase UPID uptake including facility-based registration. PEPFAR/E will trial biometrics for improved patient identification.

With continued donor financial and technical support there are no major programmatic and systems gaps to be able to achieve epidemic control. Long term financial sustainability is of high importance due to the scale of the epidemic, the economic situation and global trends in HIV donor funding. The GKoE, with the support of the GF, has initiated a Committee on Sustainable financing for the epidemic and PEPFAR is part of both the Steering and Technical Committees.

2.2 Investment Profile

Funding Landscape

Despite Eswatini's classification as a lower middle-income country, economic indicators such as a weak business climate and low foreign investment reflect a low-income country status that has significant income disparity (Gini coefficient of 0.49) and substantial poverty with 62.1% of Eswatini's population living below the lower middle income country poverty line ($3.20)[1]. Due to the ongoing fiscal crisis, economic growth continues to slow down. Revised figures indicate a marginal GDP growth of 0.6% compared to 1.9% in 2017[2]. A tax to GDP ratio of 15.5% and high total non-tax revenue of 11.2% of GDP[3] illustrate both challenges faced in domestic revenue generation and financial dependency on Southern African Customs Union (SACU) revenue sharing agreement. The dual burden of high HIV and TB prevalence and number of OVC remain major health and social concerns, while non communicable diseases also play a significant role in premature death, all of which have substantial impact on the workforce and economy, as well as significant public expenditure.

The GKoE delivers the majority of direct HIV services in the country and funds ARVs for adults, while donors support critical areas in HIV/TB care, treatment, and prevention, including direct service delivery, technical assistance (TA), commodities, and human resources (HR). Above site support for government program management and ownership, supply chain, laboratory, surveillance and Client Management Information System (CMIS) also continue to require donor support.

Eswatini received approximately US $146,580,000 in Overseas Development Assistance in 2017[4]. 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. Despite economic challenges, GKoE domestic expenditure in health is expected to rise from $133,009,265 expended in 2017/2018 to the budgeted level of $146,433,314 in 2018/2019. GKoE domestic expenditure on HIV is set to increase from $23,807,009 spent for the 2017/2018 financial year to $25,438,673 budgeted in 2018/2019. ARV purchasing expenses alone accounted for nearly $19,799,308 in expenditure in 2017/2018, and the budget for this has increased to over $21,111,037 for 2018/2019.

PEPFAR is the largest financial contributor to the HIV response at 59%, followed by GKoE at 26% and GF at 11%. By program area the greatest total PEPFAR investments were in clinical care, treatment and support, HIV case identification and health system strengthening. This investment represents both DSD and technical support. The largest contribution from GKoE was in clinical

[1] World Bank, 2018
[2] Central Bank of Eswatini, 2019
[3] Revenue Statistics in Africa 2018 oe.cd/revenue-statistics-in-africa
[4] The World Bank 2018 data.worldbank.org

care, treatment and support, predominantly through the funding of adult ARVs while GF focused support in test kits, VL and lab reagents. PEPFAR/E and GF continue to provide support for specific commodities, particularly those that are difficult for GKoE to procure at the smaller volumes required by the country. In COP19, PEPFAR/E will support VL reagents (split with GF), HIV self-test kits and VMMC surgical kits. GKoE will support all adult ARVs. At GKoE's 2015 request, PEPFAR/E agreed to supply all the public sector, free and socially marketed condoms for health programs in country.

Commencing in 2018 with two years of funding is PEPFAR/E's cervical cancer initiative, which funds the expansion of the national program. PEPFAR/E is also the main supporter of HIV prevention programming including VMMC, oral PrEP, condoms, and comprehensive interventions and services for AGYW), OVC and key populations. PEPFAR/E provides support for above site activities to strengthen government capacity and leadership for oversight, coordination and implementation of HIV programs, in addition to building the capacity of GKoE to collect, analyze and use data for HIV/TB program decision-making. PEPFAR/E investments also include laboratory support, survey and surveillance and development and systems strengthening (CMIS, LIS, WMIS, etc.) See Section 6.0 and Appendix C. Table 6 for more information. These changes to PEPFAR/E investments reflect the evolving epidemic. While total available budget remains similar, COP19 sees a strategic increase in Health System Strengthening activities that are high priorities for supporting GKoE in attaining and sustaining epidemic control.

Table 2.2.1: FY18 Investment Profile by Program Area[5]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	$32,828,315	46%	9%	42%	3%
Community-based care, treatment and support	$616,017	64%	30%	4%	2%
PMTCT	$3,697,399	82%	18%	0%	0%
HTC	$8,530,030	99%	0%	1%	0%
VMMC	$4,088,546	74%	26%	0%	0%
Priority population prevention (prisons, migrant workers, miners)	$1,853,648	100%	0%	0%	0%
Key population prevention (MSM,sex workers)	$9,595,760	16%	3%	81%	0%
Orphans and Vulnerable Children	$9,075,013	64%	15%	21%	0%
Lab and blood safety	$1,931,708	87%	13%	0%	0%
Strategic information, Surveys and Surveillance	$7,136,113	74%	19%	2%	4%
Health System Strengthening	$14,019,135	51%	14%	1%	34%
Total	**$93,371,684**	**59%**	**11%**	**26%**	**6%**

The total FY18 HIV program investment of $93,371,684 was funded predominantly by PEPFAR (59%), GKoE (26%) and GF (11%) (Table 2.2.1). The program area with largest investment was clinical care, treatment and support (including ARVS), the area where GKoE made its largest proportional financial support.

[5] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

Table 2.2.2: Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR[6]	% GF[7]	% Host Country[8]	% Other
ARVs	$20,404,270	8%	0%	92%	N/A
Rapid test kits (RTK)	$771,572	0%	100%	0%	N/A
Other drugs	$1,403,037	0%	0%	100%	N/A
Lab reagents	$5,750,889	0%	56%	44%	N/A
Condoms	$778,800	75%	0%	0%	N/A
VL commodities	$5,057,761	48%	52%	0%	N/A
VMMC kits	$602,984	82%	18%	0%	N/A
MAT	$0	0%	0%	0%	N/A
Other commodities	N/A	N/A	N/A	N/A	N/A
Total	**$34,769,313**	**15%**	**19%**	**65%**	**N/A**

The total annual budget for commodities is $34,796,313, with the GKoE paying for 92% of the most expensive component, ARVs. GF supports 100% of rapid test kits, while GKoE funds all other drugs. Lab reagent procurement is split between GF and GKoE while VL commodities are split between PEPFAR and GF.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Peace Corps	$1,125,200	$0	17389	$0	Volunteer Support
Total	$1,125,200	$0		$0	

Aside from Peace Corps, the other United States government agencies implementing health programming at post are entirely PEPFAR funded (Table 2.2.3).

[6] PEPFAR FAST FY2020

[7] Eswatini Global Fund HIV/TB Grant, FY19 – 20

[8] Eswatini Ministry of Health Quantification Report, FY 19-20

Table 2.2.4: Annual 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
Cervical Cancer – Central Funds	$0	$0		17465, 80103, 17463, 17460, 18169, 17462, 18272, 17461	**$1,018,705**	Provide cervical cancer screening and treatment services for HIV+ women aged 25-49 – the target is 40,422 women.
FBO	$0	$0		17463, 17462, 17460, 18169, 80103, 18601	**$8,000,000**	1. To engage communities of faith and traditional communities to understand the epidemic, raise community awareness, and bring critical prevention and treatment interventions for men to and through communities of faith and traditional community networks, through existing and additional partners, including FBO partners; 2. Prevent sexual violence, and HIV risk in 9-14 year old girls and boys through engagement of OVC/DREAMS, and faith and community partners, along with the justice departments
Total	**$0**	**$0**		-	**$9,018,705**	

Non-COP resources shown in Table 2.2.4 are funds received from OGAC to support specific central initiatives and do not count towards Eswatini's total allowed COP budget level. The two

centrally funded initiatives in COP19 are cervical cancer screening and treatment described in section 4.7 and the faith based initiative described in Appendix E.

2.3 National Sustainability Profile Update

Table 2.3.1 below captures progress that have been made during COP 17 and COP 18 implementation towards prioritized SID 3.0 elements, with the aim to improve the sustainability of the HIV response and transition some activities in COP 19.

Table 2.3.1 SID 3.0 Elements

Selected SID 3.0 Element and score	**COP 18 and COP 19 activities to improve sustainability element**
Sustainability Strengths	
Element 1: Planning and Coordination *SID 3.0 Score - 8.02, light green*	NERCHA and the Prime Minister's Office effectively lead the HIV response in Eswatini. Some of the gaps identified in SID 3.0 included the need to improve the coordination of efforts by HIV-response partners to maximize synergies and minimize duplications. During FY18, NERCHA restructured its organizational arrangement to achieve a better fit for organizational purposes. In COP 19, PEPFAR will continue to support the secondment of two officers to NERCHA to facilitate NERCHA's fulfilment of its mandate to coordinate the multi-sectoral and community-led HIV-response. The Prime Minister's Office, through the Secretary to Cabinet established a Sustainability, Co-Financing and Transition (SCT) Steering and Technical Committee that seeks to coordinate the country's considerations for a sustainable HIV, TB and Malaria response. In addition to the Principal Secretaries from multiple Ministries, PEPFAR, UNAIDS, European Union (EU) and WHO serve in the steering committee, and representatives from these organizations also are part of the technical committee. This structure received $100,000 funding from the GF (during FY19) to develop a sustainability strategy and transition plan that will ensure that the gains in epidemic control are maintained and transitioned to the GKoE over time.
Element 12: Technical and Allocative Efficiencies	The GKoE continues to effectively analyze and utilize relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. The Ministry of Economic Planning intensified its efforts to coordinate all Bilateral and Multilateral Partner support to the GKoE and the USG is working with the Ministry of Finance (MOF) to second an advisor from the US

SID 3.0 Score - 8.16, light green)	Treasury Department to support financing sustainability that includes HIV/AIDS investment sustainability considerations.
Sustainability Vulnerabilities	
Element 10: Laboratory *SID 3.0 Score - 5.17, yellow*	GF, MSF, and PEPFAR support the MoH laboratory systems though HR support, implementation of a laboratory information system, QMS, procurement of laboratory commodities, and sample transportation system. Médecins Sans Frontières (MSF) scaled back its laboratory support as part of the organization's revised strategy, with a complete exit for laboratory support planned during COP18. In COP 18, the Southern Africa Development Community Accreditation Service (SADCAS) recommended two laboratories for ISO accreditation. In COP 19 PEPFAR will strengthen POCT quality assurance (QA) and the implementation of the laboratory optimization action plan.
Element 7: Human Resources for Health *SID 3.0 Score - 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. In COP 17 and COP 18, PEPFAR supported the MoH to develop a strategy aimed at rationalizing HR numbers and skill-sets with client services and volumes at facilities**.** This mapping exercise pointed to heavy donor reliance that is worsened by the existence of certain cadres that are not in the GKoE establishment register (such as the 21 different lay cadres funded by donors supporting HIV care), which will make their transition to the GKoE civil service more cumbersome. The current GKoE hiring restrictions have contributed to a waiting list of 300 qualified nurses and laboratory technologists who cannot be absorbed, yet there are persistent shortages of these cadres in health facilities. HRH is likely to remain a vulnerability during COP 19 as the GKoE will continue to only permit minimal increases to the civil service.
Element 8: Commodity	The GF, PEPFAR and CHAI continued to provide support to the MoH to assure commodity security and strengthen commodity procurement and management. The

Security and Supply Chain *SID 3.0 Score - 6.90, yellow*	GKoE's continued commitment to buy all first line adult ARVs remains a strength that will contribute towards a sustainable response beyond COP 19.
Element 13: Epidemiological and Health Data *SID 3.0 Score - 3.96, yellow*	PEPFAR and GF provided additional capacity to the MoH for ongoing epidemiologic and monitoring and evaluation (M&E) activities. In COP18, PEPFAR and GF provided additional support to the MoH to enhance programmatic monitoring of the HIV program in Eswatini. The support was targeted towards the scale up of the CMIS to the 172 ART facilities in the country. In COP 19, PEPFAR will continue to support the deployment of a robust CMIS to all ART sites. In addition, PEPFAR will leverage on the government's transition to microwave technology to enhance connectivity of all CMIS sites for real-time data synchronization. PEPFAR also plans to support the government to pilot the use of biometrics to enhance unique patient identification. The CMIS is critical for tracking individual patients along the prevention and treatment cascades. Capacity enhancement for data entry and use will also be a key priority in COP19.

Transition to indigenous partners

Funding to indigenous organizations from all agencies increased from $4,629,822 in COP18 to $11,422,686 in COP19. In COP19, 23% ($7,737,308) of USAID's program budget is allocated to local organizations, including $2,552,750 of the FBO central initiative. This represents a substantial increase from COP18 when funding to local partners totaled $2,916,111 (2% of program budget). In COP 19, USAID will fund three local primes:

i) The Luke Commission, a local FBO, will continue to provide comprehensive clinical services and will also engage faith based structures for case finding and HIV and violence prevention among children.

ii) Two local subgrantees currently operating under Pact will graduate to become prime award holders to provide OVC and DREAMS services in designated SNUs.

CDC is continuing to increase funding resources to indigenous partners; from COP18 to COP19 funding to local prime partners increased from $1,713,711 to $3,685,378, which is a 115% increase. CDC's current prime indigenous partner is the Ministry of Health and CDC also funds a number of indigenous subawards. Prior to COP 18, international partners were supporting Government HR positions, but most of these positions have now been transitioned into the Ministry of Health Cooperative Agreement (CoAg). CDC is also in the process of developing new Funding

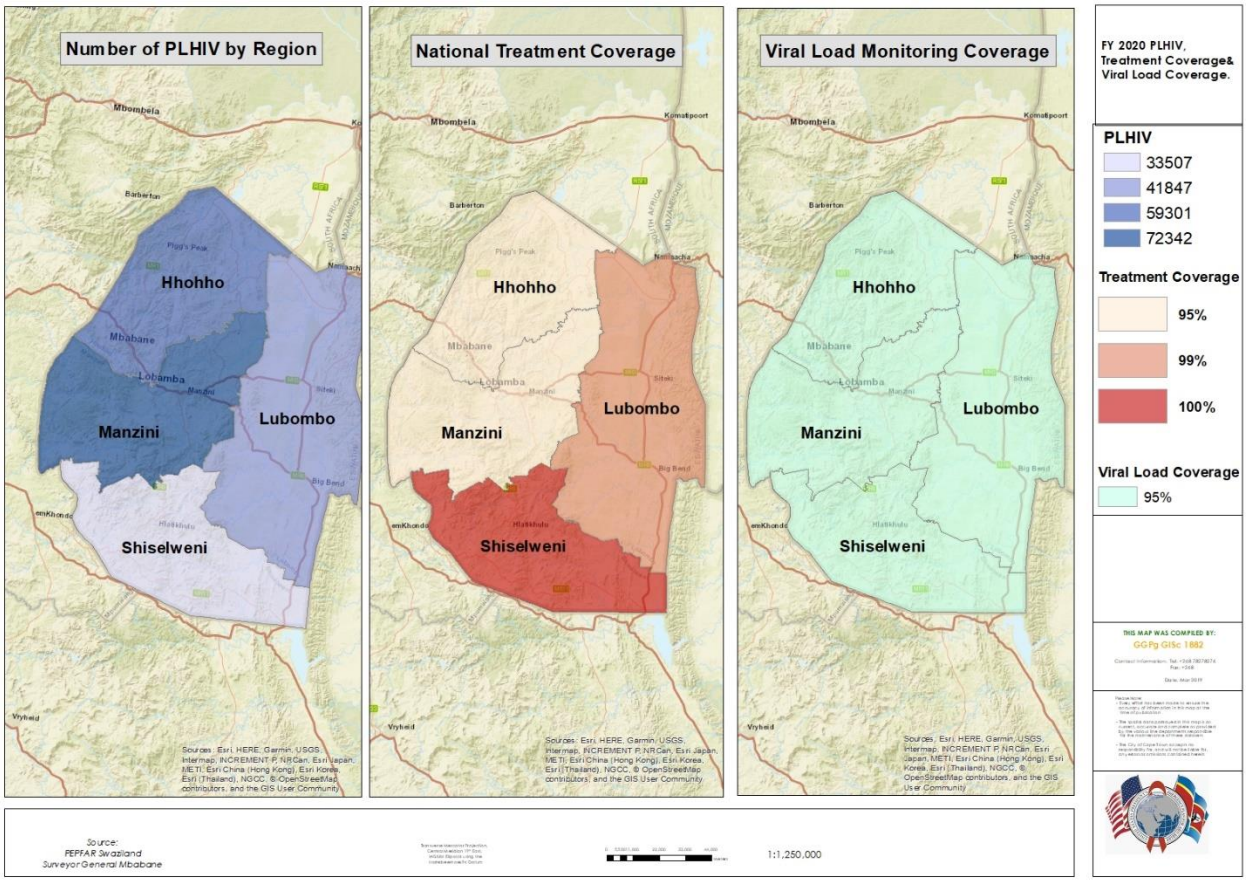
Opportunity Announcements to replace a majority of their CoAgs that will end in September 2020 and this process will be used to identify opportunities to increase funding to indigenous partners.

Eswatini is a recipient of the centrally funded Faith Based Organization (FBO) initiative, and both CDC and USAID will leverage this opportunity to increase funding to indigenous partners.

2.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR's investments support availability of clinical and community services in all four regions. Financial investment is linked to disease burden, with the most implementing partners and additional resources in the region with the most PLHIV. Analysis of the population pyramid overlaid with the PLHIV cascade for regions informed the process for setting targets for growth by subpopulation in each region. COP19 will use recency testing to identify potential transmission "hotspots" (areas identified with high levels of HIV transmission within the past 12 months). Figure 2.4.1 shows PEPFAR Eswatini's treatment and viral load monitoring coverage for PLHIV. Targets for COP19 were set ensuring that all regions had a minimum of 90% PLHIV on treatment by five year age band and sex. Key findings during this analysis led to the development of the COP19 programming focusing on special needs of different ages at various points in the cascade as a priority.

Figure 2.4.1 PEPFAR Eswatini: Targeted PLHIV treatment coverage and Viral Load monitoring coverage FY20



2.5 Stakeholder Engagement

Host country government: PEPFAR/E 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 policy development requirements, program priorities and program results. Furthermore, PEPFAR/E holds monthly meetings with the MoH and NERCHA to discuss program priorities and program progress. These meetings are used to present the quarterly results, COP Guidance and targets. In addition to participating in national-level technical working groups (TWG), PEPFAR/E also meets with MoH, Deputy Prime Minister (DPM), Ministry of Tinkhundla and Administration (MTAD), and NERCHA technical leads to discuss and agree on technical-level oversight, development of national strategies and performance management. The MoH and NERCHA Senior Leadership and technical team meetings were conducted at least weekly after receipt of the PLL to jointly set priorities for COP 19. This included pediatric ARV optimization, TLD transition monitoring, scaling up of DSD models and rapidly scaling up effective testing modalities.

PEPFAR/E continues to engage with the Ministry of Finance on the proposed secondment from the U.S. Department of Treasury to provide support around financial sustainability and domestic revenue generation.

External development partners: PEPFAR/E is a member of the Country Coordinating Mechanism (CCM), a member of the CCM Oversight Committee and continuously shares financial and programmatic information with the GF and CCM members. PEPFAR/E has standing quarterly meetings with the GF to engage on areas of shared interest, such as commodities, CMIS, supply chain management, AGYW and key populations to avoid potential duplication. PEPFAR and UNAIDS have monthly meetings for coordination, and PEPFAR participates in the quarterly UN Coordination meeting. CHAI, MSF and the broader United Nations (UN) family are also key PEPFAR/E partners, with meetings and communication as needed through the year and they participated in COP 19 stakeholder meetings.

Civil Society /community engagement: PEPFAR/E convened several meetings with Civil Society Organizations (CSOs) under the HIV Consortium of the Coordinating Assembly of Non-Governmental Organizations (CANGO), the CS umbrella coordination group, to provide updates on the quarterly PEPFAR Oversight and Accountability Response Teams (POART) results and COP 19 planning. CS (Civil Society) representatives for the Johannesburg in-person meeting were also nominated through CANGO internal coordinating processes. Large stakeholder meetings that included CS were held in January and February 2019 to solicit input for COP19. PEPFAR/E broadly shared information with CS about the COP19 strategic direction prior to and after the Johannesburg In-Person Meeting. Drafts of the Strategic Direction Summary (SDS) were also shared to gain valuable feedback and input from CS. In COP19, the PEPFAR/E small grants program will prioritize work with CSOs that benefits people living with disabilities following input from one of the COP 19 stakeholder consultation meetings on the lack of DSD for this population. PEPFAR/E will also build on COP 18 engagements with FBOs to leverage FBO structures and communities to intensify active case-finding and prevention of sexual violence activities among 9-14 yo in COP 19.

Private sector: PEPFAR/E collaborates with Swaziland Business Coalition on HIV/AIDS (SWABCHA), Swaziland Migrant Mineworkers Association (SWAMMIWA), and companies with male-dominated workplaces (such as construction companies, plantations, timber companies, and mines). PEPFAR/E also has a public private partnership (PPP) with Coca Cola and the Matsapha Town Council that could potentially serve as a model to be replicated with other companies in the private sector. PEPFAR/E has had initial discussions with the Royal Swaziland Sugar Corporation to explore potential for future collaborative efforts. PEPFAR/E anticipates expanding existing and new relationships with the private sector in COP19.

The following table (Table 2.5.1) outlines PEPFAR/E engagement with CSO and other stakeholders prior to COP19 submission.

TABLE 2.5.1. PEPFAR Engagement with Civil Society Organizations for COP19 and beyond		
Date	**Meeting/Communication**	**Objectives**
December 17, 2018	COP guidance	● Shared the draft COP guidance ● Shared the COP process and timelines
January 22 & 23, 2019	GKoE	● Discussion on initial strategies and policy adjustments to respond to PLL ● Developed initial strategies (e.g., gender/age pivots, reaching men, and plans for reaching 95-95-95)
January 31, 2019	Stakeholder 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 11 – 15, 2019 **April 2019**	CSO constituency meetings	● Reviewed priority population strategies, e.g., Key Populations, case identification and plans for reaching 95-95-95
March 7, 2019		● Meeting with PMO, MoH, NERCHA, CSO, UN Agencies and GF to refine COP 19 strategies and policy changes
March 18 - 22, 2019	Post In-Person Meeting in Johannesburg	● Meeting with MoH, NERCHA and implementing partners to develop strategies in response to key outbrief and plenary feedback ● 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 COP19 was included with a request to review the SDS prior to submission.
April 1, 2019	Pre-COP Submission and eApproval meeting	● Share draft SDS with Stakeholders for review and feedback
TBD	Post - eApproval meeting	● Communicate the outcome of the COP submission
Ongoing	Quarterly POART meetings	● POART feedback

3.0 Geographic and Population Prioritization

3.0 Geographic and Population Prioritization

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY19 Q2)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Scale-up Saturation	206,997 (National)	177,816 (National 28 day LTFU)	4 (188,300– National)	4(199,828 - National)

Although the Kingdom of Eswatini has reached it's 90-90-90 targets at the OU-level, none of the regions have reached 81% ART in all age/sex bands or 80% VMMC coverage for people ages 15-29. See population pyramids, conditional clinical cascades (Appendix D), Region Age Sex Testing/Treatment Attribution (RASTA) tables (Appendix F), maps, and clinical cascades in Section 2. Due to this a scale up approach for case finding is being taken in all regions.

The gaps in reaching age/sex specific populations on treatment were identified during COP19 planning, which resulted in development and implementation of surge programming to increase case identification, linkage and retention. Based on the identified gaps there was particular focus on men 15-29 years of age, women 25-34 years old and children. The surge strategies brought forward the COP19 plans for improving those three areas for immediate implementation during 2019. Strategies to close the gap for the age and sex sub-populations are outlined in this document in the relevant sections. The surge component during 2019 includes weekly monitoring of testing and treatment initiation, enhanced patient tracking, tracing and retention and standardized dashboards to ensure that the program progresses at a rate to reach the second 90 in all age/sex bands by September 2019.

VMMC coverage of males all ages at the end of FY18 is 35%. According to SHIMS2 data, male circumcision coverage for 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 Sub-National Unit (SNU) performance and need

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

Manzini

The highest number of PLHIV is in the Manzini region, which has an industrial corridor where many people (especially young women and men) from other regions come to 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. Aggressive promotion for male testing and outreach for testing and linkages is prioritized in this region.

Hhohho

Hhohho is the second most populated region and while there are slightly less PLHIV than Manzini, there is a need for additional testing for men especially 25 to 40 years. 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. Finding the undiagnosed men, linking them to treatment and retaining them in care will be reinforced through intensive community and male engagement, extended hours, leveraging the DREAMS/OVC platforms, and active case finding and outreach.

Lubombo

As a primarily rural region, Lubombo has lower population density, higher levels of poverty and food insecurity, a high burden of OVC and female-headed households and reduced access to services and transportation. As a reflection of need, note that only fifty-two percent 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 and community engagement and outreach.

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) to transportation and services. There are 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, Lavumisa, which is a hot-spot and has a dynamic and transient population. Mobile services and outreach to the poorest populations, along with focused programming (with extended hours) in new industrial and hotspot zones will be prioritized as well as leveraging DREAMS and other outreach efforts to link these priority populations (PPs) to testing, treatment, and social services. MSF provides support to one of the three clusters in Shiselweni, and MSF has been providing all of the lab support in the region. Beginning in COP 18 they are shifting out of lab support. PEPFAR will continue supporting VL testing in the region through VL reagents buffer stock, mentorship and QMS activities.

DREAMS

There are 19 DREAMS tinkhundla, which 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 COP19. In 25 tinkhundla, inclusive of the 19 DREAMS tinkhundla, traditional and faith leaders will be engaged to address and prevent HIV and SGBV among the 9-14 year olds. In addition, through these leaders, men (especially ages 20-39) will be reached with sharply targeted activities, linked to services (including self-testing, and HIV services, including treatment for PLHIV and VMMC and PrEP, as needed).

B. *Population Analysis*

PEPFAR/E 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/E program's PPs are: Females aged 9-34, men ages 15-39 years and OVC. These populations have been identified as the most vulnerable to HIV infection based on epidemiologic, socio-economic and contextual factors. The population pyramid and regional pyramids (Figures 2.1.9-13) demonstrate by age band and sex those who are currently negative and require tailored packages of services and interventions to keep them negative[1], and PLHIV not on treatment that need to be linked to treatment.

Analyses of the previously discussed population pyramids, Spectrum estimates and RASTA tables (See Appendix F) show that AGYW aged 15-29 years, and men aged 20-39 years old comprise 69% of all new infections. These populations, along with OVC, must be targeted with comprehensive HIV prevention and treatment services. AGYW, ages 15-24 years, have low ART coverage and VL suppression. Analysis of the population pyramids further reveals that women ages 25-29 years need increased access to testing services and those ages 30-39 years need may need better adherence support for VLS. 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 COP19, PEPFAR/E 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 to support and coordinate effective interventions and services for PPs remains a pillar of the PEPFAR/E program to build a sustainable HIV response.

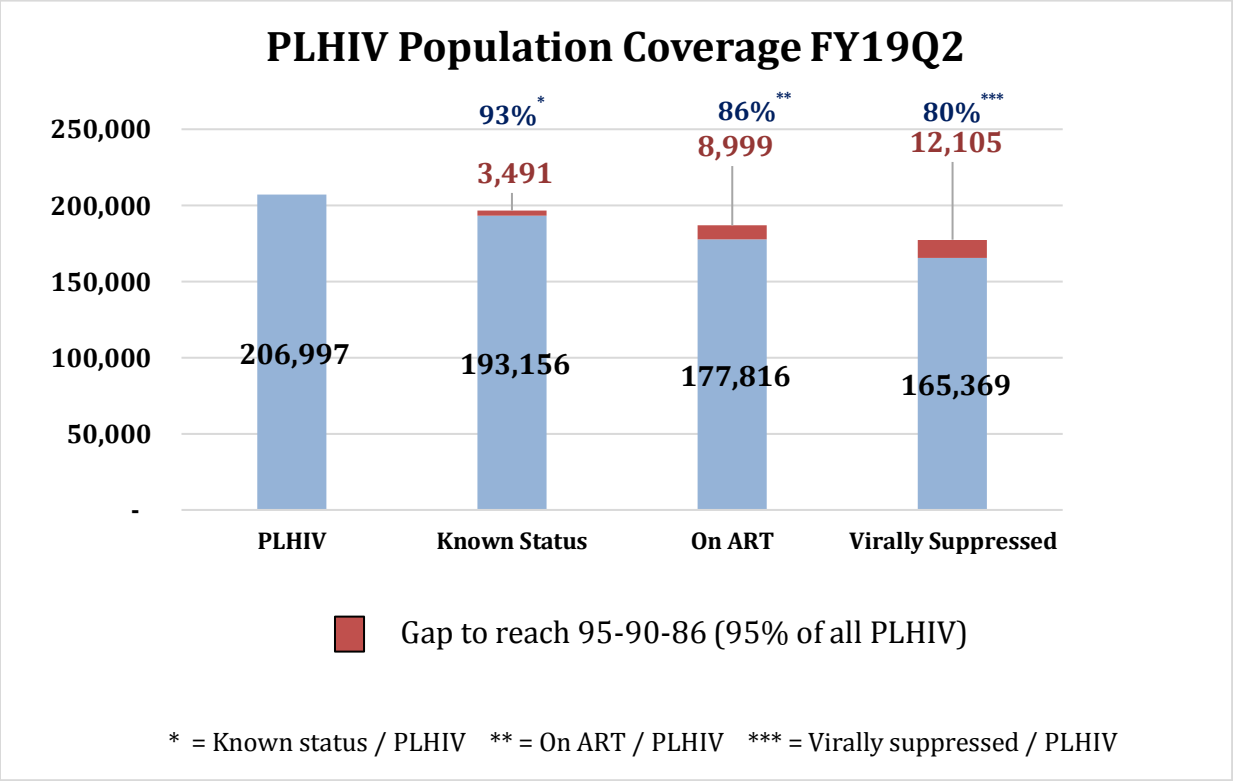
4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

First 95 – Case Identification

Eswatini adopted the 95-95-95 strategy as part of the National Strategic Plan to end HIV/AIDS by 2023 which calls for: identifying 95% of PLHIV; initiating 95% of those on antiretroviral therapy (ART); and retaining 95% them on treatment so they are virally suppressed. To achieve the first 95, the identification of PLHIV through HIV testing is key to the strategy's success. Targeted testing approaches will be more focused in COP 19 and will include index testing, HIV self-testing (HIVST) and optimized Provider Initiated Testing and Counseling (PITC). These approaches will improve the effectiveness of case finding among males, children, young people and key populations.

Figure 4.1.1 2018 PLHIV cascade against PLHIV denominator: Gap to 95-90-86



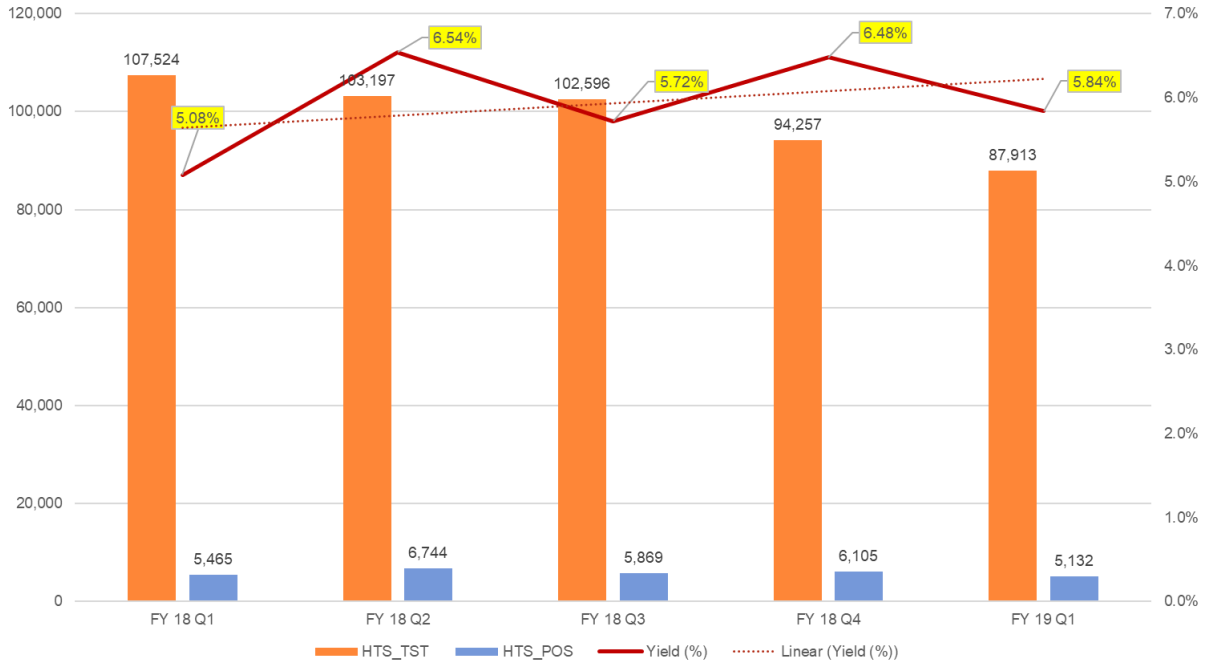
Source: PLHIV=2018 estimate from 2019 Spectrum model
Aware= estimate from UNAIDS calculations
On ART= FY19Q2 HMIS program data
Virally suppressed= FY19Q2 PEPFAR program data

The national cascade for the HIV/AIDS response (Figure 4.1.1) shows significant improvements with 93% of Emaswati living with HIV aware of their status. The national HIV testing policy framework provides a conducive environment to aggressively scale up HIV testing coverage. Moreover, the HIV testing and counseling guidelines clearly articulate the new testing strategies. These include index testing, HIV self-testing (HIVST), optimized PITC, and targeted-testing for specific populations. The guidelines also emphasize age- and sex-specific modalities.

I. Background

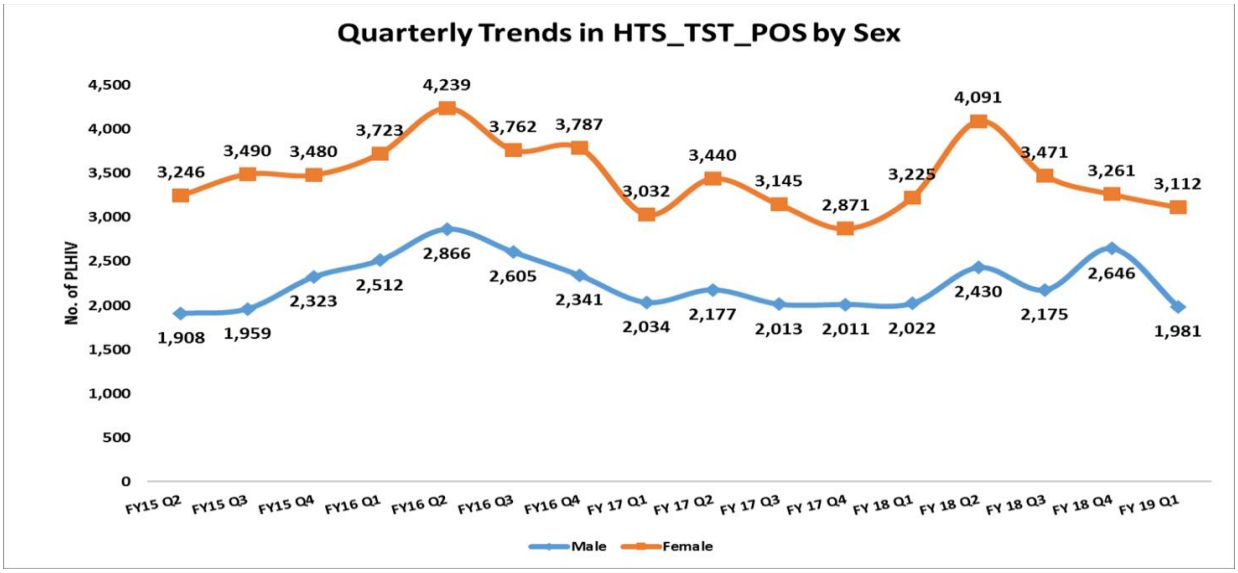
Analyses of the program data for FY 17 and FY 18 reveals that the overall testing yield has been stagnant (average 6%) from FY18Q1 to FY19Q1 (Figure 4.1.2).

Figure 4.1.2 Testing Trends FY18 Q1 to FY19Q1



Additionally, as shown in Figure 4.1.3, case finding is down in males in FY19Q1 and case finding in females is down for the last three quarters.

Figure 4.1.3 Trends in HTS_TST_POS by Sex



The graphs below (Fig.4.1.4 and Fig.4.1.5) show that for both males and females, community-based index testing and TB clinics have highest percentage yield for both sexes. However, other PITC (OPD) and VCT have the highest absolute number of PLHIV identified.

Figure 4.1.4 HTS Results by Modality and Sex - Males

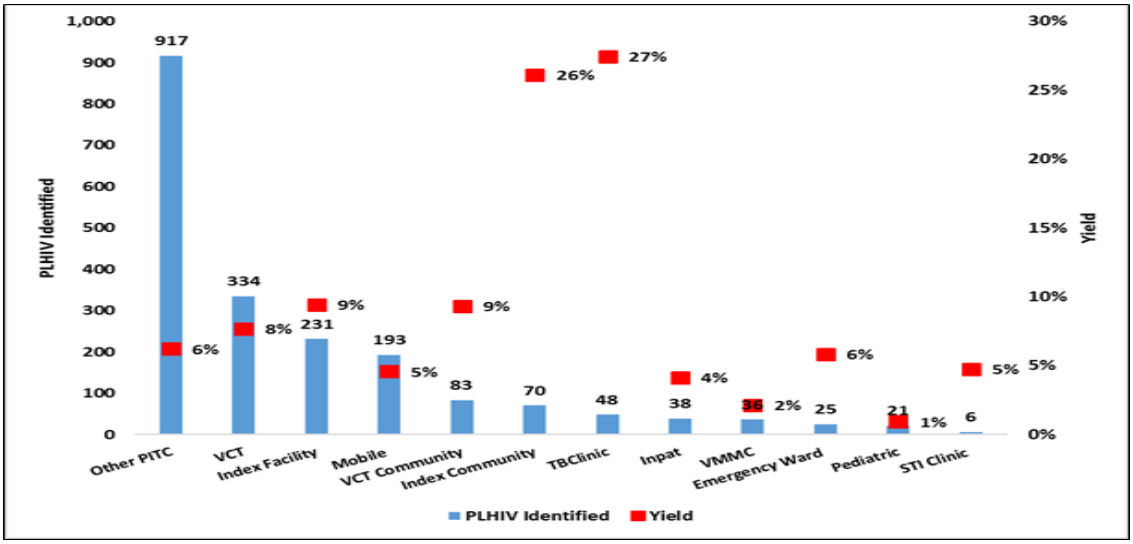
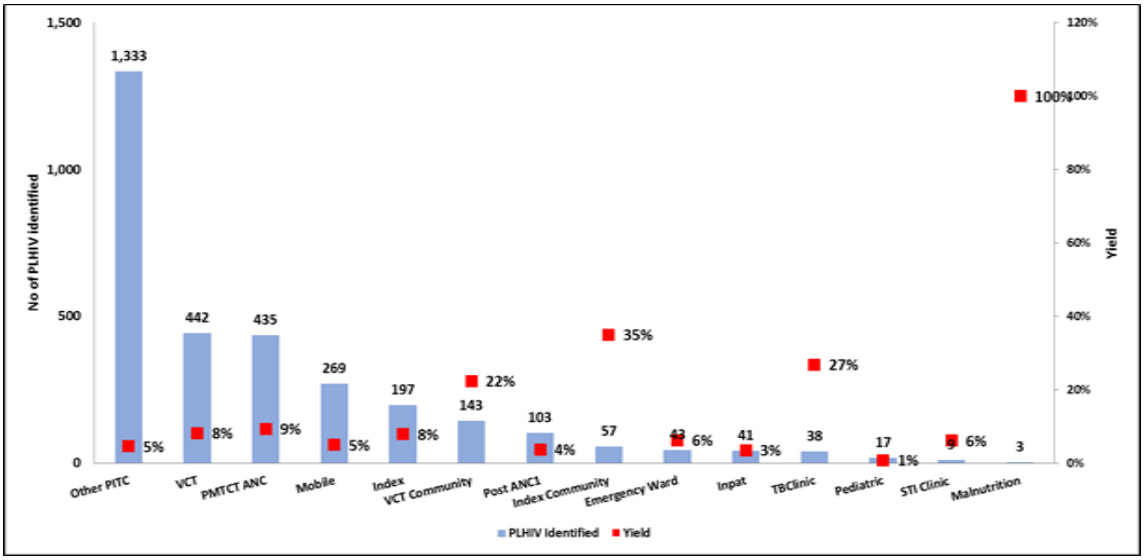
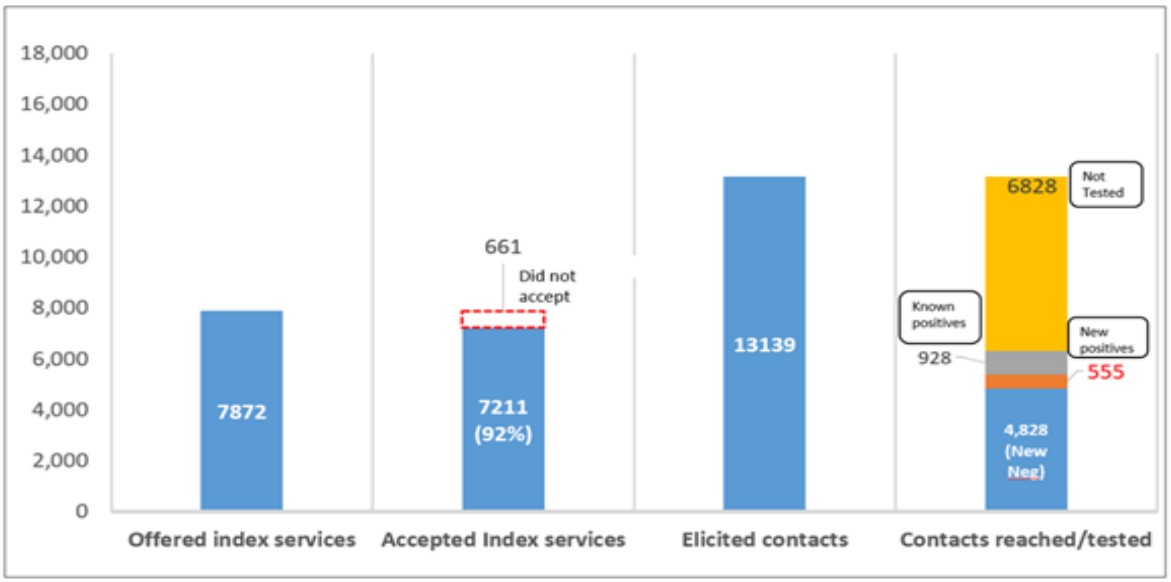


Figure 4.1.5 HTS Results by Modality and Sex - Females



In FY19 Q1, index case testing accounted for approximately 6% of all HIV tests, yet identified 28% of PLHIV. For both men and women the yield was higher in community index testing compared with facility index testing (26% vs 9% for males and 35% vs 8% for females). However, the number of positive people identified through facility index testing was greater (231 vs 70 for males and 197 vs 57 for females).

Figure 4.1.6 FY19 Q1 Index Testing Cascade Highlights Gaps



The above cascade (Fig 4.1.6) shows overall a high acceptance of index services (92%) but low testing of eligible contacts (60%) and low yield among eligible contacts tested (10.3%). To date,

index testing has not been fully implemented in all the testing sites. Following the PEPFAR Regional Planning Meeting in March 2019, the Ministry of Health called a stakeholders' meeting to discuss the urgent need for complete implementation of the HTS guidelines. The meeting outcomes included the issuing of a memorandum from the Directorate of the Ministry of Health to all facilities stating that they must urgently scale-up index testing with fidelity for all newly identified and high viral load patients; and a week-long retraining of all testers in all aspects of index testing starting on April 8,2019.

II. Improving Case Finding Approaches

1. OPD PITC Optimization

Prior to COP18 Eswatini was implementing routine HTS to all clients attending out-patient departments (OPDs). In COP 18, an HIV screening tool was introduced to identify all eligible clients for HTS (Figure 4.1.7). However, it has not been not uniformly implemented and the yield remains low with high testing volumes.

<u>Shifts beginning in COP18:</u>

- Modify and use the national screening and risk assessment tools for both adults and children; and standardize utilization of the tools across high volume facilities
    - Improve OPD testing yield: testing of all men aged 25 – 34 yrs and women 15 – 24 yrs who have not been tested in the previous 2 months
    - For others: redesign screening tool using SHIMS 2 covariates with the highest, statistically significant expected yield to generate risk profile for testing and optimize PITC across all high volume sites

Gender	Characteristic	Value	#Pos	#Neg	**Exp Yield**	% of Pos	Estimate	LowerCL	UpperCL
Male	Partner Status	Think/told me tested postitive	18.00	110.00	**14%**	13%	3.32	2.05	5.38
Female	Sexual Violence	Sexual violence w/in 12mo	5.00	34.00	**13%**	3%	3.02	1.15	7.89
Female	Multiple Partners	2+ partners	19.00	139.00	**12%**	12%	2.42	1.64	3.59
Male	Age	35-44 years	48.00	385.00	**11%**	28%	1.41	1.28	1.55
Female	Partner Status	Don't know status	81.00	815.00	**9%**	58%	1.85	1.60	2.13
Male	Hazardous Drinking	Hazardous Drinking	50.00	557.00	**8%**	29%	1.85	1.35	2.53
Male	Partner Status	Don't know status	70.00	790.00	**8%**	50%	1.53	1.30	1.80
Male	Age	45-54 years	19.00	217.00	**8%**	11%	1.59	1.28	1.97
Male	Urban/Rural	Urban	59.00	713.00	**8%**	35%	1.5959	1.2485	2.0398
Male	Age	25-34 years	64.00	826.00	**7%**	38%	1.4893	1.182	1.8764
Female	Partner Status	Think/told me tested postitive	11.00	156.00	**7%**	8%	2.43	1.36	4.34
Female	Age	25-34 years	59.00	842.00	**7%**	34%	1.53	1.19	1.98
Female	Age	35-44 years	30.00	455.00	**6%**	17%	1.49	1.42	1.57
Female	Urban/Rural	Urban	52.00	827.00	**6%**	30%	1.367	1.0599	1.763
Female	Multiple Partners	1 partner	121.00	2431.00	**5%**	74%	1.08	1.00	1.16

- Test all of the following historically higher yield populations: diagnosed/presumptive TB and STI patients, malnourished children, pregnant women, and HIV-exposed infants.

- **Site Optimization** – improve yield at high volume sites and volume at high yield sites

Median POS:	32
Median Yield %:	4.3%

SiteName	HTS_TST	HTS_TST_POS	Yield	Quadrant
Mpuluzi Clinic	369	16	4%	Low Pos/High Yield
Pigg'S Peak Hospital	4390	183	4%	High Pos/Low yield
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Matsapha Police Clinic	337	26	8%	Low Pos/High Yield
Timphisini				Low-Low
New Thulwane Clinic	665	20	3%	Low-Low
Siphocosini Clinic	845	70	8%	High-High
Lavumisa Clinic	351	10	3%	Low-Low
Ubombo clinic	703	66	9%	High-High
Mkhulamini Clinic	669	40	6%	High-High
Mshingishingini Nazarine Clinic	458	46	10%	High-High
Simunye clinic	3160	69	2%	High Pos/Low yield
Hlatikulu PHU	1443	32	2%	High Pos/Low yield
Tikhuba Clinic	1028	31	3%	Low-Low
Mathangeni Church of Christ	4853	430	9%	High-High

- Revise the scope of work (SOW) of lay cadres to ensure consistent eligibility screening in OPD settings
- Introduce concurrent, rather than the current serial, HIV testing in OPDs to improve efficiencies
- Revise and optimize client flow at the facility level to reduce missed opportunities for HTS for eligible clients
- Collect and analyse weekly data on OPD optimization; take remedial actions to improve optimization
- Develop and implement an OPD M&E tool/ system (electronic or hard copy) to be used for tracking clients through the testing cascade (Eligibility screening > Risk assessment > HTS coverage)

Figure 4.1.7 Example of electronic tool used in high volume OPDs to improve targeted testing and linkages

	Facility Observations: OPD Visits & HTS Outcomes								Eligibility-adjusted HTC Coverage		Expectations for Adults: If HTC Coverage = 100%				ARROWS Staffing Need	
	Visits*		Tested		HIV+		% HIV+				Outcomes		Coverage Gap		HTC	Linkage
Period	<15 yrs	>15 yrs	<15 yrs	>15 yrs	<15 yrs	>15 yrs	<15 yrs	>15 yrs	<15 yrs	>15 yrs	Tests	HIV+	Tests	HIV+	LCs	ECs
Aug-18		2720		195		8		4.1%		17.4%	1119	45.9	924	37.9		
(Excludes Sat/Sun)																
Daily Average[1]		118		8		0.3					118	5	110	5	5.5	5.7
Period Totals		2720		195		8.0		4.1%		17.4%	1119	46	924	38		

*Counts obtained from self report. OPD was nearly all adults because of nearby clinic

Eligibility Assumption	
Rate:	41%
Total Screened:	2720
HTS Eligible:	1119

Positive	Linked	%	Maximum Daily Clients Served	
8	8	100%	20.0	0.8

New shifts to begin in COP19

- Scale recency testing to all facilities and community sites (100% coverage)

- Integrate TB/HIV and PrEP screening tools-to maximize efficiencies and improve linkages.

2. HIV Self-Testing to find the Hard-to-Reach

HIVST is a key strategy for the testing of hard-to-reach populations and is a powerful tool for exploring sexual and social networks. HIVST remains a screening test and all positives will be confirmed using the national rapid testing algorithm. PEPFAR-supported implementation will target adolescents, young people, men and key populations - especially hard to reach MSM and clients of FSW.

Eswatini will use both assisted and unassisted HIVST approaches. PEPFAR/E will also scale-up self-testing as part of index partner testing. In COP 18-19, PEPFAR/E will use peer educators, expert clients (ECs), health care workers (HCWs), counsellors and active case finders to distribute HIVST kits and demonstrate the use demonstrate use of kits to clients. The MoH has a mobile application with instructions on how to use the test and PSI has a hotline with information on where to access confirmatory testing. A special emphasis will be on reaching men through:

- Secondary distribution for male partners by women attending maternal new-born child health (MNCH) platforms,
- Distribution of HIVST through FBOs and traditional structures
- Secondary distribution for index testing to reach sexual partners
- Workplace and hotspot distribution

3. Scale-up of index testing with fidelity

Index case testing is currently being scaled-up in COP18. In COP19, the target is to have 50% of all PLHIV identified through index case testing with an overall yield of 20-30%. Partner and children elicitation will be required of all index cases. Different approaches will be used for reaching all elicited contacts, using active follow-ups in both community and facility, as well as taking the services to communities and families. All index testing outcomes will be monitored. Collaboration amongst partners will be vital to ensure that all elicited contacts are offered HTS. A confidential information-sharing system between facility and community partners will allow the community partner to follow up on contacts who failed to report to the facility after 14 days. All HIV positive contacts will be linked to treatment within 14 days. All HIV negative persons will be actively referred to HIV prevention services (VMMC, PrEP). The index testing cycle will start over again to reach more contacts, until the tree becomes saturated. Index testing cascades will be monitored and reported to PEPFAR and MoH. Table 4.1.1 illustrates the responsibilities of the national program and implementing partners for improving the scale up of index testing.

Table 4.1.1 Responsibilities of the National Program and IPs for improving the scale up of Index Testing: COPs 18-19

Level of Implementation	Responsibilities
PEPFAR-National(Activity Managers and HTS Lead)	• Weekly site-level reporting by Partners-PEPFAR • Monthly collaboration meetings between IPs • Integration into national TWG routine meeting's agenda to engage MOH • Review of site-level cascade weekly to identify bottlenecks • Quarterly progress calls & virtual consultations with ISMEs
Implementing Partners	• Data-driven monitoring of site performance (index cascade and linkages) • Assessment and matching of HR to workload to maximize tracking of contacts (e.g. individual weekly targets) • Retraining of HCWs on index testing: motivation, skills and contact elicitation • Continuous mentorship targeting under-performing sites • After 14 days of attempts, the health care facility shares contacts community partners. Community partners plan active follow up • Community partners give feedback to the facility on the outcomes
Community level	• Community level tracking using the Unique ID to track clients • Engagement through local government, traditional and faith leaders, CSOs/CBOs/FBOs to bring key messages and information to their constituencies • Tailored social media platforms to inform populations about the importance of partner notification and index testing. • Optimize leadership platforms
Facility/site level	• Redistribution of lay counsellors to ensure indexing is being prioritized. • Site-level Indexing Focal Point • Site-level targets to staff providing weekly performance feedback • Prioritization of newly identified PLHIV, recent infections and unsuppressed patients on ART for index • Collaboration with community based testing service providers • Daily monitoring at site level • Screening HTS eligible and tested, index testing, contact lists for follow up by EC's and HTS, Linkages updates and follow up

III. Recency Testing/Case-based Surveillance

HIV recency testing is set to start in 39 health facilities in COP 2018. Recency testing will be implemented through point of care (POC) testing. Recency testing will be expanded to all HIV testing sites in COP 2019. All recency testing activities will be guided by a surveillance protocol that is currently under review by local and Columbia University IRBs as well as the CDC Associate Director of Science.

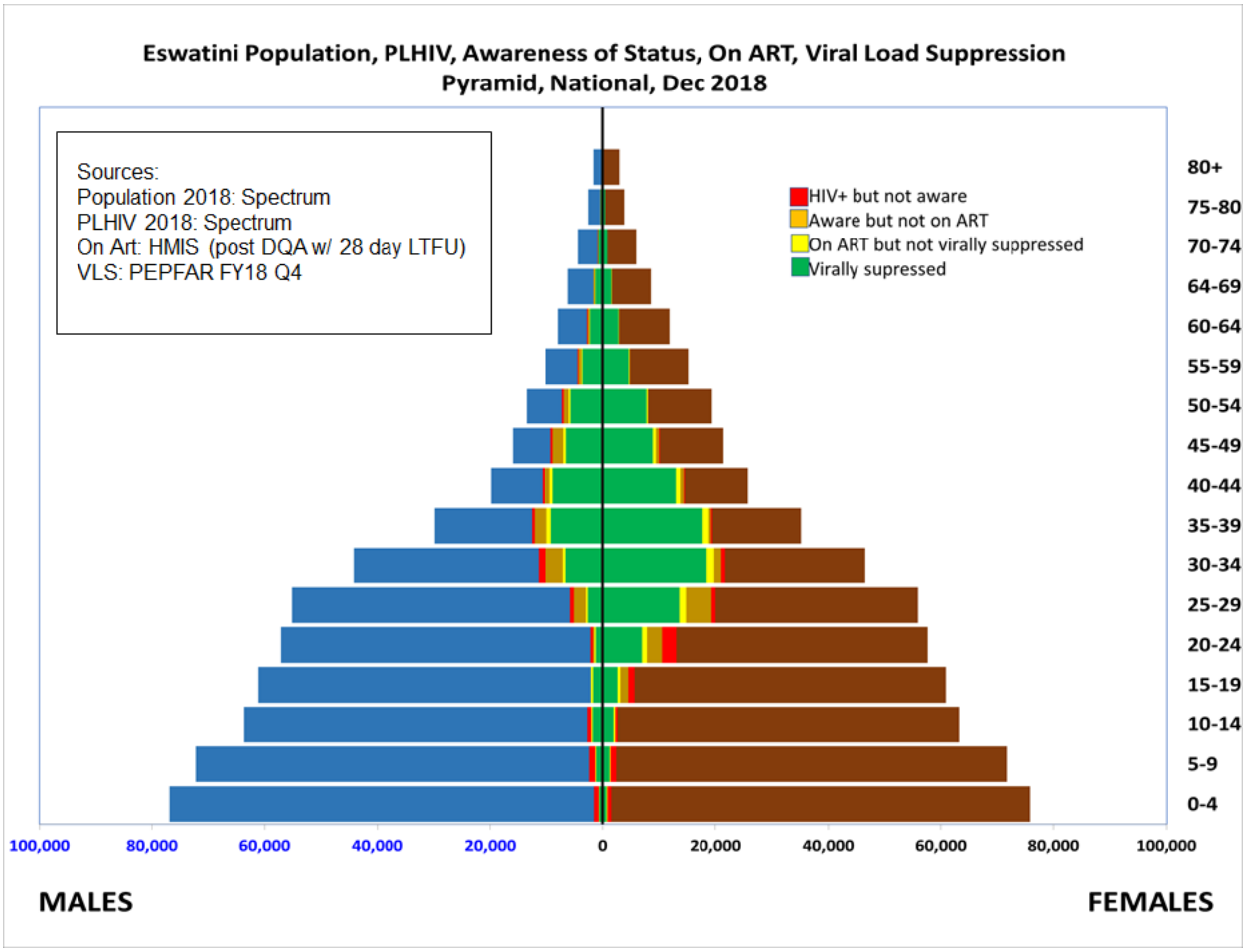
PEPFAR/E will support the HTS program through all its testing partners to implement recency testing in POC HTS. The national molecular lab will be supported through the PEPFAR/CDC laboratory implementing partner to provide technical support, management of test kits and QA activities. The MoH epidemiology unit will receive support through the PEPFAR/CDC epidemiology and surveillance implementing partner to collate, analyze and report recency testing results on a quarterly basis in line with routine HTS reporting.

The HIV recent infection surveillance system aims to rapidly detect, monitor, interrupt transmission patterns, and intervene on HIV infection during the acute and early chronic infection stage when HIV-infected individuals are at highest risk of transmitting to others. Results from HIV recent infection surveillance will be used to prioritize and target geographical areas for: index testing, equitable distribution for test and start activities, and deployment of prevention interventions such as condoms, VMMC and PrEP. The results provides an opportunity for real-time monitoring of the trajectory of the epidemic.

IV. Case finding approaches by populations

The Eswatini population pyramid (Figure 4.1.8) reveals that there is a need to focus on the following populations to identify those who are HIV positive and not aware of their status: children 5-9 years; males 25 – 34 years, and females 10 to 24 years. The pyramid also shows that there are populations, especially women 25 – 29 years, who are aware of their status but not on ART. The COP 18 – 19 program interventions to reach people who know their status but are not on ART will be discussed in Section IV - Linkages to Care.

Figure 4.1.8 Eswatini Population, PLHIV, Awareness of Status on ART, Viral Load Suppression Pyramid, National December 2018



1. <u>Case Finding Strategies for Children and Adolescents</u>

In COP19, the program will intensify pediatric case finding through a number of approaches. Eswatini will scale-up cohort monitoring for mother-baby pairs (MBP) to ensure completion of EID testing through the 18 – 24 month period. The program will also implement universal HTS for all children and young adolescents seen at TB clinics, inpatient departments, and malnutrition units. In an effort to increase testing yield among pediatric clients, the program will use a standardized risk screening tool for children and young adolescents seen at OPDs. In addition, the program will scale up index testing for mothers attending ANC and MCH service delivery points to identify eligible children and young adolescents who may not have previously been tested. Working through implementing partners, PEPFAR/E will continue to provide on-site mentorship to strengthen pediatric HIV testing services. The program will also leverage OVC programs to systematically assess all beneficiaries for HTS needs. In addition, through the OVC

program the children of FSW will be assessed for HTS and other needs and linked to services. Additionally, the DREAMS, and VMMC platforms will continue to identify adolescents living with HIV (ALHIV) through targeted testing. Adolescents, particularly those 15-19 years old, are especially hard-to-reach. In COP19, PEPFAR/E will use HIVST and peers for follow-up and support for health facility testing status confirmation.

PEPFAR/E will also work through local government, traditional and faith structures at the community level to reach vulnerable children and young adolescents who would not be reached through conventional approaches.

2. Case Finding Strategies for Females 15- 24 years

Efforts will be made to reach these young women and adolescents through the modalities where they normally present (e.g. ANC, OPD, FP, ANC, Post Natal Clinic and Child welfare settings). To access more young women and adolescents we will use voluntary partner referral and peer network referral. In COP 19, PEPFAR/E will expand index case testing embedded with HIVST. Community distribution of HIVST (through traditional and faith structures, the DREAMS platform, FBOs, campaigns, and workplaces) appeals to adolescents and young women, who for various reasons, are not currently accessing services at facilities. Social network messaging will be utilized to assist self-testing literacy and to improve linkage to care. Outreach targeting females in workplaces, will only be implemented where accessing HTS is a barrier due to challenging work shifts (factories, shops and seasonal workers). At risk AGYW are reached through DREAMS platforms with a comprehensive package of services including risk and Sexual and Gender Based Violence (SGBV) screening, sexual reproductive health, testing, and same-day ART initiation for those testing positive. Additionally, PEPFAR/E will expand youth-friendly clinical services, including the provision of targeted support through peer educators and peer expert clients in selected PEPFAR facilities.

3. Case Finding Strategies for Males 25 -34 years

A primary COP19 focus will be on identification of undiagnosed men 20 - 34 years. Modalities that will continue to be scaled up include partner testing/partner notification, mobile testing, workplace testing, the FBO initiative, and self-testing. To achieve increased coverage of PITC in facilities, all men attending facilities will be screened and offered HTS when found eligible. Universal testing will be scaled up amongst TB and TB presumptive cases and in STI clinics. PEPFAR/E will continue to strengthen military testing (yield 15% in Q1FY19) for soldiers and their sexual contacts. Targeted community level distribution of HIVST through traditional and faith leaders and peer outreach workers will be effective to reach men, who for various reasons, are not currently accessing services at facilities. Recently conducted research across different sub-populations of males in Eswatini identified key HIV testing, treatment, prevention and retention messages and identified the best channels to use to reach different categories of males. These will be shaped into social media, materials, job aids and other media to improve testing and self-

testing literacy and to improve linkage to treatment or prevention. The use of a dedicated hotline will help men to get additional confidential information about HIVST as well as where and how to link to confirmatory testing or to prevention services. In select chiefdoms, male expert clients and male champions will continue to facilitate linkages to testing, treatment, or prevention, and retention. Targeted workplace (formal and informal) HTS shows promising high yield results in identification of HIV positive men. Targeted workplace testing to achieve high yield will remain important throughout COP18-19. PEPFAR/E will continue to conduct targeted testing to reach men at factory sites, road construction, the timber industry and cane fields. The voluntary counseling and testing (VCT) modality has also proven to be more effective in identifying HIV positive men (high volumes and high yield>8%). Eswatini will continue to use this approach. Men in selected workplaces will be provided with HIVST to promote awareness of HIV status. Finally, engagement of traditional and faith leaders and FBOs will broaden prospects of reaching more men through HIVST distribution.

4. Case Finding Strategies for Key populations (KP)

In COP19, PEPFAR/E will employ an uncompromisingly focused and highly targeted KP case finding effort in order to find the hardest to reach and highest risk KP including older MSM, very young FSW, as well as hotel and home-based FSW. FY 18-Q1 FY 19 show that while the program was reaching testing targets, the numbers were low and yield was stagnant (see figure 4.1.9a, figure 4.1.9b). With COP 19 funds, PEPFAR/E will conduct IBBS and size estimations with planning starting in COP 18. This data will be critical to improve targeting, achieve program coverage and monitor trends. To turn the program around, PEPFAR/E will utilize new testing modalities including self-testing, and robust expansion of both index and associate testing. The Enhanced Peer Outreach Approaches (EPOA) has proven to be a useful model to bring KP's who have not previously accessed HIV services into the program, producing both high volume and yield. This methodology will be linked to positive seeds from newly diagnosed KPs, which has shown to elicit both indexes and other higher risk networks of KPs. In COP 19 the program will conduct quarterly EPOAs with fidelity and assure positives are linked to services and retained in the program. Recent focus group discussions with various sub-populations among the KPs revealed the need for highly segmented and specifically tailored testing, messaging and service delivery approaches based on population type, age, geography, and other contextual factors. The program will maximize all strategies including recruiting sub-population peer outreach workers from higher risk positive networks, and utilize trained counselors to facilitate trust and confidentiality, while focusing on social network penetration including the use of online and offline strategies, more sensitive risk screening to improve targeting of testing, tracking characteristics of new testers, and use of HIV self-testing with a dedicated confidential hotline. In COP 19 PEPFAR/E will intensify and expand support to KPLHIV for U=U messaging, treatment and PrEP literacy and adherence support, and improved retention programming through intensive LTFU tracking in partnership with ART providers using routine weekly data review.

Figure 4.1.9a FSW HTS

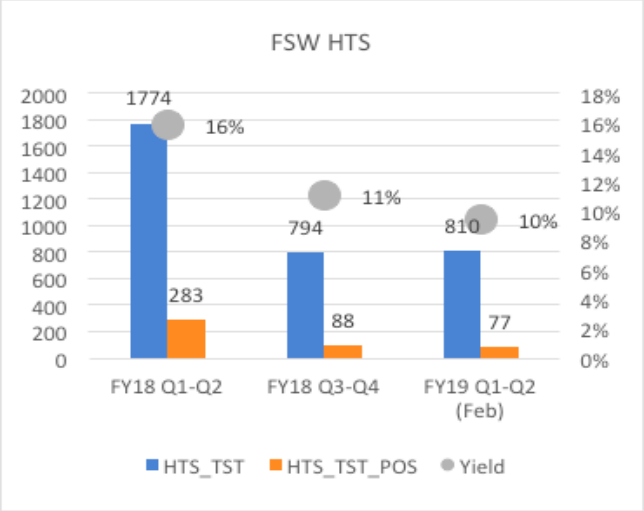
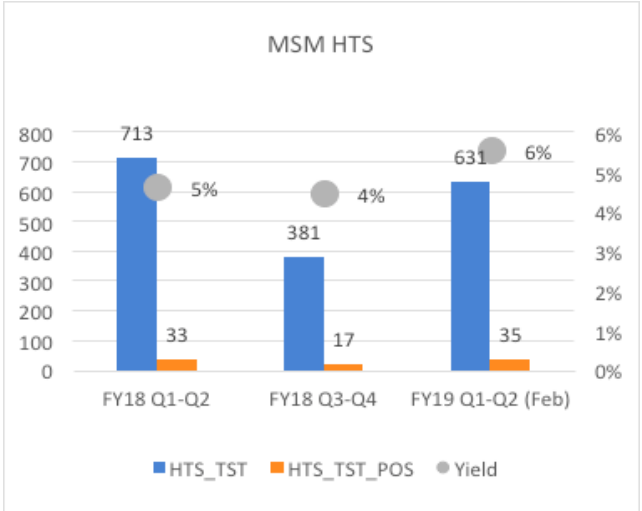


Figure 4.1.9b MSM HTS



5. Case Finding Strategies within the Military

A majority of the military population resides in communities within camps that are situated in areas away from towns. This population requires different strategies as there is usually restricted access to the camps and considerable sensitivity around military health data. To improve case finding within this group, advocacy by senior military is necessary and will be coupled with the dissemination of the military wellness policy to ensure awareness of military commitment in providing high quality care. Moreover, Expert Clients who are military staff will be identified and trained to reach their peers for HTS and early ART initiation. The military cultural group (Simomondiya) will be revitalized to inform and motivate military personnel on benefits of HTS, ART and HIV prevention services. All sexual contacts and children of newly diagnosed and military on ART will be reached for index testing by utilizing FBOs. Finally, HIVST will be made available to sexual contacts who are not able to access HTS.

V. Optimizing Linkage to Treatment

Ensuring efficient linkage of known HIV positive people to ART is essential for the success of the PEPFAR/E program. In addition to linking all those who test newly positive, it will be necessary to link those who are "Aware But Not on ART". As noted in the population pyramid, there is a more pronounced number of women 20 -34 years and men 25 - 39 in this group. This group is made up of patients who are LTFU (including former PMTCT option A recipients that were not eligible for ART at the time), those who were not ready to start ART, and those who tested positive but were never linked. The linkage to treatment for HIV-positive adolescents remains a priority area.

In COP 19, PEPFAR/E will develop and promote health and treatment literacy which will emphasize messages on the benefits of early ART and the new, better ART regimens. These messages, coupled with the promotion of cervical cancer screening for HIV positive women, can

encourage women to return to care. There will be an emphasis on tracking LTFU clients and bring them back to care through the DREAMS platform, community and faith leaders, CBO/FBOs, mentor mothers, and community experts. A defined package for follow-up of clients not ready to initiate ART on the first day has been developed in COP18 and will continue to be implemented COP 19. Lessons learnt from the CommLink/ARROWS Programs (currently known as Linkage Case Management (LCM)) have resulted in national scale-up of the LCM model to improve linkage in both facilities and communities. Figure 4.1.10 shows the linkage case management model flow chart.

A key COP 19 goal is to improve linkage to ART. While the current proxy linkage of 74% represents total new initiations over all tested positive and may underestimate the actual linkage, the true linkage is not at the targeted 95%. The MoH and PEPFAR partners have reviewed the Linkages Standard Operating Procedures (SOPs) and incorporated the LCM approach in their programs.

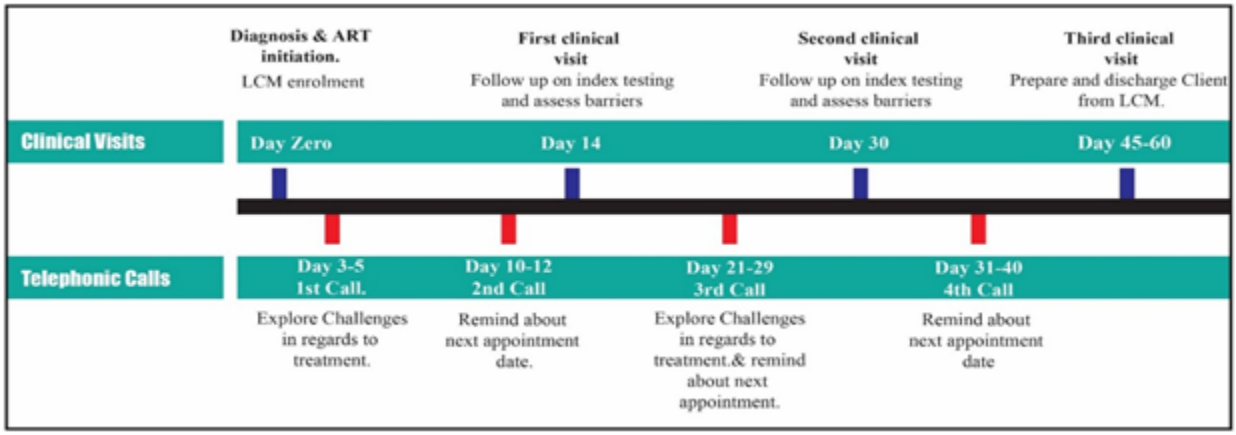
Shifts in COP18**:**

- Partner collaboration framework established between community and facility IPs to improve patient tracking and linkage between testing and ART
    - Includes EMR verification by facility IPs of prior treatment status for patients testing positive in the community
- Sensitization of traditional, faith, and community leaders on HIV, health literacy, and knowledge on benefits of early ART
- Taking linkage-case-management (LCM) approach to scale in all high volume facilities
- Deployment of expert clients (ECs) to high volume facilities to enhance linkages to treatment
- Deployment of Test and Start Champions ("influencers"- especially helpful for initiating same day ART for men)
- Community ART initiation using community-based IPs and roving facility (DSD) teams
- Collecting cohort-based patient tracking data on ART initiation timing and outcomes for newly diagnosed PLHIV (now requested routinely from IPs)

Shifts to begin in COP19:

- Initiate ART in selected high volume OPDs
- Scale-up LCM to all health facilities with deployment of additional counsellors and ECs to high volume facilities
- For adolescents, we need to pursue innovative approaches, particularly those focusing on community HTS and the development of integrated family-centered care services delivered by a multidisciplinary team.

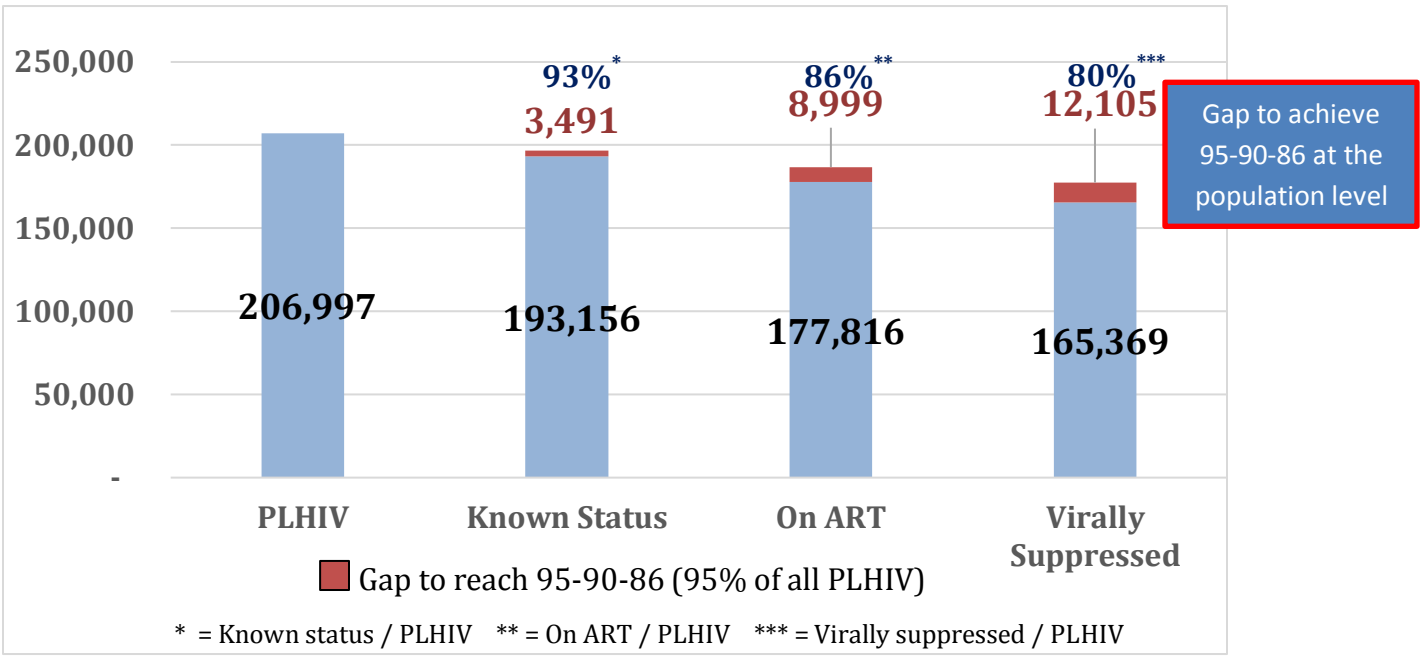
Figure 4.1.10 Linkage Case Management model flow chart



Second 95 – On Treatment

Figure 4.1.11 shows that at a national level, at the end of the second quarter of 2019 Eswatini has surpassed the 2nd 90 for ART coverage (81%) for all PLHIV, and is close to the 2nd 95 (90%).

Figure 4.1.11 Population Level 95-95-95 cascade for Kingdom of Eswatini using SPECTRUM® outputs and program data



Source: PLHIV=2018 estimate from 2019 Spectrum model
Aware= estimate from UNAIDS calculations
On ART= FY19Q2 HMIS program data
Virally suppressed= FY19Q2 PEPFAR program data

**PLHIV aware of their HIV positive status. Data source is UNAIDS 2018 SPECTRUM® output*
***Data source is program data for HMIS for Q2 FY19, adjusting for 28 day LTFU definition*
****PEPFAR APR18 data on proportion on ART that is virally suppressed applied to the national on ART number*

I. Progress towards epidemic control

At the end of Q2FY19, The Kingdom of Eswatini was supporting 177,816 PLHIV on ART (adjusting for the new 28 day lost to follow up (LTFU) guidance), translating to an ART coverage of 86%. This coverage meets the UNAIDS 2nd 90 target at the population level. To achieve the FY19 TX_CURR target of 188,300 PEPFAR/E will need to achieve a net growth of 10,848, PLHIV, effectively meeting the 2nd UNAIDS 95. The COP 19 TX_CURR target of 199,826 translates to 95% ART coverage of all PLHIV. Twelve month retention in care was 89% at APR18. There is still room for improvement with retention in care and PEPFAR/E will be implementing specific activities to improve retention by population and geography.

II. Program Performance

In APR18 PEPFAR/E achieved 52% of the TX_NEW FY18 target of 34,086. In Q2 FY19 PEPFAR/E has achieved 52% of the FY19 target of 15,530. The improved performance up to Q2 in FY19 is noted albeit against a much lower target. To ensure that the OU stays on track to meet COP targets, PEPFAR/E is instructing implementing partners to carryover targets from FY18 so that the cumulative results for FY18 and FY19 will be tracked against the combined FY18/19 target on a monthly basis.

Data Quality Assessment: In Q1 FY19, PEPFAR/E Implementing Partners (IP) carried out a data quality assessment (DQA) which reduced the TX_CURR reported in APR18 by 11% (decrease of 13,605 patient records for PEPFAR supported sites and 22,808 records at the national level). Duplicate patient records contributed to 97% of this decline with an additional 262 clients who were previously classified as active, re-classified as LTFU (144), dead (115) and stopped treatment (3). Factoring in the new PEPFAR 28 day LTFU definition (i.e. a patient is classified as LTFU if the patient has not attended the facility and 28 days have elapsed since their last appointment) led to a further 5% decline in the TX_CURR that was reported during FY19 at the OU level.

Table 4.1.2 Sites with the highest number of duplicate records in descending order

Region	Facility	Pre-DQA	DQA-90	Absolute Change Due to DQA	% Change
Manzini	AHF LAMVELASE CLINIC	15661	13919	1742	11%
Shiselweni	Nhlangano HC	5288	3674	1614	31%
Manzini	RFM Hospital	10456	9229	1227	12%
Manzini	KS II	1863	1069	794	43%
Manzini	AHF- Matsapha	7709	6938	771	10%
Manzini	Luyengo Clinic	4866	4212	654	13%
Lubombo	Sithobela HC	4075	3502	573	14%
Hhohho	Lobamba ART Clinic	3644	3099	545	15%
Hhohho	Mbabane Govt	6769	6246	523	8%
Hhohho	Dvokolwako Health Center	4212	3748	464	11%

Post the DQA, the sites in table 4.1.2 above and table 4.1.3 below are a priority in terms of addressing duplicates. There will be a national process to line list all duplicate records and correct them through merging or deletion in both Electronic Medical Record (EMR) systems used in Eswatini (the ART Patient Management Record (APMR) and the Client Management Information System (CMIS). There are intrinsic EMR system issues that can lead to duplicates and this will be a priority for the incoming HIS partner FEI Systems to address with regard to system scaling, unique IDs, connectivity and identifying, preventing and resolving duplication. The DQA showed that in some sites with high proportions of duplicates had challenges with staff capacity to capture data completely and with fidelity. Lessons learnt from the DQA will be critical in crafting site specific interventions to improve data capture and reduce duplication of records.

Table 4.1.3 Sites with the highest proportion of duplicates

Region	Facility	Pre-DQA	DQA-90	Absolute Change Due to DQA	% Change
Manzini	KS II	1863	1069	794	43%
Shiselweni	Nhlangano HC	5288	3674	1614	31%
Lubombo	Tikhuba	1325	1074	251	19%
Lubombo	Lomahasha	1685	1379	306	18%
Shiselweni	JCI Clinic	1858	1534	324	17%
Hhohho	Ndwabangeni Clinic	1328	1119	209	16%
Shiselweni	NTJANINI	1233	1042	191	15%
Lubombo	Shewula	1695	1435	260	15%
Hhohho	Lobamba ART Clinic	3644	3099	545	15%
Shiselweni	Hluti Clinic	1510	1285	225	15%
Lubombo	Lubulini	1238	1057	181	15%
Lubombo	Siteki Nazarene	1377	1176	201	15%

III. Who Are We Missing?

Figure 4.1.12 ART coverage by age and sex highlighting the populations with the lowest ART coverage

	Age Cat.	Coverage			Age Cat.	Coverage
Male	<01	18%		Female	<01	46%
	01-04	52%			01-04	60%
	05-09	66%			05-09	72%
	10-14	88%			10-14	97%
	15-19	139%			15-19	63%
	20-24	85%			20-24	64%
	25-29	57%			25-29	76%
	30-34	64%			30-34	93%
	35-39	81%			35-39	102%
	40-44	90%			40-44	99%
	45-49	82%			45-49	97%
	50+	82%			50+	115%

Key	
Green	>=81%
Red	<81%

Figure 4.1.12 clearly highlights the populations with the lowest coverage where implementation of specific interventions will propel the country to >90% ART coverage. The missing populations are children ages 0 -9 years, females aged 15-29 years and males aged 25-34 years. As noted above, the missing populations are made up of i) people who are not aware of their status (children 5-9; females 20-24; males 30-34); ii) Aware of status but not on ART (females 20-29); males 25-39); and iii) Clients who are LTFU and have not been brought back to care. These populations will require specific case finding and linkages strategies and renewed defaulter tracking efforts and messaging on ART benefits of early ART initiation, overall benefits of ART for their health and wellbeing as well reduced HIV transmission (U=U).

PEPFAR/E is supporting the implementation of a communication strategy that will highlight the benefit of ART in terms and quality of life and longer survival, the new and improved regimens (e.g., TLD) that are now available, and benefits of knowing and having a sustained viral load in terms of decreased transmission risk. Undetectable = Untransmittable (U=U) will be an integral part of this campaign.

IV. Retention in Care

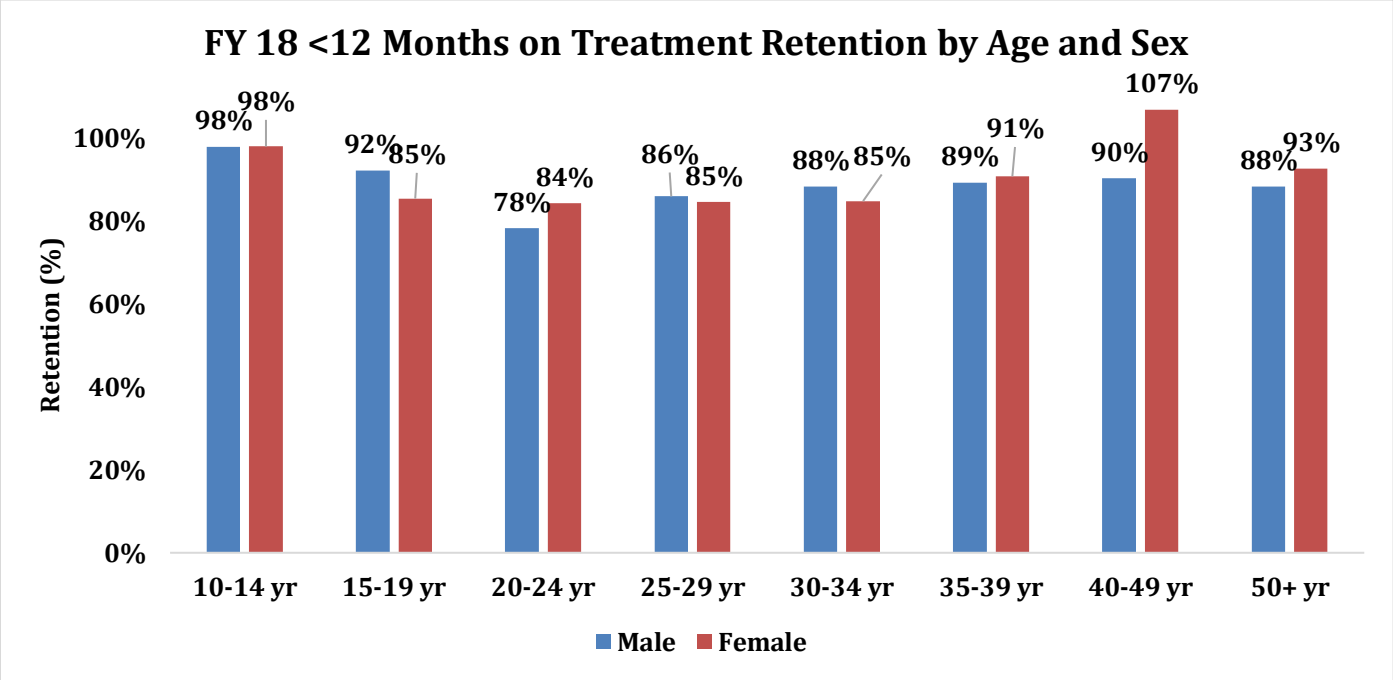


Table 4.1.6 Age, sex and site specific retention intervention

Category	Intervention
Sites with high LTFU	• Supervision of lay cadres providing patient tracking activities • Weekly data review of patient tracking efforts. Tracking: ○ # of missed appointments ○ # followed up and reached ○ # not reached ○ # returned to care
Children	• Optimize pediatric ART regimens ○ Introduce LPV/r granules ○ Phase out NVP by September 2019 and EFV by September 2020 • DTG-based regimens for all C/ALHIV who weigh more than 20 Kgs • Multi-month ARV dispensing
Adolescents	• Additional teen clubs and extended hours for teen clubs providing gender specific treatment and adherence support activities • Improved regimens (e.g., TLD) • Active tracking of those with missed appointments • Multi-month ARV dispensing

Adults males	● Active tracking of those with missed appointments ● Improved regimens (e.g., TLD) ● Drug pick/deliveries for select urban/industrial sites for clients unable to get time off work ● Multi-month ARV dispensing
Adult females	● Active tracking of those with missed appointments ● Improved regimens (e.g., TLD) ● Drug pick/deliveries for select urban/industrial sites for clients unable to get time off work ● Multi-month ARV dispensing

Program data reveals the following gaps and challenges:

1. Case finding – PEPFAR/E achieved 67% of the FY18 HTS_POS target of 35,828

2. Linkages: overall proxy linkage was at 74%. IP data showed higher intra-facility linkages (90%) with much lower community to facility linkage rates (as low as 54%)
    a. Patients not ready to initiate ART
    b. Limited access
        i. Government facilities close early
        ii. Transport costs
        iii. Time constraints – clients not able to leave work to attend health facilities
    c. Limited capacity of lay cadres to prepare patients for ART (especially in the test and start era)

IV. Solutions

1. <u>Optimization of treatment regimens:</u>

   The national introduction of TLD is outlined in the Eswatini TLD Rollout Plan. It is anticipated that the introduction of TLD will improve uptake of ART, adherence to treatment and VLS, especially in adolescents and young males. Optimization will include the urgent transition of clients on NVP based regimens to TLD and DTG based regimens. The program will also optimize pediatric ART regimens (introduce LPV/r granules, phase out NVP by September 2019 and EFV by September 2020, and utilize DTG-based regimens for female and male C/ALHIV who weigh more than 20 Kgs).

2. <u>Patient preparation</u>:

   As the country transitioned to test and start, the clinical characteristics of clients initiating ART changed significantly, i.e. clients initiating ART were likely to be healthier and less likely to have experienced a life threatening opportunistic infection. Convincing them to start and stay on treatment therefore requires a different skillset. There is a need to re-

train the lay cadres providing HTS and linkage services, as well as those who provide psychosocial assessments and support on motivational counselling, to refresh their knowledge on benefits of early ART initiation, improved treatment regimens and overall benefits of ART on health and HIV transmission. Working through implementing partners, PEPFAR/E will strengthen same day ART initiations through ongoing on-site pediatric ART mentorship to facilities providing pediatric HIV treatment. In addition, the program will leverage linkage case management and continue providing psychosocial support for C/ALHIV and their caregivers.

3. Tracking and management of patients not ready for ART:

A package of care for clients has been developed for clients who are not willing to initiate ART on the day of diagnosis. This includes but is not limited to the following: i) registration into a chronic care register ii) assistance with disclosure iii) links to an expert client for follow up appointment scheduling iv) treatment of OIs and other inter-current illnesses v) provision of prophylaxis vi) elicitation of contacts for index case testing. The program will also scale up cohort monitoring for mother-baby pairs to ensure all identified HIV positive infants are linked to ART.

4. Access to services:

Different populations have varying levels of access to HIV services for various reasons. The following interventions are designed to improve access to services:

a. Extended hours at selected facilities – especially in the industrial hub (Matsapha/Manzini) where employees are less likely to get time off to attend health facilities during working hours (8am-5pm) and to also serve key populations that do not access health facilities during the day.

b. Community ART initiations- this will provide access to PLHIV identified in the community who may not be able to attend the health facility on the same day through 90 days of linkage support. Many of these are individuals have financial constraints and are unable to afford transport to health facilities, or are bed ridden. Patients who are unable to attend facilities will be linked to a community distribution point for ARVs.

5. Provision of a package for clients who present with advanced HIV disease:

This includes scaling up of routine TB diagnosis with TB LAM, routine CrAg and presumptive treatment with fluconazole for clients with CD4 <100cells/mm3 at baseline.

6. Retention in care:

Retention strategies will include multi month scripting and dispensing, DSD and age/sex targeted U=U messaging. Specific packages will be developed to address LTFU by populations (age and sex) and at sites where the biggest losses are observed.

V. Specific Populations - Needs and Approaches

1. Adult Women

Women are disproportionately impacted by the HIV epidemic in the Kingdom of Eswatini. Women aged 30 years and older account for 40% of all PLHIV and 45% of TX_CURR; while women aged 25 years and older account for 50% of PLHIV and 55% TX_CURR. The majority of female PLHIV in this age group know their status and are in care with good retention rates (87 – 92%) and excellent viral suppression (92 – 97%). However, they are at substantial risk of cervical cancer. Worldwide in 2018, Eswatini had the highest rate of cervical cancer (75.3/100,000) followed by Malawi (72.9/100,000). (see section 4.7 on Cervical Cancer Screening and Treatment Program).

2. PLHIV over 50 years

There are a significant number of PLHIV that are over the age of 50 years. The number of older individuals living with HIV/AIDS has risen over the last decade mainly as a result of ART. While ART has led to a marked reduction in the incidence of AIDS-defining illnesses, a variety of HIV-Associated Non-AIDS (HANA) conditions are becoming increasingly common among individuals with long-standing HIV infection. In Eswatini, the proportion of individuals receiving ART that are >50 years of age is estimated at >15%, and this proportion is expected to increase as the country is expanding HIV testing services (HTS) and access to ART for all regardless of CD4 count. Moreover, individuals currently on ART are expected to live longer and thus will be susceptible to the diversity of HANA conditions. A recent study conducted in Eswatini by ICAP in collaboration with MOH targeting elderly (greater than 50 years old) individuals on ART showed that chronic disease risk factors and markers were common; hypertension occurred among 57%, diabetes mellitus in 11%, and chronic depression in 6% of study participants. However, routine testing for NCDs often was not performed, or if performed, not documented. Furthermore, the main barriers to care were structural, highlighting the importance of improved access to basic needs such as food, employment, transportation, and healthcare. Elderly individuals living with HIV were more likely to have early cognitive impairment that could interfere with adherence to treatment, substance use, polypharmacy with risk of interaction with ARVs, increased risk of toxicity from use of ARVs (including liver toxicity, lipodystrophy, osteoporosis, pancreatitis, peripheral neuropathy, and buildup of lactic acid), depression from loneliness, stigma and insufficient social support and social isolation.

In COP 19, PEPFAR/E will support the integration of clinical services targeting elderly individuals on ART by implementing the following interventions:

- All clinical staff in the ART clinic will be trained on management of comorbidities associated with aging and HIV including the tools used to document findings during routine clinical follow up care

- Site providers will be mentored to ensure that during the clinical visit or refill, elderly patients will be offered a package of services including BP and diabetes screening, assessment of chronic respiratory conditions, chronic depression and alcohol use disorders

- Facilities will be supported to establish support groups for elderly patients to convene regularly and share experiences and challenges in adherence and VL literacy and other psycho-social support related issues.

3. Key Populations

Modest improvements were observed in getting new or returning KPLHIV on treatment from Q4 FY 18 to Q1+ (Oct 2018-Feb 2019) FY 19 with increases from 52% on ART to 82% and from 52% on ART to 63%, among FSW and MSM respectively. The new MoH guidelines for KP ART initiation through outreach, drop-in centers, and 'pop-up' sites were just finalized in Q1 FY 19 and had not been implemented yet. It is anticipated that in Q3 the program will begin initiating through outreach.

Beginning now, and reinforced further in COP 19, the program will optimize linkage from the community to KP led and KP competent clinics and focus on enhanced retention through targeted and segmented strategies. PEPFAR/E, working with MoH, has identified and begun training and support to establish six safe, KP competent centers of excellence in the highest density hotspots and will continue to strengthen and expand the number of facilities that are 'KP-friendly' with a specific KP focal point within the facility including in 'men's clinics' and border facilities. In addition, with a local clinical partner providing oversight, the KP NGOs/CBOs will establish 'pop-up clinics' and select drop-in centers that can provide clinical services and psycho-social support. These quality tailored services will emphasize same-day initiation, and this along with dedicated case management teams and KP navigators who will actively follow-clients who have not initiated, will substantially strengthen linkage and retention in care. In COP19, PEPFAR/E will work with partners to set up a toll free phone line for clients to call if they experience HCWs with poor attitudes that impact care. This information with be relayed to the MoH. For HIV negative KP, counselors and management team members will offer same day initiation for those eligible for PrEP. Children of KP will be reached through the OVC program.

Third 95 – Viral Load Suppression

I. **Progress towards epidemic control**

SHIMS2, 2016 showed that 73% of all PLHIV were virally suppressed. This finding highlighted the fact that The Kingdom of Eswatini had achieved the 3rd UNAIDS 90 at the population level. PEPFAR/E estimates that VLS at the population level is at 76% (adjusting for 28 day LTFU). This is above the population level target for the UNAIDS 3rd 90 but needs to be at 86% to meet the 3rd UNAIDS 95.

II. Program performance - Challenges and Solutions

VL testing coverage improved from 49% in APR17 to 77% at APR18. VLS was 93% across PEPFAR/E, with lower suppression in adolescents and young adults. Generally, males have similar outcomes (in terms of retention and VLS) compared to females once they are put on treatment. Figure 4.1.15 illustrates viral load suppression by age and sex.

Challenges:

1. VL testing coverage is not yet at 100% for all eligible clients and was lower in Shiselweni region at the end of Q1FY19

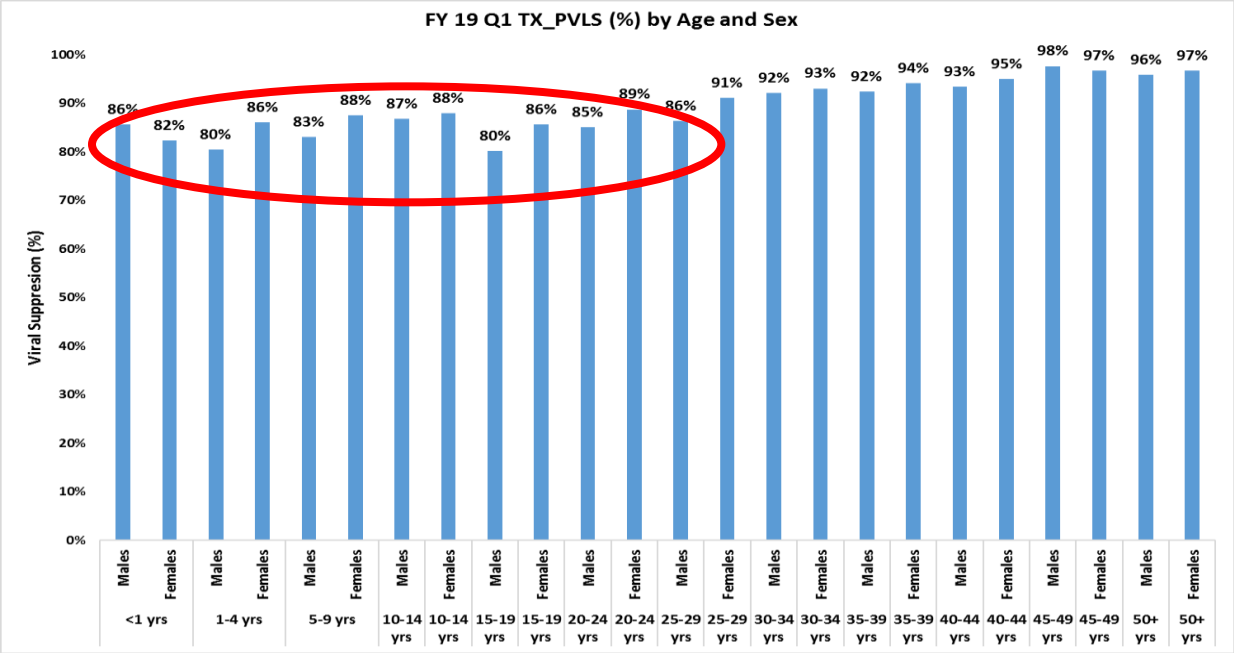
2. Limited comfort of HCWs with pediatric phlebotomy has contributed to the sub-optimal VL coverage among CLHIV currently on treatment

3. Viral suppression is significantly lower in children, adolescents and young adults as well as among clients at the military facilities

4. Difficulty getting the VL results into the patients' charts for use by clinicians. This also leads to repeat testing. Improving the lab –clinic interface for return and use of results is critical for program improvement. Plans to create an interface between the Laboratory information System (LIS) and CMIS are at an advanced stage and should be completed by end of Q3 FY19. This will ensure that VL results and other laboratory results will be linked directly to the patient record as soon as they are approved.

5. Concept of U=U is yet to be implemented – will assist with demand creation for VL testing and adherence counseling. There are plans to implement this as part of a broader communications strategy on HIV as well as part of the FBO specific interventions.

Figure 4.1.15 Viral Load Suppression by age and sex amongst PLHIV on ART (PEPFAR APR18 data)



In COP 19, VL testing coverage will be increased by use of high output VL machines and turn around times improved by an interface of the laboratory information system with the CMIS so that VL results are more easily accessed and acted upon in a timely manner by clinicians. Pediatric VL testing will increase by the use of DBS. Requisition forms will note if the patient is a pregnant or breast feeding women (PBFW) to help prioritize notification for PBFW who are not virally suppressed.

Solutions for improving viral load coverage and VLS for COP18 and COP19 are listed below in Table 4.1.7.

Table 4.1.7: Solutions for improving viral load coverage and VLS for COP18 and COP19

Population	COP18 Activities	COP19 Activities
Children (0-9 years)	• Training nurses on pediatric phlebotomy • Rolling out DBS VL beyond children less than 5 years • Pediatric ART optimization • Early diagnosis and management of treatment failure	All IPs required to line list, track and report all clients eligible for VL testing, with HVL and those requiring a switch in regimen by site
Adolescents (10-19 years)	• DBS in Teen clubs • Transition to TLD • Early diagnosis and response to treatment failure	

	• Viremia clinics	Tracking weekly data on the following indicators and adjust the program accordingly: • # and % of clients transitioned to DTG-based regimens • # and % of eligible clients receiving VL test • # and % of clients with HVL completing SUAC and repeat VL testing • # and % of clients with sustained HVL switched to second line
Adult males (>20 years)	• Use of DBS in hard to reach areas and after hours • Transition to TLD • Early diagnosis and treatment of TB • Early diagnosis and management of treatment failure • Viremia clinics	
Adult females (>20 years)	• Use of DBS in hard to reach areas and after hours • Transition to TLD • Integration of family planning and ART services • Establishment of birth registry within MNCH • Early diagnosis and management of treatment failure • Viremia clinics	
Military	• Development of sustainable management systems covering all departments • Complete the SABERS • Consolidation of the treatment pool through DQA to establish actual numbers, tracking of LTFU and improving retention to >90%. • Decentralization of high level HIV services to 5 peripheral facilities. This includes necessary renovations and required staff support. • Viremia clinics at Phocweni to improve viral suppression rates • Improve SIMS scores from an average of 30% to 70%	• System certification in 9001:2015, and ISO 15189 improvement from 1 to 4 stars. • Implement recommendations from the SABERS 2019 • Extend HIV services to an additional 2-3 clinics based on client expansion potential. Active follow up of patients to ensure >95% retention. • Ensure effective VL sample collection and turnaround time of results. • Viremia clinics at Phocweni to improve viral suppression. • Improve SIMS scores from an average of 70% to 90%
Key Populations	• Assure multi-month scripting and delivery through DSD models through KP NGOs/CBOs at 'pop-up clinics' and select drop-in centers	• Continue and Expand COP 18 activities

	• Active follow-up by case managers and peer outreach workers of clients who are lost to follow-up or who have not yet initiated will improve VL suppression • Track and assure regular VL testing and monitoring • Track individual KPs through the cascade using unique identifiers in the program • Reinforce efforts with GF to assure that the confidential KP data-base is able to pull reports from the CMIS • Support to MoH to review and analyze data on a quarterly basis in order to identify leakages in the cascade and to quickly course correct	

III. Specific Programs

1. PMTCT

Due to the high HIV prevalence and high testing yield among all age bands receiving antenatal care, there is an ongoing need to ensure that deliberate, standardized prevention and testing strategies are provided to pregnant and breastfeeding women. COP19 HTS strategies for this vulnerable population include continuing providing HTS at ANC visits (including implementing maternal retesting), index testing, utilizing the MNCH/PMTCT platform as a springboard for reaching male partners through secondary distribution of HIVST kits, and prioritizing PrEP for eligible pregnant and breastfeeding women.

ART coverage among pregnant women remains high in Eswatini at 98% with a low mother-to-child transmission rate of 2%. PEPFAR/E will continue to support placement of lay cadres at health facilities to support PMTCT activities and provide ongoing mentorship and supervision support to maintain the high ART coverage. In addition, pregnant and breastfeeding women will benefit from GKoE's commitment to optimize ART for all ages (prompt phase out of NNRT-based regimens and prioritize pregnant and breastfeeding women during the phased TLD transition).

In COP19, PEPFAR/E will implement a number of strategies to improve retention and viral suppression among pregnant and breastfeeding women. These approaches will include:

- Leveraging existing community and facility structures to strengthen mother-baby pair cohort monitoring through the end of breastfeeding

- Sensitizing and educating pregnant and breastfeeding women to generate demand for VL monitoring

- Actively identifying pregnant and breastfeeding women due for VL testing; this includes utilizing lay cadres and CMIS alerts to identify pregnant and breastfeeding women due for VL monitoring

- Supporting mentorship and supervision through implementing partners to ensure appropriate documentation of pregnancy or breastfeeding status on VL requisition forms

- Collaborating with the Eswatini Health Laboratory Services to utilize DISA Link to prioritize communication of VL for pregnant and breastfeeding women (especially for women who are not virally suppressed)

- Ensuring pregnant and breastfeeding women's VL results are appropriately recorded in patient files and electronic medical records to help ensure utilization of results

In addition, PEPFAR/E will support a number of cross-cutting activities in an effort to strengthen client-centered family planning (FP) services across the HIV clinical continuum. In particular, PEPFAR/E will:

- Strengthen the integration of FP services within HIV prevention, testing and treatment settings, including optimizing data systems to capture FP service uptake among women on ART

- Standardize counseling messages for women living with HIV and who are of child-bearing age

- Ensure voluntarism and informed choice for FP services among eligible women living with HIV

- Collaborate with the MoH to revise the FP/HIV integration SOPs, especially in light of the ongoing TLD scale up

2. Reducing TB burden in PLHIV

a. <u>TB screening and prevention</u>

TB screening is part of standard of care for PLHIV. TB preventive therapy (TPT) should be a routine service at all sites providing HIV and TB treatment services, but not all eligible patients

receive the service. WHO reports that only 10% of newly diagnosed HIV-positive patients were put on appropriate TB therapy in Eswatini (9% TB treatment and 1% TB prevention). There is a gap in providing TPT to newly enrolled PLHIV and only 3.7% percent of the eligible newly enrolled were expected to complete TPT in FY18 Q4.

PEPFAR/E will provide support to implement TPT among PLHIV, as well as strengthen monitoring and evaluation and communication/demand creation. COP19 will include:

- Renewed focus on newly enrolled- "Screen, test and start appropriate TB treatment"
    - Patients who screen negative for TB should start TPT within a month of ART initiation
    - Patients who screen positive should undergo TB testing procedures immediately and those who test positive should start TB treatment immediately
- Adoption of fixed dose formulation to decrease pill burden, facilitate TPT uptake and completion
    - By the end of February 2019, 635 patients received fixed dose combination (FDC) of INH/Pyridoxine/Co-trimoxazole (IPT) in Eswatini through MSF support. PEPFAR/E will increase access to fixed dose TPT formulation in COP 2019
    - Adoption of 3-HP: PEPFAR/E will support the processes required for adoption of shorter term regimen 3-HP as an alternative to isoniazid to ensure clients access this commodity with favorable uptake and completion. This will be facilitated by the completion of WHO prequalification of 3-HP leading to the availability of generic formulation of 3-HP at competitive prices
    - PEPFAR/E will use $244,596.00 to support MoH in procuring FDC for TPT.
- Elimination of NVP based ART regimens that have hindered implementation of TPT due increased toxicity with co-administration of isoniazid and rifampicin
- Support the process of commodity forecasting and procurement to prevent stock outs in TPT commodities

In addition, children with contact to TB patients will receive TPT as a priority.

b. <u>TB case detection and TB treatment</u>

Eswatini has experienced a continuous decline in TB case notifications from 11,057 in 2010 to 2,845 in 2018. This is largely due to enhanced TB/HIV collaborative activities, especially ART expansion which has resulted in the burden of HIV among TB patients decreasing from 82% in 2010 to 65% in 2018 according to Eswatini annual program reports.

WHO estimated an 80% TB treatment coverage rate for Eswatini in 2017. Although this is increasing, more effort is required to support the National TB Program (NTP) to identify all TB cases, initiate them on appropriate TB treatment and prevent further transmission of TB in communities. PEPFAR/E, through its implementing partners, will institute the following measures to improve TB case detection:

- Roll out of more sensitive Xpert Ultra TB testing platform to maximize case identification
- Immediately start TB treatment for all people diagnosed with TB and all TB/HIV co-infected who have "Trace Calls" Xpert Ultra results
- Conduct TB index case procedures for TB screening of families and people who are contacts of TB patients
- Administer point-of-care TB lipoarabinomannan (TB LAM) test for HIV patients who are seriously ill or have a CD_4 count of less than 100 cells/ml
- Provide TB screening for TB key populations in congregate settings according to existing national policies
- Screen all PLHIV for TB using WHO approved screening tools

Eswatini has completed data collection of TB prevalence survey and awaits data analysis and report dissemination. A precise estimate of the country's TB burden is expected from the TB prevalence survey.

c. Reducing HIV burden in TB patients - HTS for TB presumptive and TB diagnosed patients

HIV testing of TB presumptive and TB diagnosed patients will be an important approach to identify HIV positive males (15-49 years) due to the disproportionate number of males and higher HTS yield compared to the general population. HTS among TB patients stands at 99% nationally, but this figure drops for TB presumptive patients despite TB presumptive patients constituting a larger cohort when compared to TB patients. In Manzini region, testing of eligible TB presumptive patients was low at 53% and this is attributed to lack of coordination between screening officers and HTS counsellors. There is limited capacity to refer and follow-up on outcomes of HTS.

In COP19, PEPFAR will support Eswatini in creating safe and private HIV testing points for TB presumptive patients. Where screening officers have the capacity to provide HTS, HTS will be integrated in the TB screening workflow. Routine monitoring and evaluation systems will be reviewed to include HTS along the TB screening and TB diagnostic cascade. In community TB screening services where active case finders are not permitted to provide HTS, they will be training on providing assisted HIV self-testing kits that ACFs will provide to TB presumptive clients. The following key elements aim to optimize HTS among TB presumptive register:

- Provide correct TB presumptive registers to all TB screening areas
- Institutionalize routine monitoring, evaluation and reporting of HTS in TB presumptive patients in both HIV and TB programs
- Address client flow issues that prevent TB presumptive patients from accessing HTS

- Integrate HTS within TB screening areas, where screening officers can provide HTS

d. ART provision and viral suppression in TB/HIV co-infected patients

ART coverage of TB/HIV co-infected patients was at 98% nationally (2018) compared to 95% across PEPFAR supported sites (APR 2018) and the discrepancy is mainly attributed to delays in updating records at the time of PEPFAR reporting and different annual data review periods. While the achievement was high, the performance is below the optimal target performance of 100%. To ensure 100% coverage PEPFAR will support:

- Expansion of the integrated service delivery model to ensure TB treatment services, like ART, are closer to patients.
- Implementing granular site monitoring to identify the few sites that are not performing well in relation to timely ART initiation. Development and implementation of site based quality improvement (QI) activities is necessary to move poorly performing sites to 100%.
- Use of efficient regimens including Dolutegravir (DTG) to ensure viral suppression and successful treatment outcomes. Clients who require second- and third-line ART regimens will receive appropriate ARVs.
- Provision of an advanced HIV disease package, including screening for Cryptococcus, to patients who fail ART and have low CD4 counts.
- Integration of non-communicable disease screening, application of lessons from mortality audits and reviews aim to reduce mortality among TB patients through improved quality of clinical care.

e. Collaborative TB and HIV Infection Prevention and Control Measures

PEPFAR/E, through its partners, will support the NTP and ENAP to coordinate the TB/HIV response through supporting national TB/HIV coordinating committees both at national and regional levels. In addition, PEPFAR will support the following key elements:

- Implementation of all four key components of TB infection control as well as provision of condoms and PrEP to prevent HIV transmission.
- Technical assistance to NTP to finalize the revision of national TB control guidelines.
- Printing of monitoring and evaluation tools and registers to facilitate monitoring of key indicators.
- Revision and updating of TB modules and indicators in electronic medical records (CMIS).
- Training of clinicians and laboratory technicians on revised guidelines, updated TB diagnostic algorithms, and use of TB LAM and gene Xpert Ultra testing technology.

4.2 Prevention

As Eswatini nears the attainment of the 95-95-95 goals, the PEPFAR/E program must take on a greater focus and mobilize resources towards preventing new infections while continuing to prioritize the maintenance of treatment and retention coverage.

Eswatini's substantial youth bulge, persistent high incidence among AGYW, elevated rates of teen pregnancies and SGBV, and high rates of unemployment and mobility will necessitate a concerted and well-coordinated effort to reach priority and key populations with effective targeted and tailored combination HIV prevention interventions that provide HIV information, equitable access to services and referrals at scale.

The GKoE is fully committed, at all levels, to accelerate HIV prevention and support towards a sustainable community-led HIV and TB prevention response. As such, Eswatini, through the Prime Minister and NERCHA's leadership, has developed a number of key plans and guidelines that provide a robust underpinning to the PEPFAR/E HIV prevention program. These include: The National Strategic Framework 2018-2022, The National Coordination Framework, National Prevention Coordination strategy and the revised HIV Prevention Policy. In FY 18, The GKoE adopted the UNAIDS Global Accelerated HIV Prevention 2020 Road Map and developed their Prevention plan. The goal of the Eswatini Road Map (Figure 4.2.1), is to reduce new HIV infections by 75%, and will require an intensive focus on combination HIV prevention complemented by the scale-up of HIV testing and treatment. The Eswatini 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.

Figure4.2.1 Combination prevention and community HIV services, Eswatini

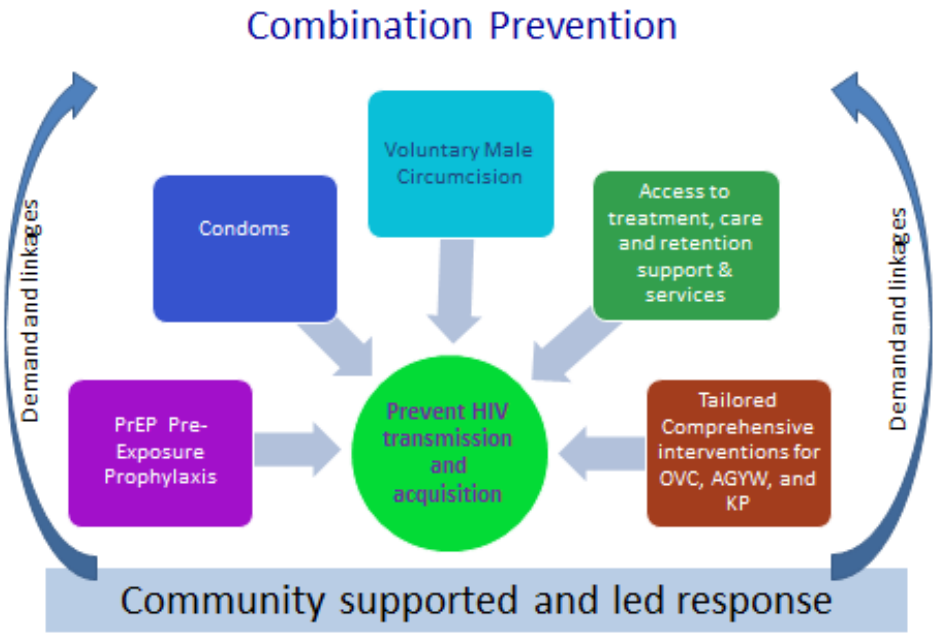
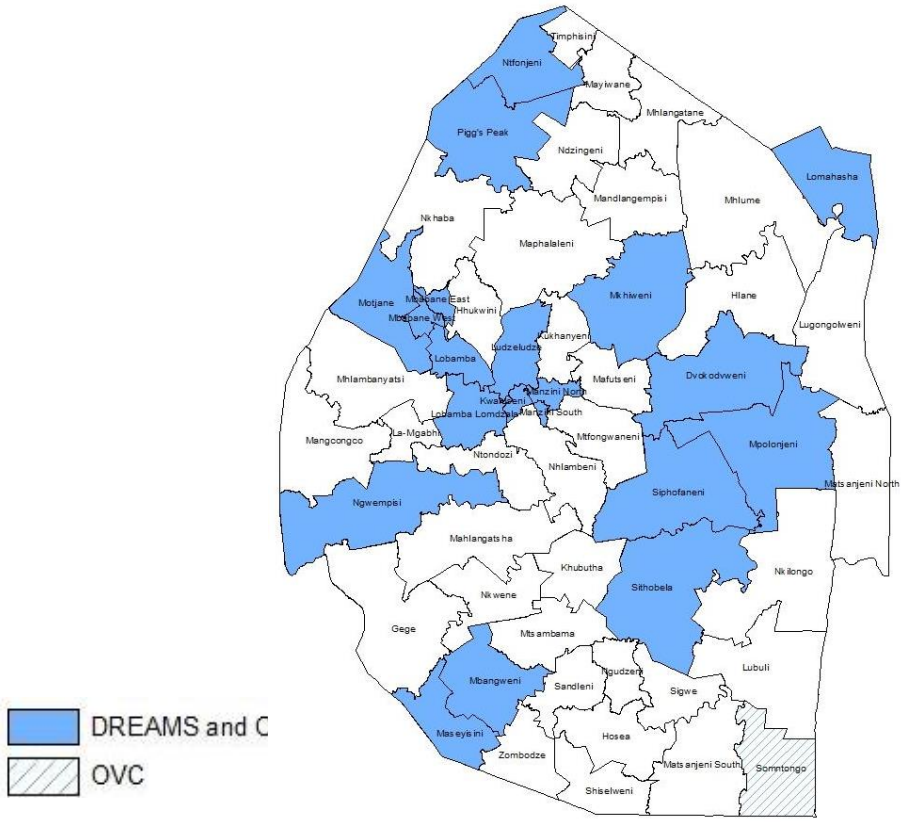


Figure 4.2.2 HIV Prevention for AGYW and children



In FY 18, PEPFAR/E AGYW and OVC interventions were consolidated under one award implemented by Pact ('Triple R'). In COP 19, integrated OVC and DREAMS programming will be implemented for all priority age groups in 20 *tinkhundla* across all 4 regions (Figure 4.2.2).

4.2.1 AGYW

The recent partner transition and consolidation allowed for some adjustment of approaches in line with the COP 18 DREAMS Efficiency Questions to ensure that the components of the package are delivered with fidelity in an efficacious manner to the most vulnerable AGYW.

Target populations are AG 10-14, 15-19 and YW 20-29. The program will especially target AG who are sexually active, out of school, in inter-generational or multiple concurrent relationships and/or OVC, are pregnant or have a child. For YW, DREAMS enrolment criteria include unemployment, low income employment, unawareness of HIV status and/or lack of family support. Most DREAMS beneficiaries display more than one of these criteria.

With the program consolidation in FY 18, the Triple R award now provides the full DREAMS package in all sites, including clinical SRH and HIV services through mobile units branded to attract AGYW ('DREAMS on Wheels').

The PEPFAR/E layering framework shown in Table 4.2.1 below defines the individual level interventions that make up the minimum core package that all AGYW will receive (primary interventions), consisting of a set of 3 interventions for 10-14 year olds, and 4 interventions for older AG and YW. Secondary interventions are delivered based on needs and vulnerability.

Table 4.2.1 DREAMS layering framework

	AGE GROUPS (years)		
	10-14	15-19	20-29
Primary Individual Interventions	• Social Asset Building • HIV & violence prevention • Condom education	• Social asset building • Condoms education, skills, or commodities • HTS or HTS screening • HIV & violence prevention	• Condoms education, skills, or commodities • HTS or HTS screening • HIV & violence prevention • Contraceptive Mix (counseling or commodity)
Secondary Individual Interventions	• Education (subsidies, tracking, or study clubs) • HTS or HTS screening • Contraceptive Mix • Post-violence care • Parenting/Caregiver Programming	• Education (subsidies, tracking, study clubs) • PrEP info or enrollment • Contraceptive Mix (counseling or commodity) • Post-violence care • Combination Socio-economic approaches Parenting/Caregiver Programming	• Combination socio-economic approaches • PrEP info or enrollment • Post-violence care • Social asset building Parenting/Caregiver Programming
Range Individual Level Interventions	3-8	4-10	5-9

In line with the priorities for DREAMS listed in Eswatini's COP 19 PEPFAR Planning Letter, PEPFAR/E will implement the following:

- Tracking system for intervention layering: Pact has put in place a monitoring system utilizing the CommCare online data management platform and DHIS2 that tracks layering of DREAMS services for all beneficiaries, including completed referrals to other service providers. The system uses the national ID as unique identifier which is also the CMIS identification system. PEPFAR/E will be able to report on the new AGYW_PREV indicator at FY19 Q2 reporting.

- Institute use of mentors and peer leaders: A mentoring system has been developed and instituted. 'Life mentors' are young women resident in the community they serve and have completed secondary education. A training tool 'How to be a Mentor' has been developed and used to train mentors on how to work with beneficiaries to identify their vulnerabilities, needs and goals. Mentors work with beneficiaries to establish a mentoring

plan according to defined steps allowing for iterative and flexible action planning, referrals and follow-up. Mentorship can be individual or in small groups, depending on the preferences of beneficiaries. Mentor partners and groups will also make use of social media platforms (WhatsApp) to strengthen peer support. AGYW who have completed their mentoring phase have a number of pathways to stay engaged and become mentors themselves, such as becoming mentor buddies to new AGYW or/and speak at group sessions. – The mentoring platform will be boosted by engaging a popular peer influencer and HIV activist who found out she was HIV+ due to a 'blesser' relationship.

- Scaling up demand for and distribution of PrEP: PEPFAR/E will support the government's roll-out plan for PrEP (see section 4.2.5 below) to additional facilities. In addition to the scale-up to an additional 20 fixed sites, the PrEP Operational Plan will also permit the DREAMS implementer to offer oral PrEP through its mobile DREAMS on Wheels sites using the national screening tools and SOPs and intensify demand creation among DREAMS beneficiaries. Messaging on PrEP as an effective prevention method will be embedded in HIV prevention group sessions and mentoring; a job aid/module on PrEP and PEP aimed at DREAMS beneficiaries is under development.

- Focus on reaching more 19-24 year olds: PEPFAR/E will intensify recruitment of YW 20-29 through optimizing current entry points and enrolment approaches, including DREAMS on Wheels, churches, higher learning institutions and engagement of traditional leaders (rural areas) and zonal leaders and mayors (urban sites). Mentors and other community cadres will use snowballing techniques to identify YW. New approaches to identify and engage YW will include intensified engagement with health facilities, including ANC sites, factories with significant numbers of YW in low wage employment, and radio and social media outreach.

Peace Corps Volunteers (PCVs) who are based in rural communities partner with health facilities, KaGogo Centers or with community members, to provide HIV-prevention services for AGYW and young men and boys ages 15-24. Volunteers provide age-appropriate HIV-education and psychosocial support messages through life skills and youth empowerment messaging, both in and out of school through Camps, Clubs & Safe Spaces (for example, Girls Leading Our World - GLOW Clubs, Grassroot Soccer Clubs, after school and community peer groups). Volunteers also support healthy decisions, prevent HIV and sexual violence, and work to create enabling communities for youth and young adults. Volunteers will link youth/young adults to PEPFAR-funded facilities and partners for testing, VMMC (Voluntary Medical Male Circumcision), PMTCT (Prevention of Mother to Child Transmission) and other services.

4.2.2 OVC

In FY18, the OVC program underwent a cohort transition, along with the partner consolidation. The new Pact mechanism ('Triple R') ensured there was no disruption in service delivery to children eligible for OVC services previously served under the predecessor Pact award. New enrolment is ongoing and targets children and families most directly affected by HIV, specifically orphans, children with PLHIV caregivers, C/ALHIV, HIV-exposed infants and their mothers, children and adolescents who have dropped out of school, live in child-headed households or/and have been neglected or abused. Triple R achieved 87% of its FY18 target and is scheduled to reach >75 of the annual COP 18 OVC_SERV target at Q2. Intensive partner management will be cascaded down to the Pact's local implementers (CBOs and FBOs) who implement the full OVC and AGYW package in assigned *tinkhundla*.

In line with the COP 19 guidance and priorities listed in the PPL, the OVC program will ensure the following:

Integrated case management: OVC aged 0-17 will receive comprehensive needs-based services defined in line with MER 2.3 Appendix D, and are focused on the PEPFAR OVC outcomes *Healthy, Stable, Safe* and *Schooled*. Case management is operationalized through vulnerability assessment at enrolment, development of tailored care plans and monthly home visits. Trained home visitors form the backbone of service delivery, referrals and service tracking. Graduation criteria across the four outcome domains provide the framework to ensure children and their family achieve a minimum level of stability before they leave the program. As the current OVC program is enrolling a largely new cohort of beneficiaries, it is expected that not more than 5% will graduate out of the program in COP 19.

Intensified primary prevention of sexual violence and HIV for 9-14 year old girls and boys: Primary prevention of HIV and sexual violence for 9-14 year olds will be strengthened through direct messaging and interaction with adolescents, through parenting interventions, through linkages with other HIV service platforms as described below, and through engagement of community and faith-based leaders via the FBO central initiative. For engagement of 9-14 year olds boys and girls, the PEPFAR prevention modules will be integrated into programming tools; OVC girls will also benefit from the full DREAMS package of service in addition to OVC services including a specific module that includes recognizing and avoiding risk situations for HIV acquisition and violence. Messages on sexual violence and HIV will be integrated into communication with caregivers during home visits, and caregivers will be offered the Sinovuyo parenting skills training.

Identifying, reaching and retaining children and adolescents living with HIV: In COP 19, the OVC program will report on the HIV status of all enrolled OVC (OVC_HIVSTAT). At enrolment, all OVC and their caregivers are asked about their HIV status, and for those with unconfirmed status, risk screening is conducted. Those at risk are referred to HTS, and for those <12 years caregiver consent is sought for HIV testing. Home visitors actively follow up to ensure the referral is closed, either through testing at a DREAMS on Wheels or the nearest clinic. For those newly

diagnosed HIV+, intensive support to families and children is provided to ensure linkage to treatment; in cases where caregivers refuse permission for children to access ART due to the associated family stigma OVC case workers will also involve social workers to ensure successful linkage. For children and adolescents living with HIV (C/ALHIV), the OVC program provides individual and family-based adherence and disclosure support in addition to the broader package of OVC services. ALHIV are supported to attend facility-based teen clubs that serve as a peer support platform for HIV positive teenagers and to provide refills and clinical monitoring. Teen clubs are held on Saturdays and supported by the OVC partner as well as the regional clinical implementers. – Information will be provided to health workers in ART clinics located in OVC program SNUs to promote referral of C/ALHIV to the OVC program.

Linking OVC to other HIV service platforms:

- **DREAMS**: As described above, DREAMS and OVC activities are integrated programmatically and geographically as well operationally within the same core IP (Pact), allowing for harmonized planning, alignment of curricula and tools, implementation and monitoring. The integrated approach ensures that AG aged 9-17 who are OVC receive the most intensive combination of DREAMS and OVC services.
- **Other prevention activities**: Adolescent OVC girls and boys access the SRH services of the DREAMS on Wheels. Linkage case management will promote and track uptake of VMMC for OVC boys. OVC who screen positive for Gender Based Violence (GBV) receive intensive post-violence care, and case management to ensure they are supported to access the appropriate clinical GBV packages as well as the necessary counselling, social and legal services.
- **Key Populations program**: In coordination with the KP program, the OVC implementer has engaged the nascent FSW organization Voice of Our Voices (VoV) to identify children of female sex workers (FSW) for enrolment in the OVC program. The *tinkhundla* of Somntongo was added to the OVC interventions sites specifically due to the prevalence of transactional and commercial sex in this border area. Care is taken to ensure that this is done in a non-stigmatizing way; thus in Somntongo as well as in other sites with high sex worker concentrations, the program will not exclusively target children of FSW, but ensure other OVC in the neighborhoods are also included in the program.
- **PMTCT**: The OVC program works with clinical implementers and by engaging directly at the facility level to promote referrals of pregnant teenagers to the OVC program. The OVC program also promotes the retention in care of HIV+ pregnant teenagers and young women.
- **FBO Central Initiative**: The OVC program will collaborate closely with the HIV risk and violence prevention activities conducted through the FBO central initiative. OVC implementers will engage with FBO implementers in joint strategizing and planning, and share tools and curricula on parenting programs

and child protection approaches. At site level, child protection and HIV prevention interventions targeted to OVC and their caregivers will be coordinated with the engagement of church leaders to saturate community level awareness and community action to prevent sexual violence and reduce HIV risk for 9-14 year olds.

In COP 19, Peace Corps will discontinue reporting on the OVC indicators. Peace Corps volunteers will continue to include OVC in its prevention interventions.

4.2.3 Community and male engagement

In COP19, PEPFAR/S will continue working with local government and traditional leaders in 25 tinkhundla (inclusive of the 20 DREAMS areas) to use data to lead their local HIV response. In COP 18 PEPFAR/E supported the chiefdom structures in the 25 tinkhundla to analyze epidemiologic and contextual data, develop community profiles, and local HIV action plans with measurable targets. These local structures, with improved governance and accountability and empowered leaders, will coordinate programming and track the up-take of HIV services across all sectors.

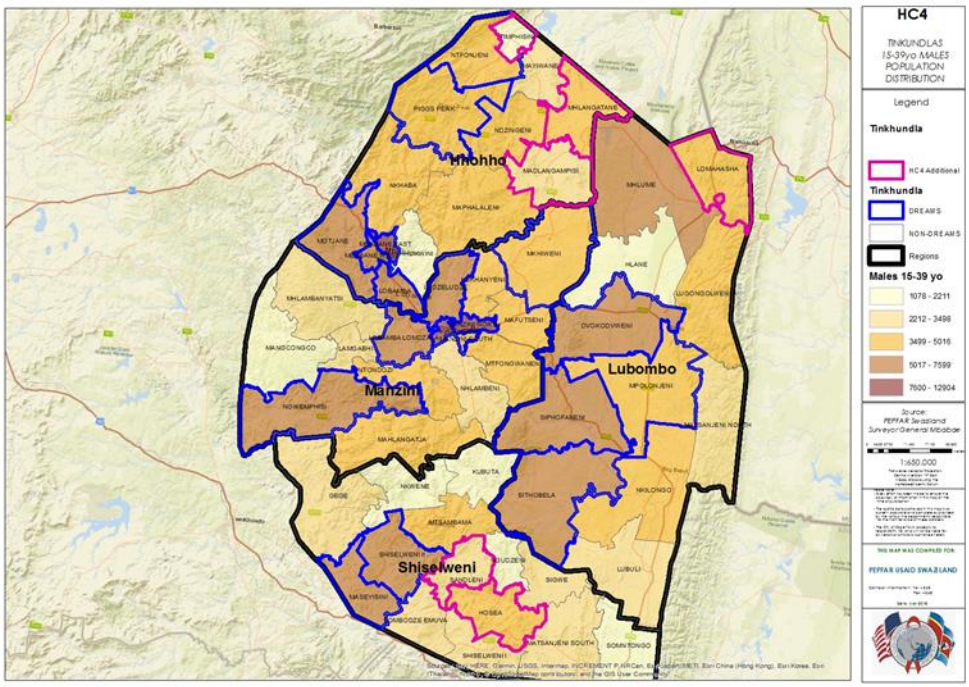
The FBO initiative will expand these efforts by intensively engaging the traditional and faith leaders, and faith groups. Eswatini is deeply rooted in its tradition and traditional structures and leaders are highly respected. These leaders are able to mobilize their populations for action and they are also able to effectively shape social and gender norms and address harmful practices. Eswatini is an oral society, thus effective methods for transmitting key HIV messages are through the traditional and faith leaders. Further, in Eswatini's patriarchal society men are the gateway to their families and community's health and wellbeing and thus it is critical to fully engage men in the community for a sustainable response. FBO initiative support will focus on two key priority areas:

1. Bringing critical HIV prevention and treatment interventions to and through communities of faith especially engaging men. This will include:
    a. Mobilizing and engaging the traditional and faith community and men in the HIV response to increase up-take of testing, treatment and or prevention (VMMC)
    b. Building demand for and distributing self-test kits and providing confidential linkage to services
    c. Targeting and disseminating key messages about HIV testing, linkage to treatment and prevention and retention;
    d. Supporting and strengthening adherence
    e. Promoting positive masculinity
2. Preventing sexual violence and HIV risk especially among 9-14 year olds including:
    a. Raising awareness among the traditional and faith leaders about sexual violence and HIV risk faced by 9-14 year olds
    b. Mobilize men and the community to address harmful gender norms
    c. Support primary prevention programming for youth

d. Creation of an enabling environment to reduce SGBV and HIV risk especially among 9-14-year-olds, and create safe spaces
e. Effectively utilize existing traditional and faith structures to support implementation of evidence-based approaches to address gender and sexual violence for youth, parents/care-givers and men

Figure 4.2.3 below shows us a map of community and male engagement.

Figure 4.2.3: Map of Community and male engagement



4.2.4 Key Populations

PEPFAR/E provides a comprehensive package of services and interventions (see Table 4.2.2) for Key Populations FSW, MSM and trans-gender populations including clinical support for HIV, sexual reproductive health, TB, as well as blood pressure, and other services, and psycho-social support. The program also offers add on programming for economic empowerment such as savings groups, and referrals to social protection, and legal, educational, substance abuse, and other support services. Children of FSW are reached through the OVC program.

In COP 19 through KPIF, PEPFAR/E will work to capacitate local/indigenous KP/Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex, Queer (LGBTIQ) and FSW CBOs/NGOs. This support will include organizational capacity building, set-up of drop-in centers and pop-up clinics, strengthening network penetration through a variety of KP-led approaches, developing KP

sub-population specific materials and messages to address 95-95-95 and preventing new infections, development of advocacy skills, training KP navigators, case managers, counselors, and outreach workers.

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/E has made progress towards breaking down these barriers, and increasing access to social and legal protection, but much remains to be done. PEPFAR/E 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.

Table 4.2.2 KP Package of Services and Interventions

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

4.2.5 VMMC

Data from SHIMS 1 (2011) and SHIMS 2 (2016/2017) reveals that only a modest increase in VMMC prevalence has been observed since 2011. Among males 18-49 years, VMMC prevalence increased from 17% (95%CI: 16.2-18.4) in SHIMS1 to 28% (95%CI: 26.0-30.4) in SHIMS2. VMMC coverage in Eswatini remains low, at approximately 35%, for ages from 10-49 years by the end of December 2018 (Table 4.2.3).

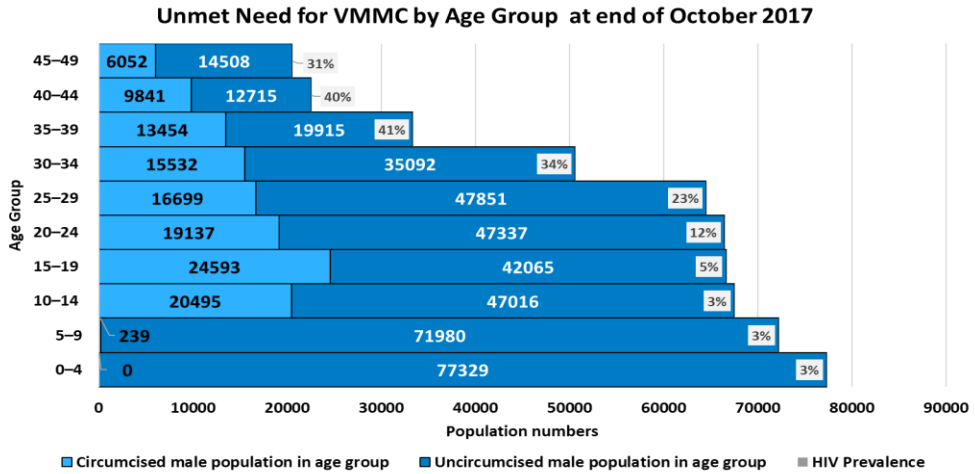
Table 4.2.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Target Populations	Population Size Estimate* (SNUs)	Age-adjusted VMMC Coverage (September 2018)	*VMMC_CIRC* (in FY20, expected)	Expected Coverage (in FY20)
Hhohho	10-49 years	102,122	29%	6,448	42%
Lubombo	10-49 years	67,388	39%	4,499	50%
Manzini	10-49 years	111,313	37%	15,138	56%
Shiselweni	10-49 years	61,959	37%	3,915	49%
	Total/Average	**342,782**	**35%**	**30,000**	**49%**

* 2017 census figures were used to compute VMMC coverage

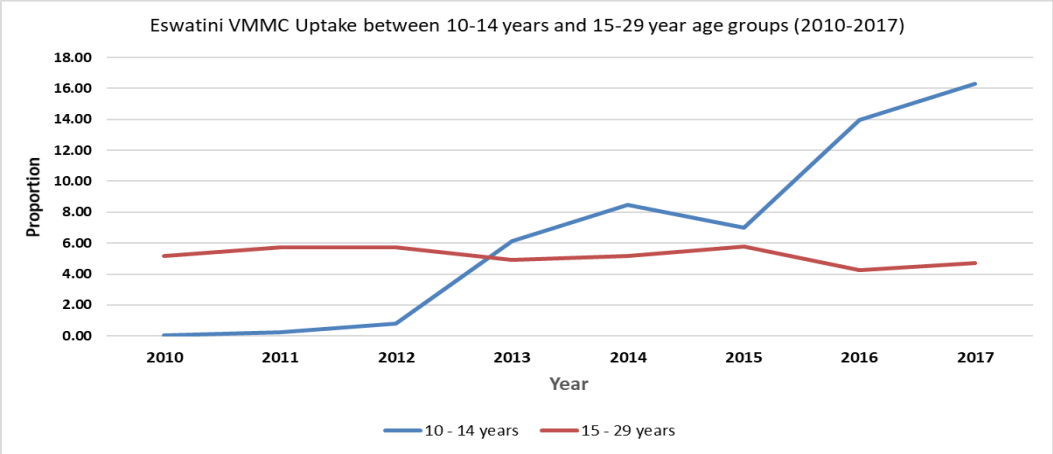
Unmet need is defined as the number of uncircumcised males in the total male population. In 2017, of the 1,093,028 people residing in Eswatini, 56% were below the age of 25 years, emphasizing a youth bulge in the population. Figure 4.2.4 shows the proportion of unmet need within each age group as of 2017.

Figure 4.2.4 Unmet Need for VMMC by Age Group



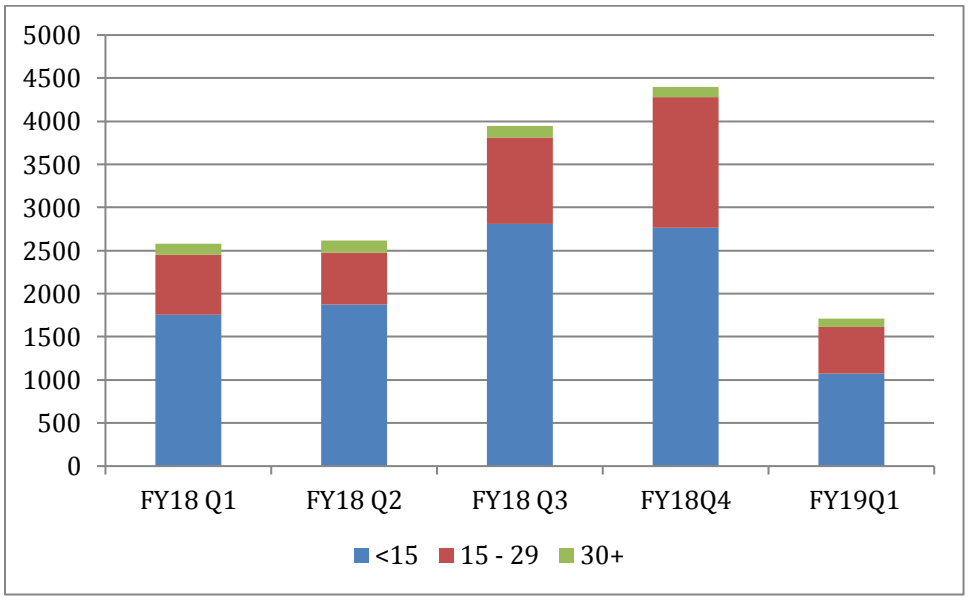
Uptake of VMMC services, defined as the proportion of males circumcised in one year divided by the proportion of males not circumcised, is still generally low in Eswatini. In the priority age group (15-29 years) there has been a levelling off over the years for this priority age group. As in many countries uptake has been naturally higher for the younger age group (10-14 years) (Figure 4.2.5). While there is a greater lag for realizing the preventive benefit of circumcision in 10-14 yo compared to 15 – 29 yo, the high intrinsic demand and youth bulge justify offering MC in this age group.

Figure 4.2.5 VMMC Uptake between 10-14 Years and 15-29 year age groups



Source: DMPPT v 2.0

Figure 4.2.6 Quarterly Trend Numbers of VMMC by Age Bands FY18Q1 – FY19Q1



Source: PEPFAR Eswatini FY19 Q1 MER Data

PEPFAR/E is working with the GKoE to scale up VMMC coverage to 80% among males 10 – 29 years throughout the country. In COP19, PEPFAR/E plans to provide direct surgical service delivery to circumcise 30,000 men. COP19 funding will support DSD at fixed (15) sites (12 of which are MoH sites) as well as through outreach VMMC services, evidence-based demand creation, salary support for health care providers and mobilizers, procurement and logistics for circumcision kits, and quality assurance activities.

In addition to offering VMMC services at the 15 fixed sites across the country, an outreach clinic initiative will ensure that clients are able to access services and are served closer to their homes. Outreach services will increase VMMC coverage not just for hard-to-reach rural areas that do not have access to a health facility, but also to populations who do not have the time to travel to a facility multiple times as a result of their work. The program will also undertake time-limited campaigns in the course of the fiscal year to address the seasonal nature that the program is currently experiencing. Additionally, GF resources will be leveraged for the expansion of services, recruitment of additional manpower, and procurement of equipment and supplies along with a special outreach program for 10 – 14 y.o. boys in the Lubombo region.

Demand creation strategies will be scaled up in COP19 to increase up-take of services, and include referrals from HIV testing sites, STI clinics, and men's clinics, as well as the strategic engagement of women (e.g., during ANC, female community groups), local and traditional leaders, faith-based organizations, and workplace VMMC programs. The program will implement Individual site planning and intensified regular performance monitoring using Site Capacity and Utilization tools, which will respectively enable teams to conduct community mapping, targeted community mobilization, and monitor site productivity in real-time to inform targeted demand creation among the age-pivot. Advocacy by community, traditional, and government leadership is essential and will be leveraged to create demand for the program. Lastly, Peace Corps Volunteers, working through their counterparts and with implementing partners, will link males to VMMC services and support demand creation through BRO (Boys Reaching Out) camps and clubs.

Given the need to achieve 80% coverage among 10 – 29 yo and attain sustained epidemic control, PEPFAR will prioritize TA to ensure quality of services and data for decision-making. TA for robust data and service quality will incorporate SIMS, DQA, external quality assessment (EQA), and CQI on a regular basis, as well as training and mentorship of site based M&E officers, in the areas of data management and use. Additionally, robust adverse event (AE) oversight by partners and PEPFAR, including routine monitoring, thorough investigation of AEs, and corrective action when necessary will be made to ensure the safest VMMC possible program. In addition, partner performance will be tracked through weekly performance monitoring reports as well as regular technical meetings with MoH and the PEPFAR team to ensure the sites are performing at capacity. This strategy will provide a basis to refining programmatic approaches on an ongoing basis. The program will also transition to resusable kits in COP 19 in order to support long term

sustainability, reduce costs, improve procedure quality and reduce waste generation. To ensure safe provision of VMMC that eliminates the risk of glans injury, PEPFAR partners will support the GKoE's adoption of the dorsal slit (DS) method of circumcision for all ages.

4.2.6 Eswatini Military VMMC Program

The VMMC program within the military has just begun in 2019. The main barrier to the onset of VMMC had been the lack of a policy that sanctioned and advocated for VMMC among active duty personnel. The policy, which provides the required framework for the implementation of the VMMC program, has been drafted and is awaiting signed off by the Army Commander.

To get the program going there will be a need for a very strong demand creation drive. This will need to begin with senior military leadership and unit commanding officer advocacy. It will require extensive education activities to address some of the residual negative perceptions from previous national VMMC campaigns. The military drama group Simomondiya will play an active role in this process.

The program is structured to integrate with the Ministry of Health National VMMC program. It will leverage central level procurement and demand creation – especially for civilian communities in close proximity to military bases. It is planned that:

- Entry points will be via OPD, HTS and through intensive peer educator recruiting activities. Peer educators will also be used for registration and retention of potential clients
- Newly graduated recruits will be targeted between the pass out and graduation period for sensitization and recruitment.
- Rank appropriate messaging and sensitization will be developed and promoted through appropriate military channels
- Barrack based education groups and focal points will be established.
- HCW will be trained on VMMC and Adverse Event (AE) Management in line with the national guidelines.
- Renovation of the military site at Phocweni will need to be completed to allow for circumcisions to be done within the facility.

It is hoped that the program will be sufficiently established so that the target of 400 circumcisions can be reached during COP19. This target has been arrived at without the benefit of current epidemiology data on the Eswatini Military. We hope the completion of the SABERS this year will facilitate more accurate targeting going forward.

4.2.7 Pre-Exposure Prophylaxis (PrEP)

PEPFAR/E has supported one of three MoH coordinated PrEP demonstration projects that were undertaken in a total of 22 sites in order to assess the acceptability, feasibility and cost-

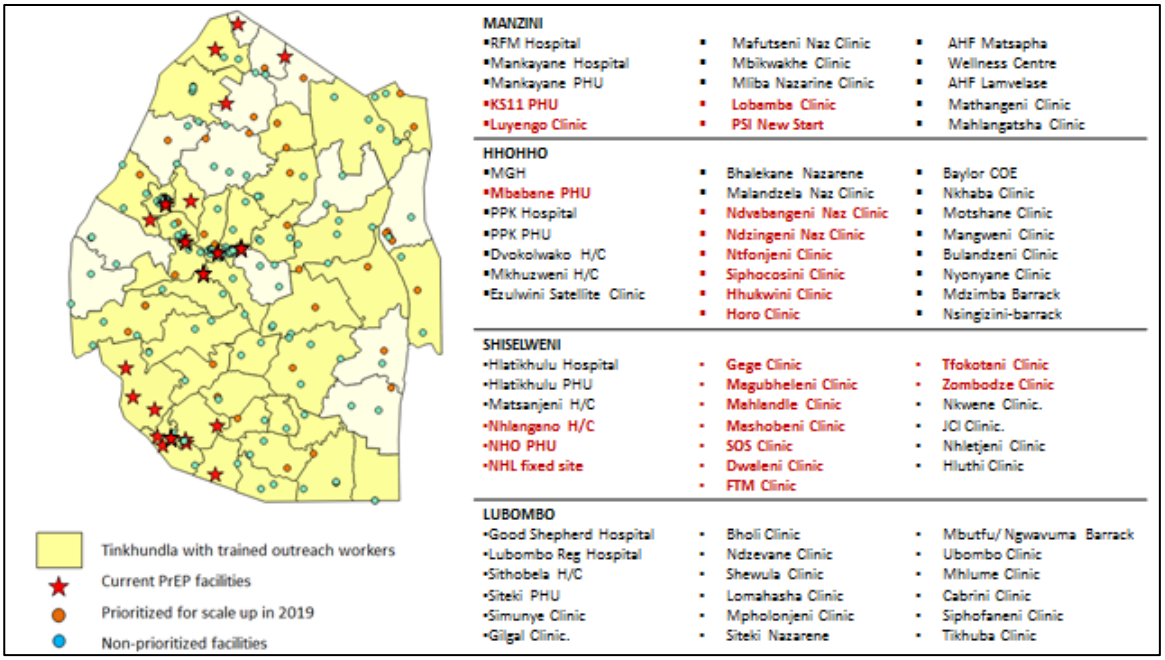
effectiveness of the intervention in Eswatini. The demonstration phase concluded in FY19/Q2. PEPFAR/E provided TA to the development of a country operational plan that provides for integration of PrEP into multiple facility service delivery points. The plan envisages scale-up of PReP to an additional 20 sites by the end of the calendar year to include, in addition to the demonstration sites, all hospitals, health centers, public health units (PHUs), select high volume clinics and the DREAMS on Wheels mobile sites (see table 4.2.4)

At site level, PEPFAR/E regional clinical implementing partners will support facilities with site readiness preparation, provider training and mentoring for health workers tasked with initiating PrEP (doctors and trained nurses), and ensure targeted demand creation at facility and community level. PrEP will be integrated into different entry points at health facilities including ANC and FP.. Through its DREAMS on Wheels SRH services, Pact will offer PrEP to all AGYW who have been identified to be at risk by health workers, counsellors or mentors. The Luke Commission started PrEP provision in FY19 and will continue to offer the intervention at its fixed site and mobile clinical services. HIV negative KP will be offered PrEP though outreach, mobile, pop-up and drop-in services, as well as through the KP centers of excellence.

At national level, PEPFAR will support the MoH to coordinate and manage the implementation of the operational plan, including finalization of job aids and training materials, and inclusion of PrEP in training curricula of all health cadres. MoH will be supported in stock monitoring, forecasting and ordering of TDF/3TC and lab commodities. The MoH has committed to procure PrEP ARVs and associated commodities as of April 2019.

In COP19, a total of 4,693 clients will be newly initiated on PrEP (PrEP_NEW). Priority groups are AGYW, clients in sero-discordant relationships, clients in transactional relationships, pregnant and lactating women, STI patients and MSM.

Figure 4.2.7: PrEP scale-up plan 2019



MANZINI

- RFM Hospital
- Mankayane Hospital
- Mankayane PHU
- KS11 PHU
- Luyengo Clinic
- Mafutseni Naz Clinic
- Mbikwakhe Clinic
- Mliba Nazarine Clinic
- Lobamba Clinic
- PSI New Start
- AHF Matsapha
- Wellness Centre
- AHF Lamvelase
- Mathangeni Clinic
- Mahlangatsha Clinic

HHOHHO

- MGH
- Mbabane PHU
- PPK Hospital
- PPK PHU
- Dvokolwako H/C
- Mkhuzweni H/C
- Ezulwini Satellite Clinic
- Bhalekane Nazarene
- Malandzela Naz Clinic
- Ndvabangeni Naz Clinic
- Ndzingeni Naz Clinic
- Ntfonjeni Clinic
- Siphocosini Clinic
- Hhukwini Clinic
- Horo Clinic
- Baylor COE
- Nkhaba Clinic
- Motshane Clinic
- Mangweni Clinic
- Bulandzeni Clinic
- Nyonyane Clinic
- Mdzimba Barrack
- Nsingizini-barrack

SHISELWENI

- Hlatikhulu Hospital
- Hlatikhulu PHU
- Matsanjeni H/C
- Nhlangano H/C
- NHO PHU
- NHL fixed site
- Gege Clinic
- Magubheleni Clinic
- Mahlandle Clinic
- Mashobeni Clinic
- SOS Clinic
- Dwaleni Clinic
- FTM Clinic
- Tfokotani Clinic
- Zombodze Clinic
- Nkwene Clinic.
- JCI Clinic.
- Nhletjeni Clinic
- Hluthi Clinic

LUBOMBO

- Good Shepherd Hospital
- Lubombo Reg Hospital
- Sithobela H/C
- Siteki PHU
- Simunye Clinic
- Gilgal Clinic.
- Bholi Clinic
- Ndzevane Clinic
- Shewula Clinic
- Lomahasha Clinic
- Mpholonjeni Clinic
- Siteki Nazarene
- Mbutfu/ Ngwavuma Barrack
- Ubombo Clinic
- Mhlume Clinic
- Cabrini Clinic
- Siphofaneni Clinic
- Tikhuba Clinic

4.2.8 Condoms

PEPFAR/E will strengthen the GKoE stewardship of the national condom program with the aim to increase sustainability including implementation of the national condom strategy (2018-2022), and improved condom promotion and distribution. Activities will be guided by recommendations from the interagency condom TDY to Eswatini conducted in Q1 of FY19. To optimize accessibility of free condoms for the most vulnerable and those in greatest need, the distribution system for free male and female condoms is currently being assessed with to shift to much more targeted, segmented and strategic distribution, while expanding the market share of low cost (fully cost recovered) private sector condoms for those with ability to pay.

<u>COP19 activities will include the following:</u>

- A distribution system facilitating distribution of condoms through Central Medical Stores (CMS) to health facilities as well as through NGOs/CBOs with adequate capacity.
- Based on COP18 activities of mapping and categorization of free condom outlets and a 'journey mapping' on consumer preferences for accessing condoms, the list of condom outlets will be revised for better alignment of supply with demand/use.
- New non-health sector outlets for free condoms will be identified that are accessible to young people and other rural / peri-urban poor PPs.
- Support an enabling environment for a total market approach that will include engagement with PSI's Regional Social Enterprise company (previously known as Company 158) through market priming activities to expand sales of low cost (fully cost recovered) commercial condoms (Trust, Lovers Plus).

- Concerted education and promotional programming supported across PEPFAR and nonPEPFAR partners that emphasizes condom's utility in preventing pregnancy and other infectious diseases.
- PEPFAR/E will continue to provide TA to government for effective condom stewardship, including planning, forecasting and quantification, as well as coordination with NERCHA and CS stakeholders. PEPFAR/E will also support the SRH program to conduct condom data and market analysis.
- As a key component of the core package of prevention, condoms will be effectively integrated into all treatment and prevention programming.
- PEPFAR/E will engage with government to advocate for a line item for condom procurement in the MoH's FP budget.

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

The additional country-specific priorities that are listed in the Eswatini planning letter relate to the following priority programming which is described in details in this document: DREAMS (section 4.2.1), VMMC (section 4.2.4), cervical cancer screening and treatment (section 4.7.1), and faith based organization Initiative (Appendix E).

4.4 Commodities

For COP 19, there are no anticipated stock outs for key commodities including pediatric and adult ARVs (counting TLD), RTK and EID, VL commodities and VMMC commodities. Regarding planned commodity procurement during COP 19 implementation;

- GKoE will continue to procure all adult ARVS in COP 19,
- PEPFAR plans to continue commodity support for pediatric ARVS and condoms,
- VL commodities will be procured by PEPFAR, GF and GKoE.

PEPFAR support will cover 75% of the condom requirements for COP19. Nonetheless, it is not expected that there will be a gap in condom supply because PEPFAR will continue to support the optimization of access to low-cost condoms for clients who can afford to pay for condoms while ensuring that the no-cost condoms are distributed according to mapped need.

Eswatini revised the integrated guidelines for the management of HIV in 2018 by considering DTG-containing ART as the preferred first-line regimen for treatment of HIV. Accordingly, men and adolescents new on treatment were initiated on DTG 50 mg, as a fixed-dose combination with tenofovir and lamivudine (TLD), from October 2018.

To minimize wastage of TLE (the out-going first-line regimen), the rapid transition of NNRTI-based regimens to TLD is balanced with due consideration of the stock status of TLE and the phased transition to TLD is detailed in a transition plan. Phase one of the TLD transition plan (spanning October 2018 – March 2019) also directed transition of men and adolescents from NNRTI-based regimen to TLD for patients who are stable on treatment as demonstrated by a suppressed VL. As of April 2019 (phase 2), the country phased in the introduction of TLD to women with reproductive potential as evidence of the safety of the drug emerged. High drug resistance to NNRTIs provides additional impetus for a rapid shift to TLD.

However, the phased approach of DTG optimization is currently facing the following additional considerations:

- NNRTI class-conferring mutations are commonly seen among patients failing second-line ART regimens and hence Etravirine cannot be used in the third-line combination. Consequently, DTG is chosen by the advisory group, and the MoH is currently considering the inclusion of DTG in the third-line regimen.
- Individuals newly started on TLD who subsequently develop unsuppressed VL on routine monitoring will require genotyping to identify drug resistance mutations. Currently PEPFAR is supporting the cost for genotyping for individuals that are failing 2nd line ART regimen.
- Currently, 19% of adults on first-line ART are on a zidovudine (AZT)-containing first-line regimen. TLD could be the option for these individuals when the initial regimen has failed. Nonetheless, the national guideline at present recommends a PI-based 2nd line regimen.
- A review of phase 1 implementation revealed that the uptake of TLD is slower than expected, hence there is a need to intensify mentorship, monitoring and reporting at facilities to increase the speed of transition of eligible patients.
- The National TB Control Program has recently resolved to put drug-susceptible TB patients co-infected with HIV on TLD, with DTG 50mg booster, and the supply chain system will need to incorporate these changes into the ARV supply plan in order to match increased DTG-containing regimen demands.

PEPFAR/E intends to support monitoring of the uptake of DTG-containing regimens for patients newly-initiating ART and for those stable on the existing first-line regimen. PEPFAR/E IPs will provide technical support to MoH in order to build systems and capacity to operationalize and roll out DTG, especially on the following:

- Support the MoH to provide supportive supervision and mentorship to health facilities so as to promote compliance with the TLD transition guidelines and ensure that eligible patients are transitioned as expected.

- Support the close monitoring of new ART initiations, transition from suboptimal regimen, failure of AZT containing first line regimen to ensure that TLD supply planning meets demand.
- Support MoH on switching of individuals failing on AZT-containing first line regimen to TLD. This will entail revisions/update of clinical guidelines on when/what to switch to 2nd line and sensitization of clinicians on the new changes
- Support the genotyping tests for individuals that have unsuppressed VL while on TLD.
- Monitor the rational use of DTG as per the national guidelines and new changes every quarter and share the data for continuous quality improvement (CQI) on the optimized use of TLD.

The GKoE responded speedily to the global guidance to transition adults on NVP-based regimen (except for women in the PMTCT program). Outstanding orders for NVP were cancelled with suppliers and facilities were informed of the need to prioritize eligible patients on NVP to TLD. Given the stocks of NVP on hand, PEPFAR committed to support the wastage of NVP and consideration of replacement ARVs in an effort to ensure that all eligible patients are on optimized regimen.

Peace Corps Volunteers will work within health facilities in rural areas to support selected supply chain management activities in Eswatini. 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 reporting through the logistics management information system (LMIS) reporting tools.

4.5 Collaboration, Integration and Monitoring

a. *PEPFAR/E 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, CS 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/E participates as members of these TWGs.
   - Commodity Planning: PEPFAR/E also regularly engages directly with MoH and GF around issues related to commodities and programming.
   - UNAIDS development partner meetings: Quarterly meeting between UN Family, NERCHA, and donors to coordinate activities. Monthly meetings between PEPFAR Coordinator and UNAIDS to coordinate activities.

     The above regular engagements ensure that there is collaboration and no duplication in implementation or procurement across donors/partners. In addition, the involvement of

MoH, GF and UNAIDS in the COP19 stakeholder and COP19 Regional Meeting provided another opportunity to further streamline and strategically plan for HIV/AIDS activities in Eswatini.

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/E 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 Eswatini. Regular SIMS visits and quarterly preparation for POART calls also strengthen IP management through standard reporting mechanisms. During COP18, more frequent meetings with testing partners are being conducted to review data for more efficient and cost-effective testing with increased yields at numerous facilities, in particular regarding implementation of risk-based screening in OPD and scale up of index testing. For all partners, monthly reviews of granular data and custom indicators, financial outlays and obligations are conducted to identify problems early and implement corrective actions to address them. Reviews of HTS activities/programs have identified barriers as well as additional strategies to improve implementation of index testing and allow for improvement of case identification strategies. Regular partner meetings are convened to share best practices and lessons learned. As necessary, PEPFAR/E 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.

PEPFAR/E will ensure that the following processes are in place to manage and monitor partner implementation:
a. Regular structured meetings

- There will be regular monthly meetings with the implementing partner with a target focused agenda that cover the following: Technical Updates on clinical cascade indicators (HTS/TX/Linkage data/Site performance), progress against annual work-plans, upcoming activities, and challenges to implementation at the site and above site level.
- Participation in meetings will be limited to relevant individuals to limited time away from implementation of individuals not required in the meetings.
- Key issues that need to be resolved will be identified and the hard decisions required to resolve them will be made. Decision making will be objective and data driven.
- A tracker of all outstanding issues will be created. This will be presented at monthly meeting with a close out update.

<u>Interagency example of IP management</u>

Areas that receives special attention is index testing and strengthening of linkages for both HIV positive and negative clients to appropriate services. This requires interagency IP management/monitoring through:

- Weekly site-level reporting by PEPFAR Partners on specific indicators
- Monthly collaboration meetings between specific IPs to foster and monitor linkages and address bottlenecks in referral processes.
- Review of site-level cascade weekly to identify bottlenecks
- Quarterly progress calls and virtual consultations with ISMEs

a. Management Updates

Timely management updates will be provided that will include:

- Administrative reminders on Important due dates, process changes, SOP updates, and review of recent NOA information, review of Restrictions, review of Post-award actions (carry-over, redirections, etc.)
- Staffing Updates on vacant positions, progress on recruitments etc.
- Financial Updates on Pipeline, Burn Rate and other Financial Issues (i.e., status of pending funds, pending procurements, planned COP funding, etc.)
- Compliance with reporting requirements

b. SIMS visits

Recognizing that Site Monitoring is effectively done by completing SIMS audits and following up on identified gaps, we will:

- Schedule and complete the SIMS assessments.
- Develop remediation plans within a month of the assessment.
- Review progress and close out of the gaps identified in the monthly meetings.
- Schedule follow up visits as per the 25/50 rule.

a. Routine DQAs

Routine DQAs will be planned and completed in collaboration with the MOH. The DQA findings will be used to amend the data and improve the quality of reporting.

b. Under-performing partners

If a partner is identified to be under performing, this will be carefully explained to the partner, then a formal Performance Improvement Plan (PIP) is developed. Weekly site level performance targets are set and monitored at weekly site level result reviews.

c. Collaboration meetings between Implementing Partners

Joint meetings of all implementing partners will be scheduled quarterly. These meetings will be used to review programmatic and financial performance to increase IP performance, collaboration and accountability.

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

In COP19, above site activities will ensure that investments in key health systems are optimally configured and integrated to better support the national HIV response including HRH, laboratory systems, supply chain, and EMR/CMIS. Eswatini currently has standalone information systems for laboratory (matured, currently proprietary), supply chain (under pilot, open source) and patient monitoring (CMIS expected to be rolled out to all PEPFAR supported facilities by end of FY19). In COP 19, PEPFAR/E will continue to provide TA to the MoH for full interoperability of the different MIS platforms for improved patient care and data visibility.

c.i. Human Resources for Health (HRH):

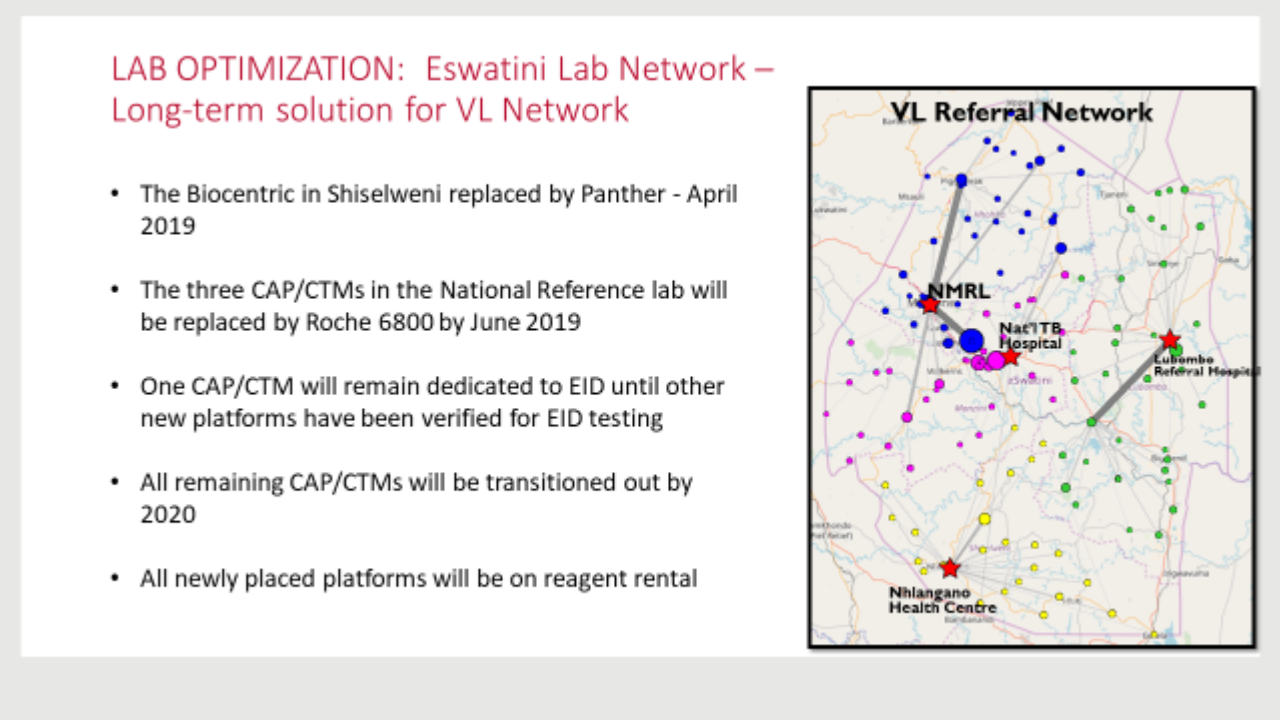
Adequate numbers, capacity and equitable distribution of human resources for health remain a fundamental requirement for sustainable epidemic control in Eswatini. PEPFAR/E has supported HRH with key investments supporting systems and governance, in particular the establishment of a Human Resource Information System (HRIS), a Training Information Management System (TIMS) and a mapping/dashboard of the total government and donor-supported HRH footprint by site, cadre, cost and funder. In COP19, specific TA will be provided to ensure that the HRIS is up to date and provides correct information for granular and site level analysis of staffing and skills to support monitoring of program performance and progress to achievement of PEPFAR targets.

Key priorities in COP19 will be to revise and align PEPFAR support to HRH by developing a uniform recruitment, remuneration, mentoring, supervision and training structure across IPs that aligns with MOH and is cost effective. PEPFAR will also support MOH to define staffing needs for new interventions or new modalities for delivering clinical interventions. Further, PEPFAR will support MOH in absorption of new graduates (laboratory technologists, nurses) and to develop a 5 year HRH transition plan for donor supported positions defining type of positions and timeline for absorption.

c.ii. Laboratory Systems:

In FY19, 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. PEPFAR/E will continue implementing equipment optimization recommendations from the optimization assessment in 2018 (Figure 4.5.1).

Figure 4.5.1 Lab Optimization Eswatini Lab Network Long-term solution for VL Network

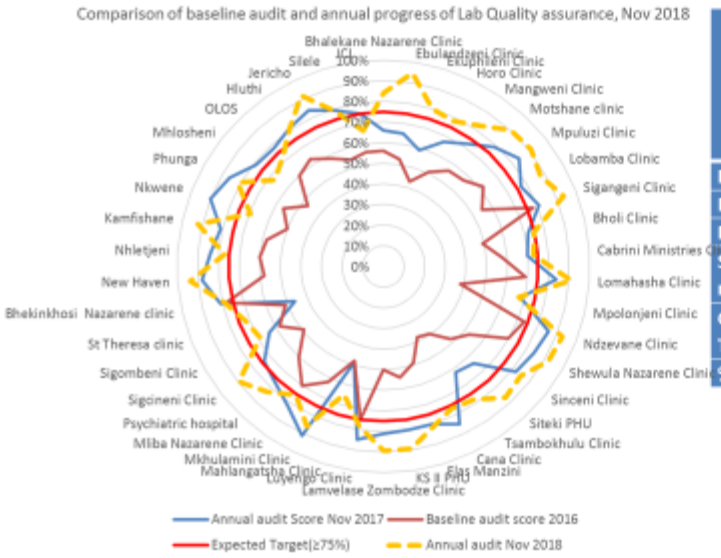


During COP18, the rollout Dried Blood Spot (DBS) VL testing plan is being implemented to all sites to cover all age groups. All testing sites have been mapped and the national transport sample transport system has been re-configured to prioritize high volume sites. The platform for VL testing in the Shiselweni region (BioCentric) will be replaced since Medicines Sans Frontiere, has transitioned out of laboratory support for the region as of October 2018. PEPFAR will support VL testing in this region, improving VL testing coverage and utilization of results. The current platform will be replaced with a Panther machine, and additionally we will continue with the human resource shift system for VL testing in order to minimize back logs.

PEPFAR will continue supporting implementation of QMS in all labs including testing sites that do not have laboratory support (Figure 4.5.2). During the 3rd week of March, 2019, two laboratories received SADCAS recommendation for ISO accreditation. A phased approach to strengthen QMS activities for other labs towards accreditation is being implemented where labs are segregated to different cohorts depending on their achievement during baseline assessments.

Figure 4.5.2 LQMS in mini labs

LQMS in mini labs



Region	Performance category					
	Excellent (≥85%)	Very-Good (75%-84%)	Good (65%-74%)	Satisfactory (50%-64%)	Not audited*	Total
Hhohho	5	4				9
Lubombo	6	3	2		1	12
Manzini	6	6	2	1	2	16
Shiselweni**	4	4	5	7	2	22
Grand Total	20	17	9	8	5	59
%	34%	29%	15%	14%	8%	100%

Mini labs which are not audited

- New Thulwane clinic (Lubombo)
- TB center & Bhahiwini (Manzini)
- Lavumisa & Nishanini (Shiselweni)

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 stakeholders, 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 a need to educate them about the importance of VL monitoring.

COP19 above site activities will continue to build on COP18 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*

Eswatini 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 with comorbitieis and/or advanced disease (hence improve retention & quality of life) by implementing care package for patients coinfected with TB and cryptococcal disease/meningitis.

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

COP19 above site activities are mapped to minimum requirements to support: the establishment of a functional procurement and supply chain management system, address inadequate demand for HIV and SRH services (e.g., VMMC, PrEP, Condoms, and family planning for AGYW), and strengthen government capacity in research, training, and data utilization. COP19 above site activities are mapped to measurable outcomes to ensure adequate progress towards achieving epidemic control and meeting minimum requirements. Expected outcomes for COP19 include: a 40% increase in the number of facilities with QMS programs with at least 80% of labs achieving accreditation, increases in recency testing and ART coverage for HIV+, and measurable increases in uptake and accessibility of HIV prevention services. As further outlined in Table 6, in addition to facilitating scale-up and refinement of current systems, COP19 above site activities also support targeted efforts to strengthen HCW capacity to collect, record, and utilize data , a critical component to achieving sustainable epidemic control.

f. Use of unique identifiers across sites and programs in clinical settings

Eswatini has adopted the use of the national ID number as unique patient identifier (UPID) in the CMIS as well as in some non-clinical record systems, such as schools. For patients without national ID, CMIS creates a unique system generated identifier. As of September 2018, 57% of all clients (regardless of HIV status) registered in the CMIS were registered with their national ID. Of ART clients registered in CMIS, 86% had a UPID based on their national ID. Nationally, over 30% of citizens do not have a national ID, which poses challenges for effective tracking of unique clients which are recognized by the MoH. In COP19, GKoE will increase access to national IDs through enabling ID registration at health facilities. In addition, PEPFAR will support targeted sensitization and mobilization activities at community level focused on client registration and use of IDs so that client records can be updated with the UPID in CMIS. In COP 19, use of biometrics as an alternative for improved patient identification will be tested.

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 Regions

Entry Streams for ART Enrollment	**Tested for HIV** (APR FY20) *HTS_TST*	**Newly Identified Positive** (APR FY20) *HTS_TST_POS*	**Newly Initiated on ART (APR FY 20)** *TX_NEW*
Total Men	**139,378**	**15,185**	**13,792**
Total Women	**115,902**	**11,974**	**10,980**
Total Children (<15)	**37,212**	**592**	**666**
Total from Index Testing	**57,981**	**11,950**	**10,727**
Adults			
TB Patients	***1,752***	**356**	**356**
Pregnant Women	***25,945***	**2,290**	**2,175**
VMMC clients	***30,000***	**829**	**786**
Key populations	***5,659***	**789**	**747**
Pediatrics (<15)			
HIV Exposed Infants	***8,489***	**123**	**117**
Other pediatric testing	***34,904***	**633**	**582**
Previously diagnosed and/or in care			

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	*VMMC_CIRC* (in FY20)	Expected Coverage (in FY20)
Hhohho	10-49 years	102,122	29%	6,448	42%
Lubombo	10-49 years	67,388	39%	4,499	50%
Manzini	10-49 years	111,313	37%	15,138	56%
Shiselweni	10-49 years	61,959	37%	3,915	49%
	Total/Average	342,782	35%	30,000	49%

* 2017 census figures were used to compute VMMC coverage

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate	Indicator	Coverage Goal FY 20	FY20 Target
MSM	5,754	KP_PREV	53%	3,051
FSW	14,581	KP_PREV	67%	9,819
AG 10-19	39,834*	PP_PREV	70%	27,703
YW 20-29	34,675*	PP_PREV	67%	23,347
Men 10-49	342,782	VMMC_CIRC	49%	30,000

* DREAMS SNUs

Table 4.6.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC*
Hhohho	107,818	16,644	14,996
Lubombo	101,483	16,748	15,250
Manzini	73,350	19,914	18078
Shiselweni	72,698	9,429	8322
TOTAL	355,349	62,735	56,646

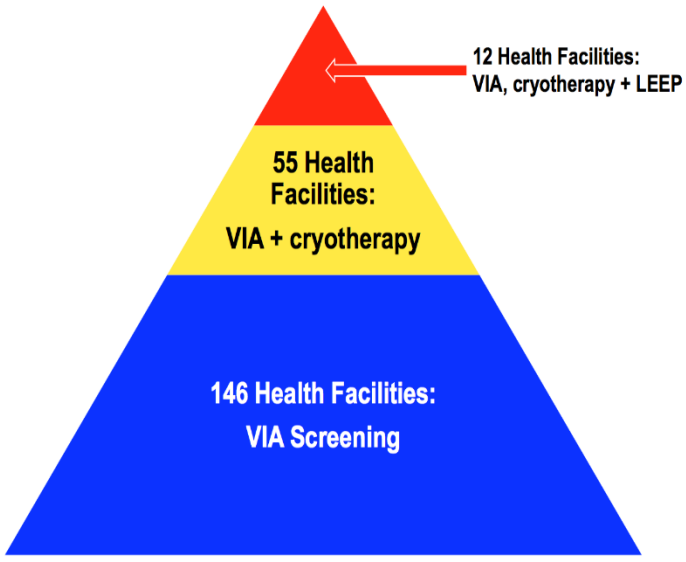
4.7 Cervical Cancer Program Plans

Eswatini through the leadership of Sexual and Reproductive Health Unit of the Ministry of Health provides cervical cancer screening services to health facilities. In January 2019, 76 (54%) PEPFAR supported facilities were offering screening services using VIA including through roving teams. These sites are providing ART and included 7 out of 8 PEPFAR supported antenatal clinics (ANC). The 76 sites reached 80% of women on ART within PEPFAR supported sites. By the end of FY19, cervical cancer screening services and treatment of pre-cancerous lesions will be fully implemented.

In COP19, Eswatini will increase access to VIA-based screening services for HIV positive women through a tiered service delivery model that takes into account the following factors:

- Number of HIV positive women seen at health facility
- Availability of adequate infrastructure (space)
- Availability of equipment
- Technical capacity to screen and treat, or conduct LEEP
- Monitoring and evaluation systems

Figure 4.7.1 Cervical cancer screening and treatment availability



Based on a national assessment conducted in November and December 2018, facilities will be provided with the necessary resources to enable them to screen and refer for treatment, screen and treat onsite, provide LEEP, or refer for further treatment. All 146 PEPFAR supported facilities, where the cohort includes women on ART, will provide screening services according to a tiered

approach as shown (see figure 4.7.1). Through this approach, PEPFAR will increase site level coverage for VIA screening to 100%, cryotherapy from 28% to 37% and LEEP from 4% to 7%. This represents 100%, 69% and 24% of women with direct access to onsite services for VIA, cryotherapy and LEEP services respectively.

Funding allocation to PEPFAR/E implementing partners was based on this needs analysis in terms of equipment, human resource quantity and capacity, and start-up costs for facilities that were not previously providing screening services. The number of women who needed to be screened was also used to guide the distribution of funds. Under the current policy, all HIV positive women are screened annually for cervical cancer. Discussions are underway to align the policy to WHO and PEPFAR recommendations. The decisions will be made at the TWG and guidelines will be revised.

Referral for cryotherapy and LEEP will be accomplished through using the national referral tool. Communication channels through existing PEPFAR support for mobile phones and airtime will be created to ensure prior booking confirmation and reduce waiting time of referred clients. Referring facilities will need to close the feedback loop to ensure that they receive information on the treatment outcomes of the patients they referred and document in patient records. Palliative care will be provided either onsite or through referral. The existing SOPs will be revised to reflect this. Roving teams comprised of technical experts will provide additional technical support on screening and treatment activities.

Mentorship and onsite trainings on cervical cancer screening will be incorporated into routine mentoring support and this will be captured through mentorship log books stationed at health facilities. An expert forum will be created that will receive mobile images of cervical cancer lesions and provide tele-mentoring and quality reviews to HCWs.

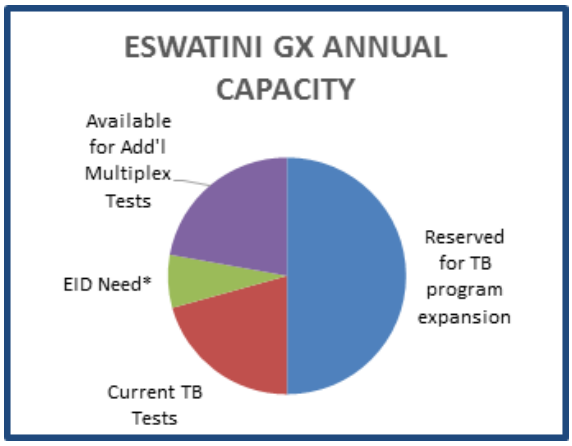
PEPFAR will support procurement of equipment, provide additional HCWs, revision of guidelines and printing of job aides and SOPs. The current M&E tools and CMIS electronic platform will be revised to capture data elements for cervical cancer screening and treatment.

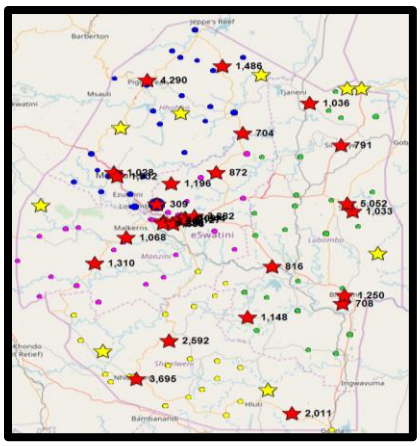
4.8 Viral Load and Early Infant Diagnosis Optimization

The country has not experienced capacity or coverage issues regarding EID testing, hence the resolution to keep EID testing centralized .However, since results return turn-around-time is still a concern, there has been discussions whether EID POC should be considered. UNITAID, working with EGPAF, has piloted EID POC in 11 high volume sites. During the discussions, the question was whether the country should consider expanding the EID POC supported by UNITAID or use the near POC Gene Xpert platform which can also do VL for PBFW and is deployed in many sites throughout the country. This was also informed by the lab equipment optimization recommendations done in 2017 and 2018. Discussions with the TB program were held and it was agreed that the Xperts were underutilized and VL and/or EID testing can be integrated. The

process was costed during COP planning, however, due to limited resources, it was not included in the FAST. For VL, optimization of conventional platforms was completed and the laboratory services is rolling out the optimization plan beginning with the Shiselweni region. Here, the existing platform is being replaced by a Panther. Optimization of other labs will be phased in beginning in June 2019, full optimization is anticipated by 2020 (see section 4.5 cii on lab).

Figure 4.8.1 Eswatini GX Annual Capacity and distribution





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

5.1 COP19 Programmatic Priorities

All regions in Eswatini contain sub-populations for which the program needs to scale-up case identification in order to reach epidemic control. The global PEPFAR definition of attained relates to reaching and maintaining 80% ART coverage in regions while the FY20 goals for Eswatini are to reach and attain 90% ART coverage in all regions and subpopulations, and since no region has yet reached this across all sub-populations, all regions are classified as scale-up for COP19. The expectation is at the conclusion of FY20 these populations will have reached 90% ART coverage.

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services			
		Expected result APR 19	**Expected result APR 20**
HIV testing (all populations)	***HTS_TST***	***256,708***	**255,280**
HIV positives (all populations)	***HTS_TST_POS***	***14,391***	**27,160**
Treatment new	***TX_NEW***	***15,530***	**24,772**
Current on ART	***TX_CURR***	***188,300***	**199,828**
OVC	***OVC_SERV***	***68,126***	**66,037**
Key populations	***KP_PREV***	***15,329***	**12,959**

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Please see Appendix C for Table 6-E tab.

PEPFAR/E has reviewed the investments needed to ensure systems are in place to achieve and support epidemic control.

Benchmarks for COP19's above site activities have been defined to ensure timely and sustainable progress towards epidemic control. Above site activities in COP19 are strategic investments to strengthen GKoE's capacity for locally managed HIV prevention and treatment programming and monitoring. Systems investments facilitate large scale information sharing ensuring adequate and reliable client and commodities data is available quickly and routinely. Furthermore, investments ensure that systems users are able to digest and utilize data to make informed decisions in programming, client care, and procurement strategies.

For COP19, Table 6 investments in the areas listed below are carefully calibrated to strengthen government capacity and systems in key technical areas that are crucial for planning, managing, coordinating and measuring HIV care, treatment and prevention programs.

Procurement and Supply Chain Management System: COP18 provided procurement and supply chain support, TA for the consolidation of different product warehouses into the CMS, and launched a pilot of an open source electronic logistics management information system (eLMIS) for commodity tracking and completing the transition to TLD. Moving into COP19, activities shift towards the scale-up of the eLMIS to provide end-to-end stock status visibility, focusing on improvements in site-level reporting to inform optimal commodity distribution, as well as ensuring systems-level integration across financing, procurement, building efficient warehousing and distribution processes. In addition to scale-up, COP19 activities will support the GKoE's supply chain governance efforts through activities that will refine supply chain management processes, including optimizing adult and pediatric ARV regimens, conducting a national warehousing assessment, developing a pharmaceutical waste management plan, introducing commodity barcoding and strengthening the pharmacovigilance system (an essential component of the TLD transition).

Client Management Information System (CMIS): By the end of COP 18, it is anticipated that of the 323 health facilities in Eswatini, 172 PEPFAR supported sites will have CMIS equipment in place. The GKoE vision is to have a fully operational EMR in all 323 facilities in the next five years and PEPFAR anticipates that over the next three years the system will be transitioned to majority GKoE support.

The overarching goal of the CMIS is to monitor the achievement of 95-95-95 and AIDS-related mortality for clients across the country. This will allow the GKoE to track epidemic control at a

national level, assess coverage gaps at a regional level, improve client health management at the facility level, and facilitate patients' access to their own medical information.

CMIS is designed to strengthen patient care by improving data quality and access to provider and patient information. This system, when deployed across the country, will ensure that secure patient information is readily available to providers at whatever location a patient chooses to be served. It is anticipated that once it is fully operational the CMIS will reduce patient wait times, improve HIV prescribing practices and ensure greater patient safety.

Two external assessments of the CMIS carried out in December 2017 and January 2018 showed that while the CMIS is fully accepted by the MoH and GKoE as a useful and necessary tool, they highlighted considerable challenges including connectivity and network issues as well as power outages that affect data quality and end-user capacity. An additional issue is the less than adequate percentage of clients presenting with their national PIN. The assessments recommend piloting new system architecture and network connectivity options; facilitating the completion of in-service training for CMIS data entry teams and users; developing a sustainable architecture for the CMIS with existing hardware and software; and gradually transitioning maintenance of the CMIS system to the MoH.

According to the Ministry of Home Affairs, an estimated 70% of the country's population have a national identity number. Currently, in the CMIS, only 58% of all people registered have a UPID. This implies that 42% of all registered clients use a system generated PIN. This has resulted in a significant number of duplicate records in the system given that not all facility data syncs automatically (i.e. only 82 sites sync automatically). Hence, the decision to explore the use of biometrics to serve as a UPID platform in the country. The implementing partner will engage with government regarding this option, building on FY18 discussions, at which point, no concrete decision was made on whether to adopt biometrics or not.

In COP 19, PEPFAR/E will advance cost effective solutions for power back up; pilot improved patient identification approaches including testing biometrics; deployment of the CMIS version 2.0 through both centralized and decentralized architecture; address data quality and synchronization; provide advanced and inservice training to inform and improve data quality and use by the end-users; address interoperability with LIS, ELMIS and other systems; work with GKoE to optimize equipment procurement; and develop specifications for mobile CMIS lite for HIV/Health outreach services.

Care & Treatment: Despite the fact that good progress has been made to link HIV patients to care and treatment services, there remains a need to provide TA to the government to build ownership, management, technical leadership, and implementation of national HIV/TB clinical programming. CDC clinical implementing partners will provide TA to the Eswatini National AIDS Program (ENAP) to assist in building their capacity to collect, analyze, and use program data to improve their Care and Treatment programs. Clinical partners will also provide support to the government for the national level development of guidelines, including guidelines for the

ART- TLD transition, TB/HIV - TPT scale-up, granular site management, and use of DBS for VL. Partners will also provide TA on the coordination of program implementation and program performance monitoring. These activities will enhance the government's ability to effectively implement national HIV/TB clinical programs, and increase ART coverage for HIV and TB patients in-country. ART coverage as of APR 18 was at 81%. For APR 19, the focus will be on increasing ART coverage from 81% to 85%.

VMMC: There remains a need for PEPFAR/E to support national TA to increase the pace of implementing VMMC services in-country. In COP19, PEPFAR will provide national level support in the scale up of VMMC demand creation to increase the number of males accessing VMMC services. VMMC partners will use various evidence-based demand creation activities to increase uptake and performance, ensure quality through CQI and EQA, and closely monitor performance to tailor strategies in real time.

Peds/PMTCT: Although significant progress has been made toward the elimination of mother-to-child HIV transmission and across the pediatric HIV clinical cascade, there remains a definitive need for PEPFAR/E to support national TA to accelerate the pace toward optimal maternal and pediatric HIV outcomes, including the elimination of mother-to-child HIV transmission. In COP19, PEPFAR will continue to provide national level support to the Sexual and Reproductive Health Unit (SRHU) and the ENAP's pediatric care and treatment programs. The Ministry of Health's ENAP and SRHU programs are responsible for coordination of investments across stakeholders to ensure that Eswatini implements standards of practice aligned with current WHO and PEPFAR PMTCT and pediatric HIV guidance. For example, through PEPFAR support, ENAP spearheaded the optimization of pediatric ART regimens (phase out of NVP) by September 2019; and the SRHU program has tirelessly advocated for the integration of FP services within ART clinics, as an essential component of client-centered care. The COP19, above site activities remain focused on enhancing clinical mentorship and supportive supervision to PMTCT and pediatric programs to ensure implementation of comprehensive and quality services throughout the continuum of HIV care at health facilities.

PrEP: As the GKoE embarks on scaling up PrEP delivery, PEPFAR/E will provide technical support to MoH to manage the implementation of the national PrEP plan to fully integrate PrEP services at appropriate entry points in facilities and through select outreach sites with continued site expansion. COP19 activities will ensure that tools, SOPs and guidelines are in place and that HCWs in PrEP sites have been trained on PrEP service delivery and tools. PrEP will be included in site level supervision, mentoring and QI activities.

Condoms: PEPFAR/E support is geared towards strengthening government stewardship and coordination of condom programming for sustainability of condom procurement and distribution. COP 18 activities focused on assessing the distribution system for more targeted community level distribution of free condoms. In COP19, PEPFAR/E will work with CMS to put in place a condom distribution system to include NGOs. COP19 activities will also further increase

the market share of low-cost (fully cost recovered) private sector condoms, while ensuring distribution of free condoms is optimally targeted to priority and key populations.

Laboratory Systems: PEPFAR/E continues to work with the government of Eswatini to build laboratory capacity in-country. Although major advances have been made in lab systems strengthening, there is a need to increase lab capacity to build on and maintain these improvements. The PEPFAR lab implementing partner will work with the government to improve quality management systems (QMS) in-country. In addition, the partner will work with the government on accreditation activities, supportive supervision & mentorship, EQA proficiency testing (PT) material production, procurement of reagents and supplies, LIS support, VL Task Force meetings, lab managers and lab technical working group (TWG) meetings, and mentorship to EHLS senior management. There is no database or listing of in-country of registered lab professionals. To address this gap, a key activity for COP19 is the establishment of a database for the registration for all lab professionals in country. PEPFAR/E will continue to support trainings on continuous laboratory professional development (competency assessment, continuous professional development, MDC support) to sustain laboratory staff skills. Three laboratories received SADCAS accreditation in COP18. In COP19, PEPFAR/E aims to have at least 80% of laboratory professionals trained on the implementation of SLMTA.

Effective Case-Based Surveillance System: The national epidemic surveillance capacity is limited, and there is a need to build capacity to improve and sustain surveillance activities. PEPFAR/E, through its implementing partners, will provide TA to the Ministry of Health to implement an effective case-based surveillance system in-country. PEPFAR partners will provide support to the MOH/Epidemiology & Surveillance Unit to implement case-based surveillance activities. Surveillance activities to be addressed include the expansion of testing activities to remaining HTS points and supporting human resource needs (counsellors for high volume clinics, addition of data clerks for data collection, and lab techs). PEPFAR will also support staff training. Support for procurement of equipment, such as tablets for data collection and freezers and centrifuges) will be provided. These activities will continue to build government capacity to maintain and sustain an effective case based surveillance system in the country,

Strengthening Government Systems for Research and Training: PEPFAR/E supported activities to strengthen government systems related to research and training. Three of these major activities include strengthening the capacity of National Health Research Review Board (NHRRB- National IRB), implementation of the Health Research Training Program (HRTP), and building capacity of the Health Research Unit (HRU). Activities related to strengthening the NHRRB include: 1) scaling up implementation of an electronic tracking system; 2) capacity building on Bioethics related topics; 3) supporting NHRRB monitoring capacity of approved studies; 4) supporting the NHRRB to develop guiding documents; 5) Supporting the NHRRB to develop study monitors guidelines; and 6) Supporting the international registration of the IRB.

PEPFAR/E is developing a transition plan for the HRTP program; it is to be moved to an indigenous academic institution. Support will also be provided so that research proposals are

finalized by the current HRTP cohort, and analyses and manuscripts of SHIMS 2 data by cohort 6 students are completed.

Coordination, planning, data review: Oversight and coordination of the HIV response is the mandate of the Prime Minister through NERCHA. The coordination of the multi sector response at national, regional, tinkhundla, chiefdom/municipality level requires engagement by various line ministries, and the different sectors including the private sector, faith sector, and civil society. In COP 18, NERCHA finalized its National Multi-sector Coordination Strategy, the Prevention Coordination Strategy; and the National Prevention Policy. In COP 19, PEPFAR/E will support NERCHA to assure the strategies and the policies are implemented including development, refinement and production of key tools and materials specifically related to coordination of the HIV response. Most important, PEPFAR/E will help to strengthen data collection, analysis, interpretation and use for programing on a quarterly basis, including the use of spatial analysis to better understand gaps in specific population and/or program coverage. As a part of quarterly data analysis, PEPFAR/E will also assist NERCHA in gathering best practices in combination prevention programming, community led approaches and communication strategies.

At the regional level, the multi-sector response is coordinated and led by the Regional Administrators (RA) working with the Regional AIDS Coordinators and the Regional Development Teams including Regional Health Management Teams, and Regional Education Officers and others. PEPFAR/E will provide support to the RA and Regional AIDS Coordinators to strengthen and assure active multi-sector engagement in the HIV response and develop regional HIV plans with targets. PEPFAR/E will assist the RAs to collect and analyze their regions' data from both the community level and regional level (CMIS, EMIS). This will assist the regions to better understand of the combined community and clinical data, to visualize gaps in program and population coverage, and to address these through coordinated programming. PEPFAR/E will support the Regions in quarterly data reviews.

7.0 Staffing Plan

7.1 Analysis of PEPFAR/E Staffing Footprint

PEPFAR/E has reviewed its staffing footprint and interagency organizational structure to be fully positioned to achieve program pivots and ensure that technical roles are defined in the interagency space. Special consideration was given to the USG staffing needs for ensuring effective partner management, including oversight and support to the transition to local prime partnerships.

The interagency team has identified missing skills sets and competencies requiring recruitment of the following additional staff:

- VMMC Specialist (CDC)
- Program Assistant (USAID)

USAID is also requesting to repurpose its Senior Medical Advisor position, previously encumbered by an expatriate, as a locally hired position of Senior Medical/Biomedical Prevention Advisor.

Additionally, USAID will be augmenting its organogram to strengthen capacity building of local entities, including the transition of key portfolio components to local partners. The following positions will be recruited as local positions (LES), as per S/GAC guidance to USAID for approved above COP19 allocation:

- Strategic Information Program Management Specialist (USAID)
- Clinical and Commodity Program Management Specialist (USAID)
- OVC/ DREAMS Program Management Specialist (USAID)

With these additional positions, PEPFAR/E will be adequately staffed to achieve balance of partner management, technical roles and interagency work processes, including meeting SIMS requirements.

7.2 Progress of Long-Term Vacant Positions

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

- The USAID LES Senior Policy Advisor position has been filled and the individual joined the team in January, 2019

There has also been progress regarding previously approved positions:

- The CDC HSS position was recently filled, and the individual is expected to start the position in 2019
- The CDC SI position was recently filled, the individual is on board and is completing headquarter training requirements and is expected to start in-country in July, 2019
- The USAID Senior Prevention Advisor position was approved in COP15. A candidate has been selected and is expected to start in 2019.
- USAID's NSDD38 position, vacant since September 2018, has been repurposed to a Senior Operations and Management Advisor. Recruitment planning is underway.

7.3 Justification for Proposed New Positions

USAID is requesting one new position in COP19, in addition to the three LES 'above COP 19' positions. USAID requires a Program Assistant to support staff in administrative functions supporting the team in general administrative tasks and coordination with the USAID mission support offices in South Africa, thus freeing up time for agency management and technical staff to focus on technical/programmatic issues.

CDC is requesting a new position of a VMMC Specialist. This position is in response to the shift in programming that necessitates a staff member to oversee VMMC activities due to an increased portfolio of VMMC activities for the agency. This is a critical role to ensure that VMMC targets are met, and that activities are coordinated within the interagency space.

7.4 Changes to CODB

- USAID's increase in CODB is due to the addition of three time-bound LES positions above the COP19 planning level. While these positions increase the agency CODB, all positions will be situated outside of the Embassy so as not to impact ICASS costs.
- CDC's CODB has risen due to the addition of educational allowance for the new SI staff member's dependents, the permanent change of station travel for one USDH and the position replacement, and the request for a new VMMC Specialist.
- Peace Corps' CODB has risen due to PEPFAR staff cost increases related to annual Within Grade increases and Local Compensation Plan increases, an increase to the Peace Corps Volunteer readjustment allowance amount, and an increase in Peace Corps Volunteer support costs and administrative costs due to inflation.
- PEPFAR/State's CODB has decreased from COP 18 due to the removal of non-recurrent costs for the relocation of the Coordinator position that was filled in FY18.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	Prioritization	Result Reported	Treatment coverage																		Overall TX Coverage
				<15		15 - 19		20 - 24		25 - 29		30 - 34		35 - 39		40 - 44		45 - 49		50+		
				Female	Male	Femal	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
Hhohho	COP 18	Attained	APR 19	88%	82%	13%	36%	10%	681%	11%	55%	4%	6%	54%	42%	46%	16%	2%	225%	62%	8%	88%
	COP19		APR 20	86%	83%	91%	152%	91%	92%	91%	91%	99%	91%	97%	91%	95%	91%	98%	91%	115%	91%	94%
Lubombo	COP 18		APR 19	81%	78%	90%	13%	110%	1376%	11%	50%	36%	115%	10%	14%	36%	3%	24%	18%	155%	13%	94%
	COP19		APR 20	104%	83%	91%	146%	91%	91%	91%	91%	96%	91%	100%	91%	100%	97%	99%	91%	137%	99%	97%
Manzini	COP 18		APR 19	59%	56%	256%	1234%	51%	627%	4%	105%	26%	92%	49%	98%	5%	77%	7%	97%	6%	1%	88%
	COP19		APR 20	69%	57%	91%	105%	91%	91%	91%	91%	92%	91%	102%	91%	99%	92%	91%	91%	103%	91%	93%
Shiselweni	COP 18		APR 19	83%	80%	532%	15%	16%	67%	9%	578%	12%	128%	101%	2%	43%	33%	370%	193%	186%	111%	95%
	COP19		APR 20	88%	84%	91%	149%	91%	91%	90%	91%	100%	91%	108%	91%	104%	91%	108%	91%	139%	96%	98%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY19)	Additional patients required for 80% ART coverage	Target current on ART (APR FY20) *TX_CURR*	Newly initiated (APR FY20) *TX_NEW*	ART Coverage (APR 20)
Scale-Up Saturation	**210,725**	**188,300**	**11461**	**199,826**	**24,772**	**95% (National)**

APPENDIX B – Budget Profile and Resource Projections

B.1.1 COP19 Budget by Program Area

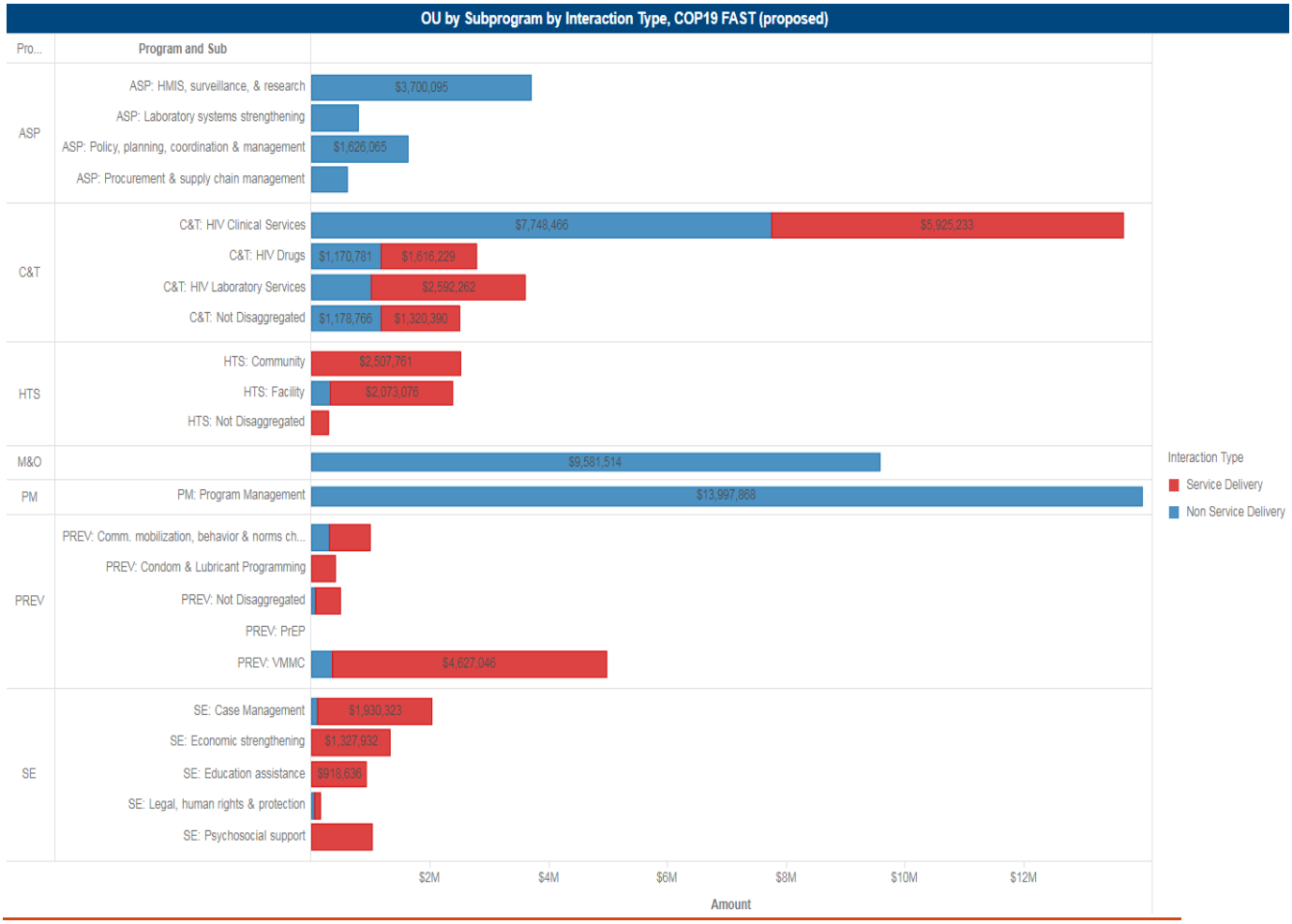


Table B.1.2 COP 19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$10,114,143	$69,515,085	$79,629,228

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)	
PEPFAR Budget Code	**Amount Allocated**
CIRC	$5,215,515
HBHC	$10,425,514
HKID	$6,700,848
HLAB	$942,155
HTXD	$1,742,474
HTXS	$13,443,372
HVAB	$4,172,550
HVCT	$9,942,457
HVMS	$4,361,405
HVOP	$1,788,759
HVSI	$2,399,931
HVTB	$2,746,881
MTCT	$952,566
OHSS	$3,375,242
PDCS	$676,500
PDTX	$628,919

B.2 Resource Projections

The PEPFAR Funding Allocation to Strategy Tool (FAST) was used to calculate budget levels by mechanism, program area, beneficiaries and allocate these to budget codes. Where FY18 expenditure data was complete the FY18 PEPFAR Expenditure Reporting results were used as a baseline for setting the FY20 budget. In the absence of full year expenditure data the FY19 budget was used as a baseline and adjusted for program variations. Estimates based on the country program's experience were used for new mechanisms that did not have historical data.

APPENDIX D– Minimum Program Requirements

During COP19, the minimum requirements for continued PEPFAR support will be met by the Eswatini HIV program. The minimum requirements are:

1. Adoption and implementation of T&S with demonstrable access across all age, sex, and risk groups (required in COP16).
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual VL testing and reporting.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls (AG) in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and C/ALHIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).
13. Scale up of unique identifiers for patients across all sites.

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith receiving central funds

In August 2018 an interagency team lead by OGAC conducted an FBO Mapping and Gap Analysis in Eswatini. During this time, multiple stakeholders expressed that FBOs are uniquely positioned to disseminate HIV prevention messages and regularly engage congregants in HIV prevention activities. In accordance with the COP19 Planning letter, PEPFAR/E will use $8 million, awarded through central funding, to involve traditional and faith leaders and faith-based organizations at the community and national level.

PEPFAR/E has had a number of subsequent dialogues with stakeholders in order to define partnerships with traditional leaders, faith based organizations, and faith groups. By building on relationships of trust and respect, these organizations will play a pivotal role in working to influence the attitudes and behaviors of members of their respective congregations and communities. Supported though the *Consortium of Concerned Church Leaders,* along with the networks they represent and with the Nazarenes and the Zionist Council these faith groups will be instrumental in implementing the priorities outlined below. The Ministry of Health (MoH) will be a partner, as FBO-related activities will support and build on MoH's priorities for epidemic control. PEPFAR/E also supports NERCHA's new coordination framework which positions the faith-based sector as a program with the Church Forum a lead institution to ensure interventions are tailored for the sector, monitored and reported. In addition, PEPFAR/E will build on investments working with the traditional leaders at chiefdom level and expand community efforts thought the faith committee and faith groups. The Luke Commission, a clinical FBO will continue to provide comprehensive HIV and health services through outreach and their facility in Manzini, serving those in most need and who lack access to care and they will expand support to faith and traditional leaders and communities.

Through the Faith and Community Initiative, together traditional and faith leaders and networks will address the following priorities:

I. Engaging communities of faith to understand the epidemic, raise community awareness, and bring critical prevention and treatment interventions to and through communities of faith, especially for finding men including:

- Adapt and or develop tailored materials/activities that can be packaged into congregation specific Toolkits. These materials will include, but are not be limited to, sermon guides, pastoral observations, responsive/liturgical readings, and bulletin inserts to address stigma. Materials will include specific information on HIV transmission, testing, adherence, retention, viral load monitoring, and prevention. New HIV messages, include TEST and START, and U=U [undetectable = untransmissible]. Additionally, key religious

leaders will be asked to develop social media tools, such as videos, that will be used as a means for discussion during population-focused ministry meetings, music groups, confirmation groups, and weekly prayer groups.
- Building the capacity among faith and traditional leaders including counselors in congregations, community and faith champions, peer outreach workers and mentors

II. Mobilizing and engaging communities and men through faith and traditional leaders in the HIV response

Traditional and faith leaders are well respected in Eswatini and are able to mobilize their populations for action as well as to effectively shape social and gender norms and address harmful practices. Eswatini is an oral society, thus effective methods for transmitting key HIV messages are through the traditional and faith leaders. Further, in Eswatini's patriarchal society men are the gateway to their families and community's health and wellbeing and thus it is critical to fully engage men in the community for a sustainable response. Through the Faith and Community Initiative FBOs, faith and traditional leaders will:

- Increase awareness and knowledge of the HIV epidemic and risks of transmission
- Facilitate and promote up-take of testing, treatment, or prevention (VMMC and PrEP) and retention
- Disseminate key messages and materials TEST and START, and U=U [undetectable = untransmissible, protection through VMMC, positive masculinity]
- Strengthen support for adherence

III. Targeted testing of men, adolescents, and potentially women 35 – 49 years

HIV self-testing kits are an ideal testing option for men and at risk adolescents as it addresses concerns of confidentiality and queuing. Additionally, the mouth swab technology makes testing more amenable to use as blood draws have served as a huge deterrent and barrier to HIV testing. PEPFAR will work with MoH's HTS program to support the partners implementing the initiative with additional guidance (e.g., HIV Self-Testing (HIVST) and Index Case Testing (ICT) Standard Operating Procedures (SOPs)) and technical assistance. This may include:

- Distribute HIV self-test kits through traditional and faith leaders for young men ages 18-39, within existing men's infrastructures
- Engage traditional and faith community carers as expert clients to ensure those with a positive HIVST receive a confirmatory test and if positive are then linked to care and those who test negative are linked to prevention including VMMC for males
- Distribution of 'VIP' cards to HIVST clients for fast-tracking if positive for a confirmatory test and ART initiation
- Utilization of a hotline (SMS/call-in system) to facilitate linkage to confirmation and care for HIVST-positive clients

- Designation of special referral health care facilities
- An initial pilot will take place with engagement of the Lutherans, Nazarenes, and Zionists in the Manzini region with the intention to scale up to Lubombo and beyond. PEPFAR/E will used a community-based participatory research (CBPR) approach to design an effective strategy for development, implementation, and evaluation of the impact of HIV self-test program geared towards these young adult men and adolescents.

Consideration may be given to target women age 35-49 as this group had the highest incidence in the SHIMS II survey =2.4. Additionally, messaging regarding the need to link to treatment may be developed for women age 25 – 29 years, who may know their status but are not linked to care (as seen in the population pyramid). These women may be aware of their status but are not on ART; and include women who previously received PMTCT option A and were not eligible for ART at the time. In religious communities where stigma is high, leaders may consider providing HIV services, including distribution of self-test kits, though comprehensive/general health screenings.

FBO Strategy to reach epidemic control within the military

DOD identified the chaplains as a strong asset in the management of HIV within the military. DOD will work with a respected and trusted FBO in order to engage chaplains in implementing strategies geared towards addressing DOD's targeted testing gaps. Led by the Chief Chaplain, each army camp has a chaplain with an assistant. Their function is to do counseling and provide support services to the military and their families. The criteria for selection of a chaplain are that they be a pastor in their community outside of the military. They therefore have access to the military, their families and to their respective communities. Upon receiving extensive training on HIV prevention activities and the use of HIV self-test kits, these chaplains will participate in the development of a military specific toolkit with both religious messaging and non-religious messaging.

IV. Preventing sexual violence and HIV risk in 9-14 year old girls and boys

Faith and traditional leaders will adapt and or develop religiously tailored messages on topics such as resiliency, physical resistance, and conflict resolution for a 9-14 year old boys and girls. Through their networks and communities, these leaders will reinforcing positive and effective communication within communities (e.g. parents and children) about sexual/reproductive health, HIV prevention, and sexual violence. With-in communities, traditional and faith leaders can work to change harmful gender norms and create a safe environment and safe spaces for children and adolescents. Furthermore**,** faith organizations will support and/or engage in the implementation of integrated evidence-based treatment approaches designed to address the psychological and behavioral impact of violence and HIV on parents, caregivers, and their 9-14 year olds (e.g. Common Elements Treatment Approach (CETA)).

In order to determine feasibility of implementing these support services, PEPFAR will conduct a needs assessment survey on church leaders' interest and church capacity to implement evidence-based approaches for children, youth, families, men, schools, and communities, from DREAMS, to advance primary prevention of sexual violence and HIV for 9-14 year old girls and boys. These findings will be used to determine how to assist with the scale-up of sexual violence prevention programs (e.g. IMpower, Families Matter! Program (FMP), and Coaching Boys into Men, SASA!).

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 230,692.00	Program and data quality management	Adequate government technical capacity to design, implement, analyze and disseminate research to inform HIV policy and programming	COP16	COP19	HRTP - Transition plan produced and finalized; HRU: 5 Abstracts are submitted for National Health Research Conference 2019; 5 manuscripts produced
HHS/CDC	FALSE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 613,000.00	Program and data quality management	Adequate government capacity to implement national epidemic surveillance activities, and to collect or utilize epi data of new HIV infections nationally	COP18	COP19	At least 90% of all HTS_POS has recency test done; 95% completeness of data on recency testing tools; All PEPFAR supported facility HTS Sites and all community HTS sites are are implementing HIV Recency Testing
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 93,369.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government technical capacity to design, implement, analyze and disseminate research to inform HIV policy and programming	COP16	COP19	1. NHRRB: Average Turnaround time is 30 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
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 411,227.00	Program and data quality management	Adequate government capacity to implement national epidemic surveillance activities, and to collect or utilize epi data of new HIV infections nationally	COP18	COP19	At least 90% of all HTS_POS has recency test done; 95% completeness of data on recency testing tools; 100% PEPFAR suported facility HTS Sites and all community HTS sites are are implementing HIV Recency Testing
HHS/CDC	University Research Co., LLC	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 181,871.00	Program and data quality management	Adequate government capacity to implement national epidemic surveillance activities, and to collect or utilize epi data of new HIV infections nationally	COP16	COP19	Increase ART coverage at the national level from 85% in APR19 to 90% at APR 20
HHS/CDC	University Research Co., LLC	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 104,496.00	National strategic plans, operational plans and budgets	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP16	COP19	Increase ART coverage at the national level from 85% in APR19 to 90% at APR 20 ; increase number of ART patients on TPT; increase VL coverage

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 793,068.00	Training in laboratory systems strengthening	Adequate laboratory systems and support for continuous training on lab professional development, QMS, and accreditation	COP16	COP19	1) 100% of selected labs in Phase One achieving accreditation; At least 80 % of Laboratory professionals have been trained on the implementation of SLMTA as one of the requirements to obtain CPD points including obtaining satisfactory pass rate on EQA PT and at least three Laboratories have received SADCAS accreditation by the end of FY 19; 2) Implementation of training to support continuous laboratory professional development where at least 50% of qualified laboratory professionals have attained minimum CPD requirements.
HHS/CDC	MINISTRY OF HEALTH	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 391,763.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP16	COP19	1) Increase by 40% the number of facilities with QMS programs; ISO-9001 certification for the four facilities; 2) Increase by 25% the number of meetings of RHMTs and improvement in performance of HIV/TB metrics at regional national data review meetings; 3) Improved metrics at the facility level; continued guidance from the MoH Directorate.
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 138,305.00	Program and data quality management	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP16	COP19	Maintain HTS amongst TB clients at 100%. Maintain ART uptake amongst TB patients at 100% in APR120. Increase TPT uptake amognst eligible PLHIV on ART from 50% in APR18 to 80% in APR20.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Population Services International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 14,018.00	National strategic plans, operational plans and budgets	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP18	COP20	A shift for COP 19 with regards to this indicator is as follows: 1. Optimize targeted testing and use of HIV screening tool to test all eligible clients.2. Scale index testing with fidelity fo all newly diagnosed clients, and proactive tracking and testing of all elicited contacts. The total overall yield for community is 11% and index yield at 30% , with a total contribution of 50% to the HTS POS indicator.HIV_SELF- will be prioritized for men and adolescents. At least 95% of all newly identfied positives should be linked to treatment
USAID	Population Services International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 102,400.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP18	COP20	Private sector share increased by 25%; Condom distribution system to NGOs through CMS established; # of free condoms distributed through NGOs
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 610,447.00	Forecasting, supply chain plan, budget, and implementation	Adequate and consistent supplies of drugs and commodities at facility level	COP16	COP21	eLMIS scaled up to all mother facilities (end-to-end stock status visibiliy); commodity bar coding intoduced at CMS; active pharmacovigilance system in place; stock levels within acceptable margins; GDPs and GSPs satified for all commodities

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	FHI Development 360 LLC	ASP: Policy, planning, coordination & management	Key Pops: Not disaggregated	$ 85,717.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP17	COP20	7 health facilities certified as Centers of Excellence for KP services; 11 facilities certified as KP friendly (with trained KP POC); TST_POS as per target; # and type of police trained; quarterly program reviews held (achievements against target)
USAID	FHI Development 360 LLC	ASP: HMIS, surveillance, & research	Key Pops: Not disaggregated	$ 550,000.00	Surveillance	Adequate government capacity to implement national epidemic surveillance activities, and to collect or utilize epi data of new HIV infections nationally	COP19	COP19	IBBS and Size estimation survey completed; IBBS and size estimate survey disseminated; IBBS and size estimate information used to update targets and indicators and encorporated into national, and partner plans
USAID	Johns Hopkins University, The	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 206,004.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP19	COP20	NERCHA holds semi annual HIV program reviews and recommendations for course correction. 50 % of regional government entities have annual HIV plans with measureable targets that have been analyzed quarterly.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	JHPIEGO CORPORATION	ASP: Policy, planning, coordination & management	Males: Not disaggregated	$ 161,906.00	National strategic plans, operational plans and budgets	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP19	COP20	CQI: (1) 95% of facilities with infection prevention and control plans, (2) 70% of providers have taken refresher training on IPC in VMMC services, (3) 95% number of facilities compliant with waste management as outlined in the national waste management guidelines, (4) IPC assessments at a70% VMMC sites as part of quality assurance measures, (5) VMMC AE rate (mild, moderate and severe) does not exceed the acceptable level of 2% according to the Adverse Event action guide for VMMC. M&E -Improve data collection and management through the implementation and use of new and existing data tools: (1) Develop VMMC data collection and reporting tools based on the M&E framework, (2) develop standard operating procedures for the collection and management of VMMC data, (3) Conduct data quality assessments on 75% of facilities. M&E- Improve recording, reporting, and monitoring of adverse events: (1) Train users at all levels on the use of data across tools to monitor, prevent and respond to adverse events, (2) Implement a mobile application for conducting continuous quality improvement and quality audits.
USAID	FHI Development 360 LLC	ASP: Policy, planning, coordination & management	Priority Pops: Not disaggregated	$ 166,392.00	Oversight, technical assistance, and supervision to subnational levels	Adequate government capacity and data utilization to manage, lead and coordinate implementation of HIV/TB care, treatment and prevention programs	COP18	COP20	80 sites delivering PrEP; increase in % of completed referals; % increase PrEP_new per the national plan; quarterly review of indicators and course correction
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ -	Surveillance	Adequate government capacity to implement national epidemic surveillance activities, and to collect or utilize epi data of new HIV infections nationally	COP19	COP19	Implementation of a household survey in all 4 regions for > 15