



PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Eswatini Country Operational Plan

(COP/ROP) 2020

Strategic Direction Summary

April 3, 2020

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Acronym and Word List

ADE	Adverse Drug Reactions
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
CBS	HIV case-based surveillance system
CCM	Country Coordinating Mechanism
CMIS	Client Management Information System
CMS	Central Medical Stores
CoAg	Cooperative Agreement
CQI	Continuous Quality Improvement
CS	Civil Society
CSD	Civil Society Organization
DBS	Dried Blood Spot
DQA	Data Quality Assessment
DMPPT	Decision Makers Program Planning Toolkit
DREAMS	Determined, Resilient, Empowered, AIDS free, Mentored, and Safe
DSD	Differentiated Service Delivery
DTG	Dolutegravir

EDCU	Epidemiology and Disease Control Unit
EHLS	Eswatini Health Laboratory Services
EID	Early Infant Diagnosis
EQA	External Quality Assessment
ENAP	Eswatini National AIDS Program
EU	European Union
FCI	Faith and Community Initiative
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
iHP	Ultra-short course regimen for daily isoniazid and rifapentine for 28 days
§HP	A short-course TPT regimen that combines two antibiotics active against TB i.e. Isoniazid (INH) and Rifapentine (RPT)
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 under Region
INSTI	Integrase strand transfer inhibitor (another group of ARVs)
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
LPV/r	ritonavir-boosted lopinavir (a group of ARVs called Protease Inhibitors)
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	Matsapha 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
NNRTI	Non-Nucleoside Reverse Transcriptors (a group of ARVs)
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	Prevention of 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
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SIMTA	Strengthening Laboratory Management Towards Accreditation
SOP	Standard Operating Procedures
SNU	Sub-National Unit
SRH	Sexual Reproductive Health
SRHU	Sexual Reproductive Health Unit
SWABCHA	Swaziland Business Coalition on HIV/AIDS
SWAMMIWA	Swaziland Migrant Mineworkers Association
TA	Technical Assistance
TB	Tuberculosis
Tinkhundla	Third level of Governance (local government institution)
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
VIA	Visual Inspection with Acetic acid
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WMIS	Warehouse Management Information System

1.0 Goal Statement

Despite facing the world's highest overall HIV prevalence, Eswatini stands on the brink of reaching epidemic control. As the country achieves 95-95-95, strategic programmatic shifts will drive the HIV program towards sustained control of the epidemic. As the testing and treatment gaps close across the board, unmet need is no longer restricted to any one age, sex or region— all people living with HIV (PLHIV) on treatment must receive services that support their ability to stay on treatment and virally suppressed. Addressing the persistently high incidence, prevention among populations who are most at risk of acquiring HIV (as determined through infection recency testing), is prioritized and expanded. The overarching goal of the PEPFAR/Eswatini (PEPFAR/E) investments remains to support the Government of the Kingdom of Eswatini (GKoE) to achieve and sustain epidemic control, provide high-quality HIV services to PLHIV, and continue to rapidly 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. Strengthening crucial systems that support information systems, infection surveillance, and laboratory capacity also remain PEPFAR priorities in COP20.

Where COP19 focused on actively finding unidentified, untreated, or unsuppressed individuals and also improving access to high-quality services, COP20 focuses on accelerating the reduction of new infections in adolescent girls and young women and other at-risk individuals with harmonized interventions through DREAMS, PrEP, STI screening and recency testing, as well as focused preventions among men through VMMC and client-centered services. COP 20 will also focus on eliminating the divide between community and facility providing seamless services to maintain people on uninterrupted treatment, and reduce co-morbidities and mortality through client-focused service provision. As the country reaches near-universal ART coverage, case identification will be predominantly through index testing and through testing modalities where people recently infected with HIV are most likely to be present.

As we seek to strengthen our focus on treatment 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, six-month scripting and dispensing, key communication interventions (such as undetectable viral load means the virus is untransmittable (U=U)), and effective use of outreach workers, expert clients, and step-up adherence counselors. Tackling two of the most significant causes of mortality amongst PLHIV in Eswatini, PEPFAR will continue to support the full implementation of TB preventive therapy, cervical cancer screening, and treatment for PLHIV.

The DREAMS package will focus on preventing HIV for adolescent girls and young women (AGYW) ages 15-29 years and will expand to reach seven additional tinkhundla. Local government structures and traditional and faith leaders' efforts to reduce HIV incidence and stigma as well as to ensure those with HIV are on treatment, will continue. VMMC services will be delivered for only those aged 15 and up within facilities and men's corners, campaigns and community-based services, based on the number in this age group reached previously, which resulted in lower targets than in prior years. While acknowledging the successes of the national HIV program, PEPFAR/E is adapting investments to meet the needs as the epidemic changes. The Eswatini Population-based HIV Impact Assessment Survey (SHIMS₃) will

provide important data on the status of the epidemic at a population level during COP20 implementation period, and strengthen the program's ability to adapt our targeted approach. Recency testing will be implemented fully across the country, which, in combination with investments in the national electronic medical record system, will enable case-based surveillance capable of defining geographic hotspots as well as testing entry points that can guide more targeted case identification. PEPFAR/E support to the government's laboratory optimization action plan includes the scale-up of improved laboratory results communication systems. PEPFAR/E will continue to monitor implementing partners' performance and immediately address performance issues. Program implementation will be monitored through quarterly performance reviews and regular SIMS visits. Partners will be required to report their monthly outlays against their approved COP20 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. COP20 shifts also include increased funding to indigenous organizations and the development and implementation of a civil society-led community feedback platform to monitor and improve HIV service delivery. Additionally, the GKoE's continued commitment to address the epidemic by fully funding adult ARVs and increasing domestic HIV funding despite financial challenges are significant sustainability milestones. Civil society (CS) and population-specific input into PEPFAR programming remain critical to appropriately tailor responsive interventions and messages to achieve results. The work with communities of faith, traditional leaders and faith-based organizations (FBOs) will leverage the unique opportunities offered by these groups' vast networks to support HIV programming. Continued collaboration with the 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

Population

Though Eswatini benefits from decades of political stability, relatively low crime, 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. Manzini has the highest population (355,945), followed by Hhohho (320,651), Lubombo (212,531), and Shiselweni (204,111).

A high ratio of the male population is seen in two inkhundla (sub-regional administrative units) in Lubombo - 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 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.

The higher population density areas are the Manzini-Mbabane corridor, connecting the economic and national capitals, Manzini in the Manzini region and Mbabane in the Hhohho region. 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 39% of the population living under the international poverty line, rising to 60.4% when the 2011 PPP of \$3.20 per person per day for lower middle-income countries is used (World Bank 2019). The unemployment rate is high at 22.8% rising to 45.8% for the youth aged between 15-24 years (ILO 2019). 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 1.3%, 2.8% and 0.8% 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 epidemic

The 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. The results show that 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.

The most recent national-level statistics and projections for the HIV epidemic in Eswatini (Table 2.1.1) show a growing youth and young adult population, and an epidemic that heavily affects younger women compared to their male peers. Additional statistics show high use of ANC clinics among pregnant women, a disproportionate burden of TB cases among PLHIV (66% of all confirmed cases) and a male circumcision rate of 27%.

Table 2.1.1. Host Country Government Results

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				Source
			Female		Male		Female		Male		Female		Male		Year
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	Year
Total Population	1,140,250	100 %	210,857	18%	213,538	19%	116,133	10%	121,327	11%	250,926	22 %	227,469	20%	A. 2020
HIV Prevalence (%)		27%		2.6		3		13.9		4.1		41.2		29.9	B. 2017
AIDS Deaths (per year)	2,159		69		72		178		119		880		841		A. 2020
# PLHIV	202,608		4,961		5,066		15,230		5,073		110,290		61,988		A. 2020
Incidence Rate (‰)		1.36 %						1.87		0.79		1.84		1.5	B. 2017
New Infections (‰)	6,133														A. 2020
Annual births	27,936	100 %													F. 2017
% of Pregnant Women with at least one ANC visit	27,517	98.5 %													E. 2014

Pregnant women needing ARVs	8,909	32%																		A. 2020
Orphans (maternal, paternal, double)	114,966																			A. 2020
Notified TB cases (Yr)	2,864																			G. 2019
% of TB cases that are HIV infected	1,890	66%																		G. 2019
% of Males Circumcised	152,788	27%			42,224	20%			70,593	40%								39,971	23%	D. 2018
Estimated Population Size of MSM*	5,754	100%																		C. 2015
MSM HIV Prevalence		17.70%																		C. 2015
Estimated Population Size of FSW	14,581	100%																		C. 2015
FSW HIV Prevalence		70.30%																		C. 2015
Estimated Population Size of PWID	1,279	100%																		H. 2018
PWID HIV Prevalence	1																			I. N/A
Estimated Size of TG	119	100%																		H. 2018

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*

A. Draft Swaziland Spectrum File (2020)	E. Swaziland Multiple Indicator Cluster Survey 2014
B. Swaziland HIV Incidence Measurement Survey 2, 2016-17 For age 25+, incidence applied is for the age 15+ from SHIMS.	F. CIA Fact Book, Swaziland National Population and Housing Census 2017
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	G. PEPFAR program data and WHO TB estimates. The age and sex disaggregate estimates are not available
D. Decision-Maker's Program Planning Tool (DMPPT), 2018 end of FY17, plus FY19 program data (the total absolute number and percentage is for 10-49 year old). The absolute number and percent for the <15 is for 10-14 year old proportion as per program data. The absolute number and percent for 15-24 year old is for the 15 to 29 year old as per program data. The absolute number and percent for >25 is for 30+ years old. Percent is calculated as the coverage within the specific age group.	H. "Validating and Estimating the number of Key Population Individuals at the Hot Spot Level in Eswatini", 2018. FHI360/Linkages
	I. Not Available

However, the above prevalence rate (based on the Swaziland HIV Incidence Measurement Survey 2, 2016-2017) masks the reality of HIV infection among men. While fewer men are HIV positive as compared to women in all +15 year age categories (e.g. Three times more women are PLHIV than men in the 15-24 year age category), HIV deaths are not so different between men and women (119 AIDS related death among men compared with 178 death among women), which indicates the higher mortality among male PLHIV. This means that HIV treatment is not reaching the men as effectively as women.

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

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
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	1,400,250	27	202,608	194,135	194,037	94%	97%	362,686	22,136	17,381
Population <15 years	424,593	3	10,072	8,424	8,424	84%	90%	57,404	921	783
Men 15-24 years	121,327	4.1	5,073	4,383	4,048	80%	96%	31,484	868	391
Men 25+ years	227,469	29.9	61,988	63,238	59,014	93%	96%	74,784	7,762	5669
Women 15-24 years	116,133	14	15,230	12,339	12,289	81%	97%	87,867	4,039	3046
Women 25+ years	250,926	41.2	100,290	103,392	107,263	97%	97%	114,427	2,546	7292
MSM	5,734	17.7%	1,028							
FSW	14,381	70.3%	10,250							
PWID	1,279									
TG	119									

Sources: Epidemiological data: Draft HIV estimates 2020; Treatment and linkage data are from PEPFAR program data (Q1, FY 2020 & Q4 2019) ; Validating and Estimating the Number of Key Population Individual at the Hot Spot Level in Eswatini”, 2018

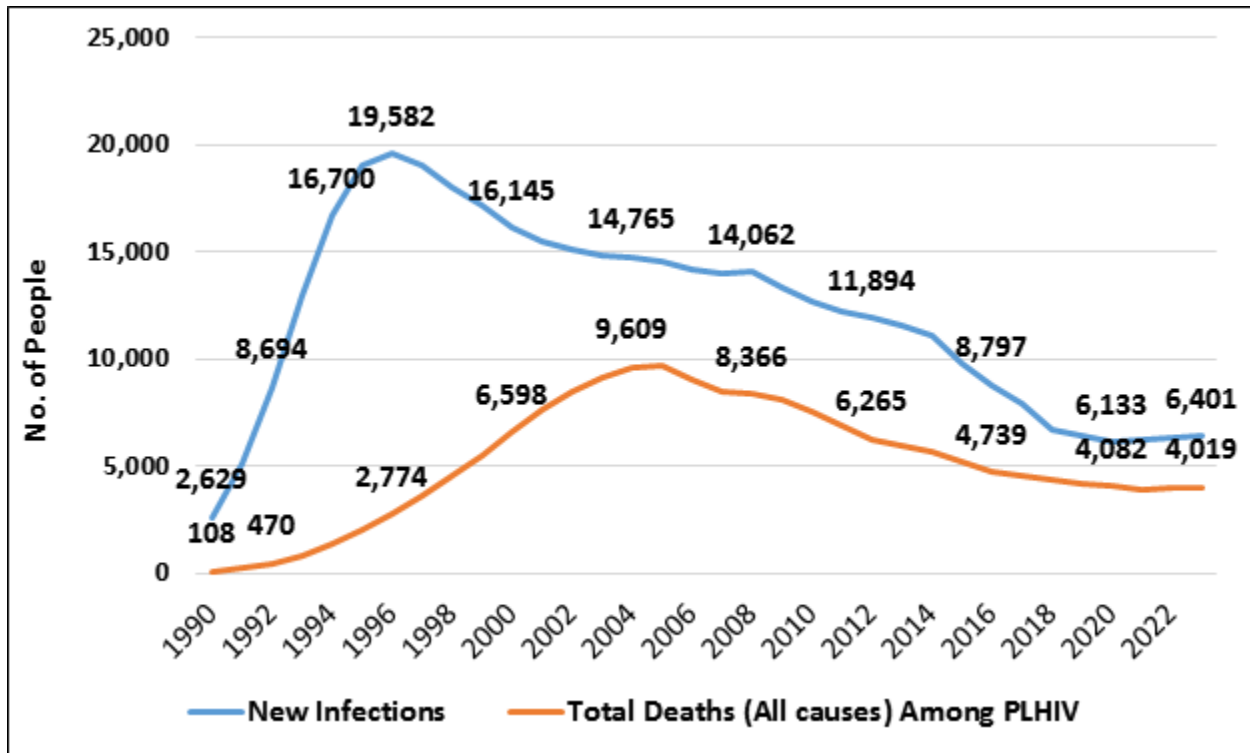
Note: The ART coverage is unconditional and VL coverage is conditional coverage.

Table 2.1.2 second column shows 2020 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. The ART coverage data shows that the treatment gap exists among the children and adolescents and young women and men with coverage ranging from 80-84%. Total ART coverage by the first quarter of FY20 was 94%, with women over the age of 25 years having the highest coverage (97%) and men aged 15-24 years having the lowest coverage (80%).

Following the initial sharp increase in the early ‘90s, new infections have declined. Total deaths for PLHIV have also declined (Figure 2.1.3), although according to Spectrum models more recent increases in mortality are due to non-AIDS related deaths as the population with HIV ages. The chart shows a leveling off of new infections suggesting that the need for robust programming to

identify and address new infections including the scale-up of PrEP. The most recent Spectrum modeling in 2020 there will be 202,608 PLHIV, 4,082 AIDS-related deaths, and 6,133 new infections.

Figure 2.1.3 Updated Trend of New Infections and All-Cause Mortality among PLHIV

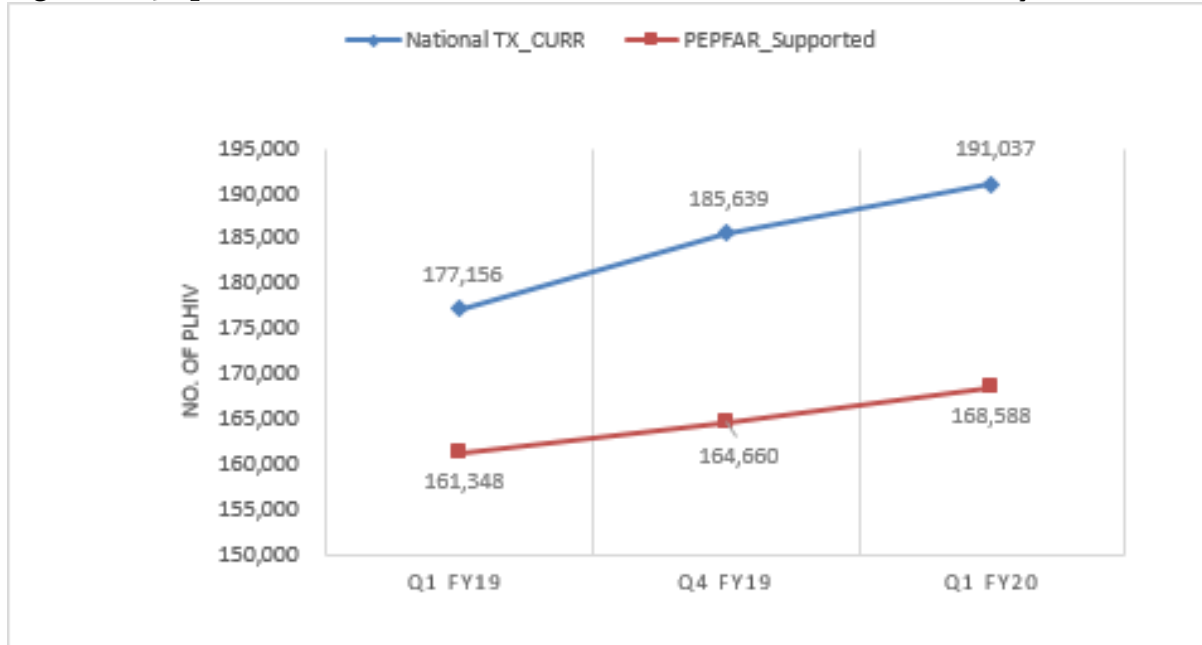


Source: PEPFAR Eswatini Spectrum 2020

HIV Program Response

Figure 2.1.4 below shows the trend over time of the total number of PLHIV compared to the total on treatment and the total that are PEPFAR-supported.

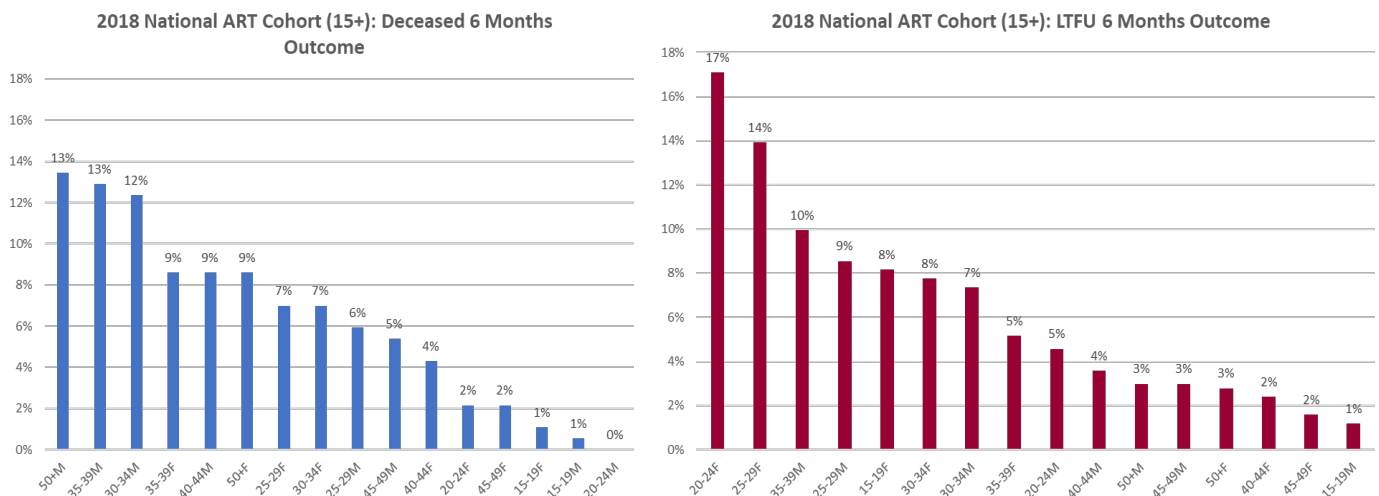
Figure 2.1.4 Updated National and PEPFAR Trend for Individuals currently on Treatment



Source: PEPFAR program data, 2020

There is a continued need to enhance our efforts to ensure the retention of patients on ART. A significant loss to follow-up (LTFU) occurs within the first year of treatment particularly among females 20-29 and males 25-39 years of age, and deaths are a big contributing factor to patient loss within the first six months, especially among men (Figure 2.1.5).

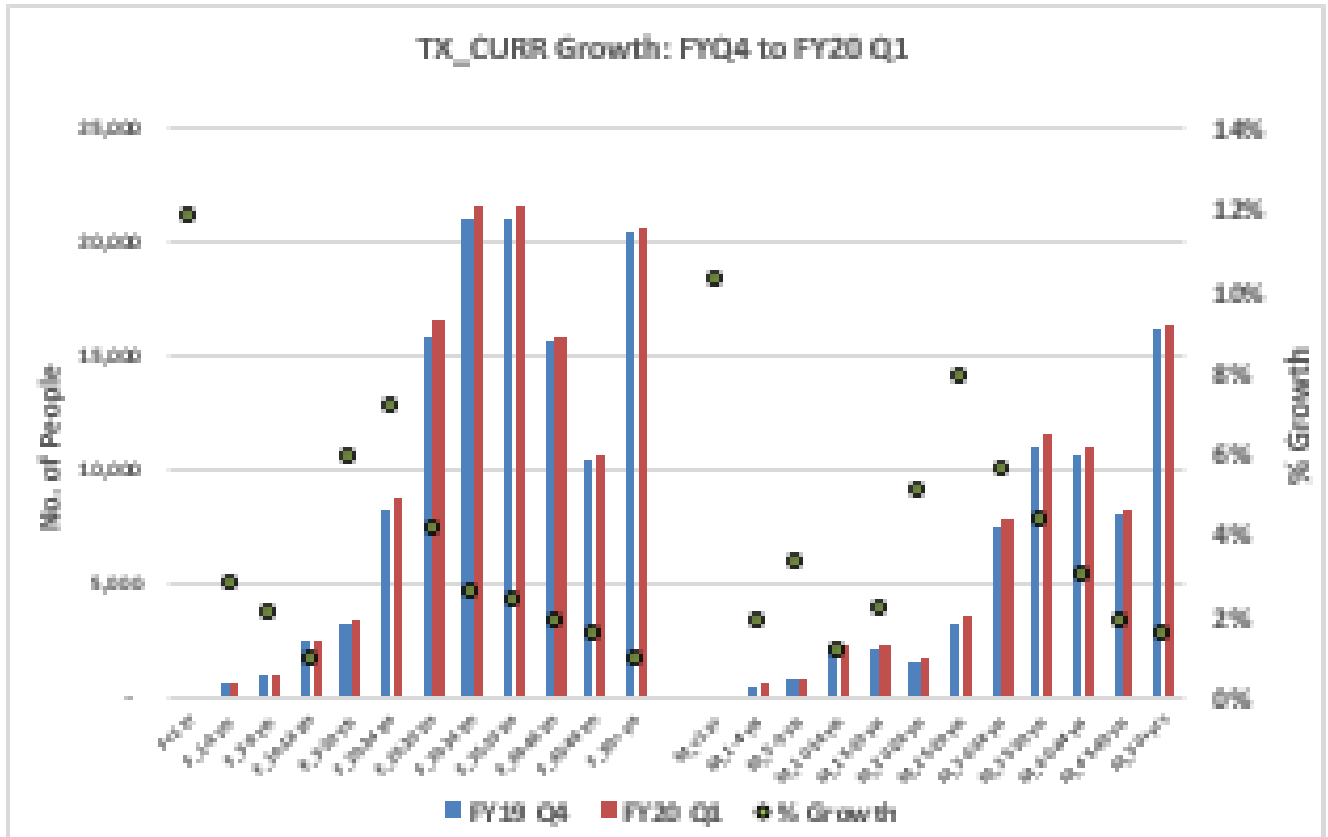
Figure 2.1.5 Clients outcomes 6 months after initiation on ART



Source: Source: 2018 National ART Cohort analysis, 2020

The early impact of the implementation of surge programming to increase case finding, linkage and retention are shown in the analysis of the first quarter of FY20 data. The PLHIV who are on treatment has been increased across all age bands with significant improvement in EID and treatment for both sexes as well as male age 25-29 and female age 20-24.

Figure 2.1.6 Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q1



Data source: National program data Q4 FY19 & Q1 2020

2.2 New Activities and Areas of Focus for COP20

Client-centered retention: COP20 focus is on improving retention and viral load suppression (VLS) for males < 40 years, children, adolescents, and AGYW by providing population-specific and client-centered services and strategically strengthening psychosocial support pre-ART initiation, through the first six (6) months to address early disengagement from care, decrease death among older men and improve the clinical outcome for children and adolescents.

Expanding geography and coverage for HIV prevention for AGYW: The DREAMS program will be expanded from 23 to 30 inkhundla targeting adolescent girls aged 10-19 and young women aged 20-29, and increasing coverage of vulnerable AGYW in these inkhundla from 50% to 77%. Layering and completion of services will be tracked in the DREAMS database using unique IDs across all implementers and sites.

Interrupting HIV transmission with pre-exposure prophylaxis (PrEP): PrEP will be scaled up significantly targeting AGYW, pregnant and breastfeeding women, KPs and men. PEPFAR will support the national PrEP program with demand creation at facility and community level, mentoring of health workers at public health facilities, and direct provision to AGYW through DREAMS on Wheels mobile clinics.

STI treatment for AGYW: With DREAMS resources, PEPFAR/E will introduce diagnostic STI screening and treatment for AGYW and their partners. STI screening and treatment for DREAMS AGYW will coincide with PrEP counseling and initiation.

Quality through community-led monitoring: From COP20, community-led monitoring will focus on improving the quality of HIV testing (with a focus on index testing); treatment and retention services, including improving service provider perceptions, attitudes and practices for improved client satisfaction at the site level. CSOs will provide service provision assessment reports to sites and a multi-stakeholder steering committee will provide oversight to patient experience monitoring and develop solutions to systemic service provision issues at the site level as informed by routine data to improve client service experience.

Ambition Funds: Through the Ambition Funding, PEPFAR/E will partner with a local faith-based organization to expand services through the public-private partnership and address the treatment gap of at-risk and mobile adults of working age in the industrial hub of Matsapha. Their unique intensified facility to community clinical outreach approach will also improve EID (specifically, PMTCT_FO), pediatric ART service delivery, and pediatric VL coverage in 6 clusters in Hhohho and Shiselweni.

VAC Study: In COP20, PEPFAR/E will support DREAMS programming by conducting a Violence Against Children survey incorporating HIV testing and oversampling 13-24-year-old age group in DREAMS SNU. The study will characterize types of violence, risk groups and perpetrators and inform PEPFAR programming for violence and HIV prevention and response strategies.

HPV trial: In COP20, PEPFAR/E will conduct HPV vaccine trial study targeting 9-24 years old females living with HIV, who have been on ART for more than 6 months and have been stable, to determine participants' immunological response to and safety of two vs three doses of the 9-valent HPV vaccine as prevention of cervical cancer.

2.3 Investment Profile

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 60.4% 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 1.3% in 2019 compared to 1.9% in 2017². A tax to GDP ratio of 15.5% and a high total non-tax revenue of 11.2% of GDP³, illustrate both challenges faced in domestic revenue generation and financial dependency on the 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 a 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 \$119,570,000 in Overseas Development Assistance in 2018⁴. 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 remains committed to protecting the gains that have been in the response against HIV and has budgeted US\$17.3 million for the procurement of ARVs for FY19/20⁵.

PEPFAR is the second largest financial contributor to the HIV response at 31%, after the GKoE which contributes 53%. GF and other donors contribute 13% and 3% respectively. 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 care, treatment and support, predominantly through the funding of adult ARVs, while GF focused support on 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 COP20, PEPFAR/E will support pediatric ARV, VL reagents (split with GF), HIV self-test kits and VMMC surgical kits. GKoE will support all adult ARVs.

PEPFAR/E also supports 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.

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

⁵ <http://www.sra.org.sz/documents/1581687723.pdf>

PEPFAR/E investments also include laboratory support, survey, and surveillance and systems strengthening (cf. CMIS, LIS, WMIS) See Section 5.0 and Appendix C, Table 6 for more information. These changes to PEPFAR/E investments reflect the evolving epidemic. COP20 sees a strategic increase in prevention activities that support the GKoE in attaining and sustaining epidemic control.

Table 2.3.1: FY19 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% Global Fund	% GKoE	Other
Clinical care, treatment and support	\$48,767,540	31%	10%	58%	0%
Community-based care, treatment and support	\$5,366,946	21%	79%	0%	0%
PMTCT	\$1,636,415	100%	0%	0%	0%
HTC	\$49,632,331	14%	0%	86%	0%
VMMC	\$4,067,751	97%	3%	0%	0%
Priority population prevention (prisons, migrant workers, miners)	\$2,585,709	42%	41%	16%	1%
AGYW Prevention	\$5,024,562	35%	0%	0%	65%
Key population prevention (MSM ,sex workers)	\$1,375,142	100%	0%	0%	0%
Orphans and Vulnerable Children	\$1,008,917	38%	0%	62%	0%
Lab and blood safety	\$9,427,367	20%	80%	0%	0%
Strategic information, Surveys and Surveillance	\$3,035,408	99%	0%	0%	1%
Health System Strengthening	\$5,976,180	57%	21%	0%	22%
Total	\$151,396,247	31%	13%	53%	3%

Source: GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD; PEPFAR Expenditure Reporting FY19, Financial Management Dossier; Global fund updated resource alignment Table 2019; Government MOH accounting System and National Lab expenditure Report 2019; Global Fund, Swaziland TB-HIV Funding landscape Table 2018 - 2020

The total FY19 HIV program investment of \$151,396,247 was funded predominantly by GKoE (53%) PEPFAR (31%), and GF (13%) (Table 2.3.1). The programs with the largest investment were HIV testing, and clinical care, treatment, and support (including ARVS), mainly due to the proportion contribution by GKoE. Other funder contributed 3% of the HIV program investment in FY19.

Table 2.3.2: Annual Procurement Profile for Key Commodities

Commodities	Total Expenditure	%PEPFAR	%Global Fund	% GKE	Other
ARVs	\$30,086,963	16%	17%	67%	N/A
Rapid test kits	\$241,012	100.0%	0.0%	0.0%	N/A
Other drugs	\$0	0%	0%	0%	N/A
Lab Reagents	\$10,009,460	0%	78%	22%	N/A
VMMC kits	\$678,788	100%	0%	0%	N/A
Condoms	\$574,263	100%	0%	0%	N/A
Viral Load commodities	\$802,078	0%	100%	0%	N/A
MAT	\$0	0%	0%	0%	N/A
Other commodities	\$927,962	0%	100%	0%	N/A
Total	\$43,320,527	15%	34%	52%	N/A

Data source: PEPFAR Expenditure Reporting FY19, Financial Management Dossier
Global fund updated resource alignment Table 2019
Government MOH accounting System and National Lab expenditure Report 2019
Global Fund, Swaziland TB-HIV Funding landscape Table 2018 - 2020

The total annual budget for commodities is \$43,320,527, with the GKE paying for 67% of the total investments on ARVs. In FY 19, PEPFAR supported 100% of rapid test kits and condoms, while the Global Fund supported 100% of viral load commodities. Lab reagent procurement was split between GF and GKE.

Table 2.3.3 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	\$1,163,800	n/a	n/a	n/a	Volunteer Support
Total	\$1,163,800				

Source: Peace Corps financial data, 2020

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

2.4 National Sustainability Profile Update

The Eswatini sustainability index and dashboard 2019 (SID 4.0) development exercise was carried out in August 2019 through a collaborative and multi-stakeholder consultative process that was coordinated by PEPFAR, UNAIDS and National Emergency Response Council on HIV and AIDS (NERCHA) under the leadership of the Prime Minister’s Office. Table 2.4.1 below summarizes the sustainability strengths and vulnerabilities that were identified and highlights the areas of focus for COP20.

Table 2.4.1 SID 4.0 Elements

Selected SID 4.0 Element and score	COP 20 sustainability areas of focus
Sustainability Strengths	
<p>Element 1: Planning and Coordination</p> <p><i>SID 4.0 Score – 9.33, dark green</i></p>	<p>The Prime Minister’s Office, through NERCHA, provides strong leadership of the HIV response in Eswatini. Since SID 3.0 in 2017, Eswatini has developed a new National HIV/AIDS Strategic Framework (2018 – 2023) and the National Health Sector Strategic Plan (2018 – 2023). A costed National HIV/AIDS Operating Plan is under development. However, participants agreed that coordination of the multi-sectoral response could also be strengthened to minimize duplication and leverage synergies among partners. In COP 20, PEPFAR will continue to support the secondment of two officers to NERCHA to facilitate NERCHA’s fulfillment of its mandate to coordinate the multi-sectoral and community-led HIV-response.</p> <p>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 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. PEPFAR will continue to participate in the finalization and implementation of the sustainability strategy in FY21.</p>
<p>Element 12: Technical and Allocative Efficiencies</p> <p><i>SID 4.0 Score – 8.16, light green</i></p> <p>Element 13: Market Openness</p> <p><i>SID 4.0 Score – 9.69, dark green</i></p>	<p>The GKoE continues to effectively analyze and utilize relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions.</p> <p>Eswatini’s government and donor policies enable fair competition and productive and non-biased participation by HIV service providers in the provision of HIV goods and services.</p> <p>The Ministry of Economic Planning intensified its efforts to coordinate all Bilateral and Multilateral Partner support to the GKoE and the Ministry of Finance continues to strengthen the enforcement of policies to ensure fair competition. The USG will continue working with the Ministry of Finance (MOF) and Swaziland Revenue Authority through technical assistance from the US Treasury Department.</p>
Sustainability Vulnerabilities	
<p>Element 6: Service Delivery</p> <p><i>SID 4.0 Score – 4.90, yellow</i></p>	<p>Health-facility level service delivery continues to be strong. The major gaps remain in the provision of consistent and high-quality community services. Although there is some community outreach, COP20 PEPFAR-support will facilitate the intensification of community outreach programs to improve patient adherence to ARVs and retention on treatment.</p>
<p>Element 10: Laboratory</p>	<p>GF, MSF, and PEPFAR support the MoH laboratory systems through HR support, implementation of a laboratory information system, QMS, procurement of laboratory commodities, and sample transportation system. Nonetheless, inadequate qualified laboratory personnel to achieve epidemic</p>

<p><i>SID 4.0 Score = 4.38, yellow</i></p>	<p>control remains a gap. The national laboratory strategic plan is still under development and although there are national health laboratory services, staffing, failure by the host government to absorb donor-supported activities and resource limitations present considerable sustainability vulnerabilities. In COP19, PEPFAR is supporting the accreditation of two laboratories through the Southern Africa Development Community Accreditation Service (SADCAS) and the implementation of the Continued Professional Development (CPD) guidelines through the Medical and Dental Council (MDC). In COP20, PEPFAR will support the ISO accreditation of the remaining three Molecular laboratories.</p>
<p>Element 8: Commodity Security and Supply Chain <i>SID 4.0 Score = 5.83, yellow</i></p>	<p>The GKoE is the primary funder of adult antiretrovirals (ARVs), an area that has continued to be prioritized despite the fiscal constraints. PEPFAR is responsible for the procurement of all pediatric ARVs and condoms. GF is the primary supporter of other lab commodities, and all three entities fund viral load reagents. Commodity management at primary facility level (clinics) remains weak and with the intensification of differentiated service delivery models, additional support will be required. In COP20, PEPFAR will continue to assist GKoE in forecasting and supply planning as well as strengthen capacity in contracting and financing.</p>

Source: Sustainable Index Dashboard, COP2020

Transition to indigenous partners

In COP20, 20% (\$8,054,799) of USAID's program budget is allocated to local organizations. This represents an increase from COP19 when funding to local partners totaled \$5,997,954 (18% of program budget). In COP 20, USAID will fund three local primes:

- The Luke Commission (TLC), a local FBO, will continue to provide comprehensive clinical services and will also engage faith-based structures for HIV case finding and violence prevention among children.
- Two local sub-grantees currently operating under Pact will graduate in FY20 Q4 to become prime award holders to provide OVC and DREAMS services in designated SNU.

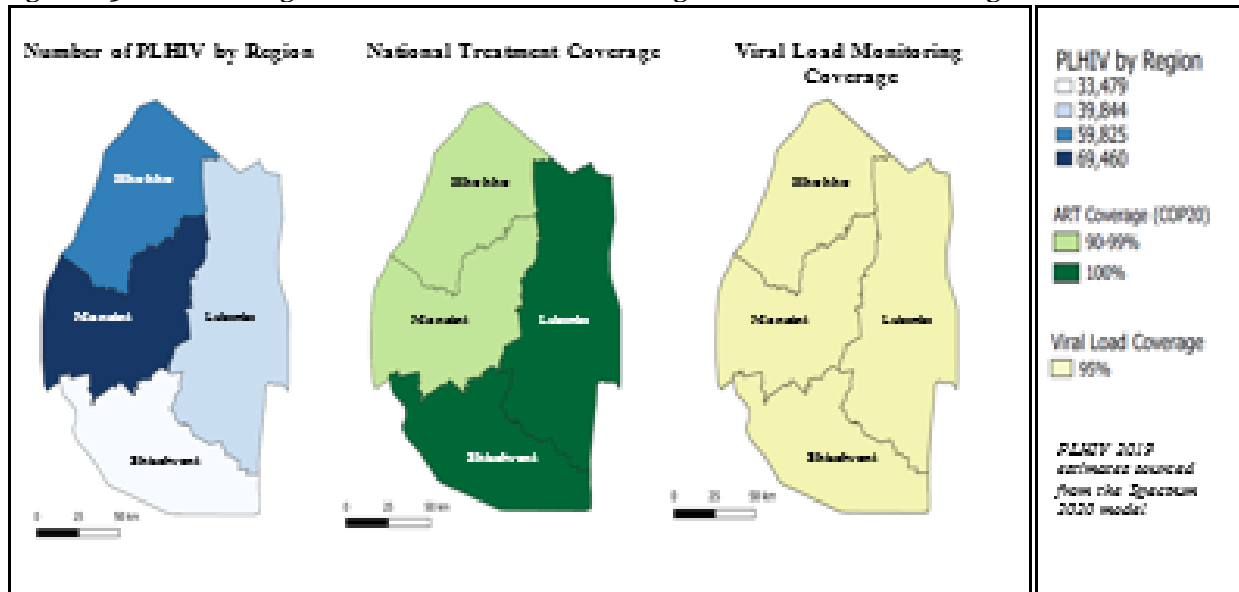
CDC is continuing its commitment to increase funding resources to indigenous partners. From COP19 to COP20, funding to local prime partners had decreased from \$3,635,517 to \$1,503,631. CDC's current prime indigenous partner is the Ministry of Health and CDC also funds many indigenous sub-awards. The major reason for this decrease in indigenous partner funding from COP19 to COP20 was that in COP19, MOH had received a significant increase in funding of \$1,897,250 to support activities related to the Faith and Community Initiative, which greatly increased the amount of funds going to the indigenous partner from COP18 to COP19. CDC has developed five new Funding Opportunity Announcements to replace cooperative agreements that will end in September 2020. We hope that this process will be used to identify opportunities to increase funding to indigenous partners.

2.5 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. COP20 will utilize real-time program data, including recency testing, to identify potential transmission “hotspots” (areas identified with high levels of HIV transmission within the past 12 months) to guide programmatic focus on subpopulations across regions. COP20 recency testing will have national coverage to enable continuous refinement of case identification and resource allocation strategies.

Figure 2.5.1 shows PEPFAR Eswatini’s targeted treatment and viral load monitoring coverage for PLHIV. Targets for COP20 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 COP20 programming focusing on responding to the particular needs or barriers at various points in the cascade for specific subpopulations.

Figure 2.5.1 COP20 Targeted PLHIV Treatment Coverage and Viral Load Coverage



SOURCE: PEPFAR Eswatini Spectrum, 2020

2.6 Stakeholder Engagement

COP20 planning process saw changes to increase stakeholder involvement. Initially the Prime Minister and select Cabinet members were briefed on the planning process and timelines. This was followed by a stakeholder meeting to review key global and country-specific planning guidance along with the program context and results. Following this Ministry of Health, NERCHA and PEPFAR leadership jointly determined membership of multi-sectoral task teams focused on Retention/Viral load suppression, Case finding, Adolescent Girls and Young Women, OVC, Key Populations, PrEP and VMMC.

PEPFAR/E provided briefings to the Prime Minister, Cabinet and Parliament during FY19 and FY20 on program progress and goals and will continue to do this during FY21. PEPFAR/E continues to meet with the senior leadership of the Ministry of Health and NERCHA monthly 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, COP Guidance and targets. In addition to participating in national-level technical working groups (TWG), PEPFAR/E also meets with Ministry of Health, Deputy Prime Minister (DPM), Ministry of Tinkhundla and Administration (MTAD), Ministry of Education, and NERCHA technical leads to discuss and agree on technical-level oversight, development of national strategies and performance management. The COP20 task teams included members from each of the above Ministries as well as Ministry of Health and NERCHA.

PEPFAR/E engages with the Ministry of Finance through visiting staff from the U.S. Department of Treasury to provide support around financial sustainability.

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) along with 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 20 planning. Four CS (Civil Society) representatives participated in the Johannesburg in-person meetings, representing PLHIV, AGYW, key populations and men. Large stakeholder meetings that included CS were held in January and February 2020 to solicit input for COP20. PEPFAR/E broadly shared information with CS about the COP20 strategic direction before 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 COP20, the PEPFAR/E small grants program will prioritize development and implementation of a CS-led platform to collect community input on HIV services. COP20 planning had several CS meetings dedicated to the planning and budgeting of the proposed platform. PEPFAR/E will also build on COP 19 engagements with FBOs to

leverage FBO structures and communities in the HIV response, particularly related to community messaging, active case-finding among men, and retention support for young adults.

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.

3.0 Geographic and Population Prioritization

The Kingdom of Eswatini has reached 95-95-95 at an OU level. The COP20 goal is to reach and sustain 95-95-95 by region, age and sex (Table 3.0).

Table 3.0 Current status of ART saturation

Prioritization Area	Total PLHIV% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	100%	191,037	4	4

Source: PEPFAR Program data, 2020

PEPFAR/E routinely analyzes epidemic patterns by age, sex and, where possible, by location (Appendix A), as well as the primary modes of transmission and underlying behavioral and structural factors among sub-populations. Continuous triangulation of treatment coverage gaps (based on the modeled PLHIV estimates) with routine program data, allows for a more informed approach to a targeted response. As such, the COP20 approach to targeting by sub-population focuses on closing the coverage gaps, but also seeks to focus on those sub-populations with disproportionate levels of recent infections, as evidenced by new programmatic recency data. These sub-populations include females 15-29 and males 20-39. Once available, SHIMS3 data will provide updated information on the population-level impact of HIV program to date and highlight the populations that continue to require greater attention and services to meet their needs. These data will be triangulated with routine program data to further support an agile programmatic approach to responding to population and geographic gaps.

VMMC coverage at the end of FY18 was 35% inclusive of all age bands. 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 over 25 year old have been circumcised. In COP20, PEPFAR/E in partnership with GoKE, will aim to scale up VMMC coverage to 80% among males 15-29 years by utilizing 15 fixed sites and an outreach clinic initiative which will expand the access to the hard-to-reach rural areas and also to populations who do not have the time to travel to a facility multiple times as a result of their work.

Geographic context

Although PEPFAR/E program coverage extends nationally, the below geographic specific information was considered during programming for COP20. An example will be the new initiative to reach the working men and women in the industrial area of Matsapha in Manzini maximizing the client-centered approach to find undiagnosed PLHIV and effectively link them to treatment and monitor the VL suppression using ambition fund.

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, where the capital of the country is located, 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.

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, it should be noted 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 eighty percent. 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 Eswatini 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 to testing, treatment, and social services. PEPFAR will continue supporting VL testing in the region through VL reagents buffer stock, mentorship and QMS activities.

4.0 Client Centered Program Activities for Epidemic Control

Table 4.0 ART Target for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	TARGET Current on ART (APR FY21) TX_CURR	TARGET Newly initiated (APR FY21) TX_NEW	TARGET ART Coverage (APR 21)
Attained	202,608	198,157	0	201,679	7,643	99.5%

Source: PEPFAR Eswatini Spectrum 2020

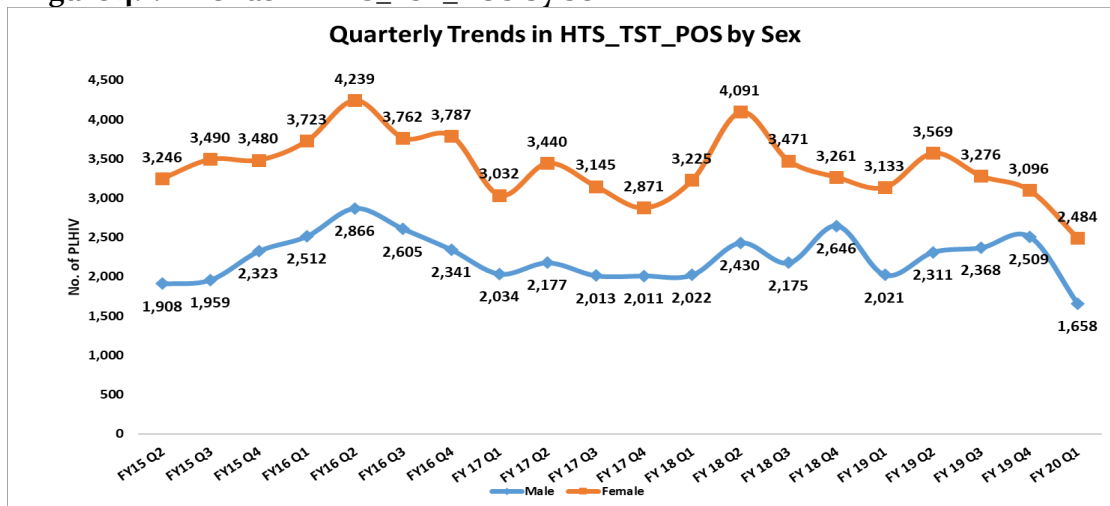
Eswatini has made significant progress and reached 95-95-95 at national level. At the end of COP18, ART coverage at the OU level was 94% of all PLHIV. In COP 20 PEPFAR targets an ART coverage 99.5% at the OU level and >90% across all age and sex disaggregates and a VLS of >95% across all age, sex and geographies. (Refer to Appendix C for current ART coverage by age/sex/geography)

4.1. Finding the missing and getting them on treatment

HIV Testing Services (HTS) in Eswatini has made significant progress in scaling up targeted case-finding strategies to all parts of the country and population groups. However, the PLHIV estimates (2019) show treatment coverage gaps amongst Females (15-24 and 35-49) and males 25-29, hence these populations still lag in HTS uptake.

Since FY 19 Q4, PEPFAR/E has been experiencing a declining trend of HIV positive cases identified across the quarters (Figure 4.1. 1) for both males and females. The decline in HIV positive cases is expected as the country reaches epidemic control. However, PEPFAR/E will continue to implement index testing with fidelity and use recency data for case identification. In FY19, PEPFAR identified 22,278 HIV positive persons, with a yield of 6%, enabling Eswatini to move even closer to epidemic control. In COP 20, PEPFAR will optimize case finding by; a) Refining PITC strategy through a specific focus on women ages 15-29 and men ages 25-39; b) continuing to scale up index partner testing, and; c) scaling up recency testing to identify populations and geographies where active transmission is occurring.

Figure 4.1.1 Trends in HTS_TST_POS by Sex



Source: PEPFAR/E program data, 2020

PEPFAR/E has continued to implement targeted testing in both facility and community using a screening tool. Towards the end of FY 19, PEPFAR/E validated the screening tools, and the tool will be revised based on the program data, addressing the gaps noted in the area of sensitivity. The tool will be applied in the OPD settings specifically at targeted age bands for men and women where program data and recency suggest that incident cases can be found.

Case finding strategies for COP20 to identifying the Remaining undiagnosed populations

In COP 20, PEPFAR will continue to implement facility index testing and refine PITC to screen the targeted population and the target age group with high proportions of recent infections. Routine site-level yield analysis and volumes will improve case finding and reduce the overall volume of testing.

With this, the yield is expected to rise, further closing the gap among positives to be identified. Community testing will focus on index testing based on follow-up needed from selected facility entry points which include ANC, TB, STI, and targeted OPD. Community testing will also include using the HIV self-test kit which will be prioritized in the KP, DREAMS, OVC, church-based platforms through the Faith and Community Initiative (FCI), and selected TB and ANC index contacts.

Routine testing in selected facility entry points

- 1. Testing for pregnant and breastfeeding mothers:** 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. The national program data also suggests that 6% of recent infections are found at ANC and PNC. In COP20, PEPFAR/E will provide HTS at ANC visits, including implementing maternal retesting at appropriate intervals in line with national testing guidelines, utilize the MNCH/PMTCT platform as a springboard for reaching male partners through secondary distribution of HIVST kits as well as index testing, and prioritize PrEP for pregnant and breastfeeding women.
- 1. Testing 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 men (15-49 years) due to the disproportionate number of men and higher HIV testing yield compared to the general population. In 2019, over 99% of TB patients received HIV testing. In COP20, 100% of TB patients should have documented HIV status. All presumptive TB patients should be offered HIV testing, and all should be investigated TB. In community TB screening services, contacts of TB patients and presumptive patients will be offered HIV self-testing kits by community health care workers. The use of presumptive TB and TB treatment registers will enable tracking of HTS services for TB presumptive and TB diagnosed patients, respectively.
- 2. Testing for STI clients:** Program data suggests high yields (16%) among STI clients but low volumes of cases identified. Moreover, the national program data suggest high proportions of recent infections amongst clients with STIs. PEPFAR/E will provide HTS to all eligible clients with STI and track sexual contacts for treatment and index testing.
- 3. Targeted OPD testing for females age 15-30 and males age 20-34 at selected sites:** The national program data suggest high recent infections among females age 15-30 and males age 20-34. For COP 20, PEPFAR/E has developed a new site list to implement targeted testing in sites that contribute 80% of the HIV cases for this age band. High volumes of recently infected

individuals are seen in OPD settings and index testing. COP20 case finding will be targeted in these age groups for OPD setting and rapid scale-up of index testing. The revised screening and risk assessment tool will also increase the OPD yield and reduce over-testing.

4. **Targeted testing among men:** Social networking strategies used in the KP program have improved case finding among men. High-risk HIV negative and HIV positive men will be recruited and trained to find other men who are at risk for HIV but have not had easy access to HIV testing services. Additionally, COP20 programming will maximize the use of expanded male-friendly services at all the designated VMMC sites, which offer VMMC, HIV testing, TB screening, PrEP, and NCDs services through health delivery approaches that attract adult men (e.g. expanded hours) and training all service providers on male-friendly service provision without requiring dedicated space or male staff.

Rapid scale-up of facility-based index testing

In COP 20, the index testing and partner notification modality will contribute at least 75% of the total newly diagnosed positives. Index testing strategies will include the following:

1. Soliciting the contacts of all newly diagnosed HIV cases identified through targeted facility-based testing in OPD, ANC/PNC, MNCH/PMTCT, TB, and STI.
2. Ensuring that newly identified PLHIVs and their biological children less than 19 years old are offered index testing services.
3. Using non-suppressed viral load registers for index testing of long-term HIV clinic clients found to have unsuppressed viral load during routine testing.
4. Mobilizing skilled index counselors/champions for elicitation to improve case finding and yield.
5. Ensuring the safety of patients through monitoring and response to all AEs of index testing⁶, including institutionalizing intimate partner violence (IPV) screening before and after index testing with proper follow-up.
6. Establishing a mentorship program for skill-sharing and capacity building
7. Using assisted partner notification methods, such as face-to-face communication, phone calls, text messages, and WhatsApp-based video messaging to improve follow up and case finding.
8. Providing reimbursement for transport to the clients who cannot come for facility testing due to financial challenges to improve HIV test uptake.
9. Following contacts in the community by the index testing team, which includes a nurse, a counselor, and an expert client, if they are unable to come to the facility.
10. Conducting community ART initiation to improve linkages, supported by the FCI community caretakers who will support members of their church.
11. Prioritizing the secondary distribution of HIV Self-Testing kits to PLHIV who refuse to bring their partners for index testing.

⁶ Certification will only be for KP sites based on OGAC guidance and PEPFAR/E will not be able to certify sites for the general population index testing implementation.

Minimum Program Requirement for Index testing safety

1. **Client-centered case finding:** Index testing implementation will be guided by the WHO 5Cs principles (informed consent, counselling, confidentiality, correct test results and connect to HIV prevention or treatment). HTS providers will be provided with trainings on index testing procedures including adherence to the WHO 5Cs principles, and close supportive supervision and mentoring will be offered by IPS.
2. **Monitoring and improved communication:** In COP19, PEPFAR/E will adapt HQ monitoring tools, which include tools for investigation reports of adverse events, and counselors will be trained on IPV and reporting procedures. Index testing counselors will be offered weekly and monthly opportunities to share best practices on client safety and counselors who experience burn-out and inability to cope with index testing challenges will be taken back to their regular counselling duties. To improve communication, civil society representative will be invited to the HTS technical working group to report and guide on better way to improve index testing in the country.

Facility and Community Index Testing and Linkages Approach

Facility and community index testing and linkages to treatment will be streamlined and strengthened using the following approach during COP20.

At the facility, skilled index counselors and Expert Clients (ECs) will be placed at OPD, ANC, TB and STI entry points. Counselors will screen and test clients attending services at these entry points. Clients assessed and at risk of HIV will be tested and index contacts, who are mainly sexual contacts and biological children under age 19, will be solicited by the skilled counselor. Newly diagnosed HIV positive clients will be referred to an EC who will also be stationed at the facility. The EC will offer psychosocial counseling and escort the clients to the ART site for initiation. EC will further solicit sexual contact of the same cases to increase the elicitation ratio. Solicited contacts will be tested in facility or community based on the notification approach. HIV negative clients will be linked to VMMC and PrEP by EC within the facility.

At the community, with a consolidated list of contacts who cannot come for facility testing, community counselor and ECs will initiate contact tracing and testing in the community. ART and PrEP will be offered in the community to all eligible contacts. Referrals to treatment, VMMC and PrEP will be sent to facilities from the community. A referral list is used to track clients referred from communities.

Case Finding Strategies for Key populations (KP)

Key populations are an important sub-population for sustained epidemic control. In COP 20 PEPFAR/E will utilize the findings of the IBBS to identify the gaps in HIV case finding and treatment outcomes for all KP. Recency testing will also provide information on where new infections are occurring so that programs can target areas and populations to get them into treatment and address the issues that propel the infections in these areas with prevention interventions.

KP program will intensify case finding efforts through KP networks, social media, and trained KP outreach workers to identify KPLHIV, link and retain them in treatment. Targeted case finding using a refined risk assessment that improved yields in COP18 and 19 as demonstrated by Q4 and Q1 data will continue. Self-testing will be optimized with intensified follow-up using social and risk network approaches to improve case finding. Case finding efforts will also actively link HIV negative KP to PrEP and other prevention and support services.

Quarterly Enhanced Peer Outreach Approaches (EPOA) will be maintained as an effective model to bring KPs who have not previously accessed HIV services into the program, producing both high volume and yield. The methodology is linked to positive seeds from newly diagnosed KPs and elicits both indexes⁷ and other higher-risk networks of KPs. Online programming will be optimized building on COP19 achievements to find KPLHIV who may not be found through the other strategies.

Based on feedback from sub-populations among the KPs, continuous adjustments will be made to the modalities that are most appropriate and effective to reach different types, ages, and other contextual factors related to different segments of KP.

2. Linkage to ART

The majority of the client's initiates on the day of diagnosis with a higher proportion of community clients unlinked compared to at the facility. In FY 19 the country adopted the linkages case model, whereby ECs physically escort HIV clients for ART initiation and follow up clients to ensure proper linkages to ART. In FY20Q1, Eswatini has achieved 80% linkage of newly identified HIV cases to treatment. In FY 19, the MOH rolled out ART initiation at the community level to improve same-day ART linkages. For COP 20, to more effectively reach out to the diagnosed but unlinked population, the program will bring to scale some key interventions to further boost linkage rates to achieve 95% by:

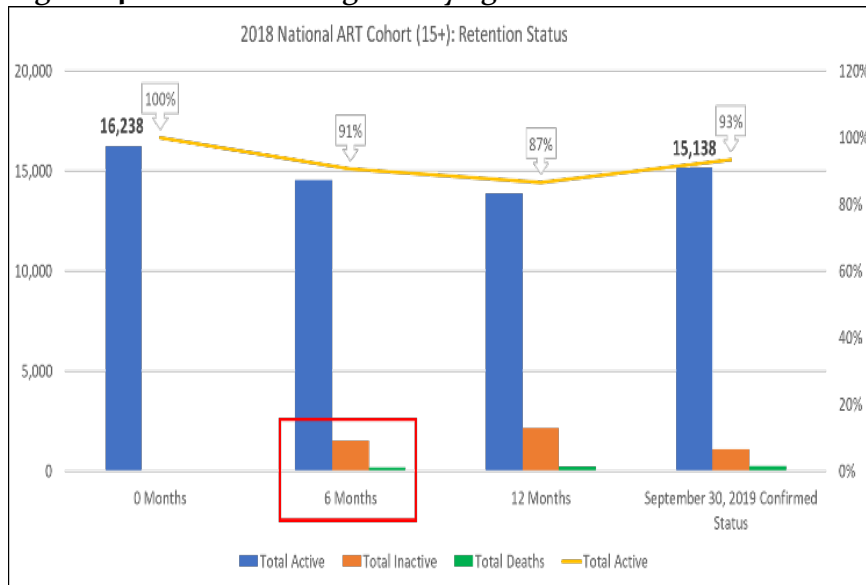
1. Implementing patient readiness tools to address patient-level barriers.
2. Provide pre-treatment VL testing for clients who feel well and not ready to start treatment with enforced messaging on the benefits of treatment and U=U (Undetectable viral load means Untransmittable)
3. Scaling-up treatment literacy and community-based support including online platforms and community-support groups to address stigma and communicate the benefit of HTS and early treatment, U=U messaging, and the availability of new, safer and convenient regimens.
4. Using the FCI platform to provide ongoing support in communities including identifying the diagnosed unlinked PLHIV to seek care.
5. Rolling-out and enforcing commART as a standard of care, including a 14-day starter pack for all community testing partners in all SNUs.
6. Implementing the linkage case model for up to 6 months to improve adherence, ensuring bidirectional linkages between facility ECs and community service providers.
7. Establishing an escalation structure for ECs to refer challenging cases to psychologists and social workers.
8. Accelerating linkage strategies specific for men such as; promotion of VMMC male-friendly clinics with male comprehensive services including ART initiations; use of peer navigators to escort from testing to ART sites.
9. Strengthening linkage for HIV positive children by promoting Mother/Baby pairs approach and supporting Community Mentor Mothers.

⁷ Note that index case finding has been suspended and will only be reinstated following certification and assurance that no human rights violations occur.

4.2. Retaining clients on treatment and ensuring viral suppression

As mentioned in the earlier part of the SDS, significant LTFU happens within the first year of treatment, what is most concerning is the early disengagement from care especially among females 20-34 and males 25-39 years of age (Figure 4.2.1 & Table 4.2.2), as well as deaths especially among men in the first six months of treatment as shown in earlier Figure 2.1.5. This early LTFU contributes to sub-optimal ART coverage and VLS in these age groups. Adolescents and youth age 10-19 years also show the early disengagement from care indicating the challenge in transitioning to adult care. Although small in number thus smaller contribution to the overall attrition rate, children also have lower retention, VL testing coverage and VLS.

Figure 4.2.1: LTFU timing and by age and sex



Source: 2018 national ART cohort analysis & DATIM FY20 Q1 TX_ML analysis

Table 4.2.2: Cause of Attrition by age and sex

Age	Died		LTFU 3+ Months Treatment		TX_ML LTFU <3 Months Treatment		Refused Stopped Treatment		Transferred Out	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
<01	0.0%	1.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
01-04	0.0%	1.5%	0.5%	1.7%	0.0%	2.2%	0.0%	0.0%	0.4%	5.8%
05-09	0.0%	1.5%	0.9%	0.9%	0.0%	0.0%	0.0%	0.0%	0.9%	2.4%
10-14	0.0%	0.0%	2.4%	2.6%	0.0%	0.0%	0.0%	7.1%	0.6%	2.9%
15-19	0.0%	1.5%	7.1%	6.0%	14.7%	6.7%	0.0%	7.1%	4.6%	2.9%
20-24	7.2%	3.0%	17.9%	5.2%	22.1%	2.2%	17.1%	0.0%	14.0%	5.3%
25-29	11.6%	3.0%	25.5%	6.0%	20.6%	22.2%	9.8%	14.3%	21.0%	10.6%
30-34	15.9%	12.1%	20.8%	12.0%	19.1%	35.5%	26.8%	17.9%	21.6%	16.9%
35-39	20.3%	9.1%	10.4%	20.7%	2.9%	4.4%	14.6%	21.4%	16.2%	13.5%
40-44	11.6%	9.1%	6.1%	17.2%	14.7%	11.1%	9.8%	10.7%	9.8%	12.1%
45-49	11.6%	15.2%	2.8%	9.5%	2.9%	13.3%	4.9%	7.1%	4.2%	10.1%
50+	21.7%	42.4%	5.2%	17.2%	2.9%	2.2%	17.1%	14.3%	6.5%	17.4%

Source: 2018 national ART cohort analysis & DATIM FY20 Q1 TX_ML analysis

PEPFAR/E will continue to support the roll-out of differentiated service delivery models for HIV care and treatment. Currently, 38% of all PLHIV are on DSD models with the remaining patients on what is considered mainstream service delivery approaches which include 3-months dispensing and monthly reviews for clients who are on ART for more than 6 months. The goal of a differentiated service delivery model is to bring the service closer to clients by ensuring seamless service delivery between communities and health facilities. During COP20, PEPFAR/E will mobilize peers in the facilities and communities (e.g. Expert Clients (ECs), peer navigators for youth and KPs) to achieve successful bidirectional referrals to improve linkages between communities and facilities and enhance the community-based support system to strengthen retention. The MOUs between the facility-based partners and partners implementing FCI, DREAMS, and the programs supporting community-based groups will also institutionalize strong bidirectional referrals. This approach will fast-track to reach the target of 80% of PLHIV receiving DSD services including 6 MMD by the end of COP20.

To address early disengagement from care especially among females 20-34 and males 25-39 years of age, PEPFAR/E will:

1. Strengthen patient preparation before ART initiation, including the use of patient readiness tool at ART initiation to address patient-level barriers to improve long term adherence retention in care.
2. Repurpose expert clients (ECs) previously deployed to support linkage case management (LCM) at facilities and communities to support retention. ECs will provide adherence and psychosocial support to newly initiated patients through the first 6 months of treatment.
3. Add social workers and psychologists which will provide higher-level support to ECs in the management of challenging cases specifically strengthening pediatric and adolescent services
4. Enhance treatment literacy and community-based support including online platforms and community-support groups will strengthen retention overall by highlighting benefits of ART, early ART initiation, availability of new and better regimens, and VLS. The treatment literacy and community support will also address concerns of the HIV positive clients who remained unlinked to care and prompt them to seek treatment.
5. Strengthen facility referrals to community platforms including FCI, traditional and outreach services to provide ongoing support in communities.

To address poor retention and VLS among adolescents and youth, PEPAR/E will:

1. Provide AGYW friendly corners and/or staff (nurses and peer navigators) in selected sites with high volumes of adolescents and youth. They will provide clinical services including SRH, PrEP, STI screening and, ART services as well as referral to DREAMS for vulnerable AGYW
2. Implement a package for transitioning youth to adult care. This will include; six-months MMD, extended peer-support up to 6-months after the ART initiation; community-based support; and referral to community services such as Safe Spaces.
3. Support peer navigators in selected facilities and communities to strengthen facility referrals to community platforms including DREAMS, FCI, traditional and outreach services to provide ongoing support in communities, especially for adolescents

High mortality among men is driven by the men who present late for treatment with advanced HIV disease. This includes men ages 30-34 and men older than 45 years. The presence of opportunistic infections, other comorbidities and increased risk for Immune Reconstitution Inflammatory Syndrome (IRIS) lead to the high mortality observed in this population. These risks among men were increased due to the suboptimal clinical management of men with advanced HIV disease as well as the lack of focus in the public health systems on men's health issues.

To address early and high mortality among men, PEPFAR/E will:

1. Aggressively implement the advanced package of care targeting men over 30 years old. The use of TB-LAM and other testing tools to diagnose and treat OIs early as well as providing presumptive treatment for cryptococcal meningitis and TPT will reduce mortality.
2. Scale-up comprehensive Men's Clinics that provide holistic services targeting men including HIV clinical services, screening and treatment for NCDs, VMMC and provision of PrEP and advanced package of care. This approach has been proved to improve the uptake of services among men. A comprehensive approach to men's health will ensure comorbidities are managed appropriately to reduce adverse outcomes.
3. Improve the clinical management of patients with advanced HIV and comorbidities
4. Scaling up 6-MMD to free up clinicians to focus on clinical patient management
5. Characterize clients who die early and focus interventions appropriately
6. Enhance treatment literacy and community-based support to address the importance of HTS, early treatment, new regimen and VLS.
7. Reach and identify men using index testing and the strengthened facility and community referral platforms including FCI, traditional and outreach services to bring men to testing, treatment and care.

In addition, to improve retention in care and VLS, PEPFAR/E will implement the site level standards for linkage and retention. These will be monitored and reported quarterly by implementing partners and monitored by USG staff as part of partner management. Reports will be shared with stakeholders through the Care and Treatment TWG. This data will be triangulated with findings from the community monitoring platform to improve services.

a. Treatment strategies for specific population

Treatment targeting children and adolescents

PEPFAR/E will improve linkages to the treatment of C/ALHIV through strengthening same-day ART initiations, linking case management and placing social workers/psychologists. At the end of FY20, PEPFAR/E would have transitioned all C/ALHIV on NNRTI-based regimens to optimal ART regimens in line with WHO recommendations. The program is also currently in the process of transitioning C/ALHIV currently on the liquid formulation of LPV/r to solid formulations (granules). PEPFAR/E will continue exploring the possibilities of introducing new pediatric regimens and formulations as they become available such as DTG-based formulations for children weighing less than 20kg. In addition, the program will also expand the Family-Centered Care Model (FCCM), a DSD model where children are seen together with their parents (or caregivers) at health facilities as one unit.

The program will scale up and strengthen the use of VL DBS to improve viral load coverage among C/ALHIV on treatment. PEPFAR/E will also improve viral load coverage through leveraging Ambition Funds to provide community based pediatric VL phlebotomy services for children who miss their clinic appointments. COP20 will see improvement in caregiver's literacy and education on the importance of early linkage to treatment, optimal ART regimens/formulations, and VL testing. Working through implementing partners and disclosure consent process whereby families consent to community referrals, PEPFAR/E will offer 90% of all C/ALHIV on treatment the enrollment into the OVC program.

Treatment targeting Key Population

To increase retention among KP, PEPFAR/E will

1. Implement an intensive case management approach for initiation and retention. Once stable on ART, clients will receive continued support through maintenance case management.
2. Maximize the use of KP-led community centers (drop-in centers equivalent), and 'pop-up' sites which provide safe, convenient and quality spaces to improve same day initiation, offer drug refills and retention support.

Treatment targeting pregnant and breastfeeding mothers

In COP20, PEPFAR/E will implement a number of strategies to improve retention and viral suppression among pregnant and breastfeeding women. These approaches will include:

1. Leveraging existing community and facility structures to strengthen mother-baby pair cohort monitoring through the end of breastfeeding
2. Scaling up and routinely offering PrEP to HIV negative pregnant and breastfeeding women
3. Sensitizing and educating pregnant and breastfeeding women to generate demand for VL monitoring
4. Supporting mentorship and supervision through implementing partners to ensure appropriate documentation of pregnancy or breastfeeding status on VL requisition forms
5. Scaling up DSD models for pregnant and lactating women such as MBP clubs and pregnant adolescent groups
6. Leveraging Ambition Funds to support intensive community follow-up of HIV-exposed infants (HEI) for determination of PMTCT final outcome (PMTCT_FO).

b. Viral Load testing and Early Infant Diagnosis (EID)

HIV-exposed infants face a higher risk of morbidity and mortality than HIV-unexposed infants. Retention of the mother and infant in care throughout the breastfeeding period is critical to reduce morbidity and mortality among those infants and to ensure prompt diagnosis and ART initiation among those infants who acquire HIV infection during breastfeeding.

PEPFAR/E programs have reached the goal to achieve testing over 90% of HIV-exposed infants by age 2 months and aim to link 95% of infected infants promptly to treatment.⁸ In the context of very high EID coverage, PEPFAR/Eswatini did not prioritize POC EID.

In COP 19, PEPFAR completed the VL testing network optimization of conventional platforms by replacing Biocentric with Panther in Shiselweni, installing one Panther and high capacity Roche 6800⁹ at National Medical Regional Lab (NMRL) in Hhohho and equipping CAP/CTM in Manzini and Lubombo. This completed the full regionalization of VL testing.

⁸ EID testing coverage in "FY 2020 COP Guidance for All PEPFAR Countries" PEPFAR Eswatini COP20 outbrief slide on PMTCT shows 94% coverage among infant with HIV on treatment

⁹ The WHO recommendations to repeat testing of all indeterminate results to avoid errors in test results classification is currently feasible only with Roche platforms for which the indeterminate range has been established (FY 2020 COP Guidance for All PEPFAR Countries)

The Roche 6800 platform can also process EID samples, further increasing testing capacity and coverage which eliminates the need for VL POC. The placement of the high capacity VL machine at NMRL will free up CAP/CTMs to be dedicated to EID if needed and decentralize EID testing to further improve results turnaround time.

DBS/VL testing targeting all age groups was introduced in COP19¹⁰ and will be further scaled up to all sites in COP20 including rural sites that are only accessible by the national transport system, and to increase access to VL testing for all age groups including pediatric VLC.

Further efforts to decrease the gap in VL testing results turnaround time are initiated in COP19 and will be scaled up in COP20. Those efforts include the M-Health SMS system, which sends client's VL result availability message from Lab Information System (LIS) directly upon authorization by the lab and improved LIS/CMIS interoperability which will ensure that every VL result is linked to the right client to improve the calculation of VL coverage.

c. Community and male engagement

Robust engagement of local government, traditional and faith leaders, and men in the comprehensive HIV response supports the strategic shift towards effective targeting of men across the entire cascade particularly focusing on their treatment retention to address early disengagement and death for PLHIV and the prevention of new infections among HIV negative males. Also, these leaders and engaged men have important roles to play in supporting DREAMS programming and addressing teen pregnancy and sexual and gender-based violence.

In COP20, PEPFAR/E will continue strengthening the multi-sector response through local government (Chieftdom and municipal structures) in 30 DREAMS tinkhundla as well as at Regional and National levels. With an aim towards sustainability, PEPFAR/E will transition this critical support from an international partner to more efficient support to NERCHA and the Ministry of Tinkhundla. PEPFAR/E will build on its investments in the Community Data for Action Platform (CDAP) and will continue to support chieftdom, municipal, and regional leaders to use data to lead and coordinate the multi-sector HIV response. Over the past two years, PEPFAR/E has trained and mentored these chieftdom structures to analyze epidemiologic and contextual data, develop community profiles, and local HIV action plans with measurable targets. The GkoE will also work to leverage the Global Fund and the World Bank to expand support to other tinkhundla.

Eswatini is deeply rooted in its culture. Traditional structures and leaders are highly respected. These leaders can mobilize their populations for action and are also able to effectively shape social and gender norms and address harmful practices. Besides, these respected leaders are effective advocates for communicating key HIV prevention, treatment and retention messages such as VMMC, PrEP and U=U. 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 for a sustainable HIV response, as well as to provide them with male-friendly health and HIV services.

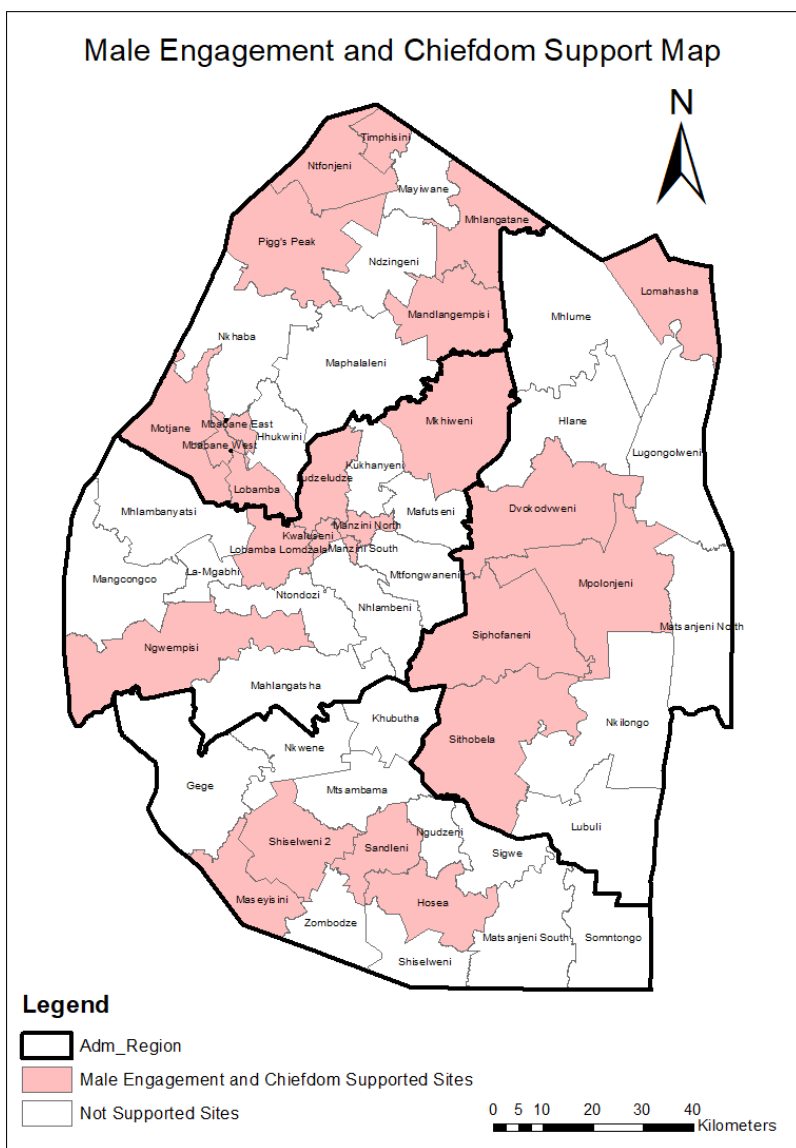
In the 30 tinkhundla that are also DREAMS tinkhundla, PEPFAR/E will bring together, the chieftdom support, DREAMS interventions (including mobile outreach services), as well as critical HIV prevention, treatment and retention services to communities and especially for men. This will include:

¹⁰ DBS/VL testing targeting under 5 years old was started in COP17.

1. Mobilizing and engaging the traditional and faith community leaders and men in the response to increasing uptake of testing, treatment, prevention (PrEP, VMMC) and condoms.
2. Targeting and disseminating key messages about HIV testing, linkage to treatment, prevention and retention;
3. Building demand for and providing male-friendly services including the confidential comprehensive HIV services
4. supporting and strengthening retention and adherence
5. Promoting positive masculinity

The below map shows the coverage of community and male engagement

Map 4.2.4 Coverage of community and male engagement



Data source: Johns Hopkins, Breakthrough Action / HC4

4.3 TB/HIV program

ART provision and viral suppression for TB/HIV co-infected patients

ART coverage was at 98% nationally (WHO report 2019) compared to 95% across PEPFAR supported sites (APR 2019) and the discrepancy is mainly attributed to deferred ART initiation for unstable patients, delays in updating records at the time of PEPFAR reporting, data collection date falling before the timely initiation, and early death before ART initiation.

To ensure that 100% of HIV-positive TB patients receive ART, PEPFAR/E will support:

1. To ensure that TB treatment is close to potential and existing ART clients by expanding the integrated service delivery model and supporting TB BMU accreditation scale up for all ART sites.
2. Implementing site-based quality improvement activities to identify and address the underlying causes of non-timely ART initiation such as clients' refusal and mortality
3. Integration of non-communicable disease screening, application of lessons from mortality audits and reviews that aim to reduce mortality among TB patients through improved quality of clinical care.¹¹

To ensure that TB/HIV co-infected patients are durably virally suppressed, PEPFAR/E will continue to strengthen the use of efficient regimens including dolutegravir to ensure viral suppression and successful treatment outcomes, and the support to clients who require second- and third-line ART regimens will receive appropriate ARVs. Provision of advanced disease package, including screening for Cryptococcus to patients who fail ART and have low CD4 counts, will also be scaled up and decentralized.

TB Preventive Therapy

Figure 4.2.3 TB screening, TPT uptake & completion FY19 Q4

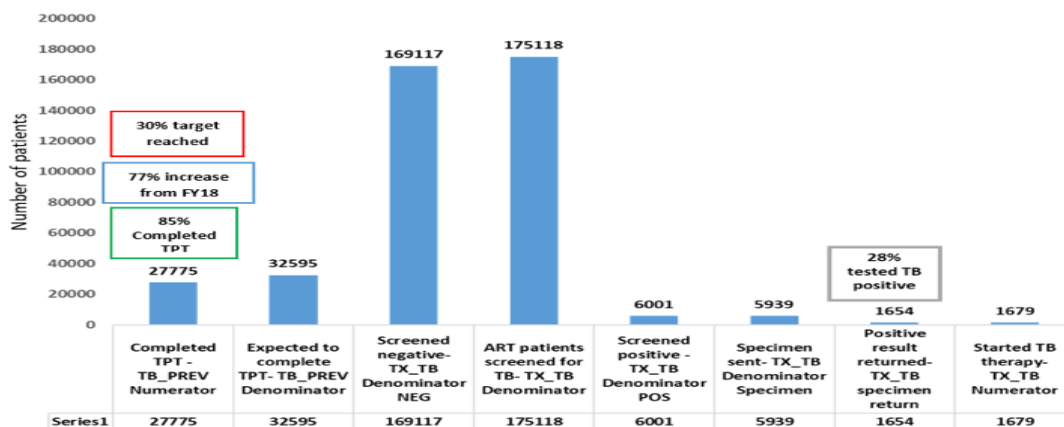


Figure 1: TB screening, TPT uptake and TPT completion FY19 Q4

Source: PEPFAR Program data

¹¹ Decentralization of CD4 PIMA, TB LAM and serum CrAg to baby clinics is part of reducing mortality for TB patients as some die of OIs related to advanced HIV disease

TB screening is part of the standard of care for PLHIV. TB preventive therapy (TPT) is provided routinely at all sites but is not at scale. The barriers to full scale-up of TPT include provider hesitancy to offer services due to fear of adverse events, pill burden by patients, and stock ruptures. Completion rates are high at 85% (Figure 4.3.1).

PEPFAR/E will provide support to implement the following among all eligible PLHIV (both newly enrolled on ART and already on ART) :

1. Early TPT initiation: Eswatini guidelines allow patients to initiate TPT at one month after starting ART. The successful implementation of Test and Start provides an opportunity for starting TPT even earlier for stable ART patients who screen negative for TB. Patients who screen positive should undergo TB testing procedures with Xpert Ultra and immediately start TB treatment if diagnosed with TB.
2. Integrating TPT activities in the existing DSD models, including efficiently aligning and harmonizing TPT provision with multi-month dispensing to optimize TPT uptake.
3. Addressing existing major barrier to TPT uptake:
 - a. Provider hesitancy due to fear of Adverse Event (AE)
 - Support MOH to train providers, strengthen ADR reporting, data analysis, strategic feedback channels and guidance to health facilities following serious ADRs.
 - b. Complaints of pill burden by patients:
 - Scale-up of fixed-dose combination of INH/Pyridoxine/Co-trimoxazole targeting new ART patients and those with low CD4 counts
 - Scale-up use of shorter-term regimen of 3-HP fixed dose combo
 - Adopting 1-HP depending on availability and relative costs;
 - c. Stock ruptures of TPT commodities:
 - Support MOH in procuring FDC alternative regimens for TPT
 - Supporting MOH with forecasting and procurement of TPT commodities including pyridoxine
 - Procuring child-friendly formulations. Additionally, shorter-term regimens for HIV-negative children of PLHIV with contact to TB patients will be supported.
4. Conducting an intensive and focused review of existing client records to identify all ART patients eligible for TPT to facilitate successful implementation of TPT 'mop up' activity necessary to achieve full TPT coverage in COP20

TB case detection and TB treatment among PLHIV

Eswatini has experienced a continuous decline in TB case notifications from 11,057 in 2010 to 2,649 in 2019. This is largely due to enhanced TB/HIV collaborative activities especially the use of gene Xpert platform for early case detection of TB and ART expansion which has resulted in the burden of HIV among TB patients decreasing from 82% in 2010 to 66% in 2018 according to Eswatini annual program reports.

WHO estimated an 80% TB treatment coverage rate for Eswatini in 2018. Although this is increasing, more effort is required to support the National TB Program (NTP) to identify all TB cases, register them, initiate them on appropriate TB treatment and prevent further transmission of TB in communities. A recently completed TB drug resistance survey showed that isoniazid mono-resistant TB patients are missed using GeneXpert and MGIT culture techniques due to the prevalent Ile491Phe mutation in Eswatini. Germany Ministry of Health will support Eswatini to establish TB genomic sequencing to identify the Ile491Phe mutation and PEPFAR will collaborate to ensure the success of this initiative. In

COP20, PEPFAR/E through its implementing partners will support MOH to increase TB case detection and provide appropriate TB treatment through the following:

1. Routine Screening all ART patients for TB using WHO-approved screening tools.
2. Providing TB screening for TB affected key populations such as miners and those in congregate settings according to the existing national policies.
3. Scaling up to more sensitive Xpert Ultra as the TB testing platform to maximize case identification.
4. Supporting Eswatini conduct TB sequencing to decrease the number of missed TB cases due to Ile491Phe mutation.
5. Conducting TB index case procedures for TB screening of families and people who are contacts of TB patients.
6. Decentralizing point of care TB lipoarabinomannan (TB LAM) test for HIV patients who are seriously ill and decentralizing CD4 PIMA for those who have a CD4 count of fewer than 200 cells/ml.
7. Immediately starting TB treatment for people living with HIV with an Xpert Ultra result of “Trace Call”.
8. Supporting MOH procure child-friendly TB medicines.
9. PEPFAR/E set aside \$65,000 to support the national TB reference lab improve its diagnostic capacity to identify different forms of TB.
10. Support MOH to ensure that all TB cases identified in-patients are registered

Eswatini awaits the dissemination of the TB prevalence survey conducted in 2018/19 which will contribute to the precise estimation of the country’s TB burden.

4.4 Prevention programs for priority programming:

The following tables provides the PEPFAR/E programs' target and coverage for COP20 by the target population and geographic area.

Table 4.4.1 Target Population for Prevention Intervention to Facilitate Epidemic Control

Target Populations	Population Size Estimate [†]	Coverage Goal (in FY21)	FY21 Target ^{**}
AG 10-19*	104,619	26%	27,072
YW 10-29*	88,767	40%	35,549
PSW	14,581	71%	10,284
MSM	5,754	55%	3,152
PWID	1,279*	13%	164
TG	119*	92%	110
TOTAL	21,335	64%	13,710

*Represents DREAMS SNUs only

**AGYW targets reflect PP_PREV targets. KP targets reflect KP_PREV targets.

†AGYW population size is sourced from census population projections for 2020. KP population sizes are based on the 2016 IBBS.

Source: * "Validating and Estimating the number of Key Population Individuals at the Hot Spot Level in Eswatini", FHI360/LINKAGES, 2018

Table 4.4.2 Targets for OVC and Linkage to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target)
Hhohho	107,818	17,092	14,350
Lubombo	101,483	19,672	16,323
Manzini	73,350	19,161	16,000
Shiselweni	72,698	11,439	9,466
TOTAL	355,349	67,364	56,139

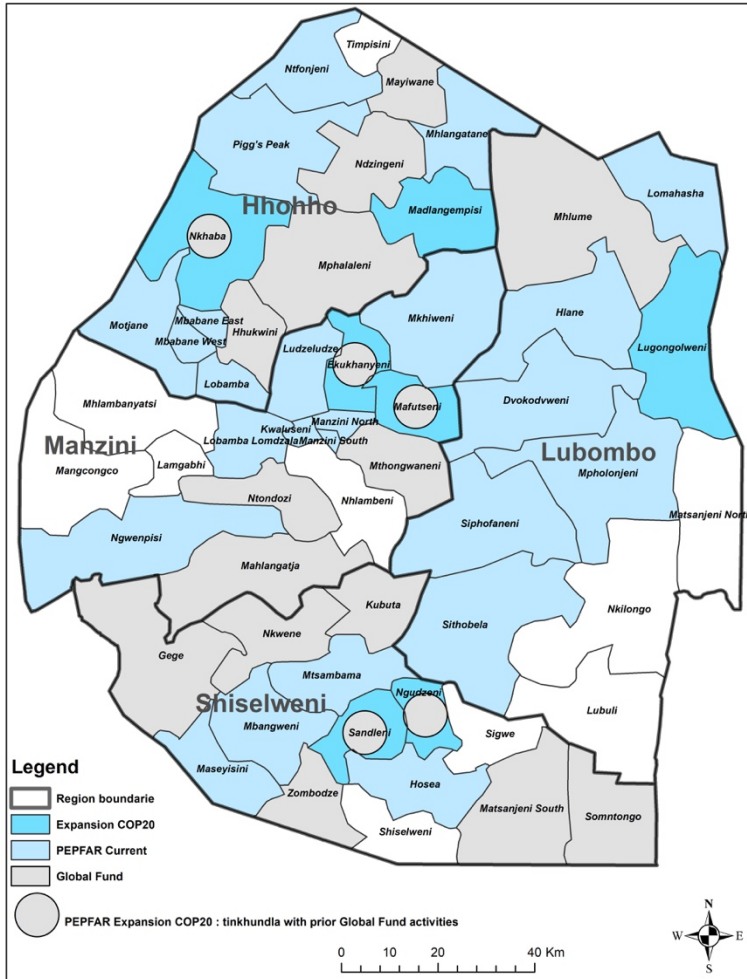
Source: PEPFAR Program data

a. HIV prevention and risk avoidance for AGYW and OVC

1. Adolescent Girls and Young Women (AGYW)

The following map shows the PEPFAR/E DREAMS program coverage change between FY20 and COP20.

Map 4.4.a COP20 Program Coverage for Adolescent Girls and Young Women Program



Data source: USAID

In line with the priorities for DREAMS listed in Eswatini's COP 20 PEPFAR Planning Letter, PEPFAR/E will implement the following:

Interagency expansion into new districts with increased DREAMS funding

Eswatini has been delivering the DREAMS package of services to AGYW aged 10–29 in 23 tinkhundla across all 4 regions. In COP 20, DREAMS will expand to an additional 7 tinkhundla (2 in Hhohho region, 2 in Shiselweni region, 1 in Lubombo region, 2 in Manzini region), increasing the coverage of vulnerable AGYW in these inkhundla from 50% to 77%. In total, 30 tinkhundla will be covered. The identification of expansion sites was guided by demographic,

epidemiologic, geographic and contextual vulnerability factors and considerations for optimizing synergy with Global Fund programming.

USAID will continue DREAMS implementation for increased saturation in the 23 current sites and will expand into the new tinkhundla in Hhohho and Shiselweni. CDC will implement the DREAMS package in the expansion sites in Manzini and Lubombo. Peace Corps will engage AGYW 10-24 years in GLOW clubs¹² in all 30 tinkhundla (2 clubs per tinkhundla) and provide service including linking AGYW to relevant DREAMS related service.

Collaboration with Global Fund AGYW programming

PEPFAR and Global Fund reviewed current AGYW interventions and geographic footprint and agreed on the need to harmonize service packages nationally with GoKE coordination. Global Fund will consider enhancing its service package in selected sites through its portfolio optimization process. PEPFAR and Global Fund agreed that the DREAMS expansion in COP20 will include 5 tinkhundla in which Global Fund delivers its interventions in FY20 and ensure that previous Global Fund beneficiaries and additional AGYW receive a full-service package, given the more limited scope of current interventions provided through Global Fund.

Significantly scale up PrEP

PrEP uptake has been increasing with the continuing roll-out of the national PrEP program in COP18 and COP19. As of Q4 FY19, the DREAMS on Wheels mobile sites are offering oral PrEP to eligible YW with a negative HIV test. PrEP is fully embedded in HIV prevention sessions for AGYW, utilizing a module on PrEP and PEP specially developed for DREAMS. In COP20, PrEP targets for AGYW have been set at 5,736.

STI testing and treatment

Eswatini currently uses the syndromic approach to the treatment of Sexually Transmitted Infections. STI prevalence is very high, with the ECHO trial in Eswatini documenting 7.1% prevalence of N. gonorrhoea (GC) and 17% prevalence of Chlamydia (CT). In COP20, GC, CT and Trichomonas vaginalis (TV) screening and diagnostic treatment will be offered. Reagents to test for GC, CT and TV will be procured as well as drugs to treat these STIs (azithromycin, ceftriaxone & metronidazole). Support for laboratory services and specimen transport (urine samples) will also be provided.

Enhanced livelihood / socioeconomic approaches

¹² Eswatini Girls Leading Our World (EGLOW) clubs is one of the primary strategies for the Peace Corps Eswatini DREAMS approach. GLOW (Girls Leading Our World) is a global project initiated by Peace Corps volunteers and local counterparts to empower young girls and improve the status of women around the world. EGLOW focuses its energy in clubs rather than camp activities and Swati EGLOW Mentors utilize a life skills curriculum that includes sexual and reproductive health education, career planning /entrepreneurship, decision-making skills, and self-esteem building to empower Swati girls to make informed and healthy decisions for their lives. EGLOW clubs offer a safe and supportive environment for girls with role modeling from trained Swati women who know and understand their realities.

The DREAMS program will intensify and diversify interventions supporting DREAMS beneficiaries with livelihood skills such as entrepreneurship and financial literacy skills development, savings groups and business mentoring. Activities will also include vocational skills development and start-up packs/supplies for small enterprises. Relationships with potential employers and internships will be promoted. Savings groups will be offered a digital savings platform.

Violence Against Children (VAC) Study

The country's first Violence against Children study was conducted in 2007 and had only female respondents. In COP20, a new VAC will be conducted with female and male respondents with oversampling of DREAMS sites. (For detail, refer to Section 5.0)

Other Minimum requirements

1. The DREAMS layering database using unique identifiers (national ID) will be expanded to include additional implementers and new sites.
2. A DREAMS coordinator will be recruited and placed in the PEPFAR coordination office.
3. 4 regional DREAMS ambassadors will be hired to support interagency DREAMS implementation and coordination with regional government structures.

2. Orphan and Vulnerable Children (OVC)

In COP20, the OVC program will continue to provide comprehensive individual case management for children aged 0-17 with known risks. Adolescents aged 9-14 who do not require comprehensive OVC care will receive group-based primary prevention of HIV and sexual violence.

Comprehensive OVC program

The comprehensive track of the OVC program targets especially children living with HIV, children of PLHIV, HIV exposed infants, children of FSW, survivors of sexual violence and pregnant teenagers/adolescent mothers as well as other very vulnerable children with known risks such as children in child-headed households and school drop-outs. Identification and enrolment will be conducted via referrals from health facilities including the mobile DREAMS on Wheels, social workers, police, community leaders and through GBV caseworkers and home visitors. All children in the OVC program with unknown HIV status will be assessed for HIV risk, and home visitors will actively facilitate HIV testing for those determined to be at risk.

For those newly diagnosed HIV positives, 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 caseworkers 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.

A specific focus will be on increasing coverage of the OVC program for children and adolescents living with HIV. Site-level analysis for TX_CURR for C/ALHIV aged 0-17 at health facilities and C/ALHIV in the current OVC cohort showed that 25% of HIV positive children are active beneficiaries in the OVC program. Throughout COP19 and COP20 this proportion will be increased to reach at least 75% of C/ALHIV residing in the OVC intervention areas. At least 90% of C/ALHIV and their families will be offered enrolment in the comprehensive OVC program. Bi-directional referral protocols between health facilities/clinical IPs and OVC implementers will be strengthened to increase access to the OVC program for C/ALHIV.

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 families achieve a minimum level of stability before they leave the program.

Children and their families in the comprehensive OVC program receive needs-based services in line with MER 2.3 Appendix D, and are focused on the PEPFAR OVC outcomes *Healthy, Stable, Safe* and *Schooled*. They include health referrals, psychosocial interventions and tailored education support (individual subsidies or school block grants). Caregivers are offered parenting skills training and participation in savings groups.

Preventive OVC program

The preventive OVC program track will target 9-14-year-old girls and boys with evidence-based HIV and sexual violence prevention education delivered to groups of adolescents. The PEPFAR prevention modules have already been integrated into the programming tool for this age group. The identification of children will be through home visitors and schools. Referrals to health and social services will be provided as needed. Children in the prevention track who show specific vulnerabilities will be referred to the comprehensive OVC program.

OVC and DREAMS integration

Female OVC aged 10-17 will be eligible to enroll in DREAMS, thus will receive the most intensive combination of OVC and prevention services. DREAMS and OVC activities are integrated programmatically and geographically as well as operationally within the same implementers, allowing for harmonized planning, alignment of curricula and tools, implementation and monitoring.

b. Prevention of Mother-To-Child Transmission (PMTCT)

The prevention of HIV transmission to the infants and children starts with ensuring that their pregnant and breastfeeding mothers are aware of the HIV status and receive treatment immediately if they are positive. In COP20, HTS at ANC visits including implementing maternal retesting, index testing and the secondary distribution of HIVST kits for their male partners, as well as prioritizing PrEP for pregnant and breastfeeding women are used to ensuring their knowledge of HIV status as a mean to receive treatment and to prevent infection to remain negative. The program will also intensify pediatric case finding through scaling up cohort

monitoring for mother-baby pairs (MBP) to ensure timely completion of EID testing through the 18–24-month period.

ART coverage among pregnant women remains high in Eswatini at 98% with a low mother-to-child transmission rate for 6-8 weeks at 1.4%. PEPFAR/E will continue to support the 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, PEPFAR/E will strengthen the integration of client-centered family planning (FP) services throughout the continuum of HIV services.

c. Key Populations

PEPFAR/E provides a comprehensive prevention and treatment package of services to FSW, MSM and transgender populations. Prevention interventions include sexual reproductive health services and psycho-social support. The program also offers programming for economic empowerment such as savings groups, and referrals to social protection, and legal, educational, substance abuse, and other support services

In COP19 PEPFAR/E began providing PrEP services through mobile and community centers and expanded access to PrEP refills. In COP20, PEPFAR/E will continue to support the MoH in providing integrated PrEP services in public health facilities. PrEP initiations will be focused on high-risk KP who want to use PrEP as the prevention method of choice. Building on efforts in COP19, PEPFAR/E will ensure tracking of seroconversion of KP on PrEP. Learning from the reasons why clients drop off PrEP, the program will address these challenges to assist those who want to continue to stay on PrEP.

PEPFAR will support the provision of targeted free distribution of condoms and lubrication for KP. Children of FSW are linked to the OVC program and FSW workers aged 18 to 29 years are actively linked to DREAMS to access the comprehensive package for young women.

Through the KPIF, the capacity of the KP CBOs is strengthened to assure the sustainability and efficiency of the response. The support includes organizational capacity building, establishment and operation of KP community centers (drop-in center equivalent) and pop-up clinics, strengthening network penetration through KP-led approaches, developing KP sub-population specific materials and messages to address initiation, and retention, U=U messaging, preventing new infections, development of advocacy skills, and training KP navigators, case managers, counselors, and outreach workers.

Stigma, discrimination and human rights violations continue to be substantial barriers to service uptake and increase risks for KPs and their children. Over the past several years, working closely with MoH, health care providers, the Royal Swazi Police Service (RSPS) 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 RSPS, 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. To reduce KP discrimination in public health facilities, PEPFAR, working with MoH, will continue to identify, train and support the establishment of KP competent centers of excellence in the highest density hotspots and will continue to strengthen and expand the number of 'KP-friendly' facilities with a specific KP focal point.

Table 4.4.c KP Package of Services and Interventions

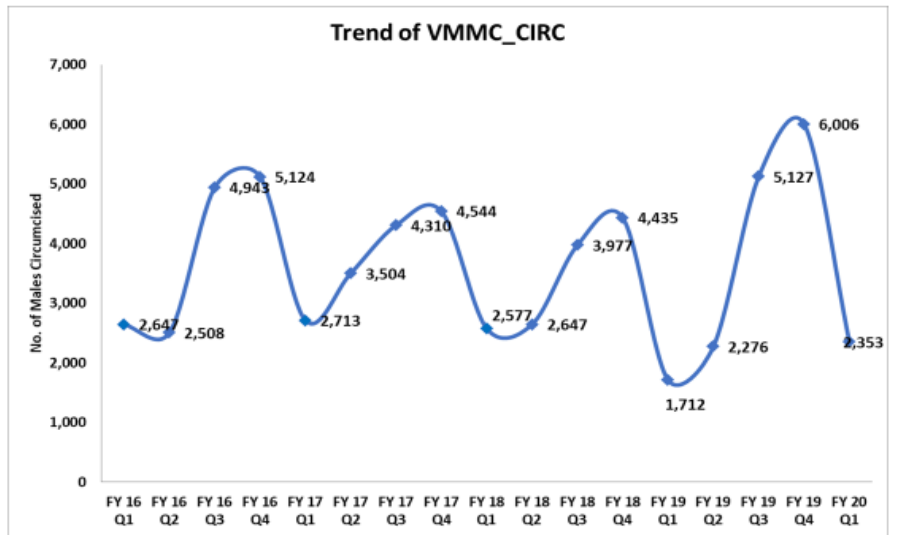
Service Package	Female Sex Workers (FSWs)	Men who have Sex with Men (MSM)
Core Services	<ul style="list-style-type: none"> Targeted Risk education and counseling (HIV transmission dynamics and different sexual practices) HIV Testing and Counseling (HTC) GBV Screening, post-exposure prophylaxis (PEP) services, and referral to GBV support and/or legal aid services Family planning: education, counseling, pregnancy testing, provision of short, and select long acting reversible 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> All Core Services Quarterly HTC and STI screening Repeated and regular risk-reduction counseling, PrEP 	<ul style="list-style-type: none"> All Core Services Quarterly HTC and STI screening Repeated and regular risk-reduction counseling, PrEP
Seropositive Not Yet on Treatment	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

d. VMMC

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. Uptake of VMMC services, defined as the proportion of men circumcised in one year divided by the proportion of men not circumcised, is still generally low in Eswatini. In the priority age group (15-29 years) there has been a leveling 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 4.3.d-2).

Figure 4.4 d-1. PEPFAR VMMC Program Trends by Quarter FY16Q1 - FY20Q1

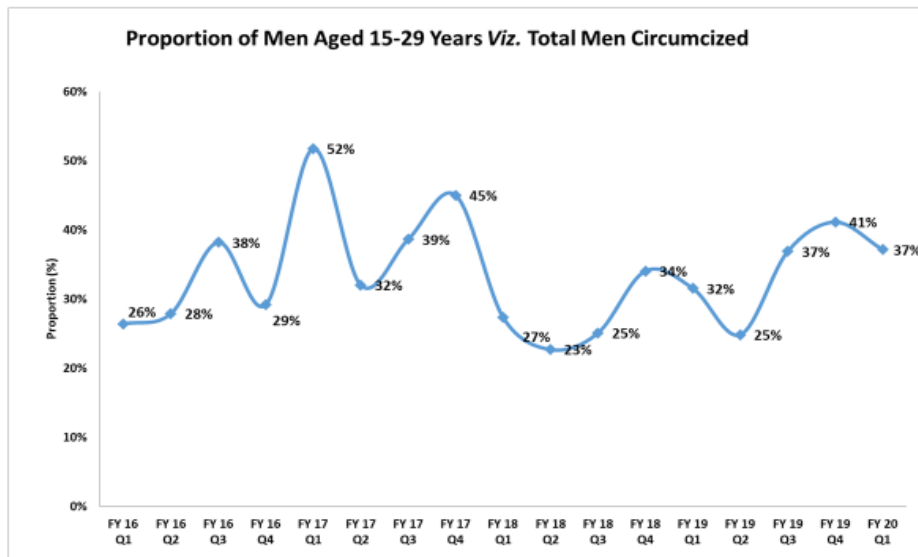
VMMC_CIRC Trends by Qtr: FY16-FY20



Data source: PEPFAR program data/DATIM, 2020

Figure 4.3.d-2. PEPFAR VMMC Program Trends by 15 – 29 yr Age Band

Trends in VMMIC_CIRC by 15-29 yr Age Band



Data source: PEPFAR program data/DATIM, 2020

Table 4.4.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate [†] (SNUs)	Current Coverage ^{**} (FY 19)	VMMC_CIRC (in FY21)	Expected Coverage ^{**} (in FY21)
15-29	175,760	40%	5,572	55%
30+	171,036	25%	1,778	27%
Total	346,796	32%	7,350	40%

^{**}Estimated coverage informed by Decision-Maker's Program Planning Tool (DMPPT2) and FY2019 program data

[†]Estimated 2019 population based on Spectrum outputs

The above table shows PEPFAR/E's VMMC Coverage and Targets by Age 15-29 and over 30 for COP20. PEPFAR/E achieved 7% (2194/29,989) of the FY19 VMMC_CIRC targets by the end of Q1FY20. There was an increase of 482 VMMC procedures compared to Q1 FY19 (1,712). There is seasonal variation in VMMC, with the highest uptake in Q3 and Q4. Of the 2194 males circumcised during Q1FY20; 812 were aged between 15-29 years. Forty-five percent of the VMMC procedures were performed in males 15 years and older. This represents a slight increase in the percentage of older males compared to Q4FY19 (41%).

Starting in Q1FY20, EGPAF started providing VMMC services at sites in Hhohho and Shiselweni regions using the facility-based integrated approach as recommended by the Ministry of Health. The Luke Commission (TLC), URC, ICAP, PSI and URC-DOD continued to support the VMMC program. CHAPS discontinued being an implementing partner. JHPIEGO started as a partner to support the program at the national level.

PEPFAR/E continues to work with the GKoE to scale up VMMC coverage to 80% among males 15-29 years throughout the country. In COP20, PEPFAR/E plans to provide direct surgical service delivery to circumcise 7,350 men. COP20 funding will support DSD at fixed 15 sites (12 of which are MoH sites) ¹³as 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. The task shifting of VMMC to the nurse-midwives will become possible with new policy implementation and this will be the major program shift during COP20. The VMMC IP that supports the MoH VMMC program at the national level (JHPIEGO follow-on) will support the training of nurse-midwives with a government approved curriculum to enable them to perform circumcisions. This IP will also work with the MoH to support monitoring of continuous quality improvement (CQI) and adverse events. Additionally, in the 15 fixed sites performing circumcision, the participants will be reimbursed for their travel cost.¹⁴

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

¹³ This includes Hlatikhulu Government Hospital and Mbabane Government Hospital. At those sites, MoH must be supported to start up VMMC facilities.

¹⁴ Some IP uses this strategy in COP19 and results can be shared to explore the harmonized way of paying the travel costs of participants across IPs.

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.

Demand creation strategies will be scaled up in COP20 to increase uptake 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, DREAMS, 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 the 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 men to VMMC services and support demand creation through BRO (Boys Reaching Out) camps and clubs.

Given the need to achieve 80% coverage among 15-29 years old and attain sustained epidemic control, PEPFAR will prioritize TA to ensure the 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, to ensure the safest VMMC program, the training of staff using OTH, planning of practicum, assessment of staff competence will be provided to the cadres including nurses who perform VMMC. Since the incorporation of nurse-midwives as a cadre to perform circumcisions is a major program shift, special attention in COP 20 will be made to monitoring and supporting competency in this new cadre through training, practicums, SIMS visits, CQI and adverse events monitoring. The robust adverse event (AE) oversight will also be conducted by partners and PEPFAR, including routine monitoring, thorough investigation of AEs, and corrective actions. These will be especially important given the change in policy to allow nurse midwives to perform circumcisions. 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 for refining programmatic approaches on an ongoing basis. By COP20 the program will have transitioned to reusable kits in order to support long term sustainability, reduce costs, improve procedure quality and reduce waste generation. To ensure the safe provision of VMMC that eliminates the risk of glans injury, PEPAR partners will continue to support the GKoE's adoption of the dorsal slit (DS) method of circumcision.

Eswatini Military VMMC Program

The VMMC program within the military began in earnest 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 program is structured to integrate with the Ministry of Health National VMMC program. Entry points are via OPD, HTS and intensive peer educator recruiting activities. Peer educators are used for registration and retention of potential clients. Newly graduated recruits are targeted between the pass out and graduation period for sensitization and recruitment. The COP20 target for the military is 438 circumcisions.

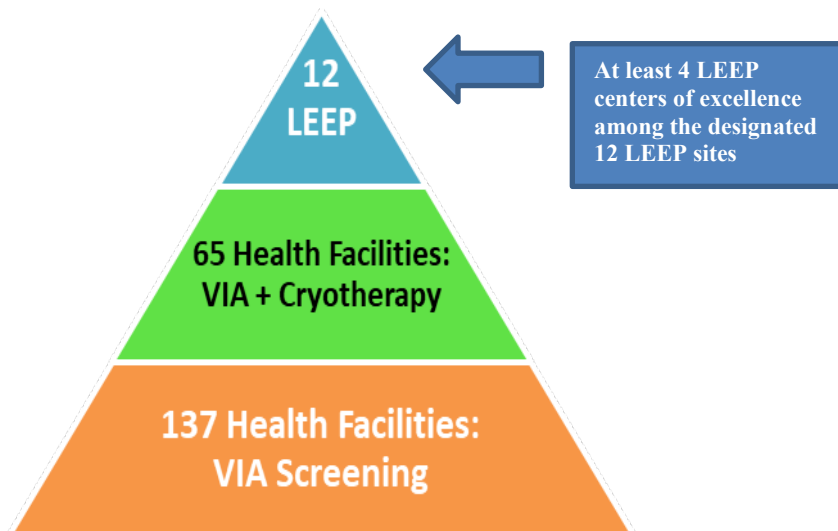
e. Cervical Cancer Program Plans

Eswatini through the leadership of the Sexual and Reproductive Health team of the Ministry of Health provides cervical cancer screening services at health facilities. Beginning FY20, 131 (96%) out of 137 PEPFAR supported facilities were offering cervical cancer screening services using Visual Inspection with Acetic acid (VIA). Mobile screening services were also offered by PEPFAR partners providing community services. The PEPFAR supported sites reached 98% of the total number of women screened.

In COP20 Eswatini will continue to increase access to VIA based screening services to HIV positive women through a tiered service delivery model that takes into account the following factors:

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

Figure 4.4.e.: Cervical cancer screening approach



Data source: PEPFAR Eswatini Program data, FY19 Q4

Based on a national assessment conducted in November and December 2018, facilities received necessary resources to enable them to screen and refer for treatment, screen and treat onsite, provide LEEP, or refer for further treatment. All 137 PEPFAR supported facilities will provide screening services according to a tiered approach as shown (see Figure 4.8.1). Regional hospitals will be selected to become LEEP centers of excellence with the capacity to provide prompt LEEP services including those referred from other facilities. This approach is necessitated by the missed opportunities noted at LEEP designated sites where there are personnel constraints, and

which will address the issue of insufficient theatre space that has caused a long backlog of women awaiting LEEP. Through this approach, PEPFAR will increase site level coverage of VIA from 96% at the end of FY19 to 100% in COP20. Likewise, cryotherapy will increase from 37% to 47%. The current 12 LEEP designated sites will be maintained with support to ensure LEEP services are functional. Each region will have at least one center of excellence for LEEP. In addition to improving laboratory capacity for histopathology services, a partnership with a private laboratory will be solicited to ensure timely availability of histopathology results from LEEP samples and appropriate further management.

In order to ensure quality services, mentorship and onsite training on cervical cancer screening will be continued and captured in mentorship logbooks stationed at health facilities. An expert forum will be created which will allow health care workers to receive mobile images of cervical cancer lesions and participate in tele-mentoring and quality reviews.

The national referral tool will be used to ensure linkage to care and referral for cryotherapy and LEEP. Communication channels through existing PEPFAR support for mobile phones and airtime will be created to ensure prior booking confirmation and reduced 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 to and document in patient records. Palliative care will be provided either onsite or through referral. The existing SOPs will be revised to reflect this.

In COP20, PEPFAR will continue funding 6 Implementing mechanisms supporting the cervical cancer program with a funding level of \$1,500,000 and will also support a HPV vaccine trial study among 1,400 females stable on ART, aged 9 - 24 years, with a funding level of \$1,500,000. This particular study will evaluate the immunologic response of two vs. three doses of the HPV vaccine.

f. Pre-Exposure Prophylaxis (PrEP)

PEPFAR/E supports a fully integrated government-led sustainable PrEP program by continuing to implement the operational plan developed in COP18. In COP20, the support shall strengthen the coordination for PrEP implementation across partners supporting the MOH, improve uptake of PrEP through demand creation activities, strengthen health facility flow to improve access for AGYW, KP, and men, PBFW, track the processes of provision, uptake and adherence to limit seroconversion rates and contribute to reduced HIV incidence. Below are service delivery activities that will be undertaken:

Strengthening the PrEP scale-up and retention

- 1. Expand HCW providing PrEP:** The MOH scale-up envisages PrEP provision in 159 facilities by end of COP19, including KP sites and DREAMS on Wheels mobiles. To strengthen PrEP implementation in these sites, more focus will be placed on ensuring that all HCWs are hands-on at a facility level to adjust client flow for PrEP provision at all entry points and beyond ART platforms for high volume sites.
- 2. Improve client flow for PrEP:** New client flow procedures at facilities will be put in place to ensure that ARV drug pickup points are where the clients are seen, particularly at hospitals.

3. **Champion PrEP provision in facilities:** Champions/focal people among the existing staff in facilities will be identified to promote prioritization of PrEP provision to high-risk negatives as part of routine services delivery.
4. **Integrate PrEP into mentorship program:** PEPFAR/E regional clinical implementing partners will continue to support facilities with site readiness preparation, training and mentoring for health workers to provide PrEP services.
5. **PrEP re-packaging:** In COP20, PEPFAR/E will support repackaging PrEP containers to improve uptake. This will address the challenge where clients do not want to carry ARVs containers because they fear being perceived as living with HIV.
6. **Strengthen PrEP retention:** PEPFAR/E will strengthen the use of the appointment register and refill reminders such as calling, messaging/messaging apps and shortening PrEP refill waiting time by integrating PrEP refill into existing community outreach by facilities and accrediting private facilities and pharmacies to offer PrEP services.
7. **Strengthen the M&E Platforms:** PEPFAR/E will support MOH to ensure that the full PrEP cascade is monitored and evaluated through electronic (CMIS) and manual platforms (registers) so that leaks can be identified and addressed. This will involve ensuring that priority population groups can be assigned to an individual patient.
8. **Strengthen demand creation for PrEP:** In COP20, PEPFAR will strengthen demand creation through the development and implementation of a communication strategy. This will be supported by mobilizations both in health facilities and the community.

g. Condom Programming

PEPFAR/E will support the GKoE stewardship of the national condom program through the implementation of the national condom strategy and the total market approach (2018-2022). Working with NERCHA and MOH, PEPFAR/E strengthen coordination of the program, improve the sustainability of condom procurement, facilitate commercial sector expansion, improve the targeted distribution of the free public sector condoms, and promote the utilization of condoms

Sustaining condoms procurement

1. **Explore government condoms procurement:** PEPFAR will engage with the MOH to explore the potential to utilize domestic funding for condom procurement. The condom strategy discusses the need to engage the government to include condoms in the reproductive health commodities budget for government or procure condoms. PEPFAR will work with the government to develop a plan to support a proportion of the procurement going forward. This will include identifying other development partners such as the Global Fund to review condom priorities in the next funding request.
2. **Expanding the market share for the commercial sector:** PEPFAR will continue to build on COP19 priming of the commercial sector by engaging the private sector to take up more of the market share for condoms. PEPFAR will support GKoE to monitor the progress in COP20 with an aim to double the commercial sector condoms. This will also support the sustainability of condom procurement, complementing the government and donor investments.

Targeted promotion and distribution

1. **Targeted free public sector condoms distribution:** PEPFAR will continue to support the targeted distribution of free public sector condoms using outlets and outreach. The journey mapping supported in COP19 will further inform improved targeting and the best positioning of free public sector condoms for men/boys, KP and AGYW who cannot afford to buy. The targeted distribution will also focus on optimizing facility and outreach platforms to ensure priority and key populations have access. Health service delivery platforms will be prioritized for the promotion and distribution of public sector condoms. For example, ANC, STIs, HIV testing, VMMC, DREAMS, ART and other platforms will be strengthened to provide the promotion and distribution of condoms.
2. **Intermediary distribution:** PEPFAR/E will explore the potential for intermediary distribution of public sector condoms from CMS to the last mile. Larger implementing partners will continue to pick up condoms from CMS for their beneficiaries
3. **Promotion for access and utilization¹⁵:** PEPFAR will continue to support the expansion of category branding to facilitate access for young people. Thus far, 864 sites have been branded as distribution points for young people.
4. **Condoms distribution strategic information:** PEPFAR will continue to support the MOH and NERCHA to effectively monitor condoms distributed outside of health facilities and have a comprehensive picture of coverage compared to the need.

4.5 Additional country priority

The above program priority areas addressed the policy changes, program changes and partner management issues where applicable as well as index testing scale-up.

Innovative solutions- Faith and Community Initiative (FCI)

In 2020, Eswatini began to engage faith structures and surrounding communities and train leaders and community carers to deliver positive messaging, health information and linkage to prevention, as well as testing, treatment and adherence services to otherwise un-reached people living with HIV. FCI program tools will capture site-level information on all services delivered, allowing for routine analysis to identify gaps in retaining men and preventing LTFU. In COP20, FCI will work with four denominations and reach 120 additional congregations covering 50,000 people.

¹⁵ As part of the KP program, PSI continue to distribute condom targeting KPs at hotspots (e.g. bars)

4.6 Commodities

In COP20, GKoE will continue to procure all adult ARVs. PEPFAR/E will support the procurement of all pediatrics ARVs, and the following commodities:

- Lab reagents such as Roche VL reagents and consumables (for plasma, DBS, plasma recency); other sample collection and consumables for recency testing;
- Reagents and consumables for STI screening; as well as urine collection cups for STI screening;
- VMMC kits and commodities for 8,000 planned circumcisions;
- TPT commodities for Fixed-Dose Combination (FDC) and 3HP (might change to IHP)¹⁶
- To support the achievement of increased PrEP targets in COP20, PEPFAR will augment the GKoE's procurement of ARVs for PrEP (3TC /TDF)
- Rapid Test Kits (RTKs) for specific entry points (ANC and PrEP)
- Self-test kits

Condoms: PEPFAR/E has requested support to procure free condoms for Eswatini. Eswatini has high utilization of condoms. Condoms remain an important HIV intervention, and the GkoE is on a path towards a sustainable condom response. PEPFAR has supported a total market approach (TMA), market segmentation, and priming of the private sector. None-the-less, a full transition to GkoE for condom commodity procurement and programming will take some time. PEPFAR has provided approximately 90% of the condoms in Eswatini for the past several years. In COP 20 PEPFAR/E will embark on intensive discussions with GF and the GkoE to take on the procurement and programming of condoms by 2022.

TLD Transition

Eswatini revised the integrated guidelines for the management of HIV in 2018 by considering DTG-containing ART as the preferred first-line regimen for the 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. This transition will be completed in COP19. Similarly, in May 2019, the GKOE released policy guidance for the transition of stable clients to six months dispensing. The transition started in February 2020 and is due for completion in COP19.

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 the 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:

¹⁶ 3HP is a short-course TPT regimen that combines two antibiotics active against TB i.e. Isoniazid (INH) and Rifapentine (RPT); 1HP - (an ultra-short-course regimen of daily isoniazid and rifapentine for 28 days

- 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, under 10% 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 will continue to monitor 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, the transition from suboptimal regimen, failure of AZT containing the first-line regimen to ensure that TLD supply planning meets demand.
- Support MoH with 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 the NVP-based regimen. Outstanding orders for NVP were canceled with suppliers and facilities were informed of the need to prioritize eligible patients on NVP to TLD.

Peace Corps Volunteers will work within health facilities in rural areas to support selected supply chain management activities in Eswatini. Volunteers will continue to be trained by the MoH and PSM, which is the national partner for the supply chain management. Volunteers will help improve the following areas: inventory management and reporting through the logistics management information system (LMIS) reporting tools.

4.7 Collaboration, Integration, and Monitoring

a. Cross-Technical Collaboration

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 increased involvement of MoH, GF and UNAIDS in the COP20 stakeholder and COP20 Planning Meeting provided additional opportunities to further streamline and strategically plan for HIV/AIDS activities in Eswatini.

b. IP Management

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.

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. 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.

c. Integration of above-site activities: HRH and laboratory (VL)

A critical component for achieving the 95-95-95 and preventing new infections is to ensure the availability of appropriate levels of HRH across the HIV and TB care continuum. In COP 19, working under the direction of the Ministry of Health, PEPFAR conducted an inventory and analysis of all the donor-supported health workforce in Eswatini, with the aim of helping GKoE establish phased HRH transition plan for donor-funded positions. As a part of the HRH inventory, PEPFAR also developed a 'mortgage tool' of the Donor HRH to provide a valuation and scenario

modeling of the costs to the GKoE to transition donor investments. This support resulted in the development of a sustainability roadmap and transition planning framework for GKoE.

In COP 20, the senior HRH Advisor PEPFAR consultant, who is working with the sustainability and transition committee chaired by the Secretary to the cabinet, will build on the investments and the transition planning framework that sets out necessary next steps required of the MOH, to ensure a smooth transition of HRH functions pivotal to sustaining advancements already made towards achieving HIV and TB epidemic control in Eswatini. The Advisor will continue to support MOH in exploring various pathways to sustain different types of donor-supported cadres and a transition plan for donor-funded professional clinical posts and for donor-funded lay cadres. This included addressing governance and leadership issues, improving HRH information for decision-making, policy review, and consideration of alternative options for delivery of community-based health volunteer services, with proposed timelines and responsibilities.

PEPFAR has engaged an HRH Policy Advisor to review the sustainability of critical cadres including human resources for laboratory that is currently heavily dependent on GF and PEPFAR resources. She will also evaluate the human resource requirement and the current lab systems to explore more integrated HRH support to the government.

d. Community Monitoring

Community-led monitoring will be supported, primarily, through the PEPFAR Coordinating Office (PCO). A Community Monitoring Coordinator position will be established to work with the embassy small grants coordinator within the mission to manage the granting process and thereafter the implementation and reporting for grant management purposes. The small grants coordinator has been appraised and engaged on the initiative during the design stage, particularly on small grant requirements and compliance to ensure that the initiatives implementation plan considers these requirements so that they are not a barrier to prompt roll out.

Community monitoring is further embedded as a component of the overall quality improvement program; thus, implementation will benefit from the ongoing systematic assessments and monitoring processes for clinical services. That system will be leveraged to ensure that community monitoring is implemented as quickly and as seamlessly as possible. Furthermore, a community monitoring steering committee will be established and working with the coordinator will develop systemic solutions to service provision issues for MOH to address.

e. Above-site activities mapped to Key Barriers

COP20 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. Each of these areas maps to a section of the 2019 Sustainability Index and Dashboard in which the country scored yellow. COP20 above site activities are mapped to measurable outcomes to ensure adequate progress towards achieving epidemic control and meeting minimum requirements. Expected outcomes for COP20 include: 100% of labs achieving accreditation, complete end-to-end stock status visibility, increases in recency testing, increases in ART coverage for children living with

HIV and adults, measurable increases in uptake and accessibility of HIV prevention services, in particular PrEP, an increase in facilities certified as KP friendly, and maintenance of a national comprehensive cervical cancer screening program. As further outlined in Table 6, in addition to facilitating scale-up and refinement of current systems, COP20 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 through increased surveillance capabilities

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

Eswatini has adopted the use of the national ID number as a 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 February 2020, almost 60% of all clients (regardless of HIV status) registered in the CMIS were registered with 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 by enabling ID registration at health facilities. In addition, PEPFAR will continue to support targeted sensitization and mobilization activities at both facility and community levels focused on client registration and use of IDs so that client records can be updated with the UPID in CMIS. The UPID is also used in PEPFAR supported community programs, including the DREAMS layering database. In order to increase the number of clients with a unique identifier, the use of biometrics using fingerprint and facial recognition will be piloted between Q3 and Q4 of COP19. The results of the pilot will be shared with the government and stakeholders for potential adoption, resources permitting.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Please see Appendix C for Table 6-E tab of Excel workbook and SRE-Tool E worksheet.

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

Benchmarks for COP20's above site activities have been defined to ensure timely and sustainable progress towards epidemic control. The above-site activities in COP20 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 COP20, 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

In COP19, leveraging on GF resources, the open-source electronic logistics management information system (eLMIS) will be piloted in three types of facilities (a hospital, a health center, a clinic). The pilot will facilitate learning and inform the roll out to the rest of the 45 mother facilities in COP20. Coupled with barcoding, this will ensure end-to-end stock status visibility, a critical piece in stock management across all levels. Once rolled out to the 45 mother facilities, the eLMIS will also be integrated with the client management information system (CMIS) as a part of the HIS integration effort at the national level.

Building on progress in COP18, the country will complete the ART optimization agenda in COP19. Embedded in this is the transition to six-month dispensing. Hence the need to strengthen the pharmacovigilance activities at the site and national levels in terms of data collection and use for decision making.

Quantification and supply planning are key tenets of the supply chain, so too are good storage, timely commodity ordering, optimal commodity distribution and management of stock at both Central Medical Stores (CMS) and site levels. PEPFAR will continue to provide TA to both CMS and facilities to eliminate supply chain interruptions. In particular, PEPFAR will continue to offer TA, including embedding staff at CMS and having regional logistical officers, for supply chain management and oversight; rational medicines use; procurement and supply chain data use; medicines regulation; pharmacovigilance activities; annual quantification and quarterly supply planning; support to CMS for warehouse management; as well as support to procurement and supply chain-related technical working groups. In addition, through PSM, PEPFAR will also continue with the procurement of PEPFAR-supported commodities (see 4.5)).

Client Management Information System (CMIS)

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 fully 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.

COP18 rolled out CMIS Version 2.0 to 179 health facilities. Of these, 154 (out of 184) were ART sites. In COP19 and part of COP20, CMIS will be rolled out to the remaining ART sites in the country, leveraging GF and World Bank resources.

Given the unreliability of the WAN connectivity in the country, an offline version of the CMIS will be deployed to an initial 56 sites in COP19. The plan is to roll it out to the rest of the ART facilities, resources permitting, to mitigate network downtime related challenges at the facility level.

The integration of the HIS systems is critical for effective and efficient patient and data management. In COP19, the priority is on the complete integration of the CMIS and the Lab Information System (LIS). In COP20, the Logistics Information System (eLMIS) will also be fully integrated with the CMIS, leveraging resources from GF and World Bank.

System-related performance enhancements will be prioritized in COP20 to ensure optimal functionality and use of the system at all levels, from facility to national levels. In addition, COP20 will continue to facilitate robust change management including pre-and in-service training and mentoring at facility regional and national levels, using super users and champions.

Care & Treatment

Through PEPFAR support the Kingdom of Eswatini is close to achieving epidemic control with >90% of all PLHIV on treatment by September 30, 2019. However, the government of Eswatini still requires support at the national and sub-national levels to close the ART coverage gaps for specific subpopulations and to shift the focus from case finding to retention in care and viral load suppression (VLS). Program data analysis shows that loss to follow up (LTFU) contributes significantly to treatment gaps especially in those <40 years who appear to be more likely to disengage from care within the first 6 months of treatment. PEPFAR will provide TA and HRH support at the national level to the Eswatini National AIDS Program (ENAP) and the National Tuberculosis Control Program (NTCP) to provide coordination and evidence-based decision making at the national level to guide facilities as they shift towards improving retention, VLS and reducing deaths by providing patient-centered services targeting sub-populations and geographies that are lagging behind in terms of ART coverage, retention, and VLS. Other program areas detailed elsewhere that support care and treatment outcomes include supply chain as PEPFAR supports the procurement of pediatric ARVs, laboratory reagents for viral load and Tuberculosis preventive therapy (TPT) medicines and PEPFAR support to laboratory services to ensure 100% viral load testing access for all PLHIV on ART.

VMMC

There remains a need for PEPFAR/E to support national TA to increase the pace of implementing VMMC services in-country. In COP20, 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 Continuous Quality Improvement (CQI) and EQA, and closely monitor performance to tailor strategies in real-time.

PMTCT and Pediatrics

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 COP20, 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 the coordination of investments across stakeholders to ensure that Eswatini implements standards of practice aligned with current WHO PMTCT and pediatric HIV guidance. For example, through PEPFAR support, ENAP is spearheading the optimization of pediatric ART regimens (phase-out of NNRTI-based regimens and introduction and scale-up of optimal ARVs) and phase-out of LPV/r liquid formulation. In addition, the Ministry of Health's SRHU program has also tirelessly advocated for the integration of FP services within ART clinics, as an essential component of client-centered care. The COP20 above-site activities remain focused on enhancing clinical mentorship and supportive supervision to PMTCT and pediatric programs to ensure the implementation of comprehensive and quality services throughout the continuum of HIV care at health facilities.

Cervical cancer

PEPFAR will continue to support the MOH's nascent cervical cancer program with technical support in planning, coordination, data collection, analysis and utilization. Support will also continue in the procurement of equipment, provision of additional health care workers, revision of guidelines and printing of job aids and SOPs. Expert clients will integrate screening services into their patient booking, tracking and return to care activities. M&E tools and CMIS electronic platform were revised to capture data elements for cervical cancer screening and treatment.

In COP20, PEPFAR/E will support a HPV vaccine trial study among 1,400 females (9-24 years old) living with HIV, who have been on ART for more than 6 months and have been stable. The purpose of the study is to determine participant immunological response to 2 doses vs 3 doses of the 9-valent HPV vaccine. It will also demonstrate the safety of a 2-dose regimen compared to a 3-dose regimen in the study group. The study sites will be 4 large-volume facilities in 2 regions of Eswatini.

HIV/TB Program

Above site support to National TB Program (NTP) will include training, mentorship, workshops, commodities procurement, and development of job aides, SOPs and guidelines in order to reach full TPT coverage with 90% completion by end of COP20.

PEPFAR/E through its partners will support NTP and ENAP to coordinate the TB/HIV response through supporting national TB/HIV coordinating committees (NCC) both at national and regional levels. In COP20, four NCC meetings will be done with PEPFAR support. In addition, PEPFAR/E will support the following key elements:

- Implementation of all four key components of TB infection control as well as the provision of condoms and PrEP to prevent HIV transmission.

- 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 the use of TB LAM and gene Xpert Ultra testing technology.

Key Population Program

PEPFAR will continue to provide technical assistance to the national KP unit in MOH for strategic, operational planning, coordination and program performance monitoring of the KP program. Continued support will be provided to ensure KP friendly services (Centers of Excellence for KP services) who will participate in the online booking system for KP services developed in COP19. Training and sensitization for health care workers and law enforcement cadre will be conducted to address stigma and protect KP's human rights.

In COP20, PEPFAR will support the finalization of the analysis of the IBBS conducted in COP 19 as well as dissemination of results, and capacity building of KP CSOs and MOH to utilize IBBS results

PrEP

At the national level, PEPFAR will support the MoH to coordinate and manage the implementation of the operational plan, including updating of PrEP tools, training materials, developing demand creation strategy and inclusion of PrEP in training curricula of all health cadres. In FY19, PEPFAR supported MoH in setting national PrEP targets using the PrEP-IT tool. In COP20, national, regional teams and mentors will be trained on how to use the tool to improve uptake, continuation and quality of services.

Additionally, PEPFAR/E will support the interoperability of tools between CMIS and the PrEP-IT tool. This will facilitate importing data from CMIS into the PrEP-IT tool to be used to assess PrEP capacity in facilities. MoH will also be supported in stock monitoring, forecasting and ordering of drugs as well as lab commodities. In COP 20, PEPFAR will also support the procurement of PrEP drugs and RTKs to support service provision.

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 COP19, through PEPFAR support, the Eswatini Health Laboratory Services (EHLS) has been able to get the National Molecular Reference and the National TB Reference laboratories internationally accredited. PEPFAR through the lab partner will continue supporting QMS for accreditation, the focus in COP20 will be to get all the three Molecular laboratories in the country accredited. The lab partner will continue to provide 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 to ensure that indicators towards achieving benchmarks are closely monitored. PEPFAR initiated the interoperability of the Lab Information System (LIS) with the Client Management Information System (CMIS). This support will continue in COP20. The second benchmark achieved in COP19 was the development of the database of in-country registered lab professionals. In COP20, PEPFAR will continue

to facilitate the implementation of the Continued Professional Development (CPD) program which was initiated in COP19. PEPFAR/E will continue to support training on CPD points acquisition and the Medical and Dental Council (MDC) support to sustain laboratory staff skills. In COP20, PEPFAR/E aims to have at least 80% of laboratory professionals trained on the implementation of Strengthening Laboratory Management Towards Accreditation (SLMTA) to be able to sustain QMS and accreditation activities.

Effective Case-Based Surveillance System:

In COP18, PEPFAR/E supported the implementation of the recent infection surveillance system at 38 health facilities and will increase the number of implementing sites to 165 in COP19. Data from recency surveillance will continue to assist Eswatini to describe the epidemic, identify areas and populations with high rates of recent infection, and use data to prioritize resources and interventions. In COP20, PEPFAR will continue to support recency surveillance and cluster response activities to sustain epidemic control by timely responding to transmission clusters through prevention and treatment interventions. Other supported activities include procurement of Asante test kits and data collection tablets, training, data dashboard maintenance, staffing in critical areas, panel preparations, QA/QC and data plan for electronic data transmission. Support for procurement of equipment, such as tablets for data collection and freezers and centrifuges will be provided. In COP20, steps will be taken to support the establishment of a HIV case-based surveillance system through linking existing electronic patient-level databases and data from recency surveillance. In addition, support will be provided to develop a data use protocol and strengthen the national capacity of the MOH Epidemiology and Disease Control Unit (EDCU) for HIV surveillance and response. 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 will support activities to strengthen government systems related to surveillance and research. Three of these major activities include strengthening the capacity of the National Health Research Review Board (NHRRB- National IRB), and building capacity of the Health Research Unit (HRU) and Epidemiology and Disease Control Unit (EDCU). Activities related to strengthening the NHRRB include: updating and supporting the implementation of the NHRRB policies and Strategic Plans; developing a sustainability plan that includes capacity building of the NHRRB to review research protocols with limited external support; and providing technical assistance (TA) to update and maintain sustainable protocol submission, review, monitoring and archiving of health (including HIV) research protocols. Activities related to strengthening the HRU to implement population-based HIV surveys (e.g. Population HIV Impact Assessment (PHIA) include: updating and supporting the implementation of HRU's strategic plan; providing TA to the HRU to implement the biennial Eswatini National HIV/Health Research Conference, providing TA to implement PHIA's; and capacity building for HRU to implement health research. Activities related to strengthening the EDCU include: capacity building and training of health care workers (HCW) at various levels to ensure the sustainability of the surveillance systems; updating and supporting the implementation of the EDCU policies and strategic plan; training HCW at different levels on implementation of HIV/TB surveillance systems; providing TA to update and maintain sustainable key HIV surveillance and response systems (such as HIV case-based surveillance); and providing TA for timely analysis and dissemination of surveillance data.

Violence Against Children Survey

In COP20, PEPFAR/E will support DREAMS programming by conducting a Violence Against Children survey as per directed by PEPFAR. The last VAC Study was conducted in 2007 and the survey only targeted the eligible female respondents age 13-24 years old in 1920 households nationally¹⁷. The VACS will inform DREAMS and OVC programming, particularly in the area of violence prevention and response. The objectives of the study were to describe the epidemiology of the violence (i.e. patterns and distribution of the violence) and to identify potential risk and protective factors.

There have been 2 major changes since the last VACS. The current VACS will incorporate: 1) HIV testing, and 2) Oversampling of DREAMS SNUs to understand subnational estimates. The new nationally representative study will provide an evidence-based approach to strategically target children at risk of violence and related HIV infection risks. VACS will target the 13-24-year-old age group, but for this study, we will also ask about lifetime experiences with violence to capture their childhood experiences of violence prior to age 13, as well as experiences up to age 24 among young adults. VACS will not target those younger than 13 since young children may not be developmentally able to understand some of the complex and sensitive questions associated with the survey.

Coordination, planning, data review

Oversight, coordination and tracking 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 supported NERCHA to assure the strategies and the policies are implemented at the community level including development, refinement and production of key tools and materials specifically related to coordination of the HIV response. In COP 20, PEPFAR/E will focus support to strengthen data collection, analysis, interpretation and use for programming on a quarterly basis, including the use of spatial analysis to better understand gaps in a specific population and/or program coverage as well as to assure the tracking of the NSF indicators. As a part of quarterly data analysis, PEPFAR/E will also assist NERCHA in gathering and optimizing 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, and coordination of the HIV response. 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 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.

¹⁷ Violence against children study, Eswatini, 2007, UNICEF

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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:

- DREAMS Coordinator (State)
- Civil Society Liaison (State)

Long-term Vacant Positions

The only long-term vacancy was the VMMC specialist position (CDC) and it was recently filled. USAID currently has 5 positions under recruitment.

Justification of Proposed New Positions

PEPFAR Coordinator Office requires a Civil Society Liaison for civil society development and implementation of community monitoring platform. S/he will be responsible for supporting the dissemination of the feedback and engagement of facility quality improvement. This position will be established to work with the embassy small grants coordinator within the mission to manage the granting process and thereafter the implementation and reporting for grant management purposes.

PEPFAR Coordinator Office also requires, as per the planning letter, a DREAMS Coordinator who will be responsible for the coordination of the inter-agency DREAMS program.

Changes to CODB

- USAID M&O has increased in COP20 by \$768,720, due to: full regional USAID Mission costs attributable to Eswatini; full costing of NSDD38 new position (only cost for 6 months in COP19); shift of one USAID position previously funded under State's M&O shifted to USAID
- Peace Corp CODB has increased by \$401,000 to fully support DREAMS programming in 30 tinkhundla including support for additional 4 Peace Corp Volunteers who will be trained to ensure linking and referral of AGYW to relevant DREAMS services.
- PEPFAR/State's CODB has decreased from COP 19 due to the re-alignment of the staffing costs with the PEPFAR/State organogram and the reduction of costs associated with invitational travelers.
- CDC's CODB is flat-lined in COP20.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1: Attained (unconditional): Treatment coverage (2020 Q1) & Target coverage (COP19/20)

SNU	COP Target	Treatment CoverageTarget																		Overall TX Coverage
		<15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
		Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
Hhohho	APR20 Q1	95%	95%	70%	105%	77%	73%	96%	69%	95%	102%	79%	102%	71%	88%	81%	80%	126%	78%	88%
	COP19	109%	103%	98%	101%	109%	72%	114%	106%	101%	141%	73%	107%	69%	85%	79%	88%	117%	82%	94%
	COP20	111%	111%	103%	113%	111%	95%	116%	108%	101%	146%	74%	107%	70%	85%	79%	88%	117%	82%	96%
Lubombo	APR20 Q1	87%	78%	71%	81%	87%	62%	105%	64%	98%	111%	82%	110%	75%	96%	85%	82%	131%	86%	92%
	COP19	112%	90%	93%	84%	117%	66%	128%	123%	113%	162%	87%	117%	80%	96%	86%	89%	145%	84%	104%
	COP20	114%	96%	98%	94%	119%	87%	131%	126%	113%	169%	88%	117%	82%	96%	86%	89%	145%	84%	105%
Manzini	APR20 Q1	94%	76%	69%	98%	87%	67%	109%	77%	110%	118%	91%	117%	87%	108%	90%	96%	131%	85%	98%
	COP19	86%	80%	109%	81%	117%	71%	116%	110%	94%	151%	80%	114%	73%	91%	78%	94%	120%	92%	97%
	COP20	101%	86%	114%	91%	120%	93%	118%	112%	94%	157%	81%	114%	75%	91%	78%	94%	120%	92%	98%
Shiselweni	APR20 Q1	73%	68%	74%	83%	95%	66%	112%	87%	108%	124%	92%	127%	87%	111%	94%	105%	128%	91%	100%
	COP19	79%	76%	95%	71%	119%	60%	119%	118%	107%	166%	86%	130%	77%	104%	86%	105%	118%	82%	100%
	COP20	80%	82%	100%	80%	121%	79%	122%	121%	107%	173%	87%	130%	78%	104%	86%	105%	118%	82%	101%

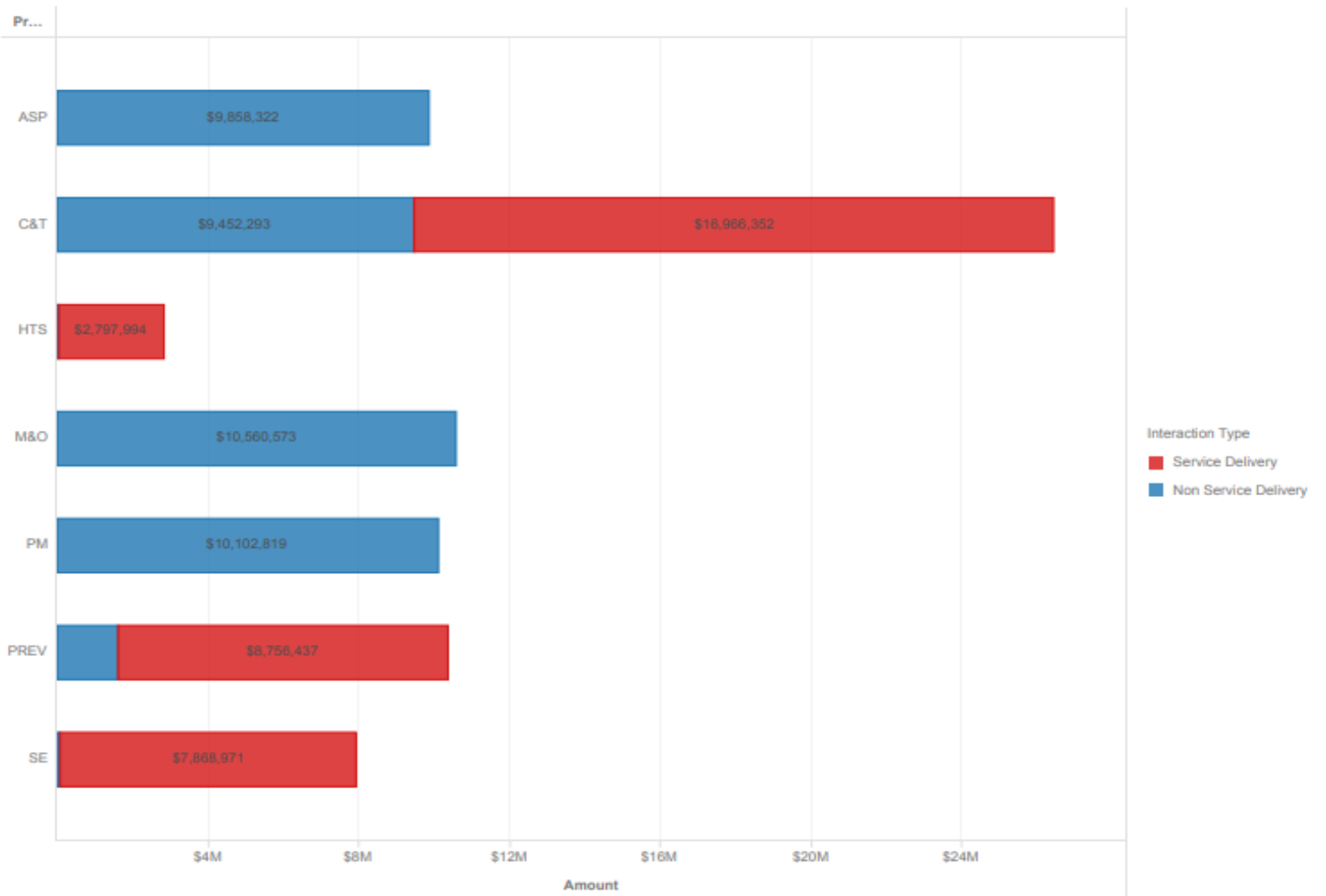
Note: All four regions are Attained SNU.

Data source: The figures included are unconditional (estimated PLHIV as denominator) ART coverage target for COP19 and COP20 calculated from Spectrum 2020 model. APR 20 Q1 shows actual ART coverage. Due to the significant changes in estimate of PLHIV in spectrum model, the target figure for COP19 has altered below the APR results for some age bands.

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Figure B.1.1 COP20 Budget by Program Area



Source: PEPFAR Eswatini COP20 FAST tool, 2020

Table B.1.2 COP 19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$2,000,006	\$76,064,833	\$78,064,839

Source: PEPFAR Eswatini COP20 FAST tool, 2020

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$207,231
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$1,958,734
HVOP	Other Sexual Prevention	\$11,927,833
CIRC	Male Circumcision	\$2,538,943
HVCT	Counseling and Testing	\$2,672,299
HBHC	Adult Care and Support	\$1,929,931
PDCS	Pediatric Care and Support	\$696,568
HKID	Orphans and Vulnerable Children	\$6,700,848
HTXS	Adult Treatment	\$27,965,372
HTXD	ARV Drugs	\$380,464
PDTX	Pediatric Treatment	\$628,919
HVTB	TB/HIV Care	\$2,710,372
HLAB	Lab	\$1,005,025
HVSI	Strategic Information	\$1,111,832
OHSS	Health Systems Strengthening	\$1,571,356
HVMS	Management and Operations	\$6,578,247
Applied Pipeline		\$2,000,006
TOTAL		\$78,064,839

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. The FY19 PEPFAR Expenditure Reporting results were used as a baseline for setting the FY21 budget. In the absence of full year expenditure data, the FY20 budget was used as a baseline and adjusted for program variations whose implementation will continue in FY21. Estimates based on the country program's experience were used for new mechanisms that did not have historical data.

APPENDIX C – Tables and Systems Investments for Section 6.o

The Table 6-E tab and SRE Tool-E tab of the Table 6 and SRE Excel workbook is attached in Appendix C. The final Excel workbook was submitted as a part of the SDS.

Table 6-E (Entry of Above Site Programs Activities)																
Funding Agency	MockName	Prime/Partner	MOU	COP10 Program Area	COP10 Beneficiary	Activity Budget	COP10 Activity Description	COP10 Activity	Key System/Center	Intermittent	High Priority	Relevant Indicator or Measurement	COP10 Baseline Data	COP10 Benchmark	COP10 Benchmark	COP10 Benchmark
USAID	GHC-PSM	Chemionics International, Inc.		ASP: Procurement & supply chain management-MSO	Non-Targeted Pop. Not disaggregated	\$763,200	TA to supply chain management and procurement at national, regional and facility levels support to Central Medical Stores (CMS) for warehouse management and staffing, rollout of the open source commodity tracking system (eCMS) at facilities, supply chain management, national medicines use, data use, medicines regulation and pharmacovigilance; support to annual quantification and quarterly supply planning.	Forecasting supply chain plan, budget and implementation	Adequate and consistent supplies of drugs and commodities at facility level	COP16	COP21	SC_STOCK: % of stock status observations where commodities are stocked according to plan, by level in supply chain; # of sites with end to end commodity visibility; stock at all levels are within min/max margins	SC_STOCK Q4: 32% out of 184 observations; eCMS pilot site with commodity visibility	Initiate active pharmacovigilance activities in light of the ART adult and paed optimization agenda, facilitate a waste management assessment at both CMS and facility level. Roll out of TransitT to facilitate transmission of real-time proof of delivery of health commodities to all the public health facilities in Eswatini.	Stock levels maintained within acceptable margins; COPs and OSPs verified for all commodities; support the full roll out of TLD to eligible clients; Facilitate destruction of all waste (expired commodities) by GDOE; development of waste management strategy for GDOE; pilot the eCMS in at least 6 facilities (leveraging OP resources)	Complete end-to-end stock status visibility (including bar coding)
USAID	Exontri Client Management Information Systems	Fel.com, Inc		ASP: HIMS, surveillance, & research-MSO	Non-Targeted Pop. Not disaggregated	\$225,000	Support to the MOH to roll out and expand the use of the Client Management Information System (CMS). Program and system focused enhancements, for effective functionality, will be a critical piece in COP20.	HIMS systems	Complete and correct Patient Electronic Medical Records	COP16	COP21	# of ART sites with a functional CMS. CMS uses generate accurate reports on quarterly basis for regional and national tracking of TB, PMS, TX, New, TX, CURA, and viral suppression within +/- 5% margin of error.	CMS deployed to 172 ART sites at least 10 sites on microwave platform; at least 110,000 ART Clients in CMS; at least 60% of registered ART Clients have PIN; CMS V2 piloted at 4 sites	CMS V2 rolled out to all 172 PEPPAR supported ART sites; additional 50 sites migrated to microwave technology; monthly data analysis and data use sessions conducted and used for QI/QA at all CMS sites; data quality at site level improved to within +/- 5% margin of error; at least one regional data summit conducted; use of biometrics/alternatives for improved patient identification tested; alternative energy sources at facility level identified (battery pack/solar/generators); CMS Helpdesk supports all 172 facilities; interoperability platform for data exchange between CMS and LIS functional; routine DQA verification conducted	CMS V2 rolled out to all 180 ART sites; additional 50 sites migrated to microwave technology; monthly data analysis and data use sessions conducted and used for QI/QA at all CMS sites; data quality at site level improved to within +/- 5% margin of error; use of biometrics/alternatives for improved patient identification pilot tested; CMS Helpdesk supports all 180 ART facilities; interoperability platform for data exchange between CMS and LIS functional; routine DQA verification conducted	Operational maintenance, security plan development and performance enhancements implemented.

APPENDIX D– Minimum Program Requirements

Green activity has been met the Minimum Program Requirements. Yellow activity is on-going during COP19.

Issue	Policy or implementation status change
Test and start with direct and immediate linkage to treatment	Ongoing implementation
Differentiated service delivery models	Maintenance of full-scale implementation
Optimization of ART: TLD	Maintenance of ART optimization
Scale up of index testing and self-testing, ensuring consent procedures and confidentiality	Train index HCWs on confidentiality issues around index testing. Scale up HIVST distribution to priority population
TPT scale-up	All supported sites will be implementing TPT at scale.
Completion of Diagnostic Network Optimization: 100% EID and VL	Maintenance of existing and increasing number of sites that are fully accredited.
Elimination of all formal and informal user fees	No fees
Offer prevention services, including PrEP	National scale up
Evidence of host government assuming greater responsibility of the HIV response	Continued commitment of government to fund increasing numbers of adults on first line treatment in addition to the majority of facility and HRH costs
Scale-up of case-based surveillance and unique identifies for patients across all sites	Continue to improve access to patient IDs. Not funded to implement roll out of biometrics.
Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services	Increased enrolment of C/ALHIV; new preventative of OVC services
Clear evidence of agency progress toward local, indigenous partner prime funding.	Increasing progress towards local, indigenous partner prime funding.
Continual Quality Improvement	Continued CQI at facility level, IP workplans and national policy
Health Promotion/health literacy activities	Treatment and VL literacy education actively integrated into community programming and facility service delivery.

Source: PEPFAR Eswatini COP20 Outbrief slide for COP20 planning meeting, 2020