



FY 2015 Swaziland Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Swaziland.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

**Swaziland Country Operational Plan
(COP) 2015
Strategic Direction Summary**

August 12, 2015

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Goal Statement

The overarching goal of the PEPFAR/Swaziland program is to support the Government of Kingdom of Swaziland (GKOS) to control the HIV epidemic and reverse its impact per the extended National Multisectoral Strategic Framework for HIV and AIDS (eNSF) 2014-2018 through the following:¹

1. Reduce new HIV infections among adults and pediatrics by 50% and 90%, respectively,
2. Avert 15% deaths amongst PLHIV, in particular those with TB/HIV co-infection,
3. Alleviate socio-economic impacts of HIV/AIDS among vulnerable groups and the population generally,
4. Improve efficiency and effectiveness of the national response.

PEPFAR/Swaziland (PEPFAR/S) is planning to support the GKOS in all four regions with a more aggressive time line to achieve 90-90-90 by 2017. In order to do this, PEPFAR/S will pivot the program to focus on the following:

- ▶ Identifying the remaining HIV positive people: the first “90”
 - ▶ Pivot 1: Maintain focus on provider initiated HIV testing and counseling (PIHTC) and increased focus on finding undiagnosed, HIV-positive people in the community
 - ▶ Pivot 2: Work with the GKOS to roll out treatment at CD4 <500 in COP15 and adopt test and treat in COP16 in order to maximize numbers of pre-ART individuals on treatment
- ▶ Improving linkages to treatment: the second “90”
 - ▶ Pivot 3: PEPFAR support of test and treat
 - ▶ Pivot 4: Community ART
 - ▶ Pivot 5: Improve linkages to care and treatment
- ▶ Assuring viral suppression: the third “90”
 - ▶ Pivot 6: Expand viral load monitoring

To monitor progress towards 90-90-90 PEPFAR/S will monitor key indicators and engage in continuous data-quality monitoring with MOH (details provided in Sections 4.5 and 6.2).

PEPFAR/S assessed its partners’ performance, costs and gaps using the Global Fund (GF) gap analysis, PEPFAR Expenditure Analysis (EA) data, eNSF cost-estimates and donor contributions

¹The Extension of the National Multisectoral HIV AIDS Framework (eNSF) 2014-2018

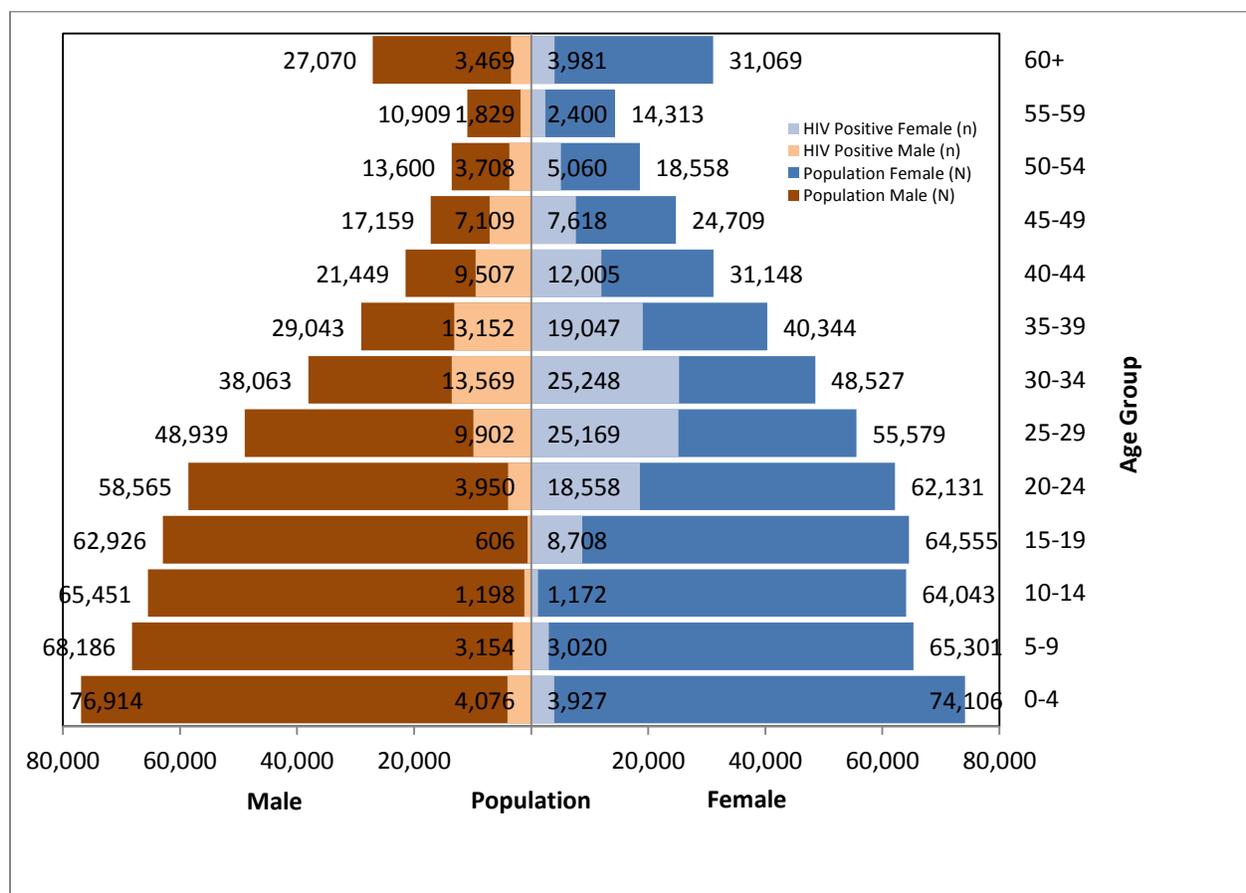
and presence in different regions to strategically position itself and align resources to most efficiently achieve these goal.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Swaziland's population is 1,132,657 (2016 projected), 37% are <15 years old and 76% are rural. About 24% of children <18 years are orphans, and 45% are either orphans or vulnerable.²

Figure 1.1.1: Population and Number of PLHIV, Swaziland, 2016



Source: Swaziland Population Projections 2007-2030; Swaziland HIV Estimates and Projections Report 2013

HIV prevalence is 32% for adults aged 18-49 years (men: 24%; women: 39%)³ and 26% among adults aged 15-49 (men: 26% women: 31%).⁴ Prevalence for persons aged ≥ 2 years is 19% (2-14

² Central Statistics Office (2007). Swaziland Population Projections, 2007-2030

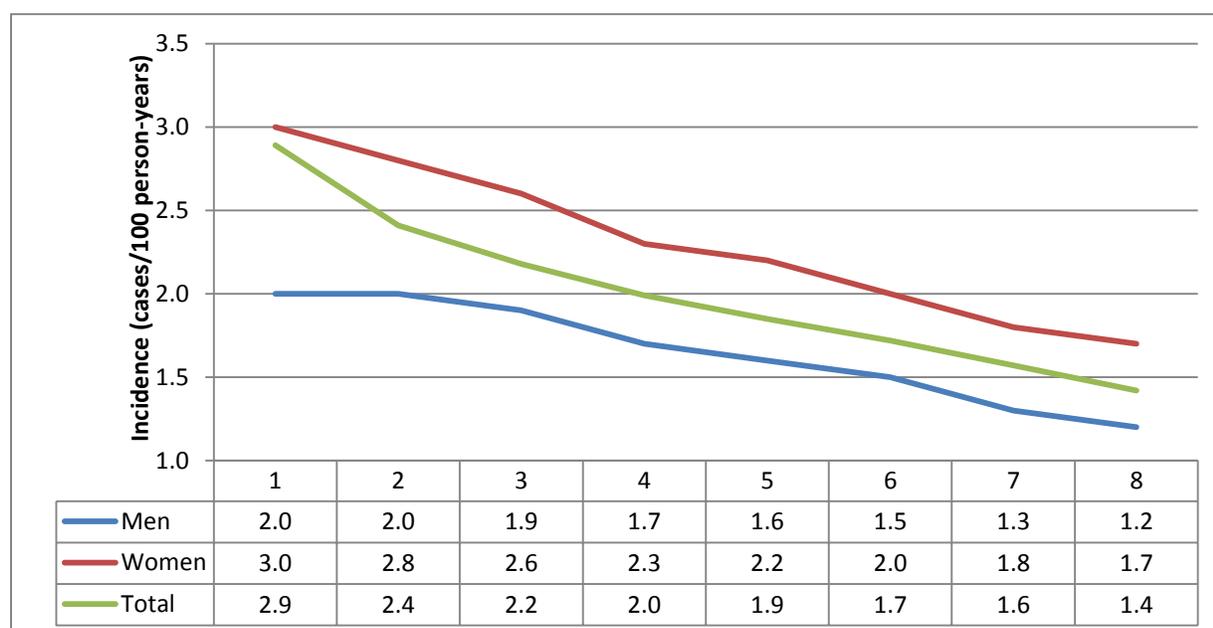
³ MOH (2012). Swaziland HIV Incidence Measurement Survey (SHIMS)

⁴ Central Statistics Office (2008). Swaziland Demographic and Health Survey 2006-2007

years: 4%; 50+ years: 14%).³ Men aged 35-39 have the highest male prevalence (47%), while women aged 30-34 years have the highest female prevalence (54%).³ This is a generalized epidemic affecting all subnational units (SNU=regions); among 18-49 year-olds, HIV prevalence is 31% in Hhohho, 34% in Manzini, 31% in Shiselweni, and 32% in Lubombo.³ Reliable HIV prevalence data are available only at the first SNU.

HIV incidence among adults 18-49 years old is 2.4/100 person-years (men: 1.7; women: 3.1).³ The age groups with highest incidence are men aged 30-34 years (3%) and women aged 20-24 years (4%) and 35-39 years (4%).³ Modeled estimates from Spectrum suggest incidence is declining from 2.4 in 2012 to 1.6 in 2015 (men: 1.6; women: 2.2). Spectrum projects further decline to 1.1 (men: 1.2; women 1.7) in 2018 for adults aged 15-49 years.⁵

Figure 1.1.2: Projected trends in HIV incidence in adults 15-49 years, 2011-2018



Source: Swaziland HIV Estimates and Projections Report 2013

Among 6,665 TB patients, 4,747 (71%) are co-infected with HIV.⁶ Cumulatively, 69,777 male circumcisions were performed; 47,536 (68%) occurred in men aged >15 years.⁷ National guidelines for treatment eligibility moved from CD4 count <200 cells/mm³ to <350 cells/mm³ to <500 cells/mm³ in 2014.⁸

Epidemic control ratio (# new infection/# AIDS-related death) has decreased from 2.5 in 2011 (new infections: 13,654; AIDS-related deaths: 5,563)³ to 2.1 in 2014 (new infections: 10,440; AIDS-related deaths: 5,019); in 2016 the projected ratio will be 1.7 (new infections: 9,438; AIDS-related deaths: 5,601). Although expected to continue to decline, epidemic control ratio is not expected to reach <1 by 2018 under current conditions, unless the number of new infections is significantly reduced. The number of AIDS-related deaths is expected to decrease due to improved treatment

⁵ NERCHA (2013). Swaziland HIV Estimates and Projections Report 2013

⁶ MOH (2013). TB National Report 2013

⁷ Population Services International (2014). Male Circumcision Program Report

⁸ MOH (2014). National ART Guidelines

and quality of care. The current number of new infections needs to reduce by half to achieve epidemic control.

The GKOS used a variety of models⁹ with different intervention levels (Table 1.1.o) to determine targets for incidence reduction. Although the goal of halving new infections by 2016 could not be met under any scenario, the downward trend in the eNSF-max scenario will continue beyond 2018 to reach the target of halving incidence in 2021¹⁰. The impact on adult mortality will be substantially less than the impact on new infections. (Figure 1.1.6).

The model suggested that incidence would be halved by 2018 under a universal test-and-treat (UT) scenario (Figure 1.1.7)

Table 1.1.o: Proposed coverage at different intervention scenario for the eNSF

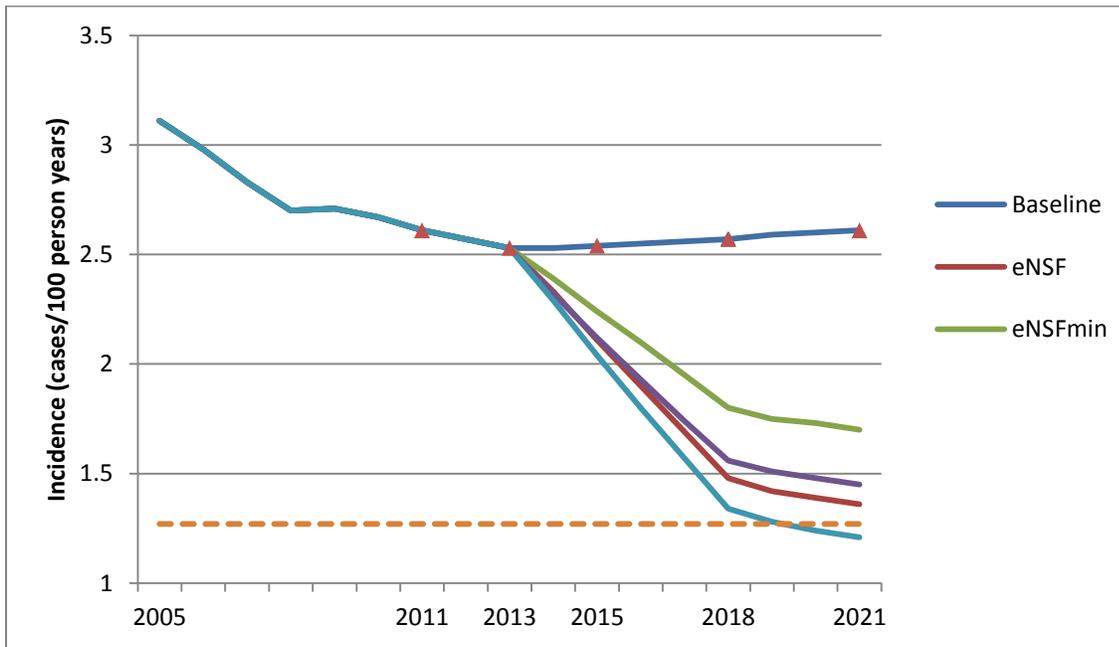
| | Proposed Coverage | | | | |
|--------------------------------------|-------------------|------|---------|---------|---------|
| | Baseline 2013 | eNSF | eNSFmin | eNSFmed | eNSFmax |
| Condom promotion | 30% | 60% | 60% | 70% | 80% |
| VMMC Males | 19% | 70% | 40% | 55% | 70% |
| CD4>350-CD4<500 cells/uL | | | 30% | 50% | 70% |
| Children ART | 66% | 95% | 75% | 85% | 95% |
| PMTCT coverage | 85% | 95% | 85% | 90% | 95% |
| ART started before current pregnancy | 22% | 69% | 59% | 64% | 69% |

Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland 2013

⁹ SPECTRUM, GOALS, Prevtool, and Resource Needs Model

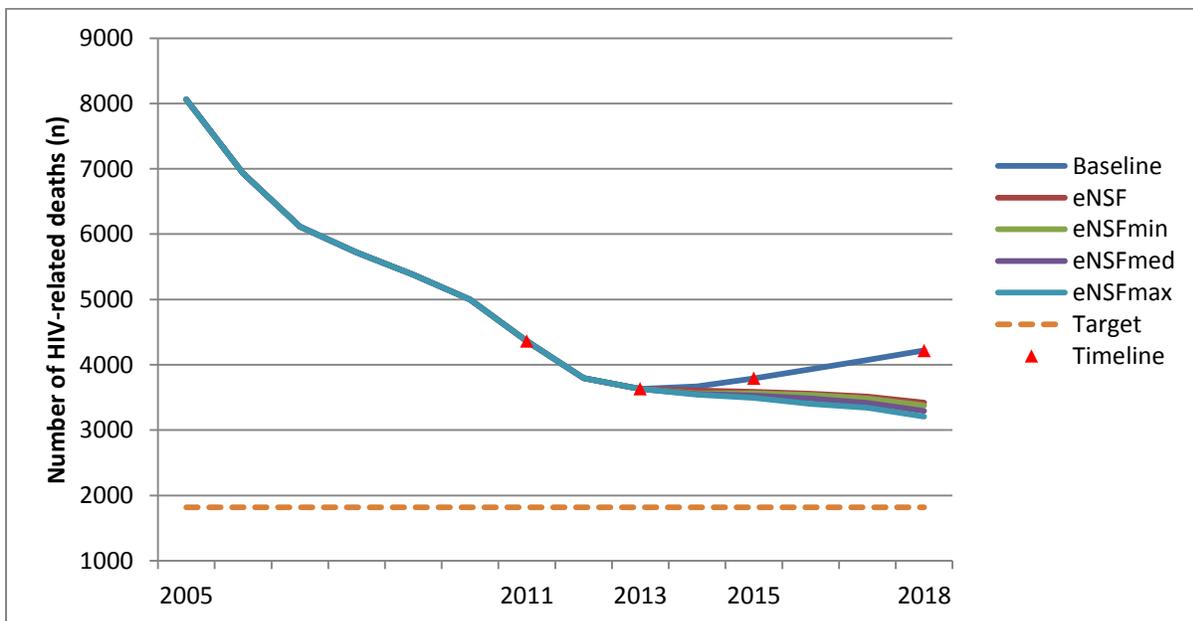
¹⁰ Carel Pretorius & John Stove, Futures Group (2013). The Cost and Impact of the Extended National Strategic Framework in Swaziland

Figure 1.1.3: Projected incidence using eNSF coverage scenarios, adults 15-49 years



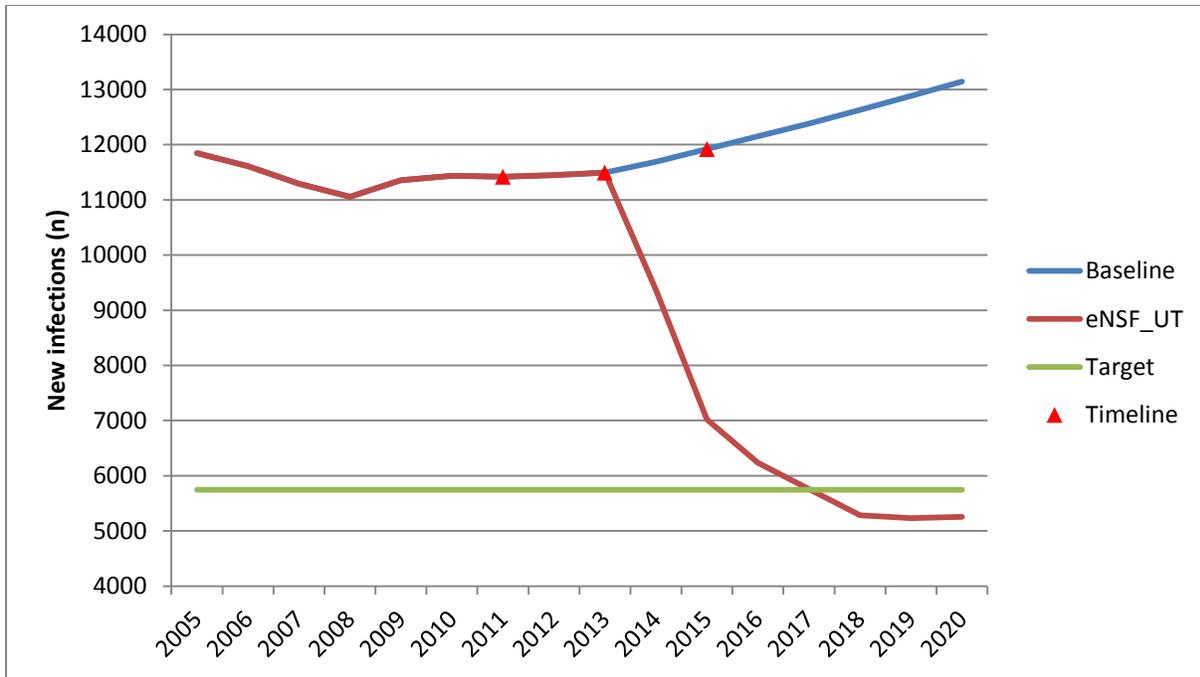
Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland

Figure 1.1.4: Projected HIV-related deaths using eNSF coverage scenarios, adults 15-49 years



Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland

Figure 1.1.5: Projected new infections using eNSF Universal Treatment (UT) scenario, adults 15-49



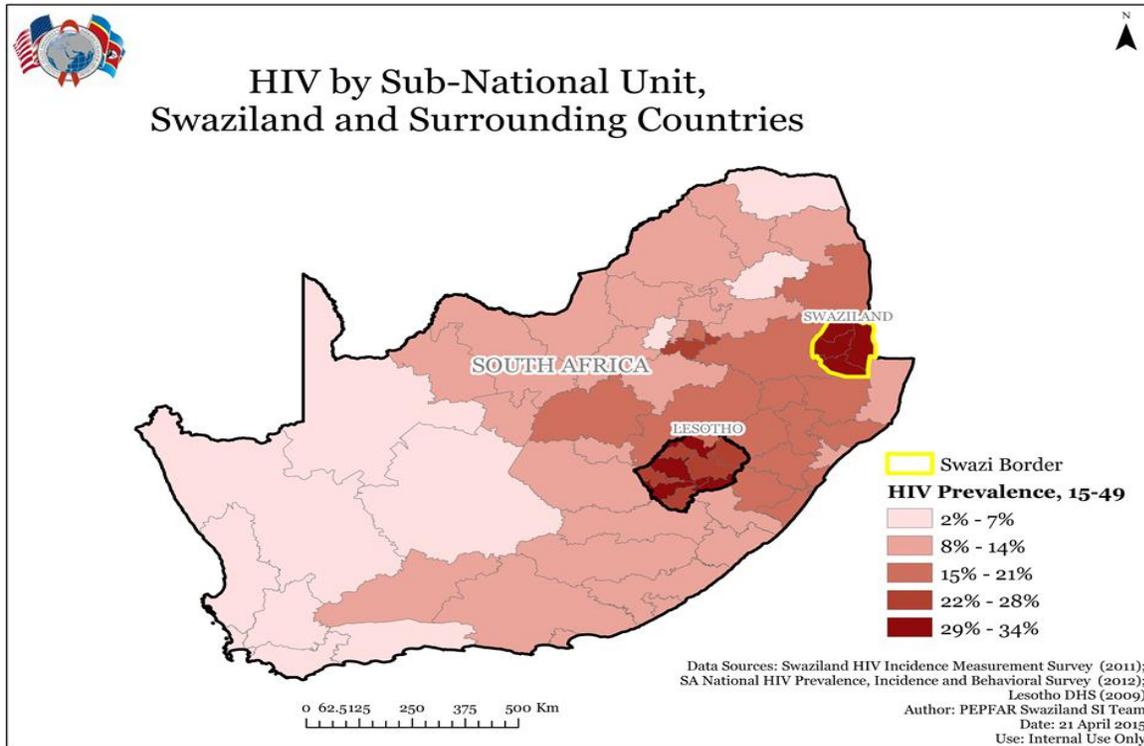
Source: The Cost and Impact of the Extended National Strategic Framework in Swaziland

A significant proportion of rural households and urban-based informal settlements rely on migrant remittances for their sustenance. High population mobility has been identified as one of the key drivers of the AIDS epidemic¹¹.

PEPFAR/S plans to scale up the epidemic control in all four regions due to 1) high level HIV prevalence in all regions, and 2) high migration of population across the regions¹¹ with fluctuating catchment areas. Swaziland's homogenously high HIV prevalence is epidemiologically comparable to sub-national unit of its neighbors (Figure 1.1.6).

Figure 1.1.6: HIV Prevalence by Sub-National Unit, Swaziland and Surrounding Countries

¹¹ Briefing Note On HIV And Labour Migration In Swaziland 2008. Author: International Organization for Migration



Other major challenges to achieve epidemic control include:

1. Lost to follow up (LTFU) of patients starting ART at $CD4 > 500$ and also PMTCT B+ women ($CD4 > 350$ and WHO stage I/II);
2. Deeply engrained socio-cultural and gender norms that are barriers to uptake of services;
3. Compromised supply chain and warehousing for treatment scale up;
4. Lack of physical space and human resources for scale up at the high volume facilities already at peak capacity;
5. Human resource (HR) shortages especially among lay and supportive cadres (lab technicians);
6. Limited coordination and effective use of strategic information for program improvement and policy decision making.
7. Knowledge of HIV positive status was 62.4% in 2011 (females 68.7%; males 50.4%). HIV testing has been scaled up significantly since 2011 and these numbers are likely to have gone up. Finding the remaining positives in a generalized epidemic to reach the first 90% will be a major challenge.
8. Tracking linkage to care/treatment within the health system is a major challenge because of the lack of a unique patient identification to help track patients across the different programs

Table 1.1.1 Key National Demographic and Epidemiological Data

| | Total | | <15 | | | | 15+ | | | | Source, Year |
|--|---------------------|------------------|---------|-----|------------------|------------------|---------|-------|------------------|------------------|---|
| | | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | |
| Total Population, 2016 | 1,132,657 | 100 | 203,450 | 18 | 210,551 | 19 | 390,933 | 35 | 327,723 | 29 | Swaziland Population Projections 2007-2030 |
| Prevalence (%) | | 18.8 | | 3.7 | | 4.0 | | 31.2* | | 19.7* | DHS, 2007 *Age group 15-49 |
| AIDS Deaths (2016 projection) | 5,601 | | 266 | | 272 | | 2,358 | | 2,705 | | HIV Estimates and Projections Report, 2013 |
| PLHIV (2015) ^a | 211,144 | | 8,285 | | 8,444 | | 116,524 | | 77,891 | | HIV Estimates and Projections Report, 2013 |
| Incidence Rate (2012) | | 2.4* | | N/A | | N/A | | 3.1* | | 1.7* | SHIMS, 2012 *Age group 18-49 |
| New Infections (2016 projection) | 9,438 | | | | | | | | | | HIV Estimates and Projections Report, 2013 |
| Annual births | 34,724 | 100 | | | | | | | | | Swaziland Population Projections 2007-2030 |
| % >= 1 ANC visit | 29,835 | 100 | N/A | N/A | | | N/A | N/A | | | SRH Report, 2013 |
| Pregnant women needing ARVs | 10,660 | 100 | | | | | | | | | HIV Estimates and Projections Report, 2013 |
| Orphans (maternal, paternal, double; 0-17 years) | 98,595 | | N/A | | N/A | | N/A | | N/A | | HIV Estimates and Projections Report, 2013 |
| TB cases (2013) | 6,665 | | N/A | | N/A | | N/A | | N/A | | TB National Report 2013 |
| TB/HIV Co-infection | 4,747 | 71 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | TB National Report 2013 |
| Males Circumcised | 69,777 | 100 | | | 22,241 | 32 | | | 47,536 | 68 | PSI MC Program Report, 2014 |
| Key Populations | | | | | | | | | | | |
| Total MSM | 5,719 ^b | 100 | | | | | | | | | JHU-HC3 Draft Key Populations Report, 2015 |
| MSM HIV Prevalence | N/A | 17.7 | | | | | | | | | MARPS BSS, 2012 |
| Total FSW | 12,274 ^c | 100 | | | | | | | | | JHU-HC3 Draft Key Populations Report, 2015 |
| FSW HIV Prevalence | N/A | 70.3 | | | | | | | | | MARPS BSS, 2012 |
| Total PWID | N/A | N/A | | | | | | | | | N/A |
| PWID HIV Prevalence | N/A | N/A | | | | | | | | | N/A |
| Priority Populations | | | | | | | | | | | |
| AGYW 15-24 years | 126,686 | 100 | | | | | | | | | Swaziland Population Projections 2007-2030 |
| Males 20-34 | 145,456 | 100 | | | | | | | | | Swaziland Population Projections 2007-2030 |
| OVC (10 -17 years) | 92,208 | 100 | 29,282 | 32 | 28,630 | 31 | 16,990 | 18 | 17,306 | 19 | Swaziland Population Projections 2007-2030; Multiple Indicator Cluster Survey, 2010 |
| Military | N/A [#] | N/A [#] | | | N/A [#] | N/A [#] | | | N/A [#] | N/A [#] | N/A |

^aGKOS uses 2015 HIV estimates for 2016 program targets

^b95% confidence interval of size estimation = 2,455-7,993

^c95% confidence interval of size estimation = 2,727-25,174

[#]Data available but cannot be printed due to national military sensitivity

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (Jan-Dec 2013)

| | | | | HIV Care and Treatment ¹ | | | | HIV Testing and Linkage to ART ¹ | | |
|-------------------------------|------------------------------------|--------------------|----------------------|-------------------------------------|------------|-------------------------------|-----------------------------|---|----------------------------|----------------------|
| | Total Population Size Estimate (#) | HIV Prevalence (%) | Total PLHIV (#) | In Care (#) | On ART (#) | Retained on ART 12 Months (#) | Viral Suppression 12 Months | Tested for HIV (#) | Diagnosed HIV Positive (#) | Initiated on ART (#) |
| Total population | 1,093,158 ² | 18.8 ³ | 204,066 ⁴ | 157,038 | 133,420 | 117,410 ⁹ | N/A | 93,162 | 9,497 | 15,213 |
| Population less than 15 years | 404,936 ² | 3.9 ³ | 17,324 ⁴ | 11,091 | 10,269 | 9,760 ⁹ | N/A | 3,893 | 157 | 1,166 |
| Pregnant Women | 34,091 ¹ | 37.7 ³ | 11,307 ⁴ | N/A | 3,386 | N/A | N/A | 22,742 | 4,496 ¹⁰ | 1,640 |
| MSM | | | | | | | | | | |
| | 5,719 ⁵ | 18 ⁶ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| FSW | | | | | | | | | | |
| | 12,274 ⁵ | 70 ⁶ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| PWID | | | | | | | | | | |
| | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Priority Population | | | | | | | | | | |
| AGYW 15-24 years | | | | | | | | | | |
| | 126,686 ² | 21.5 ⁷ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Males 20-34 | | | | | | | | | | |
| | 145,456 ² | 18.8 ⁷ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| OVC (10 -17 years) | | | | | | | | | | |
| | 92,208 ⁸ | 4.8 ⁷ | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Military | | | | | | | | | | |
| | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

¹Annual HIV Programs Report 2013, MOH

²2013 Projections, Swaziland Population Projections 2007-2030

³Swaziland Demographic and Health Survey, 2007

⁴HIV Estimates and Projections, 2013

⁵HU-HC₃ Draft Key Populations Report, 2015

⁶2016 Projections, Swaziland Population Projections 2007-2030

⁷Extrapolated prevalence from age specific incidence (SHIMS 2011) and population projections (2007)

⁸Swaziland Population Projections 2007-2030; Multiple Indicator Cluster Survey, 2010

⁹Assuming 88% retention (Draft Annual HIV Programs Report 2014, MOH)

¹⁰Newly tested HIV positive

Figure 1.1.7: Swaziland Clinical Cascade and Unmet Need for 90-90-90

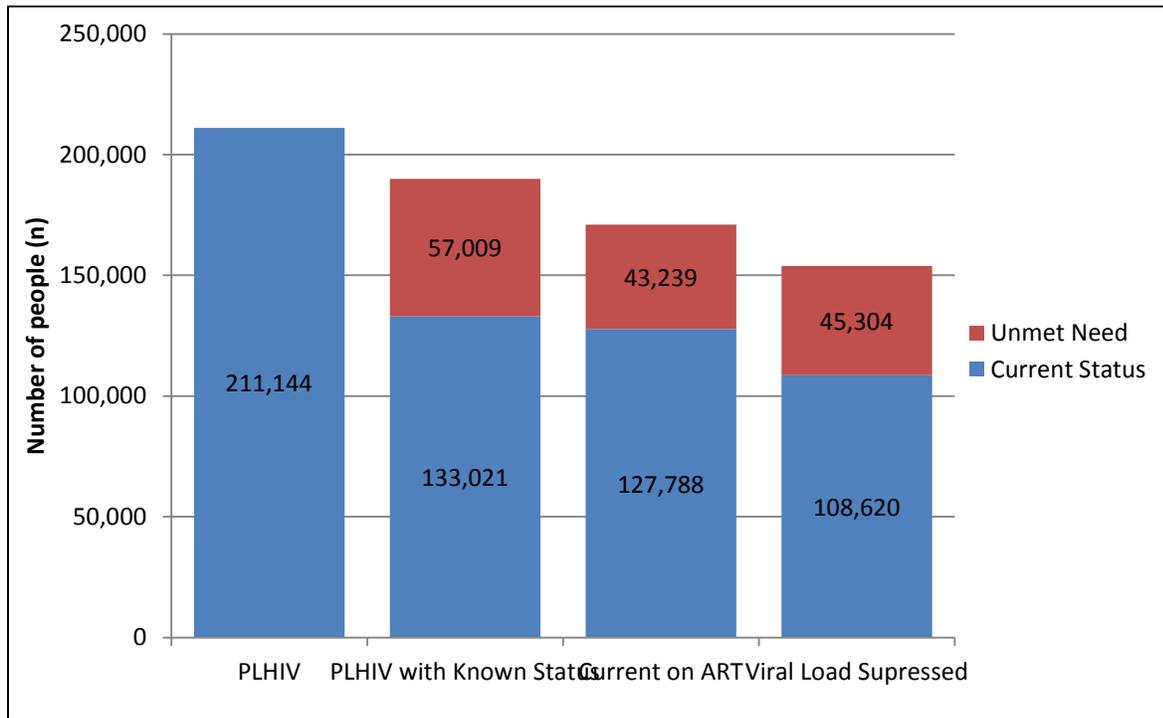


Figure 1.1.8: Swaziland Clinical Cascade and Unmet Need for 90-90-90, by Sex

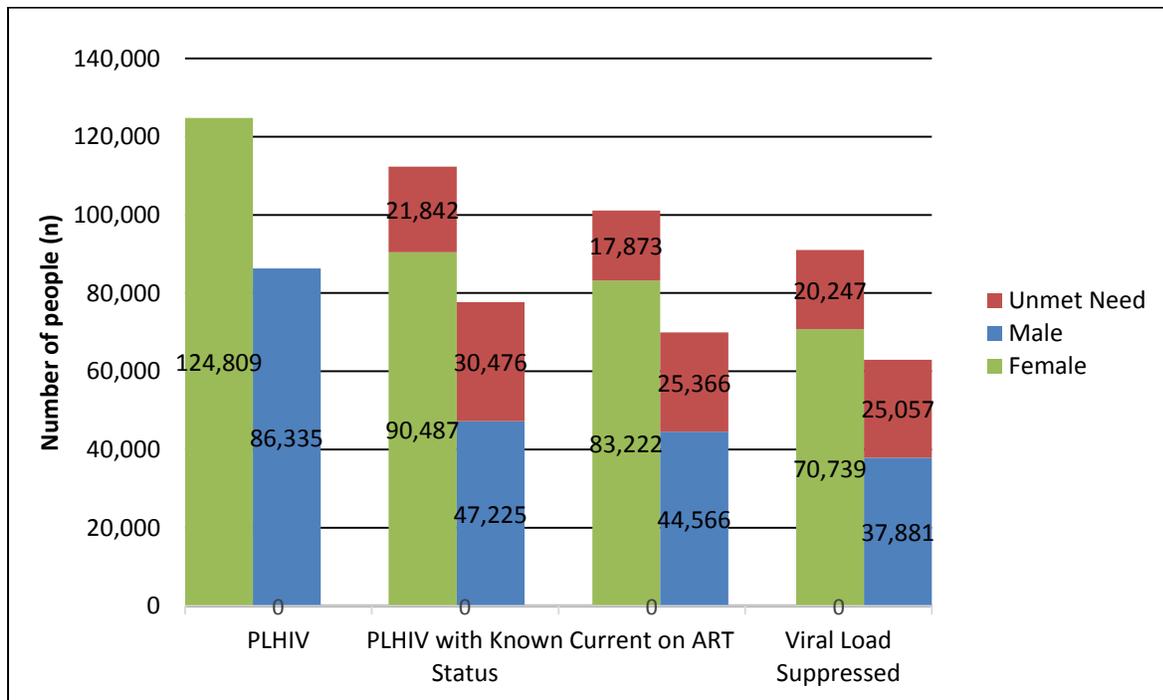
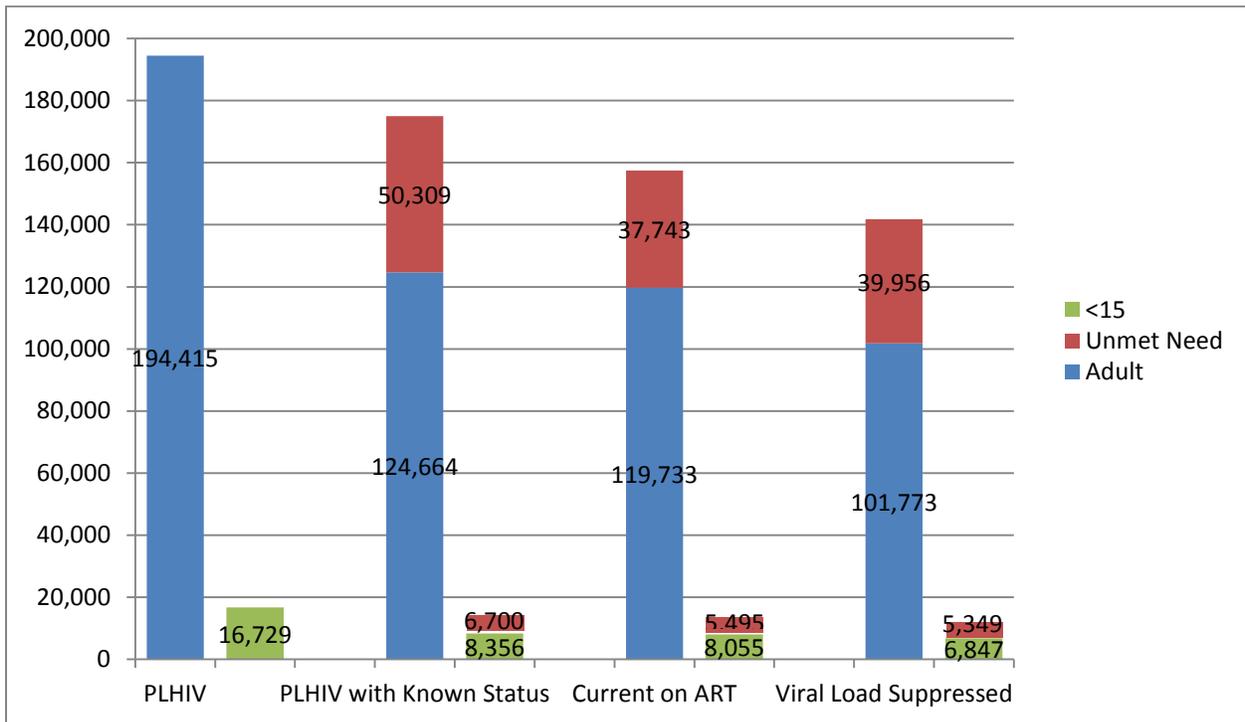


Figure 1.1.9: Swaziland Clinical Cascade and Unmet Need for 90-90-90, by Age



1.2 Investment Profile

Funding landscape: The World Bank (WB) classifies Swaziland as a lower-middle-income country with a Gross Domestic Product (GDP) per capita income of \$3,042 (2012). Trends in GKOS allocation for health show fluctuations between 9-16 % of total funds over the past five years. Total volume of Overseas Development Assistance (ODA) provided to Swaziland in 2011/12 was approximately \$ 11.9 million; the equivalent of 7.7% of the 2012/13 national budget and 2.7% of the country's GDP. The biggest provider of ODA is the United States Government (USG) which disbursed around \$35.6 million in 2012/13 through PEPFAR. In 2012, GNI per capita was 6,220 PPP\$.¹² ; total expenditure on health per capita was \$448 and total expenditure on health as % of GDP was 8.5%.¹³

How response is funded: Table 1.2.1 shows GKOS as the highest contributor (36.6 %), followed by PEPFAR (35 %), Global Fund (GF) (10.2%), and Medecins Sans Frontieres (MSF) (5%).

PEPFAR is the primary donor supporting the HIV response in Swaziland. Since 2009/10, GKOS committed to fund 100% of ARVs and most HIV test kits. Donor resources fill gaps: donors support critical areas in care and treatment such as technical assistance (TA) and human resources. Although GKOS has committed to fund all ARVs and test kits for scale up, there are periodic shortages and an emergency stock is needed to avoid interruption of ART availability. Additional donor support is also required to support viral load scale up. Swaziland continues to face challenges in maintaining a continuous condom supply. PEPFAR is the main supporter of VMMC. The National VMMC Strategic and Operation Plan (2014-2018) aims to achieve 70% VMMC among 10-49 year olds and is costed at \$4,900,000 per year.

¹² World Bank (2014). World Development Indicators Database, 1 July 2014

¹³ WHO (2015). <http://www.who.int/countries/swz/en/>

Table 1.2.1: Investment Profile by Program Area

| | PEPFAR ¹ | Global Fund ² | GRP ³ | Other ⁴ | Total | % PEPFAR | % GF | % Gov | % Other | Total |
|--|---------------------|--------------------------|---------------------|---------------------|---------------------|------------|------------|------------|------------|-------------|
| Clinical care, treatment and support | \$7,995,707 | \$4,364,298 | \$21,007,971 | \$6,098,757 | \$39,466,733 | 20% | 11% | 53% | 15% | 100% |
| Community-based care, treatment and support | \$2,680,526 | \$841,379 | \$40,105 | \$344,102 | \$3,906,112 | 69% | 22% | 1% | 9% | 100% |
| PMTCT | \$3,825,686 | \$618,969 | \$0 | \$1,657,739 | \$6,102,394 | 63% | 10% | 0% | 27% | 100% |
| HTC | \$2,481,033 | \$195,745 | \$175,824 | \$373,934 | \$3,226,536 | 77% | 6% | 5% | 12% | 100% |
| VMMC | \$4,567,893 | | \$8,189 | \$0 | \$4,576,082 | 100% | 0% | 0% | 0% | 100% |
| Priority population prevention | \$0 | \$7,616 | \$0 | \$0 | \$7,616 | 0% | 100% | 0% | 0% | 100% |
| Key population prevention | \$569,240 | \$0 | \$85,981 | \$0 | \$655,221 | 87% | 0% | 13% | 0% | 100% |
| Risk-reduction for vulnerable and accessible populations | \$356,740 | \$764,202 | \$165,471 | \$1,517,445 | \$2,803,858 | 13% | 27% | 6% | 54% | 100% |
| OVC | \$3,519,560 | \$1,850,186 | \$11,924,196 | \$1,197,082 | \$18,491,024 | 19% | 10% | 64% | 6% | 100% |
| Lab | \$2,710,513 | \$649,628 | \$2,922,046 | \$1,115,000 | \$7,397,187 | 37% | 9% | 40% | 15% | 100% |
| SI, Surveys and Surveillance | \$660,656 | \$544,752 | \$0 | \$43,322 | \$1,248,730 | 53% | 44% | 0% | 3% | 100% |
| HSS | \$5,462,036 | \$333,684 | \$248,667 | \$4,692,515 | \$10,736,902 | 51% | 3% | 2% | 44% | 100% |
| Total | \$34,829,590 | \$10,170,459 | \$36,578,449 | \$17,039,896 | \$98,618,394 | 35% | 10% | 37% | 17% | 100% |

Data sources/Key

1Expenditure Analysis

2GF Disbursement Report- HIV Round 7

3Resource Mapping and Government Budget estimates

4National AIDS Spending Assessment

Other donors include : JICA , EU, UNICEF, UNDP, UNFPA, WHO, CHAI, MSF, World Bank

N/A - data not available

Table 1.2.2: Procurement Profile for Key Commodities

| | PEPFAR ¹ | Global Fund ² | GRP ³ | Other ⁴ | Total | % PEPFAR | % GF | % GRP | % Other | Total |
|-------------------|---------------------|--------------------------|------------------|--------------------|--------------|----------|------|-------|---------|-------|
| ARVs | \$0 | n/a | \$15,237,483 | \$103,125 | \$15,340,608 | 0% | | 99% | 1% | 100% |
| Rapid test kits | \$0 | n/a | N/A** | \$24,039 | \$24,039 | 0% | | | 100% | 100% |
| Other drugs | \$0 | n/a | \$20,964,912 | \$725,229 | \$21,690,141 | 0% | | 97% | 3% | 100% |
| Lab Reagents | \$30,308 | \$3,508,851 | \$2,562,113 | \$1,347,210 | \$7,448,482 | 0% | 47% | 34% | 18% | 100% |
| VMMC kits | \$384,582 | \$0 | n/a | \$0 | \$384,582 | 100% | 0% | | 0% | 100% |
| Condoms | \$1,267 | \$0 | n/a | \$441,755 | \$443,022 | 0% | 0% | | 100% | 100% |
| Other commodities | \$629,985 | \$3,518,483 | n/a | \$1,376,867 | \$5,525,335 | 11% | 64% | | 25% | 100% |
| Total | \$1,046,142 | \$7,027,334 | \$38,764,508 | \$4,018,225 | \$50,856,209 | 2% | 14% | 76% | 8% | 100% |

N/A ** Government provides Rapid Test Kits. Though monetary data is not available.

Data sources / Key

¹Expenditure Analysis

²GF Disbursement Report- HIV Round 7

³Resource Mapping and Government Budget estimates

⁴National AIDS Spending Assessment

Other donors include : JICA , EU, UNICEF, UNDP, UNFPA, WHO, CHAI, MSF, World Bank

N/A - data not available

Table 1.2.3: Internal USG Program Integration and Leveraging, FY13

| | Total Investment | Leveraged Funds | PEPFAR In-country Contribution | # of IMs | Objectives |
|----------------------------|--------------------|--------------------|--------------------------------|----------|--|
| USAID MCH | | | | | |
| USAID TB | | | | | |
| USAID Malaria | | | | | |
| NIH | | | | | |
| CDC NCD | | | | | |
| Peace Corps | \$573,550 | | | 1 | Health PC volunteers |
| DOD Ebola | | | | | |
| Millennium Challenge Corp. | | | | | |
| Private Sector | \$3,500,000 | \$2,000,000 | \$1,500,000 | 1 | The objective is to reach 70% of the vulnerable adult population in Matsapha with high impact interventions to improve their health and productivity. The project seeks to increase access to critical prevention, treatment and care services, provide effective information and support for behavior change to reduce risk and vulnerability to HIV/TB; and effectively engage other private sector companies in the HIV response |
| PEPFAR Central Initiatives | \$200,000 | | | 2 | In FY 15, HC3 will provide support to KP for better consistency in approach. HC3 provides TA to MOH; comprehensive HIV outreach and mobile clinic services to KP in 15 hotspot areas; improved access to static KP friendly services; strengthen networks among KP; and establish supportive environment for KP with the police and municipalities. |
| | \$1,812,500 | | | 1 | OVC Special Initiative (ECD implementation and research): The OVC Special Initiative Funds focuses on the youngest of OVC through an integrated evaluation of whether there are differences in HIV-related health outcomes for children whose mothers have participated in parent education program compared with children whose mothers have not. These initiatives complement COP FY2014 HKID investments that are geared towards strategic integrated programming across ages and stages. |
| Total | \$6,086,050 | \$2,000,000 | \$1,500,000 | | |

1.3 Sustainability Index

The Sustainability Index identified “Epidemiological and Health Data” and “Resource Commitments” as elements that are unsustainable and require additional investment. HRH, Supply Chain, Resource Generation, Allocative Efficiency and Technical Efficiency are assessed as emerging sustainability (yellow).

Resource Commitments is an area that requires additional discussion around options for ensuring the long term sustainability of the HIV response in Swaziland. PEPFAR will not prioritize investments in this area, instead PEPFAR will work closely with CHAI, the lead partner working with the Ministries of Finance, Economic Planning and Development, to address aspects of health financing.

Additional support for Strategic Information (SI) is needed. GF is investing in infrastructure required to support HMIS, while GKOS supports key personnel and recurring costs for HMIS. PEPFAR/S will invest in technical assistance for HMIS and improving the quality and utilization of epidemiological and health data. With the GKOS, PEPFAR designed a capacity development strategy that focuses on creating demand for quality national health data, coordinated data sharing mechanisms, country ownership of data, and data management.

To support sustained epidemic control PEPFAR will invest in HRH systems, strengthening the capacity of the MOH in planning, budgeting and management of HRH. PEPFAR’s investment will focus on assessing staffing levels, skills mix and costing of cadres essential for treatment scale up and epidemic control.

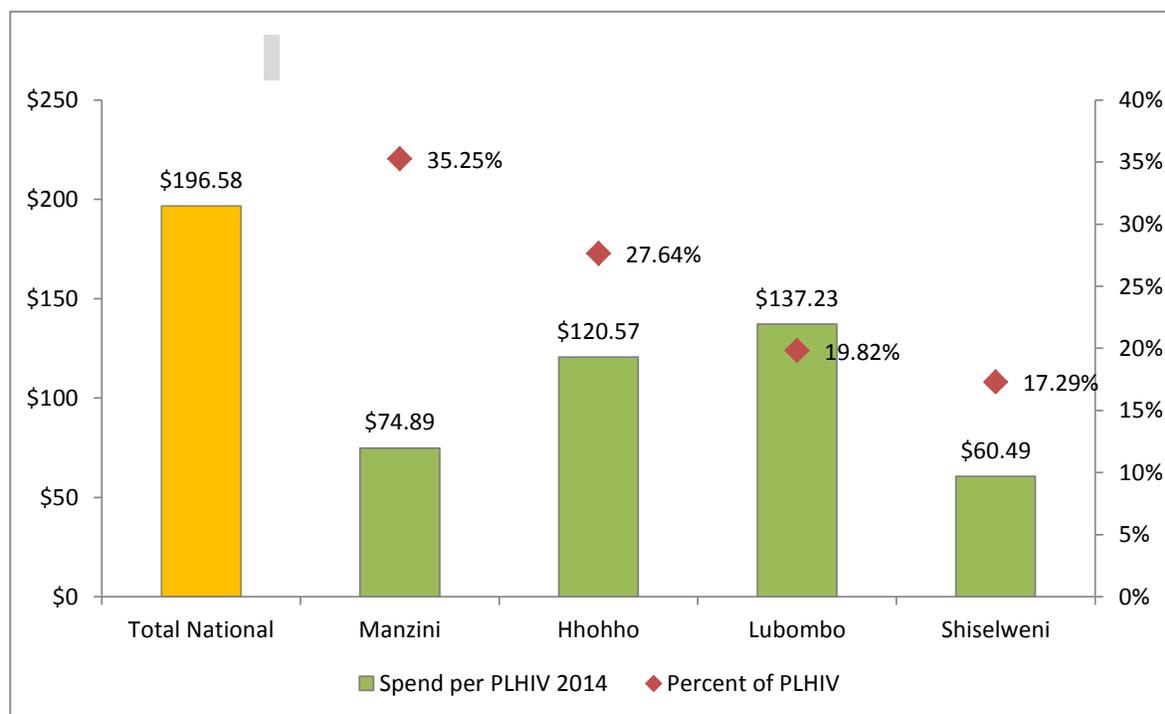
In the area of supply chain, PEPFAR will strengthen HIV drug and commodity security at central, regional and facility levels. Regional clinical partners will provide TA at site level, while a central partner will address prioritized bottlenecks at the national level. GKOS approved FY15 budget provides funding for ART scale up, however based on past experience with procurement challenges and resulting shortages, PEPFAR will procure a stock of first line adult ARVs bolster commodity security. In COP15 PEPFAR will also procure all pediatric ARVs since the small quantity required presents challenges in attracting reliable suppliers and has previously resulted in stock outs.

The MOH developed a Quality Management System in 2012. The process is reliant on PEPFAR funding and coordination. PEPFAR will support the MOH to establish a structure that will fully integrate and institutionalize the QMS.

Currently, Allocative and Technical Efficiency are highly dependent on partner support and resources. As PEPFAR/S builds local capacity and demand for data, strengthens supply chain management, HRH management and planning, and a sustainable QM system, these categories are expected to move towards sustainability.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1: PEPFAR Expenditure per PLHIV and Percent of PLHIV by Region, 2014



All SNUs in Swaziland have a high burden of disease with prevalence ranging from 31% to 34% among persons 18-49 years of age. Given the small size and population of Swaziland, and the regular movement of the population across regions (including for employment, healthcare, school, etc.), PEPFAR/S will scale up its care and treatment support across all four regions. Facilities with high volume or potential for high volume will be scaled-up, while concurrently supporting the MOH decentralization strategy. Combination prevention, other prevention and OVC services will be intensified and focused in locations identified for DREAMS, where there are higher densities of the priority populations, including in urban, peri-urban and labor magnet areas (farming, mining, wood pulp).

In an effort to improve efficiencies, PEPFAR/S is transitioning from a vertical approach where one partner was providing national, regional and facility-level support in one technical area to a new configuration where one partner will support comprehensive clinical HIV and TB services in a region, while providing national level TA in one technical area.

The outlier analysis considered a threshold cut off of 2X across all program areas. This calculated the weighted average above the average Unit Expenditure (UE) for all observations in a particular program area. The following program areas showed outliers: pediatrics, pre-ART, infants in care, HTC, HTC positive, prevention for priority populations, and MSM. The SNU with the highest number of outliers was Hhohho (7), followed by Manzini (6), Lubombo (3), and Shiselweni (1).

Program areas with more outliers are likely driven by low beneficiary numbers (pediatrics, pre-ART), wider scope of inputs (HTC) and costs of reaching hard-to-reach populations (priority populations, MSM). To address these outliers PEPFAR/S will regionalize clinical partners, and pursue efficiencies for non-clinical partners (See Annex 5).

PEPFAR/S spending per PLHIV will continue to be lower in Shiselweni because MSF supports a portion of the HIV and TB services in the region.

1.5 Stakeholder Engagement

Host country government: PEPFAR/S holds monthly meetings with the MOH and the National Emergency Response Council on HIV and AIDS (NERCHA) directorates. PEPFAR presented the data analyses that factored into proposed decisions, priorities, geographic focus and program shifts in COP FY15 and DREAMS. PEPFAR/S also met with MOH and NERCHA technical leads to ensure that they were in agreement and supported implementation of PEPFAR-supported targets.

GF and other external donors: Swaziland HIV and TB grants were approved by the Grants Approval Committee in July. PEPFAR/S technical leads engaged in the CN development, and continue to engage in the grant making process. PEPFAR shares financial and programmatic information with the GF and CCM members. CHAI and the UN family are also key partners. Frequent discussion of COP15 development occurred through the CCM platform. PEPFAR continues discussion with GF to effectively support viral load scale-up.

Civil Society (CS): PEPFAR/S convened meetings with CS to provide updates on COP14 and gather input for COP15. PEPFAR also established an email address for CS to provide additional feedback on COP15 and PEPFAR generally.

Private sector: The primary platform for engagement with the private sector is Swaziland Business Coalition on HIV and AIDS (SWABCHA) (also member of CCM). While broad private sector engagement is limited, a new PPP with Coca-Cola and the Matsapha Town Council provides an opportunity to work more closely with the business community.

In 2013, PEPFAR/S embarked on a review of the Partnership Framework. One key finding was a desire of stakeholders for more frequent direct engagement with PEPFAR. As part of the process of creating space for better transparency and engagement around COP15, PEPFAR is establishing a process for joint oversight, decision-making and sharing of financial and program data.

2.0 Core, Near-Core and Non-Core Activities

PEPFAR/S undertook an extensive core, near-core and non-core activity analysis during the conclusion of COP14 preparation and again early in the development of COP15. In categorizing activities several factors were considered including activities essential for epidemic control, the evidence base for assessing activity effectiveness, the COP15 gap analysis, results of the SID, SIMS data, as well as the broader funding landscape in Swaziland, feasibility of transitioning activities to GKOS or another partner, and PEPFAR/S's comparative advantage. Details are available in Appendix A.

3.0 Geographic and Population Prioritization

Geographic Prioritization

PEPFAR/S estimated the regional HIV burdens using SHIMS 2011 and Central Statistical Office (CSO) population projections estimates for 2016 and prioritized all regions for scale up. The estimated PLHIV by region are 71,496 in Manzini, 60,143 in Hhohho, 41,109 in Lubombo and 38,394 in Shiselweni.

Concentration of PLHIV receiving ART in high-volume urban clinics is, to some extent, a consequence of previous policy where only physicians were allowed to provide ART. The result was congestion at mostly urban facilities where physicians worked. To increase access to ART for PLHIV, the GKOS initiated decentralization of HIV services using a hub-and-spoke model since 2007. In this model, more central ART initiation facilities (hubs) are linked with surrounding primary healthcare clinics (PHC) or spokes.

According to national guidelines for decentralization, a patient who is stable on ART at the hub can be down-referred to a nurse-managed PHC (spoke) closer to the patient's home. In addition, new ART-eligible patients can be started on ART at the PHC by nurses Auld *et al* showed increase retention at spoke sites.¹⁴

PEPFAR will scale up treatment coverage in all four regions, prioritizing high volume hubs and their spokes. The level of support in Shiselweni region will differ due to the presence of MSF. MSF will support 22 out of 25 spokes and one hub facility in the areas of ART and TB/HIV service delivery (accounting for approximately 50% of ART patients in the region).

¹⁴ Auld AF, Harrison K, Azih C, et al. Evaluation of Swaziland's Hub-and-Spoke Model for Decentralizing Access to Antiretroviral Therapy Services. JAIDS 2015; 69(1):e1-e12.

Figure 3.1: ART Hub and Spoke Delivery Model, Pigg's Peak Hospital with Spoke Facilities

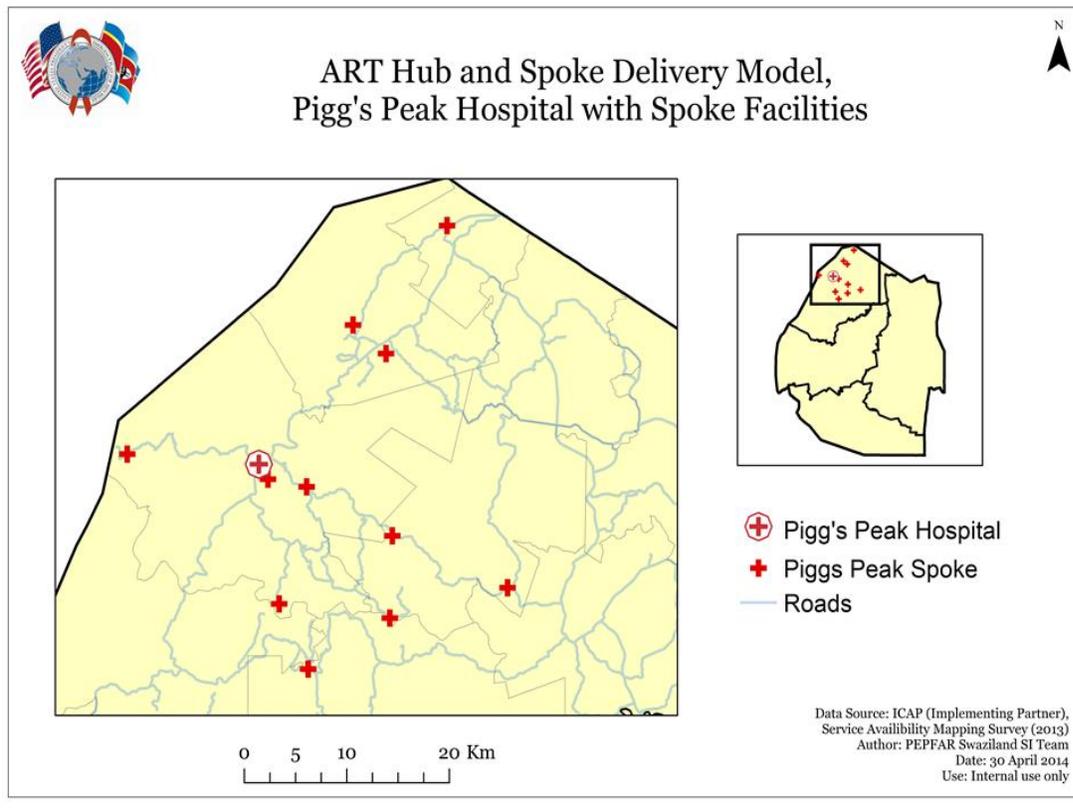
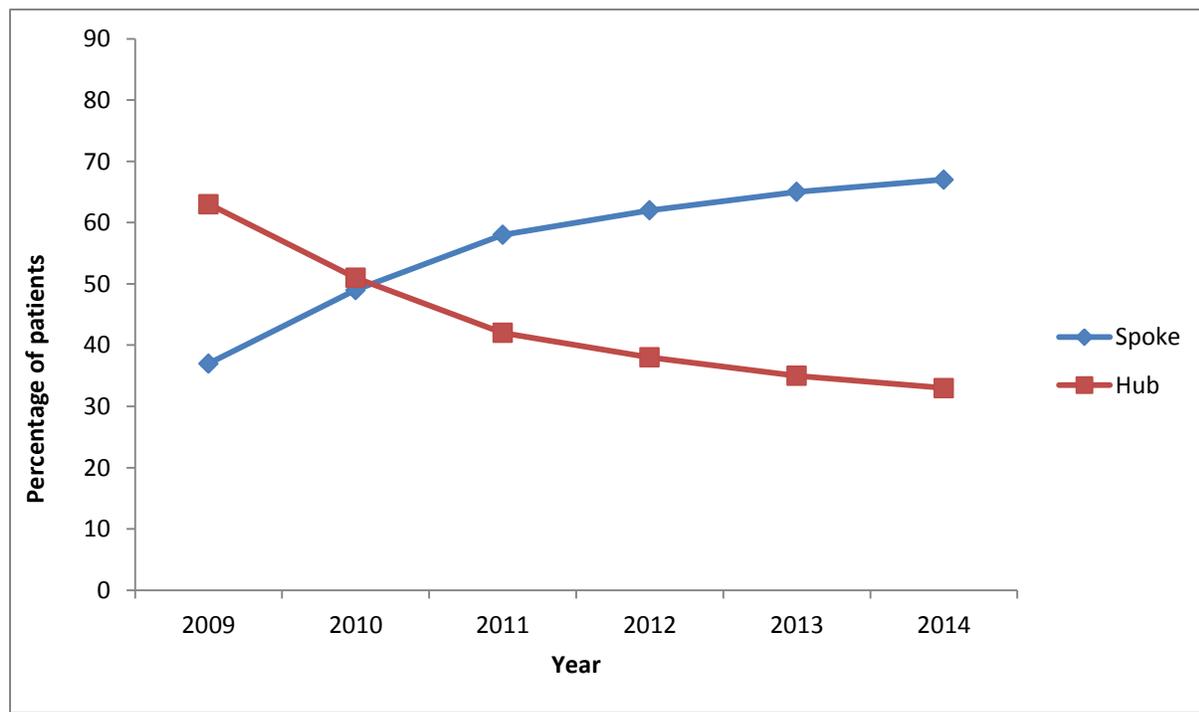


Figure 3.2: ART Initiation Trend by Facility Level

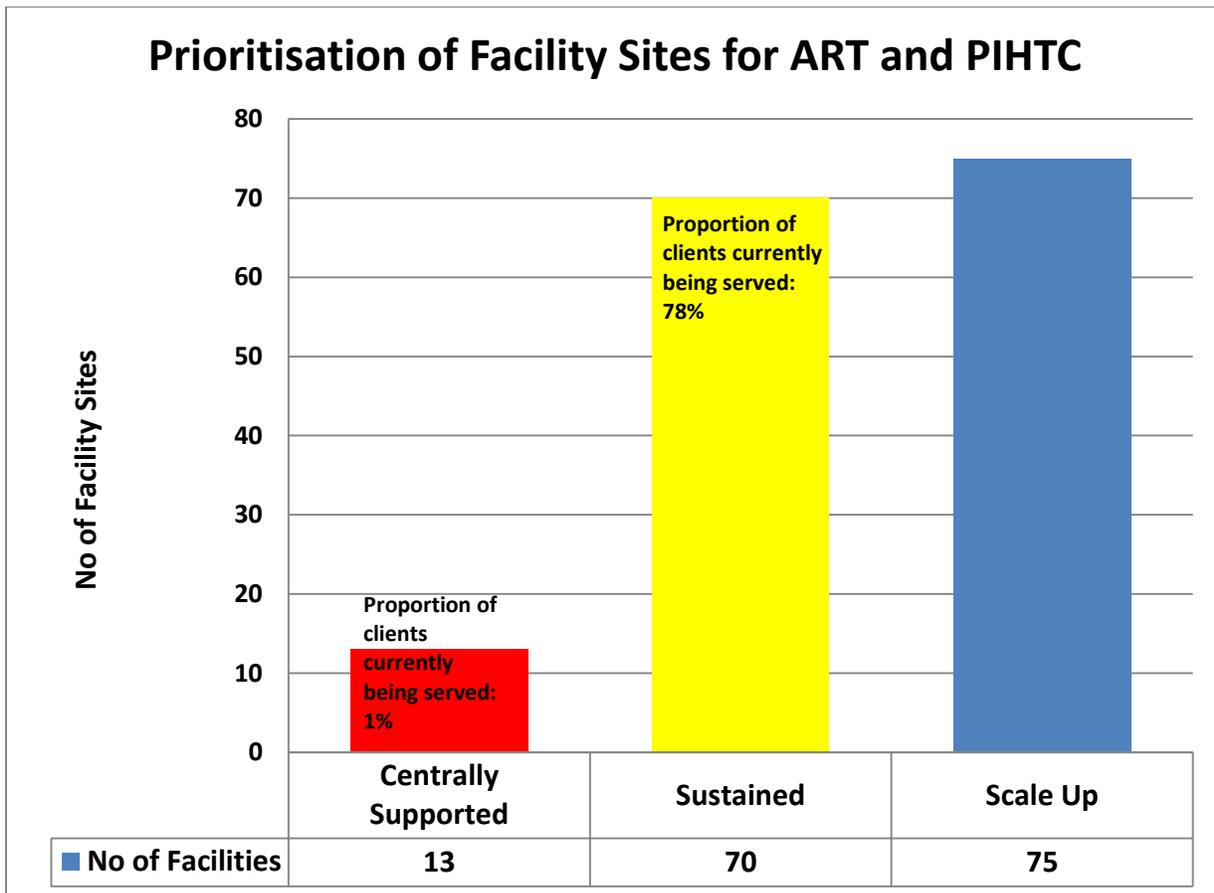


Source: Swaziland National HIV Annual Report, 2014

Site/Clinic Prioritization

In order to decompress patient loads at congested hub sites, facility data was used to determine whether clinics were capable of absorbing additional clients but also seeing sufficient clients. Seventy clinics (mostly hubs) were seeing 78% of clients; these were determined to be sustained clinics. Seventy five clinics (mostly spokes) currently served 21% of clients but could absorb additional clients from congested hub sites. These were categorized as scale up sites. Thirteen sites were serving only 1% of clients and did not have the capacity to scale up and were determined to be centrally supported (Figure 3.4).

Figure 3.3: Prioritization of Facility Sites for ART and PIHTC



PEPFAR/S will expand mobile outreach approaches to reach priority and key populations in locations where they work/live. The objective of the mobile approach is to rapidly increase uptake of HTC and linkages to and/or enrollment in care for HIV+s and linkages to prevention services for HIV negative individuals in select geographic locations with higher concentrations of the priority and key populations (19 focus DREAMS Tinkhundla, 15 KP hot spots). A yield analysis, based on the APR 14 results showed 35% (75 out of 217) of sites contributed 80% (20,039 out of 24,976 positives) of the HIV+s identified (Figure 3.4), while 40% of sites (56 out of 142)

contributed 80% of HIV+ pregnant women identified (7,618) (Figure 3.5). The average community initiated HTC (CIHTC) yield was 10%; PMTCT HTC yield was 36%. Most (at least 75%) of the HIV+s were identified through provider initiated HIV testing (PIHTC). Manzini region had higher HTC yield at 12%. Nine HTC sites were identified as having four positives or less during the APR 14, and will not be supported in FY 15.

Figure 3.4: HTC Yield by Site and Cumulative Number of Positives Identified, FY14

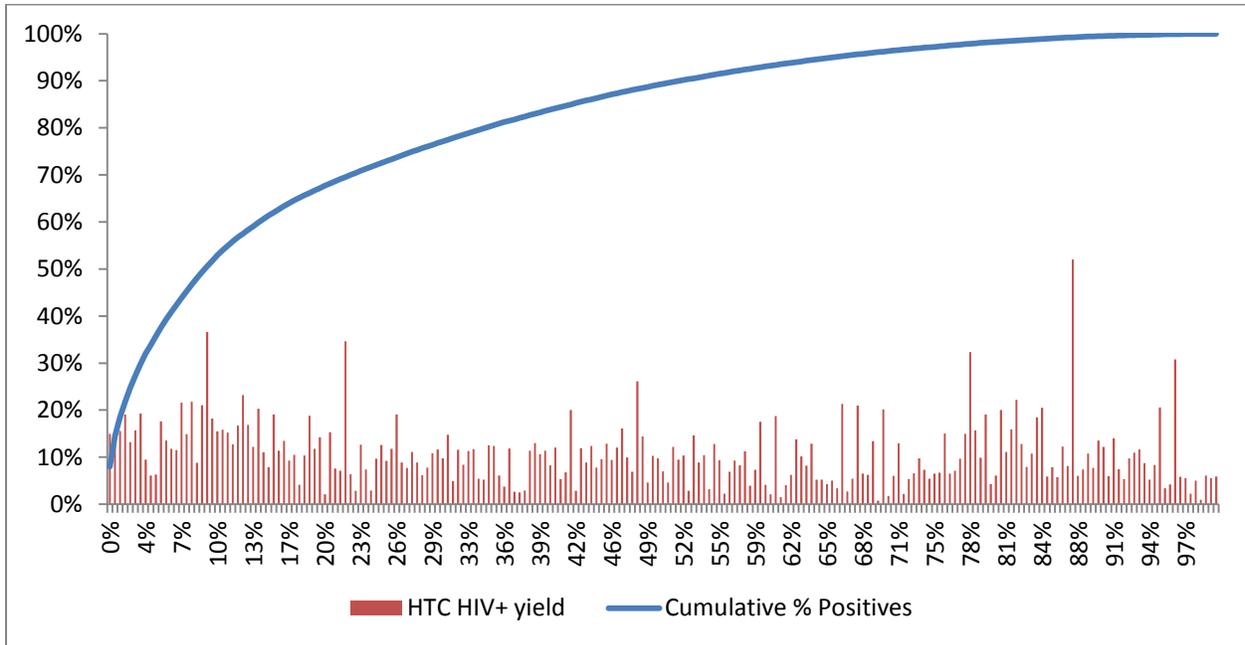
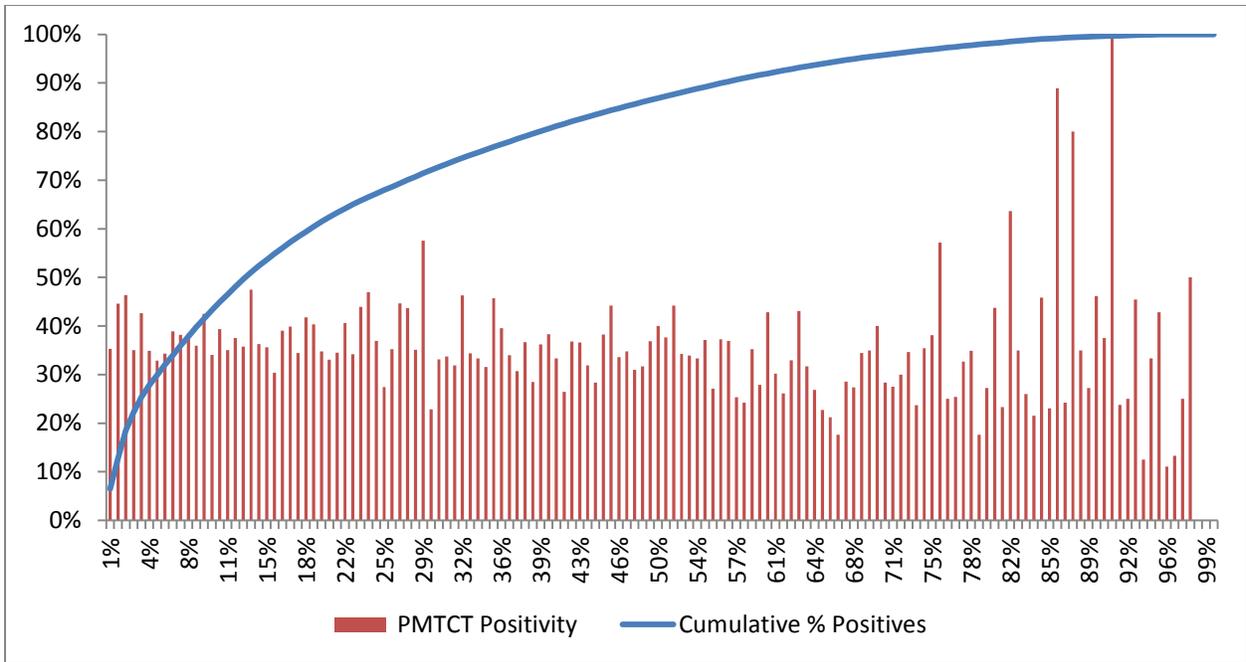
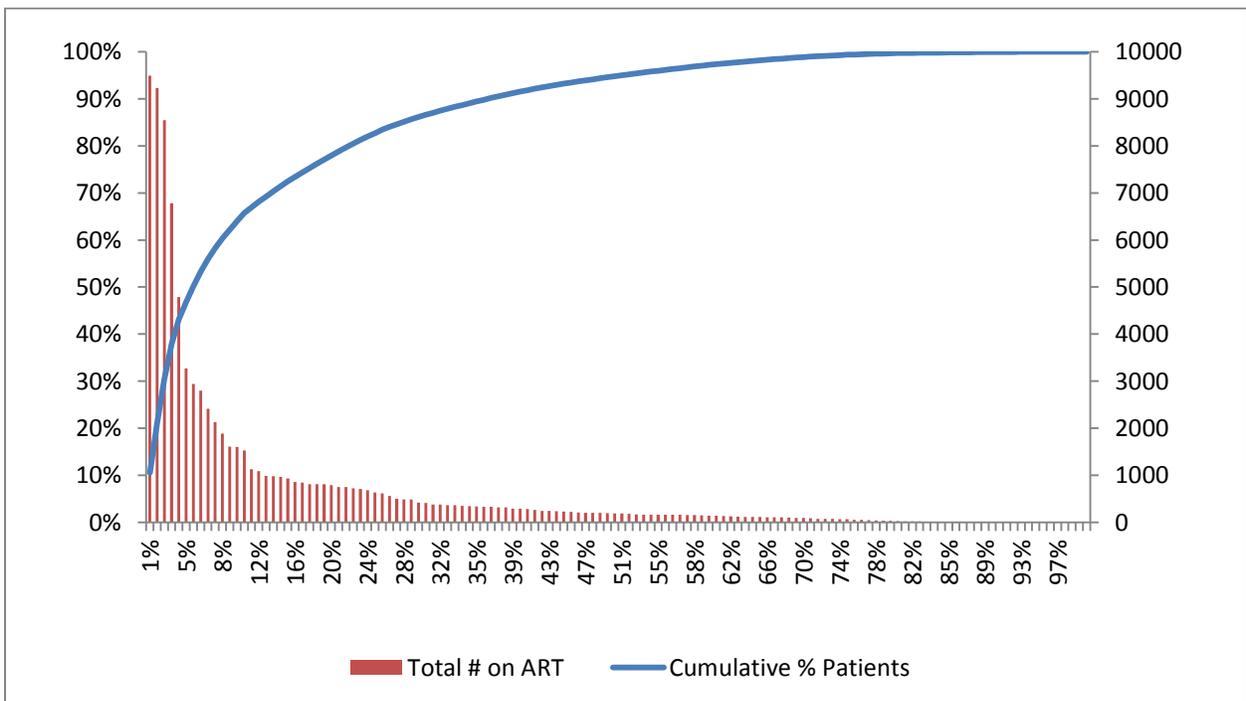


Figure 3.5: PMTCT Yield by Site and Cumulative Number of Positive Pregnant Women Identified, FY14



ART Volume analysis indicated that 22% of the sites (29/ 130) contributed 80% of clients currently on ART (72,284/89,856) (Figure 3.6).

Figure 3.6: ART Volume by Site and Cumulative Number of Patients on ART, FY14



Populations:

In addition to PLHIV, PEPFAR/S identified adolescent girls and young women (AGYW) (15 – 24 years), men (20-49 years), the Military, and OVC as priority populations (PP) (see Annex 4 on DREAMS Initiative). These population segments were selected based epidemiologic and contextual factors including:

- High HIV prevalence among women 20-24 at 30% (SHIMS 2011)
- Highest incidence groups include men aged 30-34 years (3%) and women aged 20-24 years (4%)
- 50% of HIV+ men are likely to be unaware of their HIV status, and have high viral load (SHIMS 2011)
- High rates of sexual and gender based violence (SGBV); 38% of women aged 18-24 years experienced sexual violence¹⁵
- 15% of young women aged 18-19 years are living with HIV compared to less than 5% of young men (SHIMS 2011)
- AGYW report having unprotected sexual relations with men 5-10 years older than them (SHIMS 2011)

Figure 3.7: PEPFAR Supported Key Population Hot Spots, 2015

¹⁵ VACS 2007

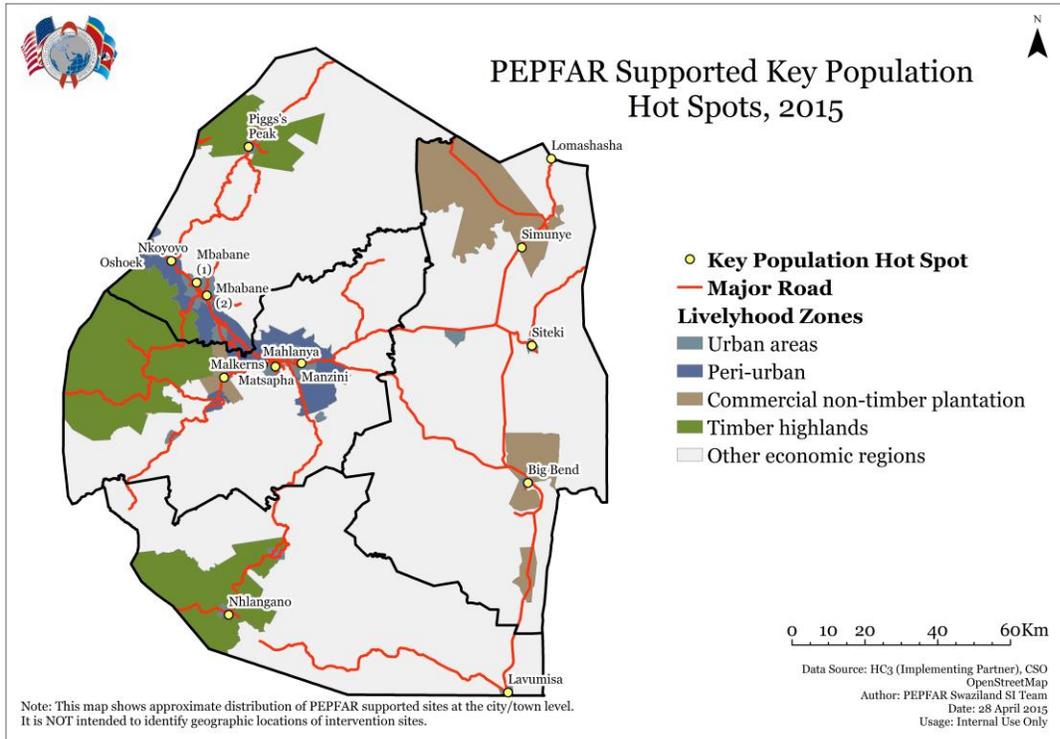


Figure 3.8: COP15 Focus Areas, Hhohho and Manzini Regions

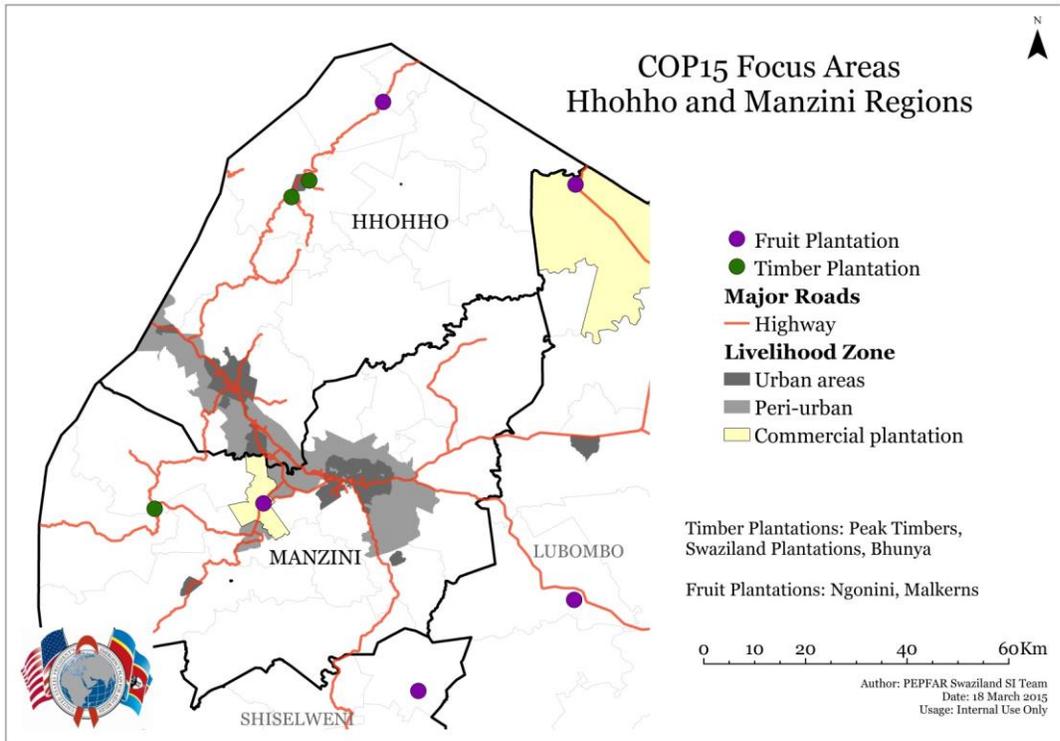
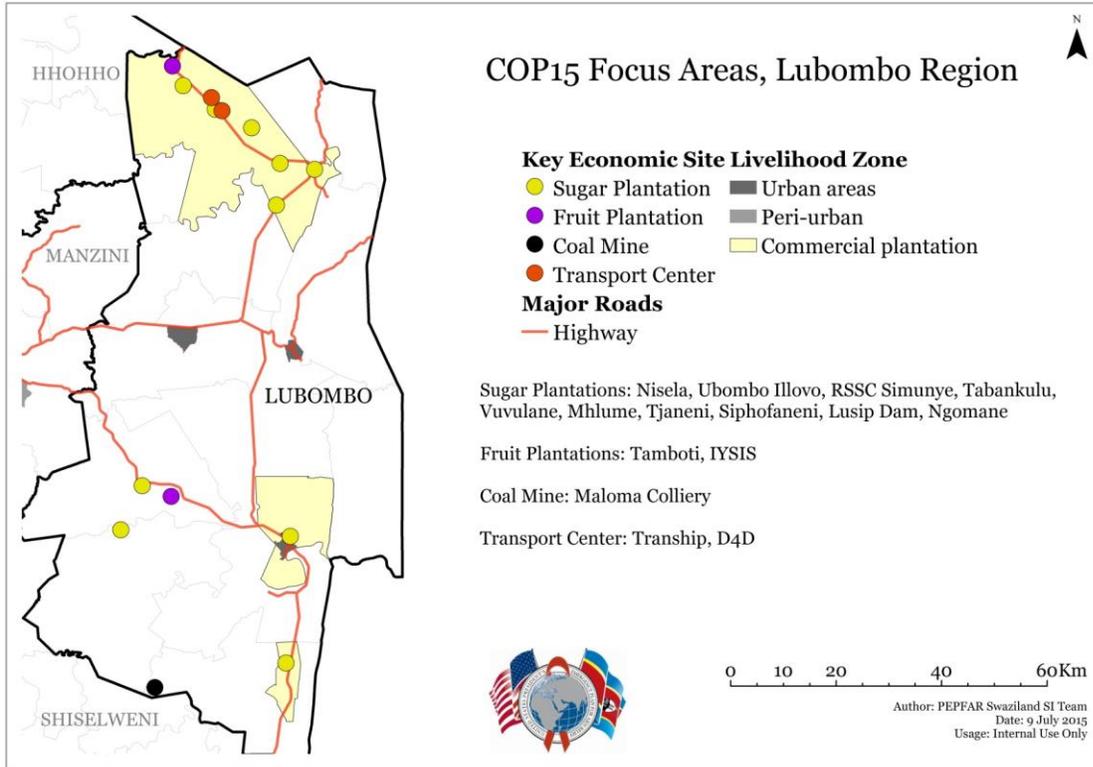


Figure 3.9: COP15 Focus Areas, Lubombo Region



4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

PEPFAR/S aims to treat 20,476 new clients and 130,836 current clients on ART by APR 16 (Table 4.1.1).

Figure 4.1.1 Targets for Priority Locations and Populations

| Region | Total PLHIV | Expected Current on ART in FY 15 | Additional Patients Required for 80% Coverage (as of FY 15) | Target Current on ART (APR 2016) | Newly Initiated in FY16 | Target Current on ART (APR 2017) | Newly Initiated in FY17 |
|--------------|----------------|----------------------------------|---|----------------------------------|-------------------------|----------------------------------|-------------------------|
| Hhohho | 53,091 | 32,704 | 4,883 | 34,403 | 3,923 | 36,952 | 5,022 |
| Lubombo | 42,723 | 24,931 | 9,247 | 28,630 | 5,818 | 34,178 | 8,211 |
| Manzini | 77,817 | 35,110 | 18,366 | 40,987 | 8,980 | 49,803 | 12,783 |
| Shiselweni | 37,514 | 7,055 | 8,631 | 8,195 | 1,755 | 9,904 | 2,493 |
| Total | 211,144 | 99,800 | 41,127 | 112,214 | 20,476 | 130,836 | 28,509 |

It is expected that 30% of those in care and not on ART (11,449 of those in pre-ART) will become eligible for ART. Swaziland adopted Option B+ and is rolling out these guidelines in FY15. Therefore, 95% of pregnant mothers will be tested in all four regions and 95% of those testing HIV+ will be enrolled into ART, resulting in the initiation of an additional 5,040 patients. PEPFAR/S will continue to support TB/HIV services in all regions and will enroll an additional 960 HIV+ patients on ART through the TB clinics.

The remaining patients required to meet the ART (test and treat) target for new initiations will be identified and linked through PIHTC and CIHTC. Twelve percent positivity and 80% linkage to care rates have been assumed. It is expected that 70% of those positives identified will be eligible for ART initiation. In the military catchment 6,371 will be tested for HIV resulting in 1,115 HIV+s being identified and 892 being initiated on ART. (Table 4.1.2)

Table 4.1.2: Entry Streams for Newly Initiating ART Patients in Scale-up Sub-National Units

| Region | PRE-ART | TB | PMTCT | < 15 Years | Key Populations | VMMC | Military | Other PIHTC | Other CIHTC | TX NEW (PEPFAR Supported) | Newly Identified (PEPFAR Supported) | Total Tested (PEPFAR Supported) |
|--------------|--------------|------------|--------------|--------------|-----------------|------------|------------|--------------|--------------|---------------------------|-------------------------------------|---------------------------------|
| Military | | | | | | | | | | | | 6,371 |
| Hhohho | 1,256 | 243 | 1,296 | 298 | 193 | 79 | | 328 | 230 | 3,923 | 3,321 | 40,804 |
| Lubombo | 954 | 149 | 1,038 | 279 | 79 | 28 | | 2,218 | 1,074 | 5,818 | 6,792 | 87,424 |
| Manzini | 1,350 | 418 | 1,717 | 545 | 263 | 49 | 892 | 2,314 | 1,433 | 8,980 | 10,811 | 111,730 |
| Shiselweni | 272 | 150 | 989 | 107 | 37 | 48 | | | 151 | 1,755 | 1,652 | 17,294 |
| Total | 3,832 | 960 | 5,040 | 1,228 | 572 | 204 | 892 | 4,860 | 2,888 | 20,476 | 22,575 | 257,252 |

The National VMMC Strategic Plan (2014-18) established national and Tinkhundla targets for 10-34 year old males to achieve the most immediate and greatest magnitude of impact at lowest cost. PEPFAR/S will continue to support the national VMMC program, with a particular focus on increasing demand and services for the 15-29 ages. With current circumcision coverage of 23%, it is estimated that there are 157,006 uncircumcised males. This year PEPFAR/S will target 15,300 males (35% of the national VMMC target). PEPFAR/S will focus its demand creation and services around the scale up sites, and locations where there is a high density of male populations. To increase demand and services for males 15-29, PEPFAR/S will create active linkages with male-friendly HTC services, work with private sector providers offering attractive, confidential services for men, link with work-places and the uniformed services. The Military will circumcise 800 males. (Table 4.1.3)

Table 4.1.3 VMMC Targets by Age Bracket

| Age Bracket | FY14 | COP15 Target |
|-------------|-------|--------------|
| <9 Years | 855 | -- |
| 10-14 Years | 6,811 | 4,590 |
| 15-29 Years | 3,047 | 9,792 |
| ≤30 Years | 437 | 918 |

In DREAMS locations, PEPFAR will target 52,296 adolescent girls and young women (15-24 years) and 55,370 males aged 20 -34 with an intensified combination prevention package, representing 80% coverage of these priority populations in the targeted areas. An additional 12,937 individuals will be reached in rural remote and hard to reach areas. The Military is identified as a priority population, with 1,650 people targeted in FY16 for prevention services and treatment services; size estimates are not documented due to the sensitive nature of Military data.

According to results from the KP size estimation study, there are 1,719 MSMs and 12,274 FSWs in Swaziland. In FY 16, PEPFAR will target 6,499 FSWs, representing coverage of 53%, and 1,945 MSMs representing coverage of 34%. (Table 4.1.4)

Table 4.1.4: Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Target Group | Population Size Estimate | Coverage Goal | APR16 Target |
|-----------------------|--------------------------|---------------|--------------|
| Females 15-24 years | 65,370 | 80% | 52,296 |
| Males 20-34 years | 69,213 | 80% | 55,370 |
| Key Populations (FSW) | 12,274 | 53% | 6,499 |
| Key Populations (MSM) | 5,719 | 34% | 1,945 |
| OVC 10-17 years | 74,905 | 25% | 18,726 |
| Military | * | | 1,650 |
| Total | 227,481 | | 136,487 |

PEPFAR will support 45,491 OVC in FY 16. HIV+ children identified will be actively linked to ART services.

Table 4.1.5: Targets for OVC and Linkage to HIV Testing, Care and Treatment

| SNU 1 | Estimated number of PLHIV <15 | Target # of active OVC (FY16 Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC | Target # of children tested (FY16 Target) | Target # of children on ART (FY16) |
|--------------|-------------------------------|---|--|---|------------------------------------|
| Hhohho | 4,247 | 9,053 | 2,263 | 2,263 | 2,832 |
| Lubombo | 3,418 | 12,689 | 3,172 | 3,172 | 3,236 |
| Manzini | 6,225 | 11,135 | 2,784 | 2,784 | 5,470 |
| Shiselweni | 3,001 | 12,614 | 3,154 | 3,154 | 1,155 |
| Total | 16,891 | 45,491 | 11,373 | 11,373 | 12,693 |

Table 4.1.6: COP14 Targets Compared to COP15 Targets

| | Current on ART | HTC | Minimum Prevention Package | VMMC | OVC |
|---------------|----------------|---------|----------------------------|--------|--------|
| Targets COP14 | 108,916 | 275,477 | 64,803 | 13,463 | 32,080 |
| Targets COP15 | 134,895 | 274,553 | 136,487 | 15,300 | 45,491 |

Assumptions made with these targets are that there is 1) sufficient supply of ARVs and test kits; 2) sufficient demand for VMMC; and 3) improved linkages to care.

4.2 Strategic Community Prevention Portfolio

PEPFAR/S strategy for averting new infections uses the community platform to reinforce bi-directional linkages with facilities across the continuum of care (see Annex 7). In COP 15, PEPFAR/S will focus on priority and key populations in targeted geographic locations (see section 3.o). This focus will increase the uptake of core services (HTC, ART, PMTCT, SRH, VMMC) and condoms, and will reduce vulnerability and increase resilience. Through DREAMS, community leaders will be given tools and skills to challenge social cultural and gender norms, effectively address barriers to the uptake of core services, support disclosure and adherence, and create a supportive, safe environment for AGYW. PEPFAR will expand its comprehensive mobile and outreach services to achieve greater coverage of the KPs.

Under NERCHA's leadership, PEPFAR/S supports the development of national quality standards for evidence-informed prevention interventions. These standards are based on the PEPFAR Prevention MER guidelines¹⁶ and will provide consistency of approaches and improved

¹⁶ Components of the quality standard package for adults in priority population include:

monitoring of coverage. PEPFAR partners will tailor and use evidence-based curricula and tools¹⁷ that have been shown to reduce HIV, SGBV, and other prevention outcomes. In addition to mobile and outreach services for KP, PEPFAR/S has urban and rural mobile outreach and core services that are demonstrating results in reaching PPs where they live and work. For example, the recently launched PPP with Coca-Cola and the Matshapa town council provides comprehensive, mobile community-based services for young women and men in the main industrial hub; this model will be scaled up through DREAMS. Many of the focus Tinkhundla are in industrial, mining and/or farming areas and PEPFAR/S will seize this opportunity to leverage other private sector entities. PEPFAR/S recently launched condom promotion campaign focusing on young adults (*got-it, get it*) will improve access to, and correct and consistent use of free condoms. Promotion of specialty condoms and lubricants for KP will increase consistent use. PEPFAR/S anticipates distribution of 10 million condoms in COP 15 compared to 5.3 million in COP 13. Through community partners, PEPFAR/S will generate awareness and demand for post violence services including the importance of Post Exposure Prophylaxis (PEP), while clinical partners will assure post violence care is available at facilities. PEPFAR will provide TA to GKOS to expand “One Stop Centers”¹⁸.

The Umbutfo Swaziland Defense Force (USDF) implements community-based activities among soldiers, their sexual partners, and surrounding communities to promote safer sexual behaviors and practices. The key prevention strategies are peer education and interpersonal communication (including drama/edutainment) to address social and gender norms, SGBV, STIs, alcohol and drug abuse; and promotion of condom use and HTC including partner testing. In COP15, the USDF will reach at least 3000 people. USDF will increase membership in the Military AIDS support group and expert clients.

SIMS does not show any major areas for improvement; however PEPFAR/S 2013 review of its SBC and community-based interventions showed program fragmentation, the need for standardization of approaches, improved targeting, and monitoring of coverage. COP15 addresses these recommendations through population and geographic targeting, standardization of approaches, and improved monitoring.

At GKOS request, PEPFAR/S will supply all condoms for three years while strengthening GKOS procurement mechanisms. Strengthening the community platform and establishing a common framework to support community cadres will be critical.

-
- Targeted risk assessment, education and/or counseling to gauge and personalize risk for HIV infection.
 - Condom promotion, condom skills training and facilitated access to condoms.
 - Referrals to or the provision of HTC services.
 - Interventions to increase the uptake of clinical services (VMMC, PMTCT, HIV care and treatment, TB testing and treatment, and reproductive health).
 - Activities which promote gender equitable principles; address harmful norms related to sex, sexual orientation, and gender; seek to reduce stigma and discrimination associated with HIV; and prevent gender-based and homophobic violence.

¹⁷ Such as:

- Stepping Stones- <http://www.steppingstonesintl.org/>
- IM Power-<http://pediatrics.aappublications.org/content/133/5/e1226.full.pdf+html>
- Positive Action- <https://www.positiveaction.net/applications/violence-prevention>
- From Research, To Program Design, To Implementation Programming For Rural Girls In Ethiopia: A Toolkit For Practitioners , Population Council 2011. Available online at <http://www.girleffect.org/media?id=2997>

¹⁸ “One Stop Center provides forensic services, post violence medical care, legal, and psycho-social support for survivors of SGBV at one center.

4.3 Voluntary Medical Male Circumcision (VMMC)

Swaziland recently launched its National VMMC Strategy and Operation Plan (2014-2018). The process included extensive consultations with traditional, religious and community leaders at all levels and other key stakeholders. The strategy was informed by the robust VMMC 2009-2014 database that is age and location disaggregated to analyze yield from different service delivery modalities and approaches, and the VMMC Decision Makers Program Planning Toolkit (DMPPT) 2.0 model that helps define the most immediate and greatest magnitude of impact at the lowest cost by segmenting the age groups of 10-49 year old males. The model also segments targets by locality based on current coverage.

The PEPFAR/S program aligns with the national strategic and operational plan, and will focus on increasing circumcisions particularly among 15-29 year olds. The program will aggressively create demand and provide VMMC services in and around the ART scale up sites, particularly in areas where there are men aged 15-29 such as secondary and tertiary institutions, farming, mining and industrial areas, and the military.

To improve efficiency, PEPFAR/S analyzed the VMMC EA data and targets from FY13-14. The cost per circumcision was reduced \$443.79 in FY13 to \$227.10 in FY14, while achievement of targets increased from 55% to 83%. PEPFAR used a VMMC unit expenditure of \$221.00 for COP15 and the team is confident that this cost will be further reduced while continuing the positive trend in achieving targets. The new PEPFAR VMMC award is performance-based and the local partner has established cost savings approaches, including being housed by the MOH rather than renting office space. The program will also leverage CIHTC efforts to ensure referrals of HIV negative males to VMMC. DOD will increase coverage of VMMC among the Military from 26 to 40%. The VMMC service delivery model consists primarily of outreach and mobile sites¹⁹, with very few static sites, thus accurate yield data requires more complex analysis than facility yield. In COP15, PEPFAR/S will assure quality standards are in place, through both external quality assessment and continuous quality improvement in the services. PEPFAR will ensure all PEPFAR, National and WHO standards, guidelines and policies are implemented.

The program maintains a high quality data base with age, location and service delivery approach (mobile, outreach and static) disaggregated data. This data will be reviewed monthly with MOH and implementing partners to inform and improve programming. Furthermore, demand creation approaches will also be closely monitored on a monthly basis and adjusted as necessary.

In SIMS assessments, there are no common issues identified across sites and most of the sites are meeting or surpassing national standards. In 2014, PEPFAR/S received additional central funding for VMMC kits and associated commodities; these are being utilized during FY15.

4.4 Prevention of Mother-to-Child Transmission (PMTCT)

In October 2014 the Swaziland national PMTCT program began rolling out Option B+ and it is expected to be complete by June 2015. In COP15 PEPFAR/S will focus on quality implementation in all four regions, prioritizing support to high volume sustained and scale-up facilities, including staff placements (lay cadres), and laboratory support.

¹⁹ Over 58% of VMMC procedures performed between January 2013 and May 2014 were from outreach and mobile services (Swaziland MC Strategic and Operation plan 2014) .

PEPFAR/S will review the performance of facilities regularly using volume analysis, yield and quality of service delivery to determine their status within site categorization.

In COP14 Swaziland received additional central initiative resources to support PMTCT/ART integration and Option B+ roll out. Part of these funds will be used to assess the quality of counseling provided by health care workers (HCW) with a view towards strengthening counseling techniques to improve client adherence. PEPFAR/S is monitoring attrition among mothers on lifelong ART, but it is still too early for reliable data.

PEPFAR/S PMTCT service delivery model is mainly TA, with some direct service delivery (DSD) support at high volume sites. PEPFAR/S will support the development of new national PMTCT standards, policy documents, and guidelines, and HCWs through nurse-led ART initiation in Swaziland (NARTIS) trainings, comprehensive clinical mentoring, supportive supervision and on-site trainings. PEPFAR/S adheres to the WHO PMTCT four-pronged approach and will use PMTCT as an entry point to support the broader maternal newborn and child health (MNCH) platform, including family planning. This platform also provides the opportunity to reach partners and family members with HTC and linkages to care. PEPFAR will continue supporting nutritional assessment, counseling, support (NACS), as well as referral of clients in MNCH sites for food for prescription services. PEPFAR will provide limited therapeutic food support for under 5 malnourished HIV exposed and infected children. According to the 2010 MICS, 5.8% and 0.8% of children under 5 were classified as moderately to severely underweight and wasted respectively.

PEPFAR will continue to support mentor mothers at high volume sustained sites and scale-up sites to provide HTC, adherence counseling, nutritional counseling, disclosure support, SGBV screening, and client follow-up. PEPFAR/S will also support mentor mothers in communities which are linked to high volume sustained sites and scale-up facilities to ensure strong bi-directional client referrals and increase retention of mother-baby pairs in care. PEPFAR will collaborate with the GF as it expands the community mentor mother model to more communities. This model will address high LTFU among PMTCT B+ clients to improve retention in care²⁰. PEPFAR/S will evaluate this model to assess its effectiveness.

While these cadres are critical for epidemic control, GKOS does not have a clear plan to absorb them. PEPFAR will continue to advocate for more resource allocation to support these critical cadres.

PEPFAR will continue collaborating with the UN agencies, and other stakeholders in providing national level TA, HIV/FP integration efforts, HIV and TB services, supply chain management, and to leverage competencies and resources to ensure the delivery of a robust national PMTCT program through Technical Working Group (TWG) participation and joint planning.

The PMTCT program experiences intermittent ARV shortages and supply gaps. While the GKOS has made a commitment to procure ARVs for Option B+, PEPFAR/S will budget for an emergency stock of first line ARVs.

According to the SIMS assessments, most sites have met, or surpassed, national standards. However, some common issues were observed across sites including challenges with undocumented nutritional assessment results for pregnant mothers and children. The program has performed below standard across sites for documenting facility-community referrals. This is

²⁰ *JAIDS*. 2015;69(1):e1-e12

because the national registers do not capture these data. PEPFAR/S will work with the national program and partners to ensure resolution.

Communities are critical in creating demand, uptake and retention of PMTCT services. PEPFAR/S will work closely with communities to establish a strong bi-directional referral system that will ensure that retention in care and community activities are closely linked to facilities.

4.5 HIV Testing and Counseling

In the 2011 SHIMS study, 62.4% of people HIV positives reported being aware of their HIV status. Since then, PEPFAR/S has scaled up HTC through separate PIHTC and CIHTC initiatives. Although Swaziland has an HIV prevalence of 26% among adults >15 years (DHS 2007), the adjusted expected HIV yield for undiagnosed positives is 7.8%. This means that the first 90% is within reach for Swaziland. That said, identifying the remaining undiagnosed positive in this generalized epidemic still presents a challenge and will require significant efforts. These efforts should be paired with improved linkages to care to pave the way towards achieving the second 90%.

GKOS adopted the WHO 2013 integrated HIV management guidelines in 2014. Changes include universal testing of all children at 9, 18 and 24 months. The age for consent was reduced to 12 years. These measures will assist in early identification of pediatric HIV cases and early linkage to care and treatment. There is also emphasis on ensuring correct HTC results and connection/linkage to appropriate prevention (e.g. VMMC), care, and treatment services. HTC coverage by Tinkhundla is as shown below with some areas having coverage over 150%.

The HTC program will collaborate with community leaders to mobilize priority populations and communities with low HTC uptake (identified through GIS mapping) for scale up of services, especially targeting men.

To reach the first 90%, PEPFAR Swaziland need to find an estimated 40,314 positive people that are currently undiagnosed in PEPFAR supported locations. For COP15, the level of effort by region is shown in the chart below, which shows that Lubombo and Manzini need more active effort to find more positives.

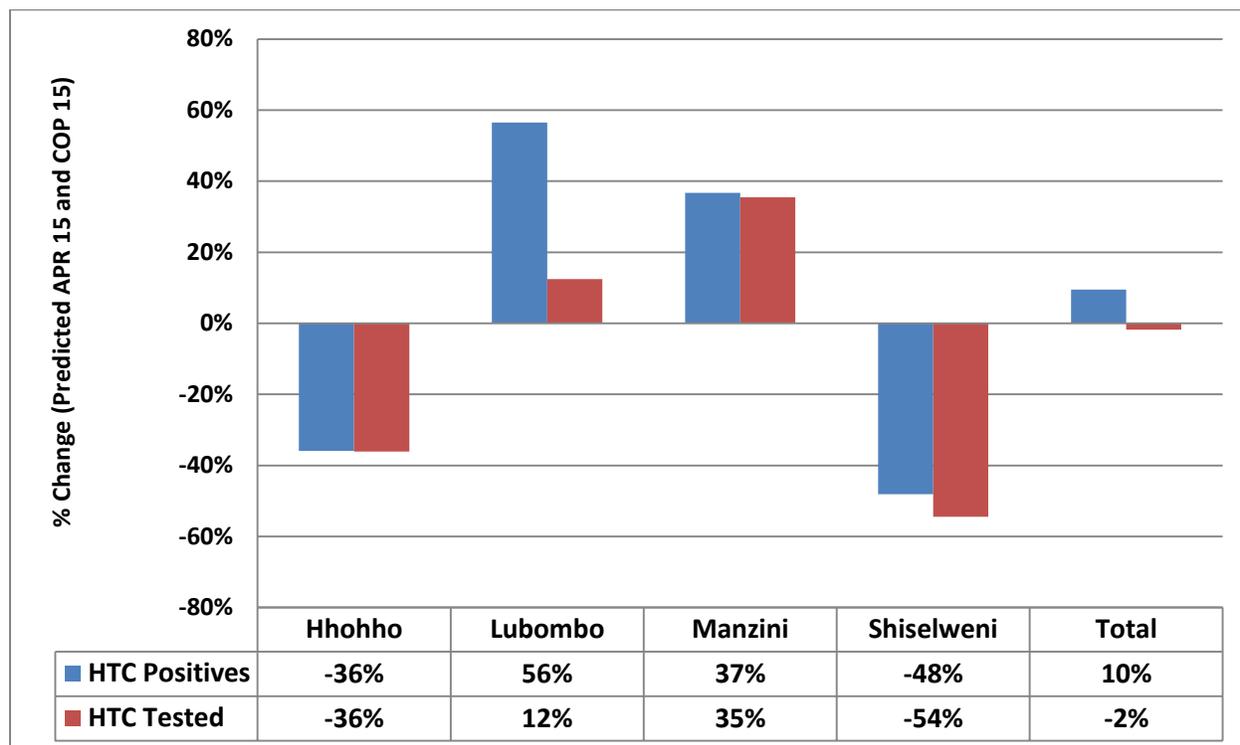
Based on the availability of funding from OGAC, PEPFAR/S evaluate progress towards 90-90-90 in FY18 PEPFAR/S will request funding and TA to develop and implement protocol as follows:

- First 90: Community-based evaluation
- Second 90: Clinic-based evaluation
- Third 90: Clinic-based evaluation

If not funding is available, PEPFAR/S will use best available data as follows:

- First 90: PHIA 2016 results and M&E data
- Second 90: program data
- Third 90: program data

Figure 4.5.1: Percent Change of Positives Identified and HTC Tested from Predicted APR15 to COP15



Based on the expected level of effort for HTC by region, PEPFAR/S has identified key pivots to reach the first 90%. To main focus for HTC is finding the remaining positives and the tactic that will be employed by PEPFAR/S is testing priority populations such as men, key populations, partners and family members of HIV positive clients using the index case approach as well as scaling up community based strategies such as mobile testing and home-based testing. The table below describes summary pivots by region for PIHTC and CIHTC.

| Region | Key Pivots for PIHTC | Key Pivots for CIHTC |
|---------|---|--|
| Manzini | <ul style="list-style-type: none"> Scale up PIHTC at scale up facilities Strengthen men’s health days to get more men into facility-based testing | <ul style="list-style-type: none"> Aggressive scale up of CIHTC and active linkage Scale up testing among key pops Targeted mobile testing around male dominated industries and in urban and peri-urban areas Collaborate with ILO and male-dominated industries After hours mobile services to reach men Community events led by chiefs |
| Lubombo | <ul style="list-style-type: none"> Scale up PIHTC at scale up facilities Strengthen men’s health days to get | <ul style="list-style-type: none"> Targeted scale up of CIHTC and active linkage including OVC |

| | | |
|------------|---|--|
| | more men into facility-based testing | <ul style="list-style-type: none"> • Collaborate with ILO and Male-dominated industries • After hours testing to reach men • Community events led by chiefs • Scale up testing among key pops |
| Hhohho | <ul style="list-style-type: none"> • Sustain PIHTC Efforts • Strengthen men's health days to get more men into facility-based testing | <ul style="list-style-type: none"> • Targeted community sweeping to identify the positives left • Targeted mobile testing around male dominated industries, and in urban and peri urban areas • Scale up testing among key pops |
| Shiselweni | <ul style="list-style-type: none"> • Focus PIHTC on pregnant women and TB clients | <ul style="list-style-type: none"> • Targeted CIHTC of Key pops and OVC • MSF to support other CIHTC activities |

PEPFAR/S will intensify efforts for finding positives, especially male positives in focus DREAMS locations and in the Manzini and Lubombo regions using strategies specific to the demography and context.

For Manzini Region, PEPFAR Swaziland will use the following strategies:

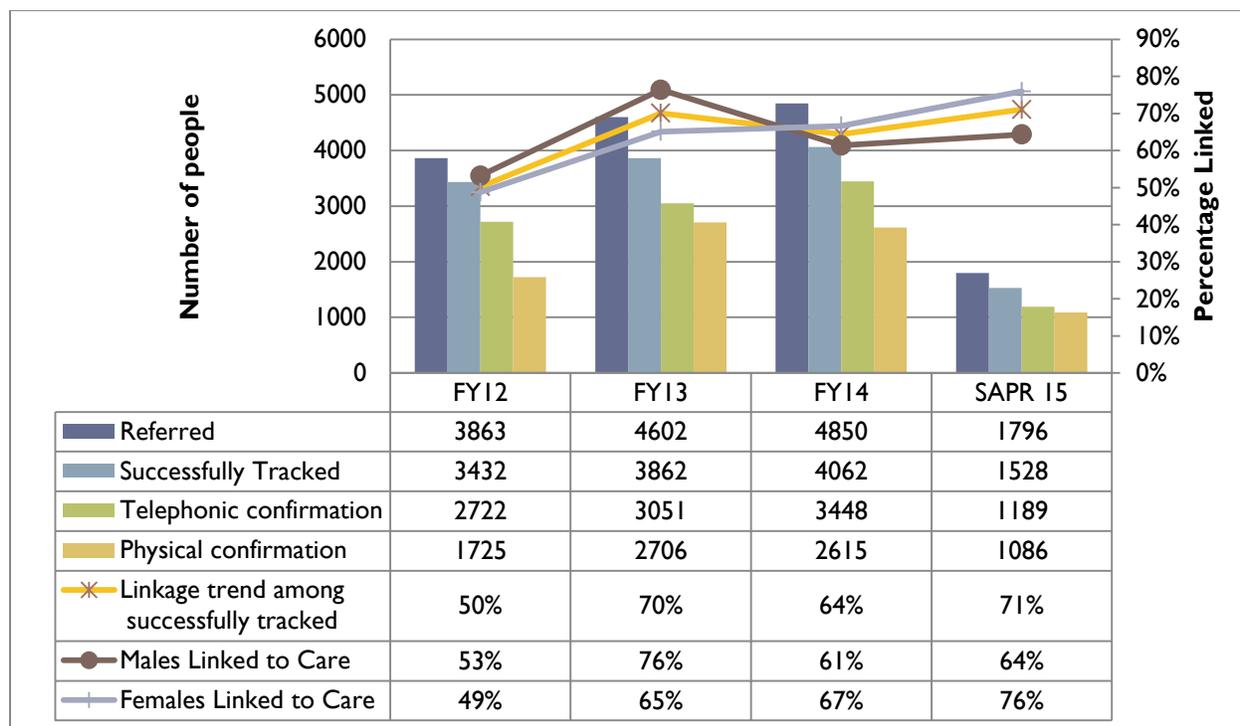
- Increase HRH for scale up at facilities to strengthen testing
- Index case approach to partner and family testing
- Offer testing at all points of contact with a provider
- Scale up after hours testing around the hot spots and industrial areas
- Public-Private-Partnership
- Develop partnerships with facility management and ILO
- Use a multi-disciplinary team approach for demand creation
- Scale up CIHTC to the tertiary schools
- Demand creation at military sites, correctional facilities and police camps
- Annual HTC for uniformed services
- Partner with transport unions to create demand among union members and around transport hubs
- Conduct more promotions and community-based testing
- Sweep communities identified to have high yield
- Scale-up testing and linkage to care among key populations
- Increase demand creation and marketing of stand-alone sites

For Lubombo Region, the strategic approach will be as following:

- Communication strategies to address barriers to access
- Increased HRH needs at scale up facilities to strengthen testing
- Index case approach to partner and family testing
- Offer testing at all points of contact with a provider
- Improve collaboration with company clinics
- Community sweeping within company locations
- After hours service access
- Community sweeping in targeted areas outside company locations
- Establish community linkages for referrals between company facilities and communities

PEPFAR/S will scale up evidence-based approaches to strengthen active linkage from CIHTC to care and treatment which is currently around 65% (as shown below). Strategies will include (i) Case management at point of testing (ii) Strengthen counselling and peer navigation (iii) Patient enrollment into care at the community testing sites (iv) Create demand and services for same day ART initiation (v) Stigma reduction communication strategies (vi) Strengthen gaps in national referral system (vi) National roll out of CommLink Program.

Figure 4.5.2: Linkage from Community-Based Testing to Care (Source – PSI)



In the 15 KP hotspots, MSM and FSWs will be targeted with a package of HTC, condoms, lubricants, SRH services, and enrollment and linkage to care and treatment services. A youth focused package of these services will be offered to adolescent girls in the DREAMS Tinkhundla.

Most HTC activities were identified as core, but with a focus on targeted programming to identify people who are more likely to test positive. DREAMS will include a special focus on increasing testing uptake (and linkages to care and treatment) for men age 20-34.

GKOS procures all HIV test kits. Swaziland has not experienced any major test kit gaps. During SIMS visits, the main issues identified across facilities, in all regions, include inappropriate retesting of clients who test negative, and weaknesses in quality control. The issue of retesting is addressed in the new guidelines and trainings. Efforts are ongoing to step up mentoring and supervision for HTC QA.

4.6 Facility and Community-Based Care and Support

With adoption of new treatment guidelines, an estimated 3,832 of pre-ART patients will immediately become eligible for ART. This will impact on the ability of health facilities to cope with increased volume of clients.

The care package includes DSD for psychosocial and adherence support, and TA to support for patient monitoring, family planning integration, clinical services for SGBV and PEP and QA/QI. The program works with MOH funded Rural Health Motivators (RHM), community partners, and Expert Clients to provide care and support services at the community level. This will be expanded to support community based ART refills where possible. The CIHTC partners will scale up use of point of care (POC) CD₄ for newly diagnosed patients to help facilitate linkages to care and treatment. The CIHTC partner will enroll all new HIV+ clients into care at the point of diagnosis using mobile van services that have integrated HTC and care services (enrollment into care, baseline CD₄, and one week prescription Cotrimoxazole and referral). Through community approaches, regional clinical partners will strengthen pain management for terminally ill HIV+ patients.

PEPFAR/S supports integration of cervical cancer screening management for HIV+ women (Visual Inspection with Acetic Acid (VIA) and cryotherapy) at three high volume sites (one per regional partner). Positive Health Dignity and Prevention (PHDP) activities will be strengthened by introducing activities to provide immediate ART for the HIV+ partner in a discordant relationship. Efforts are currently ongoing to strengthen NACS. PEPFAR will adapt the Engender Health Stigma/Discrimination Reduction and Infection Prevention and Control Training manual for use in training all health facilities, starting with high volume sites to help address issues of stigma around HIV and discrimination of KPs.

All care and support services were classified as either core or near core.

SIMS visits revealed weaknesses in NACS. PEPFAR is working with implementing partners to strengthen NACS and is seeing significant improvement. Facilities were supplied with instruments for measuring weight and height and job aides for calculating BMI. Site mentoring and quality improvement (QI) projects are also ongoing.

4.7 TB/HIV

Seventy one percent of TB patients are co-infected and 4.2% of TB patients have MDR TB. The recently revised national TB/HIV policy states that all TB treatment facilities should provide HTC, care and treatment to ensure early enrollment of co-infected patients to ART. Currently, Swaziland is evaluating the effectiveness of the 4-symptom TB screening questionnaire among HIV+ pregnant women.

Case detection rate is 53% however case notification rate is 900/100,000. Swaziland uses the WHO 4 symptom screen questionnaire at all OPDs, In-patient wards and HIV clinics. However, in COP 15, PEPFAR-Swaziland has classified TB screening among the general population as non-core and that assistance has been transitioned to Global fund and Government. SIMS visits have shown that over 97% of HIV+ clients are normally screened for TB; however, in APR14, there was an unexpected acute shortage of screening questionnaires which affected performance. This problem has since been rectified. Sputum from all TB suspects (both TB and HIV sides) is analyzed using gene X-pert as the first line of diagnosis. See below charts for cascades from TB and HIV settings.

Figure 4.7.1: TB/HIV Cascade from TB Clinics

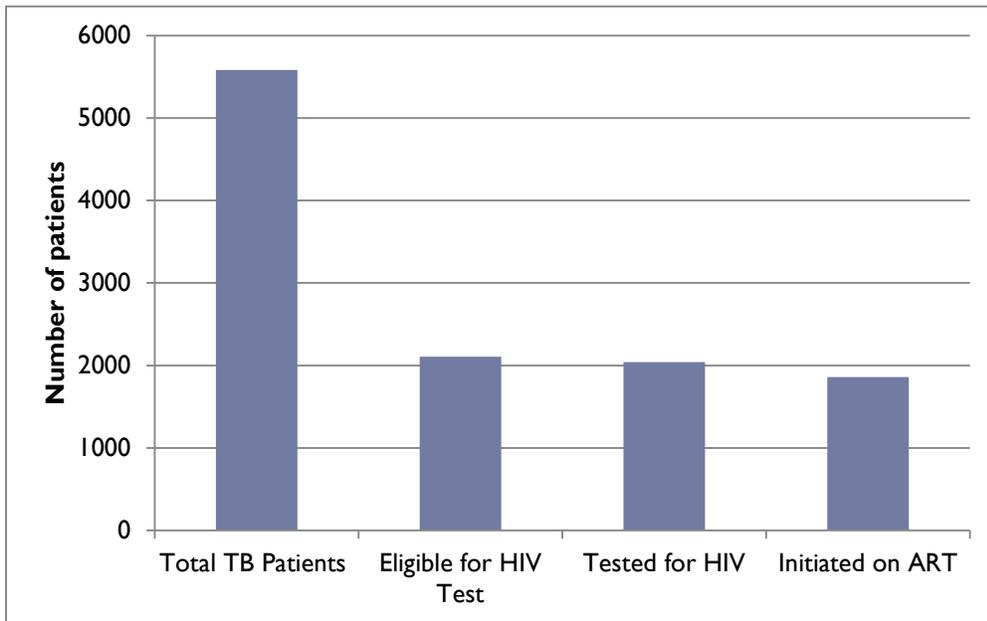
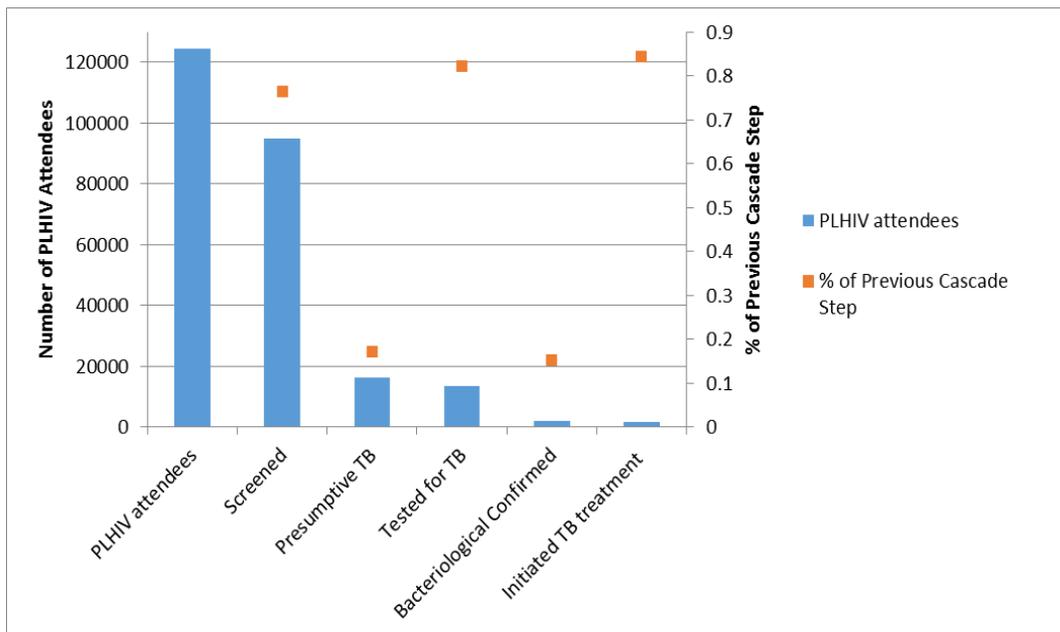


Figure 4.7.2: TB/HIV Cascade from HIV Clinics



Isoniazid Preventive Therapy (IPT) coverage is currently low at 12% nationally. In COP15 PEPFAR/S will expand IPT to all facilities and strengthen TB infection prevention and control (IPC). PEPFAR/S also plans to introduce POC chemistry tests to improve monitoring of patients on MDR-TB treatment. The use of Bedaquiline, and other WHO approved drugs for MDR-TB patients will be introduced.

The country will support introduction of more efficient and quicker diagnostic tools as well as scale up the use of Gene-Xpert. Pediatric TB diagnosis and management will be improved by introducing better diagnostic tools, management algorithms, and clinical mentoring. Community-based support services for TB screening, contact tracing and compliance with TB treatment will be expanded. Active case finding among pregnant women will be strengthened using evidence from the PMTCT/ART integration-funded TB screening tool evaluation. PEPFAR/S will collaborate with the WB and GF to strengthen TB diagnosis and treatment for miners and ex-miners. At the regional level, TB/HIV coordinating bodies will be revitalized or established and capacitated to help in planning and coordinating joint TB/HIV activities. Facilities that only provide TB treatment will be capacitated to initiate ART to ensure at least 95% coverage of ART among TB patients co-infected with HIV.

TB/HIV program activities are part of the integrated clinical package for the regional partners. The regional partners will support all public facilities for decentralized TB/HIV services using DSD. Sites that are currently providing only HIV care and treatment will be capacitated to integrate TB screening and services.

Swaziland TB/HIV activities align with core activities for reducing HIV related mortality. TB screening for the general population who are HIV-negative was classified as non-core and will be transitioned immediately to GKOS. Swaziland has not experienced challenges maintaining adequate stock of TB commodities.

SIMS visits identified gaps in IPC and IPT (100% of facilities scored either red or yellow in IPT). Many facilities have neither an IPC focal person nor plan, and very few are implementing IPT. Efforts are currently ongoing to remedy this gap. Mentoring activities for IPT have been intensified and QI projects have been instituted. The PEPFAR CIHTC partner is collaborating with the national TB partner to integrate TB screening for newly diagnosed HIV+s into HTC services at the community level. Likewise, the KP partner will integrate TB screening into their mobile services.

4.8 Adult Treatment

GKOS provides the infrastructure/space, most human resources and ARVs for ART. PEPFAR/S provides TA, lay cadres HCWs, strategic information (SI) and evaluation capacity to the MOH, pediatric ARVs, and an emergency supply of first-line ARVs. The new guidelines shifted ART eligibility to CD₄<500 and supports early ART initiation regardless of CD₄ for HIV+ individuals in a discordant relationship, TB and Hepatitis B patients co-infected with HIV and all HIV+ pregnant women.

Partial (patients start ART at central hospitals and are down-referred to PHCs when stable) and full (patients start and continue ART at PHCs) decentralization models were initiated in 2007, using a rollout of a hub-and-spoke system. Auld *et al* in Swaziland showed that down-referral and spoke-initiation were protective against both LTFU and overall attrition. Currently, there is more new ART enrollment in spoke facilities than hub facilities (Figure 4.8.1). PEPFAR/S will monitor enrollment rates at individual spoke and hub facilities. If a spoke has low enrollment, determining the reason will be important (e.g. hub many not be down referring, or clinicians at spokes do not feel adequately trained to initiate ART). Given the uniformly high HIV burden in

the country PEPFAR/S anticipates increased enrollment at spokes if decentralization and NARTIS guidelines are followed.

Beginning in FY15, PEPFAR/S is rationalizing its clinical partners with only one partner per region providing integrated comprehensive clinical services (PIHTC, care, treatment, TB/HIV and PMTCT). The regional partner will support all public facilities in the region. This approach will ensure consolidation of comprehensive services in all PEPFAR/S supported facilities, as well as ensure efficiencies through program synergies, combined trainings, mentoring and QI activities. PEPFAR/S will facilitate close linkages between DREAMS partners and regional clinical partners to ensure priority populations access early ART as part of a complete package of combination prevention.

To reach the second 90%, PEPFAR/S will need to put 20,476 people on treatment in FY15. The level of effort for achieving this goal is as shown in the chart below. More active efforts are need in Manzini and Lubombo regions, and efforts to identify and link positives in these regions are described under section 4.5. In general, PEPFAR/S will introduce community based ART initiations and scale up ART refills in the communities to help decongest the health facilities. In addition, PEPFAR will advocate for early roll out of the new guidelines while advocating for early implementation of test and offer of ART regardless of CD4. PEPFAR Swaziland will also support GOKS to have a robust system for health products procurement and contract management while collaborating with Global fund to ensure adequate supply of ARVs to meet the ARV needs for the 90-90-90 targets.

Figure 4.8.1: Percent Change of ART Current and New from Predicted APR15 to COP15

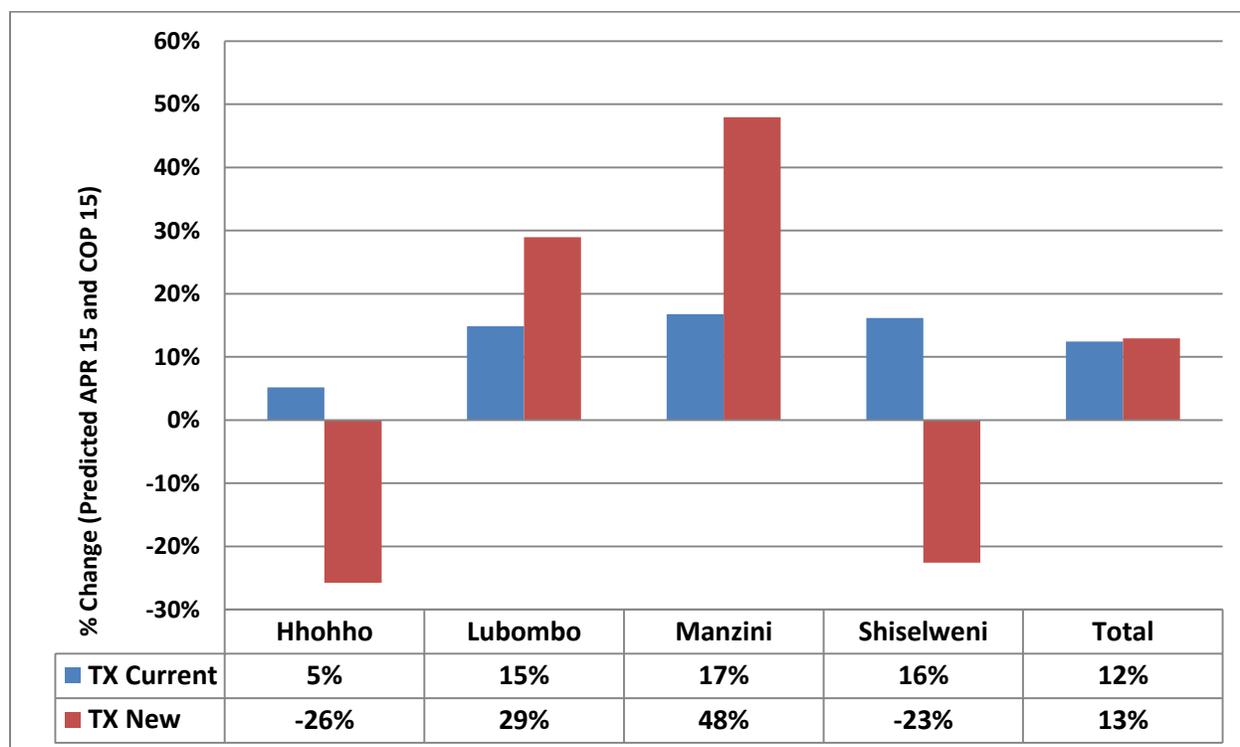
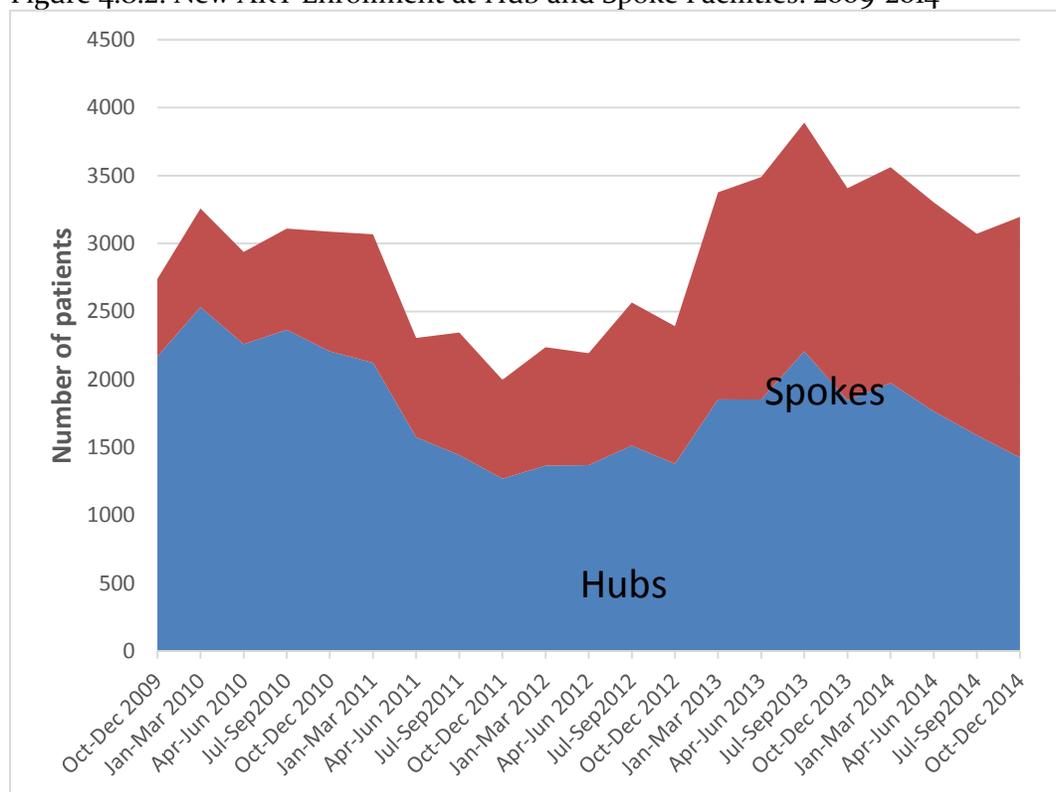


Figure 4.8.2: New ART Enrollment at Hub and Spoke Facilities: 2009-2014



Patient monitoring will shift from CD₄ to routine VL monitoring. Swaziland received central funding for PMTCT/ART integration to strengthen VL monitoring by supporting sample transportation, lab information systems, and early return of lab results through SMS. It also provides support for training more nurses to prescribe ARVs. In COP15, PEPFAR/S will support sample transportation for scale up of VL, while GF will supply VL reagents. Clinical mentoring will be strengthened to ensure quality service delivery to all clients as well as efficient delivery of ARVs to health facilities. PEPFAR has supported Swaziland to develop an SOP that guides use of VL to determine treatment failure as a result of resistance vs. treatment failure as a result of non-adherence. The SOP outlines strategies for step-up adherence as well as when to switch to 2nd line. This is supported by a job aid in the form of an algorithm for easy implementation. Currently, government pays for all ARVs, including 2nd line drugs. PEPFAR provides technical assistance for implementation and buffer stock to mitigate stock outs.

Community-based ARV delivery strategies, currently being piloted, will be scaled up and regional clinical partners will collaborate with community-based HTC and other community partners to strengthen linkage and facilitate early enrollment on treatment. In 2011, to help document and improve early enrollment and retention in HIV care, GKOS implemented a new set of standard operating procedures on linkage and retention. Evaluation of these systems, with over 1000 clients, found that less than 40% of those testing positive and referred to clinical care, were enrolled in HIV care within two years of their diagnosis. Of those enrolled, 94.4% were initiated on ART and 85.5% were retained after two years of initiation. Of the few clients who enrolled in pre-ART, 35.1% were retained in pre-ART care two years after enrollment. The findings from this retrospective study informed the COP15 focus on assessing and improving services for linkages, early enrollment, and retention in HIV care.

PEPFAR partners will provide lay CHWs to support PIHTC, adherence counseling and support services to scale up identification of positives and enrollment to ART. As part of the QM program (see section 6 Program Support), PEPFAR will build the capacity of Regional Health Management Teams (RHMT) to improve leadership and governance issues related to site management. Regional partners will work with the RHMTs to establish systems for mentoring and supervision and will ensure QM is institutionalized at the RHMT level for sustainable quality service delivery.

The GKOS has budgeted for the ARVs forecasted for scale up in line with the new guidelines. In the past, there were shortages of some key adult first-line drugs as well as second line drugs. In COP15, PEPFAR will budget for an emergency supply of first line ARVs to ensure continuity of treatment services.

From the SHIMS study, 140 samples were genotyped by (SBA), thus providing an estimate of the national transmitted drug-resistance (TDR) for HIV. Per WHO definitions, TDR level in Swaziland is low (<5%) based on sequencing-based assay, but moderate (between 5-15%) based on the real-time PCR (personal communication RS Beard). These patterns reveal that current first-line regimens recommended in the GKOS Treatment Guidelines are mostly efficacious for patients initiating ART.

Common program gaps identified during SIMS visits are in the area of nutritional assessment using BMI, with 100% of facilities scoring red or yellow in this area. Partners have been notified. BMI charts were procured and made available to facilities and onsite mentoring is ongoing. Swaziland relies on community Expert Clients and Regional Health Motivators (RHM) to support patient tracking. This approach will be strengthened and scaled up.

A key to epidemic control is engaging men. Early HIV testing, linkage and retention programs targeting men (see section 4.5) could significantly improve the impact of Swaziland's ART program on HIV incidence and HIV-related mortality. With Option B+ and routine HTC for all pregnant women, that ratio of female to male ART enrollees is likely to keep increasing unless a similar gateway to early ART for men is found. Without increased ART enrollment for HIV infected men, HIV incidence among young females (15-24) will not decline as fast as it should. If VMMC is the intervention to protect young HIV negative men, then early HIV testing, linkage and retention is the package for HIV+ men—both for their own health, as well as a protective intervention for young women.

Through task shifting and decentralization, Swaziland reached universal ART coverage (93%) at CD₄ ≤ 350. In COP15, PEPFAR/S will focus on scaling up ART coverage in line with the new guidelines through strengthening decentralization of integrated clinical services as well as scaling up community-based ARV delivery and improving linkages to care. Adoption of the new WHO guidelines reduces ART coverage to about 50%. To reach 80% coverage, Swaziland will need to enroll over 78,563 clients on ART by 2017. For Swaziland to halve its incidence by 2018 and reach epidemic control, modeling shows that a “test and treat” approach must be implemented. This approach was approved, in principle by GKOS, and will be implemented in a phased manner, as pilots are ongoing in 20 facilities.

4.9 Pediatric Treatment

Swaziland adopted WHO 2013 Pediatric ART recommendations recommending ART for all children under five, regardless of CD₄ count; for children above five years ART initiation at CD₄ < 500; and universal testing for all children at 9 months, 18 months and 24 months.

Implementation of the new guidelines will identify more HIV+ children for treatment. As seen with adults, partial decentralization within the hub-and-spoke system was protective against LTFU and overall attrition among children, while full decentralization was not associated with higher rates of mortality, LTFU, or attrition²¹. These findings suggest both partial and full decentralization models should be expanded to allow increased enrollment of children on ART, while maintaining or reducing program attrition rates.

VL will become the marker of preference for monitoring children on treatment. The one-time PMTCT/ART integration funds will support sample transportation, centrifuges and refrigerators at facility level to help separate and store plasma while waiting for samples to be transported to the National Referral Lab.

Key program directions include: strengthening collaboration with the Expanded Program of Immunizations (EPI) to link HTC and vaccinations; strengthening diagnosis and management systems for treatment-experienced children; improving follow-up and tracking of exposed infants to ensure they are linked to treatment without delay; and strengthening NACS and support (e.g. provision of Plumpy Nut) to malnourished children. The approach will be DSD to all sites, however, high volume facilities will be prioritized for additional TA. Lay providers will assist in adherence preparation of caregivers for ART initiation, adherence monitoring, counseling and support, and patient tracking to improve retention. The TA support includes on-site training, clinical systems mentoring, and ongoing QI.

At the regional level, PEPFAR will support RHMTs in establishing and monitoring performance standards and establishing sustainable systems for supportive supervision, mentoring and QM. At the national level, PEPFAR will continue to provide TA to the Swaziland National ART Program to strengthen its coordination, program monitoring and management functions for quality assurance.

All pediatric treatment activities were defined as core. GKOS approved the full budget forecasted for ARV scale-up of the new guidelines. However previous challenges with procurement systems and processes resulted in past stock-outs of pediatric ARVs. Until these issues can be resolved, PEPFAR/S will procure all pediatric ARVs through the central PFSCM/SCMS mechanism.

SIMS visits reveal significant gaps in NACS using appropriate tools; 100% of facilities scored yellow or red in this area. MUAC tapes, weighing scales and stadiometers are now available to all sites and on-site trainings and mentoring are ongoing. Equipment for pediatric blood draw was also generally lacking.

Swaziland relies on community Expert Clients and RHMs to support patient tracking. This approach will be strengthened and scaled up, and community-led programs, such as partnerships with neighborhood care points (NCP), will be supported to ensure early diagnosis of pediatric HIV, enrolment on treatment and retention in care.

4.10 Orphans and Vulnerable Children (OVC)

According to MICS (2010), 45% of Swaziland's children are categorized as orphaned or vulnerable (229,000); 23% of all children have lost one or both parents. It is estimated that 38% of rural households have at least one orphan (VAC 2012); only 22% of children are raised in two-parent

²¹ Andrew Auld et al (CROI 2015)

households. Violence, especially sexual violence, against children is a serious concern, with a third of girls under 18 experiencing some form of sexual abuse (VACS 2007). Swaziland's legal and policy framework for OVC has a sound foundation in the Children's Welfare and Protection Act (CWPA) and in the eNSF which focuses on strengthening families to provide care and support to OVC, as well as combating SGBV against children. Swaziland completes the roll-out of free primary education provision in 2015. No progress has been made on the enactment of the Domestic Violence and Sexual Offences Bill and on drafting regulations to implement the CWPA. Leadership and coordination of children's issues remains weak, and the establishment of a Children's Department at the Deputy Prime Minister's Office is still in early planning stages. The CWPA's provision of permitting children aged 12 and above to provide consent for HIV testing, and the new HIV guidelines recommending ART for all HIV+ children <5 and ART initiation at CD4<500 for children above 5 will compel the OVC program to promote the testing of children through parent/caregiver education.

Swaziland will receive funds from two central initiatives, DREAMS and the OVC Special Initiative, and will focus on priority age groups in locations aligned with the geographic focus of the DREAMS Initiative.

Priority age groups for the OVC program will be vulnerable adolescents aged 10 – 17, and children under two years. HIV infection risk is highest among older adolescents, especially girls; prevalence of vulnerability²² increases with the age of children (peaking at 57% for 15-17 year olds MICS 2010). Adolescent girls are also at high risk of sexual violence. For the youngest children, who have in general a higher risk of morbidity and mortality, the OVC program seeks to build the evidence for improved Early Child Health and Development (ECD) outcomes.

Service delivery will be designed to contribute to achieving the PEPFAR-defined child outcomes of keeping children healthy, safe, stable, and schooled. Technical assistance to the Department of Social Welfare (DSW) in the Lubombo region and at national level will contribute to child protection, and build social workers' capacity and tools for case management. It will also focus on developing coordination approaches with civil society partners providing social welfare services to OVC. PEPFAR support will ensure that previous investments in this area, such as the establishment of child-friendly court facilities and training of key stakeholders in the court process will be sustained.

The service delivery package for adolescents aged 10-17 aims to address and mitigate the multiple vulnerabilities that children experience as a result of the effects of HIV in their families and communities, and integrate these OVC services with HIV prevention services, in line with DREAMS. Approaches to strengthen resiliency and social assets will include structured group-based life-skills interventions and mentoring. Home visiting will ensure that the most vulnerable and hard to reach children, such as out-of-school adolescents and those in households without adequate adult support, receive individually targeted support to ensure their basic needs are met, and that referrals are provided to social, sexual reproductive health and HIV services. Parents and caregivers will receive economic strengthening through financial literacy and savings schemes, which will be augmented with parenting skills training.

²² MICS classifies children as vulnerable if "either parent is chronically ill, or if an adult (age 18-59 years) in the household either died (after being chronically ill), or was chronically ill in the year prior to the survey". (Multiple Indicator Cluster Survey 2010)

Under the OVC/ECD Special Initiative, the entry point to reach vulnerable infants and young children will be PMTCT, through the expansion of the existing mentor-mother program. The approaches will include delivery of a structured ECD mentoring curriculum through home visits starting during pregnancy and lasting up to 24 months. The intervention will build the knowledge of pregnant and new mothers/caregivers on young children’s health, nutrition and development, and their skills on early stimulation. It will emphasize retention in care of mother-baby pairs graduating from PMTCT.

Violence against children, including SGBV, will be mainstreamed throughout the OVC portfolio. Interventions with adolescents in- and out-of-school will raise awareness on GBV and where to seek help. Interventions with caregivers and mothers of young children will focus on decreasing acceptability of extreme child discipline. Case management to respond to and prevent rape and other violence will feature prominently in capacity building for social workers and strengthening referrals between CSOs and government. PEPFAR/S will continue advocating for the roll-out of One-Stop Centers from the current pilot site in Mbabane.

TA will also be provided to capacitate civil society, led by the country’s NGO umbrella body CANGO, to strengthen its advocacy skills to improve accountability and availability of services (i.e. as stated in the CWPA) for children and PLHIV. Through training, coaching and practical skills application, CANGO and its consortia will be capacitated to develop and implement advocacy plans.

All OVC activities described above align with the country’s core/near core framework. The activity for economic strengthening of OVC caregivers through strengthening agricultural value chains, classified as non-core by PEPFAR/S, is scheduled to close out at the end of FY 16.

Most OVC program activities take place at community level. In each chiefdom of the intervention Tinkhundla, the traditional leadership will be sensitized on program activities. Community leaders and existing volunteer cadres and structures will serve as entry points for identifying the most vulnerable and hard to reach children.

SIMS assessments did not identify common issues across sites.

Swaziland will conduct its first MER 1.5 Essential Survey in Q4/FY 15 – Q1/FY16.

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

N/A

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

N/A

5.2 Plans for Centrally Supported sites and for redirecting PEPFAR support to priority locations and populations

N/A

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Technical assistance is required to provide guidance towards attaining quality diagnostic. This will require collaboration with ASLM and WHO.

Technical priorities include: expanding QA for HIV rapid tests and HIV-related POC testing, supporting laboratory continuous quality improvement projects, supporting VL and EID implementation and scale up, providing TA for development and implementation of HIVDR surveys, and building laboratory capacity for HIVDR testing. Salary support for national-level laboratory technicians was classified as non-core and has been transitioned to government. . . . Targets to achieve 90-90-90 goals will require; increased HIV testing in high-yield populations, ensuring accuracy of HIV-positive tests prior to treatment, and measurement of VL to confirm suppression. These key laboratory activities will be supported as core elements. Activities to ensure sustainability are: increase numbers of qualified laboratory professionals through training and accreditation; increase laboratory capacity to support quality management systems; decentralize laboratory services; and implement a cost-effective laboratory information system.

Decentralization of services necessitates increased laboratory testing at all levels. There is need to increase support on quality assurance for HIV rapid testing. This is crucial for implementing lifelong ART for pregnant and breastfeeding woman (Option B+), test and treat, for TB/HIV sero-discordant couples, and HBV co-infection with advanced liver disease. Rapid HIV Testing QI includes scale-up of proficiency testing and internal quality control programs using Dried Tube Specimen technology, and strengthening lab capacity to conduct new kit lot verification as part of post-marketing surveillance. POC test provide an opportunity to increase access to laboratory testing at all sites as well as expanding patient care services into the community. The impact of centralized testing has been hampered by specimen transport, infrastructure, maintenance, human resource and result reporting constraints.

There is need to incorporate HIVDR into routine national HIV surveillance programs; surveillance of pre-treatment HIV drug resistance in adult populations initiating ART and surveillance of acquired drug resistance in populations receiving ARVs.

To ensure that laboratory systems are strengthened as part of overall health systems, the focus of Quality Management Systems (QMS) will be directed towards achieving international accreditation of laboratories. Most of the gaps identified during SMS/SIMS visits, included issues around quality control and assurance, waste disposal, and Biosafety training.

The scale-up of laboratory services including VL, means an increase in the number of service contracts for equipment.

| Brief Activity Description Laboratory | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism (s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|--|--|----------------------------------|---------|----------------------------------|---|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Increase numbers of qualified lab professionals through training, faculty support and accreditation | Strategy developed to support faculty salaries. Interim council established to work under the medical and dental council for accreditation of lab professionals. | Increased of use of laboratory licensing and accreditation system by the interim committee. All graduates registered in the medical and dental council's register. | HLAB | HLAB | ICAP LAB | Human Resources for Health Yellow | X | | X | | X |
| Develop Laboratory services capacity to support quality management systems (QMS) | Increased active role of Swaziland Health Laboratory Services' (SHLS) in monitoring and evaluating implementation of the lab strategic plan | Increased implementation of M&E findings to improve SHLS | HLAB | HLAB | ICAP LAB | Quality Management Light Green | X | | | | X |
| Decentralization of lab services to improve sample transport | Increased number of labs, including mini-labs with competent staff to provide quality lab services including POC | Increased number of health facilities that provides access to quality lab services | HLAB | HLAB | ICAP LAB | Access and Demand Light Green | X | | X | | X |
| Identify and implement a cost effective laboratory information system (LIS) | Increase the number of laboratories and mini-labs that use LIS | Increased number of laboratories and mini-labs that use LIS that is sustained by government | HLAB | HLAB | ICAP LAB | Performance Data Access and Demand Light Green | X | | X | | X |
| Develop an equipment maintenance plan | Developed an equipment maintenance plan for VL, Chemistry, CD4, and Hematology equipment | Reduced testing interruptions due to equipment downtime | HLAB | HLAB | ICAP LAB | N/A | X | X | | | X |

6.2 Strategic information (SI)

Identified SI gaps in Swaziland are lack of national data coordination , insufficient SI human resources, suboptimal HMIS, and limited epidemiology and research capacity.

PEPFAR/S will support:

1. HMIS Unit to introduce an electronic medical records system (EMR). In FY15 PEPFAR/S supported Client Management Information System (CMIS) piloting at four sites. A planned evaluation will inform roll out to high volume facilities in 2016. TA will include IT support, consolidation of patient level data collection tools, and implementation of a health sector unique patient identifier. A well-functioning EMR system is critical for strengthening linkages, improve quality of services, and reduce LTFU.
2. M&E Unit to better analyze, synthesize, communicate, and use data for decision making. PEPFAR/S will help ensure interoperability of PEPFAR mobile/community partners and MOH HMIS through stakeholder engagements, needs assessment, and identification and provision of key technical assistance.
3. Epidemiology & Surveillance Unit (ESU) to implement Integrated Disease Surveillance and Response (IDSR) to ensure consistent and sustained surveillance data collection for key issues such as HIV DR, MDR-TB, HIV among pregnant women, and MTCT. TA will enhance ESU's capacity to: 1) prepare and disseminate critical national surveillance reports, and 2) to detect outbreaks then conduct and document outbreak investigations.
4. Health Research Unit (HRU) to coordinate a National Health Research Review Board (NHRRB) that can independently review all research protocols. TA will help develop a standard national training curriculum for local clinical and research staff, focusing on documentation, confidentiality, and ethical research. A HRU will also be supported to conduct biennial national health research conferences.
5. Central Statistical Office (CSO) to improve survey data collection methodology and tools, regularly produce vital statistics, and manage a National Data Coordinating Center.
6. Key stakeholders to enhance program and epidemiological data analysis using geographic information system (GIS). PEPFAR/S will support regular meetings of the PEPFAR GIS TWG to develop governing and data sharing agreements as well as conduct data analysis workshops.
7. A HIV Impact Assessment (HIA) to be conducted in FY2016. This will provide current population-based HIV prevalence and incidence estimates. Capacity strengthening in epidemiology and research will be embedded in the HIA activities together with the Health Research Training Program (H RTP). Two cohorts of six fellows each have undergone a one year on-the-job modular training program for basic epidemiology and research methodology. PEPFAR/S will expand this program to train a diverse cadre of mid-career professionals to produce and use epidemiological information in policy and programming.

PEPFAR/S will monitor progress towards 90-90-90 PEPFAR/S will monitor the following indicators on a quarterly basis:

- HTC_TST; TX_NEW; TX_CURR; PMTCT_STAT; PMTCT_EID; PMTCT_ARV; VMMC_CIRC; PP_PREV; KP_PREV; CARE_NEW; TB_STAT; TB_ART; OVC_SERV; OVC_ACC
- LTFU; HTC yield; % linkage to care; % patients virally monitored; pregnancy status, CD4 count at diagnosis

In addition PEPFAR/S will engage in continuous data-quality monitoring with MOH collaboration to ensure:

- Enhanced during SIMS visits
- Quarterly data verification and DQA
- Minimized data entry backlog by providing HRH support for data entry facility and regional levels
- Leveraging current PEPFAR investment in HMIS to improve clinic data quality and accessibility

The table below provides a summary of monitoring plan for 90-90-90:

| | | First 90 | Second 90 | Third 90 |
|----------|--------------------|---|--|---|
| National | Numerator | 63% of PLHIV know their status (SHIMS) + estimated new diagnoses since SHIMS | Current on ART from MOH M&E unit | VL suppression estimate from MOH M&E unit |
| | Denominator | PLHIV from Spectrum projection | 63% of PLHIV know their status (SHIMS) + estimated new diagnoses since SHIMS | Current on ART from MOH M&E unit |
| PEPFAR | Indicator | HTC_TST; HTC yield TX_NEW; PMTCT_STAT; PMTCT_EID; PMTCT CTX, CARE_NEW; TB_SCREEN; TB_STAT; OVC_ACC; % linkage to care; CD4 count at diagnosis (healthy positives) | TX_CURR; CARE_CURR PMTCT_ARV; TB_ART; LTFU | TX_VIRAL; TX_UNDETECT |

These activities promote country ownership of health data to ensure sustainability. The main goal is to establish a robust national HMIS, surveillance systems, and research capacity by improving data quality, availability, and utilization. This will lead to an evidence-based understanding of the underlying health priorities in the country.

| 1. Brief Activity Description Strategic Information | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|--|----------------------------------|----------|---------------------------------|--|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Support MOH SID in developing a functioning national health information system including introduction of electronic medical records | Complete piloting at 4 sites | Pilot evaluation completed Plan for roll out to additional high volume sites developed Patient level data collection tools consolidated A unique patient identifier is in use | HVSI, C&T | HVSI C&T | Measure Evaluation | Performance Data Light Green | X | X | X | | X |
| HIVDR surveillance | Pilot completed | Full reporting from all facilities, evaluation of the system | HVSI, | HVSI | ICAP EPI | Epidemiological and Health Data Red | | X | | | |
| Pediatric HIV reporting | Pilot completed | Full reporting from all facilities, evaluation of the system | HVSI | HVSI | IACP EPI | Epidemiological and Health Data Red | X | X | X | | |
| HIV Impact Assessment (HIA) | Protocol development, planning, training | Data collection completed, data analysis | HVSI | HVSI | ICAP EPI | Epidemiological and Health Data Red | X | X | X | | X |
| Capacity strengthening in epidemiology and research for MOH and MOEPD | Meetings with key stakeholders, continue with HRPT, support CSO, support ESU, support HRU | H RTP Cohort 3 enrolled, follow up with H RTP Cohorts 1 & 2 completed | HVSI | HVSI | ICAP EPI | Epidemiological and Health Data Red | | | | X | |
| Increase capacity of key PEPFAR stakeholders to use data visualization tools (GIS) | Monthly meeting of the PEPFAR GIS TWG, governing documents, data sharing agreements | Data analysis and sharing workshops | HVSI | HVSI | Measure Evaluation | Epidemiological and Health Data Red | X | X | X | X | X |
| Support MOH interoperability of PEPFAR mobile/community partners HIS (& SHAPMOS) | Needs assessment completed, technical assistance identified | Core data sets identified Partner systems adapted | HVSI | HVSI | Measure Evaluation | Performance Data Light Green | X | X | X | X | |
| TA to MOH SID M&E Unit to increase capacity to analyze, synthesize, communicate and use data for decision making | Gap analysis, needs assessment for the M&E Unit, action plan developed, annual HIV program reports produced | Data quality management strategy developed and implemented | HVSI, | HVSI, | Measure | Performance Data Light Green | X | X | X | X | X |

6.3 Health System Strengthening (HSS)

Health System Strengthening (HSS) – Supply chain

As a result of the introduction of new HIV and TB guidelines, revision of the treatment eligibility threshold from CD4 <350 to CD4 <500, test and treat pilots, introduction of Option B+, and the scale up of viral load testing, there is an increased demand for HIV drugs and commodities as well as increased financial, infrastructure, logistics and human resource needs. GKOS is committed to funding the country's ARV needs, including the increase required for scale-up in FY15.

While much progress has been made in supply chain management (through PEPFAR and CHAI support), the commodity security and supply chain elements of the Sustainability Index scored yellow. The main issues are inefficient GKOS procurement processes, limited capacity in the MoH Procurement Unit, and weak coordination between the MOH and Ministry of Finance departments involved in procuring health commodities. For example, GKOS will approve funding for the full annual ARV need, but funds are not always available when needed, resulting in delayed orders and drug shortages. In addition, the pool of interested suppliers is limited due to a poor payment record, coupled with relatively small quantities being ordered. Warehouse space is also insufficient to accommodate the planned scale up.

UNFPA ceased providing condoms and family planning commodities in 2014 when Swaziland was re-classified as a middle income country in the UN tiered support system. Coordination of the condom supply chain has been challenging due to the utilization different sources of condoms (UNFPA, Global Fund, AIDS Healthcare Foundation) and the many, varied condom distribution channels/points. Going forward, USAID will support condom procurement and it is anticipated that with this support and through support to the central medical stores and the condom TWG, coordination will improve. SIMS data shows that drug availability is generally good at the site level, but there is difficulty maintaining stock within the required minimum and maximum levels. Required guideline documents have not been introduced in facilities and the computer systems for inventory control and commodity tracking have not been adequately rolled out.

The 90-90-90 vision will not be attained unless there is a reliable supply chain of HIV-related drugs and commodities, including condoms. In COP15 the program will prioritize activities at above site and site level necessary for rapid scale up of ART and a robust condom program. PEPFAR will develop the capacity of the newly appointed Chief Pharmacist and Director of the Central Medical Stores in the areas of governance, forecasting, budgeting, procurement, use of computerized systems for commodity tracking and inventory management. The emphasis will be on building sustainable systems to allow for a smooth transition of partner-led activities to the MOH. All above site activities have been categorized as near core. PEPFAR will also supply all Pediatric ARVs and an emergency supply of first line ARVs to ensure continuity in drug supply. In COP 15, PEPFAR/S will procure all condoms.

Site level support for supply chain and pharmaceutical services management were ranked as core. Site level support will include skill building in adverse drug reaction monitoring, adherence monitoring, reporting, and inventory management. Condom programming at the site level is described in the prevention technical narrative.

| Brief Activity Description Supply Chain | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|--|---|----------------------------------|-----------|--|---|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Support policy change to address procurement bottlenecks (contracting, supplier relations, coordination with CMS, MoH Procurement and Ministry of Finance); assist MOH to implement recommendations of the "Options Analysis for the Procurement of ARVs" to institute a cost effective procurement process | SoPs between CMS, Procurement, MoF, Treasury developed | A cost effective procurement process in place | OHSS | OHS S | MSH /SIAPS | Commodity security and supply chain Yellow Allocative efficiency Red | X | X | X | X | X |
| Fully transition to CMS tools and skills for annual forecasting and budgeting, and quarterly supply demand projections for HIV, TB, Laboratory and family planning commodities including condoms | CMS staff do own forecasting +budgeting | | OHSS | OHS S | MSH /SIAPS | Commodity security and supply chain Yellow | X | X | X | X | X |
| Improved drug distribution to and stock management within facilities of products for PMTCT (option B+), first line adult and pediatric ARV/TB drugs, CD4 reagents, HIV rapid test kits, condoms | Drug distribution and stock management procedures documented and implemented | Maintenance of minimum/ maximum stock levels | OHSS | OHS S | MSH /SIAPS Regional Clinical Partners | Commodity security and supply chain Yellow | X | X | X | X | X |
| Mentor Regional Pharmacists to monitor Adverse Drug Reaction (ADR) at HIV and TB Sites through passive surveillance, bi-monthly supportive supervision, and monthly data collection Improve site level adherence monitoring and reporting using the multi method adherence assessment tool | ADR systems developed, monthly data routinely collected | ADR and adherence systems in place and run by MOH | Care& Tx | Care & Tx | MSH /SIAPS Regional Clinical Partners | Commodity security and supply chain Yellow | X | X | X | X | X |
| Procurement of all pediatric ARVs and an emergency stock of adult first line ART to ensure continuity | Adequate pediatric medications and buffer stocks in facilities | Adequate pediatric medications & buffer stocks in facilities. | OHSS | OHS S | MSH /SIAPS | Resource Commitment Red | X | X | X | X | X |
| Support the role out and use of inventory management (Rx Solutions) and commodity tracking (CTS) applications and develop a transition strategy to MOH | 42 facilities supported on use of Rx Solutions and CTS | MOH responsible for use of Rx Solutions and CTS | OHSS | OHS S | MSH /SIAPS Regional Clinical Partners | Commodity security and supply chain Yellow | X | X | X | X | X |
| Train Health Care Workers and Managers on: <ul style="list-style-type: none"> Pharmaceutical and Supply Chain Management of HIV, TB, and family planning including laboratory supply management New HIV and TB (2015) guidelines ADR and Drug Adherence | Training for Health Care Workers and Managers conducted | MOH doing in-service training | OHSS | OHS S | MSH /SIAPS | Commodity security and supply chain Yellow | X | X | X | X | X |

Health System Strengthening (Quality)

There are a number of quality policy changes: the National Quality Policy was developed in 2012 but was only officially launched in 2014, and the Swaziland Standards Authority (SWASA) launched several standards for Hospitals and Health Centers.

The MOH redefined the Quality Management Program (QMP) and its reporting structure, however there is still a lack of clarity within the QMP of their role in quality improvement function, the quality assurance function, and the role in systems development. The QMP has been identified by the MOH as a major priority.

The number of health facilities in which QM initiatives need to be supported is considerable. The staff within the QM program has very limited experience.. The plan is to capacitate the QMP to perform the QA functions, and train heads of departments within facilities to identify and implement QI initiatives. All high volume facilities are targeted. The QMP is also expected to take responsibility for ensuring that MOH senior management is aware of all findings and recommendations from the SIMS visits.

The QA and QI functions will be components of a quality management systems based on the international standards organization 9001:2008 standard, which will improve sustainability of the intervention.

The above site quality activities are considered to be near core and the quality activities in the facility considered to be core.

The quality element scored a light green in the sustainability index, however the MOH is heavily reliant on partners and without them it is unlikely that regional and national reviews would occur.

Data from SIMS visits show a significant gap around the development of SOPs in all departments, and in performing proficiency and quality testing in the laboratory.

| Brief Activity Description Quality | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|--|--|--|----------------------------------|---------|---------------------------------|--|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| 1. Quality Improvement in facilities | | | | | | | | | | | |
| Development of the National Quality Management program to provide an assurance function. | QM Program functions defined | QM assurance functions in place | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Identification, development, implement quality standards within health facilities (including ISO 9001: 2008 standard) | Quality standards developed | Quality standards implemented within health facilities | C&T | C&T | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Capacity building of HCW in the facilities on Quality Improvement Concept and Methodology and implementation of QI projects | Training of HCW on QIP in high volume sites completed | QIPs implemented in high volume sites | C&T | C&T | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Mainstreaming QI in in-service training | Training department capacitated to provide QI training | QIP training being rolled out | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| 2. Development of Quality Management systems within facilities (leading to ISO 9001 Certification) | | | | | | | | | | | |
| ISO technical support (ISO Certification Administrator for each facility, local quality authority accredited body). | ISO technical support hired | Technical support provided to facilities | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Capacity building on implementation requirements for ISO certification: directorate, RHMTS, facility management, administration, staff | Training on implementation requirements completed | Training on implementation requirements completed | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |

| | | | | | | | | | | | |
|---|--|---|------|-------|----------|-----------------------------------|---|---|---|---|---|
| Capacity building on development and internal auditing requirements for ISO: core staff in the facilities | Training on systems development and internal auditing completed | Training on systems development and internal auditing completed | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Establishment of a document control office at each facility | Document control office established | Document control office functional | OHSS | OHS S | MOH CoAg | Quality Management GREEN | X | X | X | X | X |
| Development of ISO Manual and implementation of standard | ISO manual developed | Manual implemented | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| 3. Development of Regional Support base for Quality Management systems in the facilities | | | | | | | | | | | |
| Training for RHMTs: management systems, workplan development and follow up, strengthening of PHC | Training for RHMTs management systems, and work-plans conducted | Training for RHMTs strengthening of PHC | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Consultant to identify organizational structures for decentralization and to develop a strategy for revival | Consultant identified and report done | Regional structures implemented | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Development of a REGIONAL document management system and site monitoring system | Regional document management system developed | Regional document management system implemented | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| 4. Leadership and governance | | | | | | | | | | | |
| Definition of roles and responsibilities, key processes at national regional and facility level | Roles and responsibilities , at national regional and facility level defined | Key processes at national regional and facility level defined | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |
| Establish national management reviews (Accountability measures) | Management reviews introduced | Management reviews done regularly | OHSS | OHS S | MOH CoAg | Quality Management Light Green | X | X | X | X | X |

Health Systems Strengthening (Human Resources for Health)

The PEPFAR/S HRH strategy was developed during COP15 preparation and demonstrates a significant pivot. Until COP15, PEPFAR/S had focused on the national level such as support for implementation of the National HRH Strategic Plan, central HR management capacity, in-service training (IST) coordination, and strengthening regulatory professional councils. The PEPFAR/S HRH strategy aligns to the five PEPFAR global HRH objectives, and emphasizes continuity and inter-relatedness of national, regional and site level HRH support. The overall goal is to ensure appropriate HRH are in the right places doing the right things to enable achievement of the program's ambitious targets for epidemic control. An inter-agency PEPFAR HRH task team will be established to guide the implementation of the HRH strategy and ensure operational efficiencies.

PEPFAR/S will capitalize on the newly updated national HR information system (HRIS) and partner transition process to carry out an assessment of current PEPFAR-funded HRH support provided at site, regional and national level and then develop a systematic approach to defining staffing levels. A workload-based analysis will be used to develop skill mix prototypes for different types of facilities. Site level HRH plans will be developed with standardized methods of supporting HRH gaps, including a common process for supporting MOH-established cadres and non-established cadres such as lay counselors and expert clients. COP15 will also focus on developing strategies to improve efficient utilization and productivity of the HRH at PEPFAR priority sites, including a review of lay cadres. Site level performance improvement plans will be developed in alignment with the MOH's QMP. Building on the successful IST coordination activity (due to conclude in September 2015), implementing mechanisms will use a standardized training needs assessment to develop a PEPFAR IST Training Plan, which will form part of the MOH Training Calendar. In addition, PEPFAR/S will develop standardized approaches for HRH recruitment (job descriptions, benefit packages) to which all partners will work towards adhering.

In COP15 above site support to the MOH/HRH Unit will focus on strengthening the national and regional systems that will ensure adequate workforce densities, site performance, and quality improvement to deliver services and meet targets across programs. PEPFAR will also continue to support the MOH to update and utilize its donor-funded transition plan.

COP15 pre-service targets are consistent with the number of PEPFAR-supported nursing and allied health students already in training at local and regional institutions. Direct funding of pre-service training was defined as non-core, with transition in 2017 to accommodate the final training cohort. However, support for full-time lecturers for Laboratory Technology was identified as near-core because of the difficulty faced by local training institutions to attract fulltime qualified faculty.

| 1. Brief Activity Description Human Resources for Health | Deliverables | | Budget codes and allocation (s) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|--|---|---------------------------------|---------|---------------------------------|--|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Develop site-level plans to support HR gaps at PEPFAR supported facilities | Costed plan of HRH gaps, disaggregated by established and non-established posts, developed | | OHSS | OHSS | Abt HFG | Human Resources for Health: Yellow | X | X | X | X | X |
| Identify and improve HR efficiencies at PEPFAR supported sites | Strategy for efficient utilization of PEPFAR supported lay cadres developed | Strategy for efficient utilization of PEPFAR supported lay cadres fully implemented | OHSS | OHSS | Abt HFG | Human Resources for Health: Yellow | X | X | X | X | X |
| Develop and implement standardized HRH strategy, including recruitment strategy, across PEPFAR partners | PEPFAR partner HRH strategy developed (including recruitment policy) PEPFAR HRH task team established and functional | PEPFAR HRH strategy (including recruitment policy) fully implemented by partners | OHSS | OHSS | Abt HFG | Human Resources for Health: Yellow | X | X | X | X | X |
| Conduct standardized IST needs assessment for PEPFAR supported sites | Needs assessment conducted 2015 training plan approved by MOH | Needs assessment conducted 2016 training plan approved by MOH | OHSS | OHSS | Abt HFG | Human Resources for Health: Yellow | X | X | X | X | X |
| Develop and implement site level HRH performance improvement plans to monitor quality of services | Tools for HRH performance improvement developed Site level HRH performance assessment conducted | Site level HRH plans implemented | OHSS | OHSS | Abt HFG | Human Resources for Health: Yellow | X | X | X | X | X |

7.0 Staffing Plan

In COP FY 2014, PEPFAR/S conducted an assessment of programmatic alignment of our staff and staff capacity to implement the PEPFAR 3.0 business model. All program and support staff are 100% funded by PEPFAR/S. As part of the analysis, we reviewed the scopes of work and individual skill sets available within the current staffing pattern and revised PDs to address gaps. We added two positions to effectively implement PEPFAR 3.0.

The Project Management Assistant and GF Liaison PDs (these positions are not additive but being re-purposed) are revised to reflect an additional focus on SI (PMA) and financial analysis (GFL). In COP15, USAID is adding one locally employed (LE) Program/Financial Analyst who will manage a regular schedule of SIMS visits for all USAID awards and assist with SIMS implementation. This individual will also be responsible for IM financial tracking, analysis, and monitoring of expenditures against achievement of targets in all program areas. CDC is adding one LE Technical Advisor for Community-based HTC and Linkages to Care who will serve as the interagency lead for HTC. Currently, programs for testing and treatment and linkages to care are overseen by the same person who oversees treatment and care programs. This position's focus will optimize the opportunities to increase the numbers of persons tested, counseled and linked to care as well as focus on community-based HTC and linkages to care.

Based on increased requirements for SIMS and the move to the New Embassy Compound (NEC), State is adding an additional driver.

The main factors that will change the CODB is the move to the NEC in 2015 and the full implementation of SIMS, which will result in a 25-30% increase in ICASS costs. Based on the analysis done using the SIMS Action Planner we anticipate US\$99,956 will be the additional cost to M&O. For the additional HR required for SIMS, USAID will rely on existing USAID Regional HIV/AIDS Program staff in Pretoria to fill the gap; approximately \$50,000 was added to the USAID M&O travel line for this purpose.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

| Level of Implementation | Core Activities | Near-core Activities | Non-core Activities |
|-------------------------|--|--|---|
| Site Level | <p>HTC</p> <ul style="list-style-type: none"> Provision of HTC across the range of community and facility settings Linking HTC-users to the appropriate services and tracking those linkages Supply, provision and distribution of RTKs Mobilization to support HTC and testing demand creation Activities that support HTC to widen the access, utilization and uptake by families HIV testing among priority populations and locations <p>Care & Treatment</p> <ul style="list-style-type: none"> Direct service provision as well as direct technical support to the site, including VL reagent procurement Sample transport and results return at the site level (CD4/VL) for care and treatment, PMTCT, pediatrics All ARVs, including PEP, ARVs for adult treatment, pediatric treatment, and PMTCT. Procurement of HIV+ monitoring commodities (CD4) HIV care and treatment drug delivery – distribution costs to facility level Procurement of Cotrimoxazole and associated support (e.g. training, monitoring, oversight/mentoring, etc.) Services related to prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related complications All PHDP activities for HIV+ individuals Activities that will increase direct linkages between facility and community Support adherence to improve overall retention on treatment and establish functional linkages between programs and with the community to reduce loss to follow up HIV testing for all pregnant and breastfeeding women and their partners Service delivery for option B+, including support for clinic personnel Facility based services for HIV exposed infants | <p>Care & Treatment</p> <ul style="list-style-type: none"> Support referral for screening and treatment to prevent cervical cancer in HIV-infected women Procurement of VIA and cryotherapy equipment for cervical cancer screening for HIV+ women in selected referral facilities Nutritional assessment, counseling, and support for HIV+ women and men Support to the government to roll out updated pediatric treatment guidelines <p>Prevention</p> <ul style="list-style-type: none"> Support MOET in school life skills education roll out <p>HSS</p> <ul style="list-style-type: none"> Renovation of health facilities | <p>Care & Treatment</p> <ul style="list-style-type: none"> All TB screening for general population <p>Prevention</p> <ul style="list-style-type: none"> Direct service delivery and TA for EIMC <p>OVC</p> <ul style="list-style-type: none"> Household economic strengthening: IGA Household economic strengthening: Value chains |

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| | <ul style="list-style-type: none"> • Early infant diagnosis services implemented at the site level • Salary support for CHWs that assist with PMTCT specific adherence and retention activities • Nutritional evaluation and care of malnutrition in HIV+ and exposed infants, children under 5 • Activities promoting case finding and integration of pediatric HIV treatment services into MNCH platforms • Building capacity to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services) • Support the needs of adolescents with HIV (ALHIV) • Providing clinical services to HIV+ children • In-service training for clinicians and other providers to provide pediatric care • Providing community support to HIV+ children • Activities to address psychosocial support of children and adolescents • Clinical and laboratory monitoring of children and adolescents on treatment (CD4/VL reagents) • All TB screening for HIV infected individuals • INH prophylaxis for all HIV+ populations • Laboratory investments for TB/HIV, including GeneXpert equipment, test kits, and other consumables • Exams, clinical monitoring, related laboratory services, treatment and prevention of TB • Screening of TB clinic clients for HIV testing and clinical care • TB activities targeting key pops <p>Prevention:</p> <ul style="list-style-type: none"> • Strengthen community structures and linkages to core services (increase demand and access) • Services related to the procurement, promotion and distribution of male and female condoms and condom-compatible lubricants • Sexual prevention programs targeted for key populations (peer outreach, small group prevention, hot spots, training, enabling environment networks) • Strengthening access to and provision of PEP and referrals to comprehensive care for survivors of sexual assault • Providing a comprehensive package of support to increase AGYW resilience and access to SRH services • VMMC supplies and commodities • Communication and demand creation for VMMC • Training (in-service, safety, curriculum creation) • Support the implementation of VMMC minimum package of clinical and prevention services which MUST be included at every VMMC | | |
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| | <p>delivery point</p> <ul style="list-style-type: none"> • Linkages to treatment/ Care services for men who test HIV+ <p>OVC</p> <ul style="list-style-type: none"> • Household economic strengthening - savings groups that integrate financial literacy and job preparedness • Access to adolescent friendly services/ reproductive health services • Early Childhood Development programs including access to health services and growth monitoring • Linkage and referral to facility and community-based services • Strengthen resilience among adolescents <p>HSS</p> <ul style="list-style-type: none"> • In-service training for clinical and other personnel supporting HIV activities • Time bound direct personnel support for cadres on government register required for scale up • Direct personnel support for cadres NOT on the government register but required for scale up • Site level support for HRH planning, deployment and management • Site level implementation of electronic medical records to strengthen linkages, improve quality of services and reduce loss to follow up • Site level support in stock management (Rx Solutions), forecasting, adherence monitoring and reporting through mentoring • Strengthen pharmacy services at site level • Site level quality management support • Decentralization of lab services to improve sample transport | | |
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| <p>Sub National</p> | <p>OVC</p> <ul style="list-style-type: none"> • Strengthen community structures and linkages for child protection • Provide TA for social welfare and service networks including the social workforce <p>HSS</p> <ul style="list-style-type: none"> • Time-bound direct personnel support for cadres on government register required for scale up | <p>Care & Treatment</p> <ul style="list-style-type: none"> • Support to the government to roll out updated pediatric treatment guidelines • National/district level support for B+ roll out <p>Prevention</p> <ul style="list-style-type: none"> • Support MOET in school life skills education roll out <p>HSS</p> <ul style="list-style-type: none"> • TA to HR Unit, RHMTs and regional/national decision makers to establish strategic staffing plan based on scale up • Regional level TA to monitor adverse drug reaction (ADR) at HIV and TB sites through passive surveillance, bi-monthly supportive supervision • Regional level quality management support | |
| <p>National Level</p> | | <p>Care & Treatment</p> <ul style="list-style-type: none"> • Support to the government to roll out updated pediatric treatment guidelines • Efforts to improve monitoring, evaluation and reporting of collaborative TB/HIV activities. <p>OVC</p> <ul style="list-style-type: none"> • Multi-sectorial response to VAC and SGBV (protective services for children) • Strengthening the capacity of local NGOs and CBOs who work on OVC issues <p>Prevention</p> <ul style="list-style-type: none"> • Strengthen delivery of quality SBCC/Interventions • Strengthening access to and provision of PEP and referrals to comprehensive care for survivors of sexual assault (national level) | <p>HSS</p> <ul style="list-style-type: none"> • National systems planning and coordination for in-service training • Above site TA for HRIS • Support to the Nursing Council for review of and advocacy for enactment of Nursing Act (task shifting) • Direct financing of Pre-service training • Blood safety donor recruitment, |

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| | | <p style="text-align: center;">HSS</p> <ul style="list-style-type: none"> • Standardization of PEPFAR HRH support (salary structure, job descriptions) • TA to HR Unit, RHMTs and regional/national decision makers to establish strategic staffing plan based on scale up • Support MOH to develop/update donor funded position transition plan • Support standardized IST needs assessment and planning across PEPFAR partners • Develop/implement site level HRH performance improvement plans • Program specific M&E, evaluations • Strengthening national health information system operations, data quality, and utilization of data for decision making • Increase capacity of key PEPFAR stakeholders of use data visualization tools (GIS) • TA to MOH SID M&E Unit to increase capacity to analyze, synthesize, communicate and use data for decision making • HIV Impact Survey (HIA) • HIVDR surveillance • TA to support country wide electronic medical records (HMIS) • Capacity strengthening in epi and research • Support MOH interoperability of PEPFAR mobile/community partners HIS • Support policy change to address HIV drug and commodity procurement bottlenecks • National level TA for annual forecasting and budgeting, quarterly supply demand projections for HIV, TB, Laboratory and family planning commodities including condoms • Training Health Care Workers and managers on pharmaceutical and supply chain management of HIV, TB and family planning including laboratory supply management, ADR, drug adherence • National level quality management support • Blood bank accreditation TA • Blood safety QA • Develop Laboratory Services capacity to support quality management systems • Increase numbers of qualified lab professionals through training, faculty support | <p>collection & testing, blood storage & distribution, transfusion procedures, appropriate use of clinical blood</p> |
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| | | <p>and accreditation</p> <ul style="list-style-type: none">• Lab SLMPTA accreditation• Identify and implement a cost effective laboratory information system (LIS)• In-service lab training, mentoring/supervision• Develop a laboratory equipment maintenance plan• Support to Global Fund programs and activities, and donor coordination• Development and implementation of policy, advocacy, guidelines and tools (foundational for epidemic control and sustainability) | |
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Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

| HTC | Core Activities | Near-core Activities | Non-core Activities |
|---------------------------|---|---|---|
| HTC | The provision of HIV testing and counseling across the range of community and facility settings | | |
| HTC | Supply, provision and distribution of RTKs | | |
| HTC | Mobilization to support HTC and testing demand creation | | |
| HTC | Linking HTC-users to the appropriate services and tracking those linkages | | |
| HTC | Activities that support HTC to widen the access, utilization and uptake by families | | |
| HTC | HIV testing among priority populations and locations | | |
| Care and Treatment | Core Activities | Near-core Activities | Non-core Activities |
| Care and Treatment | Direct service provision as well as direct technical support to the site, including VL, reagent procurement | Support referral for screening and treatment to prevent cervical cancer in HIV-infected women | All TB screening for general population |
| Care and Treatment | HIV care and treatment drug delivery – distribution costs to facility level | | |
| Care and Treatment | All ARVs, including PEP, ARVs for adult treatment, pediatric treatment, and PMTCT. | | |
| Care and Treatment | Procurement of HIV+ monitoring commodities (CD4) | | |
| Care and Treatment | Services related to prevention and treatment of OIs (excluding TB) and other HIV/AIDS-related | | |

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| | complications | | |
| Care and Treatment | Procurement of cotrimoxazole and associated support (e.g. training, monitoring, oversight/mentoring, etc.) | | |
| Care and Treatment | All PHDP activities for HIV+ individuals | | |
| Care and Treatment | Activities that will increase direct linkages between facility and community services | | |
| Care and Treatment | Support adherence to improve overall retention on treatment and establish functional linkages between programs and with the community to reduce loss to follow up | | |
| Care and Treatment PMTCT | HIV testing for all pregnant and breastfeeding women and their partner(s). | National/district level support for B+ roll-out | |
| Care and Treatment PMTCT | Service delivery for option B+, including support for clinic personnel | Procurement of VIA and cryo-therapy equipment for cervical cancer screening for HIV+ women in selected referral facilities | |
| Care and Treatment PMTCT | Facility based services for HIV exposed infants | Nutritional assessment, counseling, and support for HIV+ women and men | |
| Care and Treatment PMTCT | Early infant diagnosis services implemented at the site level | | |
| Care and Treatment PMTCT | Salary support for CHWs that assist with PMTCT specific adherence and retention activities | | |
| Care and Treatment PMTCT | Sample transport systems for specimens at the site level for clinical monitoring of PMTCT clients (CD4/VL) | | |

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| Care and Treatment PMTCT | Sample transport and results return for pediatric specimens at the site level (CD4/VL) | Human resources to accelerate planning and implementation of collaborative TB/HIV | |
| Care and Treatment Pediatrics | Nutritional evaluation and care of malnutrition in HIV+ and exposed infants, children under 5 | Support to the government to roll out updated pediatric treatment guidelines | |
| Care and Treatment Pediatrics | Activities promoting case finding and integration of pediatric HIV treatment services into MNCH platforms | Efforts to improve monitoring, evaluation and reporting of collaborative TB/HIV activities | |
| Care and Treatment Pediatrics | Building capacity to monitor, supervise and implement uninterrupted HIV treatment services from infancy to adolescents (including transition to adult services) | | |
| Care and Treatment Pediatrics | Support the needs of adolescents with HIV (ALHIV) | | |
| Care and Treatment Pediatrics | Providing clinical services to HIV+ children | | |
| Care and Treatment Pediatrics | In-service training for clinicians and other providers to provide pediatric care | | |
| Care and Treatment Pediatrics | Providing community support to HIV+ children | | |
| Care and Treatment Pediatrics | Activities to address psychosocial support of children and adolescents living with HIV | | |
| Care and Treatment Pediatrics | Clinical and laboratory monitoring of children and adolescents on treatment (CD4/VL reagents) | | |
| Care and Treatment TB | All TB screening for HIV infected individuals | | |

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|-----------------------|---|---|----------------------------|
| Care and Treatment TB | INH prophylaxis for all HIV+ populations | | |
| Care and Treatment TB | Laboratory investments for TB/HIV, including GeneXpert equipment, test kits, and other consumables | | |
| Care and Treatment TB | Exams, clinical monitoring, related laboratory services, treatment and prevention of TB | | |
| Care and Treatment TB | Screening of TB clinic clients for HIV testing and clinical care | | |
| Care and Treatment TB | TB activities targeting key pops | | |
| Prevention | Core Activities | Near-core Activities | Non-core Activities |
| Prevention | Strengthen community structures and linkages to core services (increase demand and access) | Support MOET in school life skills education roll out | |
| Prevention | Services related to the procurement, promotion and distribution of male and female condoms and condom-compatible lubricants | Strengthen delivery of quality SBCC/Interventions | |
| Prevention | Sexual prevention programs targeted for key populations (peer outreach, small group prevention, hot spots, training, enabling environment networks) | | |
| Prevention | Strengthening access to and provision of PEP and referrals to comprehensive care for survivors of sexual assault (site level) | Strengthening access to and provision of PEP and referrals to comprehensive care for survivors of sexual assault (national level) | |
| Prevention | Provide a comprehensive package of support to increase AGYW resilience and access to SRH services | | |

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| VMMC | VMMC supplies and commodities | | Direct service delivery and TA for EIMC |
| VMMC | Communication and demand creation for VMMC | | |
| VMMC | Training (in-service, safety, curriculum creation) | | |
| VMMC | Support the implementation of VMMC- minimum package of clinical and prevention services which MUST be included at every VMMC delivery point | | |
| VMMC | Linkages to treatment/ Care services for men who test HIV+ | | |
| OVC | Core Activities | Near-core Activities | Non-core Activities |
| OVC | Household economic strengthening - savings groups that integrate financial literacy and job preparedness | | Household economic strengthening - IGA |
| OVC | | Multi-sectorial response to VAC and SGBV (protective services for children) | Household economic strengthening - Value chains |
| OVC | Access to adolescent friendly services/ reproductive health services | | |
| OVC | Early Childhood Development programs including access to health services and growth monitoring | | |
| OVC | Strengthen community structures and linkages for child protection | Strengthening the capacity of local NGOs and CBOs who work on OVC issues | |
| OVC | Provide TA for social welfare and service networks including the social workforce | | |
| OVC | Linkage and referral to facility and community-based services | | |
| OVC | Strengthen resilience among adolescents | | |

| Program/system support | Core Activities | Near-core Activities | Non-core Activities |
|-------------------------------|--|---|--|
| Systems Strengthening HRH | In service training for clinical and other personnel supporting HIV activities | Standardization of PEPFAR HRH support (salary structure, job descriptions) | National systems planning and coordination for in-service training |
| Systems Strengthening HRH | Time-bound direct personnel support for cadres on government register required for scale-up | TA to HR Unit, RHMTs and regional/national decision makers to establish strategic staffing plan based on scale up | Above site TA for HRIS |
| Systems Strengthening HRH | Direct personnel support for cadres NOT on the government register but required for scale-up | Support MOH to develop/update donor funded position transition plan | Support to the Nursing Council for review of and advocacy for enactment of Nursing Act (task shifting) |
| Systems Strengthening HRH | Site level support for HRH planning, deployment and management | Support standardized IST needs assessment and planning across PEPFAR partners | TA to Medical and Dental Council to develop strategic plan |
| Systems Strengthening HRH | Direct financing of Pre-service training | Develop/implement site level HRH performance improvement plans | |
| Systems Strengthening SI | Site level implementation of electronic medical records to strengthen linkages, improve quality of services and reduce lost to follow up | Program specific M&E, evaluations | |
| Systems Strengthening SI | | Increase capacity of key PEPFAR stakeholders to use data visualization tools (GIS) | |
| Systems | | Strengthening national health information system operations, data quality, and | |

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| Strengthening SI | | utilization of data for decision making | |
| Systems Strengthening SI | | TA to MOH SID M&E Unit to increase capacity to analyze, synthesize, communicate and use data for decision making | |
| Systems Strengthening SI | | HIV Impact Survey (HIA) | |
| Systems Strengthening SI | | HIVDR surveillance | |
| Systems Strengthening SI | | TA to support country wide electronic medical records system (HMIS) | |
| Systems Strengthening SI | | Capacity strengthening in epi and research | |
| Systems Strengthening SI | | Support MOH interoperability of PEPFAR mobile/community partners HIS | |
| Systems Strengthening Supply Chain | Site level support in stock management (Rx Solutions), forecasting, adherence monitoring and reporting through mentoring | Support policy change to address procurement bottlenecks | |
| Systems Strengthening Supply Chain | | National level TA for annual forecasting and budgeting, and quarterly supply demand projections for HIV, TB, | |

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| | | Laboratory and family planning commodities including condoms | |
| Systems Strengthening Supply Chain | | Training Health Care Workers and Managers on pharmaceutical and supply chain management of HIV, TB, and family planning including laboratory supply management, ADR, drug adherence | |
| Systems Strengthening Supply Chain | | Regional level TA to monitor Adverse Drug Reaction (ADR) at HIV and TB Sites through passive surveillance, bi-monthly supportive supervision | |
| Systems Strengthening Quality Management | Site level quality management support | National level quality management support | |
| Systems Strengthening Quality Management | | Regional level quality management support | |
| Systems Strengthening Blood Safety | | <ul style="list-style-type: none"> • Blood bank accreditation TA • Blood safety QA | Blood safety donor-recruitment, collection & testing, blood storage & distribution, transfusion procedures, appropriate use of clinical blood |
| Systems Strengthening Lab | | Decentralization of lab services to improve sample transport | |
| Systems Strengthening Lab | | Develop Laboratory services capacity to support quality management systems (QMS) | |

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|---------------------------|--|---|-------------------------------|
| Systems Strengthening Lab | | Increase numbers of qualified lab professionals through training, faculty support and accreditation | Lab research training program |
| Systems Strengthening Lab | | Lab SLMPTA | |
| Systems Strengthening Lab | | Identify and implement a cost effective laboratory information system (LIS) | |
| Systems Strengthening Lab | | Develop a laboratory equipment maintenance plan | |
| Systems Strengthening Lab | | In-service lab training, mentoring/supervision | |
| Systems Strengthening | | Renovation of health facilities | |
| Systems Strengthening | | Support to GF programs and activities, and donor coordination | |
| Systems Strengthening | | Development and implementation of policy, advocacy, guidelines and tools (foundational for epidemic control and sustainability) | |

Table A.3 Transition Plans for Non-core Activities

| Transitioning Activities | Type of Transition | Funding in COP 15 | Estimated Funding in COP 16 | # of IMs | Transition End date | Notes |
|---|--|--------------------------|-----------------------------|----------|---------------------|-------|
| All TB screening for general population | To transition to GKOS | No | 0 | 1 | 9/30/2015 | |
| Direct Service Delivery and TA for EIMC | DSD: end FY15 transition to GKOS. TA: end FY16 transition | Yes, minimal for EIMC TA | 0 | 1 | 9/30/2016 | |

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| | to GKOS | | | | | |
| Household economic strengthening – IGA & value chains | Phase out | Yes | o | 1 | 12/2016 | |
| National systems planning and coordination for in-service training | To transition to GKOS | No | o | 1 | 9/30/2015 | |
| Above site TA for HRIS | To transition to GKOS | No | o | 2 | 9/30/2016 | One mechanism will phase out support by 3/31/2016. The remaining mechanism will complete by 9/30/2016. |
| Support to the Nursing Council for review of and advocacy for enactment of Nursing Act (task shifting) | GKOS | No | o | 1 | 3/31/2016 | |
| TA to Medical and Dental Council to develop strategic plan | Medical and Dental Council | No | o | 1 | 3/31/2016 | |
| Procurement of lab commodities/consumables (with exception of CD4, EID, VL) | GKOS | No | o | 1 | 3/2016 | COP14 last year of funding |
| Lab research training program | GKOS | No | o | 1 | 3/2015 | COP14 last year of funding |
| Blood safety donor-recruitment, collection & testing, blood storage & distribution, transfusion procedures, appropriate use of clinical blood | GKOS | No | o | 1 | 9/2014 | |
| Pre-service training for Pharmacy Assistants | To transition to Southern Africa Nazarene University | No | No | 1 | 9/30/2015 | |

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| | (SANU) | | | | | |
| Direct financing of Pre-service training | \$85,000 | \$85,000 | | | 2017 | |
| | | | | | | |

APPENDIX B

B.1 Planned Spending in 2016

| Table B.1.1 Total Funding Level | | |
|---------------------------------|-----------------|-----------------|
| Applied Pipeline | New Funding | Total Spend |
| \$US 1,687,302 | \$US 47,112,698 | \$US 48,800,000 |

| Table B.1.2 Resource Allocation by PEPFAR Budget Code | | |
|---|--------------------------------------|-------------------|
| PEPFAR Budget Code | Budget Code Description | Amount Allocated |
| MTCT | Mother to Child Transmission | 572,142 |
| HVAB | Abstinence/Be Faithful Prevention | 42,750 |
| HVOP | Other Sexual Prevention | 2,252,093 |
| IDUP | Injecting and Non-Injecting Drug Use | 0 |
| HMBL | Blood Safety | 85,000 |
| HMIN | Injection Safety | 0 |
| CIRC | Male Circumcision | 3,041,328 |
| HVCT | Counseling and Testing | 1,304,493 |
| HBHC | Adult Care and Support | 3,059,009 |
| PDCS | Pediatric Care and Support | 902,295 |
| HKID | Orphans and Vulnerable Children | 4,650,157 |
| HTXS | Adult Treatment | 14,995,554 |
| HTXD | ARV Drugs | 7,101,201 |
| PDTX | Pediatric Treatment | 1,281,977 |
| HVTB | TB/HIV Care | 1,598,761 |
| HLAB | Lab | 681,608 |
| HVSI | Strategic Information | 1,583,204 |
| OHSS | Health Systems Strengthening | 1,570,601 |
| HVMS | Management and Operations | 2,390,525 |
| TOTAL | | 47,112,698 |

B.2 Resource Projections

The OGAC supplied PEPFAR Budget Allocation Calculation Tool (PBAC) was used to calculate the required funding level for each budget code. Partner targets were then used to allocate available resources to each partner. For the few partners without targets a ratio of their contribution towards the achievement of each budget code was used as a basis to estimate their required funding level. In FY2016 GFTAM grants will begin implementation making available approximately \$42 million available to the response.

Annex 1: Focus Tinkhundlas

| Inkundla | Female Population 15 - 24 Yrs | Cumulative Population | Cumulative population Percent |
|------------------|--|----------------------------------|--|
| Kwaluseni | 7,410 | 7,410 | 6% |
| Manzini North | 5,985 | 13,395 | 10% |
| Mbabane East | 5,037 | 18,432 | 14% |
| Lobamba | 3,759 | 37,810 | 28% |
| Maseyisini | 3,861 | 30,246 | 23% |
| Mbabane West | 3,292 | 51,780 | 39% |
| Motjane | 3,934 | 26,385 | 20% |
| Mbangweni | 3,757 | 41,567 | 31% |
| Ludzeludze | 4,019 | 22,451 | 17% |
| Sithobela | 3,805 | 34,051 | 25% |
| Dvokodweni | 3,548 | 45,115 | 34% |
| Mkhiweni | 3,201 | 54,981 | 41% |
| Ngwempisi | 3,373 | 48,488 | 36% |
| Lobamba Lomdzala | 2,672 | 66,267 | 50% |
| Siphofaneni | 2,937 | 57,918 | 43% |

| Inkundla | Male Population 20 - 39 Yrs | Cumulative Population | Cumulative population Percent |
|------------------|--|----------------------------------|--|
| Kwaluseni | 8,423 | 8,423 | 7% |
| Manzini North | 6,615 | 15,038 | 12% |
| Mbabane East | 6,419 | 21,457 | 17% |
| Mbabane West | 4,424 | 25,881 | 21% |
| Lobamba | 3,917 | 33,990 | 27% |
| Ludzeludze | 3,557 | 37,547 | 30% |
| Mbangweni | 3,533 | 41,080 | 33% |
| Maseyisini | 3,168 | 47,513 | 38% |
| Lobamba Lomdzala | 2,983 | 50,496 | 40% |
| Pigg's Peak | 2,933 | 53,429 | 43% |
| Siphofaneni | 2,907 | 56,336 | 45% |
| Dvokodweni | 2,829 | 59,165 | 47% |
| Sithobela | 2,774 | 61,939 | 49% |

Annex 2: Outlier Analysis Findings

| Program Area | Unit Expenditure Label | Outlier Cutoff Value Used | Mechanism Name | SNU | Outlier UE Value | Outlier UE Beneficiary Volume | Weighted Average UE | Outlier M-SNU funded in COP15 for same activities? | Why is this UE a high outlier? (explanation type) | Notes on explanation | Data source for explanation | Rationale for continued investment for epidemic control | Any data source for rationale? |
|--------------|------------------------|---------------------------|--|---------|------------------|-------------------------------|---------------------|--|---|---|---------------------------------|--|--|
| FBCTS | Peds/Pre-ART | 2 | ICAP/CDC Improving Quality of Treatment Services | Manzini | \$24.82 | 112 | \$9.94 | Funded, but for different activities | Low beneficiary volume | Number of children who were identified to be HIV+ is significantly lower than the efforts put | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2018 |
| FBCTS | Peds/Pre-ART | 2 | ICAP/CDC Improving Quality of Treatment Services | Hhohho | \$26.94 | 145 | \$9.94 | Not funded | Low beneficiary volume | in place to enroll them into care and maintain them on treatment. Trainings and other mentoring support activities were however maintained at the same level | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2019 |
| FBCTS | Peds/Pre-ART | 2 | ICAP/CDC Improving Quality of Treatment Services | Lubombo | \$47.88 | 108 | \$9.94 | Not funded | Low beneficiary volume | | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2020 |
| PMTCT | Infants and Care | 2 | EGPAF-EPAS (Eliminating Pediatric AIDS in Swaziland) | Manzini | \$708.02 | 192 | \$236.14 | Not funded | Low beneficiary volume | The low numbers of children seen by these partners result in the observed high unit | PMTCT activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2021 |
| PMTCT | Infants and Care | 2 | EGPAF-EPAS (Eliminating Pediatric AIDS in Swaziland) | Hhohho | \$1,096.29 | 62 | \$723.14 | Funded, but for different activities | Low beneficiary volume | expenditures. While EGPAF provides a more comprehensive service under PMTCT, URCS support mainly focused on TB. However, with the new regional approach, such challenges will be minimized. | PMTCT activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2022 |
| PMTCT | Infants and Care | 2 | URC-ASSIST | Manzini | \$2,466.80 | 1 | \$236.14 | Not funded | Low beneficiary volume | | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2023 |
| PMTCT | Infants and Care | 2 | EGPAF-EPAS (Eliminating Pediatric AIDS in Swaziland) | Hhohho | \$2,832.07 | 48 | \$236.14 | Funded, but for different activities | Low beneficiary volume | | PMTCT activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2024 |
| PMTCT | Infants and Care | 2 | URC-ASSIST | Hhohho | \$3,137.84 | 1 | \$236.14 | Not funded | Low beneficiary volume | | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2025 |
| PMTCT | Infants and Care | 2 | EGPAF-EPAS (Eliminating Pediatric AIDS in Swaziland) | Lubombo | \$3,897.71 | 22 | \$236.14 | Not funded | Low beneficiary volume | | PMTCT activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2026 |

| Program Area | Unit Expenditure Label | Outlier Cutoff Value Used | Mechanism Name | SNU | Outlier UE Value | Outlier Beneficiary Volume | Weighted Average UE | Outlier M-SNU funded in COP15 for same activities? | Why is this UE a high outlier? (explanation type) | Notes on explanation | Data source for explanation | Rationale for continued investment for epidemic control | Any data source for rationale? |
|--------------|------------------------|---------------------------|---|-----------|------------------|----------------------------|---------------------|--|--|--|---------------------------------|--|--|
| HTC | HTC | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Manzini | \$20.82 | 23,792 | \$9.25 | Funded, but for different activities | Hard-to-reach population (small number, marginalized, or physically dispersed) | The whole of the CIHTC program including HRH and management is fully funded through PEPFAR as compared to PIHTC where MOH funds most of the HRH needed for service delivery. | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2027 |
| HTC | HTC Positive | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Shiselven | \$238.80 | 612 | \$93.21 | Funded for same activities | Wider scope of inputs to activity | The whole of the CIHTC program including HRH and management is fully funded through PEPFAR | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2028 |
| HTC | HTC Positive | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Hhohho | \$241.80 | 808 | \$93.21 | Funded for same activities | Wider scope of inputs to activity | As compared to PIHTC where MOH funds most of the HRH needed for service delivery. CIHTC | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2029 |
| HTC | HTC Positive | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Manzini | \$273.50 | 1,811 | \$93.21 | Funded for same activities | Wider scope of inputs to activity | also has lower yield as compared with PIHTC | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2030 |
| HTC | HTC Positive | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Lubombo | \$334.28 | 727 | \$93.21 | Funded for same activities | Wider scope of inputs to activity | | Treatment care activity manager | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2031 |
| GP-PREV | Prevention-Gen Pop | 2 | C-BLD (Capacity Building and Livelihoods Development) | Hhohho | \$149.75 | 596 | \$61.58 | | | The partner has been using a very intensive, process-heavy community engagement approach. Going forward, this approach has been streamlined. | Prevention lead | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2032 |
| KP-MSMTG | Prevention-MSM | 2 | PSI-CPP (Combination Prevention Program) | Hhohho | \$1,965.09 | 47 | \$965.74 | Not funded | Hard-to-reach population (small number, marginalized, or physically dispersed) | The MSM program in Swaziland is quite new. Homosexuality is illegal in this country and there are deeply entrenched homophobic norms. Based on the 2011 BSS, this population is extremely marginalized and have experienced human rights violations and are reluctant to seek testing and other HIV/social services. The | Prevention lead | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2033 |
| KP-MSMTG | Prevention-MSM | 2 | PSI-CIHTC (Client-initiated HIV Testing & Counseling) | Manzini | \$2,599.05 | 14 | \$965.74 | Not funded | Hard-to-reach population (small number, marginalized, or physically dispersed) | | Prevention lead | Services are now integrated into consolidated regional TA approach | eNational Strategic Framework 2014-2018 and Health Sector Strategic Plan 2014-2034 |

Annex 3: DREAMS Initiative Summary

SWAZILAND DREAMS:

Preventing New Infections in Adolescent Girls and Young Women

Background

The statistics paint a grim picture regarding the vulnerability to HIV for Swaziland's adolescent girls and young women. More than half of Swaziland's population of 1.4 million is younger than 20 years and a staggering 57% of teenagers aged 15 – 17 is classified as either orphaned or vulnerable (MICS 2010). Sixty percent of adolescent girls don't attend secondary school and of the girls who do attend secondary school, nearly half drop out due to school costs and/or pregnancy (2011 annual School census). One in five women had had her first baby before her 18th birthday, and among those who did not complete secondary school one in three are mothers (DHS 2007). Thirty-eight percent of young women aged 18-24 report having experienced sexual violence during their lifetime (UNICEF VACs 2007). Women are more affected by unemployment than men – in 2010 25.7% of Swazi men were unemployed in comparison with 31.3% of women (DHS 2007). During the period between 2001 and 2010, the unemployment rate fell for men, but rose for women. Women also earn less than men. The overall average wage of women in formal sector is 30% below that of men (DHS 2007).

Many of the risk factors that render adolescent girls and young women vulnerable to HIV infection are well known including sexual violence, early sexual debut, coerced sex, teen pregnancy, intergenerational and transactional sex, inconsistent condom use, lack of access to services, income disparity, and OVC status. While the risk factors are known, deeply entrenched social, cultural, and gender norms, and poverty, create significant barriers to effective HIV prevention and the up-take of care and treatment services.

Program Overview

DREAMS will enable PEPFAR to intensify programming in locations with high numbers of adolescent girls (AG) and young women (YW) as well as high burden of PLWHA.

This will include a special focus on areas with high burden of OVC and out of school adolescents particularly for the 15-19 AG. In targeting young women and men, a geographic focus will be on the Mbabane-Manzini corridor and other areas that attract labor migration and are presumed to play a role in fueling the epidemic nationally.

DREAMS aligns well with our COP priorities and will target 19 of the 55 Inkhundla. PEPFAR will focus on adolescent girls in 14 Tinkhundla where 35% of 15-19 year olds live. To address the needs of young women aged 20-24, and men 20-35, DREAMS will focus on 17 Tinkhundla which include major employment centers that attract rural, mobile employment seeking young adults, including the Mbabane-Manzini corridor. Of these, 12 are the same Tinkhundla where DREAMS will focus on adolescent girls.

In the DREAMS tinkhundla, almost 35,000 AG and YW aged 15-24, or 60% of the populations in these locations, will be reached with DREAMS funds. An additional 11,500 will be reached with COP funds.

DREAMS target populations and locations

1. Adolescent girls (AG) aged 10-19:

For AG, DREAMS will focus mostly in the rural Tinkhundla through a ‘whole girl/whole community’ approach. This population includes adolescent girls in and out of school, including orphaned girls, girls with absent parents and those with a history of abuse.

Vulnerable girls will be identified in their communities through existing structures and platforms, PEPFAR OVC and prevention partners, community leaders, partner CBOs, school administrators/teachers and clinics where pregnant/other girls seek ANC, HTC and other SRH services.

Priority tinkhundla: Dvokodvweni, Lobamba, Lobamba Lomdzala, Ludzeludze, Maseyisini, Mbangweni, Mkhweni, Motjane, Mpolonjeni, Ngwempisi, Ntfontjeni, Piggs Peak, Siphofaneni, Sithobela.

2. Young women (YW) aged 20-24:

Typically YW are unmarried, with at least one child, engaging in low-wage work and/or transactional sex, and sex for survival.

Key strategies for reaching the most vulnerable of this population include community outreach in informal settlements through existing municipal and chiefdom structures, and exploring evidence-informed innovative approaches to improve access with mobile services. In addition, DREAMS will reinforce “in-reach” within ANC/PMTCT, SRH and other services that YW frequent, through PEPFAR partners, MOH, Church fora, CSO and other formal and informal institutions. Social assets will be strengthened through community and YW support networks, savings groups, and equipping YW to be mentors to adolescent girls.

Priority tinkhundla: Dvokodvweni, Kwaluseni, Lobamba, Lombamba Lomdzala, Ludzeludze, Manzini North, Manzini South, Maseyisini, Mbabane East, Mbabane West, Mbangweni, Mkhweni, Motjane, Ngwempisi, Piggs Peak, Siphofaneni, Sithobela.

These Tinkhundla include the Mbabane-Manzini corridor and other areas where young men and women migrate in search of jobs (plantations, sugar belt, pulp industry, etc.) 12 overlap with priority Inkhundla for AG.

3. Young men (YM) aged 20-34:

These men may be unmarried, or if married, working away from home in occupations ranging from manual labor to professional positions. DREAMS will target men in tinkhundla with major employment centers which overlap with those prioritized for women 20-24.

Key strategies for reaching this population include targeted, innovative, male-friendly mobile and fixed services and linkages with intensive outreach in informal settlements, workplaces, and

places where targeted men gather. Innovative efforts such as ‘franchising’ male friendly services with select private practitioners may be explored.

Priority tinkhundla: Dvokodvweni, Kwaluseni, Lobamba, Lombamba Lomdzala, Ludzeludze, Manzini North, Manzini South, Maseyisini, Mbabane East, Mbabane West, Mbangweni, , Mkhweni, Motjane, Ngwempisi, Piggs Peak, Siphofaneni, Sitobela

Comprehensive Package for Adolescent Girls

DREAMS will deliver a comprehensive age-appropriate core package emphasizing the “whole girl” and a “whole community” approach:

- Empower AG, reduce their risk, improve access to comprehensive SRH services
 - ✓ Social asset building, self-esteem, leadership, risk perception, safe places
 - ✓ Mentoring program through YW
 - ✓ Condom promotion & provision, skills (male and female)
 - ✓ HTC, linkages to care and prevention services, STI screening
 - ✓ Post-violence care and linkages
 - ✓ Expand SRH access/improve contraceptive mix & promote dual protection
- Engage (mobilize) communities to reduce vulnerabilities and increase safety
 - ✓ School and community-based HIV prevention and care
 - ✓ School and community-based violence prevention, norms change and linkage to care and prevention services
- Strengthen families and assets for AG & families
 - ✓ Parenting/caregiving programs
 - ✓ Combination socio-economic empowerment approaches: financial skills, savings clubs combined with self-esteem and leadership
 - ✓ Educational subsidies: explore savings accounts for keeping girls in school as a pilot program in subset of intervention locations.
- Decrease risk in sexual partners
 - ✓ Improved targeting of highly effective interventions to male sexual partners of sexually active AG

Comprehensive Package for Young Women

Young Women will be reached with SRH services, social asset building and financial literacy skills + savings clubs. Select YW will receive training and employment as mentors for younger girls.

- Empower YW, reduce their risk, improve access to comprehensive SRH services (using mobile and intensive linkage to facilities – outreach/in-reach)
 - ✓ Social asset building, risk reduction counseling and risk perception
 - ✓ Condom promotion & provision skills
 - ✓ HTC and linkages; STI
 - ✓ Post-violence care, linkage to other services
 - ✓ Expand/improve contraceptive mix, understanding HIV and pregnancy, PMTCT, other SRH services and promotion of dual protection
- Engage (mobilize) communities to reduce vulnerabilities and increase safety
 - ✓ Outreach and strengthening support networks among YW and key gatekeepers
 - ✓ Community-based HIV prevention*
 - ✓ Community-based violence prevention and norms change²³
- Strengthen families (YW networks) and asset building for YW
 - ✓ Focused social and economic empowerment approaches
 - ✓ Savings clubs
 - ✓ Leadership and mentoring training (select YW are identified, trained in leadership, lay counseling techniques, sexuality and mentoring, they are then employed as AG mentors, peer outreach workers for YW)
- **Decrease risk in sexual partners**
 - ✓ Improved targeting of highly effective interventions to male sexual partners of AGYW

Improved targeting of men:

For Swaziland, men 20-34 are one of the DREAMS priority populations. Developing a better understanding of the sexual networks of the AGYW will be critical to the success of DREAMS. It will also be important for PEPFAR to specifically target this population and facilitate their access to and use of high impact services.

²³ Different approaches and structures will be used for urban vs. rural areas

PEPFAR will conduct a rapid assessment (possibly using an adapted PLACE methodology) to garner an understanding of the different profiles of the partners, where they are, who they have relations with, where they seek services now, and where and how to best reach them with high impact services. DREAMS will leverage COP funding (ART, VMMC) to enhance and improve male programming.

In order to get HIV + AGYW partners tested and linked to care, and HIV- AGYW partners actively linked to VMMC services, PEPFAR will conduct rapid operational research to create appropriately segmented, male centric/male friendly testing, SRH, VMMC, and ART²⁴ services. PEPFAR will build on and expand male centered approaches through community HTC and VMMC programming, including potentially engaging with private sector health providers.

²⁴ VMMC, ART will be supported through COP

Annex 4 - Community Interventions - Conceptual Framework

Conceptual Framework

Using the community platform to increase uptake of core services (PMTCT, ART, VMMC, + condoms) and reduce vulnerabilities to HIV transmission and acquisition

Effective social and behavior change communication is planned and purposeful; it is grounded in theory and relies on proven models that predict patterns of behavior. In Swaziland, communication for HIV prevention has focused largely on changing individual behavior to the neglect of the social, structural and cultural foundations of human behavior. The fundamental challenge to changing human behavior that PEPFAR will address, assuming funds are available, is to understand how individuals act within their social context and adhere to or break away from socially patterned behavior. Rather than focusing only on individual behavior, PEPFAR will focus on the social ecology of human behavior and social norms, and will use strategic communication at the levels in the model below (Figure 1) to create an environment within which such dialogue occurs and new visions for a better future are shared. Since individual behavior is embedded within layers of family, community and social structure, barriers to behavior can arise at any level and communication can help to overcome those constraints.

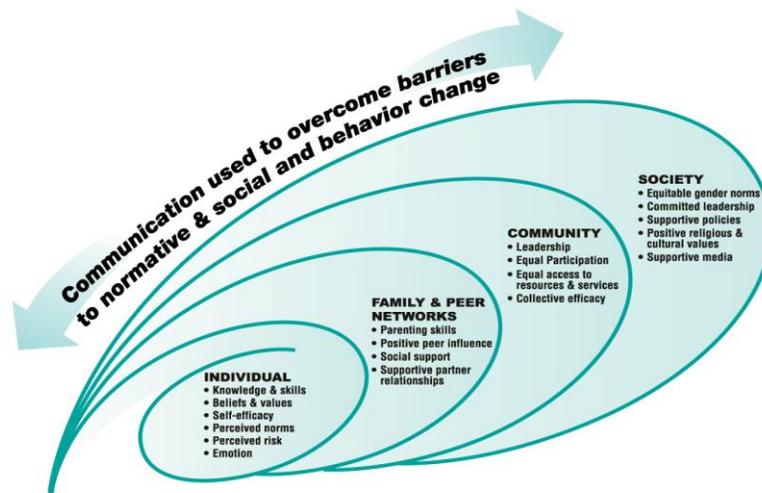


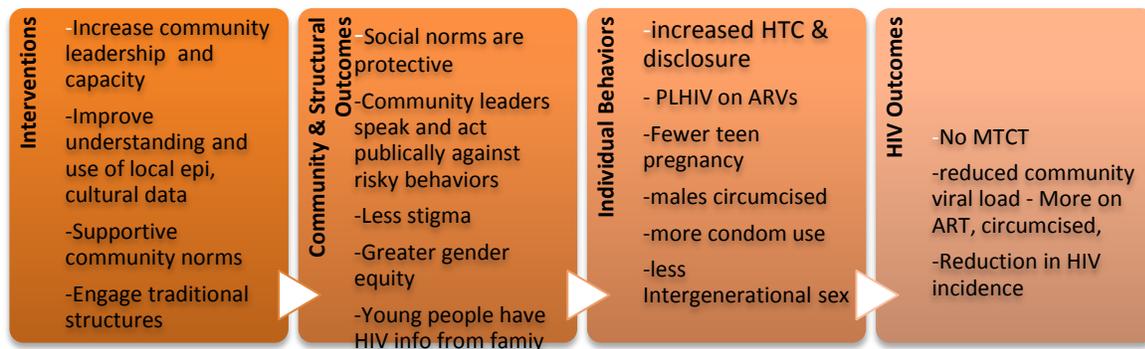
Figure 1:
Social Ecological Model for Human Behavior and Social Norms

Social norms—acquired during one’s formative years and reinforced through positive and negative social sanctions—heavily influence human behavior and are the bonds that connect and sustain social networks. Social norms can be a springboard to positive social change when positive values are mobilized against common, but deleterious, practices. Social norms are powerful determinants of behavior, but they are frequently misconstrued; people may be reluctant to change because they perceive that others would not support their endeavors so communication can play a critical role in disseminating accurate information about prevailing norms that can act as agents of change.

Social norms are best understood within a larger social ecological framework that recognizes the influence of social context on behavior, including institutional and cultural factors. There are individuals' traits that cannot be understood without knowledge of their social networks, family relationships, partner relationships, and community relationships. Change at one level may be facilitated or obstructed by conditions at higher levels. Thus, individuals will be constrained in their efforts to change unhealthy behaviors if they continuously encounter resistance within the family or community networks. Conversely, supportive community norms can propel individual actions, and such actions can precipitate change at higher levels.

Social norms, particularly gender norms and unequal power relations —are among the strongest underlying factors that influence sexual behavior and therefore HIV/AIDS epidemic, suppressing positive behaviors such as HIV prevention, and encouraging negative behaviors such as violence against women. HCP will ensure that social and gender norms receive prominent attention in all program communication and will highlight the benefits to men and women of adapting these new masculinities, and model how it can be done.

Using the social-ecological framework as a theoretical foundation, we propose the model below to explore and affect the pathways that lead to behavioral and biomedical outcomes to reduce transmission.



The underlying conceptual framework and model for the Swaziland program recognizes that social and individual behavior change will not happen as a result of one intervention alone or focusing on one domain, but rather through social, individual, and structural change coming together to produce a supportive society. Thus, strengthening community capacity, changing social norms, and improving protective behaviors requires attention to mobilizing communities and engaging leaders and individuals; creating effective bi-directional linkages (from community to services and from services to community); and supporting enabling environments so safer norms and behaviors are supported.

V.Guiding Principles

Interventions will be guided by several core principles. These principles provide a base from which PEPFAR will implement strategic community and communication programs in Swaziland.

- **Strengthening Community Capacity**

Community-driven approaches create sustainable social change and empower communities with the capacity to address their needs. Strengthening this capacity will be a central focus of PEPFAR's support. Helping communities to use data and develop a better understanding of the

HIV epidemic and the factors that increase transmission and acquisition are central to strengthening community capacity to address their norms and behaviors. Strengthening Community Capacity is aimed at increasing meaningful and effective involvement of community leaders, community members and other gatekeepers to prevent HIV and improve access and utilization of services.

- **Community as the Foundation**

The most successful responses to HIV prevention are built upon committed community ownership along with leadership at the household level. Engaging traditional structures and linking communities to other supportive mechanisms is key to this process. Communities must 'own' their epidemic and their response. Greater community involvement is central to more relevant, accountable and sustainable health outcomes and will serve as the foundation for PEPFAR in Swaziland. Building on existing community structures, rather than creating parallel systems, will improve efficiency, effectiveness and the potential for greater sustainability.

- **Links to Services Essential**

Community systems are complementary to and closely connected with health systems and services, particularly in advocacy, community mobilization, demand creation and the linkage of communities to services. Communities can play key roles in health promotion and delivery of community health services, and in monitoring health systems for quality of services. Health systems are not something separated from communities. Innovative approaches can bring community and health systems together in stronger partnership. Integration of services is essential in meeting the multiple health needs of a client.

- **Coordination and Linkages**

Functioning community networks, linkages and partnerships are needed to enable community engagement and delivery of activities/services. Community actors contribute unique knowledge and experience about their communities and should be able to interact with providers and other partners in a spirit of collaboration and respect. In doing so, they can in turn enable services to reach into communities and be shaped by better knowledge of community needs with a respect for rights and equal access.

- **Commitment to Individual & Social Change**

While aiming to influence and sustain positive individual behavior change, PEPFAR will focus on efforts to affect social change. The greatest impact on the epidemic will be made within supportive environments that allow and encourage individuals to practice and maintain protective behaviors.

- **Gender**

Gender is an important factor influencing the HIV epidemic in Swaziland with women bearing the greatest burden. This disparity arises from systematic disadvantages faced by adolescent girls and young women increasing their vulnerability and early exposure to HIV. Many young women are forced into sexual activity and are at risk of unintended pregnancy, HIV, and sexual violence. PEPFAR will work with communities to address gender norms to focus on reducing vulnerability to HIV among both men and women and catalyzing collective behavior change.

Swaziland COP15 Targets by Region: Clinical Cascade

| | Number of individuals who received HIV Testing and Counseling services for HIV and received their test results | Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of adults and children newly enrolled on antiretroviral therapy (ART) | Number of adults and children currently receiving antiretroviral therapy (ART) |
|---------------------|--|---|---|--|--|
| _Military Swaziland | 6,372 | 1,387 | 3,208 | 895 | 2,792 |
| Hhohho | 49,200 | 2,068 | 39,562 | 3,943 | 34,404 |
| Lubombo | 92,819 | 5,836 | 32,924 | 5,818 | 28,630 |
| Manzini | 123,970 | 8,746 | 45,434 | 7,990 | 41,472 |
| Shiselweni | 20,682 | 1,381 | 9,424 | 1,755 | 8,195 |
| Total | 293,043 | 19,418 | 130,552 | 20,401 | 115,493 |

Swaziland COP15 Targets by Region: Key, Priority, Orphan and Vulnerable Children Indicators

| | Number of the target population who completed a standardized HIV prevention intervention including the minimum components | Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS |
|---------------------|---|---|---|
| _Military Swaziland | 1,650 | - | - |
| Hhohho | 18,121 | 1,141 | 11,476 |
| Lubombo | 18,668 | 465 | 20,625 |
| Manzini | 26,885 | 1,810 | 10,703 |
| Shiselweni | 16,082 | 220 | 11,380 |
| Total | 81,406 | 3,636 | 54,184 |

Swaziland COP15 Targets by Region: Breastfeeding and Pregnant Women

| | Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
|---------------------|--|---|
| _Military Swaziland | 22 | 22 |
| Hhohho | 7,867 | 2,403 |
| Lubombo | 5,746 | 1,947 |
| Manzini | 9,527 | 3,392 |
| Shiselweni | 5,706 | 1,824 |
| Total | 28,868 | 9,588 |

Swaziland COP15 Targets by Region: Tuberculosis (TB)

| | Number of registered new and relapsed TB cases with documented HIV status | The number of registered TB cases with documented HIV-positive status who start or continue ART |
|---------------------|---|---|
| _Military Swaziland | 257 | 187 |
| Hhohho | 1,560 | 912 |
| Lubombo | 956 | 559 |
| Manzini | 2,366 | 1,399 |
| Shiselweni | 1,008 | 567 |
| Total | 6,147 | 3,624 |

Swaziland COP15 Targets by Region: Voluntary Male Medical Circumcision (VMMC)

| | Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program |
|---------------------|--|
| _Military Swaziland | 800 |
| Hhohho | 3,680 |
| Lubombo | 2,030 |
| Manzini | 5,214 |
| Shiselweni | 3,576 |
| Total | 15,300 |