Eswatini

Country Operational Plan

(COP) 2022

Strategic Direction Summary

April 29, 2022

Contents

Acronym and Word List

ADR	Adverse Drug Reactions
AE	Adverse Event
AG	Adolescent Girls
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Diseases
AHF	AIDS Healthcare Foundation
ALHIV	Adolescents Living with HIV
ANC	Antenatal Clinic
APIs	Active Pharmaceutical Ingredients
APN	Access Point Name
ARV	Antiretroviral
ART	Antiretroviral Therapy
C/ALHIV	Children and Adolescents Living with HIV
CAGs	Community Adherence Groups
CANGO	Coordinating Assembly of Non-Governmental Organizations
CBS	Case-based surveillance
CBO	Community Based Organizations
CCD	Community Commodity Distribution
CCM	Country Coordinating Mechanism (Global Fund)
CDC	(U.S.) Center for Disease Control
CERA	Community Engagement and Rehabilitation Alliance
CLM	Community-Led Monitoring
CMAC	Conciliation, Mediation and Arbitration Commission
CMIS	Client Management Information System
CMS	Central Medical Stores
CoAg	Cooperative Agreement
COP	Country Operation Plan
COVID-19	Coronavirus Disease 2019
CQI	Continuous Quality Improvement
CS	Civil Society
CSO	Civil Society Organization
DBS	Dried Blood Spot
DNO	Diagnostic Network Optimization
DQA	Data Quality Assessment
DMPPT	Decision Makers Program Planning Toolkit
DREAMS	Determined, Resilient, Empowered, AIDSfree, Mentored, and Safe
DSD	Differentiated Service Delivery
DTG	Dolutegravir
ECHO	Efficiencies for Clinical HIV Outcome
EDCU	Epidemiology and Disease Control Unit
EHHRRB	Eswatini Health and Human Research Review Board
EHLS	Eswatini Health Laboratory Services
EID	Early Infant Diagnosis
eLMIS	Electronic Logistic Management Information System
EQA	External Quality Assurance

EMR	Electronic Medical Record
ENAP	Eswatini National AIDS Program
EU	European Union
FBO	Faith Based Organization
FCI	Faith and Community Initiative
FDC	Fixed dose combination
FP	Family Planning
FSN	Foreign Service National
FSW	Female Sex Workers
GBV	Gender Based Violence
GKoE	Government of the Kingdom of Eswatini
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
HCWs	Health Care Workers
HCD	Human-centered design
HIS	Health Information System
1HP	Ultra-short course regimen for daily isoniazid and rifapentine for 28 days
3HP	A short-course TPT regimen that combines two antibiotics active against TB i.e. Isoniazid (INH) and Rifapentine (RPT)
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HIVST	HIV self-testing
IBBS	Integrated Biological and Behavioral Surveillance
ICT	Index Case Testing
IEC	Information, Education and Communication
IIT	Interruption in Treatment
IM	Implementing Mechanism
Inkhundla	Government Administrative Unit under Region
INSTI	Integrase strand transfer inhibitor (another group of ARVs)
IP	PEPFAR Implementing Partner
IPV	Intimate Partner Violence
KP	Key Population
KPLHIV	Key Populations Living with HIV
LCM	Linkage Case Management
LES	Locally Employed Staff
LGBTIQ	Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex, Queer
LPV/r	ritonavir-boosted lopinavir (a group of ARVs called Protease Inhibitors)
LIS	Laboratory Information System
MBP	Mother-Baby-Pair
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Reporting
MEPD	Ministry of Economic Planning and Development
M&O	Management & Operation

MOPS	Ministry of Public Service
MICS	Multi Indicator Cluster Survey
MMD	Multi-Month Dispensing
MNCH	Maternal Newborn and Child Health
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MPI	Master Patient Index
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
MTAD	Ministry of Tinkhundla and Administration
MTC	Matsapha Town Council
MTCT	Mother-To-Child Transmission
NACS	Nutritional Assessment, Counseling, Support
NARTIS	Nurse-led ART initiation in Swaziland
NASA	National AIDS Spending Assessment
NERCHA	National Emergency Response Council on HIV and AIDS
NHRID	National Health Research and Innovation Department
NTCP	National TB Control Program
NCD	Non-Communicable Diseases
NCP	Neighborhood Care Points
NCCP	National Cancer Control Plan
NNRTI	Non-Nucleoside Reverse Transcriptors (a group of ARVs)
NTCP	National TB Control Program
ODA	Overseas Development Assistance
OI	Opportunistic Infections
OPD	Outpatient Department
OVC	Orphans and Vulnerable Children
PCO	PEPFAR Coordination Office
PCV	Peace Corps Volunteer
PEP	Post Exposure Prophylaxis
PEPFAR/E	President's Emergency Plan for AIDS Relief/Eswatini
PFSCM/SCMS	Partnership for Supply Chain Management/Supply Chain Management System
PHIA	Population-based HIV Impact Assessment
PHU	Public Health Unit
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PLL	Planning Level Letter
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Clinic (Post Anti-natal Clinic)
POART	PEPFAR Oversight and Accountability Response Teams
POC	Point of Care
PPs	Priority Populations
PPP	Public Private Partnership or Purchasing Power Parity
PrEP	Pre-exposure Prophylaxis
PWD	People with Disabilities
QA	Quality Assurance
QI	Quality Improvement

QIP	Quality Improvement Plan
QMS	Quality Management System
RA	Regional Administrator
RASTA	Region Age Sex Testing/Treatment Attribution
RHM	Rural Health Motivators
RHMT	Regional Health Management Team
RITA	Recent Infection Testing Algorithm
RM	Responsibility Matrix
RTK	Rapid Test Kit
SBC	Social Behavioral Change
SDS	Strategic Direction Summary
SGBV	Sexual and Gender Based Violence
SGAC	Strategic Global AIDS Coordinator
SHIMS	Swaziland HIV Incidence Measurement Survey
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SLMTA	Strengthening Laboratory Management Towards Accreditation
SOP	Standard Operating Procedures
SNU	Sub-National Unit
SRH	Sexual Reproductive Health
SRHU	Sexual Reproductive Health Unit
STI	Sexually Transmitted Infection
SWABCHA	Swaziland Business Coalition on HIV/AIDS
SWAMMIWA	Swaziland Migrant Mineworkers Association
TA	Technical Assistance
TB	Tuberculosis
Tinkhundla	Third level of Governance (sub-regional administrative units)
T&S	Test and Start
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Therapy
TSP	Technical Support for PEPFAR Programs
TWG	Technical Working Groups
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESWA	University of Eswatini
UNICEF	United Nations Children's Fund
UNDP	United Nation Development Program
UPID	Unique Patient Identifier
VACS	Violence Against Children Study
VCT	Voluntary Counselling and Testing
VIA	Visual Inspection with Acetic acid
VL	Viral Load
VLC	Viral Load Coverage
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WMIS	Warehouse Management Information System
WHO	World Health Organization

1.0 Vision and Goal Statement

Despite facing the world's highest overall HIV prevalence, Eswatini stands on the brink of reaching epidemic control. Marked by the UNAIDS declaration of Eswatini as one of only two countries that has achieved the ambitious 95-95-95 fast track targets based on modeled estimates, the country's strategic focus in programming will shift towards sustaining the gain and the control of the epidemic. New HIV infections and deaths among PLHIV in Eswatini have been on the decline, which is also a clear indicator of progress towards epidemic control. As gaps in testing and treatment close across the board, the analysis of unmet need requires finer approaches to identify the groups with the persistent high HIV incidence by age, sex, and region through expanded use of recency testing. An estimated 11% of PLHIV (above 3rd 95 target) remain virally unsuppressed, either due to unknown status (-8%) or suboptimal treatment (-3%). In COP22, addressing these gaps and tailoring strategies for case-finding, linkage to treatment and uptake of high-impact prevention strategies to meet the needs of these populations will be prioritized and expanded.

The overarching goal of the PEPFAR/Eswatini (PEPFAR/E) investments remains to support the Government of the Kingdom of Eswatini (GKoE) to achieve and sustain epidemic control, provide high-quality client-centered HIV services to PLHIV, and continue to rapidly reduce the number of new infections. The program activities are guided by and aligned to Eswatini's National Multi-Sectoral Strategic Framework for HIV and AIDS 2018-2023. Strengthening health information systems, supply chain, infection surveillance, and laboratory capacity also remain PEPFAR priorities in COP22.

The Eswatini COP22 vision centers around evolving service delivery support to close gaps to 95-95-95 in sub-populations and increase the sustainability of the National response while strengthening health systems and facilitating an enabling environment to increase domestic responsibility and maintain HIV epidemic control. Key priorities based on the current stage of the HIV epidemic for COP22 are prevention interventions for Adolescent Girls and Young Women (AGYW); key populations and military including scale-up of PrEP; emphasis on combined use of self-testing and index testing as a case-finding strategy to identify AGYW 15-29, men 20-34, and children under the age of 15 years; and continued close dialogue and careful planning with the government and stakeholders on financing the HIV response, which is essential for sustained impact.

Close the gaps

Critical to the long-term and sustainable success of the HIV program is the ability to close all gaps to 95-95-95, particularly among key populations - both MSM and FSW who have significantly higher HIV prevalence than general population, children under the age of 15, youth and military through targeted case finding. Index and self-testing will be maximized while outpatient

department and voluntary counselling and testing (VCT) entry points will be optimized using the validated screening tools and HIVST, maximizing opportunities to utilize new diagnoses as springboard for index testing through improved elicitation, and scaling implementation of social network strategies. To improve timeliness of diagnosis, COP22 will also scale promising community case finding approaches including expanding access to HIVST through private pharmacies, faith communities, workplaces, and educational institutions, conducting cluster investigations identified through recency testing, and utilizing social media platforms to increase awareness of need for early testing.

COP22 aims to further optimize screening at OPD and VCT using validated tools and HIVST, maximizing opportunities to utilize new diagnoses as "seeds" for index testing through improved elicitation, and scaling implementation of social network strategies. To improve timeliness of diagnosis, COP22 will also scale promising community case finding approaches including expanding access to HIVST through private pharmacies, faith communities, workplaces, and educational institutions, conducting cluster investigations identified through recency testing, and utilizing social media platforms to increase awareness of need for early testing.

For those on treatment, institutionalizing client-centered approaches to support adherence and prevent attrition as well as to bring the clients who interrupted in treatment back to care are critical to maintaining treatment continuity and viral suppression. Successful interventions being taken to scale include linkage case management for 6 months after initial diagnosis, integration of adherence support at every visit, increasing access to community ARV pick-up, maximizing multi-month dispensing, and daily follow-up of missed appointments. The largest proportion of individuals experiencing treatment interruption remains among those aged 20-39 years, while the largest gaps in viral suppression continue to be among children and adolescents. Additional strategies to address barriers to treatment continuity and viral suppression include creating a welcoming atmosphere for clients reengaging in care, expansion of viral load dried blood spot testing and point of care viral load testing, completing the transition to pediatric dolutegravir (DTG)-based regimens, maximizing the use of platforms such as teen clubs, youth transition clinics, and the Family-Centered Care model, enhancing linkage with orphans and vulnerable children (OVC), key population (KP), gender-based violence (GBV) support programs, and timely regimen switching for those experiencing treatment failure. Overall, integrated service delivery will be strengthened, and differentiated service delivery models will be deployed more widely to reduce stigma to achieve full-realization of a person-centered approach.

Reduction of mortality among PLHIV will be achieved by addressing advanced HIV disease, implementing full scale TB preventive therapy, detecting and treating cervical dysplasia, and integrating non-communicable disease (NCD) and HIV services.

Prevent new infections

Scale-up of effective prevention efforts in the highest risk populations is needed to dramatically reduce new infections. COP22 will focus on cutting HIV transmission by effectively linking those

most at risk, including negative partners and high-risk contacts of people living with HIV, to prevention interventions, with an increased focus on PrEP. New HIV infections will be prevented especially among AGYW 15-24 years old and men 29-39 years old by scaling up PrEP combined with HIV Self testing and HTS and enhance coordinated prevention interventions across IPs including DREAMS and OVC, VMMC and KP programs. DREAMS will work to scale the offering of youth-friendly services through facility and mobile platforms and ensure linkage with high volume entry points for offering of PrEP, family planning and STI services along with DREAMS enrollment. Through the COP22 plan, the uptake of integrated HIV, sexual and reproductive health services and sexually transmitted infections within facilities and communities will be improved. Key populations and AGYW-led PrEP strategies, scale up of community and workplace offerings, and commodities will increase access for prevention retention. PEPFAR will provide support to National-level GBV coordination, while strengthening community platforms for timely detection and access to clinical service offerings at PEPFAR-supported facilities.

Evolve Service delivery

In order for Eswatini to mount a sustainable response, the current program must evolve to meet the needs of the epidemic in its current state and to be better integrated into national programming. In COP22 service delivery support shifts will include:

- refining the clinical mentorship model in collaboration with the MoH to reduce costs while maintaining quality, capitalizing on virtual platforms and reinforcing national and regional MOH structures
- generating joint accountability between clinical and community IPs to strengthen differentiated service delivery to reach the most vulnerable and address program gaps
- assessing effectiveness, feasibility, and cost of service delivery models to inform decision-making for a sustained response
- begin alignment of PEPFAR HRH investments with MoH staffing norms, salary scales and structures
- begin alignment of implementing partners' costs per beneficiary at facility and community-based services, reducing costs and standardizing service delivery

Strengthen Systems

Investments in COP22 will be targeted to address identified health system vulnerabilities. Health systems will be strengthened to improve service delivery and increase capability for domestic responsibility, working towards building long-term sustainability. Additional program evolution in strategic information, laboratory, and supply chain will see MOH capacity strengthened in core health systems through:

- building a data exchange repository with individual record matching capability to support clinical care, national routine program monitoring and surveillance

- advancing institutional capacity of MOH strategic information department for robust data management, analytics and reporting and use
- initiating case surveillance to identify and track sentinel events (e.g. new diagnoses, recent infections, treatment failure, opportunistic infections, death) among PLHIV to inform a public health response building on investments in the national electronic medical record system and fully scaled recency surveillance
- localizing laboratory processes for sequencing and quality assurance
- standardized and routine joint commodity planning
- investment in digital platforms and right-sizing the current electronic patient management system

During COP22, the results of the Eswatini Population-based HIV Impact Assessment Survey commonly referred to as the Swaziland HIV Incidence Measurement Survey (SHIMS3) will be released. This survey will provide important data on the status of the epidemic at a population level and strengthen the program's ability to adapt the targeted approach.

Sustainability

COP22 will include the continuation of formal discussions and mapping of a pathway to sustainability of the national HIV response. Efforts in COP22 in this direction include supporting:

- strengthened GoKE leadership and oversight of service delivery and program quality
- demonstrated ability to detect and respond to early warning signals
- institutionalized core health system capacity
- strengthened health infrastructure
- diversified health financing schemes and leveraging private sector partnership

Specific programming, working with all stakeholders and co-led by GKoE, to shape the future direction of PEPFAR's clinical technical assistance through planned transition to government commenced in COP21 and will continue into COP22. The program will continue to localize implementation where possible through development and utilization of local and regional capacity building on longstanding PEPFAR investments and private sector partnerships. Critical risks to long-term program sustainability remain with systemic issues such as gender-based violence, unemployment and insufficient domestic revenue generation, requiring a multisectoral approach.

Progress monitoring and collaboration

PEPFAR/E will continue to monitor implementing partners' performance and immediately address performance issues. Program implementation will be monitored through quarterly performance reviews and regular SIMS visits. Partners will be required to report their monthly outlays against their approved COP22 levels, achievements, and targets.

COP22 will see continued implementation of a civil society-led community feedback platform to monitor and improve service delivery, including specific funding to support community input on service satisfaction for key populations and people with disabilities. Civil society and population-specific input into PEPFAR programming remain critical to appropriately tailor responsive interventions and messages to achieve results.

Continued work with communities of faith, traditional leaders and faith-based organizations (FBOs) will leverage the unique opportunities offered by these groups' vast networks to support HIV programming. Continued collaboration with the Global Fund and UNAIDS, through the coordination of the GKoE, will ensure that the full range of PEPFAR's investments are maximized. Civil society and the private sector have significant roles to play in ensuring a sustainable response.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	Year
Total Population	1,138,166	100	204,750	18	207,574	18	117,876	10	120,083	11	251,333	22	236,550	21	A. 2022
HIV Prevalence (%)		27		2.6		3.0		13.9		4.1		41.2		29.9	B. 2017
AIDS Deaths (per year)	2,176		108		110		189		100		907		762		A. 2022
# PLHIV	215,208		3,756		3,817		14,472		6,574		115,115		71,474		A. 2022
Incidence Rate (Yr.)		1.36						1.87		0.79		1.84		1.5	B. 2017
New Infections (Yr.)	5,694														A. 2022
Annual births	27,936	100													F. 2017
% of Pregnant Women with at least one ANC visit	27,517	99													E. 2014

Pregnant women needing ARVs	8,625	31													A. 2022
Orphans (maternal, paternal, double)	110,355														A. 2022
Notified TB cases (Yr.)	2,259														G. 2020
% of TB cases that are HIV infected	1,462	65													G. 2020
% of Males Circumcised	157,324	44							64,643	41			45,488	29	D. 2020
Estimated Population Size of MSM*	4,000	100													J. 2021
MSM HIV Prevalence		21													J. 2021
Estimated Population Size of FSW	7,100	100													J. 2021
FSW HIV Prevalence		59													J. 2021
Estimated Population Size of PWID	1,279	100													H. 2018
PWID HIV Prevalence															I. N/A
Estimated Size of TG	119	100													H. 2018
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

A. Draft Swaziland Spectrum File (2022)	E. Swaziland Multiple Indicator Cluster Survey 2014
B: Swaziland HIV Incidence Measurement Survey 2, 2016-17	F. CIA Fact Book, Swaziland National Population and Housing Census 2017

For age 25+, incidence applied is for the age 15+ from SHIMS.	
C. Characterizing the HIV prevention and treatment needs among key populations, including men who have sex with men and female sex workers in Swaziland 2015 June	G. PEPFAR program data and WHO TB estimates. The age and sex disaggregate estimates are not available
D. Decision-Maker's Program Planning Tool 2 (DMPPT2), end of FY20, (the total absolute number and percentage is for 15+ year old males). Percent is calculated as the coverage within the specific age group.	H. "Validating and Estimating the number of Key Population Individuals at the Hot Spot Level in Eswatini", 2018. FHI360/Linkages
	I. Not Available
	J. IBBS 2021

Population

The Kingdom of Eswatini is one of Africa's geographically smallest countries, with just 17,300 square kilometers of land, landlocked between neighboring South Africa and Mozambique. In 2017, the country's National Population and Housing Census had counted 1,093,028 people in the population; 36% are <15 years old and 56% are <25 years old, indicating a substantial youth bulge. The population experienced an annual growth rate of 0.7% (Hhohho 1.3%; Manzini 1.1%; Shiselweni -0.2%, and Lubombo 0.2%) between 2010 and 2017, with 76% of the population living in rural areas. Manzini has the highest population (355,945), followed by Hhohho (320,651), Lubombo (212,531), and Shiselweni (204,111).

A high ratio of the male population is seen in two tinkhundla in Lubombo - Mhlume inkhundla (143 males/100 females) and Nkilongo inkhundla (130 males/100 females), and the ratio is consistently higher along the western border to South Africa in Hhohho region. These areas are locations of male-dominated economic activities such as sugarcane and wood pulp plantations that have programmatic implications to find and link men to treatment or prevention. Additional programmatic considerations arise from Eswatini having substantial crossings through both formal and informal borders, major trucking routes east to west, and to the south with well-established hot spots.

The area with the highest population density is the Manzini-Mbabane corridor, connecting the economic and national capitals - Manzini in the Manzini region and Mbabane in the Hhohho region. A small geographic area, porous borders and high unemployment rates all contribute to the increasing mobility of the population, both within and across borders. Population mobility increases the challenges in the delivery of ongoing health care services and in measuring progress in the epidemic.

Economy

Eswatini is classified as a lower middle-income country: however, income inequality is high, with a Gini coefficient estimated at 54.6 in 2016. Economic challenges persist with 58.9% of the population living below the national poverty line. Use of international poverty lines also supports the persistence of poverty: the $1.90/person/day (2011 purchasing power parity (PPP)) international poverty rate has hovered around 30% since 2016, estimated at 29.7% in 2020. This rises to 52.7% when the 2011 PPP $3.20 per person per day poverty line for lower middle-income countries is used (World Bank, 2021). The COVID-19 pandemic threatens to perpetuate the historically high poverty levels. Projections indicate a stagnation in poverty rates in the medium term due to reduction in employment incomes and remittances because of the COVID-19 pandemic. Eswatini is currently recovering from a 2020 COVID-induced recession which resulted in a 1.85% economic contraction, while 2021 saw a growth estimate of 2.1% . Economic growth projections for 2022 and 2023 are 2% and 1.8% respectively. (World Bank.org). Economic recovery remains uncertain and depends on the evolution of the COVID-19 pandemic, the rollout of vaccines and the pace of recovery of the global and regional economies particularly that of South Africa and the Southern Africa Customs Union (SACU). In response to the impact of the pandemic, the government launched a private sector led Post COVID-19 Economic Recovery Plan in August 2020.

HIV epidemic

The average life expectancy in Eswatini declined sharply from 60 years in 1991 to a low of 46 years

in 2005 (UNDP 2017), due to the intensity of the HIV and TB epidemics. The country mounted a forceful response to HIV, including availing life-saving ART that steadily increased the life expectancy to 60 years in 2019, nearly returning to the pre-1991 level. The lingering effects of the epidemic's past high mortality remain; about 20% of children aged 0-17 years are orphaned.

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

The most recent national-level statistics and projections for the HIV epidemic in Eswatini (Table 2.1.1) show a growing youth and young adult population, and an epidemic that heavily affects younger women compared to their male peers. Additional statistics show high use of antenatal care (ANC) clinics among pregnant women, a disproportionate burden of TB cases among PLHIV (66% of all confirmed cases) and a male circumcision coverage of 39% in males age 15+ as of the end of COP20.

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

Table 2.1.2 95-95-95 cascade: HIV Diagnosis, Treatment and Viral Suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV	PLHIV diagnosed	On ART	Diagnosed HIV Positive	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(#)	(%)	(#)	(#)	
Total population	1,138,166	27	215,208	206,689	198,005	96%	97%	208,847	10,990	9,245
Population <15 years	412,324	3	7,573	7,084	6,844	94%	93%	20,110	321	302
Men 15-24 years	120,083	4.1	6,574	5,479	4,887	83%	92%	17,176	396	247
Men 25+ years	236,550	29.9	71,474	68,100	61,003	95%	98%	37,838	3,640	2,946
Women 15-24 years	117,876	14	14,472	13,913	13,969	96%	94%	68,092	2,219	1,871
Women 25+ years	251,333	41.2	115,115	112,113	111,302	97%	98%	65,631	4,414	3,716
MSM	4,000	21%	840							
FSW	7,100	59%	4,175							
PWID	1,279									
TG	119									

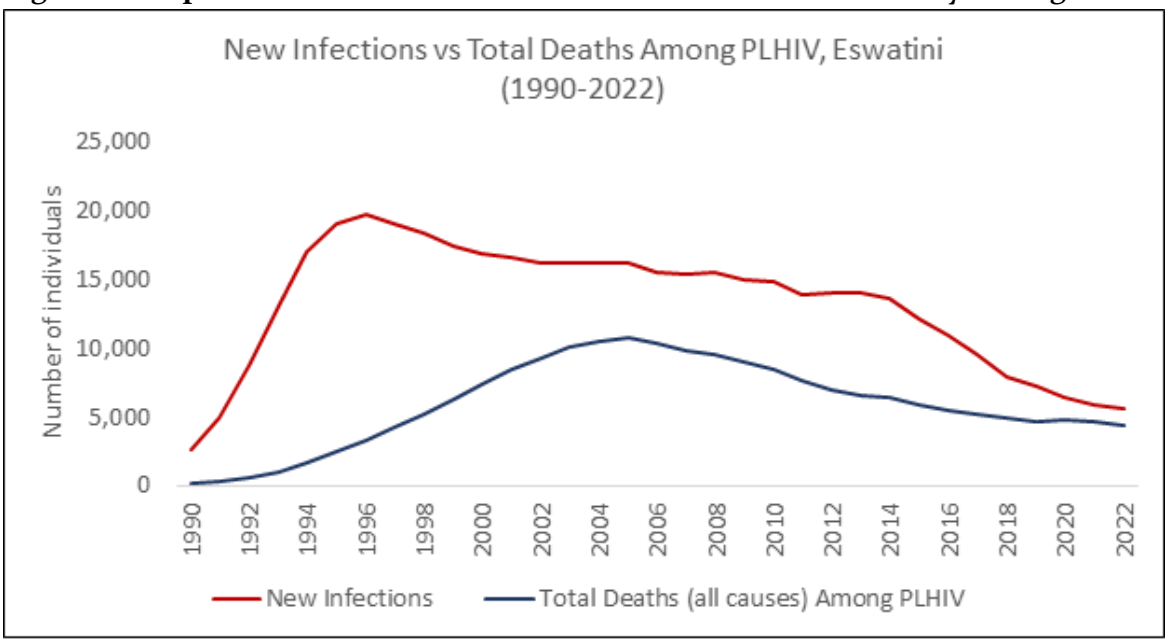
Sources: Epidemiological data: COP22 HIV Estimates, Naomi model 2021; Treatment and testing data: PEPFAR program data (Q1, FY 2022 for ART and Viral Load & Q4 2021 for Testing and ART initiations); Key Population data: Validating and Estimating the Number of Key Population Individual at the Hot Spot Level in Eswatini", 2018, Characterizing the HIV Prevention and Treatment Needs among Key Populations, including Men who Have Sex with Men and Female Sex Workers in Swaziland: From Evidence to Action, June 2015.
Note: The ART coverage is unconditional and VL coverage is conditional coverage. Individuals reported with unknown age were captured in the aggregate totals, but not included in the age disaggregated data for HIV testing and linkage.

Eswatini continues to make progress against closing the coverage gaps in all age and sex bands. As the coverage gap in Eswatini becomes increasingly narrow, estimating a precise gap at detailed age and sex levels becomes more challenging. Nonetheless, in utilizing the best available data, the ART coverage data shows that a treatment gap persists primarily among young women and young

men. Total ART coverage by the first quarter of COP21 was 91%, with women continuing to have higher ART coverage than their male counterparts.

Following the initial sharp increase in the early 1990s, new infections have declined. Total deaths for PLHIV have also declined (Figure 2.1.1), although according to Spectrum models more recent increases in mortality are due to non-AIDS related deaths as the population living with HIV ages. The modeled data show a continued decline in new infections, but at a decreased rate suggesting a need for continued robust programming to identify and address new infections including the scale-up of PrEP. COP22 Spectrum projections for PLHIV estimates 215,208 PLHIV by September 2022. Additional projections from Spectrum for COP22 planning further estimates 4,300 deaths among PLHIV (all causes), and 5,590 new infections.

Figure 2.1.1 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

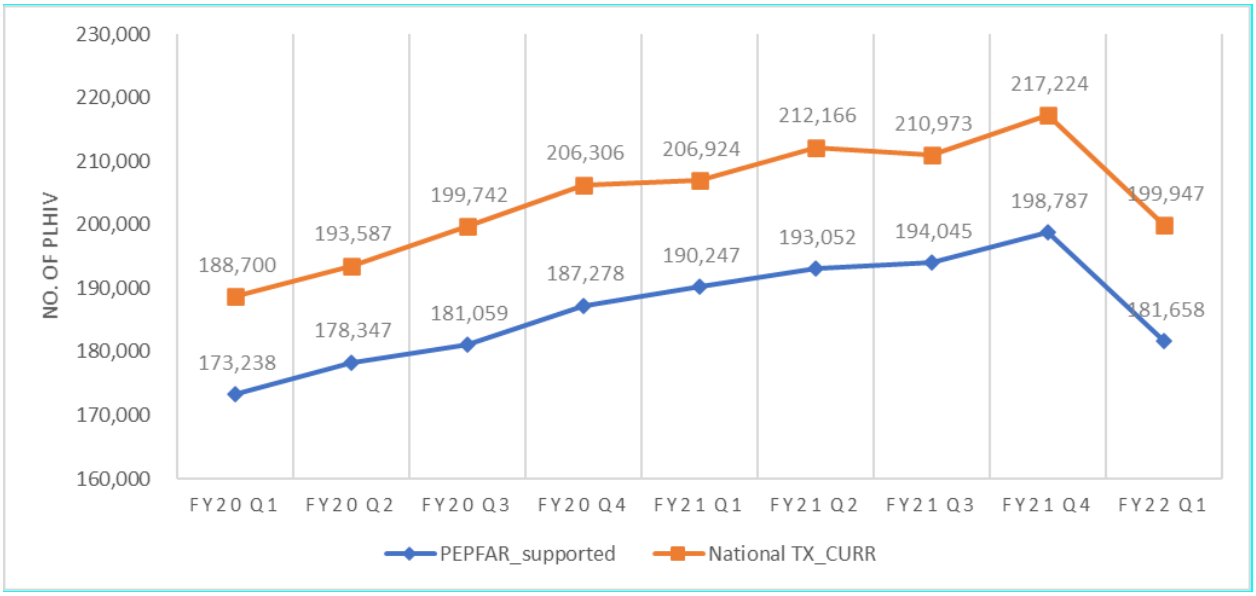


Source: Spectrum estimate, 2022

HIV Program Response

Figure 2.1.2 below shows the trend over time of the national number of individuals currently on treatment compared to the total subset that are PEPFAR-supported. Treatment growth continues to be experienced in efforts to close the coverage gaps. A robust data verification exercise covering >80% of the PLHIV currently on treatment concluded in January 2022, resulting in a verified FY22 Q1 current on treatment result.

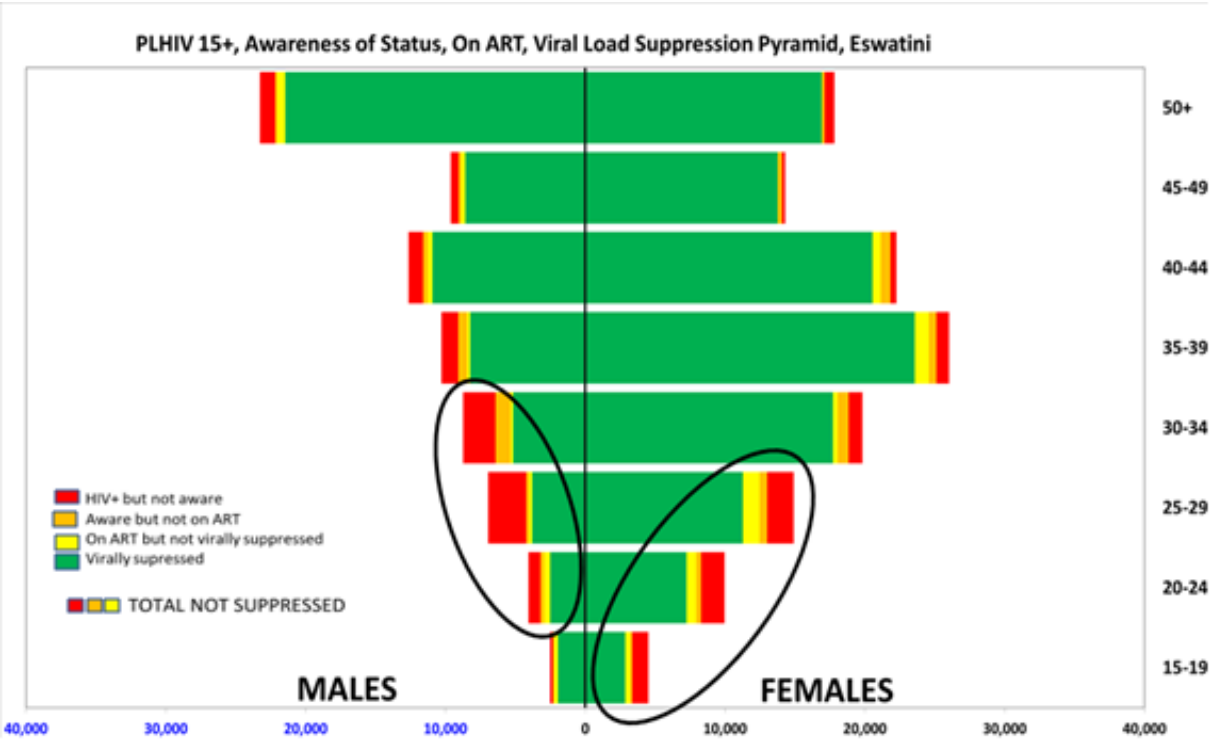
Figure 2.1.2 National and PEPFAR Trend for Individuals Currently on Treatment



Source: National and PEPFAR program data, 2020-2022

Despite this readjustment of the number of PLHIV who are on treatment, it is observed all age bands have experienced continued growth for both sexes. Focused growth in the treatment cohort is evident for targeted subpopulations where evidence suggests treatment gaps persist and new infections are occurring, primarily among females 15-29 and males 20-34. Strategies seek to continue to advance closing of gaps in case identification, treatment, and viral suppression for all populations, with ongoing intensified focus on females ages 15-29 years and males 20-34 years. As evidenced in Figure 2.1.3, these populations continue to contribute to the remaining gaps, and to the highest number of recent cases.

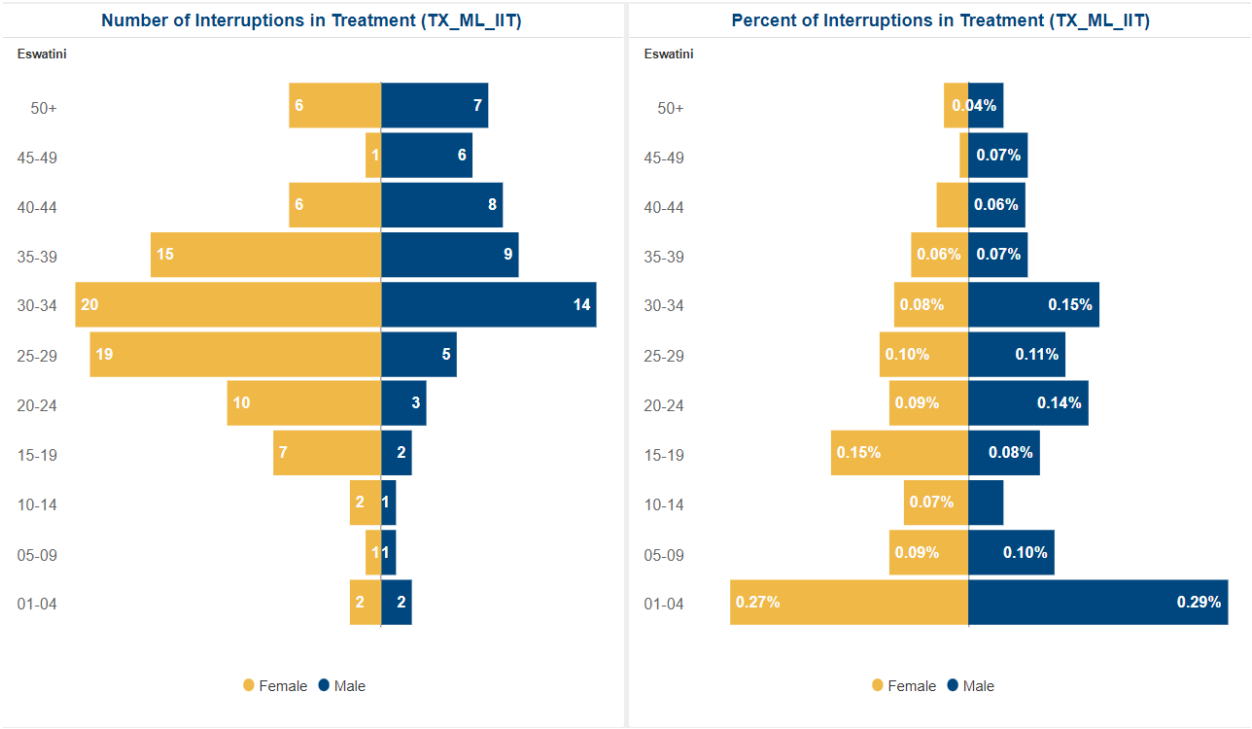
Figure 2.1.3 Treatment coverage and viral load suppression gaps, including populations contributing to the highest numbers of recent cases (Ages 15+)



Source: 2022 Spectrum PLHIV estimate and informed by provisional SHIMS3 estimate

There is a continued need to enhance our efforts to ensure the continuity of treatment for clients on ART. Whereas the percentage of reported interruptions in treatment remain relatively low in Eswatini at 3%, there is a noticeable shift that has occurred in the timing of when clients on ART are starting to experience interruptions in treatment. Previously, the Eswatini HIV program was observing early disengagement from care within the first six months of treatment initiation. Implementation of focused interventions have resulted in a significant decrease in early interruptions in treatment. However, it is now observed that 98% of all treatment interruptions are occurring in clients who have been on ART for more than 6 months, and these interruptions span across all age and sex bands (Figure 2.1.4). This is discussed in further detail in Section 2.4.

Figure 2.1.4 Clients Experiencing Interruptions in Treatment by Age/Sex, FY22 Q1



Source: PEPFAR Program data, 2022

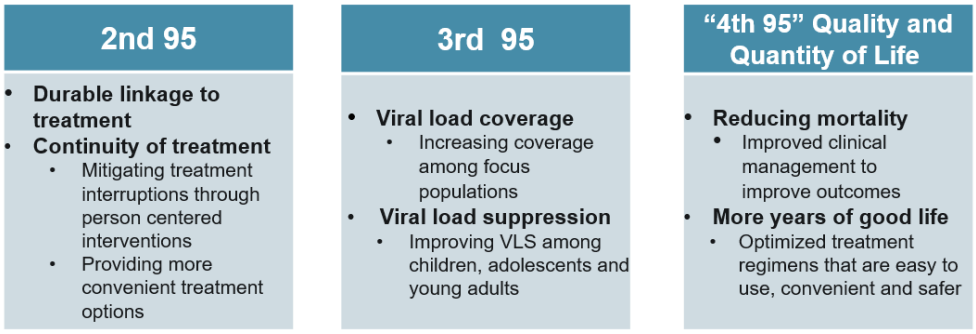
2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

PEPFAR/E continuously reviews and triangulates data from routine program, surveillance (e.g., recency, case surveillance), and population-based surveys to understand:

- Who, how, and where new PLHIV identified,
- Where (populations and geographies) ongoing HIV transmission is happening,
- Who is not accessing HIV prevention and treatment services,
- Who is interrupting treatment, when interruption happens, and who is brought back to care and when?
- Which PLHIV are dying and of what causes?

The program uses these data to refine response strategies for testing, prevention, and for optimizing treatment and maximizing VLS.

Figure 2.2.1 Treatment priorities for COP 22



Optimizing Case Identification

Given the gaps remaining in case identification among females 15-29, males 20-34, children < 15, and key populations, and that 97% of new diagnoses are long-term infections, COP22 emphasizes a revised approach to early case finding focusing on strategies targeting these subpopulations. Facility based targeted testing and index testing remain mainstays of case identification with over 70% of new diagnoses in the target age groups identified through these modalities. COP22 aims to further optimize screening at OPD and VCT using validated tools and HIVST, maximizing opportunities to utilize new diagnoses as "seeds" for index testing through improved elicitation, and scaling implementation of social network strategies. To improve timeliness of diagnosis, COP22 will also scale promising community case finding approaches including expanding access to HIVST through private pharmacies, faith communities, workplaces, and educational institutions, conducting cluster investigations identified through recency testing, and utilizing social media platforms to increase awareness of need for early testing.

Maintaining high viral suppression

HIV testing and ART initiation contribute directly to program growth and to closing gaps in ART coverage. PEPFAR/E has worked to provide durable linkages to treatment and prevention services by addressing barriers to ART uptake and providing ongoing tailored peer support (up to six months post treatment initiation). Once PLHIV is identified and initiated on treatment, the goal moving forward is to minimize Interruption in Treatment (IIT), promote re-engagement in care and maintain viral suppression. With regards to minimizing IIT and improving Viral Load Suppression (VLS), PEPFAR/E continues to work on providing durable (high resistance barrier), safe (good toxicity profile) and easy to use (Fixed Dose Combinations (FDC) and once daily dosing) treatment options through tailored and convenient service delivery modalities (6MMD, Community Commodity Distribution (CCD), smart lockers, fast track etc.) to improve program efficiency and meet individual patient needs. HIV drug resistance surveillance utilizing routinely collected viral load samples is being introduced during COP21 and will continue in COP22 as a critical tool to track dolutegravir (DTG) resistance patterns in order to maintain the integrity of optimized ART regimens.

Interrupting HIV transmission with pre-exposure prophylaxis (PrEP)

COP22 strategies will build on COP21 activities focusing on consolidating PrEP activities in facilities by normalizing PrEP services to those testing negative, scaling up PrEP in private sector workspaces using existing workplace programs, offering PrEP services in communities, and closely monitoring PrEP services using the PrEP cascade. PEPFAR will continue supporting the national program in generating demand for PrEP in targeted and general audiences, expanding differentiated and integrated service delivery and in introducing new biomedical prevention products.

2.3 Investment Profile

Despite Eswatini's classification as a lower-middle-income country, economic indicators such as a weak business climate and low foreign investment reflect a low-income country status that has significant income disparity (Gini coefficient of 0.49) and substantial poverty with 60.4% of Eswatini's population living below the lower-middle-income country poverty line ($3.20)1 Despite the COVID19 pandemic and the June 2021 political unrest, the country's economy rebounded in 2021 with real GDP growth estimated at 2.1% rising from a 1.9% contraction in 20202. A tax to GDP ratio of 15.5% and a high total non-tax revenue of 11.2% of GDP3 illustrate both challenges faced in domestic revenue generation and financial dependency on the Southern African Customs Union (SACU) revenue-sharing agreement. The dual burden of high HIV and TB prevalence and number of OVC remain major health and social concerns, while non-communicable diseases also play a significant role in premature death, all of which have a substantial impact on the workforce and economy, as well as significant public expenditure.

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

Eswatini received approximately US $230,200,000 in Overseas Development Assistance in FY 2020/214. The health sector has been the largest beneficiary of grant external assistance (69%) and the HIV/AIDS and tuberculosis (TB) epidemics have received a significant response from global development partners and donors. Despite economic challenges which are exacerbated by the COVID-19 pandemic, GKoE remains committed to protecting the gains that have been in the response against HIV and has budgeted US$17.67 million for the procurement of ARVs for FY21/225.

The investment profile for FY2020 was challenged by the unavailability of disaggregate expenditure data for the domestic government contributions for FY2020. In prior years, PEPFAR/E relied on the National AIDS Spending Assessment (NAS) 2020 report for disaggregated HIV expenditure data, coupled with the Government accounting system reports for commodity

1 World Bank, 2018
2 World Bank, 2022
3 Revenue Statistics in Africa 2018 oe.cd/revenue-statistics-in-Africa

4 External Assistance to Eswatini Report 2018/19 - 2020/21

5 Government of Eswatini Budget Report 2021/2022

expenditures. However, for this round of the resource alignment and investment profile, there was no current NASA data that could be used as it only covered the period 2015/16 to 2018/19. Available Domestic Government expenditure data lumps health expenditures and does not necessarily disaggregate by HIV expenditures and this makes it difficult to compare PEPFAR/E, GF and other funder contributions with Domestic Government contributions.

Given the above challenge, table 2.3.1 was compiled utilizing data from the NASA 2020 report for domestic government contributions while data for PEPFAR/E, Global Fund and Other Funders contributions was pulled from the Resource Alignment 2020. While it is noted that the NASA data is not as current as the data from the Resource alignment, the data mix allowed for a more accurate reflection the Domestic Governments' contributions to the HIV response in Eswatini compared to utilizing aggregate health expenditure data. The government's health finance systems enhancement is part of the areas PEPFAR/E's health finance work will support to strengthen in COP22, enabling a more up to date and accurate reflection of expenditure.

Based on data mix alluded to above, the GKoE is the largest contributor to the HIV response (56%) and PEPFAR/E is the second largest contributor at 38%. The GF and other donors contribute 6% and 1% respectively. By program area the greatest total PEPFAR investments continued to be in clinical care, treatment and support, HIV case identification, Prevention and health system strengthening. This investment represents both DSD and technical support. The largest contribution from GKoE was in clinical care, treatment, and support, predominantly through the funding of adult ARVs, while GF focused support on VL and lab reagents. PEPFAR/E and GF continue to provide support for specific commodities, particularly those that are difficult for GKoE to procure at the smaller volumes required by the country. In COP22, PEPFAR/E will continue to support pediatric ARVs, VL reagents and VMMC surgical kits. GKoE and GF will continue to support adult ARVs.

PEPFAR/E also supports HIV prevention programming including VMMC, oral PrEP, condoms, and comprehensive interventions and services for AGYW, OVC and key populations. PEPFAR/E provides support for above-site activities to strengthen government capacity and leadership for oversight, coordination, and implementation of HIV programs, in addition to building the capacity of GKoE to collect, analyze and use data for HIV/TB program decision-making. PEPFAR/E investments also include laboratory support, survey, and surveillance and systems strengthening (cf. CMIS, LIS, WMIS) and supply chain support. Changes to PEPFAR/E investments reflect the evolving epidemic.

Table 2.3.1: Investment Profile (Expenditures) for HIV Programs, 2020

Program Area	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	$	%	%	%	%
Care and Treatment	**$54,340,012**	**48%**	**10%**	**42%**	**1%**
HIV Care and Clinical Services	$19,479,467	12%	5%	83%	0%
Laboratory Services incl. Treatment Monitoring	$10,264,951	32%	33%	35%	0%
Care and Treatment (Not Disaggregated)	$24,595,594	83%	3%	12%	1%
HIV Testing Services	**$50,032,356**	**86%**	**1%**	**14%**	**0%**
Facility-Based Testing	$2,321,817	0%	0%	100%	0%

Community-Based Testing	$2,145,308	0%	0%	100%	0%
HIV Testing Services (Not-Disaggregated)	$45,565,231	94%	1%	5%	0%
Prevention	**$14,238,367**	**35%**	**5%**	**56%**	**3%**
Community mobilization, behavior and norms change	$3,941,075	0%	8%	88%	4%
Voluntary Medical Male Circumcision	$3,817,657	0%	5%	94%	1%
Pre-Exposure Prophylaxis	$698,821	0%	0%	100%	0%
Condom and Lubricant Programming	$0	0%	0%	0%	0%
Opioid Substitution Therapy	$0	0%	0%	0%	0%
Primary Prevention of HIV & Sexual Violence	$0	0%	0%	0%	0%
Prevention (Not Disaggregated)	$5,780,814	87%	4%	5%	4%
Orphans and Vulnerable Children	**$16,997,007**	**72%**	**0%**	**28%**	**1%**
Case Management	$2,437,928	0%	0%	100%	0%
Economic Strengthening	$610,503	0%	0%	84%	16%
Education Assistance	$468,639	0%	0%	100%	0%
Psychosocial Support	$1,124,738	0%	0%	100%	0%
Legal, Human Rights, and Protection	$192,524	0%	0%	100%	0%
OVC (Not Disaggregated)	$12,162,675	100%	0%	0%	0%
Above Site Programs	**$11,267,873**	**41%**	**12%**	**45%**	**1%**
Human Resources for Health	$113,978	0%	50%	50%	0%
Institutional Prevention	$0	0%	0%	0%	0%
Procurement and Supply Chain Management	$1,034,630	0%	45%	55%	0%
Health Mgmt Info Systems, Surveillance, and Research	$4,146,814	5%	21%	72%	2%
Laboratory Systems Strengthening	$155,421	0%	0%	100%	0%
Public Financial Management Strengthening	$52,000	0%	0%	0%	100%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$1,311,925	0%	0%	100%	0%
Laws, Regulations and Policy Environment	$8,571	0%	0%	100%	0%
Above Site Programs (Not Disaggregated)	$4,444,533	100%	0%	0%	0.3%
Program Management	**$16,390,834**	**7%**	**9%**	**84%**	**0%**
Implementation Level	$16,390,834	7%	9%	84%	0%
Total (incl. Commodities)	**$163,266,449**	**56%**	**6%**	**38%**	**1%**
Commodities Only	**$31,516,186**	**66%**	**14%**	**20%**	**0%**
% of Total Budget	19%				

Source: PEPFAR/E, GF & Other Funders Data: PEPFAR Resource Alignment Report 2022; Domestic Gov't Data: NASA 2020, Government MOH accounting System expenditure Report FY2019/20 and National Lab expenditure Report 2019/2020

The total FY20 HIV program investment of $163,266,499 was funded predominantly by GKoE (56%), PEPFAR (38%) and GF (6%) (Table 2.3.1). The programs with the largest investment were clinical care, HIV testing, and treatment and support (including ARVS), mainly due to the

proportion contribution by GKoE. Other funders contributed 1% of the HIV program investment in FY20.

Table 2.3.2: Investment Profile (Expenditures) for HIV Commodities, 2020

Commodities	Total	Domestic Gov't	Global Fund	PEP FAR	Other Funders
	$	%	%	%	%
Antiretroviral Drugs	**$18,930,842**	**93%**	**0%**	**7%**	**0%**
Laboratory Supplies and Reagents	**$5,556,409**	**53%**	**0%**	**47%**	**0%**
CD4	*$0*	*0%*	*0%*	*0%*	*0%*
Viral Load	*$2,599,409*	*0%*	*0%*	*100%*	*0%*
Laboratory Supplies	*$0*	*0%*	*0%*	*0%*	*0%*
Laboratory (Not Disaggregated)	*$2,957,000*	*100%*	*0%*	*0%*	*0%*
Medicines	**$287,554**	**100%**	**0%**	**0%**	**0%**
Essential Medicines	*$0*	*0%*	*0%*	*0%*	*0%*
Tuberculosis Medicines	*$44,170*	*100%*	*0%*	*0%*	*0%*
Other Medicines	*$243,384*	100%	0%	0%	0%
Consumables	**$5,920,456**	**0.3%**	**72%**	**28%**	**0%**
Condoms and Lubricants	$100,795	*8%*	*0%*	*92%*	*0%*
Rapid Test Kits	$1,015,236	*0%*	*0%*	*100%*	*0%*
VMMC Kits and Supplies	*$533,479*	*0%*	*0%*	*100%*	*0%*
Other Consumables	*$4,262,882*	0.2%	100%	0%	0%
Health Equipment	**$830,387**	**0%**	**56%**	**44%**	**0%**
Health Equipment	$830,387	0%	56%	44%	0%
Service and Maintenance	*$0*	*0%*	*0%*	*0%*	*0%*
PSM Costs	**$820,926**	**0%**	**18%**	**82%**	**0%**
Total Expenditure, Commodities Only	**$31,516,186**	**66%**	**14%**	**20%**	**0%**

Source: PEPFAR Resource Alignment Report 2022; NASA 2020, Government MOH accounting System and National Lab expenditure Report 2020/2021

Table 2.3.2 was compiled utilizing the MOH accounting system and the Resource Alignment 2020. For commodities, the MOH accounting system reports on HIV drugs and commodity expenditures for FY2020. The total annual expenditure for commodities is $31,516,186, with the GKoE paying for 93% of the total investments in ARVs. In FY20, PEPFAR supported 100% of VMMC kits and 92% of condoms, while the Global Fund supported 100% of other consumables.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID	$2,425,000	Yes	3	n/a	COVID19 vaccination program support
CDC	$1,270,000	Yes	4	n/a	COVID19 vaccination program support
Peace Corps	$1,025,348	No	0	n/a	Volunteers support
Total	$3,695,000	Yes	7	n/a	

Source: Global Vax Interagency Acceleration Plan 2022, Peace Corps financial data, 2021

In FY22, USAID and CDC received non-PEPFAR funds to support the vaccination program in Eswatini.

2.4 National Sustainability Profile Update

The Eswatini sustainability index and dashboard 2021 exercise were carried out in October 2021 through a collaborative and multi-stakeholder consultative process that was coordinated by PEPFAR, UNAIDS and National Emergency Response Council on HIV and AIDS (NERCHA) under the leadership of the Prime Minister's Office. A SID core team comprising of NERCHA, UNAIDS and PEPFAR planned and facilitated the virtual Responsibility Matrix (RM) and Sustainable Index Dashboard (SID) stakeholder meetings. Table 2.4.1 below summarizes the sustainability strengths and vulnerabilities that were identified and highlights the areas of focus for COP22.

Table 2.4.1. SID 2021 Elements

Selected SID 2021 Element and score	COP 22 sustainability areas of focus
Sustainability Strengths	
Element 1: Planning and Coordination *SID 2021 Score – 9.33, dark green*	The Prime Minister's Office, through NERCHA, provides strong leadership of the HIV response in Eswatini. The National HIV/AIDS Strategic Framework (2018 – 2023) and National Health Sector Strategic Plan (2018 – 2023) provide strategic direction for the response. Nonetheless, participants agreed that a National Decentralization Policy should be finalized to enable formal linkages between national plans and regional service delivery goals and targets. Further, coordination of the multi-sectoral response should also be strengthened to minimize duplication and leverage synergies among partners. Private sector HIV services should also be mapped and tracked routinely. For COP22, PEPFAR will support the

	government's efforts to improve coordination of a sustainable HIV response and continue to participate in the GF CCM Evolution project committee.
Element 12: Technical and Allocative Efficiencies *SID 2021 Score - 8.60, light green*	There was slight improvement in the score from 2019, a reflection that the GKoE, with donor-support, has strong systems to analyze and utilize relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. During the COP22 implementation year, The GKoE will focus on improving the sustainability of these systems.
Element 13: Market Openness *SID 2021 Score – 9.41 dark green*	Eswatini's government and donor policies enable fair competition and productive and non-biased participation by HIV service providers in the provision of HIV goods and services. The Ministry of Economic Planning intensified its efforts to coordinate all Bilateral and Multilateral Partner support to the GKoE and the Ministry of Finance continues to strengthen the enforcement of policies to ensure fair competition.
Sustainability Vulnerabilities	
Element 6: Service Delivery *SID 2021 Score – 5.06, yellow*	Health-facility level service delivery continues to be strong and the score improved slightly from 2019. The major gaps remain in the provision of consistent and high-quality community services. Although there is some community outreach, the need to intensify community outreach programs was highlighted. Linkages to services still need to be strengthened and the formal recognition of community lay cadres continues to be one of the areas for improvement. In COP22, PEPFAR will strengthen the collaboration between community and facility-based implementing partners to improve the linkage of beneficiaries to prevention and treatment services and to improve continuity of treatment. The Health Bill of 2022, recently tabled in Parliament by the Minister for Health, will facilitate the GKoE's efforts aimed at strengthening this element.
Element 10: Laboratory *SID 2021 Score – 4.24, yellow*	The score declined slightly from 2019 because staffing and resource limitations continue to present considerable sustainability vulnerabilities for the national health laboratory services. The quality of community-based point-of-care testing also needs to be improved. The Laboratory Strategic Plan has been finalized and will provide strategic direction for GKoE, PEPFAR and GF investments that seek to minimize barriers to achieving and maintaining epidemic control in this area.
Element 8: Commodity Security and Supply Chain *SID 2021 Score – 4.79, yellow*	The GKoE is the primary funder of adult antiretrovirals (ARVs), an area that has continued to be prioritized despite the fiscal constraints. PEPFAR is responsible for the procurement of all pediatric ARVs, viral load reagents and condoms. GF is the primary supporter of other lab commodities, including CD_4 reagents. Commodity management at primary facility level (clinics) remains weak and with the intensification of differentiated service delivery models, additional technical support is needed from PEPFAR. The unavailability of a supply chain assessment within the past three (3) years and an increase in ARV prices compared to benchmark international prices led to a lower 2021 score compared to 2019. PEPFAR will

	continue to assist GKoE in forecasting and supply planning as well as strengthen capacity in contracting and financing.
Element 14: Epidemiological and Health Data *SID 2021 Score – 5.45, yellow*	The GKoE routinely collects, analyzes, and makes available HIV/AIDS epidemiological data and plays an important leadership role through respective MOH units. However, GKoE autonomy in fully financing these activities remains limited, and substantial technical assistance continues to be necessary for implementation, which are the primary drivers for scoring remaining static from 2019. PEPFAR has played a key role in supporting the three population-based HIV impact assessments and continues to do so in other activities to ensure updated epidemiological data, including those focused on key population groups. SID 3.0 combines surveys and surveillance for each portion of this assessment, and therefore does not adequately differentiate the strengths and vulnerabilities for each of these important sources of data. Importantly, the existence of a functional HIV case surveillance system for routine epidemic monitoring and identification of emerging issues for public health response remains a gap.

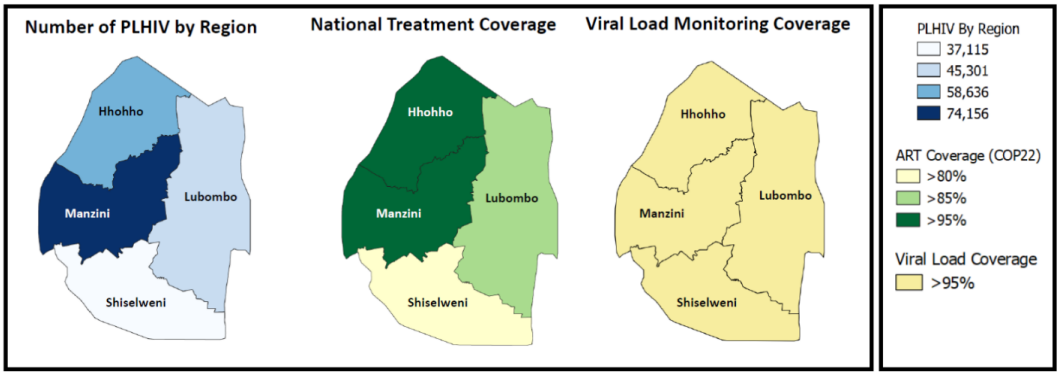
Source: Eswatini Sustainable Index Dashboard, 2021

2.5 Alignment of PEPFAR investments geographically to disease burden

PEPFAR's investments support the availability of clinical and community services in all four regions. Financial investment decisions are aligned with disease burden, with the most implementing partners and resources invested in the region with the most PLHIV. COP22 will continue to utilize real-time program data within Eswatini's developing HIV case-based surveillance strategy to monitor new infections by population, place, time, and other characteristics to guide programmatic focus on subpopulations across geographic areas. This includes identifying any early clusters of recent infections where they occur and seeking to respond in a timely fashion with the appropriate public health interventions that are focused on interrupting further transmission. COP22 recency testing will have national coverage to enable continuous refinement of case identification and resource allocation strategies. The PHIA study, known as SHIMS3, that was scheduled for FY20 was delayed due to COVID-19, but was completed at the end of 2021 and is currently being analyzed. Results from this survey will be used to shift programming to align with any identified gaps that are not already addressed through the COP22 strategy.

Figure 2.5.1 below, shows PEPFAR/E's targeted treatment and viral load monitoring coverage for PLHIV. Cascade targets for COP22 were set to ambitiously close coverage gaps across regions and five-year age and sex bands. In addition, the targets were guided by continuous triangulation of modeled treatment gaps with routine program data and available survey data to ensure responsiveness to known gaps and the current epidemic as evidenced by real-time program data. As such, they are calibrated to ensure that the right subpopulations are newly diagnosed, linked to treatment, remain on treatment, and attain and maintain viral load suppression.

Figure 2.5.1. COP22 Targeted PLHIV Treatment Coverage and Viral Load Coverage



Source: 2022 Spectrum and COP22 national target

2.6 Stakeholder Engagement

The COP22 planning process maintained a high level of stakeholder involvement, despite challenges posed by COVID-19. A virtual stakeholder meeting was held in January 2022 to review key global and country-specific planning guidance along with the program context and results. Following this, the Ministry of Health, NERCHA, UNAIDS and PEPFAR leadership jointly determined membership of multi-sectoral task teams focused on continuity of treatment and viral load suppression, case finding, AGYW, OVC, key populations, PrEP, VMMC, laboratory and strategic information. The task teams met to review the program-specific guidance, prior year's program implementation, COP20 results and to hold discussions to reach consensus on the proposal of program adjustments. Task team's co-leads presented the COP22 program proposals to PEPFAR/E and MOH leadership, PEPFAR headquarters staff including the SGAC Chair and Agency points of contact, and external stakeholders in February 2022.

PEPFAR/E continues to provide briefings to the Prime Minister and Cabinet on program progress and goals. PEPFAR/E also continues to meet with the senior leadership of the Ministry of Health monthly and NERCHA regularly to provide high-level briefing on the overall policy development requirements, program priorities, program results, COP guidance and targets. In addition to participating in national-level technical working groups (TWG), PEPFAR/E also meets with Ministry of Health, Deputy Prime Minister (DPM), Ministry of Tinkhundla and Administration (MTAD), Ministry of Education, and NERCHA technical leads to discuss and agree on technical-level oversight, development of national strategies and performance management. The COP22 task teams also included implementing partners, other bilateral and multilateral donors, NGOs, civil society representatives and the private sector (as represented by Business Eswatini and the Swaziland Business Coalition on Health and AIDS).

External Development Partners

PEPFAR/E is a member of the Global Fund Country Coordinating Mechanism (CCM) and sits on the CCM Oversight Committee. PEPFAR/E shares financial and programmatic information with the GF and CCM members. PEPFAR/E has standing quarterly meetings with the GF to engage on areas of shared interest, such as commodities, CMIS, supply chain management, AGYW and key populations to harmonize efforts. PEPFAR and UNAIDS have monthly meetings for coordination, and PEPFAR participates in the quarterly coordination meetings convened by UNAIDS. Médecins

Sans Frontières (MSF), AIDS Healthcare Foundation (AHF) and the broader United Nations (UN) family are also key PEPFAR/E partners, and meetings are held and communication exchanged as needed throughout the year and they participate in COP22 stakeholder meetings.

Civil Society

PEPFAR/E convened several meetings with civil society organizations (CSOs) along with the Consortium of the Coordinating Assembly of Non-Governmental Organizations (CANGO), the Civil Society (CS) umbrella coordination group, to provide updates on the quarterly PEPFAR Oversight and Accountability Response Teams (POART) results and COP22 planning. Five CS representatives participated in the Virtual Planning Meetings, representing PLHIV, AGYW, key populations and men. Large stakeholder meetings that included CS were held in January and February 2022 to solicit input for COP22. PEPFAR/E shared information with CS about the COP22 strategic direction before and after the Virtual Planning Meeting, incorporating input into the PEPFAR programming. Drafts of the Strategic Direction Summary (SDS) were also shared to gain valuable feedback and input from CS. In COP22, the PEPFAR/E small grants program will continue to prioritize implementation of the CS-led platform to collect community engagement in HIV services.

2.7 Stigma and Discrimination

In COP22, building on previous COPs, PEPFAR/E continues to involve marginalized populations to inform PEPFAR programming process and implementation to ensure client-centered approach for accessing HIV services. An example of this is the Community-Led Monitoring (CLM) and its tool has a strong focus on Key population, AGYW and PLHIV and the CLM coordination mechanism integrates KP and PLHIV networks. All implementers and service delivery points will ensure implementation of policy to safeguard against stigma and discrimination and those policies will be periodically assessed to evaluate the actual quality of services.

PEPFAR/E will continue to strengthen the inclusive service delivery model by integrating non-judgmental services delivery into the ongoing training and mentorship for health care workers in health facilities. Services Integration includes ensuring that clients are provided services without experience of stigma and discrimination. One example from PEPFAR/E is the re-labeling of PrEP bottles for all populations, specifically AGYW and key populations, to address stigma issues attached to ARV bottles. Expert clients will provide peer-to-peer services to PLHIV to help navigate them to health facilities and ensure that the services are responsive to the needs of PLHIV clients and promote access.

While progress has been made to reduce stigma and discrimination, self-stigma and limited disclosure to family and friends remain a challenge among PLHIV. This leads to the delay in starting treatment and interruptions in treatment. Therefore, in COP22, PEPFAR/E will implement a literacy campaign targeting PLHIV and communities to address stigma and discrimination by promoting acceptance and support to PLHIV.

3.0 Geographic and Population Prioritization

The Kingdom of Eswatini has reached the second and third 95 at a national level, resulting in all regions attaining saturation (Table 3.1).

Table 3.1 Current status of ART saturation

Prioritization Area	Total PLHIV% of all PLHIV for COP22	# Current on ART (FY22 Q1)	# of SNU COP21 (FY22)	# of SNU COP22 (FY23)
Attained	99%	199,947	4	4

Source: PEPFAR Program data (national),2022

PEPFAR/E routinely analyzes epidemic patterns by age, sex, and location, as well as the primary modes of transmission and underlying behavioral and structural factors among sub-populations. Continuous triangulation of treatment coverage gaps (based on the modeled PLHIV estimates) with routine program data allows for a more informed approach to a targeted response. As such, the COP22 approach to targeting by sub-population focuses on closing the coverage gaps, but also seeks to focus on those sub-populations with disproportionate levels of recent infections, as evidenced by HIV recency data. These sub-populations include females 15-29 and males 20-39. Once available, SHIMS3 data will provide updated information on the population-level impact of HIV programs to date and highlight the populations that continue to require greater attention and services to meet their needs. These data will be triangulated with routine program data to further support an agile programmatic approach to responding to population and geographic gaps.

VMMC coverage at the end of 2021 was approximately 39% in males age 15+. According to SHIMS2 data (2017), male circumcision coverage for men in this age group is highest in Manzini at 29%, followed by Hhohho and Lubombo at 26.6% and 25.7% coverage respectively, with Shiselweni having the lowest coverage at 22.9%. Among the target age bands 15-29, SHIMS2 self-reported data showed that 29% of males ages 15-24 and 17% of over 25-year-old have been circumcised. In COP22, PEPFAR/E in partnership with GKoE, will continue to scale up VMMC coverage to 80% among males 15-29 years through continuing to expand access to VMMC services by generating demand, scaling up task shifting while maintain quality and improving efficiencies.

Geographic Context

Although PEPFAR/E program coverage extends nationally, the below geographic specific information was considered during programming for CO P22.

Manzini

The highest number of PLHIV is in the Manzini region, which has an industrial corridor where many people (especially young women and men) from other regions come to seek employment. These areas are also known hot spots for sex workers and men who have sex with men (MSM). Other areas in Manzini region have lumber and mining activities that attract men for employment, and subsequently the women who follow them. Services with extended hours and specific activities to engage men cater to those employed in factories or male-dominated jobs in

this region. Aggressive promotion for male testing and outreach for testing and linkages is prioritized in this region.

Hhohho

Hhohho, where the capital of the country is located, is the second most populated region and while it has slightly less PLHIV than Manzini, there is a need for additional testing for men especially 20 to 34 years. The northern and western areas of Hhohho are dominated by logging, citrus farming and small-scale industries that attract men. The main border crossing at Oshoek is a large truck stop with transient men and women.

Lubombo

As a primarily rural region, Lubombo has lower population density, higher levels of poverty and food insecurity, a high burden of OVC and female-headed households and reduced access to services and transportation. As a reflection of need, it should be noted that only 52% of the population in this region has access to safe water, compared to the urban regions who have closer to 80%. This level of poverty impacts people's ability to seek health services at facilities and thus there is a greater reliance on mobile services and community engagement and outreach.

Shiselweni

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

4.0 Client-Centered Program Activities for Epidemic Control

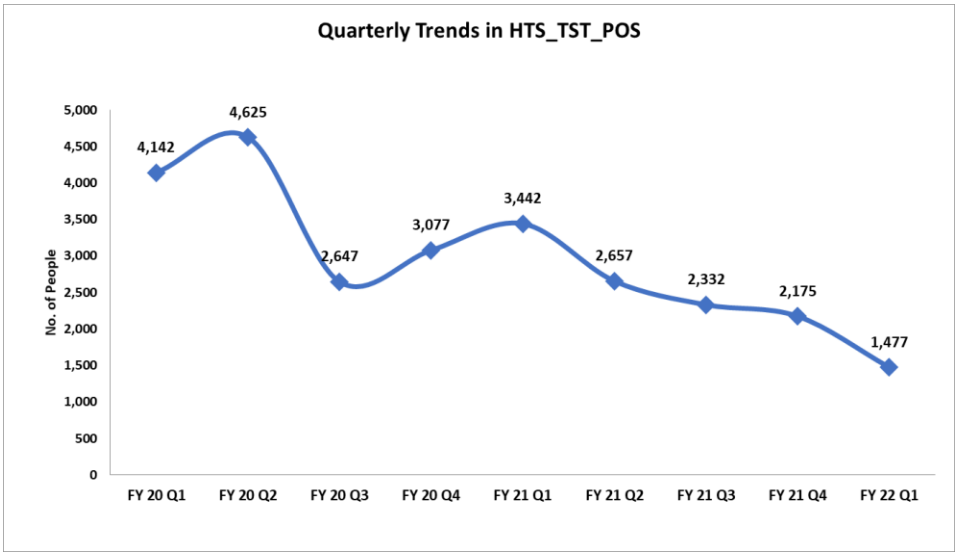
Eswatini has made significant progress and reached 95-95-95 at national level. As of December 2021, ART coverage at the national level is estimated to be about 93% of all PLHIV (This is above 2nd 95 Target). In COP 22 PEPFAR targets an ART coverage of 99% at the national level with a focus on closing treatment gaps by specific age and sex bands, and a VLS of >95% across all age, sex, and geographies.

4.1 Finding people with undiagnosed HIV and initiating treatment

Data suggests that approximately 8% of PLHIV in Eswatini remain undiagnosed and that the gap remains in identifying males age 20-34, females age 15-29 and children. In addition, recency surveillance has shown that 97% of new cases are long term infections, indicating that the vast majority of those identified are diagnosed over 12 months following HIV infection. These data point to the importance of optimizing case finding strategies, including maximizing index testing and HIVST, along with OPD and VCT entry points to facilitate early identification and linkage to ART across all sex, age and population groups.

HTS targets aim to achieve a national ART coverage of 95% and 95/95/95 across all sex and age bands by SNU for epidemic control at the national level. In FY21, PEPFAR Eswatini identified 10,606 HIV positive persons. (Figure 4.1.1) This reflects a downward trend in case identification, which is expected given Eswatini's reach of 95% of PLHIV with known status and its progress towards epidemic control. COVID19 has also impacted HTS positive results

Figure 4.1.1. Quarterly trends in HIV testing positives (FY 20 Q1 – FY21 Q1)



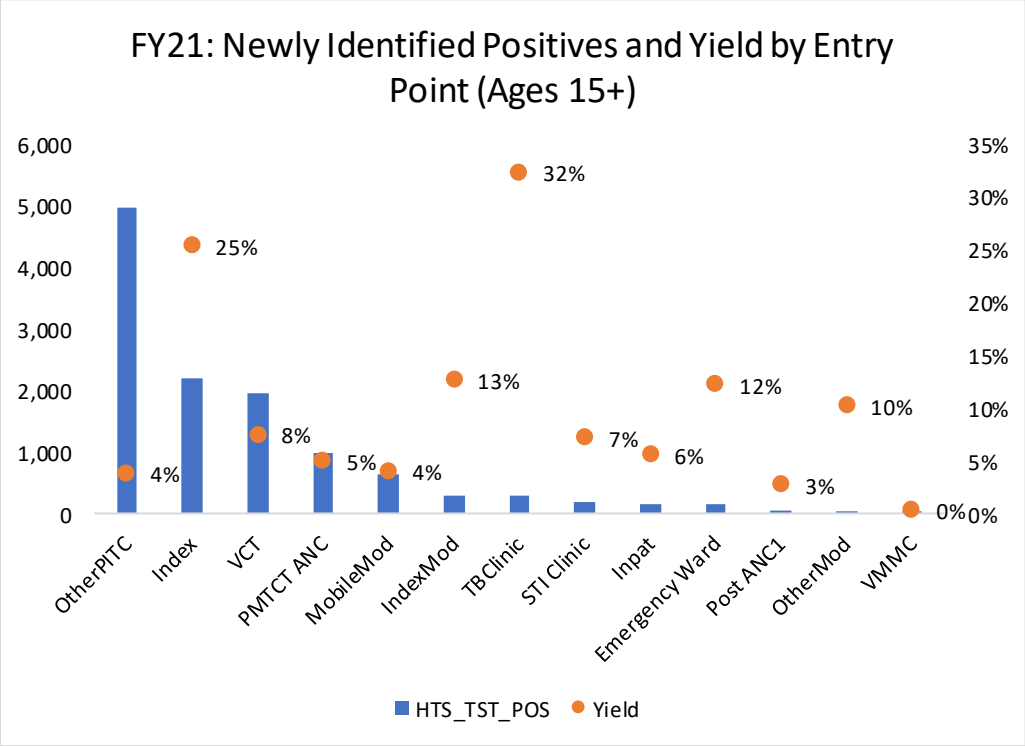
Source: National and PEPFAR program data, 2020-2022

Results from FY21 show a significant shift in programming especially for facility-based index testing. However, volumes for community index testing remain suboptimal. COP22 HIV case finding approaches will reflect a pivot in HTS programming to evolve with the country's changing epidemic. PEPFAR supported community partners will ensure that the positives identified in community will be linked to treatment through accompaniment by community navigators and the PEPFAR supported care and treatment partners will ensure minimal loss of patients on treatment through the cascade and ensure cost efficiencies in the program, building towards sustainability in the era of epidemic control.

For COP22, PEPFAR/E will continue to support the MOH and other implementing partners to scale and refine index testing and other targeted testing approaches through intensified site-level support. Ensuring the safety of patients through intimate partner violence (IPV) screening remains a critical component of index testing. Additionally, PEPFAR/E will support community testing partners to implement approaches targeted by geography and tailored by population group and age/sex cohort. Efforts will focus on key hotspots informed by recency data where active transmission is occurring.

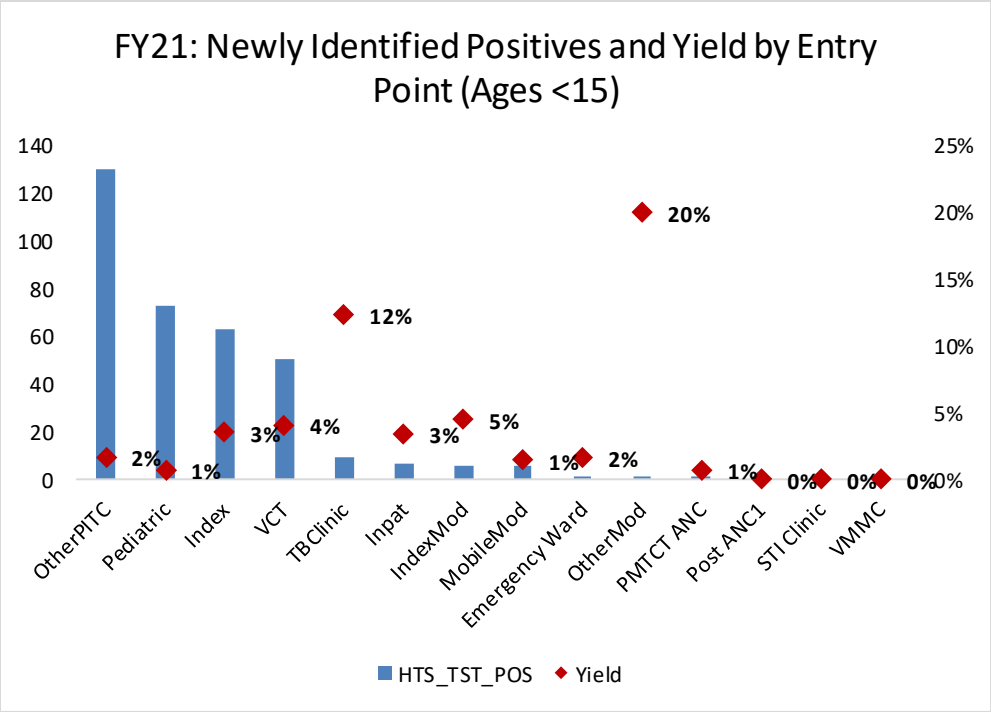
Case finding results by age and modality show that for FY21, facility index testing and other PITC, VCT and PMTCT modalities were most successful in finding HIV positive cases in PEPFAR-supported regions (Figure 4.1.2.a). Facility index and TB recorded the highest yield at 25% and 32% for adults.

Figure 4.1.2 a. Adult HIV testing and yield by entry point (FY21)



Source: PEPFAR Program data, 2021

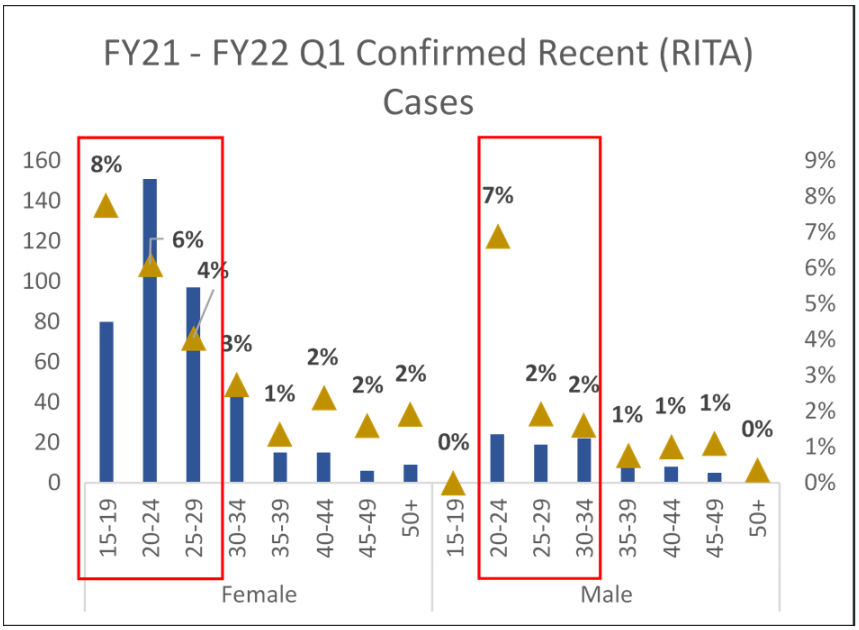
Figure 4.1.2 b. Child HIV testing and yield by entry point (FY21)



Source: PEPFAR data, 2021

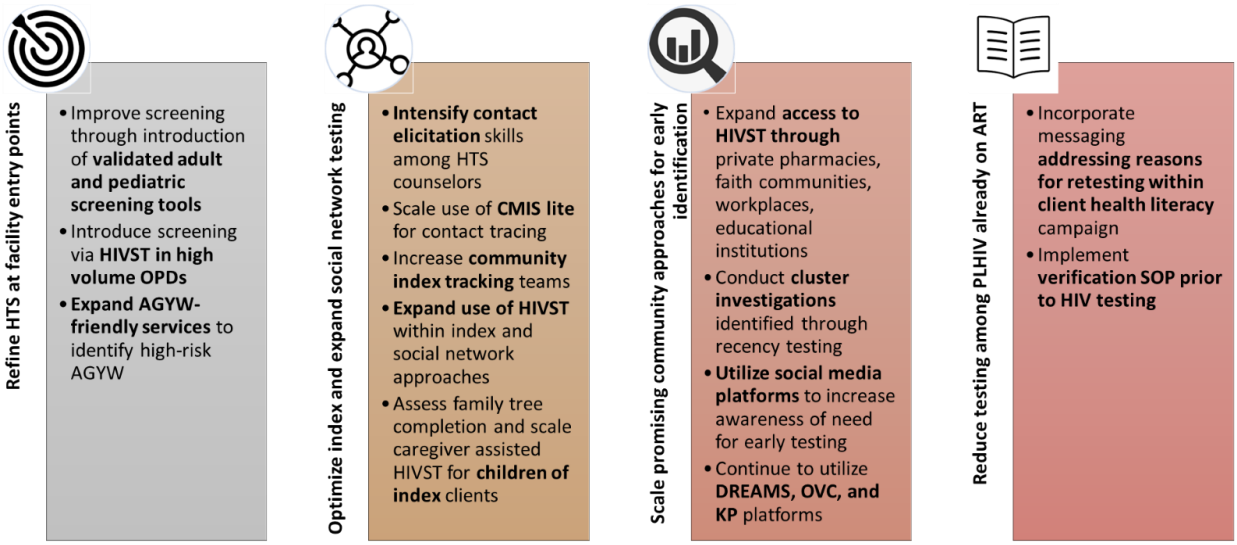
Recency testing results have shown persistent new infections among AGYW (15-24) and men (29-39) as shown in the below FY21 to FY22 Q1 HTS confirmed recent cases.

Figure 4.1.3. HTS confirmed recent cases (FY21 to FY22 Q1)



Source: PEPFAR program data, 2021-2022

Figure 4.1.4 Case finding approaches to identify the remaining undiagnosed PLHIV



The case finding strategic vision for COP22 will build upon the successes of COP21, with adjustments to address remaining gaps in priority populations, including females aged 15-29, males 20-34 years of age, key populations, and children through the strategies described below.

a. Refine HTS at facility entry points

In COP21, the MOH and PEPFAR partners trained all providers on the approved HIV screening tool, which was subsequently rolled out to all HIV testing sites. This tool will be validated in COP 22 to ascertain its sensitivity and specificity to improve targeted testing and reduce unnecessary testing. Optimized targeted testing using the HIV screening tool will be implemented in OPD and VCT settings as the national program data suggest high recent infections among females aged 15-29 and males aged 20-34 as seen above. In COP 22, PEPFAR/E and MOH will introduce HIVST as a screening tool in high volume OPDs to increase testing uptake, lowering HRH requirements, and allowing to reach individuals missed through PITC and risk-based screening due to its high sensitivity. Moreover, HIVST will be integrated into service delivery settings for pregnant and breastfeeding women, STI, family planning and TB clients through secondary distribution to their sexual partners.

b. Optimize index testing and social network testing

All newly diagnosed PLHIV, virally unsuppressed clients and biological children (19 years old and under) of PLHIV and partners of KP will be prioritized for index testing services. For COP22, PEPFAR/E will continue to support the MOH and other implementing partners to scale and refine their index testing and targeted testing approaches through intensified site level support. To improve case identification through index testing, PEPFAR/E will continue to use skilled counselors for contact elicitation, increase

community index tracking teams and expand use of HIVST within index and social network approaches. At ART sites, expert clients will assess family tree completion for index testing and scale-up caregiver assisted HIVST for children of index clients, including offering index testing to all virally unsuppressed clients. At the community level, contact tracing will be improved by the use of CMIS-lite tablets to monitor the index trees.

Other modalities for HIV testing services such as peer driven social network testing and outreach-based testing with integrated HIV self-testing programs among men, AGYWs and KPs will also be supported. Program monitoring will be strengthened at site level to identify performance issues, target interventions to poor performing sites, and use best practices from the highest performing sites across the program. Ensuring the safety of patients through intimate partner violence (IPV) screening remains a critical component to index testing and will be tracked pre- and post-index testing services. All HTS implementing partners will continue to report on index testing monthly to monitor trends and ensure scale and fidelity with the strategy. Continuous site support supervision will be provided utilizing the MOH standardized tool along with collaboration and oversight with in-country CSOs to ensure that index testing remains confidential, voluntary, and consented.

c. Scale promising community HIV testing approaches for early identification

To improve early case identification amongst men, AGYWs and KPs, PEPFAR/E will scale promising community approaches outside facility setting through the following approaches:

a) Expand access to HIVST through private pharmacies, faith communities, mobile outreaches for KP/OVC/DREAMS, workplace, and educational institutions. PEPFAR/E will support MOH to develop MOUs with local pharmacies on HIVST distribution, and provide technical support around regulations, reporting and ordering of the kits.
b) Conduct cluster investigations identified through recency testing; routine surveillance data from the recency testing program will be fully utilized to map hotspots for targeted HIV testing, HIVST distribution, index testing, prevention, and other related services to target areas of new infections amongst men and AGYWs.
c) Utilize social media platforms to increase the awareness of the importance of early testing, with emphasis on messages targeting adolescents and young men.
d) Continue to utilize DREAMS/OVC/KP for targeted HIV testing with index testing and HIVST distribution.

d. Reduce testing among PLHIV on ART

Recency data shows significant retesting among patients on ART with 47% of recent infections being virally suppressed. PEPFAR has developed SOPs for testing facilities to verify before and after diagnosis, which are being rolled out. However, to fully understand the challenges associated with retesting, PEPFAR/E and MOH will use qualitative

approaches to understand the reasons for frequent retesting, and inform messaging and behavior change across client literacy campaigns and programming.

4.2 Ensuring viral suppression and ART continuity

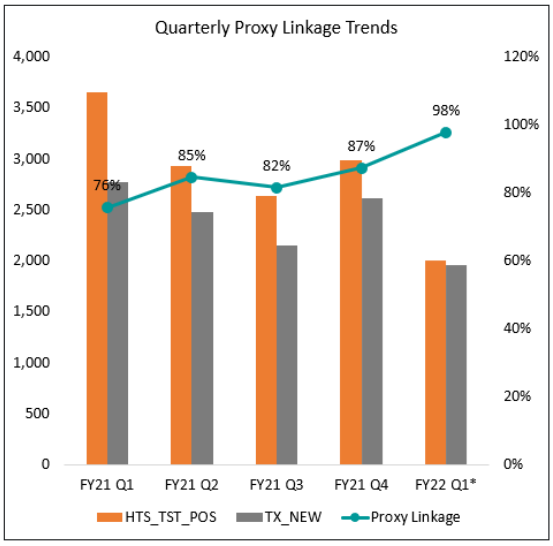
Durable linkages

Improving treatment outcomes starts from client preparation prior to ART initiation as this phase impacts long term adherence, IIT and VLS. The program has made significant strides through the Linkage Case Management (LCM) approach. This is an intervention that employed peers to:

1. Serve as focal persons for referrals: a) within facilities, b) between facilities and c) between facilities and communities, to close the facility-community divide.
2. Help clients to navigate the health system and facilitate access to services.
3. Provide adherence and peer support for a period of six months post ART initiation. This allows for ongoing counselling support to strengthen disclosure, contact elicitation, identification and addressing of barriers to adherence, and prompt reporting and management of adverse events.

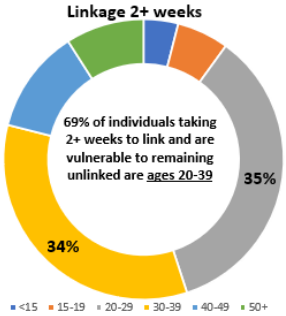
Significant improvements have been made in linkages as demonstrated by the figure below. It should be noted that the strong program interventions have managed to overcome disruptions to service delivery due to COVID-19 and the civil unrest that occurred in the country.

Figure 4.2.1 Trends in linkages over the last five quarters & Time to ART initiation by age



*represents PEPFAR-supported only

- Strong improvements in linkage continue to be observed.
- In 2022 Q1, **89%** of clients experienced **same-day ART initiation**.
- 10% of clients took longer than 2 weeks to link or remained unlinked as of December 2021.
- Strengthening collaboration between DREAMS and clinical programs is key to improving linkages and ART uptake for AGYW



Interruption in Treatment (IIT)

A total of 3% of males and females on ART (TX_CURR- Q1 FY2) had experienced interruption in treatment (IIT). Forty-five percent (45%) of IIT was among clients aged 20-39 years. Fifty-six percent (56%) of those returning to care are also aged 20- 39 years. Ninety-eight percent (98%) of those who experience IIT had been on treatment for more than 6 months. This IIT is spread evenly amongst clients whose time on treatment ranges from one to five years. PEPFAR/Eswatini continues to work with partners to examine IIT data to characterize who is interrupting treatment, when, and why in order to derive tailored solutions to address this persistent challenge.

The PEPFAR/Eswatini program has a robust structure in place to track and bring patients back to care. This includes but is not limited to the following:

- SOPs to guide patient tracking and appropriate documentation
- Updates to EMR to track appointments, including appointment reminders
- Cadres employed to call and conduct home visits for clients who miss appointments,
- Provision of resources for patient tracking like cellphones, airtime and vehicles (and fuel).
- PEPFAR/E continues to work with MOH and facilities to create a welcoming environment for clients who interrupted treatment. This follows input from the community-led monitoring (CLM) initiatives that reported poor treatment of clients returning to care including some rather punitive approaches employed by some facilities and healthcare workers.

The PEPFAR/E program efforts to limit early disengagement from care through improving linkages and ensuring durability of linkages through linkage case management (LCM) have almost eliminated IIT within the first six months of starting treatment.

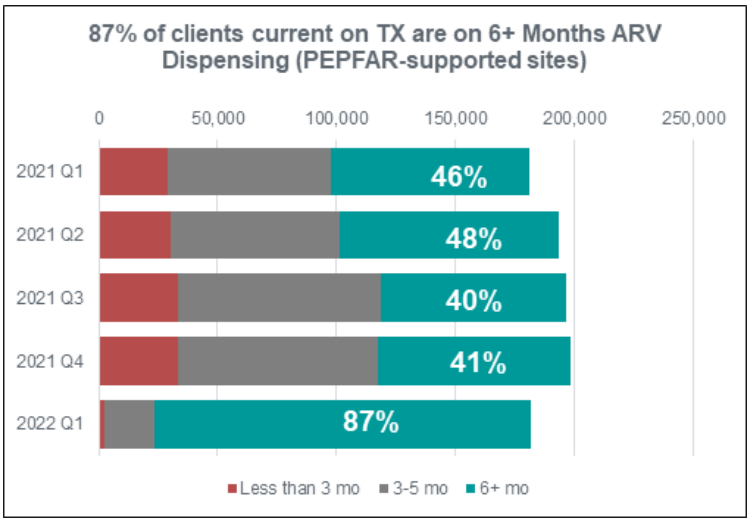
All the above interventions are geared towards improving patient outcomes. Key outputs and outcomes that the country is tracking include viral load testing coverage (VLC) and Viral Load Suppression (VLS). Eswatini is performing well on both indicators and well above the global average with VLC at 91% and VLS and 98% at the end of Q1 FY22 which has improved from 92% in 2017. However, the following populations are lagging with regards to these indicators. For VLC, females 10-29 years and males 20-39 years continue to have lower than expected access to viral load testing. Children and young people under 25 years have VLS lower than the targeted 95%.

Client centered interventions and viral load testing coverage

The country supports a variety of interventions to meet specific client needs. These include Viraemia clinics/ challenge clubs (to improve management of clients with high viral loads so they benefit from multidisciplinary teams), advanced HIV disease services, teen clubs and transition clubs (to provide adolescent centered services and to support transition from adolescent to adult services). Underlying these interventions is a commitment to optimize ART regimens, scale up six multi-month scripting and dispensing (6MMD) and Community Commodity Distribution (CCD) to overcome service delivery disruptions due to COVID-19 and civil unrest. The OU has made significant progress in the scale up of 6MMD as shown in Figure 4.2.2 below, increasing from 41%

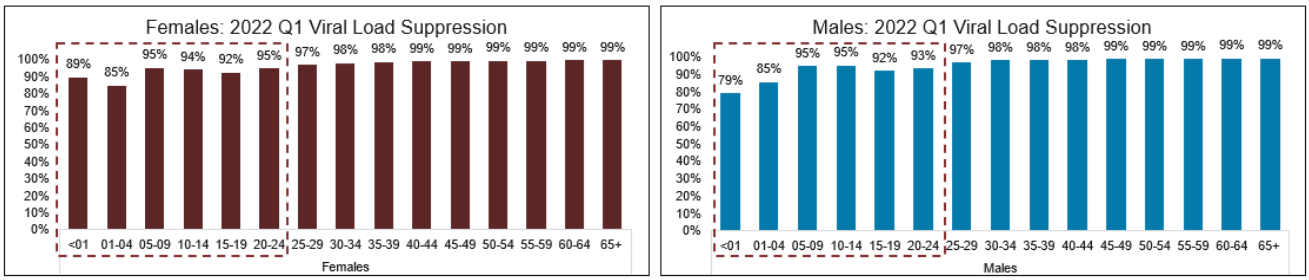
in Q4 FY21 to 87% in Q1 FY22. This is due to the combined impact of an intensified scale-up of 6MMD at targeted facilities and the result of the treatment data verification exercise which corrected and updated the documented 6MMD data. With the growing population of adults on ART, PEPFAR/E will support integration of NCDs as part of client centered differentiated service delivery. PEPFAR/E will provide technical assistance to implement GF-supported HIV/NCD care models that focus on quality improvement.

Figure 4.2.2. 6MMD by quarter



Source: PEPFAR program data, 2022

Figure 4.2.3. Viral Load Suppression by age and sex



Source: PEPFAR Program data, 2022

To improve viral load testing coverage, the OU is working to develop SOPs and processes around sample transport to ensure DBS vial load is collected during Community Commodity Distribution (CCD) visits in the community and in teen clubs held over the weekend. The national laboratory services will decentralize DBS viral load testing to ease sample transport constraints and scale up capacity to do DBS viral load testing to 30% of all tests done. This will increase access for clients who have limited access to facilities due to work and school commitments. PEPFAR will continue to support POC viral load scale up to i) improve access to viral load testing for priority populations and ii) provide a platform for quick decision making for clients that need clinical decisions to be made based on the level of VLS.

4.3 Prevention, specifically detailing programs for priority programming

4.3. a. HIV Testing for Prevention services

HIV testing services directly contribute to HIV prevention outcomes when individuals with a seronegative HIV status are offered appropriate HIV prevention services and linking them to person-centered prevention services. HIV prevention pathways provide individuals with the tools they need to stay healthy, and to interrupt HIV transmission. HIV testing for prevention allows HIV negative individuals who test positive to seamlessly transition to receive HIV care and treatment services. PEPFAR/E and MOH have established standards articulating HIV testing services as a critical component of HIV prevention interventions among discordant couples along with VMMC, PrEP monitoring, OVC programs, DREAMS programs, ANC, and post-ANC services.

HIV Testing for PrEP

Testing for PrEP enrollment requires standard HTS to ensure an HIV negative status. PEPFAR/E and MOH will continue to provide HTS for all clients accessing PrEP services. To monitor the outcomes for HIV testing for PrEP, some custom indicators have been developed and partners are currently being oriented with full implementation expected between COP21 and COP22. Repeat testing for PrEP clients will be done every 3 months to monitor sero-conversion. Additionally, HIVST for PrEP continuation was started in FY22, and this will improve service uptake especially during COVID-19 related restrictions.

HIV Testing for VMMC/DREAMS/OVC

Targeted HIV testing will be provided to VMMC/DREAMS/OVC clients through use of the HIV screening tool to identify all high-risk individuals and minimize unnecessary testing. HTS in VMMC settings is voluntary and not routine or universal. In COP 22, HTS for AGYWs and men will include mobile HTS, after-hours services in health facilities, HTS delivered in Safe Spaces/Girls Clubs, and HIV self-testing. In COP22 the OU will increase the number of sites providing AGYW /Men friendly corners in selected facilities across the country. At the community level, HIVST kits will be distributed in DREAMS/OVC platforms and follow-ups will be made to ensure proper linkages. HTS and HIVST will also be offered to the partners of DREAMS/VMMC clients.

HIV Testing for PMTCT ANC and Post ANC1

Due to the high HIV prevalence and high testing yield among all age bands receiving antenatal care, there is an ongoing need to ensure that deliberate, standardized prevention and testing strategies are provided to pregnant and breastfeeding women. Recency surveillance data, suggest that recent infections are proportionately higher among pregnant and postpartum women. This highlights the need for intensified prevention interventions and routine retesting at ANC and

PNC. Routine testing will be implemented to reduce vertical transmission and to ensure continuation of prevention services to women with a negative HIV serostatus and to prompt treatment for women who seroconvert.

In COP22, PEPFAR/E will provide HTS at ANC visits, including implementing maternal retesting at appropriate intervals in line with national testing guidelines, utilize the maternal, newborn and child health (MNCH)/PMTCT platform as a springboard for reaching male partners through secondary distribution of HIVST kits as well as index testing, and prioritize PrEP for pregnant and breastfeeding women.

4.3. b. DREAMS

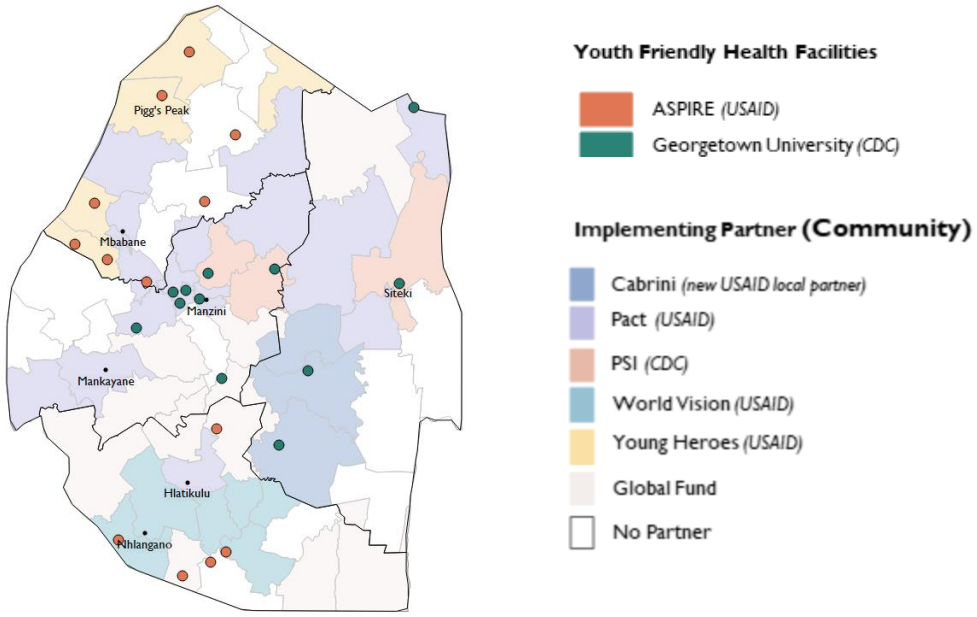
Geographic Implementation

In COP 22, the PEPFAR/E DREAMS program will continue implementation in 36 Tinkhundla across the four regions of Eswatini. USAID will continue DREAMS implementation in 33 Tinkhundla across the four regions of Eswatini whilst CDC will continue to implement in 3 Tinkhundla in Manzini and Lubombo. In addition, Peace Corps will engage AGYW 10-24 years in EGLOW clubs in 36 Tinkhundla and refer those eligible to DREAMS partners for enrollment. Further, to complement the mobile outreach services provided through DREAMS on Wheels, the PEPFAR/E program will expand the provision of youth-friendly health services in the Hhohho and Shiselweni region in 14 PEPFAR-supported facilities whilst continuing to provide youth-friendly services in the 12 facilities in the Lubombo and Manzini.

PEPFAR/E DREAMS will work closely with the Global Fund to complement interventions and optimize community and service platforms to reach AGYW.

The map below shows the PEPFAR/E DREAMS program coverage in COP 22 including youth friendly health facilities.

Figure 4.3.b DREAMS Map: COP 22 coverage for DREAMS program



Source: DREAM partner data system and Global Fund recipient data, 2022

Scale up PrEP for AGYW in DREAMS SNUs

PrEP information or enrollment is included in the primary package of DREAMS interventions for AGYW aged 15-29. In COP22, DREAMS on Wheels will be expanded to provide more community PrEP initiations and refills, and the number of PrEP mobilizers/ambassadors will be increased. Data from health needs forms will be used to generate targeted demand to AGYW showing interest in PrEP messages, and PrEP strategies targeting AGYW will be developed in the national PrEP communication strategy, including the DREAMS social media platforms. Referrals from PrEP mobilizers and uptake will be tracked through custom indicators to ensure accountability among demand creation and service delivery partners.

AGYW accessing PrEP services will undergo HTS and those who test HIV positive will be linked to ART services. Further, HIVST is now being used for PrEP which will also improve the service uptake especially during COVID-19 restrictions. DREAMS mentorship sessions will be used to ensure PrEP referral completion and support PrEP follow-ups. DREAMS interventions will include specific "PrEP days" that will provide PrEP information, referrals, and enrolment as possible. The PrEP job aid will be made compulsory for those aged 15-29, and the importance of dual protection from sexually transmitted infections, including HIV, as well as pregnancy, will be emphasized. The PrEP ring, a monthly self-administered insertable ring for HIV prevention for cisgender women, will be introduced in selected PEPFAR/E sites through an implementation science study. The clinical implementing partner youth-friendly sites will also utilize peer navigators to help

AGYW avoid queues to fast-track service provision and will further facilitate linkages to PrEP for AGYW accessing antenatal care, STI and other clinical services. PrEP targets for AGYW have increased from 7,359 new AGYW PrEP clients in COP21 to 11,577 new AGYW PrEP clients in COP22.

With the persistent increase of new HIV infections among AGYW in FY21, Peace Corps' HIV Prevention Program is also aligned to the DREAMS layering approach through integrating PrEP information and linking PrEP services to the Financial Literacy Programs and Parental & Care Giver programs. This program alignment facilitates the scale up and uptake of HIV Prevention interventions by AGYW across Eswatini.

STI treatment for AGYW

With DREAMS resources, PEPFAR/E will continue diagnostic sexually transmitted infection (STI) screening and treatment for AGYW and their partners. STI screening and treatment for DREAMS AGYW will coincide with PrEP counseling and initiation. In COP22, we plan to screen sexually active AGYWs with GeneXpert for Neisseria Gonorrhea, Chlamydia Trachomatis and Trichomonas Vaginalis in AGYW-friendly facilities and DREAMS on Wheels outreach services.

Increase Completion of DREAMS Packages

In COP 21, the delivery of DREAMS curricula has been accelerated following the relaxation of the COVID-19 restrictions which allowed for face-to-face activities, thus improving completion rates, particularly for AGYW that transitioned from COP20. On this same note, the opening of schools in January of 2022 has facilitated the delivery of programming to the 10-14 age cohort. In COP 22, the program will continue to expedite curriculum delivery and increase referrals to clinical services prioritizing AGYW that have been in the program for more than 12 months. The program will also collaborate with clinical partners to ensure that they co-facilitate sessions such as PrEP to fast-track referrals as well as inviting other AGYW that completed and exited the program to share testimonials and motivate beneficiaries to complete sessions.

Improve Access to GBV Services

In COP 21, the program continued to provide first-line support for those who disclose experience of violence at enrollment and during group sessions; implement evidence-based gender norms change and GBV prevention interventions for AGYW and their communities; provide post-violence clinical care services including PEP and emergency contraception. In COP22, responding to the findings of the Violence Against Children Study (VACS) will be a key priority for DREAMS programming and GBV activities will be integrated across the HIV clinical cascade. PEPFAR/E and partners will also conduct the GBV data quality assessment of the minimum package (PEPFAR's GEND_GBV MER indicator) at both facility and community to better understand the current challenges and packages offered as part of post-violence care services. Further, the DREAMS program will work closely with the Gender Unit in the Deputy Prime Minister's Office (DPMO) to improve referrals to GBV One Stop Centers as well as working with UNICEF and other

partners to support the Unit to implement the GBV Coordination Framework. In addition, there will be a scale up of interventions that address the social and cultural norms that foster gender-based violence through community-based activities such as engaging adolescent boys, young men, and partners of AGYW via electronic, social, and other forms of media.

Strengthen Facility-based Youth-Friendly SRH Services

The provision of youth friendly services continues to be a focus for the DREAMS program. In COP 22, in addition to the Youth corner model in Lubombo and Manzini, an integrated model will be introduced in the Hhohho and Shiselweni Regions which will utilize existing YF trained nurses who will work with peer navigators/linkage assistants to deliver services. This will improve screening of the most vulnerable AGYW at facility level and ensure linkages to DREAMS program. Vulnerable AGYW will include those coming for ANC, STIs, FP, and GBV care. Further, youth friendliness will be built into the clinical mentorship package to ensure that YF guidelines are being implemented.

Peace Corps will also strengthen its Youth Friendly Services (YFS) Program through strengthening its partnership with the MOH's Eswatini National HIV/AIDS Program (ENAP) in the delivery of YFS training in community clinics.

Saturation and Plans for Maintenance

Eswatini is tracking cumulative completion and saturation rates by age group for all DREAMS Tinkhundla. In COP22, size estimations of vulnerable AGYW will be validated with the VACS data and SHIMS 3 results. The program will also develop maintenance plans for sites nearing saturation in COP22.

Above Site Activities

In COP 22, the DREAMS program will introduce the following above site activities.

1. **Enhance Economic Strengthening Approaches:** The DREAMS program will continue to scale up economic strengthening interventions with a strong focus on vocational training, internships, and business start-ups. In COP 21, DREAMS partners signed an MOU with the Ministry of Education and Training (MoET) to collaborate on the implementation of community-based HIV prevention and OVC programs. This partnership will be leveraged in COP 22 to decentralize Technical and Vocational Education and Training (TVET) institutions to increase access for vulnerable AGYW as these institutions are situated around the major cities making it difficult for AGYW to access. PEPFAR/E will work with the MoET to design a model that will support delivery of vocational training at community level. The "block grant" approach will also be explored to increase enrollment of AGYW where TVET institutions will be supported with equipment and materials in lieu of tuition fees for a specified number of AGYW.

2. **Integrate Mental Health Support Services:** Mental health has been identified as a missing service in DREAMS considering that the targeted population is at high risk of mental health problems associated with their vulnerabilities as well as the impact of COVID-19. In COP22, PEPFAR/E will collaborate with the Government to adapt mental health content for AGYW and design a service delivery model that will integrate mental health support services into DREAMS programming. The program will further explore introducing custom indicators for tracking this activity as well as a feedback mechanism that will facilitate learning and improvement.

3. **DREAMS Database:** The database is currently managed by an implementing partner and in COP22, as a strategy for increased sustainability, the DREAMS database will be integrated into existing Health Information System (HIS) as well as facilitate the dissemination of DREAMS data to stakeholders for national intersectoral decision-making on AGWY issues and to support package completion

4.3. c. OVC

PEPFAR/E will continue to provide OVC services in 34 Tinkhundla across all 4 regions. The OVC comprehensive track will continue to provide comprehensive individual case management for children aged 0-19yrs with known risks. Adolescents aged 10-14 will receive time-bound HIV and violence education. Adolescent girls in the OVC program will also be referred to the DREAMS program. The overall target for OVC_SERV is 81,723 and is comprised of 63,160 OVC aged 0-17 years, 2,025 OVC aged 18-20 years and 16,538 caregivers. In COP22, the target proportion for the comprehensive track has increased from 75% in COP 21 to 77% of the total OVC_SERV target. The OVC comprehensive track will continue to provide comprehensive individual case management for children aged 0-17 years with known risks. The targeted proportion for the preventive and DREAMS track have been slightly reduced with the preventive from 13% in COP21 to 12% in COP22 and the DREAMS track from 12% in COP 21 to 11% in COP 22.

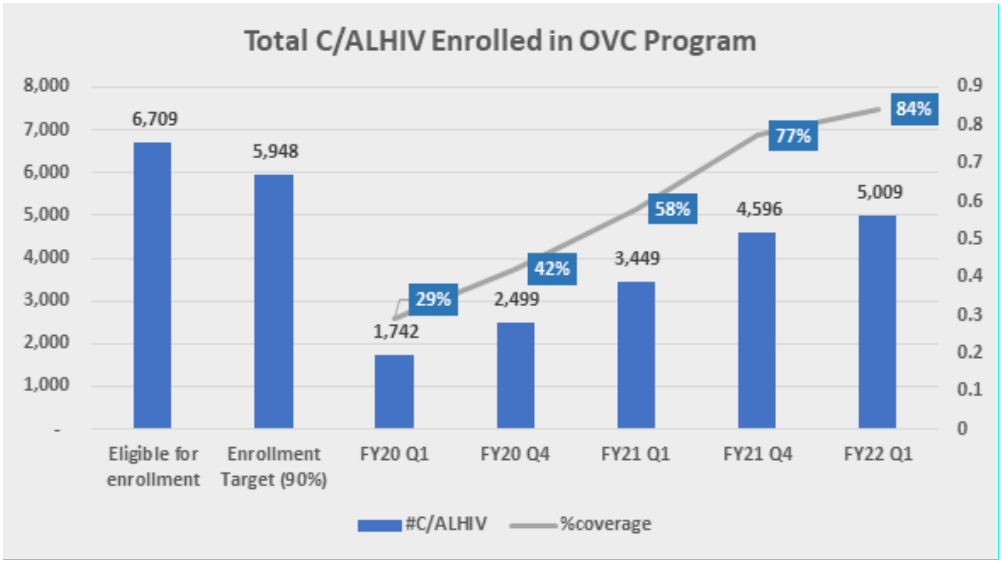
Comprehensive OVC Program

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

C/ALHIV Enrollment into OVC Program

In COP22, the OVC program will continue to work closely with clinical partners to increase enrollment of C/ALHIV into the program. Following the national TX_CURR Data Validation Exercise conducted in COP 21, OVC partners conducted an additional exercise to further map C/ALHIV to correct facility Inkhundla and patient Inkhundla to estimate OVC program coverage. The site-level analysis showed that 52% (6,709) of HIV positive children on ART are resident in OVC program sites. In COP 22 the OVC program will continue to enroll at least 90% (5,948) of children under 18 in PEPFAR supported sites into the OVC program. Of those eligible, it was discovered that 48% (3,245) reside and receive their clinical services in OVC sites, whilst 52% (3,464) reside in OVC sites but receive their clinical services in facilities outside OVC sites. The program has successfully enrolled 75% (5,009) of the eligible C/ALHIV (6,709) and achieved 84% of 90% coverage target, which has increased from the 77% reported in COP20 as shown by the graph below.

Figure 4.3.c Total C/ALHIV enrollment in OVC program



Source: PEPFAR program data, 2022

In COP22, in addition to the placements of OVC Linkage Assistants at high volume sites, the program will offer a modified service package for C/ALHIV that have been found to receive clinical services in facilities within OVC sites but reside outside of the OVC sites. Through the data mapping, it was discovered that a total 1,134 C/ALHIV receive their clinical services within OVC sites but reside outside OVC sites, which means that they are already interfacing with Linkage Assistants but are not receiving the other comprehensive services. The modified service package will involve expanding the scope of Linkage Assistants to include providing case management activities such as enrollment assessment and case planning as well as other services in the comprehensive program. The table below shows modified service package.

Table 4.3.c Modified OVC Service Package

Service Area	Standard Package	Modified Package
Community Cadre	Home visitor	**Linkage assistant / linkage officers**
Vulnerability Assessment	Enrolment assessment	**Enrolment assessment**
Case Planning	Care plan: household (caregivers, siblings)	**Care plan: C/ALHIV**
Home Visits	Monthly	**Quarterly**
Adherence Support (household level)	Home-based (monthly) Facility-based: teen clubs	**Home-based in person (quarterly); virtually (monthly)** **Facility based: teen based**
Livelihoods for Caregivers	Savings groups	**n/a- link to other community-based implementers**
Education Support	Individual Subsidies, Block grants	**Individual Subsidies**
Parenting	Parenting sessions (Sinovuyo)	**Caregiver forums (quarterly, facility-based)**
Viral Load	VL monitoring	**VL monitoring**
Index testing	Identify children of PLHIV with unknown status, referral/self-test provision	**Identify children of PLHIV with unknown status, referral/self-test provision**

Source: PEPFAR

OVC Preventive Program

The preventive OVC program track will continue to target 9-14-year-old girls and boys with evidence-based HIV and sexual violence prevention education delivered by Home Visitors through group sessions at community level using the PEPFAR prevention modules. Home Visitors will continue to identify the risk cases, provide referrals to health and social services as needed and children who will show specific vulnerabilities will be referred to the comprehensive OVC program.

OVC and DREAMS Integration

In COP 22, DREAMS and OVC activities will continue to be integrated programmatically and geographically as well as operationally within the same implementers, allowing for harmonized planning, alignment of curricula and tools, implementation, and monitoring. Therefore, adolescent girls from the OVC program aged 10-20yrs will continue to be enrolled in DREAMS and receive additional layered HIV services.

4.3. d. Primary prevention of HIV and sexual violence among 10–14-year-olds

DREAMS

The 10–14-year-olds curriculum targeting HIV and sexual violence prevention was approved for Eswatini and aligns with the S/GAC modules. This curriculum is delivered by mentors to AG through group-based and safe spaces approaches. In COP 22, the DREAMS program will continue

to strengthen the delivery of evidence based curricular and interventions to prevent HIV and sexual violence among 10–14-year-olds. In COP 22, PEPFAR/E is also working with the Government of the Kingdom of Eswatini, Civil Society Organization and PEPFAR implementing partners to galvanize consented effort beyond the DREAMS and OVC platforms to accelerate efforts in addressing sexual violence and the broader GBV response.

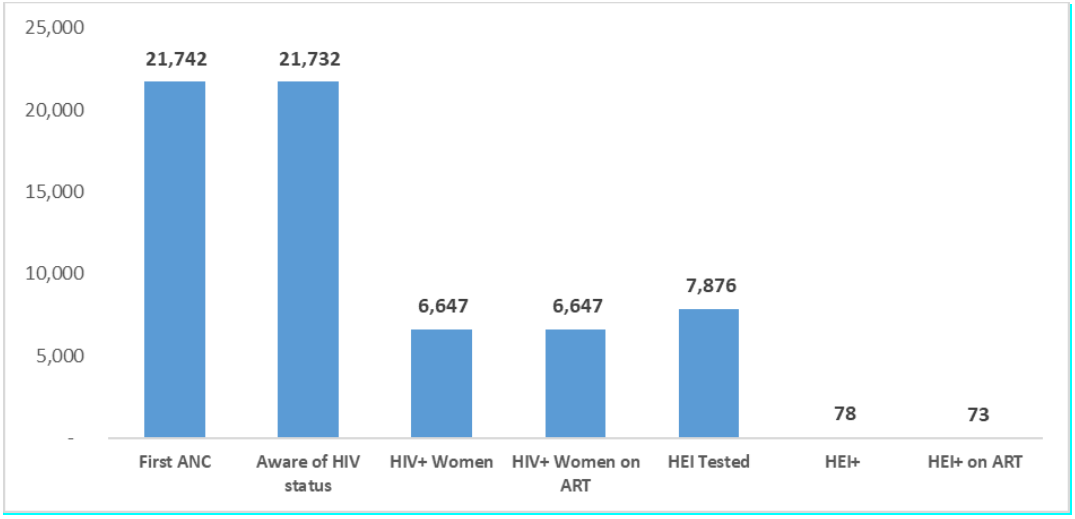
OVC

The three S/GAC modules for 10–14-year-old OVCs have been integrated into the home visitors' manual and delivered through small group sessions. The PEPFAR/E program will continue to strengthen and monitor the implementation of these evidence-based interventions to strengthen the response for HIV and violence against children. PEPFAR/E will further collaborate with the Deputy Prime Minister's Office will strengthen prevention of sexual violence using data from the VACS study to strengthen and guide the country's response to prevent sexual violence against children.

4.3. e. Children / PMTCT

Prevention of Mother-to-Child transmission (PMTCT)

Figure 4.3.e FY21 PMTCT Cascade



Source: PEPFAR program data, 2021

The national PMTCT program continues to demonstrate resilience despite the disruptions caused by COVID-19 and the recent civil unrest. This observation is supported by the high levels of awareness of HIV status at first ANC (ANC1), high ART coverage among pregnant women living with HIV (PWLHIV), high proxy early infant diagnosis (EID) coverage, and low mother-to-child transmission (MTCT) rate.

Despite these successes, the national PMTCT program continues to identify new HIV infections during ANC and at delivery, thereby limiting Eswatini's ability to achieve elimination of mother-to-child transmission. While the proportion of infants with unknown HIV status at 18-24 months has reduced from 47% in 2017 to 20% in FY21, the proportion remains unacceptably high. In addition, the misalignment between the numerator and denominator when calculating viral load coverage among pregnant women using the MER approach results in a proxy viral load coverage of less than 50%. PEPFAR/E will implement several strategies in COP22 to address the above gaps. These include:

a. Universally offering PrEP services to pregnant and breastfeeding women using the opt-out approach
b. Scaling up adolescent and youth-friendly services at health facilities
c. Strengthening collaboration between facility and community partners (DREAMS and OVC platforms) to improve AGYW bi-directional referrals, and track HIV-exposed infants with unknown final outcome
d. Expanding proactive follow-up of HIV-exposed infants to other existing community cadres such as the rural health motivators (RHMs)
e. Estimating viral load coverage among pregnant women using an approach similar to the one used for the general population
f. Leveraging CMIS to do cohort monitoring for viral load coverage for pregnant women
g. Rolling out point-of-care viral load testing for pregnant and breastfeeding women and children using the GeneXpert platform.

Pediatric Care and Treatment

PEPFAR/E continues to strengthen its pediatric care and treatment to ensure the best health outcomes for clients. COP22 approaches used include: 1) improve and optimize pediatric case-finding, 2) strengthen collaboration between clinicians and community health care service providers, and 3) improve VL coverage (VLC) and sustain VL suppression (VLS).

To enhance pediatric case-finding, PEPFAR/E will use a validated pediatric screening tool at selected points-of-entry and continue routine testing for high-risk pediatrics and biological children (less than 19 years) of newly identified and virally unsuppressed PLHIV. PEPFAR/E will leverage community partners to improve index testing and strengthen the use of care-giver assisted HIVST amongst eligible pediatric populations aged 2 years and older by further expanding access to HIVST through diversified distribution platforms.

To complement pediatric case finding efforts and improve health outcomes, PEPFAR/E will strengthen linkage to treatment of newly identified C/ALHIV by offering same day ART initiations. In addition, PEPFAR/E will offer services through the linkage case management (LCM) model in both the clinical and eligible community-based platforms. To continue C/ALHIV on treatment, PEPFAR/E will promote pediatric ARV client pickup through community-level and multi-month dispensing for all eligible C/ALHIV. PEPFAR/E will also continue to support DSD models for C/ALHIV, such as teen clubs and the Family-Centered Care model. In addition, healthcare workers will be trained in methods that support a seamless return-to-care for C/ALHIV after interruption in treatment.

To maintain viral load suppression and minimize gaps in VLC among certain pediatric age bands, PEPFAR/E will continue to focus on improving VLC and results turnaround time and reinforce efforts to promote pediatric treatment adherence. The adoption of POC VL testing will shorten turnaround time for clinical decision-making and decrease the need for repeated clinical visits. The expansion of VL DBS testing will relieve the pressure on the sample transportation network by prolonging sample integrity to reduce sample rejection rates and the need for patient blood redraws. PEPFAR/E will continue to offer optimized pediatric regimens that are easier to administer and adhere to for caregivers and clients, such as DTG-based and fixed-dose regimens. PEPFAR/E will continue to enhance referral networks to programs that offer social protection and other services for pediatric clients to improve retention-in-care, including OVC and key populations. PEPFAR/E will strengthen collaboration between the OVC program and the key population program to improve adherence and continuation in care of C/ALHIV of KPs.

Above Site Activities

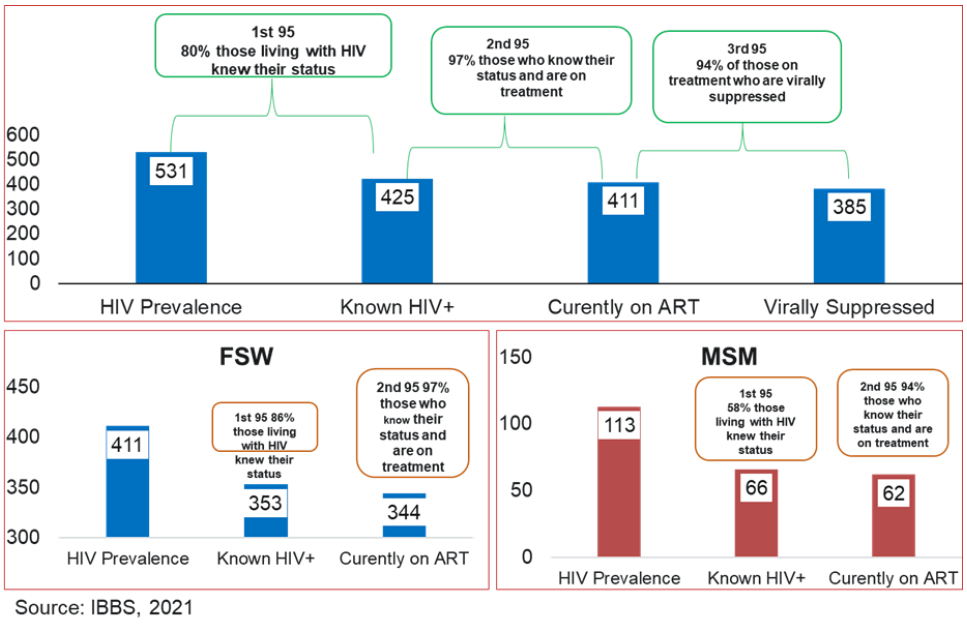
Although significant progress has been made toward the elimination of mother-to-child HIV transmission and across the pediatric HIV clinical cascade, there remains a definitive need for PEPFAR/E to support national-level TA to accelerate the pace toward optimal maternal and pediatric HIV outcomes, including the elimination of mother-to-child HIV transmission. In COP22 PEPFAR/E will provide support to ENPAP and PEPFAR will continue to provide national-level support to the Sexual and Reproductive Health Unit (SRHU) and the ENAP's pediatric care and treatment programs.

The Ministry of Health's ENAP and SRHU programs are responsible for the coordination of investments across stakeholders to ensure that Eswatini implements standards of practice aligned with current WHO PMTCT and pediatric HIV guidance. For example, through PEPFAR support, ENAP is spearheading the optimization of pediatric ART regimens (introduction of DTG 10mg Dispersible Tablet in COP20 and full transition of all eligible CLHIV to DTG-based regimens in COP21). In addition, the Ministry of Health's SRHU program has also tirelessly advocated for the integration of FP services within ART clinics, as an essential component of client-centered care. The COP21 above- site activities remain focused on enhancing clinical mentorship and supportive supervision to PMTCT and pediatric programs to ensure the implementation of comprehensive and quality services throughout the continuum of HIV care at health facilities.

4.3. f. Key Populations

PEPFAR/E provides a comprehensive prevention and treatment package of services to key populations, focused on FSW, MSM, transgender populations, people who inject drugs and people in prisons. Prevention interventions include HIV and recency testing, pre-exposure prophylaxis (PrEP), post exposure prophylaxis (PEP), GBV screening and services, along with sexual and reproductive health services including: STI screening and treatment, family planning, including condoms and lubricants. The treatment package HIV services includes HIV testing, antiretroviral treatment including adherence support for viral suppression, and psycho-social support.

Figure 4.3. f –1: KP cascade by KP type



Source: IBBS, 2021

In COP 22, the KP program will focus on improving case finding to close the gap of KPLHIV who know their status from 80% (IBBS, 2021) through the differentiated mobilization and HIV testing modalities. Social network and risk network referral strategies will be key strategies used to find KP who does not know their status, especially older MSM who stood at 27% among 35 to 39, 18% among 40 to 44 and 4% for MSM at 50 and older. Mobilization and testing strategies will be tailored to the needs of different age cohorts of KPs and KP type, along with maximizing the use of index testing, HIVST, mobile services and community centers. This will include not only KP platforms, but also strengthening of KP services offered through PEPFAR-supported clinical platforms, integrating the KP navigators to ensure KP access, case identification, and linkage. Once tested, PEPFAR will continue to ensure that differentiated treatment services are provided for KP and that KP access treatment services in facilities of their choice to ensure person-centered care. Viral load testing will be strengthened by increased awareness raising on U=U and accompaniment to eligible KP for VL testing.

The program also offers interventions to address structural barriers facing key populations. Structural interventions include economic empowerment and referrals to social protection, legal services, educational support, substance abuse reduction and violence prevention including gender-based violence. PEPFAR will continue to support violence prevention by integrating the following key areas: build core knowledge among implementers and key population communities; map the prevalence of violence and stakeholders working to address it; create networks to ensure key populations access to holistic services; create systems to detect and respond to violence, promote accountability to prevent violence, and document and monitor violence prevention and response programs including opportunities for feedback from survivors.

Pathways for Children of FSW and FSW aged 18 to 29 years will continue to be linked to the OVC and DREAMS programs respectively to ensure access to a comprehensive package of services for

children and young women. The KP program will utilize the mapping of structural interventions to continue to refer and link KP to other existing structural interventions to support improved HIV outcomes. These service networks will also be facilitated to PEPFAR-supported facilities to expand the referrals available for KPs.

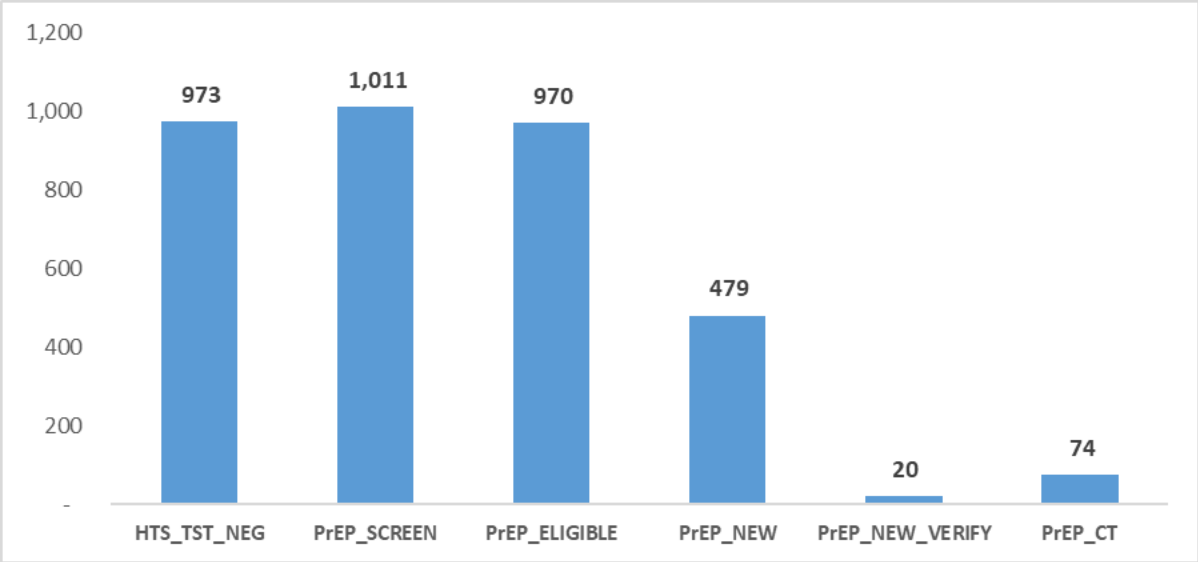
In COP22, PEPFAR/E will continue to work with the MOH, Royal Swazi Police Service (RSPS) and Human Rights Commission to address structural barriers to access to services for KP. The IBBS of 2021 shows a reduction in structural barriers in 2021 compared to 2011. However, stigma, discrimination and human rights violations continue to persist as substantial barriers to service uptake thereby increasing the risks for KP and their children. In response, PEPFAR/E will continue to address these barriers, and increase access to social and legal protection. The support will include training and mentoring the REPS (Royal Eswatini Police Services) and establish point of contact at key police stations and within the domestic violence units. PEPFAR will continue to work with the human rights commission to facilitate access to legal services for KP.

Building on COP21 model where the NUPAS capacity building approach was utilized to assess, characterize, and accredit CBOs in the stages of organizational growth, and to develop plans and indicators for tracking progress, in COP22, PEPFAR/E will monitor the growth of the organizations and target support to some CBOs who meet the benchmarks to graduate in a few years. PEPFAR/E support will continue to strengthen KP community centers (drop-in center equivalent) to expand packages of services to appeal to diverse KPs ensuring that the centers remain safe and accessible for all who seek services. To improve service delivery for KP, PEPFAR/E will support the development of KP competency standards that will be used by all service providers in delivering services for KP. This will also assist to strengthen health facilities to provide KP friendly services. The capacity strengthening of the KP community will include addressing the polarization of the networks of KP by funding a KP consortium to improve the advocacy agenda for inclusion and stigma and discrimination reduction.

Pre-Exposure Prophylaxis (PrEP) for Key Populations

PEPFAR/E will continue to scale up PrEP for key populations in COP22 among FSW, MSM, PWID, Transgender (TG) and People in closed settings. To reach KPs with PrEP, PEPFAR/E will offer PrEP to negative KP clients found through HIV testing including index testing; utilize HIV self-testing (HIVST) as an entry point for PrEP offer; and continue to deploy PrEP ambassadors by KP type to mobilize for PrEP linkage. Learning from COP21, PrEP packaging will be reviewed for scale up or adaptation to attract KP for improved uptake. Differentiated PrEP messages by KP type will continue to be disseminated in mass media, social media, and interpersonal communication to increase PrEP uptake. PEPFAR/E will support the MOH in the scale up of event-driven PrEP for men, aligned with WHO recommendations and national guidelines. To better understand PrEP use, exit interviews will be conducted with KPs to assess reasons for initiation, interruption, and reengagement of PrEP. The target for the number of new KP initiated PrEP will be increased from 2,328 in COP21 to 2,829 in COP22.

Figure 4.3.f-2 FY22 Q1 Prevention Continuum by Key Population Group



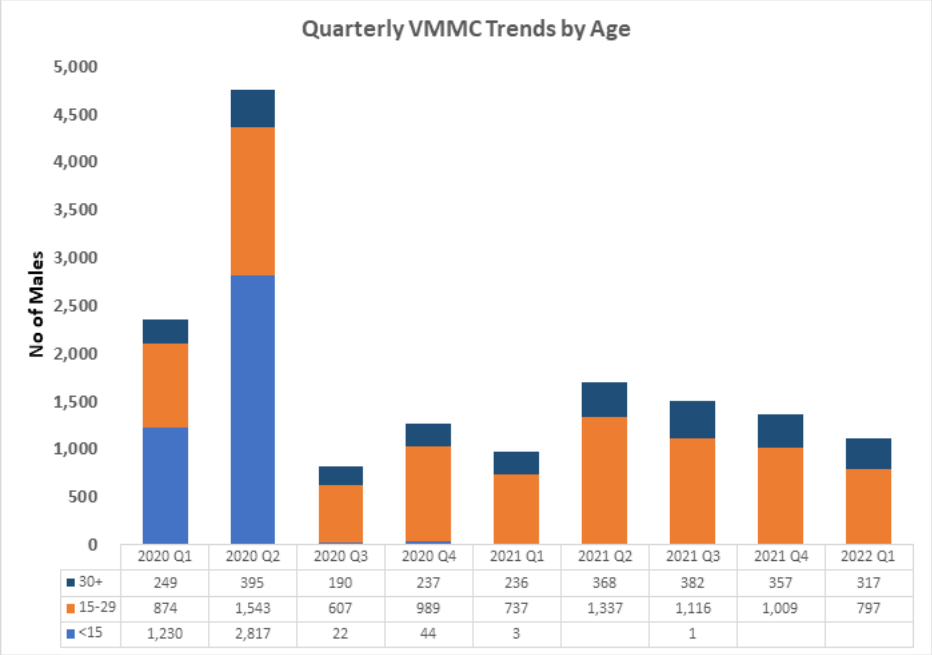
Source: PEPFAR program data, 2022

Above Site Activities

PEPFAR will continue to provide technical assistance to the national KP unit in MOH for strategic, operational planning, coordination, and program performance monitoring of the KP program. Continued support will be provided to ensure the utilization of the IBBS and tracking of the treatment cascade to ensure 95 95 95 for key populations, KP friendly services in health facilities with some certified as Centers of Excellence for KP services, strengthening of online programming including an online booking system for KP services developed in COP19 and expansion of service packages in the program and in KP community centers (drop-in centers). Training and sensitization for health care workers and law enforcement cadre will be conducted to address stigma and protect KP's human rights.

4.3.g. VMMC

Figure 4.3.g Quarterly VMMC reach by age group



	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
30+	249	395	190	237	236	368	382	357	317
15-29	874	1,543	607	989	737	1,337	1,116	1,009	797
<15	1,230	2,817	22	44	3		1		

Source: PEPFAR program data, 2020-2022

PEPFAR/E achieved 16% (1114/6983) of the FY22 VMMC_CIRC targets by end of Q1FY22 and the VMMC beneficiaries only targets 15+ since FY21. The negative impact of COVID-19 and the civil unrest in Q3-Q4 FY 21 is evident as the program reach continues to be on downward trend since Q2 2021. It is also common that Q1 data show a slow start of the program, and the program has put together strategies that will improve VMMC uptake in the next few quarters. The program is learning that there are still good lessons to learn from the other clinical partners on VMMC scale up especially on targeted demand creation and quality of VMMC service delivery. From the beginning of Q4 FY21 to Q1 FY22, the program implemented data-driven demand creation strategies using GIS and DMPPT2 data to identify areas with large volumes of uncircumcised men, targeting less saturated areas, and this improved performance particularly in Manzini and Shiselweni regions.

In Q3 and Q4 of FY21, the VMMC program started a major shift to implement nurse led VMMC as COP22 priority program shift required by PLL. The implementation started slow as it was heavily impacted by COVID 19. However, task shifting is beginning to pick up as a VMMC nurse has been hired to lead the task shifting agenda. A task shifting implementation plan was finalized and the first round of training for nurse VMMC providers was conducted in Q1 FY22. This is competency-based training, and the nurses are still undergoing follow up mentorship and coaching to reach the desired level of competency. Considering the prevailing COVID-19 pandemic, the program continues to ensure a safe environment for implementing VMMC activities. Monitoring sites and external assessments will be conducted to enhance continuous quality of care. The program is

currently implementing a demand creation campaign, aiming at motivating men in Eswatini to take more active role on health matters including VMMC and other HIV Prevention interventions. It is a 3-month surge effort aiming to circumcise at least 700 men per month. The program has struggled to reach targets and improve VMMC uptake and underperforming sites will increase adaptations to improve performance. The program will scale up task shifting of nurse-led implementation country wide. Enhanced supervision and mentoring systems will be increasingly important as the nurse-led program establishes and expands.

VMMC priorities for COP 22

In COP22, PEPFAR/E will continue to provide technical support to the MOH and other relevant government entities at the national and community level to manage and coordinate VMMC delivery. Safety is the primary consideration in the Eswatini VMMC program and the minimum age of eligibility for VMMC remains 15 years old. However, once ShangRing implementation is approved, the program will review the eligibility age to 13 years. The program will find efficient ways to implement VMMC within the limited budget without compromising on quality. The program will update the current VMMC policy which was developed July 2009 and provide TA to support the development of a VMMC transition and sustainability plan. The program's COP 22 strategic approach is to scale up task shifting, maintain quality, expand VMMC access, generate demand and improve efficiencies.

1. **Task Shifting:** The program will continue to support the Ministry of Health in the process of task shifting from a doctor-led program to a nurse-led program by scaling up proficient clinical-based trainings and providing mentorship to trained nurses as VMMC providers. Task shifting is heavily dependent on capacity building, mentorship, and coaching. This is a new skill among the new service providers and will require strengthening of quality assurance and CQI to monitor and respond to non-serious adverse events if they occur. Virtual training and mentorship through ECHO platforms will be scaled up to make mentoring frequent and impactful while making efficient use of time. Quality of services will continue to be a priority and support will be provided to the MOH and implementing partners to deliver effective, patient-centered, and human-rights- based quality VMMC services. The program will work with nurse-training institutions to incorporate VMMC skills into the pre-service curriculum and in the clinical procedure manual. Facility managers will be oriented on their role for task shifting to improve support towards service integration at the facility level. Capacity building will be scaled up in COP 22 for additional facilities on VMMC to increase the number of service providers.

2. **Expand Access:** In COP 22, The program will also introduce device-based VMMC, ShangRing, and additionally accredit more sites beyond the 15 fixed sites to make the service more routinized and widely available. In addition to offering VMMC services at the

15 fixed sites across the country, outreach clinics will be expanded to increase access to services including optimizing the use of mobile clinics. Referrals will be strengthened from other HIV prevention programs including PrEP. The program will further strengthen community referrals, specifically focusing on leveraging Fatih and Community Initiative (FCI) referrals from health committees. PEPFAR/E will continue to provide direct surgical service delivery to circumcise 6,285 men. COP22 funding will support DSD at the current fixed 15 sites and new sites that will be accredited by the MoH as well as through outreach VMMC services, providing evidence-based demand creation, salary support for health care providers and mobilizers, procurement and logistics for circumcision kits, and quality assurance activities. Specific focus will to improve intra and inter facility referrals, referrals through champions and satisfied clients at community level, and referrals from navigators who link interested clients from HIV prevention program to VMMC. Service provision during the weekend will be scaled up to accommodate the needs of target groups. The program will introduce VMMC camps in areas with poor VMMC coverage. VMMC sites will strengthen relationships with ART sites to assure that immediate linkage to treatment is available for those testing positive.

3. **Demand generation:** Demand creation campaign will leverage the community based VMMC champions and will be targeted based on the analysis of DMPPT2 data, which is currently being updated to provide more current information of VMMC coverage to precisely inform demand creation. Implementing partners will continue to use the social media platform and other virtual platforms to maximize their reach. The program will further support the national VMMC coordination office to conduct quarterly data reviews to produce data for evidence-based decision making. For those presenting for VMMC services between 10-14 years of age, age appropriate sexual and reproductive health education will be provided along with education on returning for VMMC at age 15. The program will continue to implement the person-centered model for demand creation through VMMC Champions-led community demand creation in each region involving the church, traditional leaders, women's group and men's regiment. Activities will explore other social media platforms to promote VMMC and improve referrals across partners such as between Key populations IPs with VMMC IPs. In COP 22, above site TA will continue to provide technical assistance to develop and strengthen national and regional demand creation strategies and support the development of a system to monitor them.

4. **Maintain quality**: To achieve 80% coverage target among 15-29 years old and attain sustained epidemic control, PEPFAR will prioritize TA to ensure the quality of services and data for decision-making. Advocacy by the community, traditional, and government leadership will be leveraged to create demand for the program. The program will explore the use of incentives given to clients for VMMC uptake. The incentives will be non-coercive in type and quantity, designed to overcome practical barriers to obtaining male circumcision such as covering out-of-pocket costs. The use of incentives will include

monitoring effectiveness and an evaluation plan. PEPFAR will continue to support the government to implement adverse event reporting. The country has not had an external quality assurance (EQA) of the VMMC program due to COVID travel restrictions but with lifting of restrictions, EQA is planned for COP 22. The program will strengthen CQI teams to maintain the quality of VMMC services during the scale-up of nurse-led VMMC. TA will be provided to support Quality Improvement Plan (QIP) development to respond to identified gaps during quality assessments. Support will be extended to the VMMC national office to monitor Adverse Event (AE) and conduct an AE audit to inform program strategies as nurse-led VMMC scales up. HIV testing is not a requirement to receive VMMC. However, testing will remain available to any VMMC client. In recent years, severe adverse events have been reported among men living with HIV who have received VMMC services. Although men living with HIV are eligible for VMMC, they should be on ART and virally suppressed prior to being circumcised to optimize immunocompetence for wound healing and decrease risk of infection, and to decrease the risk of HIV transmission especially with a circumcision wound that is not fully healed. Starting in COP22, at a minimum, all clients known to be living with HIV will be compliant on ART for at least 3 months prior to receiving circumcision. Men with ongoing high-risk sexual behavior testing HIV negative for HIV will be offered VMMC and/or referred for PrEP.

5. **Improve efficiency:** From the beginning of COP20, the program made significant improvements to transition to reusable kits to support long term sustainability, reduce costs, improve procedure quality, and reduce waste. In COP 22, the program will continue to scale up transition to reusable kits. The unit expenditure has been increasing in part because of COVID 19 mitigation strategies as well as an increase in commodity costs. The program will maximize efficiencies through consolidation of partners to reduce HR expenditure and demand creation costs and to ensure limited regional competition of clients among partners. A 10% target drop reflects the increased focus of resources in task shifting and mentoring to ensure quality and expanded access as well as to create adequate demand for services, while absorbing a 25% overall budget reduction for the program

4.3. h. Pre-Exposure Prophylaxis (PrEP)

PEPFAR/E supports a fully integrated government-led sustainable PrEP program by continuing to implement the operational plan developed in COP18. By the end of COP21, 155 PEPFAR-supported facilities had been activated to offer PrEP, and nationally, PrEP is offered at 208 sites6. Observed barriers to PrEP uptake and continued use include 1) lack of knowledge about PrEP and its benefits; 2) limited PrEP options especially for women. To address these barriers, in COP22 PEPFAR/E will support PrEP expansion through: 1) expanding differentiated and integrated service delivery; 2) generating demand for PrEP in targeted and general audiences; 3) using

6 Source: MOH HMIS Data, February 2022

custom data for decision-making; and 4) supporting the introduction of new biomedical prevention products and regimens. These strategies will be implemented across the PEPFAR program in facility and community platforms and tailored to vulnerable populations including AGYW and KPs. Specifically, PEPFAR/Eswatini will:

a. **Expand differentiated and integrated PrEP service delivery:** PrEP will be offered at all facility access points using an opt-out approach. PrEP services, as part of the full range of combination prevention services, will be offered to those who test negative, including individuals identified through index testing and individuals who test negative using HIV self-testing. PrEP will be scaled-up at private and community access points, including increasing the number of mobile clinic visits, having designated "PrEP days" at the mobile clinics, and deploying PrEP mobilisers/ambassadors in the community. Additionally, to improve PrEP uptake and effective use among men, PEPFAR/E will support event-driven PrEP as an alternate dosing strategy for men as aligned with WHO recommendations and national guidelines.
b. **Generate demand for PrEP in targeted and general audiences:** To normalize PrEP, PEPFAR/E will identify or develop messages to generate PrEP demand among targeted and general audiences using messages from the national PrEP communications strategy finalized in COP21; the use of human-centered design (HCD) models for targeted PrEP campaigns in the community; and the use of social behavioral change (SBC) strategies to address structural barriers and stigma reduction. PrEP messages will be deployed through mass media, online, and through interpersonal communication by DREAMS and KP ambassadors in the community. Onsite training for healthcare workers will be conducted at different entry points and refresher training for community partners will be held, emphasizing the normalization of PrEP and relevant PrEP messages for priority populations. PEPFAR/E will continue to support the re-labeling of PrEP bottles for all populations, specifically AGYW and key populations, to address stigma issues attached to ARV bottles.
c. **Use custom data for decision-making:** PEPFAR/E will use custom indicators to closely monitor the uptake and continued use of PrEP among priority populations (adolescent girls and young women; men 25-39; key populations; and pregnant and lactating women) and the general population. PEPFAR/E will also monitor PrEP coverage, PrEP offer, and PrEP acceptance by access points, and closely track PrEP referrals by both community and facility partners to ensure the completion of PrEP referrals.
d. **Support the introduction of new biomedical HIV prevention products:** PEPFAR/E will support an implementation science study to assess the feasibility and acceptability of the PrEP ring, a monthly, self-administered, insertable ring for HIV prevention for cisgender women. This study will inform PrEP programming broadly and provide a roadmap for the introduction of forthcoming biomedical prevention products (e.g., injectable PrEP).

Strategies for PrEP delivery are also detailed in the DREAMS section (4.3.b) and Key populations sections (4.3.f).

Above Site Activities

At the national level, PEPFAR will continue to support the MOH to coordinate and manage the implementation of the PrEP operational plan, including updating of PrEP tools, standardization of training materials, packaging of messages from the demand creation and communication strategy and inclusion of PrEP in training curricula of all health cadres. In COP22, PEPFAR/E will support the introduction of new biomedical prevention products and regimens. This will include planning and forecasting for the roll-out of new PrEP products.

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

The country-specific priorities from planning level letter are addressed throughout the appropriate sections of SDS.

4.5 Additional Program Priorities

4.5. a. Advanced HIV Disease Management (AHD)

Mortality from TB and cryptococcal diseases remain high in Eswatini at 13% and 17% respectively (Eswatini AHD report, 2020). To reduce morbidity and mortality among PLHIV, PEPFAR/E will support the training, scale up, and routine M&E of advanced HIV disease (AHD) package to identify TB, cryptococcus, histoplasmosis and other serious infections. PEPFAR/E will fund the procurement of point of care CD4 test kits (Visitect/ PIMA) to enable identification of patients presenting with AHD among new ART patients, those failing ART and patients returning to ART after interrupting treatment for ≥1 year. PEPFAR/E will support MOH programs to decentralize the AHD package to lower-level facilities. Serum CrAg screening for cryptococcal disease and TB LAM for diagnosing TB will be used.

4.5.b. TB case identification and treatment among PLHIV

Eswatini experienced increasing ART coverage and a continuous decline in TB case notifications from 11,057 in 2010 to 2,259 in 2020 nationally. Enhanced TB/HIV collaborative activities and use of more sensitive GeneXpert platforms facilitated early TB case detection. However, the decline between 2019 (n=2,900) and 2020 (n=2,259) is due to COVID-19 pandemicrelated missed TB cases. Consequently, estimated TB treatment coverage dropped from 69% to 58% (WHO Global TB reports, 2020, 2021).

PEPFAR/E will support the National TB Control Program (NTCP) and HIV program (ENAP) to regain pre-COVID levels of TB case detection. The following will be implemented to increase TB presumptive yield, TB case detection and treatment coverage:

- C-reactive protein (CRP) screening strategy will be implemented for new ART patients.
- Decentralized TB LAM testing will be implemented on expanded population of PLHIV and will include those who are TB presumptive regardless of CD4 count and in-patients with CD4 count <200 cells/ml.
- Promoting stool-based TB diagnosis for children.
- Conducting TB screening audits to identify areas for improvement to improve use with fidelity and TB presumptive yield.
- Improving facility-community TB/HIV collaboration at community level through linking community TB champions with DREAMS/OVC programs to support specimen collection and referrals.
- Training of health care workers on revised screening, diagnostic and treatment algorithms.

PEPFAR/E will also support MOH to implement TB sequencing diagnostics to mitigate findings from the Eswatini TB drug resistance survey (2018) which showed that 58% of rifampicin resistant TB cases are missed by the GeneXpert platform due to prevalent Ile491Phe mutation hence are at risk of receiving inappropriate treatment.

4.5.c. TB Preventive Therapy

TB preventive therapy (TPT) has been scaled up at ART clinics. The program is scaling up 3HP in 2022. Completion rates are high at 97%, based on Q4 FY21 results. The OU targets to initiate, and complete, TPT for 30,368 ART patients by the end of FY23.

In COP22, PEPFAR/E will support MOH to reach and maintain full TPT coverage among all eligible PLHIV (both newly enrolled on ART and patients already on ART). Building from the Global Fund supported TPT strategic initiatives, PEPFAR/E will support the following initiatives:

a. Early TPT initiation: Eswatini guidelines allow patients to initiate TPT at one month after starting ART. TB presumptive patients will be tested for TB using Xpert Ultra and immediately start TB treatment if diagnosed with TB. Those who do not have evidence of TB will receive TPT.
b. Integrating TPT activities with DSD models, including efficiently aligning and harmonizing TPT provision with multi-month dispensing to optimize TPT acceptability and uptake.
c. Training healthcare workers on TPT including use of short-term regimens.
d. Conducting facility audits, reviews and QIPs to improve uptake among eligible ART patients.

4.5. d. ART, viral suppression and reducing TB mortality in TB/HIV patients

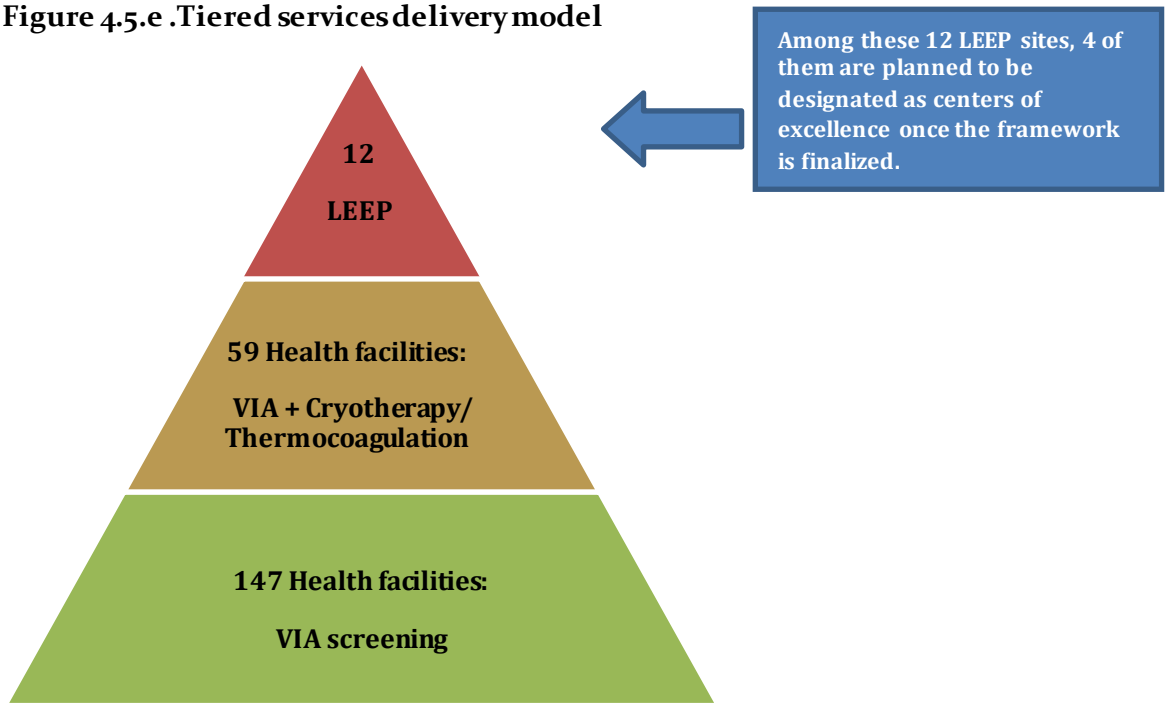
To maintain high ART coverage, currently at 98% (MOH annual report 2020, PEPFAR APR 2021), and improve quality of care for all HIV-positive TB patients, PEPFAR/E will support:

- Continued expansion of the integrated service delivery model seeking to increase number of ART sites accredited to become TB basic management units (TB BMUs).
- Integration of non-communicable disease screening, using lessons from ongoing TB mortality reviews to increase quality of care and reduce mortality among TB/HIV coinfected patients.
- Strengthen the use of effective regimens including dolutegravir and provide technical support in appropriate ART regimen for clients who require second and third-line regimens.

4.5.e. Cervical Cancer Program

Beginning COP21, 147 PEPFAR-supported facilities were offering cervical cancer screening services using Visual Inspection with Acetic acid (VIA). These sites are a combination of ART clinics and public health units offering Maternal and Child Health (MCH) services. Mobile screening services are also offered by PEPFAR partners providing community services. In COP22 PEPFAR/E will continue to increase access to VIA based screening services to HIV positive women through a tiered service delivery model. All 147 PEPFAR supported facilities will continue to provide screening services according to a tiered approach as shown (see Figure4.9.1)

Figure 4.5.e .Tiered services delivery model



Source: PEPFAR Eswatini Program data, FY21 Q4

The overall focus of the PEPFAR/E Cervical Cancer program in COP22 is on re-gaining the milestones achieved prior to COVID-19. This will be achieved through:

- optimizing cervical cancer screening while ensuring that targeted age groups are reached,
- ensuring provision of quality cervical cancer screening and treatment services,
- improving linkage to treatment of all women found to have pre-invasive lesions
- putting strategies in place to refer women screening positive for cervical cancer to the appropriate treatment.

Specifically, PEPFAR/E will:

1. Optimize cervical cancer screening while ensuring that targeted age groups are reached: To reach more eligible women with screening services, the cervical cancer program will expand demand creation strategies being implemented during COP21. These will include use of videos at waiting areas, leveraging on alternative platforms including VMMC platforms and PMTCT service delivery points for demand creation. Training will continue to be supported to ensure that the number of service providers is increased in facilities. To increase the provision of screening services, roving teams and mobile screening services will be expanded.
2. Ensure offering of quality cervical cancer screening and treatment services. In COP22, the national quality assurance framework will be implemented. This framework will, among other things, assist with defining the quality standards for cervical cancer services, standardizing the national training curricula, and establishing cervical cancer centers of excellence. PEPFAR/E will work with the National Cancer Coordinating Unit and the Eswatini Health Laboratory Services on meeting the benchmarks for introducing HPV DNA testing in the testing algorithm.
3. Improve linkage to treatment of all women found to have pre- invasive lesions: The program will establish clear referral mechanisms (with feedback) for women needing treatment not available on site. To ensure easy service access and closure of referral loops, partnerships between facilities will be strengthened. The procurement of thermo-coagulators will be prioritized to ensure that most facilities currently offering screening services only are capacitated to also offer treatment services. Use of thermo-coagulation as a treatment modality will be expanded through supporting procurement and service provider training targeting sites that are currently offering only screening services.

Above Site Activities

PEPFAR/E will continue to provide technical support to the MOH's cervical cancer program in planning, coordination, data collection, analysis & utilization. In COP22, PEPFAR/E will continue to support the procurement and placement of equipment in the different supported facilities. The procurement of thermo-coagulators will be prioritized to ensure that most facilities currently offering screening services only are capacitated to also offer treatment services. Training will be supported to ensure that the number of service providers in facilities is increased. PEPFAR/E will work with the National Cancer Control Unit to ensure that supplies and equipment are included in the national quantification and maintenance plans. Support will continue to be provided to the laboratory systems to strengthen and expedite timely processing of LEEP samples and return of

results to guide patient care and support. To ensure provision of quality cervical cancer services, PEPFAR/E will ensure that a national quality assurance framework is implemented with fidelity.

4.6 Commodities

Eswatini does not anticipate any commodity gaps due to funding gaps or stock outs in COP22, to supplemental GKoE funding for commodities. PEPFAR/E will support the procurement of all first-line Pediatric ARVs and the following commodities:

1. RTKs including Rapid test kits for recency testing,
2. Viral load reagents and consumables,
3. POC EID/VL reagents and consumables,
4. Condoms and personal lubricants
5. VMMC commodities and consumables, including the Shang ring.

The Global Fund will further support the GKoE with the procurement of:

a. Tuberculosis treatment and prophylaxis drugs,
b. RTKs including Self-Test HIV kits,
c. POC EID reagents and consumables,
d. Adult ARVs and PrEP,
e. Condoms and personal lubricants,
f. Tuberculosis diagnosis lab reagents and consumables, and
g. Advanced HIV disease diagnosis kits (TB LAM Ag, serum CrAg).

PEPFAR/E will continue to support the procurement of VL reagents and consumables through all-inclusive pricing models for Hologic and Roche VL platforms. PEPFAR/E and MOH/GF will closely monitor the international supply chain dynamics for selected key products from their production, freight, and lead-time. In COP21, orders were placed early and closely tracked by PEPFAR/E. PEPFAR/E plans to continue the practice of placing orders early for COP22 to mitigate any challenges in global supply and delivery as well as mitigate increases in freight costs. PEPFAR/E will leverage existing investments and efforts made by the MOH and global donor community to roll out eLMIS within the public health supply chain to improve stock accountability and expand capacity for end-to-end data visibility. PEPFAR/E will continue to support Regional Logistics Officers to respond to facility-level supply chain challenges, including stock management and reporting. PEPFAR/E will support the country in the CCD model in line with the country's COVID-19.

Condoms

Securing adequate funding and procuring Condoms remain a key intervention for the HIV/AIDS prevention response in Eswatini. PEPFAR/E will support the GKoE with procurement of public sector female and male condoms and lubricants. This procurement support will be complemented by advocating to the GKoE for its subsequent incremental funding commitments to condom and lubricant procurements.

4.7 Collaboration, Integration and Monitoring

4.7. a. Cross-Technical Collaboration

PEPFAR, MOH and Donor collaboration

The PEPFAR Eswatini program is structured around strong interagency coordination. Weekly interagency technical meetings are used to coordinate programming for clinical services, prevention, strategic information, and health system strengthening. The full interagency PEPFAR team as well as agency leadership meet weekly. PEPFAR program areas form an integrated cascade across the three 95s, with the community, facility, and health system programming successfully providing or supporting comprehensive service provision.

PEPFAR/E participates in a number of stakeholder forums that improve collaboration and coordination between MOH, GF and other external stakeholders. These include but are not limited to:

i. **CCM:** The CCM coordinates all GF activities in the country, and includes representatives from PEPFAR, MOH, UNAIDS, WHO, CS and other stakeholders. PEPFAR/E technical team participated in the 2022-2025 HIV Grant writing process.
ii. **TWGs**: The TWGs, chaired primarily by the MOH and NERCHA, are designed to coordinate ongoing activities within the different program areas across all donors/partners. PEPFAR/E participates as members of these TWGs.
iii. **Commodity Planning**: PEPFAR/E also regularly engages directly with MOH and GF around issues related to commodities and programming.
iv. **UNAIDS development partner meetings**: Quarterly meeting between UN Agencies, NERCHA, and donors to coordinate activities. Monthly meetings between PEPFAR Coordinator and UNAIDS to coordinate activities.

The above regular engagements ensure that there is collaboration and no duplication in implementation or procurement across donors/partners.

Private Sector Engagement

As a small economy, Eswatini does not have a robust-large private sector to facilitate large scale cocreation and responsibility to support the HIV response. PEPFAR/E, however, has a long-standing public private partnership (PPP) with Coca-Cola and the Matsapha Town Council that targets the economically mobile population of Matsapha. In collaboration with Business Eswatini, the PPP fills gaps in access to services, through the provision of comprehensive clinical services at times and places that are convenient to the population of Matsapha. The model includes workplace service provision to reach hard to reach populations in spaces and times convenient to them. This model could potentially be replicated with other companies in the private sector as part of PEPFAR/E's sustainability strategy.

With the emergence of the COVID-19 pandemic, PEPFAR/E has significantly increased engagements with the private sector through numerous partnerships that were formed to support the COVID-19 response, including the Coca-cola Foundation, Kirsh Foundation, Standard Bank as well as the arts and culture industry through the Bushfire festival. The partnerships that have been ignited serve as a platform for PEPFAR/E to further harness private sector resources for the

HIV response. In COP 22, PEPFAR/E will leverage such partnerships built from the COVID -19 response, to harvest private sector technologies, models and resources to strengthen client centered approaches as well as build sustainability of Eswatini's HIV response. Within the DREAMS program, PEPFAR/E will leverage private sector resources to increase opportunities for AGYW to engage in economic strengthening activities, while for the treatment program, partnerships with the private sector will include the use of smart lockers, supporting last mile distribution as well as digital health.

PEPFAR has successfully invested in health information systems that have already drastically improved data flows for decision making and are now leveraging systems to strengthen client centered digital services to address key programmatic HIV/TB challenges. The scale, impact and sustainability of these systems has been impeded by power and connectivity challenges. Building on recent success of MTN private sector partnership to scale up APN back up network, in COP 22, PEPFAR/E will work with Power Africa and private sector partners to secure 3:1 match in investment to equip all PEPFAR supported facilities with reliable and sustainable electrification and connectivity.

4.7. b. IP Management

PEPFAR/E regularly holds joint partner meetings to review data, measure progress towards targets and identify innovative strategies that can be implemented throughout HIV/AIDS programs in Eswatini. During COP20 and COP21 implementation, regular SIMS visits were interrupted due to COVID19. However, virtual monthly meetings with detailed partner presentation were conducted to determine partner performance. SIMS visits will resume in COP21 and be continued in COP22 either in person or virtually, depending on the conditions on the ground. Visits will be conducted by both technical and business staff to achieve comprehensive assessments of IP's performance. Quarterly preparation for POART calls also strengthens IP management through standard reporting mechanisms.

For all partners, monthly reviews of granular data and custom indicators, financial outlays and obligations are conducted to identify problems early and implement corrective actions to address them. CDC plans to implement separate monthly financial meetings to improve financial management and to flag disproportionate burn rates to program output. DOD will continue to conduct monthly IP management meetings, monthly financial oversight meetings, and complete annual SIMS assessments for each of the operating Umbutfo Eswatini Defense Force sites. USAID will be conducting routine site visits and monthly meetings with partners to review progress and expenditure. The site visits and meetings will involve technical staff who will focus on performance, and business staff who will focus on expenditure and outlays. Regular partner meetings are convened to share best practices and lessons learned. As necessary, PEPFAR/E staff review weekly updates from poor or underperforming partners to monitor progress towards targets. Monthly and quarterly partner SI meetings are conducted to review results and reporting requirements and to provide guidance. The Agency Leadership will continue to cover the interagency business processes.

PEPFAR has continued to support the phase two Diagnostic Network Optimization process to optimize existing VL testing platforms and integrate POC VL monitoring. This will be achieved by multiplexing existing near POC platforms (e.g., GeneXpert) and add to the existing conventional

system in order to increase access to and coverage of VL especially for PBFW, AGYW and the under15 year old who continue to show suboptimal VL coverage and suppression. PEPFAR/E will continue to work with the MOH and other stakeholders to monitor the DNO implementation plan which will include placement of platforms with the capacity of performing EID and both plasma and DBS VL testing. Such platforms have already been identified and will replace existing platforms at regional level that have become obsolete. In collaboration with GF, PEPFAR will continue to support HR at the four centralized VL testing laboratories to reduce interruption of testing activities.

4.7. c. Quality through improved models of care

PEPFAR/E utilizes MER and SIMS data and the community monitoring platform to improve quality of prevention and treatment services delivered at both facility and community levels. This includes but not limited to regular review of i) index cascades; ii) missed appointment/patient tracking cascades; iii) cohort linkage data; iv) high viral load cascades; v) PrEP initiation and continuation cascades; and vi) DREAMS layering by site, age, sex, and region. Completion of referrals and facility and community linkages focusing on KP, OVC, GBV, and KP are also key outputs that will be monitored. This combination of MER and custom indicators is used to track and continuously improve program quality and forms a critical part of partner management. DOD has successfully implemented the ISO 9001:2015 at its referral facility at Phocweni and it will continue to improve and expand on this quality management system as well as the ISO 15189 laboratory management system.

PEPFAR continues to invest in monitoring and maintaining program quality improvement nationally through the Ministry of Health Quality Management Program, regionally through placement of program quality leads within each of the four regional health management teams (RHMTs), and at facility and community levels through the implementing partners. In COP 22, PEPFAR/E will build on foundational program quality elements and structures to consolidate leadership and coordination under the MoH quality management program and senior management team. Priority activities include; 1) leading semi-annual program reviews and ensuring corrective actions are taken to address identified gaps, 2) driving national quality improvement initiatives, simplifying and scaling site quality certification and, 3) working through the office of the Senior Health Administrator, supporting operationalization of the recently endorsed RHMT terms of reference.

4.7. d. Community Led Monitoring

CLM is being implemented by CSOs under the leadership of CANGO, the umbrella body for NGOs in Eswatini and coordinator for CLM, and Community Engagement and Rehabilitation Alliance (CERA), the technical Coordinator for CLM. CANGO and CERA support 4 CBOs who conduct assessments at facilities in each region. CLM oversight is carried out through a Steering committee. The steering committee is constituted as a national level body with multi-stakeholder

representation whose responsibility is to foster the ownership of the platform and to ensure the integration and actioning of the systematic corrective actions for barriers to accessing health services that would be identified through CLM.

In COP 21 PEPFAR/E, working in collaboration with UNAIDS, continued to provide support to the CLM by providing technical assistance for the CLM tool development and indicator calibration processes. Technical assistance also served to identify an interim CLM platform for implementation (COMMCARE) while the development of the CLM module within the CDAP is ongoing. While the focus for CLM in COP 21 was to scale reach to facilities for a greater opportunity for client feedback at facilities, for COP 22, CLM implementation builds on facility coverage and assessed HIV services by increasing both facility coverage and the services being assessed to include PrEP and DREAMS services. This includes a population focus on AGYW (15 – 24 years), KP and men. CLM will also diversify data collection approaches and tools to include a mixed methods approach for data collection and the utilization of the community score card and other qualitative tools. The expansion of these modalities will serve to pull additional insights and nuances from clients' feedback.

Under the leadership of CANGO, [supported by CERA and the implementing CBOs] supported by PEPFAR/E and UNAIDS, CLM results are reported on a monthly basis to participating facilities and on a quarterly basis to the region though Reginal Health Management Teams (RHMTs) and quarterly at National level as well. At all levels corrective action plans are developed and recommendations made to address issues identified through CLM. In COP 22 PEPFAR/E in collaboration with UNAIDS, will work to strengthen data utilization and build the sustainability of CLM by establishing a data analysis and advocacy group drawn from implementing CSOs and key stakeholders. The advocacy group will develop a long-term advocacy plan in order to strengthen CLM ownership among stakeholders and facilitate a consistent and iterative process of service improvement.

CLM in Eswatini has a strong focus on key populations and currently implements a KP services specific assessment tool and a focal CBO conducting assessment in KP sites. Furthermore, KP networks were consulted and participated in the development of the CLM KP tool such that the tool integrated the local KP networks service delivery assessment tool. COP22 civil society consultations revealed significant gaps in understanding of and addressing barriers for people with disabilities (PWD) in relation to HIV services. Following these consultations, the PEPFAR program designated an additional grant in COP21 for the development and implementation of a PWD tool, following on the process for engagement and implementation for KPs. PWD-specific CLM work will continue in COP22. In COP 22 CLM will strengthen the integration of KP and PWD networks and PLHIV into CLM coordination mechanism and implementation of CLM.

4.7 e PEPFAR HRH Footprint and Direction

PEPFAR supports over half of the donor-supported HRH (~1,400 positions), with the majority of positions sitting with the Eswatini National AIDS Program (ENAP) to support lab service provision at the National and Regional levels. In addition to these positions, PEPFAR/E also supports community cadres through implementing partners, who provide decentralized prevention and care services at the community level in coordination with health facilities.

PEPFAR HRH systems' support in COP 22 will seek to work closely with government counterparts to examine the current HRH health system priorities and adjust PEPFAR-supported HRH to

match these priorities. PEPFAR will work directly with the Ministry of Public Service to examine the current footprint of HRH supported by PEPFAR and generate a process for transition or consolidation of positions and new recruitments in accordance with the HR guidelines. This will be guided by the Ministry of Public Service's HRH recruitment guidelines in close consultation with senior management at the Ministry of Health to guide the process. This will ensure the operationalization of the recruitment guidelines, standardization of pay packages, and job descriptions, which will be applied to the different PEPFAR-supported HRH. In addition, PEPFAR will also strive to strengthen the MOH and Ministry of Public Service's joint coordination of technical trainings, which are implemented by an array of partners. Given the Ministry of Public Service's appointed role and priority to revise the training programs for civil servants, this offers the opportunity to strengthen HIV nursing curriculum and the BTech laboratory & pharmacy programs offered by Good Shepherd Nursing College, University of Eswatini (UNESWA) and the Southern Africa Nazarene University.

As PEPFAR support evolves, there is need to broaden partnerships beyond Ministry of Health that has traditionally been the key government recipient of support. PEPFAR will work to identify opportunities to leverage other donor funding, such as efforts currently supported through the World Bank's five-year HSS grant with the MOH. Further, coordinating with other Ministries such as the Ministry of Education, Social Welfare and Finance and UNESWA is important given their equities and role in sustaining HRH that play an essential role in health systems functions.

4.8 Targets by population

Table 4.8.1. ART Targets by Prioritization for Epidemic Control

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY22)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY23) *TX_CURR***	**Newly initiated (APR FY23) *TX_NEW***	**ART Coverage (APR 23)**
Attained	215,208	209,531	N/A	214,040	9,343	99%

Source: PEPFAR program data 2021 and COP22 targets

Table 4.8.2 VMMC coverage and targets by age bracket

	Population Size Estimate† (SNUs)	**Current National Coverage** (end 2021)**	**VMMC_CIRC PEPFAR-supported targets (in FY23)**	**Targeted National Coverage** (in FY23)**
15-29	174,554	46%	4,657	53%
30+	182,079	36%	1,628	38%
Total	**356,633**	**39%**	**6,285**	**43%**

**Estimated coverage informed by Decision-Maker's Program Planning Tool (DMPPT2) and FY2021 program data
†Estimated 2022 population based on Spectrum outputs

The above table shows PEPFAR/E's VMMC Coverage and Targets by Age 15-29 and over 30 for COP22.

Table 4.8.3. Target populations for Prevention interventions to facilitate Epidemic Control

Target Populations	Population Size Estimate†	Disease Burden)	FY23 Target**
AG 10-19*	87,094	5.3%	25,436
YW 20-29*	75,3331	29.2%	30,070
FSW	14,581	58.8%	14,290
MSM	5,754	21%	3,452
PWID	1,279*	n/a	100
TG	119*	42.2%	20

*Represents DREAMS SNUs only

†AGYW population size is sourced from saturation analysis tool for COP 22. KP population sizes are based on the 2016 IBBS.

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

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

Table 4.8.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23Target) OVC_SERV Comprehensive	Target # of OVC (FY23Target) OVC_SERV Preventative	Target # of active OVC (FY23Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Hhohho	107,818	20,412	1,953	2,071	11,216
Lubombo	101,483	23,744	3,230	1,886	12,462
Manzini	73,350	24,438	2,838	3,682	11,941
Shiselweni	72,698	13,129	1,683	1,112	7,161
TOTAL	**355,349**	**81,723**	**9,704**	**8,751**	**42,780**

Source: PEPFAR Program data 2021 and COP22 Target

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

5.1. Above site activities mapped to key barriers

PEPFAR/E identified key barriers gaps to achieving epidemic control by 2025 through analysis of the SID 2021 findings, MER results and SIMS visit reports. These barriers include:

1) COMMODITY SECURTY AND SUPPLY CHAIN: Inadequate and inconsistent supplies of drugs and commodities at facility level;

2) EPIDEMIOLOGICAL & HEALTH DATA FOR DECISION MAKING: Limited complete and correct Electronic Medical Records and inadequate GoKE capacity to implement national surveillance activity and to use Epidemic and Health Data;

3) LABORATORY: Inadequate laboratory systems (e.g. specimen transport systems, quality management systems, and accreditation), and limited GoKE's resource to monitor HIV/TB drug resistance and support for continuous training on lab professional development;

4) SERVICE DELIVERY: Inadequate community systems to improve linkage and retention;

The lack of proper coordination between the Civil Service Commission and MOH's planning and HR units in recruitment, allocation and retention of HR is an overarching issue that affects all those vulnerabilities.

COP22 above site activities are mapped to the aforementioned key barriers as well as minimum requirements to support: 1) the establishment of a functional procurement and supply chain management system, 2) strengthen government capacity to monitor epidemiological trend and use data for program readjustment, 3) laboratory system and lab professional capacity building and 4) strengthening the community linkage with health facilities with development of trained lay cadre and investing in the capacity of the community-based organizations for sustained HIV response. Each of these areas maps to a section of the 2021 SID in which the country scored yellow. COP22 above site activities have measurable outcomes to ensure adequate progress towards achieving epidemic control and meeting minimum requirements.

In COP22, PEPFAR will continue to engage the HIV/AIDS stakeholders including GFTAM and GKoE to develop the roadmap to sustainability by identifying the area of transition to greater domestic responsibilities and discuss the way to achieve the milestones towards building sustainability.

PEPFAR/E has included in the COP22 budget activities to address threats to maintaining 95-95-95 achievements and progress towards sustained epidemic control. These resources will be used to fund activities that will complement other systems investments. PEPFAR has set annual benchmarks for each above-site activity that will be used to monitor implementation and ensure

achievement of results. The above-site activities in COP22 are strategic investments to strengthen GKoE's capacity for locally managed HIV prevention and treatment programming and monitoring. Systems investments facilitate large scale information sharing ensuring adequate and reliable client and commodities data is available quickly and routinely. Furthermore, investments ensure that systems users can utilize data to make informed decisions in programming, client care, and procurement strategies.

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

5.2 Procurement and Supply Chain Management System

In COP21, the availability of health commodities was negatively impacted COVID-19 due to logistical constraints, freight increases, shortages of active pharmaceutical ingredients (APIs) and raw materials. In-country logistics was also impacted by human resource constraints at the Central Medical Stores (CMS). To respond to the effect of COVID-19 on the global and national supply chain in COP22, PEPFAR/E will closely monitor commodity stock levels and delivery timelines, ensure procurements are placed well in advance of need, and communicate regularly with suppliers and other stakeholders, while mitigating any risks that arise.

Quantification and supply planning have been the backbone to ensuring commodity security and availability. PEPFAR/E will continue to support annual quantification and quarterly supply planning through staff embedded at the CMS to mitigate supply chain interruptions. Procurement and supply chain data will be used to inform discussions within procurement and supply chain-related technical working groups. Technical assistance will also be provided for proper commodity storage, distribution, and warehouse management information systems to manage stock. To strengthen the use of best practices for stock management at lower levels, PEPFAR/E will continue to support Regional Logistics Officers to strengthen commodity management at the regional and facility level. In addition, PEPFAR/E will support activities that promote rational medicine use, medicine regulation, and pharmacovigilance.

PEPFAR/E continues to support donor and government efforts to strengthen data availability and use at the facility level through the rollout of e-systems. The open-source electronic logistics management information system (eLMIS) has been piloted at 3 facilities. An additional 19 sites were assessed in COP21 and deemed to be ready to transition to eLMIS. PEPFAR/E will continue to support the rollout of eLMIS through project management support and MIS technical assistance to NERCHA and CMS. This effort will help ensure that eLMIS is efficiently rolled out and operational in selected sites to ensure end-to-end stock availability.

5.3 Health Information System and Digital Health Investments

PEPFAR Eswatini is working closely with the GKoE to implement its Health Information System (HIS) Strategy. The HIS strategy builds on past PEPFAR investments in CMIS and outlines actions

to achieve "*a health information system that provides comprehensive, timely and quality health information that is used for decision making by the entire health sector and other stakeholders in pursuit of a healthy nation.*" To achieve these shared goals, PEPFAR/E HIS investments will address leadership, governance and coordination, data security, data sharing, data analysis and dissemination, client level and aggregate data systems, facility and community, interoperability, data exchange, and system infrastructure.

HIS Leadership, Governance and Coordination: PEPFAR/E will partner with the GKoE, WHO, WB, GF and other funding and implementing partners to establish a Health Data Collaborative (HDC) to improve coordination of all HIS inputs. HIV Systems and investments are more likely to achieve data objectives, impact HIV and TB programs and be sustainable when they are part of wider health systems initiatives and planning that addresses wider health sector requirements and are supported through multiple sources of funding.

Data Security and Data Sharing and MOH Capacity to Analyse, Use and Disseminate Data: PEPFAR has developed advanced data analysis and use capabilities through its parallel collection of aggregate data from partners for MER reporting and use of PEPFAR tools like DATIM and Panorama. Although recent CMIS successes have dramatically improved client level data across sites and services over time, the GKoE MOH and PEPFAR have not yet made full use of these new capabilities and rich data sources. In FY23 PEPFAR/E will invest in data security and data sharing policies and guidelines so MOH can manage secure access to cleared data sets for key internal and external stakeholders. This data access will be vital for PEPFAR IPs to transition away from parallel data reporting to automated data exchange between MOH and PEPFAR systems. PEPFAR/E will work closely with MOH M&E section to support development of dashboards and analysis tools linked to de-identified cleared data and strengthen section capacity to develop dissemination products, analysis or issue briefs.

CMIS, Master Patient Index and Health Information Exchange:

The overarching goal of PEPFAR investments in CMIS is to monitor the achievement of 95-95-95 goals and AIDS-related mortality for clients across the country and support client centered care. Monitoring capabilities will allow the GKoE and PEPFAR to track epidemic control at a national level, assess coverage gaps at a regional level, improve client health management at the facility level, and facilitate patients' access to their own medical information.

CMIS is designed to strengthen patient care by improving data quality and access to provider and patient information. The CMIS system is ensuring secure patient information is readily available to providers at whatever location a patient chooses to be served, supporting efforts to follow up on lost patients to reduce interruptions in treatment, improving HIV prescribing practices and ensure greater patient safety. As of Q1 FY22, CMIS is live in 189/202 ART sites and covers approximately 70% of current HIV positive clients currently on treatment. By the end of COP23 PEPFAR/E and the MOH intend to ensure CMIS achieves 95% client level treatment data coverage and establish baselines and future targets for other key case-based surveillance sentinel events coverage. To continue to improve completeness of uniquely identified client level data for

case-based surveillance sentinel events, PEPFAR/E and the MOH will support design of a new Master Patient Index and begin development of a Health Information Exchange (HIE) to facilitate the linking and exchange of data from non CMIS sites including FBO or private sites.

CMIS and interoperable systems are now well positioned to support new digital health innovations or digitally supported clinical processes specifically designed to address key programmatic challenges. In COP22, PEPFAR/E will support two new service delivery innovations through a clinical IP above site HIS partner collaborations with one of these innovations specifically focused on addressing interruptions in treatment or movement of clients across different sites over time.

Use of Unique Identifiers across Sites and Programs in Clinical Settings

Eswatini has adopted the use of the national ID number as a unique patient identifier (UPID) in the CMIS as well as in some non-clinical record systems, such as schools. For patients without national ID, CMIS creates a unique system-generated identifier. As of April 2021, almost 64% of all clients (regardless of HIV status) registered in the CMIS were registered with their national ID. Nationally, approximately 30% of citizens do not have a national ID, which poses challenges for effective tracking of unique clients which are recognized by the MOH. In 2021, the Ministry of Home Affairs extended its operating hours and has begun mobile outreaches to facilitate uptake of UPID registration. The UPID is also used in PEPFAR supported community programs, including the DREAMS layering database. To increase the number of clients with a unique identifier, the use of biometrics using fingerprints was initially planned be piloted in June-August 2021. The biometric pilot was delayed due to COVID-19 restrictions.

PEPFAR will support the MOH by working with the USAID Health Information System Data Fi project to develop a Master Patient Index (MPI) to support unique client identification and data exchange of identified client records. The MPI will improve the ability of the CMIS system to uniquely identify and match client records across systems, sites, and services over time for clients that do not have National IDs by using multiple identifying fields and probabilistic matching. The MPI will also help non CMIS systems including those used by FBOs or private clinical partners to allow integration with CMIS through a Health Information Exchange.

Network and Electrical infrastructure

Over the early years of CMIS investments, the major factor that impeded the program from realizing the benefits of the system was the unreliability of the microwave WAN system in the country and impact of power and network disruptions. In FY22, PEPFAR/E and GKoE successfully deployed multiple strategies to resolve network downtime issues, including a scaled Access Point Name (APN) cellular network solution, as well as the deployment of the CMIS Lite platform. CMIS Lite is a mobile-based CMIS application that will provide offline functionality when there are network or power outages. In FY23, PEPFAR/E will scale up the use of offline capabilities and tablets and engage in Public Private Partnerships in collaboration with Power Africa to strengthen

health electrification and connectivity. The partnership is anticipating a 4 to 1 match for PEPFAR funds and expects to strengthen electrification in 2 referral hospitals, 2 health centers and 35 larger clinics in FY23. Through connectivity partnerships, PEPFAR/E expects to increase broadband connectivity to all PEPFAR supported sites.

5.4 Surveillance and Research

A strong HIV surveillance system will assist the Kingdom of Eswatini in ensuring that programs are continuing to meet existing and emerging needs according to population, place, and time, as well as provide guidance towards the allocation of resources. SID 3.0 does not adequately assess the comprehensiveness and robustness of the routine national surveillance system to provide timely data for epidemic monitoring, separate from national population-based surveys. Given strategic gaps in this area, COP22 focuses on the establishment of a HIV case-based surveillance system, building upon and leveraging the existing foundation of the digital health and HIV recency surveillance platforms.

HIV case-based surveillance will be important in tracking the progress towards epidemic control and beyond by providing the signals or warnings needed to understand where there are "failures" or "disparities" along the HIV continuum from diagnosis to death that warrant specific interventions as part of an ongoing public health response. The success of the HIV case-based surveillance system will be highly dependent on the implementation of two key digital health activities in COP22. The first is to have a data exchange repository with individual record matching capability as necessary data across sentinel events will be coming from more than one system. Second is ensuring systematic access to the deidentified and deduplicated client level data elements through a cleared data repository for routine review, analysis, and use.

In addition, COP22 will focus on other non-information system requirements that need to be in place to ensure a functional and quality case surveillance system. This includes support to the Ministry of Health Epidemiology and Disease Control Unit (EDCU) in the establishment of a case surveillance governance and leadership framework, enhancement of human resource skills and capacities, and support for data management, data analysis, and use.

Implementation of HIV recency surveillance represents a key element within the larger HIV case surveillance strategy contributing to the reach and sustaining of epidemic control. The characterization of new infections by whether they are recent or long-term provides unique data signaling the successes and/or failures of program reach and program impact on interrupting ongoing transmission. Since COP19, PEPFAR/E has been supporting the scale up of recent infection surveillance from 38 health facilities towards a target of 165. In COP22, PEPFAR/E will support maintenance of recency surveillance activities at these 165 sites with more focus on programmatic and epidemic response actions to limit the spread of HIV. Enhanced data use from recency surveillance will enable programs to refine and timely implement targeted prevention interventions for cluster groups where increased number of recent infections are seen including interventions targeting AGYW such as DREAMS and prevention of new infections among pregnant and breastfeeding women. COP22 support will include procurement of Asante test kits

and related supplies, training, staffing in critical areas, data management and use support, and laboratory quality assurances processes.

PEPFAR Eswatini will support strategic activities to strengthen government systems to respond to existing gaps in epidemic monitoring through an enhanced multi-stakeholder collaborative approach. Efforts will seek to improve the monitoring of mortality and morbidity of PLHIV through advancing the completeness and quality of data reporting for medical cause of death reporting. Technical assistance will be provided to civil registration and vital statistics systems strengthening efforts in digitizing the medical certificate cause of death and supporting the transition from ICD-9 to ICD-11.

The Ministry of Health National Health Research and Innovation Department (NHRID) will be supported to advance the dissemination of research data and translation of those data into practice. This includes national population-based survey data, clinical trials, surveys, evaluations, and other study data generated by local researchers. Further, technical support will advance the existing foundation of the Eswatini Health and Human Research Review Board (EHHRRB) to improve the ethical review of research protocols in a sustainable manner and increase the board's capacity in reviewing a greater breadth of research protocols with limited external support.

5.5 Laboratory Systems

To address existing VL/EID testing gaps and increase the testing capacity at national level, PEPFAR/E will support the implementation plan based on the recommendation of the recently completed Diagnostic Network Optimization. This will entail optimizing or replacing existing VL/EID testing high throughput instruments at regional level and multiplexing existing near point of care (e.g. GeneXpert) for TB diagnostics. These approaches help increase access to and coverage of VL especially for PBFW, AGYW and the under 15-year-old who continue to show suboptimal VL coverage and suppression. Moreover, PEPFAR/E will continue to work with the MOH and other stakeholders to monitor the placement of the platforms with the capacity of performing EID-both plasma and DBS VL testing - and provide logistical support to the sample transport and return of results to clients. Furthermore, PEPFAR/E will expand the SMS system capability to transfer high VL results directly to patients. Building on the successful development of the National Laboratory Strategic Plan in FY22, PEPFAR/E will continue to support the development of the laboratory Strategic implementation plan during COP22.

In COP22, the PEPFAR/E lab implementing partner will continue to work with the Ministry of Health to improve quality management systems (QMS) toward accreditation. Support will be provided to the National Molecular and TB Reference Laboratories to maintain their accreditation status. Continuous support will focus on ensuring the three remaining molecular laboratories are accredited and training on the implementation of Strengthening Laboratory Management Towards Accreditation (SLMTA) to sustain QMS and implement Strengthening Laboratory Improvement Program Towards Accreditation (SLIPTA) process. PEPFAR/E will provide resources for supportive supervision and mentorship, proficiency testing material production, procurement some of reagents and supplies, laboratory information systems (LIS), viral load (VL) Task Force meetings, lab managers and lab technical working group meetings, and mentorship to

EHLS senior management to ensure that indicators towards achieving benchmarks are closely monitored. PEPFAR/E achieved the interoperability of the LIS with the Client Management Information System (CMIS).

5.6 Leadership and Coordination

PEPFAR continues to support the strengthening of existing government structures and reenforces the government's leadership role by embedding technical leadership within the Ministry of Health programs under the direct authority of the Ministry of Health Directorate through a Government-to-Government (G-to-G) mechanism. Implementing partners provide technical assistance to build the national capacity to ensure continuous service provision and improved and sustained outcomes for all PLHIV and PLTB. This support allows ENAP, NTCP, and the NCCP to quickly adapt and bring into practice new research findings and global guidance that impacts HIV and TB service delivery. In order to maximize effectiveness of these positions toward HIV and TB epidemic control, COP22 will focus on the following activities: 1) rollout of the updated HIV and TB national guidelines, 2) review and realignment of PEPFAR-supported national level MoH positions to the current priorities of the program, 3) expanded use of virtual platforms and learning collaboratives building on COVID-19 lessons learned for training and mentorship, 4) completing semi-annual program reviews (NaHSAR; ReHSAR), 5) strengthening the leadership and coordination role of the regional health management teams, and 6) developing a roadmap for transitioning clinical service delivery support and mentorship from implementing partners to government structures at national, regional, and facility levels.

Oversight, coordination and tracking of the multisectoral HIV response is the mandate of the Prime Minister through NERCHA. The coordination of the multi-sector response at national, regional, tinkhundla, chiefdom/municipality level requires engagement by various line ministries, and the different sectors including the private sector, faith sector, and civil society. PEPFAR/E has provided ongoing TA support to NERCHA to assume greater responsibility in leading the community coordination and engagement of multi-stakeholders in the response. This support will continue to strengthen NERCHA's key role in the coordination of national-level prevention programming, by focusing on utilization of data derived from different sources to generate a prevention cascade and facilitate coordination and discussion of how to reinforce key gaps with partners and stakeholders.

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

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Eswatini's COP22 vision for sustaining epidemic control employs an agile and adaptive approach to management, operations and staffing that is aligned with the country's focus on preventing new infections and maintaining the treatment cohort. We do this while at the same time being thoughtful about laying the foundation for a sustainable transition post epidemic control by strengthening critical national health systems.

PEPFAR/E has reviewed its staffing footprint and interagency organizational structure to be fully positioned to achieve program pivots and ensure that technical roles are defined in the interagency space. All agencies continue to invest in staff training, based on identified training needs during performance evaluations. Agencies are encouraged to budget adequate funds in the COBD for staff training and explore south to south TA for capacity building to address identified gaps in current program knowledge.

The State Department PEPFAR Coordination Office (PCO) currently consists of six staff members: one direct hire (PEPFAR Coordinator) and five FSNs (PEPFAR Deputy Coordinator, PEPFAR Program Officer, Administrative Assistant and two Driver/Clerks) and includes one vacancy for the DREAMS Coordinator (FSN). The vacant interagency DREAMS Coordinator position was shifted during COP21 from the State Department to a Peace Corps secondment to PCO and is currently under recruitment. COP22 includes a shift of the PEPFAR Coordinator hiring mechanism from the State Department to a USAID secondment to PCO, impacting budget only, with the function and structure of the position remaining unchanged. COP22 includes a new position in the PCO for an interagency Communications Officer. This position will cover a current gap identified in the program and will provide all agencies with high quality and sustained technical assistance in the development, implementation and analysis of communications and media relations in support of the PEPFAR Eswatini program.

CDC's staffing footprint includes 13 staff positions: four direct hires (country director, deputy director, SI advisor, and laboratory advisor); two high level technical contractors (Care and Treatment Advisor and TB/Associate Director for Science Advisor), four FSN technical leads (VMMC, SI, prevention, and lab), and two FSN M&O positions (program management specialist and program management assistant). One of the FSN positions is expected to shift to a contracting mechanism before the end of COP21 as a retention strategy. Limitations of the current job classification scheme have made it difficult to promote high performing staff within the FSN structure. CDC currently has one technical Foreign Service National (FSN) vacancy, the Health Systems Strengthening lead. This post has been vacant for over 12 months due to the reclassification process. Recruitment is expected before the start of COP22. CDC has no other skillset gaps currently.

DOD is staffed by one individual who coordinates all program areas. The program has adopted an integrated approach and has not identified any current need to expand the staff footprint. Capacitation in program management, IT and financial management will be further needed.

Peace Corps staffing footprint includes 8 positions currently funded by PEPFAR. Six of these positions are currently filled and 2 are actively being recruited. These positions complement additional staff totaling 35 as well as up to 100 Volunteers. Volunteers are planning to return to the country in a phased approach, starting in September of 2022. By the end of 2023, we anticipate up to 50 Volunteers. All PEPFAR-funded Peace Corps staff positions are hired through Personal Service Contracts. Specifically, PEPFAR funding covers a monitoring and evaluation lead, a small grants coordinator, a program manager for community health, a volunteer program and training assistant, a finance assistant, and a medical assistant. Two new positions, an IT assistant and a driver, are planned to ensure IT and logistics support to volunteers given Peace Corps' shift to increased remote communications and need to address new COVID related travel policies for Volunteers. In addition, PC will recruit the DREAMS coordinator position, which will be seconded to and be housed with the PCO.

USAID's staffing complement currently includes 14 positions in addition to two newly added positions for a total of 16. These include: four direct hires (Country Director, Deputy Director, Senior SI/HSS advisor, Management and Operations specialist), one third country national position (Senior Clinical advisor), seven Foreign Service Nationals (FSN) technical leads (Prevention lead, Public Health specialist/Supply Chain, Senior medical advisor, Policy and program analyst, DREAMS/OVC program specialist, SI specialist and HSS) and two FSN finance and administrative positions (Budget specialist and program management assistant). Two of these technical positions (Prevention lead and Senior Medical advisor) are currently hired under an institutional contract mechanism and will being converted to FSN positions by the end of FY22. Two new additional FSN positions were also approved in COP 22, which include a Community-Facility linkage specialist and Health sustainability specialist. These positions will be hired in FY23 to support the transition and management of additional local partner awards and key efforts for program sustainability. The SI advisor and management and operations specialist are currently vacant and will be filled by the end of FY22.

The overall agency CODB decreased slightly as agencies found M&O efficiencies. ICASS costs decreased marginally for CDC and DOD, increased slightly for State Department and increased considerably for USAID.

CLM is being implemented through the PEPFAR small grants mechanism. Grants Management is done with the support of the Small Grants Coordinator while program oversight is provided through the PCO office, through an existing position that was adapted for this purpose during COP20. Working with the embassy Small Grants Coordinator, new CLM grants are processed 90 days prior to the end of the preceding grant, ensuring little to no program interruptions and that funds are available to partners in a timely manner. Civil society coordination of the CLM program is funded through one of the small grants.

APPENDIX A -- PRIORITIZATION

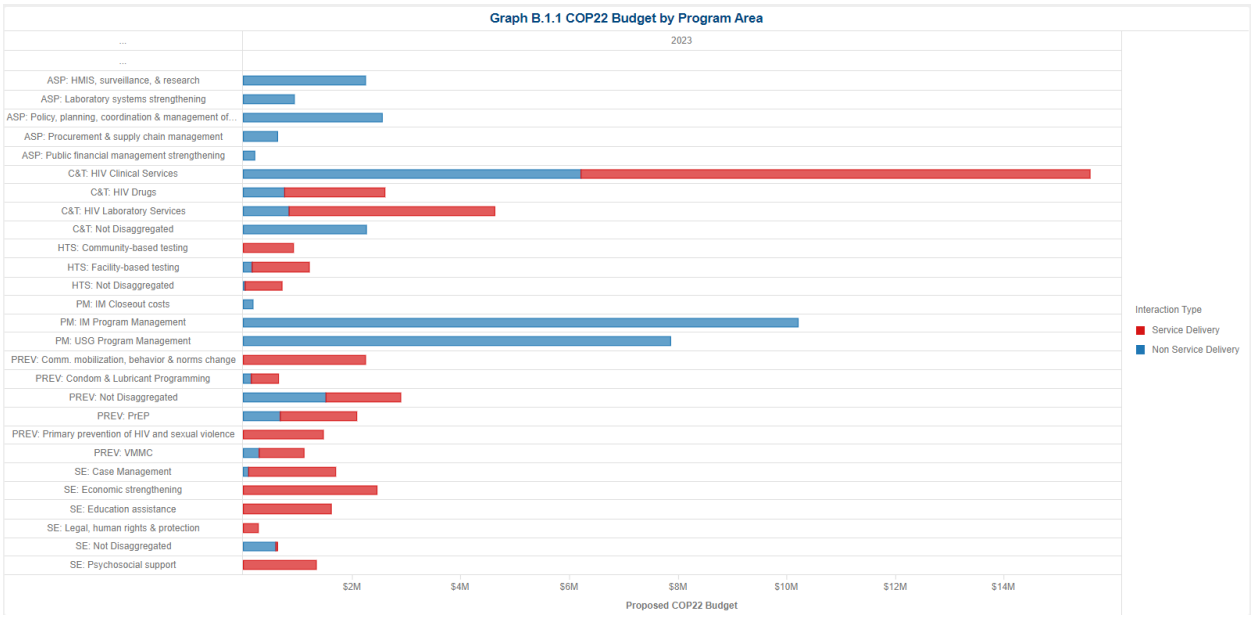
Continuous Nature of SNU Prioritization to Reach Epidemic Control

The Eswatini program continues to support activities across all four SNUs in the country. The prioritization of all four SNUs continues to be at “Attained”.

APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area



Source: COP22 FAST Dossier in PAW 2022

Table B.1.2 COP22 Budget by Program Area

Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		$38,422,309	$32,817,691	$71,240,000	54%	46%	100%
C&T	Total	$10,088,497	$14,998,867	$25,087,364	40%	60%	100%
	HIV Clinical Services	$6,216,001	$9,364,948	$15,580,949	40%	60%	100%
	HIV Drugs	$705,191	$1,847,114	$2,552,305	29%	71%	100%
	HIV Laboratory Services	$847,639	$3,786,805	$4,634,444	18%	82%	100%
	Not Disaggregated	$2,269,666		$2,269,666	100%		100%
HTS	Total	$182,669	$2,654,997	$2,837,666	6%	94%	100%
	Community-based testing		$919,141	$919,141		100%	100%
	Facility-based testing	$154,000	$1,053,167	$1,207,167	13%	87%	100%
	Not Disaggregated	$28,669	$682,689	$711,358	4%	96%	100%
PREV	Total	$2,628,414	$7,846,577	$10,474,551	25%	75%	100%
	Comm. mobilization, behavior & norms change		$2,245,907	$2,245,907		100%	100%
	Condom & Lubricant Programming	$150,163	$489,837	$640,000	23%	77%	100%
	Not Disaggregated	$1,520,945	$1,379,121	$2,899,962	52%	48%	100%
	PrEP	$672,557	$1,409,009	$2,081,566	32%	68%	100%
	Primary prevention of HIV and sexual violence		$1,476,402	$1,476,402		100%	100%
	VMMC	$284,949	$834,301	$1,119,150	25%	75%	100%
SE	Total	$435,692	$7,317,250	$8,010,932	5%	91%	100%
	Case Management	$80,214	$1,800,906	$1,834,120	4%	94%	100%
	Economic strengthening		$2,456,131	$2,456,131		100%	100%
	Education assistance		$1,623,045	$1,623,045		100%	100%
	Legal, human rights & protection		$272,929	$272,929		100%	100%
	Not Disaggregated	$600,468	$25,000	$625,468	96%	4%	100%
	Psychosocial support		$1,337,239	$1,337,239		100%	100%
ASP	Total	$6,575,445		$6,575,445	100%		100%
	HMIS, surveillance, & research	$2,244,391		$2,244,391	100%		100%
	Laboratory systems strengthening	$938,092		$938,092	100%		100%
	Policy, planning, coordination & management of disease control programs	$2,549,962		$2,549,962	100%		100%
	Procurement & supply chain management	$638,000		$638,000	100%		100%
	Public financial management strengthening	$205,000		$205,000	100%		100%
PM	Total	$10,253,602		$10,253,602	100%		100%
	IM Closeout costs	$175,000		$175,000	100%		100%
	IM Program Management	$10,216,081		$10,216,081	100%		100%
	USG Program Management	$7,662,521		$7,662,521	100%		100%

Source: COP22 FAST Dossier in PAW.

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level			
Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	$6,309,005	$64,930,995	$71,240,000
Eswatini	$6,309,005	$64,930,995	$71,240,000

*Data included in Table B.1.3 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary															
Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Eswatini	**Total**	**$25,087,364**	**$2,837,666**	**$10,474,991**	**$8,010,932**	**$6,575,445**	**$18,253,602**	**$71,240,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Females	$1,775,943	$28,669	$5,817,188	$2,453,168	$330,000	$1,796,791	**$12,201,759**	7%	1%	56%	31%	5%	10%	**17%**
	Key Pops	$302,408	$371,655	$451,402	$206,000	$80,000	$515,000	**$1,926,465**	1%	13%	4%	3%	1%	3%	**3%**
	Males	$160,228	$141,000	$1,487,987		$281,850		**$2,071,065**	1%	5%	14%		4%		**3%**
	Non-Targeted Pop	$21,258,440	$1,955,242	$2,292,003	$7,500	$5,883,595	$14,549,361	**$45,946,141**	85%	69%	22%	0%	89%	80%	**64%**
	OVC			$406,411	$5,344,264		$1,392,450	**$7,143,125**			4%	67%		8%	**10%**
	Pregnant & Breastfeeding Women	$787,033	$107,100					**$894,133**	3%	4%					**1%**
	Priority Pops	$803,312	$234,000	$20,000				**$1,057,312**	3%	8%	0%				**1%**

Source: COP22 FAST Dossier PAW

B.2 Resource Projections

The PEPFAR Funding Allocation to Strategy Tool (FAST) was used to calculate budget levels by mechanism, program area, beneficiaries according to the COP22 strategies that were agreed upon by all stakeholders. The FY21 PEPFAR Expenditure Reporting results and FY22 budget were used as a baseline for setting the FY23 budget. Adjustments were made for activities that will not be carried into FY23, activities that will be implemented more efficiently and other program variations whose implementation will continue in FY22. Estimates based on the country program's experience were used for new mechanisms that did not have historical data.

The National Health Accounts, National AIDS Spending Assessment and Responsibility Matrix reports were used to facilitate discussions with the GKoE and GF on areas of common support to identify potential funding gaps, maximize efficient resource allocation and minimize duplications.

APPENDIX C – Tables and Systems Investments for Section 6.0

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook are saved as a PDF with SDS.

APPENDIX D– Minimum Program Requirements

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Ongoing implementation at national scale In FY22 Q1, 89% of the client received same-day ART initiation. 69% of clients taking more than 2 weeks to link or remain unlinked are aged 20-39 years.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Maintenance of ART optimization TLD transition continues as drug supply and TLE expiry avoidance allows, on track to increase from 63% of all clients to 85% during COP21 implementation
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Expansion exceeded COP21 goals; 87% of eligible clients now on 6 months dispensing.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT has been scaled up and all supported ART sites are currently providing TPT services routinely and in DSD models. 3HP scale up is in progress for both new on ART and existing ART patients.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	DNO assessment completed; workplan under development. VL testing platforms optimized across regions. Point of care multiplexing initiated during COP21. continued expansion of LMIS/CMIS interface.
Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under	Ongoing Implementation of safe and ethical index testing to all index contacts and observing the WHO 5Cs principle of HTS. Targeted HIVST distribution to all priority

age 19 with an HIV positive biological parent should be offered testing for HIV.	populations at facility and community settings.
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	PrEP site activation for the targeted national scale-up completed in 2021
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Ongoing implementation with the introduction of a modified service package for C/ALHIV in high volume sites residing outside OVC sites Increased enrolment of C/ALHIV via strengthened collaboration w/clinical partners. Comprehensive OVC track-children w/ vulnerabilities (especially C/ALHIV); Preventative OVC track - primary prevention of sexual violence & HIV to 10-14yo boys & girls; OVC DREAMS track - comprehensive DREAMS services to adolescent girls 10-19yrs
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	Access to health and law enforcement services through peer navigators , KP safe spaces developed, KP IBBS demonstrating reduction of stigma in accessing services, Stigma Index demonstrating overall reduction of stigma, community-led monitoring focused on key populations in COP21&22.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	All fees eliminated

11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	Continued CQI at facility level, IP workplans and national policy
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Treatment literacy and VL literacy including U=U are continued to be supported targeting vulnerable groups and healthcare providers to increase retention and VLS and address stigma.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Increasing progress towards local, indigenous partner prime funding including FY21 transition of 2 local subs to Prime and an additional transition planned for FY22
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Continued planning with government to evolve programs and take on additional technical responsibility for the HIV response
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Piloted transition to electronic documentation of medical certificate of cause of death and ICD-11 CODING. This includes improved capture of facility-based deaths in the national population registry as part of the CRVS system
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Improvements in patient ID access led to 80% of clients having one. CMIS generates a unique ID that is complementary to National ID (the primary ID in CMIS). CMIS scale-up continues and is targeted for completion in Q4 FY22

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

The Government of the Kingdom of Eswatini (GoKE) provides strong political leadership in HIV/AIDS, as well as in policy formulation, strategy development, oversight, and service delivery. With long term robust support through PEPFAR and the Global Fund, Eswatini now stands on the brink of epidemic control. Civil society and the private sector roles are critical and growing, buoyed by essential and urgent multisectoral work on covid vaccination, and they represent enormous potential to enhance the capability of Eswatini to sustain the HIV response.

Eswatini's strong country-led HIV/AIDS response is based on the best available data and clinical practice guidelines, and made the country, with the world's highest HIV prevalence, on the cusp of epidemic control. Eswatini is one of only two countries (along with Switzerland) to be named by UNAIDS to have met the 95-95-95 FAST-TRACK 2030 targets.

Eswatini's success in controlling HIV is due to several key factors. First, the government has been wholly committed to addressing HIV as a crisis that threatens the health and livelihoods of all emaSwati. Second the collaborative approach between the Eswatini government, PEPFAR, UN, GF, civil society and other stakeholders created effective partnerships and impactful programs while minimizing duplication. Third, with the availability of multiple sources of data to identify remaining gaps to epidemic control, the program was able to expand efforts to support specific vulnerable populations – children, adolescent girls and young women, men ages 24-39, military and people with disabilities.

During the COVID pandemic the country's key public health management systems such as facility staffing and provider training, laboratories, supply chain, surveillance and information management systems have been put under immense pressure, and although some were considerably compromised, they generally fared better than expected, a testament to the years of investments by government and development partners to ensure a public health system that is able to support sustainable HIV/AIDS epidemic control.

PEPFAR Eswatini strategy

PEPFAR Eswatini's strategy to support the sustained impact of the HIV/AIDS response is the model of Evolve, Achieve, Transition, and Sustain; to **evolve** the HIV program to match the current epidemic and sustainability needs; to **achieve** 95-95-95 in all populations and reduce new infections; to **transition** programs or components to local government or other local implementers; and to support capacitation of local systems and structures to **sustain** the gains.

Evolve

While programs are adjusted and adapted in order to achieve 95-95-95 for all populations, they must also concurrently evolve to better align with the national health system structure, and improve efficiency, representing reduced cost with maintained high standards of quality. The support provided and approach to implementation needed to reach epidemic control under an emergency response framework is likely not what is needed, nor available, to sustain it. It is incumbent upon PEPFAR to therefore evolve our support toward treating HIV as a chronic disease, including institutionalizing integrated quality management across the health system. At the same time, government systems and structures themselves are being reimagined by government leadership for efficiency and sustainability. The development, optimization and increased resiliency of supply chain, laboratory, HRH management, and strategic information systems are critical for sustainability. The co-evolution of PEPFAR programming and government health system structure is essential for success.

Achieve

New infections among young people need to be drastically reduced and 95-95-95 reached in all populations. With over 10% of PLHIV in Eswatini remining virally unsuppressed and an HIV incidence of 1.87% (15-24 years), there is a need to ensure that clinical cascade and prevention interventions to address remaining gaps are scaled-up, and that effective programming is optimized or rightsized in preparation for a maintenance phase of the response.

Transition

As the HIV epidemic in Eswatini evolves, there is a need to shift and align programming with the demands of the new reality. This includes using data to hone in on cost-effective models, finding efficiencies within existing activities, institutionalizing unique program quality management and improvement approaches, and enhancing local capacity to allow for transitioning of the program to local management. Key to this will also be reducing the PEPFAR-supported HRH footprint without compromising the impact of the response, strategically supporting the government to optimize its workforce. Sustainability of the HIV response hinges on the ability to responsibly and mindfully transition central, regional and site-level HIV prevention, testing and treatment programming and support to government and local partners.

Sustain

PEPFAR/E has been engaging the GoKE on the evolution of the HIV/AIDS response through existing technical structures and platforms, in addition to meetings and briefings between PEPFAR and the King, Prime Minister and Cabinet. The quarterly high-level HIV Sustainability Steering Committee chaired by the Secretary to the Cabinet and made up of Principal Secretaries from the Prime Minister's Office, Ministries of Health, Finance, Economic Development and

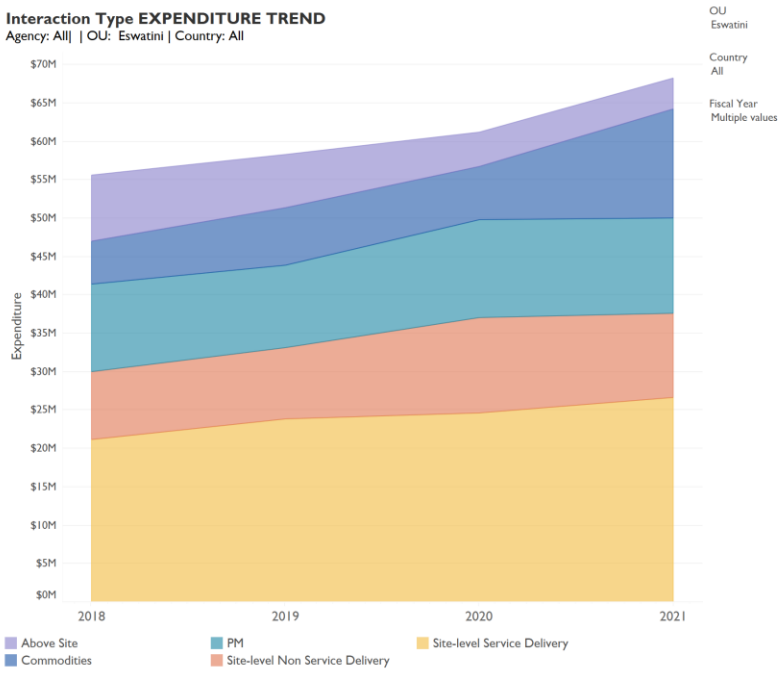
Planning, Education, ICT, as well as representation by NERCHA, PEPFAR and Global Fund is planned to be reinstated in 2022.

To truly sustain the impact of the HIV interventions, support to Eswatini is needed beyond the health sector. Investments that will increase domestic revenue for Eswatini, as well as strengthen the country's economy are needed for long-term success. Addressing the country's gender-based violence crisis and other structural issues creating vulnerability to HIV, particularly for young women, is essential for reaching and maintaining epidemic control.

Alignment between Investments and Outcomes

PEPFAR expenditure increased between 2018 and 2021 and is expected to decrease slightly for 2022 and 2023. Changes between 2018 and 2021 include a reduction in above site expenditure, which may be due to reduction in recency start-up costs and CMIS investments. Commodities prices increased sharply in 2020 due to COVID. Site level services expenditure rose slightly, while non-service delivery and program management remained relatively stable. Costs and results of prevention and community-level service packages currently delivered primarily by implementing partners will be assessed to determine viable models for sustainability by the government moving forward.

Figure E.1.1. Assessing Eswatini's PEPFAR Expenditure Trends by Interaction Type

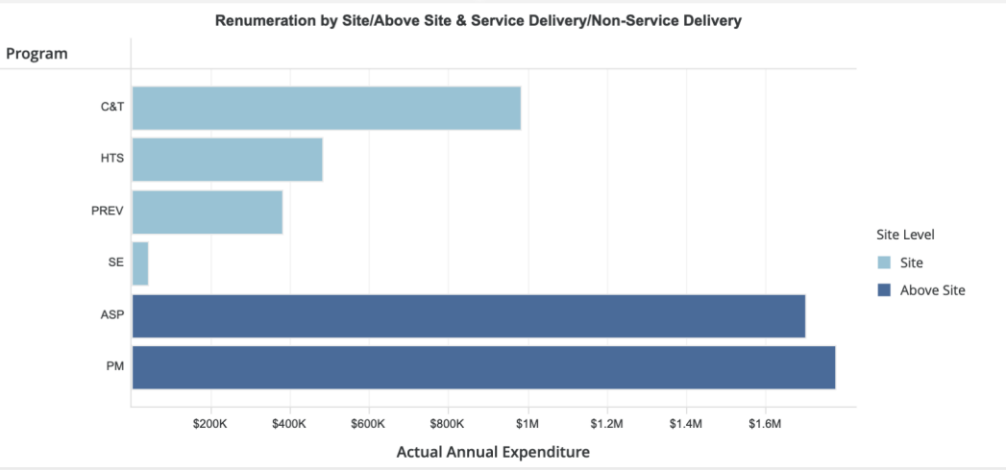


Source: Tableau OHA Dashboard, USAID, 2022

Human Resources for Health

PEPFAR/Eswatini invests significant resources in HRH, both in the form of staff directly seconded to the Ministry of Health, primarily to the eSwatini National AIDS Program (ENAP) and to health systems efforts in supply chain and laboratory. Additional staff represents implementing partner staff, including technicians, health facility providers and community health workers, for a total of over 3,000 supported HRH for Eswatini.

Figure E.1.2. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



As illustrated in Figure E.1.2, the largest HRH investments are in program management and above-site programming (systems support), followed by care and treatment. As detailed in Section 4.7.e, PEPFAR/E will work closely with the Ministry of Health and Ministry of Public Services to assess the current staffing support footprint and prioritize positions in alignment with government priorities.

Program Expenditures vs. SID Score Trends

PEPFAR/E has worked to reduce the misalignment between its investments and public health outcomes, by using the results of the biennial SID process to identify gaps in public health outcomes, particularly for HIV/AIDS as well as the sustainability of service delivery platforms and health system components. Analysis conducted by the PEPFAR/E team revealed significant sustainability vulnerabilities and programmatic gaps that must be addressed for the country to achieve sustained epidemic control. The Sustainability Index and Dashboard (SID), which was completed through a participatory process with key stakeholders, revealed vulnerabilities in four sustainability elements: Laboratory, Service Delivery, Epidemiological and Health Data, and Commodity Security and Supply Chain. Analysis of the SID 3.0 identified four critical programmatic gaps that must be addressed. These programmatic gaps are: 1) inadequate community systems to improve linkage and retention; 2) inadequate supply chain capacity and infrastructure; and 3) inadequate qualified laboratory personnel to achieve epidemic control 4) inadequate capacity for collection, analysis and use of epidemiological data including a functioning HIV case surveillance system.

Trends in investment in the past three years show that PEPFAR/E expenditure focused on the area of Epidemiological and Health data, Service Delivery, Laboratory, and Commodity Security and Supply Chain. Except for Service Delivery, all three areas increased investment in COP20.

Table E1.1 Sustainability Index Score Trend (2015-2021)

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.50	8.02	9.33	9.33
2. Policies and Governance	6.40	7.13	7.30	7.38
3. Civil Society Engagement	4.17	5.83	5.83	5.83
4. Private Sector Engagement	3.96	5.24	5.93	5.73
5. Public Access to Information	7.00	7.00	7.89	7.33
National Health System and Service Delivery				
6. Service Delivery	6.53	4.95	4.90	5.06
7. Human Resources for Health	6.33	5.37	5.56	5.97
8. Commodity Security and Supply Chain	6.01	6.90	5.83	4.79
9. Quality Management	7.76	6.81	7.10	7.76
10. Laboratory	5.74	4.83	4.38	4.24
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	8.61	7.58	7.17	6.86
12. Technical and Allocative Efficiencies	8.57	8.16	8.56	8.60
13. Market Openness	N/A	N/A	9.69	9.41
Strategic Information				
14. Epidemiological and Health Data	5.00	3.96	5.45	5.45
15. Financial/Expenditure Data	5.42	5.83	6.67	6.67
16. Performance Data	7.80	7.39	7.67	7.40
17. Data for Decision-Making Ecosystem	N/A	N/A	8.00	7.19

Table E.1.2 Trends in Investments and SID Scores for System-Related Elements

Above Site Activities and Budget Reported in Table 6						
	COP18	COP19			COP20	
SID Budget Activity	Activities	Activities	Budget		Activities	Budget
Planning and Coordination	4				1	$85,717
Policies and Governance	1					
Service Delivery	13	9		$1,504,609	6	$1,267,224
Human Resources for Health	2					
Commodity Security and Supply Chain	4	1		$610,447	1	$763,264
Laboratory	3	1		$793,068	2	$818,192
Domestic Resource Mobilization	1					
Epidemiological and Health Data	8	7		$3,655,159	6	$5,633,509

Program Responsibility

Through the process of completing the 2021 Responsibility Matrix stakeholders indicated which program areas have government, donors or private sector with primary, secondary or nominal responsibility for service delivery, above site support or planning (Figure E1.3 below). Where donors are noted as having sole or shared primary responsibility with the government, this indicates that programming would cease or be drastically affected in this area without the outside investment. Development of a sustainability strategy includes discussion with government of where priorities and technical capacities are regarding these program areas to ensure appropriate program evolution and transition. PEPFAR shares or has sole primary responsibility for more

than half of the assessed service delivery and above site functions (Table E1.3), while the Eswatini government plays the primary role for most strategy formulation and planning functions.

Figure E.1.3. Percent Primary Responsibility Ratings from Responsibility Matrix

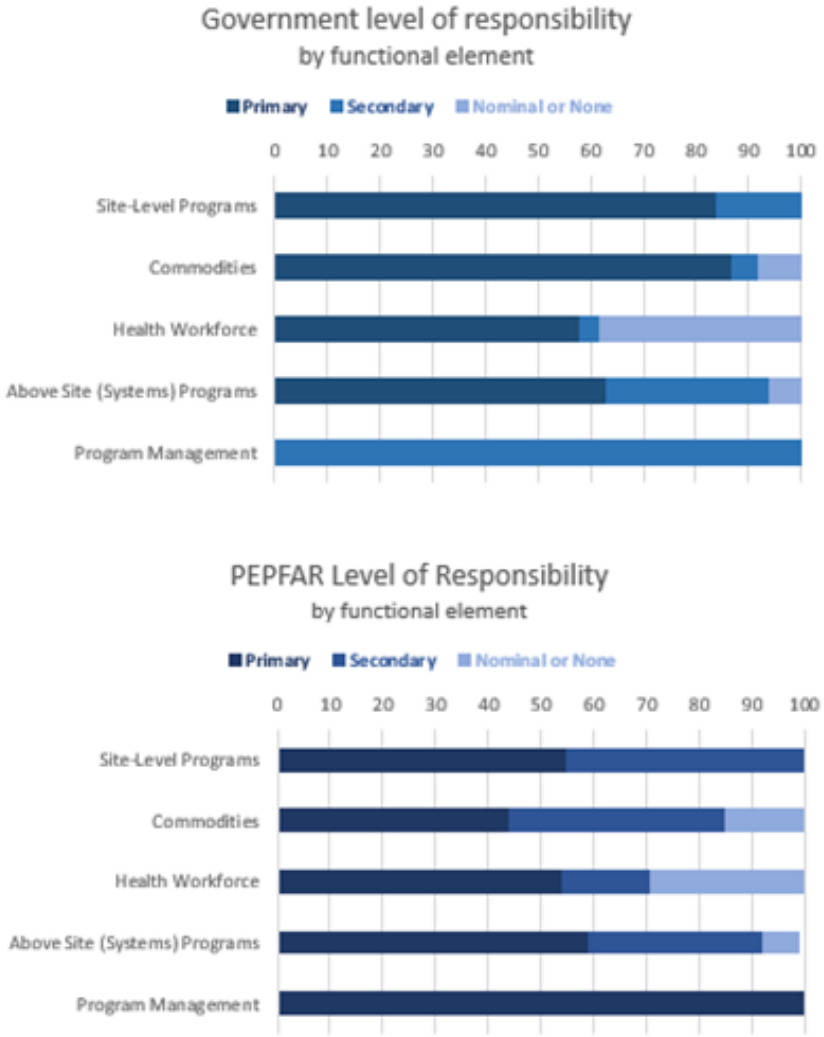


Table E1.3. Programming Areas Where PEPFAR has Shared or Primary Responsibility

Service Delivery	Above site (non-service delivery) Support	Strategy Formulation and Planning
• All Care and treatment & Testing services	• Health Workforce training, mentorship and supervision for HIV/AIDS for all testing, clinical services, prevention, key	• Adolescent girls and young women • Self-testing • VMMC

• Community outreach
• Community mobilization, behavior change and norms
• VMMC
• Cervical cancer screening and treatment
• AGYW
• Key populations (except prisoners)
• GBV programming
• HIV Commodities (all except rapid test kits)
• Health workforce salaries and benefits
• Clinical health care worker training and supervision
	populations, adolescent girls and young women, orphans and vulnerable children and gender-based violence services
	• Development of program guidelines and SOPs
	• Procurement of
	  ○ Pediatric ARVs
	  ○ Viral load reagent, CD4 reagent, and other regeants and supplies
	  ○ VMMC kits
	  ○ Condoms
	  ○ CD4
	• Central level workforce salaries, top ups and benefits
	• Training and supervision
	• Procurement and supply chain management functions
	• Laboratory systems support
	• Health systems surveillance and research
		• PSM
		• In-service training and CME
		• Most procurement and supply chain functions
		• Most HMIS, surveillance, research functions
		• Most laboratory Systems

Identifying Areas for Transition

Three major areas for transition are already underway in the PEPFAR Eswatini program: 1) The increased government role in the technical support for clinical implementation of the national HIV program, 2) transition of community-delivered HIV prevention services to local community partners, and 3) strengthening of financial management capacity of government and local implementing partners.

Technical Transition to Government

The GoKE currently is supported technically by two PEPFAR clinical mechanisms, each providing assistance to two of the four regions as well as central and regional levels for implementation and technical support. Work commenced in 2021 to begin a multiyear technical transition of the HIV clinical program support to government. An HIV clinical service delivery transition core leadership group (CLG) was established in 2022 to oversee the evolution and transition of PEPFAR HIV/TB clinical service support across the country, specifically ensuring that there is a systematic and coordinated approach to maintaining and monitoring the provision of high-quality clinical services to sustain HIV epidemic control.

A consultative process to develop a transition roadmap commenced in 2021 with an initial workshop to establish five core working groups (program leadership/coordination, service

delivery, financial management, HRH, and SI) and conduct a SWOT analysis for transition. These findings were incorporated into a modified WHO sustainability assessment tool designed to quantify gaps in staffing, resources, technical capacity, etc. Working groups reviewed the tool and began scoring at a subsequent workshop; the tool is undergoing some revision based on feedback. Further engagements were planned during COP21 to complete the assessment, identify areas amenable for transition, and draft a roadmap outlining activities and necessary actions for short-, medium-, and long-term transition. We anticipate availability of the draft roadmap to inform COP23 planning.

Transition to local partner

PEPFAR will continue efforts to strengthen local partner capacity to lead and transition to direct awards for the implementation of key technical areas. The OVC/DREAMS portfolio currently includes three local implementing partners, along with an award which includes local sub-awardees. During COP22, an additional local partner will transition from an international award to a direct agreement with PEPFAR. The team will also conduct an activity design process to devise strategies by which additional local partners are able to assume greater leadership in a new follow-award that will be granted in COP23. Capacity building efforts tailored to strengthen key population-led community-based organizations will remain a priority, with exploration of expanded roles for these organizations in COP22.

A direct G-to-G local Cooperative Agreement award supports the majority of the national level technical program officers who lead and coordinate the HIV response through ENAP, NTCP, and NCCP. Funding through the cooperative agreement also supports implementation of the Quality Management program at select sites. While clinical implementing partners currently support facility mentorship and regional oversight, opportunities are being explored to incrementally transition some implementing partner roles (and requisite funding) to the Ministry of Health as steps toward more direct local government technical mentorship, program oversight and financial accountability. The substantial involvement of USG in the management of the MoH Cooperative Agreement provides the opportunity for USG to work in partnership with MoH on this transition and closely monitor progress and outcomes.

Strengthen local financial management capacity

PEPFAR will work to explore existing platforms for the management of local grants and subawards to transition to more locally led efforts. A formal capacity assessment will be conducted in COP21 to explore opportunities to strengthen NERCHA's sub-grant management unit for management of grants under contract and local awards that are currently managed by PEPFAR clinical and community international partners. Options for establishment of a grants management unit within the Ministry of Health to manage PEPFAR and other donor funds is also being explored to ensure robust structures and personnel are in place to manage and account for multiple program-related funding streams.

As per the Responsibility Matrix (Table E1.3), PEPFAR currently carries a large burden of the financing of most key components of the National HIV response. PEPFAR/E will begin dialogue together with the Ministry of Health and Finance to better understand the current health finance landscape and to produce strategic information to reflect the costs of service packages currently provided by partners. This will both guide PEPFAR's understanding of the different investments and costs of service delivery models, along with the level of alignment with Ministry of Health investments and priorities.

Data Sharing and Data Alignment to Support Epidemic Monitoring

PEPFAR continues to work closely with the GKOE MOH to jointly monitor the comprehensive HIV response in Eswatini at national, subnational, and population-specific levels. Since 2017, a quarterly data alignment activity has served to ensure that the MOH has an unambiguous view of PEPFAR/Eswatini's role in the national response while providing PEPFAR with a total view of the epidemic response in country through engagement in this validation exercise. Routine data alignment supports ongoing improvements in ensuring quality of the data collected and results reported. Three primary steps are taken as part of this activity:

1. Indicator mapping – Working with the MOH M&E Department to map indicator and disaggregation definitions from the MOH system with the indicator and disaggregation definitions used by PEPFAR
2. Master Facility List alignment – Collaborate with the MOH Strategic Information Department to ensure harmonization between the PEPFAR System Organizational Unit List and the MOH Master Facility List for a fully inclusive list
3. National result reporting – Reporting national level data for a specified set of indicators as part of quarterly PEPFAR reporting with data for PEPFAR-supported sites being a subset of the national results

The data alignment activity is governed by an existing data sharing agreement between PEPFAR/Eswatini and GKOE MOH, which is updated on an annual or as-needed basis to ensure seamless review of and access to comprehensive data to inform ongoing implementation and resource allocation and planning efforts. As described in Section 5.3, in COP22, PEPFAR will invest in enhancing existing data sharing policies and guidelines alongside data security measures to support automated exchange of data between MOH and PEPFAR systems in support of full data alignment and consolidated efforts to improve quality of data through supported GKOE systems.