Eswatini

Country Operational Plan

(COP) 2023

Strategic Direction Summary

April 22, 2023

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Acronym List

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
ANC	Antenatal Clinic
ARV	Antiretroviral
ART	Antiretroviral Therapy
C/ALHIV	Children and Adolescents Living with HIV
CANGO	Coordinating Assembly of Non-Governmental Organizations
CBS	Case-based surveillance
CBO	Community Based Organizations
CCD	Community Commodity Distribution
CDC	(U.S.) Centers for Disease Control and Prevention
CERA	Community Engagement and Rehabilitation Alliance
CLM	Community-Led Monitoring
CMIS	Client Management Information System
CMS	Central Medical Stores
COP	Country Operational Plan
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DBS	Dried Blood Spot
DNO	Diagnostic Network Optimization
DOD	U.S. Department of Defense
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD	Differentiated Service Delivery
DTG	Dolutegravir
EDCU	Epidemiology and Disease Control Unit
EID	Early Infant Diagnosis
eLMIS	Electronic Logistic Management Information System
ENAP	Eswatini National AIDS Program
FP	Family Planning
FSN	Foreign Service National

FSW	Female Sex Workers
G2G	Government-to-government
GBV	Gender Based Violence
GKoE	Government of the Kingdom of Eswatini
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
HCWs	Health Care Workers
HIS	Health Information System
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
HTS	HIV Testing Services
HIVST	HIV self-testing
IBBS	Integrated Biological and Behavioral Surveillance
Inkhundla	Government Administrative Unit under Region
IP	PEPFAR Implementing Partner
KP	Key Population
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Reporting
M&O	Management & Operation
MMD	Multi-Month Dispensing
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MPI	Master Patient Index
MSM	Men who have sex with men
MTCT	Mother-To-Child Transmission
NARTIS	Nurse-led ART initiation in Swaziland
NERCHA	National Emergency Response Council on HIV and AIDS
NCD	Non-Communicable Diseases
NTCP	National TB Control Program
OPD	Outpatient Department

OVC	Orphans and Vulnerable Children
PCO	PEPFAR Coordination Office
PCV	Peace Corps Volunteer
PEP	Post Exposure Prophylaxis
PEPFAR/Eswatini	President's Emergency Plan for AIDS Relief/Eswatini
PHIA	Population-based HIV Impact Assessment
PLL	Planning Level Letter
PMTCT	Prevention of Mother-to-Child Transmission
POART	PEPFAR Oversight and Accountability Response Teams
POC	Point of Care
PP	Priority Populations
PrEP	Pre-exposure Prophylaxis
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Plan
QMS	Quality Management System
RHMT	Regional Health Management Team
RITA	Recent Infection Testing Algorithm
RTK	Rapid Test Kit
SDS	Strategic Direction Summary
SGBV	Sexual and Gender Based Violence
SGAC	U.S. Department of State's Office of the U.S. Global AIDS Coordinator and Health Diplomacy
SHIMS	Swaziland HIV Incidence Measurement Survey
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SOP	Standard Operating Procedures
SNU	Sub-National Unit
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis

Tinkhundla	Plural of Inkhundla: Government Administrative Unit under Region
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Therapy
TWG	Technical Working Groups
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nation Development Program
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
WHO	World Health Organization

1.0 Vision, Goal Statement and Executive Summary of PEPFAR's investments and activities in support of the COP plan.

1.1 Vision, Goal Statement

Eswatini has made striking progress in controlling the HIV/AIDS epidemic, led by the Government of the Kingdom of Eswatini (GKoE), and in partnership with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, other donors, as well as with civil society organizations (CSOs). While Eswatini has the world's highest HIV prevalence rate, with 24.9% of adults living with HIV, tremendous forward movement has been measured and attained. The recently completed 2021 Eswatini Population-based HIV Impact Assessment survey, locally known as "SHIMS3", demonstrated sustained progress towards the ambitious UNAIDS 95-95-95 targets well before the global 2025 benchmark. SHIMS3 revealed that Eswatini is at 94-97-96 for adults 15 years and above. This is compared to the SHIMS2 (2016-2017) results of 87-89-91, reflecting laudable progress despite the threats presented by the COVID-19 pandemic and other overlapping crises.

SHIMS3 revealed that the 95-95-95 targets have been achieved for women, despite disproportionately holding the burden of the disease. The rate of new HIV infections has also dropped by nearly half in the past five years. However, gaps towards these targets remain among certain subpopulations. About 25 percent of men aged 25-34 and 34 percent of men who have sex with men (MSM) who are living with HIV are unaware of their status; approximately 4,000 individuals 15 years and older, mainly young women, continue to be infected with HIV annually, at a rate nearly seven times that of men; and 11% of children under five years are not virally suppressed. The 2021 Eswatini Violence Against Children Survey (VACS) found that gender-based violence continues to play a role, with 1 in 12 women aged 13-24 reporting having experienced sexual violence at least once in their lifetime.

The PEPFAR/Eswatini (PEPFAR/E) Country Operational Plan 2023 (COP23) vision centers around (1) evolving service delivery support to close gaps to 95-95-95 in sub-populations, (2) accelerating the sustainability of the National HIV response and (3) strengthening health systems and facilitating an enabling environment to increase domestic responsibility while maintaining HIV epidemic control. Key priorities based on the current stage of the HIV epidemic for COP23 are: high-impact combination prevention interventions for Adolescent Girls and Young Women (AGYW); scale-up of Pre-Exposure Prophylaxis (PrEP) for key populations (KPs); pivots in the HIV testing strategy for children, AGYW, men aged 25 – 34, military and key populations; client-centered services to close early antiretroviral therapy (ART) initiation and treatment continuity gaps among men aged 25 – 34 years; and reducing morbidity and mortality among People Living with HIV (PLHIV) through largest contributors to mortality among People Living with HIV (PLHIV) by programming for advanced HIV disease (AHD), tuberculosis (TB) prevention and case identification, detecting and treating cervical dysplasia, and expanding the integration of NCD and HIV services.

More specifically, COP23 will build on COP22 to tailor case-finding strategies to close testing gaps among AGYW (15 – 24 years), men aged 25 – 34 years, female sex workers (FSW) and MSM, military and

children. These strategies will include using HIV self-tests (HIVST) as a screening tool, index testing and universal testing at selected entry points for the population groups with case-finding gaps. To close treatment gaps, particularly among men aged 25 – 34 years and military populations, COP23 seeks to institutionalize client-centered approaches to support adherence and prevent attrition as well as to bring clients who experienced treatment interruption back to care to maintain treatment continuity and viral suppression. New interventions include pretreatment viral load testing as part of the undetectable equals untransmittable (U=U) strategy, maximizing the use of digital health platforms and integrating HIV services with non-communicable disease (NCD) and male wellness services, as well as the use of strategic marketing and peer-to-peer approaches to reach wealthier men aged 30 and above.

COP23 seeks to further reduce new infections among AGYW, KP and men (15 -34) through tailored approaches to increase the uptake of high-impact prevention interventions. Strategies include expanding availability of and access to voluntary medical male circumcision (VMMC), proactively offering PrEP through an opt-out approach to high-risk individuals and introducing the injectable PrEP formulation during calendar year 2024. COP23 will also prioritize buttressing interventions targeting the largest contributors to mortality among PLHIV with a focus on improved TB case finding, increasing coverage of advanced HIV disease (AHD) detection and treatment, introduction of more sensitive cervical cancer screening methods, and systematically integrating HIV and non-communicable disease services through an integrated chronic disease management approach.

Carefully considered health system strengthening investments will be implemented to ensure a resilient public health system aligned to support the GKoE in forwarding sustainability planning. Further, COP23 continues to expand transformational partnerships, particularly to address infrastructure challenges, public health preparedness and response, and socioeconomic strengthening for Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) beneficiaries. The programming also takes into consideration the goal of achieving sustainable epidemic control and reflects the significant work that has begun under the leadership of the GKoE.

The overarching goal of the PEPFAR/Eswatini (PEPFAR/E) investments remains to support the GKoE to achieve and sustain HIV epidemic control, provide high-quality client-centered 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.

1.2 Summary Statistics, Disease Burden and Country Profile

1.2.1 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. Eswatini's most recent National Population and Housing Census took place in 2017. Using this as a basis, the 2022 national population is projected to be 1,174,014 people; 35% are <15 and 56% are <25 years old, indicating a substantial youth bulge. It is projected that about 76% of the population lives in rural areas.

Manzini (386,251) is the region with the highest population, followed by Hhohho (346,334), Lubombo (230,694), and Shiselweni (210,736).

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, major trucking routes east to west, 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 against the epidemic.

1.2.2 Economy

Eswatini is classified as a lower middle-income country: however, income inequality is high, with a Gini coefficient estimated at 54.6, most recently measured in 2016. Economic challenges persist with 59 percent of the population living below the national poverty line and GKoE estimating that 58 percent of youth are unemployed. Eswatini is currently recovering from a 2020 COVID-induced recession which resulted in a 1.85 percent economic contraction, while 2021 saw a growth estimate of 2.1 percent. Economic growth projections for 2022 and 2023 are 2 percent and 1.8 percent respectively (World Bank).

1.2.3 HIV epidemic

The average life expectancy in Eswatini declined sharply from a peak 63 years in 1990 to a low of 42 years in 2005 (World Bank estimates), due to the impact of the HIV and TB related morbidity and mortality. The country mounted a forceful response to HIV, including use of life-saving ART, and is now re-approaching the 1990 life expectancy. PLHIV now constitute 50 percent of the 45–49-year-old population in Eswatini (SHIMS3) and it is expected that prevalence will increase in the older age groups as the cohorts with a high prevalence of individuals living with HIV continue to age (Figure 2). Women continue to hold the disproportionate burden of disease. SHIMS3 2021 revealed that more than half the women in the age groups between 35-49 are living with HIV, and among those aged 25-29 years, HIV prevalence was more than five times higher among women than men.

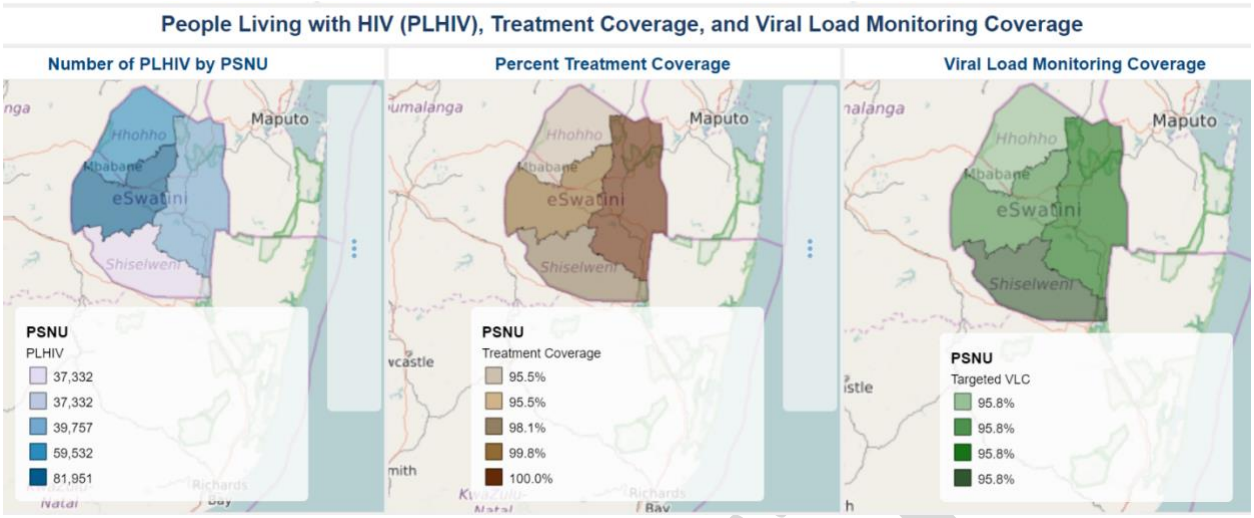

Figure 1: PLHIV, Treatment Coverage and Viral Load Monitoring Coverage (2022)

Source: COP22 HIV Estimates from Spectrum and Naomi model 2023; PEPFAR program data; Map source: COP23 Target Setting Tool Dossier, PAW

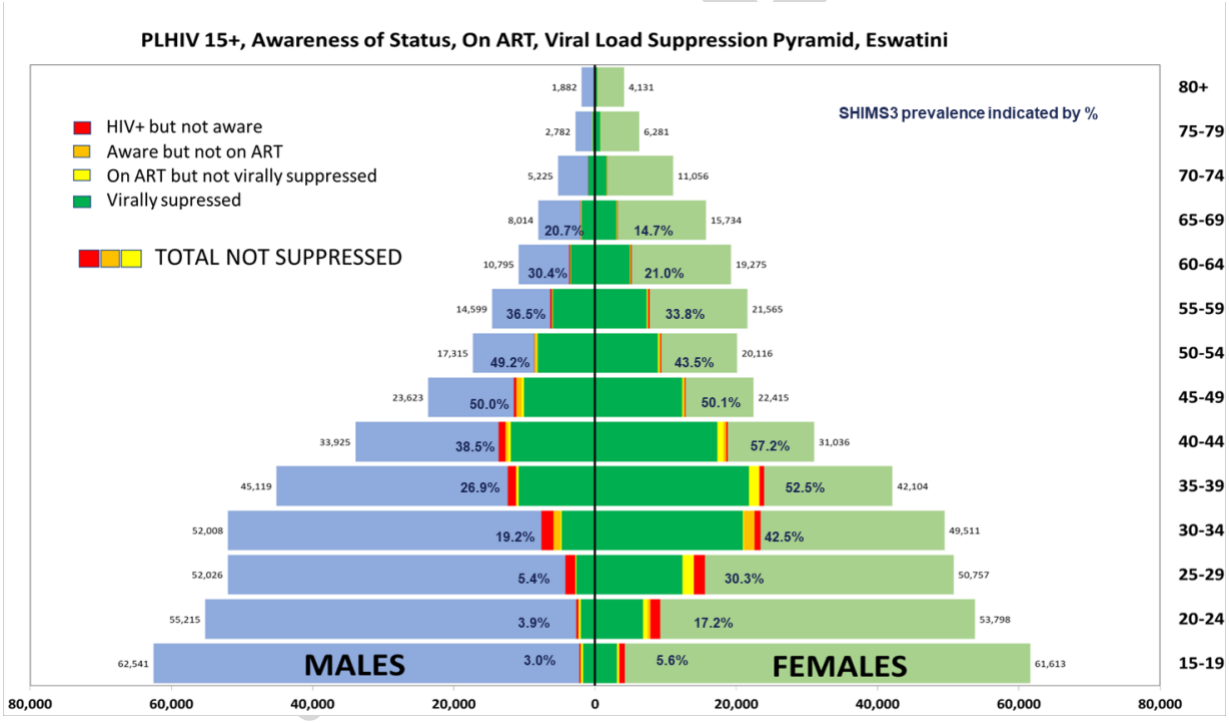

Figure 2: Awareness of Status, On ART, Viral Load Suppression Pyramid, Eswatini PLHIV 15+ (2022)

Source: World Population Prospects Eswatini Estimates 2022; SHIMS3 2021

The PLHIV population above the age of 35 years has reached epidemic control, despite the heavy burden of disease. Sustaining this progress is critical to protect these gains. Opportunities are present to optimize patient management and support continued strong outcomes as part of the life-long care of these individuals. Although the burden of disease is lower in the younger population, we have not reached epidemic control, and we see where population-specific gaps remain. These individuals make

up a high proportion of the total population, and we see the youth bulge evident here. This demonstrates the critical importance of heightening prevention efforts and closing remaining gaps.

SHIMS3 results show tremendous progress in viral suppression at a population level, surpassing the unconditional target of 86 percent overall, for both men and women. However, specific sub-populations, namely women 15-24 and men 25-34, fall well below the target. This is driven by the case finding gap of 16 percent among young women 15-24 and for men 25-34 a case finding gap of 25 percent alongside linkage to treatment challenges. Other critical case finding gaps remain among certain sub-populations, with 29 percent of the military, 34 percent of MSM, and 12 percent of FSWs being unaware of their status.

Table 1: 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 (%)** FY24	**Estimated Total PLHIV (#)** FY24	**PLHIV Diagnosed (#)** FY23	**On ART (#)** FY22	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)** FY22	**Diagnosed HIV Positive (#)** FY22	**Initiated on ART (#)** FY22
Total population	1,218,476	19.2	218,572	216,584	209,344	95.1	97.9	199,381	9,081	9,350
Population <15 years	410,410	1.6	6,718	6,730	6,642	65.3	93.6	18,909	423	369
Men 15-24 years	119,850	3.7	4,420	4,199	4,594	71.5	92.2	13,603	295	280
Men 25+ years	271,499	29.7	70,366	69,787	65,657	96.5	98.4	34.933	3,121	3,045
Women 15-24 years	117,711	9.6	11,272	11,232	10,906	71.8	93.0	61,356	1,736	2,031
Women 25+ years	299,006	50.1	125,796	124,636	121,545	101.1	98.5	70,580	3,506	3,625
MSM	4,000	21%	840		164		98	2,459	155	*162*
FSW	7,100	59%	4,175		225		100	2,890	241	*214*
PWID	1,279				10		100	269	9	*11*
TG	119				3		100	63	2	*2*

Source: COP23 Target Setting Tool Dossier, PEPFAR Analytic Workspaces (PAW); Epidemiological data: COP23 HIV Estimates, Naomi model 2023; Treatment and testing data: PEPFAR program data; 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.

SHIMS3 demonstrated that Eswatini continues to experience a downward trend in incidence for both men and women overall (Figure 3). However, incidence remains high among women at 1.11 (seven times higher than among men), driven by the 15–34-year-old female population, where we have not

seen much change in incidence in the last five years. Routine recency surveillance shows higher rates of recent infections in this same population, particularly among 15–24-year-old females.

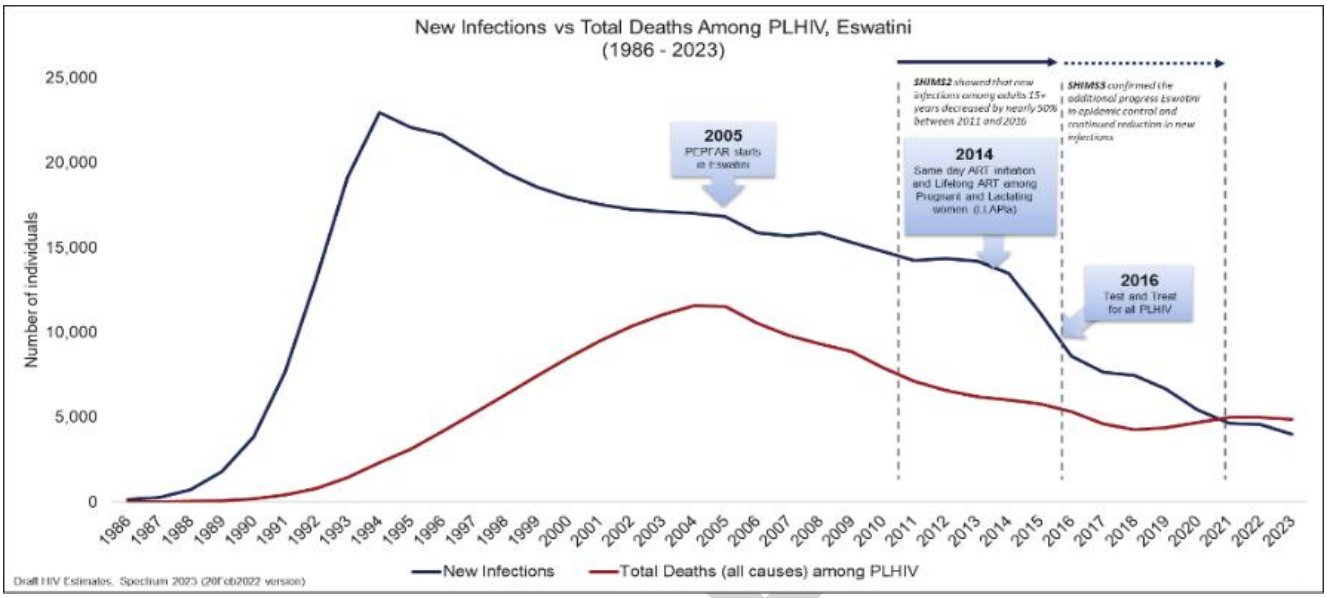

Figure 3: New Infections vs. Total Deaths Among PLHIV, Eswatini

Source: COP23 HIV Estimates from Spectrum, 2023

To continue to protect infants from HIV acquisition through breastfeeding, we must also ensure that the mothers remain virally suppressed. Program data show that pregnant and breastfeeding women who are tested for viral load are suppressed, but viral load coverage is inadequate which may indicate potentially overlooked vertical transmission. According to UNAIDS estimates, the top three contributors that continue to drive vertical transmission are: 1) mothers not receiving ART during pregnancy; 2) mothers infected during breastfeeding; and 3) mothers infected during pregnancy.

1.3 Alignment of PEPFAR Strategy and Government Strategic Objectives

PEPFAR Eswatini has engaged the GKoE in the planning process such that the PEPFAR strategy aligns with the government strategies as outlined in the National Strategic Framework. In COP 23, and based on progress summarized in Tables 1 and 2, the focus will be prioritizing certain populations as means of addressing the remaining gaps to ending HIV as a public health threat. Through transformative partnerships with the private sector and other development partners, the HIV response will be transformed from being an emergency to a sustained response in line with Pillars 2 and 4 of the PEPFAR Five-year strategy (2022-2027). Civil society and key population organizations have been meaningfully engaged in COP23 planning. COP23 will see an increased role for the community in the HIV response through engagement of traditional leadership and community-based structures.

Table 2: Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP23	# Current on ART (FY22)	# of SNU COP22 (FY23)	# of SNU COP23 (FY24)
Attained	218,572 (100%)	209,344	4	4
Total National	218,572	209,344	4	4

Source: COP23 Target Setting Tool Dossier, PAW

1.4 Ensuring Health Equity

PEPFAR/E will strive toward attaining health equity for marginalized populations and subpopulations that are yet to reach prevention and treatment targets. Specifically, case-finding gaps remain among children<15 years, AGYW 15-29 years, young men 25-34 years, and KP. Young men also continue to be the only group in which <95% of those known to be living with HIV are on treatment. Young women continue to face high HIV incidence. COP23 addresses both access and structural barriers by strengthening person-centered programming in both facilities and communities and expanding differentiated service delivery (DSD) models tailored to specific populations. The program commits to more actively engaging beneficiaries in program planning and service delivery to better meet their needs. Community led monitoring (CLM) is one of the approaches that PEPFAR will continue to expand to ensure community voices are informing service delivery improvement. PEPFAR/Eswatini will address structural barriers that marginalize key and priority populations by advocating for an enabling legal and policy environment (e.g., advocating for decreasing the age requirement for parental consent to access HIV self-testing from 16 years to 12 years to align with the age of consent for other HIV prevention and treatment interventions). The program will also increase economic strengthening opportunities for vulnerable populations, improve social protections and continue to address social norms that perpetuate stigma and discrimination. Partnerships with the private sector will also be further developed to address health equity gaps.

2.0 Pillar 1: Health Equity for Priority Populations

2.1 Adolescent Girls and Young Women (AGYW)

Eswatini has made significant progress in reducing new HIV infections; however, incidence among women remains nearly seven times that of men, with no change in incidence among 15–34-year-old women between SHIMS2 2016 and SHMIS3 2021. This highlights a need for more intensive and reimagined approaches to providing high-impact HIV prevention interventions for AGYW. Further, AGYW remains one of the subpopulations with significant gaps in case finding and viral suppression. Given that Eswatini is approaching epidemic control, COP23 presents an opportunity to make strategic shifts in AGYW programming as informed by stakeholders and program beneficiaries.

2.1.1 Reducing incidence

According to the most recent DREAMS saturation analysis, and projections for the end of FY23, 13 DREAMS SNUs will be completely saturated across all age bands, nineteen will be partially saturated, and four will not be saturated in any age band. As a result, in COP23, PEPFAR/E will streamline DREAMS services in saturated SNUs in line with DREAMS NextGen guidance, maintain core DREAMS services in partially or not saturated SNUs, and develop a novel approach for sustainable Adolescent and Young People (AYP) services in select non-DREAMS tinkhundla. Figure 4 below provides an overview of the COP 23 programming approaches for DREAMS Core, Enabling DREAMS and additional AYP services.

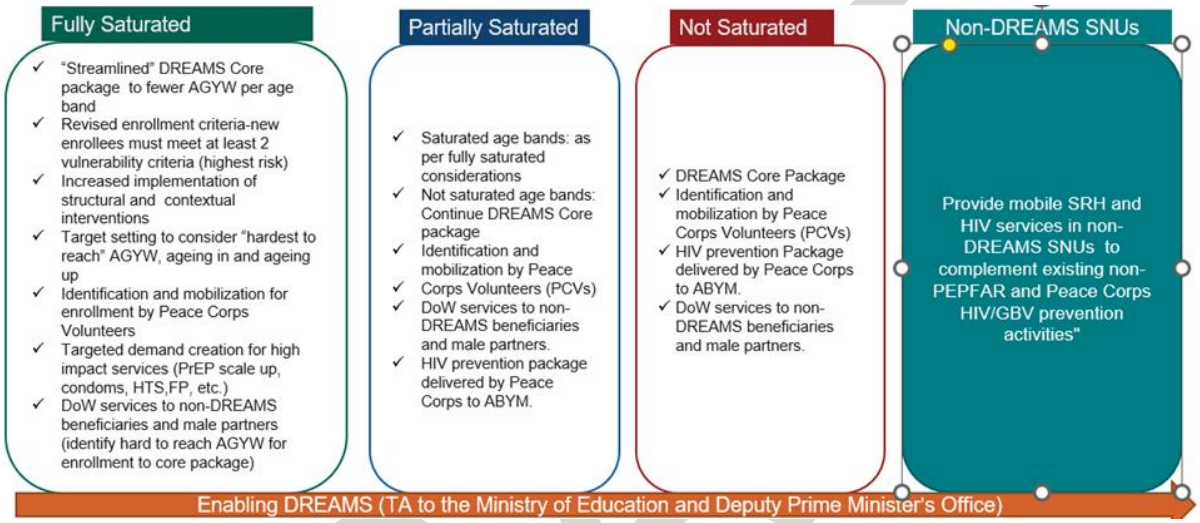

Figure 4: COP23 Programming Approaches for DREAMS

In saturated SNUs, PEPFAR will work with implementing partners to modify the DREAMS package to focus on the most relevant high impact HIV prevention services. This will involve a more targeted approach for the identification and enrollment of "hardest to reach" AGYW. For both unsaturated and saturated SNUs, the DREAMS program will expand access to PrEP products, such as the PrEP ring and CAB-LA, to provide more options to AGYW. Efforts will be made to further improve PrEP messaging that is tailored to different groups of AGYW, taking into consideration their unique socio-cultural circumstances. In addition, health care providers, peer groups, social media platforms, community events, and radio will be used to reinforce PrEP messaging. The DREAMS program will also implement an "opt-out" strategy for high-risk AGYW.

To remove the barrier for accessing health facility, PEPFAR/E will continue to strengthen provision of clinical services targeting AGYW through supporting the MoH to increase the number of facilities that fulfill national standards for Adolescent and Youth Friendly Health Services (AYFHS) at the same time continuing to provide DREAMS on Wheels (DoW) mobile outreach services to reach those who do not come to facilities. Further, PEPFAR/E will implement a novel model for sustainable AYP services in five non-DREAMS tinkhundla by improving access to youth-friendly biomedical prevention interventions, leveraging existing non-PEPFAR HIV prevention services, and, with catalytic support of LIFT-UP funds, introducing "No Means No" to bolster GBV prevention efforts. PEPFAR/E will also work with the Ministry

of Education and Training (MOET) to institutionalize in-school evidence-based prevention and norms change programming for AGYW and adolescent boys and young men (ABYM), as well as provide technical assistance to the Deputy Prime Minister's Office (DPMO) to strengthen the coordination of the national gender-based violence (GBV) response.

2.1.2 Engaging Adolescent Boys and Young Men (ABYM) to break the cycle of HIV transmission

PEPFAR/E will also engage ABYM as necessary collaborators in the strategy to reduce new HIV infections among AGYW. Through existing AGYW platforms, PEPFAR/E will intentionally strengthen engagement with sexual partners of AGYW to provide a package of care designed primarily to reduce HIV transmission. Additionally, ABYM will be reached through intensified index case testing; those who are living with HIV and not on ART will be encouraged to take up and adhere to ART to improve viral load suppression (VLS). Given that GBV is a contributing factor to new HIV infections among AGYW, PEPFAR/E will also work with GKoE and other partners to introduce GBV prevention interventions targeting ABYM. The orphan and vulnerable children (OVC) program will also be leveraged to reach out to more ABYM with HIV/VAC prevention education.

Since 2014, PC Eswatini has been engaging ABYM (ages 9-24) in HIV/AIDS prevention programming through its Boys Reaching Out (BRO) clubs. The BRO programming was re-designed in 2021 to complement the goals and objectives of the AGYW DREAMS program and ensure that ABYMs receive equitable services and information as a supplement to the DREAMS services provided to AGYW. During COP23, PC will collaborate with DREAMS partners to expand BRO service delivery via community-based club activities, including HIV and violence prevention, PrEP sensitization and demand creation, life skills education, employability and financial literacy education, and parenting-caregiver education. ABYM will be referred to DREAMS on Wheels and local clinics for clinical services.

2.1.3 Addressing violence prevention and response

Following findings of the Violence Against Children Survey (VACS) 2022, which reported that 25.5% of females aged 13-24 experienced violence in their lifetime, with 1 in 12 having experienced sexual violence, PEPFAR/E will optimize the operations of One Stop Centers to enhance survivors' access to comprehensive health, psychosocial, legal, and police services in a safe environment in close collaboration with the Gender Unit in the Deputy Prime Minister's Office. Further, through the DREAMS Core program, PEPFAR/E will continue to implement evidence-based gender norms change and GBV prevention interventions for AGYW and their communities, and further strengthen timely access to, and provision of, the full minimum package of comprehensive and age-appropriate post-violence clinical services. Additionally, PEPFAR will explore opportunities (such as offering LIVES training to teachers) in collaboration with the MoET to strengthen violence against children (VAC)/GBV case identification and response within schools, recognizing the need to first establish systems and policies to ensure provision of appropriate support and safeguards for students who disclose. With LIFT-UP catalytic funding, PEPFAR/E will target specific gaps along the GBV prevention and response continuum. “No Means No” GBV prevention programming will be introduced in tinkhundla not receiving other AGYW-focused services. Norms change and structural barriers to GBV response will be addressed through introduction

of the “Every Hour Matters” peer-led intervention to sensitize AGYW on the importance of accessing GBV response services in a timely manner, in-service and pre-service GBV response training for first responders, and renovation and furnishing of an existing government building for repurposing into a shelter in Mbabane. Finally, in collaboration with the DPMO and UNICEF, PEPFAR will support the updating of Eswatini’s National Action Plan to address VAC/GBV based on the outcomes of the VACS Data-to-Action workshop planned for July 2023.

PEPFAR/E will work closely with UNICEF to leverage the Education Plus Initiative which intends to address barriers to schools’ completion, promote community engagement, and integrate sexual and reproductive health services in response to higher HIV infection rates amongst girls and young women. PEPFAR/E will also work with political leadership and partners to support youth employment and more efficient transitions from school to work, particularly for young women.
Building on partnerships with the private sector and government ministries, PEPFAR/E will continue to prioritize provision of high impact economic strengthening services with a strong focus on decentralized vocational training, internships, and business start-ups. Further, the GKoE, through the National Emergency Response Council on HIV and AIDS (NERCHA), will establish a multi-sectoral youth economic strengthening forum to coordinate economic activities targeting the youth population.

2.1.4 Strengthening the clinical cascade

Recognizing the need to close the gap in case finding for AGYW (16 percent unaware of HIV status per findings from SHIMS3), and proactively link high-risk AGYW to prevention services, PEPFAR/E will support implementation Eswatini’s revised HTS strategy including DSD approaches tailored to AGYW. To improve the sensitivity of screening, HIVST will be offered to all AGYW presenting to facilities, and in the community for PrEP continuation and as part of the DREAMS package. Targeted outreaches to female dominated formal and informal workplaces, and partnerships with tertiary institutions and community pharmacies will be utilized for messaging and HIVST distribution. The program will also fully leverage social networks strategies to reach youth with similar risk profiles, digital/social media platforms, and traditional community structures. According to SHIMS3, nearly 10% of AGYW 15-24 years are on ART but not virally suppressed. To encourage continuity on treatment for AGYW, PEPFAR/E will continue to support and strengthen support groups and other peer-led strategies. The MOH will be supported to review the teen club curriculum and conduct an assessment on teen club participation to increase the treatment adherence among young people.

2.2 Pregnant and Breastfeeding Women (PBFW)

Prevention of Mother-to-Child transmission of HIV (PMTCT)

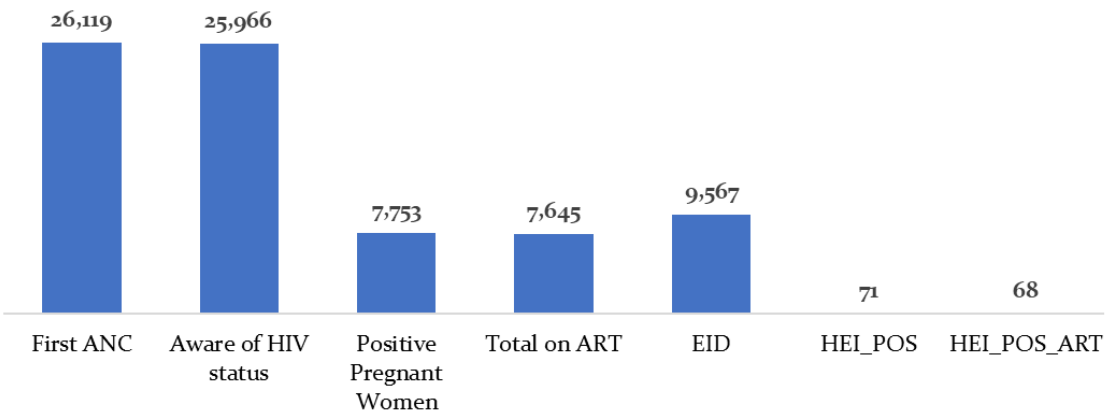

Figure 5: FY22 National PMTCT Cascade

Source: National level data from SRHU program (FY22)

In FY22, the Eswatini PMTCT program continued to demonstrate high performance in the key PMTCT indicators, as shown in Figure 5. Eswatini maintains high levels of awareness of the HIV status at the first antenatal care visit (ANC1), high ART coverage among pregnant women living with HIV, high proxy early infant diagnosis (EID) coverage and low mother-to-child transmission (MTCT) rates.

Despite the successes highlighted in Figure 5, persistent gaps are hindering Eswatini from eliminating MTCT. UNAIDS estimates that women who are not on ART during pregnancy, and those who seroconvert during pregnancy and breastfeeding contribute the highest proportion of new infections. This is consistent with program data that shows ongoing seroconversion among pregnant and breastfeeding women (PBFW) and suboptimal PrEP coverage. Other notable gaps among PBFW include persistent suboptimal viral load coverage. In addition, the uptake of family planning (FP) services among HIV-positive women remains low. COP23 provides a renewed emphasis on HIV prevention among PBFW. Eswatini will scale up PrEP coverage among PBFW through universal offer and the opt-out approach as well as utilizing the one-stop-shop model for the provision of HIV/FP services at facility and community levels. More deliberate integration of HTS for mothers who bring their infants for immunization is being explored to minimize missed opportunities. Optimizing GeneXpert platforms through multiplexing for near point-of-care viral load (VL) testing is expected to improve VL coverage.

2.4 Children

2.4.1 Pediatric HIV Service Delivery

Improving pediatric case finding and reducing seroconversion in infants; While the proportion of infants with unknown HIV status at 18-24 months has reduced from 47 percent in 2017 to 13 percent in FY22, the gap in testing for final outcome among HIV-exposed infants (HEI) remains unacceptably high. Additionally, there has been non-uniform cohort tracking of the exposed children up to their final outcomes across the regions. In COP23, cohort tracking of mother-baby pairs will be standardized utilizing the mother-baby pair linking functionality in the Client Management Information System (CMIS) to document longitudinal follow up. PEPFAR will also expand opportunities for improving caregiver literacy and enhancing mother-infant pair follow-up by linking with the existing platforms such as the OVC and the Community Mentor Mothers. PEPFAR/E also will optimize multiplexing on GeneXpert

platforms to include EID. Infants identified as HIV-positive will be promptly initiated on ART. Finally, as indicated in the PMTCT section, PEPFAR/E will work closely with the EPI program and community partners to strengthen maternal retesting, routine review of HIV exposure status, and subsequent linkage to appropriate HIV services.

COP23 approaches to further strengthen childhood case finding, linkage to services and improved client outcomes will continue to leverage: 1) assiduous index testing supported by caregiver-assisted HIVST to optimize pediatric case-finding, 2) strengthened synchronization of the community and clinical client services, and 3) upscale community patient literacy efforts to supplement facility-based demand creation services. To enhance case finding among older children ages 2-11, the current pediatric HIV screening tool will be replaced with a simpler and more sensitive 3-question tool for use in both OPD and community settings. Testing strategies described in the AGYW section including scaling HIVST as a screening method, optimizing index contact tracing, and expanding social network strategies will be employed to improve identification and linkage to prevention services among adolescents and youth.

Optimizing viral load coverage in eligible pediatrics clients; VL coverage and suppression remain suboptimal for children, with VL coverage for those under 10 years well below 95% per program data. COP23 strategies to improve coverage include wide distribution of pediatric blood draw supplies, strengthening skills in pediatric phlebotomy, expanding use of DBS for pediatric VL, advocating for after-hours VL sample collection, and intensified demand creation among caregivers for the service including the use of digital reminders and amplified treatment literacy.

To address low VL suppression among the younger children, new pediatric fixed dose formulations are being procured by PEPFAR. To further support continuity on treatment efforts, PEPFAR/E will continue providing community-level and multi-month dispensing for all eligible C/ALHIV, 2) support DSD models for C/ALHIV, such as teen clubs and the Family-Centered Care model, and 3) train healthcare workers in methods that support a seamless return-to-care for C/ALHIV after interruption in treatment including creating a welcoming environment for those returning to care. The MoH is reviewing and updating the teen club curriculum and guidance, potentially adapting the Zvandiri model from Zimbabwe (currently being piloted by GF), and/or Operation Triple Zero (OTZ) from Kenya.

Improving client outcomes by leveraging OVC and mental health support; Children and adolescents living with HIV (C/ALHIV) on treatment in Eswatini continue to receive optimized regimens for treatment, however they still face broader socioeconomic and mental health challenges. To mitigate these challenges, PEPFAR/E will promote and saturate enrollment into the OVC program for all eligible clients. This will be further bridged through utilizing digital support systems availed by UNICEF to supplement Mental Health support and health information.

2.4.2 Vulnerable Children

PEPFAR/E will continue to provide OVC services, with a strong emphasis on providing a comprehensive package of services to priority subpopulations such as children living with HIV, children of PLHIV who are newly diagnosed or not virally suppressed, HEIs, children of FSW, survivors of sexual violence, and pregnant teenagers/adolescent mothers, as well as other extremely vulnerable children with known risks

such as children in child-headed households and children with disabilities. At the end of the FY22, PEPFAR/E had provided holistic support services to more than 80,000 children across the four OVC well-being domains (Healthy, Safe, Stable, and Schooled). These services included community case management, education support and subsidies, assistance with birth registration, and household-based adherence support to C/ALHIV and their caregivers.

In COP21, the OVC program achieved the target of enrolling 90 percent C/ALHIV residents in OVC sub-national units (SNUs) into the OVC program (Figure 6). In COP22 the program introduced the provision of a modified package of services to OVC residing outside of OVC SNUs, prioritizing high volume facilities. In COP23, the OVC program will continue to increase enrollment of C/ALHIV into the OVC program and providing the modified package of services to all C/ALHIV within and outside of OVC SNUs who are clients in any PEPFAR supported facility. PEPFAR/E will review the enrollment of Children of People Living with HIV (CPLHIV) into the OVC program by prioritizing children at high risk for treatment interruptions, and families experiencing challenges with continuity of treatment and ART adherence. Linking the OVC program with healthcare facilities remains a critical component. Therefore, the Linkage Assistants will continue to work in facilities for identification, enrollment, and follow-up of children living with HIV, PLHIV and their families.

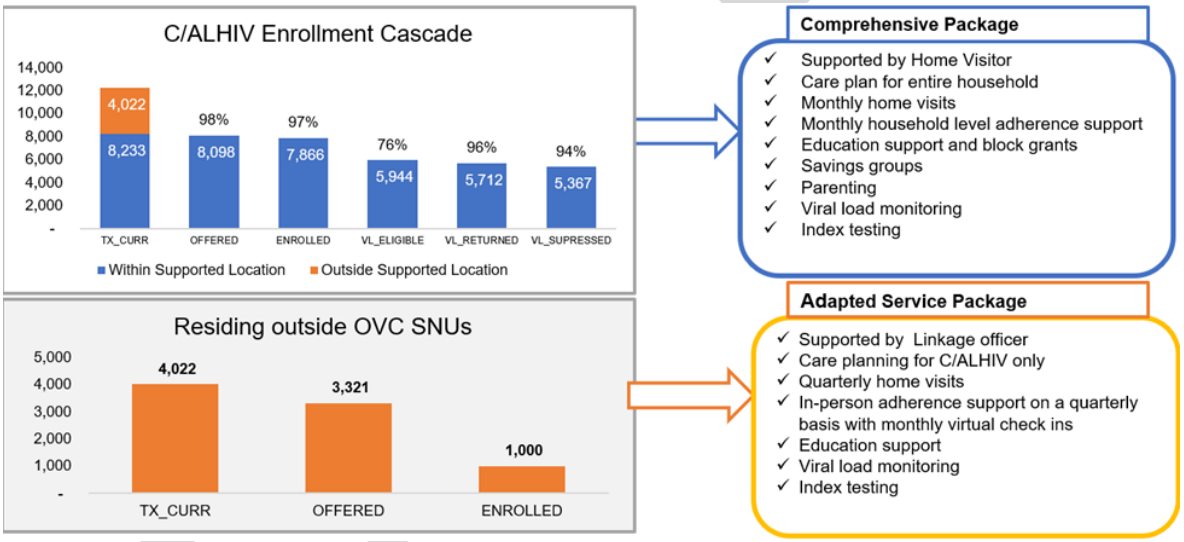

Figure 6: Increasing C/ALHIV Enrollment in OVC Programs

By leveraging partnerships established through the DREAMS program, the program will work closely with government ministries and the private sector to provide supplementary services for OVC and their caregivers to fast-track progress towards meeting the graduation benchmarks. These will include expanding economic strengthening activities for caregivers beyond savings groups. DREAMS and OVC activities will continue to be integrated programmatically and geographically as well as operationally within the same implementers, which will allow for harmonized planning, alignment of curricula and tools, implementation, and monitoring. HIV and violence prevention, including providing referrals to post-GBV/VAC care, will continue to be a priority within the OVC program.

2.3 Key Population

PEPFAR/Eswatini supports equitable KP programming targeting harmful social norms, policy and legal barriers, weak health and community systems to facilitate the provision of comprehensive and client centered diagnostic, prevention, and treatment services for key populations prioritizing FSW, MSM, transgender (TG) persons, people who inject drugs (PWID), people in prisons, men who purchase sex (MWPS) and children of KP. Diagnostic services include HIV and recency testing. Combination prevention biomedical services include PrEP, post-exposure prophylaxis (PEP), condoms and lubricants, sexual and reproductive health services such as sexually transmitted infection (STI) screening and treatment, and FP. Behavioral combination prevention services include information provision for creating demand for HIV services including increasing the use of condom and lubricant, GBV prevention and response, including psychosocial mental health support. Structural combination prevention interventions include access to justice services, stigma and discrimination reduction, advocacy for an enabling policy and legal framework, social protection, and economic strengthening. The treatment package of HIV services includes linkage to and provision of ART, and adherence and psychosocial support for viral suppression. In COP22, the program will develop a minimum package for young KP inclusive of FSW, TG and LGBTIQ to address their unique vulnerabilities. In COP23, PEPFAR/E will support the implementation of the minimum package by building synergies with existing programming. The PEPFAR/E program will continue to support KP-specific mobile and community drop-in centers, and service delivery platforms in designated hotspots to address challenges in access as well as to support mainstream health facilities in providing KP competent services.

The Integrated Biological and Behavioral Surveillance (IBBS) survey shows that 34 percent of MSM and 12 percent of FSWs are unaware of their status. In COP23, PEPFAR/E will support conducting the IBBS to update on progress made towards closing these gaps to 95/95/95 targets for KP. The IBBS will be designed to provide updated size estimates for FSW and MSM, as well as estimate the population size for TG and PWID for the first time. The program will continue to use both MER and custom indicators to track KP cascade performance through community based KP service delivery platforms to mainstream health facilities.

In COP23, PEPFAR will support a surge to find new KP living with HIV by intensifying the following mobilization strategies: increasing frequency of the implementation of the Enhanced Peer Outreach Approach (EPOA); optimizing online programming for MSM and FSW who do not know their status, including mapping additional social media sites to deploy outreach workers and mobilization materials; deploying diverse outreach workers for in-person and virtual mobilizations using social and risk network referrals; saturating virtual sites with promotional materials linking them to testing services through the online booking; and follow-up systems to ensure successful linkages to treatment for KP. PEPFAR will support strengthening the tracking system to track cohort of mobilized KP against size estimates to distinguish KP who are new to the program.

The program will scale up testing by providing universal HIV testing for KP at all entry points, supporting secondary distribution of HIVST for KP social and risk networks to increase index testing uptake by motivating those who hesitate to come for testing at the health facility. , The program will continue to

mobilize KP, particularly FSWs, to bring their children for HIV testing together with expanding caregiver-assisted HIVST for children above two years of age using OVC platform Testing services will also prioritize people in prisons.

In COP23, PEPFAR/E will continue to support in-person and virtual comprehensive case management to facilitate initiations and continuity on treatment through the mobile clinics, drop-in centers and navigation to mainstream health facilities. In addition, Community Commodity Distribution (CCD) through smart lockers, pharmacies, and vending machines in appropriate spaces will also be expanded to address stigma and discrimination. LIFT-UP funds will broaden community pharmacy partnerships and use of smart lockers to accelerate PrEP and HIV self-testing access, incorporating use of digital technologies. PEPFAR/E will continue to support high-quality HIV treatment programming within prisons.

To intensify the prevention effort, PEPFAR/E will shift to implement an opt-out approach where all KP will be supported to utilize at least one biomedical intervention including condoms, and STI screening and treatment. Demand creation strategies to increase the uptake of those services, include 1) developing KP type-tailored comprehensive HIV prevention messages which will be disseminated through in-person and virtual mobilizations. 2) training outreach workers on messaging of biomedical HIV prevention strategies, and health care workers on provision of the HIV prevention opt-out approach to KP, according to their preferences and needs. 3) optimizing PrEP uptake by repackaging PrEP bottles informed by the results of the PrEP repackaging pilot conducted among KP in COP21. 4) implementing the PrEP communication strategy focusing on addressing key barriers identified by the program data on low PrEP utilization. 5) introducing and integrating new PrEP options such as the dapivirine ring (DPVR) and CAB-LA while continuing to offer daily and event-driven (ED) PrEP.

As one of the countries to receive CAB-LA injectable for pre-exposure prophylaxis in COP23, Eswatini has started preparations for its introduction. Through the PEPFAR- funded MOSAIC project Eswatini conducted an end-user consultation on CAB-LA to assess product acceptability, perceptions and associated needs to inform the positioning and eventual introduction of CAB-LA. Building on the findings of the assessment, Eswatini will be including CAB-LA in the PrEP Implementation Guidelines that are currently being updated. The end-user assessment also explored potential messaging to increase awareness about injectable PrEP and to foster an open, collaborative environment for discussing perceived benefits and challenges of CAB-LA uptake and continued use. These findings and messages from the recently launched Eswatini National PrEP Communication, Advocacy and Behavior Change Strategy will be used for demand generation and training materials on the injectable. PEPFAR will support the medicines regulatory and registration aspects of CAB-LA which are being led by the Ministry of Health. Further, PEPFAR Eswatini will support the roll-out arrangement, HIV testing requirements for CAB-LA and development of a pharmacovigilance plan for monitoring of adverse events.

In the second year of COP23 implementation, IBBS results will elucidate the extent of the need for opioid agonist therapy (OAT) and thus inform the design of the program (Figure 7). In COP23, the program will leverage the partnership with various ministries within GKoE and existing program

structures to address key structural barriers including supporting the GKoE to identify a government ministry to champion KP advocacy and expanding violence prevention and response packages to include mental health and psychosocial support provided in drop-in centers and other public health facilities. This will include support for safeguards for community workers against violence due to executing their functions of the KP program. Legal services will be mapped to facilitate linkage of KP for those in need and support capacity building for KP CBOs to have an emergency response including paralegals for community members when the need arises. Norms change interventions for KP will be integrated into DREAMS and other government community engagement platforms. Specific efforts to address stigma and discrimination include: 1) support for parents of KP to be engaged through social workers in drop-in centers, 2) support service delivery points that will be supported with KP inclusivity messages to promote stigma free services. 3) support for the annual FSW conference and supergroups to identify and advocate for FSW issues across government and society, and 4) Institutionalizing CLM data sharing in program platforms, including the national technical working group, regional coordination, and health facility and community-based platforms to acknowledge and promote positive perceptions and reception of the community while addressing persisting barriers.

Additionally, in COP23, the PEPFAR/E will map and link KP to existing economic strengthening, legal aid and social protection interventions including the youth and development funds for eligible KP. To improve access in mainstream facilities by addressing the stigma and discrimination experienced at the facilities, PEPFAR/E will support the development of KP competency standards and the accreditation of health facilities that implement the standards by the MOH. PEPFAR/E will continue to train and provide mentorship and supervision of health care workers (HCW) on KP competent service provision by supporting learning exchange visits to community centers and defining national centers of excellence. The program will engage the MOET to identify opportunities to strengthen gender diversity and inclusivity in the school system.

In COP23, in order to support integration of the KP program into the government system, PEPFAR/E will support a costing exercise for the national KP program with the MOH. PEPFAR will also begin shifting KP program staff to the MOH to facilitate government-led implementation towards sustainability. PEPFAR will continue to support greater involvement of KP in designing, implementing and monitoring through the establishment and functioning of a KP consortium to harmonize KP advocacy, sustainable KP programming, and rights. The program will continue to provide capacity strengthening for KP community-based organizations (CBOs), develop a resource mobilization strategy focusing on domestic resourcing of the KP program, and support domestic financing approaches, including social enterprise models for KP organizations.

2.5 Men (25-34 years) and Military

Men aged 25-34 years have the lowest population viral load suppression across all population groups at 62.9 percent (SHIMS3). According to SHIMS3, 25 percent (3,953 estimated) of males aged 25-34 years are unaware of status. Breaking it down further, 34 percent (1,910 est.) of males 25-29 years and 23 percent (1,066 est.) of males aged 30-34 years are unaware of their HIV positive status. Prevalence of undiagnosed

males aged 25-34years is calculated to be 3,2 percent using a combination of SHIMS3 and population projections data from the Eswatini Central Statistics Office (CSO). 13 percent of males 25-34 years are aware of their HIV positive status but not on ART. This proportion has not changed in the five years between SHIMS2 and SHIMS3. This proportion is driven by males 30-34 years (12 percent are aware of status but not on ART). For all males unaware of their HIV positive status, the biggest gap was in those with level of education equal to secondary (9.4 percent) and greater than secondary (14.9 percent) and in those in the middle to fourth wealth quintile. It is noteworthy that males of the highest wealth quintile have the highest linkage rate (98 percent) and the lowest awareness of status gap (5.3 percent).

Additionally, analysis of the military cascade indicated that only 71 percent of the military population know their status, there is also a need to improve uptake on ART (from 66 percent) and adherence support to increase VLS. (From 83 percent < 1000/copies).

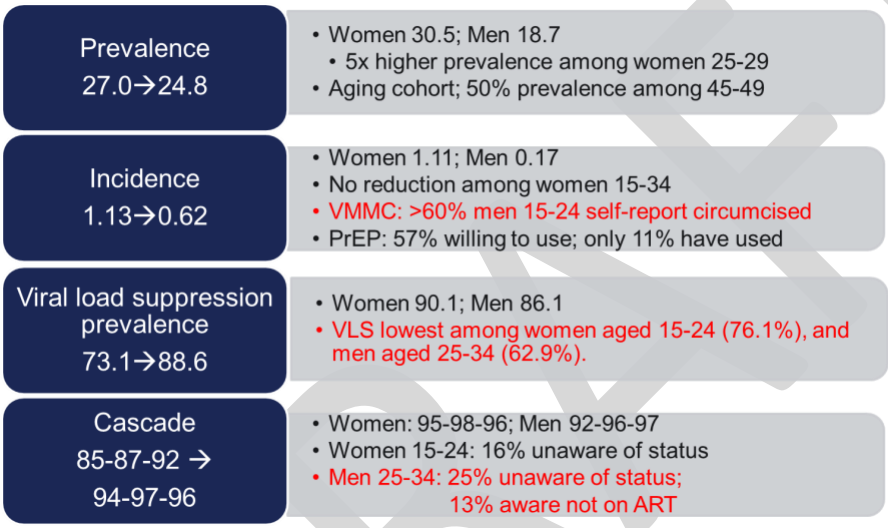

Figure 7: Summary of SHIMS3 Findings highlighting key gaps in males aged 25-34 years

Source: SHIMS3 2021

The gaps in this population cut across the treatment cascade but primarily impact case finding, linkage and possibly interruption in treatment. Viral load suppression of those on treatment is similar to the general population. Interventions are designed to address gaps across the treatment cascade for this population.

2.5.1 Case finding

Universal HIVST testing for males 25-34 years: this intervention is designed to reduce the number of eligible clients who are not tested due to misclassification by the current HIV screening tool. Eswatini will screen this population using an HIVST when they present to facilities or any testing points unless they qualify for routine testing using national HIV testing algorithm (Routine Testing: TB ANC, Presumptive and on treatment, STI, Index-testing, Inpatient and VCT). Those who screen positive with the HIVST will be tested using the national HIV testing algorithm. Those who test HIV positive will be linked to HIV treatment while those who screen or test HIV negative, will be actively linked to prevention services.

Provide an enhanced package of services for men: Generally, health facilities do not offer male specific services outside of treatment services, limiting platforms to engage men and share critical health information. Conversion of voluntary medical male circumcision (VMMC) clinics to comprehensive male clinics that provide screening and treatment for NCDs (diabetes, hypertension, mental health), addressing male sexuality and sexual and reproductive health needs as well as addiction and substance use is a key intervention to reach this population. Peer supported HIV specific services will be tagged on to these comprehensive services and will include VMMC, PrEP, PEP, HIV testing service (HTS) and HIV treatment services.

Targeted community testing approaches: An enhanced peer - support package of services for men including HIVST distribution will also be provided to male dominated workplaces, informal workplaces (transport operators, carwashes, cane cutters, dagga fields etc.), and tertiary institutions including pharmacies. Moreover, social network strategies will be integrated into index testing for male in the community.

2.5.2 Linkage and Continuity in Treatment

Pre-Treatment viral load: Newly identified PLHIV are generally in good health and therefore may not see the need to start treatment, potentially contributing to the high proportion of "aware and not on treatment" in this age group. In addition to the standard counseling messages outlining the known benefits of early initiation on ART, VL will be used in the same way CD4 was used in the past to explain to the client their clinical condition and the need for treatment. The high VL at ART initiation and a demonstrated change to a suppressed VL once on treatment can be used to explain how the concept of U=U directly relates to the client and to reinforce the effect of ART. This intervention, planned for national implementation through the program, is anticipated to help newly identified clients internalize U=U messages, improve ART uptake, reduce time to ART initiation and reinforce adherence. Given the lack of existing evidence on this intervention, the program will track ART uptake and time to ART initiation by age and sex or population group, and other parameters as needed, to monitor the impact of the intervention to inform future investment.

Collect data to improve understanding of males that the program is missing: The program does not have a full understanding of why males do not utilize HIV services. There is a need to collect additional qualitative data to improve PEPFAR/E's understanding of the barriers to uptake of HIV services. This will be done through focus group discussions, stakeholder engagements, and deeper dives into existing program and survey data.

Maximize use of digital health platforms and automation: This intervention intends to utilize existing and upcoming digital platforms to provide patient centered services. There have been significant investments made in digital platforms by PEPFAR/E, the Global Fund and the World Bank. These investments include audiovisual equipment in secondary and tertiary health facilities, connectivity platforms and drug dispensing lockers. These will be used to facilitate linkage to care, ongoing adherence through connecting peers to recipients of care, improve access to medication through

dispensing lockers, and build HCW capacity through and mentorship support using virtual-real-time support and online training programs.

Demand Creation and community engagement: There is a clear need to create demand for male-specific health services and to communicate the benefits of ART for men. This should accelerate uptake of HIV services. The program is looking at several potential pathways including push notifications through SMS, aggressive marketing of male sexual and reproductive health (SRH) and linked HIV services, use of community male peers and influencers to facilitate engagement with health services (leverage on VMMC peer to peer investments), use of personalized marketing approaches to reach men, rebranding of male wellness clinics to resonate with what men want, use of crowd sourcing to get ideas from men on how they want to receive services and understanding their knowledge, attitudes and perceptions regarding HIV and HIV service provision.

2.5.3 Voluntary Medical Male Circumcision (VMMC)

The program's COP 23 strategic approach is to scale up task-shifting, maintain quality, expand VMMC access, generate demand and improve efficiencies. The program will scale up VMMC services uptake and maximize linkage to other prevention services including PrEP. HTS is part of the minimum package of services for VMMC and PEPFAR/E will prioritize the distribution of HIVST to males within the VMMC program. There is a need to fully integrate HIV prevention services in all entry points in facilities and strengthen linkages of HIV-negative clients identified in facilities to prevention services. Those who test negative for HIV will be offered VMMC and other prevention services. People identified through VMMC as HIV positive will be linked to ART and then offered VMMC after at least three months on ART.

VMMC services will be further decentralized. Building on the newly rolled out nurse-led approach. The program will assess an additional 15 sites over the next two years and accredit them to provide VMMC services with the goal of improving access to these services. PEPFAR will support investments for innovative demand creation strategies, including the use of community male peer-to-peer mobilizers to facilitate demand generation. Pending discussions on the introduction of the ShangRing, in FY24-25, no males under 15 years of age will be circumcised, However, the program will work with the MOH to identify innovative approaches to facilitate VMMC uptake, including exploring device-based circumcisions if sustainable. The GKoE has prioritized early infant male circumcision (EIMC) as a long-term HIV prevention strategy and EIMC is included in the National Strategic Plan for VMMC, however, PEPFAR will not be supporting EIMC-related activities.

The program will make investments to support the national coordination office to integrate VMMC quality management system (QMS) into routine HIV programming through technical assistance aimed at transitioning some partner-led initiatives to government over the next two years. Approximately 38 percent of the military population are circumcised, and the focus on military populations and new recruits will continue through the US Department of Defense (DOD). VMMC Implementing Partners (Ips) will improve privacy, use interpersonal communication to improve service uptake, assure linkage and referral from other PEPFAR services, and strengthen linkage of PLHIV to care and treatment. Although

men living with HIV are eligible for VMMC, they should be on ART and virally suppressed prior to being circumcised.

2.6 Addressing Stigma and Discriminations, HR and Structural Barriers

In COP23, PEPFAR/E will utilize the stigma index conducted by the government to build on previous COP investments to address stigma and discrimination. Supporting government to identify a champion ministry for gender diversity will be prioritized. CLM will be institutionalized to inform programming at national, regional, facility and community platforms. PEPFAR will support the implementation of youth friendly standards, and development and implementation of KP standards to ensure equitable access for AGYW, KP, PLHIV and other vulnerable populations. Building on previous COPs, all implementers and service delivery points will ensure implementation of policy to safeguard against stigma and discrimination. The policies will be periodically assessed to evaluate the actual quality of services utilizing tools such as the CLM. IPs will also integrate stigma and discrimination reduction in community engagements for norms change.

In COP23, PEPFAR/E will continue to strengthen and demonstrate the inclusion of integrated non-judgmental services delivery in the training and mentorship for health care workers in health facilities. PEPFAR will also ensure that implementing partners facilitating community interventions train and mentor community cadres in diversity, inclusiveness, and stigma and discrimination reduction. In COP23, PEPFAR/E will monitor the impact of repacking of PrEP bottles in addressing stigma and improving uptake. Expert clients, linkages officers and KP navigators are the case management cadre PEPFAR/E deploys to facilitate peer-to-peer navigation in health facilities. This also includes structures such as youth corners and integrated package for youth friendly services to ensure that the services are responsive to the needs of young PLHIV and other marginalized populations. PEPFAR will continue to work with law enforcement to sensitize them on gender diversity and ensuring equitable access to health for all vulnerable populations especially KP. Additionally, the MOET will be engaged to strengthen gender diversity and inclusion for children of KP and adolescent and young KP in the school system.

3.0 Pillar 2: Sustaining the Response

3.1 Sustainability Roadmap

The GKoE provides strong political leadership in HIV/AIDS, as well as in policy formulation, strategy development, oversight, and service delivery. PEPFAR continues to be the largest external contributor to Eswatini's HIV response, followed by the Global Fund. Civil society and the private sector roles are critical and growing and they represent enormous potential to enhance the capability of Eswatini to sustain the HIV response.

The GKoE and PEPFAR/E started working on a strategy to support the sustained impact of the HIV/AIDS response in 2021 through a model dubbed Evolve, Achieve, Transition, and Sustain. The shared vision through this model is centered around **evolving** the HIV program to match the current epidemic and

sustainability needs; **achieving** 95-95-95 in all populations and reducing new infections; **transitioning** programs or components to local government or other local implementers; and supporting the capacitation of local systems and structures to **sustain** the gains.

A multistakeholder consultative process led by MoH and PEPFAR 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, human resource for health (HRH), and strategic information (SI)) and conduct a Strengths, Weaknesses, Opportunities, and Threats 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 during subsequent workshops. The MoH also conducted an internal sustainability planning retreat in 2022 to outline MoH priorities and decision points. Further engagements are planned during COP22 to agree upon priorities for program evolution, identify areas amenable for transition, and draft a roadmap outlining activities and necessary actions for short-, medium-, and long-term transition.

To advance this process, the GKoE plans to revive an existing Sustainability Steering Committee to oversee the development of the sustainability road map. The core working groups will feed into the Steering Committee which is composed of principal secretaries from six core ministries, PEPFAR, Global Fund principal recipients representing Global Fund programming, WHO, UNAIDS and CSOs. The MOH and PEPFAR will serve as secretariat responsible for convening meetings, tracking deliverables, and ensuring that timelines are met.

3.2. Government to Government awards & Partner Localization

A direct MOH-CDC government-to-government (G2G) cooperative agreement supports the MOH to provide technical leadership, coordination, human resources support, and quality management of the HIV response. Technical program officers within Eswatini National Aids Program (ENAP), National TB Control Program (NTCP), and National Cancer Control Plan (NCCP), funded by PEPFAR, drive guideline development and dissemination, coordinate technical working groups, oversee program implementation, monitor progress toward NSP targets, and run semiannual program reviews. The cooperative agreement also supports the MOH to strengthen the regional health management team structures, implement Quality Management audits and processes, and coordinate faith communities to incorporate HIV messaging and testing services through their networks.

Aligned with the PEPFAR 5x3 strategy, sustainability goals and the MOH vision for maintaining HIV program impact, COP23 begins the incremental process of shifting core program activities (and requisite staff and funding) from implementing partners to the MOH with support through the MOH-CDC cooperative agreement. Utilizing the financial and program management structures established over the past 15 years, MOH will begin to directly manage program activities for which it is responsible as the next step toward further organizational capacity building. Specific activities are likely to include mentorship and accreditation for regional laboratory quality management, full responsibility for organizing technical working group meetings and well-established HIV in-service trainings (NARTIS and IMAI), updating the ENAP staffing structure, and coordinating the MOH sustainability roadmap meetings

to outline the direction and evolution of activities that fall under the purview of MOH. Implementing partners will continue to provide technical assistance with an increased focus on technical capacity building of MOH counterparts. Over time, as further organizational and technical capacity is built, additional resources and responsibilities will be allocated to the MOH, as guided by the sustainability roadmap, to fully institutionalize program ownership and implementation as well as to leverage PEPFAR investments for public health preparedness and response.

A new cooperative agreement with NERCHA, the multisectoral parastatal under the Prime Minister's Office, is being explored. Similarly, mechanisms are being put in place to incrementally transition implementing partner roles (and requisite funding) to NERCHA as steps toward more direct program and financial oversight. The substantial involvement of the U.S. Government (USG) in the management of the MoH and NERCHA cooperative agreements provides the opportunity for USG to grow its direct technical collaboration and work in partnership with national institutions on this evolution while closely monitoring progress and outcomes. This will lay the foundation for eventual transition of core program staff and activities to government once domestic or alternative resource envelopes become available.

Moving towards building sustainability through local CSO partners, 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 includes four local implementing partners, with the majority of service delivery implementation having rapidly transitioned to local organization by the end of FY 2023. 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 COP23. Eswatini has made significant progress in localizing the portfolio. In COP22, there were four local implementing partners accounting for 21 percent of all program funding. By COP24, there will be six local implementing partners.

3.3. Health Financing

The majority of HIV clinical services in the country are delivered by GKoE, which also funds ARVs for adults. GKoE is committed to protecting the fiscal space for HIV commodities and has budgeted US$17.67 million for the procurement of ARVs for FY22/23. As per Table 3, PEPFAR provides technical and financial contributions to most key components of the National HIV response. Donors support critical areas in HIV/TB care, treatment, and prevention, including direct service delivery, technical assistance (TA), commodities, and human resources (HR). Health system support for government program management, supply chain, laboratory, surveillance and Client Management Information System (CMIS) continue to receive significant support from development partners Community-focused programming, including the DREAMS/OVC portfolio, are funded in large part by international resources.

While it is not a single payer system, Eswatini's health market is dominated by the public sector. The National Health Sector Strategic Plan (NHSSP) focuses on promoting universal health coverage (UHC) through models that expand services provided at the primary care level. The development of a national health insurance (NHI) model is in a conceptual planning phase, though MOH officials have stated publicly that it is a priority. Non-governmental organization NGO providers, including faith-based

organizations (FBOs), covers a significant proportion of public health services in Eswatini; however, government financing of these efforts is limited to subventions (grants) for operating expenses and the contribution of consumables, medication, and equipment from the Central Medical Stores (CMS). Efforts to convert CMS to a performance-based parastatal are in process with support from PEPFAR. A public-private partnership policy is situated under the Ministry of Finance and there is interest in social contracting models; that neither is covered by legislation may create opportunities to work with the World Bank and other development partners to inform policy by demonstrating new health financing approaches. During the COP23 development process, GKoE leadership expressed the intention to transition all HIV-related health commodity costs to domestic financing.

Table 3: Programming Areas Where PEPFAR has Shared or Primary Responsibility

Service Delivery	Above site (non-service delivery) Support	Strategy Formulation and Planning
● HIV and TB testing, are and treatment services ● Community outreach ● Community mobilization: norms and behavior change and norms ● Biomedical prevention including VMMC and PrEP ● Cervical cancer screening and treatment ● AGYW, Key populations, and GBV programming ● Health workforce salaries and benefits ● Procurement of ○ Pediatric ARVs ○ Viral load reagent, CD4 reagent, EID and other reagents and supplies ○ VMMC kits and consumables ○ Condoms and lubricants ○ HIV test kits	● Health Workforce training, mentorship and supervision for HIV/AIDS for all testing, clinical services, prevention, key populations, adolescent girls and young women, orphans and vulnerable children and gender-based violence services ● Development of program guidelines and SOPs ● National and regional level workforce salaries and benefits ● Training, mentorship and supervision ● Procurement and supply chain management functions ● Laboratory systems support ● Health information systems surveillance and research	● Adolescent girls and young women ● Self-testing ● VMMC ● In-service training and CME ● Most procurement and supply chain functions ● Most HMIS, surveillance, research functions ● Most laboratory Systems

3.4. Quality Management

PEPFAR/E will continue to utilize program and site monitoring data (MER, custom indicators, SIMS), and the community monitoring platform to improve quality of prevention and treatment services delivered at both facility and community levels. This includes, but is not limited to, routine review of 1) index cascades; 2) missed appointments and patient tracking; 3) cohort linkage data; 4) high viral load cascades; 5) PrEP initiation and continuation cascades; and 6) DREAMS layering by site, age, sex, and region. Completion of referrals and facility and community linkages focusing on KP, OVC, and GBV are also key outputs that will be monitored. In COP23, PEPFAR will continue to support quality improvement activities at all levels that are aimed at addressing service delivery gaps. Data quality assessments and

data verification activities will be conducted as part of quality management processes. NAHSAR, REHSAR and FAHSAR platforms will continue to be supported as part of QMS support structures.

PEPFAR's support will also focus on sustaining ISO 9001:2015 international quality management standard at one DOD site and four facility sites (one in each region). The program will sustain accreditation of National Molecular Reference Laboratory and National Testing Reference Laboratory. Partnership with Eswatini Standards Authority (SWASA) will be established to institutionalize the local certification of both facility and laboratory sites using the SLIPTA checklist. The MOH led the process of developing national HIV standards and PEPFAR will support the use of MOH HIV Standards tool as part of efforts in sustaining local monitoring of HIV service quality in facilities.

PEPFAR will continue to invest in monitoring and maintaining program quality improvement at the national level through the MOH 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 addition, support to scale up implementation of QMS in health facilities will continue in COP23. By the end of COP22, 34 facilities will be implementing QMS activities. Support will also be provided towards certification of AGYW and KP friendly/competent sites.

4.0 Pillar 3: Public Health Systems and Security

4.1 Person-Centered Services

In the spirit of improving patient centered services there are critical areas in the program that will be evolving to improve efficiency and efficacy and address populations that may have been missed. To incorporate these new innovations and changes requires PEPFAR and key stakeholders to work closely together. These changes include:

1. Exploring the use of digital platforms to support key program processes and interventions to improve efficiency and open possibilities for recipients of care who are technologically inclined. These include support for linkages to treatment, ongoing adherence support and to provide training and mentorship support through virtual platforms. This feeds into approaches to provide a wider range of patient-centered services and take services out of the facility setting for the convenience of recipients of care.
2. Acknowledging that current definitions for VLS may need to evolve to ensure optimized management of recipients of care with low level viraemia (LLV) i.e., VL between 20 cp/ml and 1,000 cp/ml. Patients with LLV may be at an increased risk to develop virologic failure. This is currently not addressed in clinical management of HIV guidance in the country. This requires further discussion and exploration and potentially development of new guidance to inform on key thresholds for VLS and how they impact patient management, and patient outcomes. This will address a population that was previously treated as suppressed yet they have specific needs to prevent disease progression and poor outcomes.

3. Accelerating the integration of HIV services into local health service delivery infrastructure through altering PEPFAR support to intentionally build government capacities and systems as well as capacities of community-led organization to lead the response and deliver key HIV services. This will be key in sustaining the gains that have been made. PEPFAR/E will continue ensuring that HIV services are integrated enough to offer "one stop" approaches for patients with comorbidities. DSD options need to align with the local health delivery structures and maximize PEPFAR support and relationships.

4.1.1 HIV Clinical Services

Patients in Eswatini receive HIV services primarily through government, PEPFAR, NGO, and industrial clinics. The government also provides free ARVs to accredited private for-profit facilities. Coordination for the HIV response at the multisectoral level happens thorough the National Emergency Response Council for HIV and AIDS (NERCHA), while the clinical component is coordinated thorough the Ministry of Health (MOH) structures, i.e., the Senior Management Team (SMT), public health programs (ENAP, SRHU, NTCP, NCCU) at the national level and regional health management teams (RHMT) at the regional level. PEPFAR provides technical assistance, financial and human resources to strengthen the HIV/TB response through these structures.

The country has made remarkable progress towards reaching the UNAIDS targets However, children (<15 years), adolescent girls and young women (AGYW) (15-29 years), Key populations and men (25-34 years) have not achieved this milestone and continue to be the focus of the response moving forward. The gaps remain in case finding, linkages and VLS among age<25 years continue to be below the 95 percent threshold.

The PEPFAR Eswatini remains focused on providing client-centered services, ensuring durable linkages, reducing interruption in treatment, and improving VLS across all populations. This will be guided by the nine (9) PEPFAR Core Standards, specifically for the treatment program, this means: 1) full implementation of "test and start", 2) ensuring all HIV services are free, 3) optimizing and standardization of treatment regimens, 4) offering differentiated services and 5) integrating tuberculosis (TB) care.

4.1.2 Case Finding to Maintain Epidemic Control

HIV Testing for Case Finding

Even though Eswatini has made tremendous progress towards HIV Epidemic Control, findings from SHIMS3 (2021) indicate that critical case finding gaps remain at sub-population level including among children, women 15-24, men 25-34. Other critical case finding gaps remain among certain sub-populations with 29% of the military (SABERS 2022), 34% of MSM, and 12% of FSWs being unaware of their status Moreover, HIV incidence remains persistently high among women 15–29-years (1.63 in the 15 – 24 age group and 1.90 in the 25 – 34 age group), whilst recency surveillance suggests late case identification for both populations. These case finding gaps need to be addressed through the following strategies to ensure Eswatini fully achieves and maintains the first 95 UNAIDS HIV epidemic control target.

The goal is to increase case finding among priority populations and achieve >95 percent linkage to treatment. The main case finding strategy is to provide safe and ethical comprehensive index testing both at community and facility levels. To optimize provider-initiated testing and counseling, universal screening using HIVST will be offered to males 20-34 and females 15-24 years receiving care through the outpatient department (OPD) unless they qualify for routine testing using national HIV testing algorithm (Routine Testing: ANC, TB presumptive and on treatment, STI, Index-testing, Inpatient and VCT). To improve pediatric case-finding, PEPFAR/Eswatini will use a validated pediatric screening tool at OPD entry-points for children aged 2-11 years and continue routine testing for high-risk pediatrics (malnutrition, TB, presumptive TB, and in-patients). To further improve case identification in communities, HIVST will be distributed will be distributed through a peer-led strategy (Social Network Strategy). HIVST will be offered to men, AGYW, KP through targeted community platforms including tertiary educational institutions, formal workplaces, pharmacies and informal workplaces (transport operators, carwashes, cane cutters, dagga [marijuana] fields etc.). This novel strategy will create a refined, targeted, and focused approach for high-risk populations who may not be willing to test, especially youth and male networks. HIV self-testing will continue to be utilized for secondary distribution to hard-to-reach sex partners and biological children >2 years of index clients. The program aims to fully leverage digital/social media platforms to reach young people in urban settings and community structures to reach young people in rural settings.

HIV Testing for Prevention Services

The country has adopted the status neutral approach to HIV testing, prevention and care. At the entry point, clients' needs are assessed, and they are engaged and linked to appropriate services based on these needs, regardless of whether their HIV test is positive or negative. PEPFAR/E and MOH have established standards articulating HIV testing services as a critical component of HIV prevention interventions among sero-discordant couples along with VMMC, PrEP monitoring, OVC, DREAMS, and KP programs, ANC, and post-ANC services. 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. HIVST will be particularly appropriate to support PrEP continuation and reduce follow-up clinic visits and for re-initiation of more experienced PrEP users. Hence repeat testing for PrEP continuation using HIVST will be done every three months to monitor sero-conversion as per WHO recommendation.

HTS is part of the minimum package of services for VMMC and PEPFAR /E will prioritize use of HIVST to males within the VMMC program. Those who test HIV negative will be offered VMMC and other prevention services. People identified through VMMC as HIV positive will be linked to ART and then offered VMMC after at least three months on ART. To further improve PrEP uptake amongst DREAMS beneficiaries, HIVST screening will be done to newly recruited beneficiaries, and those who test HIV negative will be confirmed with standard HIV testing algorithm and enrolled on PrEP. Semi-annual re-testing of DREAMS beneficiaries will be conducted based on risk assessment tool. For PBFW routine testing will be implemented (based on PMTCT guidelines) to reduce vertical transmission and to ensure continuation of prevention services to HIV-negative and to prompt treatment for women who seroconvert while pregnant or breastfeeding.

4.2 Reducing Morbidity and Mortality among PLHIV

4.2.1 Non-Communicable Diseases (NCDs)

As PLHIV live longer and virally suppressed on ART, PEPFAR/E recognized the importance of systematic screening of NCDs such hypertension, diabetes, and mental health in addition to cervical cancer screening for women. PEPFAR will support MOH's plans to implement chronic disease care model at ART clinics. This proposed model will ensure that ART patients receive NCD screening and treatment services under one roof and referral systems are in place for complicated cases. The model will also serve HIV-negative clients who have NCDs at the same clinics which will further promote the destigmatizing efforts around HIV and ART clinics. PEPFAR will use its existing expertise and mentorship platforms to achieve functional integration of HIV and NCD services through the following interventions:

- Supporting quantification of diagnostic and treatment commodities which are expected to exponentially increase in the immediate term.
- Integrating NCD screening and management into the existing HIV/TB in-service training curricula such as IMAI and NARTIS
- Supporting Eswatini Essential Medicines List to satisfy priority country needs and prescription requirements.
- Working with other partners and funding streams such as the Global Fund, WHO and World Bank to cover existing gaps in equipment, testing, training, and treatment needs for NCDs.

4.2.2 Cervical Cancer Program Support

PEPFAR supports cervical cancer screening at all PEPFAR supported sites with 158 health facilities providing screening services with visual inspection with acetic acid (VIA). Thermocoagulation, cryotherapy and loop electrosurgical excision procedure (LEEP) services are tiered depending on human resource capacity and patient volumes (Figure 8). Treatment of precancerous lesions is provided either on site or through referral for those who screen positive. Eswatini has achieved high treatment coverage for those diagnosed with precancerous lesion. In COP23, PEPFAR will support phased transition to the screen, triage and test approach using human papillomavirus (HPV) DNA testing. Integration of services within ART clinics will continue to ensure sustainability of cervical cancer screening among women living with HIV. PEPFAR Eswatini will support the following initiatives:

- Laboratory systems strengthening to expand HPV DNA testing and maintain expedited processing of LEEP samples.
- Closing the gaps of human resource capacity at health facility to ensure women who have not yet screened are reached with cervical cancer screening services.
- Support MOH in strengthening quality assurance activities for cervical cancer services, including linkage to treatment, and closing of referral loops for women with invasive lesions.
- Training to ensure health care providers have necessary skills to conduct VIA, HPV DNA testing, thermocoagulation, cryotherapy and LEEP.
- Above site support to the National Cancer Control Unit to update guidelines, SOPs, job aids and training materials to facilitate expansion of HPV DNA testing and align screening frequency with WHO recommendations.

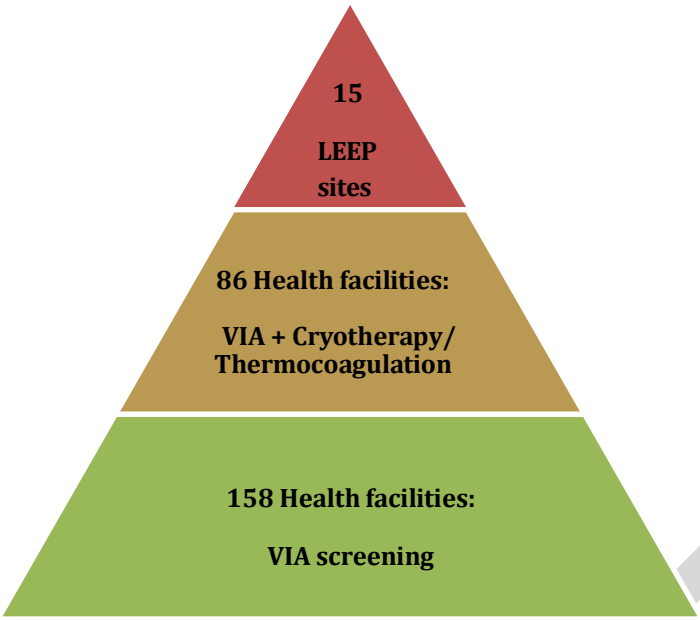

Figure 8: Tiered services delivery model

Source: PEPFAR Eswatini Program data, FY23 Q1

4.2.3 TB/HIV Program

Eswatini has made great strides in reducing the burden of TB from 1,590 cases per 100,000 people in 2010 to 348 cases per 100,000 people in 2022. Although symptom-based screening has remained as the gateway to TB services, new diagnostics approaches have been adopted and treatment options have also matched the current global best practices for both drug sensitive and drug resistant TB. HIV testing for TB patients has remained at 100 percent and more than 97 percent of TB/HIV coinfected patients receive ART. TB preventive treatment (TPT) provision has increased over the last four years from 15,674 annually in 2018, peaking at 43,724 in 2020, and then stabilizing to 24,018 ART patients in 2022. Despite these successes, Eswatini remain challenged with the following major gaps:

- 13 percent of TB patients still die from TB, no significant change in reducing mortality
- 54 percent of TB cases do not have any of the four symptoms
- 58 percent of rifampicin resistant TB cannot be diagnosed with the usual diagnostic platform due the TB mutation, I491F
- Frequent stock out of laboratory TB diagnostic reagents and TB treatment regiments
- Delayed transition from paper-based to electronic-based medical records. This has contributed to data quality challenges especially for TPT and TB diagnostic cascade data.

To address these challenges, PEPFAR support to the Eswatini MOH will focus on the implementing strategies described in the following subsections.

Increasing case identification and correct classification of people with TB

PEPFAR/E will support the revision of diagnostic approaches for TB especially among those living with HIV. This will involve inclusion of additional layers for TB screening for PLHIV who screen negative using

the symptom-based approach. The approaches will include expansion of use of C-reactive protein for screening, reviewing policies for the use of CXRs for TB screening as well as other chest-based infections and pathologies, use stool based Xpert MTB/RIF testing, and supporting MOH to routinely implement TB genomic sequencing to identify missed rifampicin resistant TB that may be missed by the current Xpert MTB/RIF Ultra or TB culture platforms. The targets for number of TB patients diagnosed were increased by 13 percent to 2,322 compared to the COP22 target. Through partnerships with the Global Fund and other funding partners, MOH will be supported to ensure adequate quantities of reagents, medicines and nutritional supplements are procured to ensure the best uninterrupted services are provided to patients.

TB preventive treatment and infection prevention and control

While national guideline now promotes early initiation of TPT among patients starting ART, PEPFAR will use its matured mentorship program to support service providers develop standard procedures to ensure that newly enrolled patients receive TPT within one month of starting ART. Facility based quality improvement projects will be conducted to ensure that those already on ART who never received TPT are identified and put on the TPT. Eswatini is now using a combination of 3HP, fixed dose INH/CTX/B6 and 6H for TPT and all products are sufficiently stocked. Using findings from the recently concluding joint TB/HIV program review, PEPFAR will support the TB/HIV and Quality Management programs to address gaps identified mainly related to the implementation of infection prevention and control workplans and monitoring and evaluation of these activities.

Addressing gaps in data use and information generation

PEPFAR plans to support MOH to consolidate data within CMIS. Indicators review will be prioritized to ensure that all mandatory TB indicator reporting requirements are fulfilled within CMIS. PEPFAR will support Eswatini to implement the following:

- Conduct TPT data evaluation to estimate true TPT coverage given the persistent challenges with TPT data that has been observed following the migration from paper based and electronic APMR data to electronic CMIS platform.
- Develop a system to utilize mortality reviews and audits data for improving clinical care and clinical systems will be developed through stakeholder engagement. These reviews will be extended from mainly TB mortality to also cover ART patient death review.
- Implement integrated NCD screening activities for both TB and ART patients.

4.2.4 Advanced HIV Disease (AHD) Management

Eswatini has made significant strides in reducing the estimated adult HIV incidence from 1.16 percent in 2016 to 0.62 percent in 2021. The UNAIDS 95-95-95 targets are at a high of 94-97-96 based on the population survey of 2021. Despite these successes, at least 12 percent have a low CD4 count <200 cells/µL and an even higher proportion presents with AHD at health facilities. CD4 testing coverage is low at 33 percent. TB/HIV coinfection is at 65 percent. The advanced HIV disease package which

includes CrAg screening and pre-emptive fluconazole prophylaxis is only available at secondary and tertiary facilities thus increasing catastrophic costs for patients from communities served mainly by clinics. Therefore, the following activities are planned for COP23 to support MOH deliver accessible quality AHD services:

- Increasing availability of CD4 testing, PEPFAR will support procurement of POC Visitect testing kit
- Supporting policy barriers to the implementation of basic AHD services at primary care clinics. PEPFAR will support MOH to provide exemptions and work towards relisting of fluconazole for primary care use in the essential medicines' lists
- Decentralization and testing protocols for TB LAM and CrAg to facilitate screening of AHD conditions
- Quantification and forecasting of AHD commodities to reflect expanded scope and facility coverage.

4.3 Community Health

PEPFAR Eswatini supports access to health services for key and priority populations by providing person-centered care in health facilities and extend this to community through the differentiated service delivery (DSD) models. Mobile facilities support mainly KP and AGYW populations. Community Commodity Distribution (CCD) was initiated in COP19 as part of providing services in communities during the COVID-19 lockdowns. It is currently being explored for expansion so as to continue with decongesting health facilities and providing all PLHIV with alternative methods to obtain services in the community. This platform has provided services beyond ART including NCD, HIVST, PrEP, SRH and other prevention services. The PEPFAR program deploys community health care workers to mobilize and support AGYW, KP, ABYM to test for HIV, link and adhere to both prevention and treatment services. In COP23 PEPFAR/E will continue to bridge the divide between community and health facilities by creating pathways from community to facility and vice versa to ensure that referral loops are closed. These pathways will strengthen clinical management, social and economic empowerment to improve health and HIV outcomes. PEPFAR/E will continue supporting integration of HIV services into primary health care through community health worker-led approaches which involve Rural Health Motivators and other community health cadres.

4.4 Supply Chain Management

Eswatini continues to endure commodity stock ruptures which emanate primarily from a mix of historical challenges with timely releasing of committed funds from key commodity funders leading to delayed payments and subsequently delayed deliveries, limited agility to respond to supply chain stressors and ad hoc early warning systems to respond to stressors. In COP23, PEPFAR Eswatini will continue to support the national annual quantification, forecasting exercise, and the subsequent commodity quarterly supply planning approval. PEPFAR and the Global Fund, the key partners to the GKoE, have historically provided funding guarantees and have committed funds in a timely manner. This

has resulted in Eswatini experiencing a reduction in TB/HIV commodity stock outs and stock stability for the selected supported procurements. To further reduce stock out rates PEPFAR/E, the Global Fund and the GKoE will further improve coordination and ensure timely release of funds for order placement into the multiple procurement platforms made available for the GKoE to utilize.

PEPFAR/E continues to monitor international logistical constraints, freight increases, and shortages of active pharmaceutical ingredients (APIs) and raw materials to inform partners and the GKoE on anticipated challenges and guide on appropriate response To improve commodity security PEPFAR/E will closely monitor in country 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. PEPFAR /E will further improve both central medical stores (CMS) commodity stock management and end-to-end visibility through provision of support to the maintenance and troubleshooting of the electronic warehouse management information system. Technical assistance will also be provided for proper warehouse commodity storage and security, business reconfiguring of the warehouse to improve turnaround time and further improvement of in-country logistics through provision of electronic proof of delivery.

In-country logistics were also impacted by human resource constraints at the CMS. PEPFAR/E still supports some positions to improve in-country logistics for commodity deliveries. The open-source electronic logistics management information system (eLMIS) has been piloted and has rolled out with challenges due to funding. PEPFAR/E does not directly fund eLMIS, however PEPFAR/E will provide technical support and overall project management support. In COP23 PEPFAR/E will continue to collaborate with the Global Fund to support the efficient roll-out of the eLMIS in selected sites to promote end-to-end stock availability. To strengthen the use of best practices for stock management at lower levels, PEPFAR/E will continue to support Regional Logistics Officers to strengthen regional and facility level commodity security and management through supply chain supportive supervision and commodity redistribution. In addition, PEPFAR/E will support activities that promote sustainable waste management solutions, rational medicine use and pharmacovigilance.

4.5 Commodities

PEPFAR/E, the Global Fund and other funding partners will continue to advocate for incremental domestic funding and a committed funding contribution from the private sector for commodity procurement. Subsequently, Eswatini will have the budget ring-fenced around more HIV/TB commodity categories that are all inclusive and cover rapid test kits (RTKs), laboratory reagents and pharmaceuticals to support the programs in the whole cascade of the HIV/TB continuum of Care. For COP23, the GKoE does not anticipate any commodity funding gaps after extensive mapping across all funding sources to develop a commodity plan. Table 4.5 summarizes COP23 commodity coverage.

Table 4: COP23 Commodity Coverage

GKoE	PEPFAR	GF
• 100% adult ARVs including PrEP and PEP • TB treatment and prophylaxis medicines • Essential medicines including all NCD medicines • Portion of laboratory reagents • RTKs • Advanced HIV Opportunistic infection diagnostics and treatment • VMMC commodities and consumables	• Pediatric ARVs • RTKs including rapid test kits for recency testing and dual HIV/Syphilis tests • Viral load reagents and consumables • EID reagents and consumables • Condoms and personal lubricants • VMMC commodities and consumables • Advanced HIV disease diagnostics	• TB laboratory diagnostics, treatment and prophylaxis • RTKs including HIVST • POC EID reagents and consumables • Adult ARVs including PEP and PrEP (not for FY24) • Condoms and personal lubricants • Advanced HIV Opportunistic infection diagnostics and treatment

PEPFAR/E will continue to support the procurement of VL reagents and consumables through all-inclusive pricing models for the newly placed Panther Hologic and 5800 Roche platforms as per the diagnostics network optimization (DNO) recommendations. End-to-end commodity security will be ensured through support for electronic warehouse management information system, electronic proof of delivery at facility level, and continued support and advocacy for rolling out the electronic logistic management information systems. PEPFAR/E will continue to support Regional Logistics Officers to respond to regional and facility-level supply chain challenges, including reverse logistics support, optimized stock management, stock redistribution and supply chain data management and reporting. PEPFAR/E will support the country in the Community Commodity Distribution model.

4.6 Laboratory Systems (VL, EID, DNO)

The 2021 DNO recommendations are being rolled out in COP22, beginning with the VL GeneXpert multiplexing followed by the replacement of the obsolete CAP/CTM platforms with selected high throughput platforms that have the capacity of conducting DBS VL. In COP23, Eswatini will continue to close gaps in VL testing coverage among priority populations including PBFW and children under 5 years through optimizing existing GeneXpert multiplexing in selected sites. DBS VL testing will also be scaled up using the plasma separation card (PSC) to ensure that all new platforms have the capacity to incorporate the test for hard-to-reach areas and after working hours access to VL testing. This will also close the existing gap in community VL testing access. In COP23, as an innovation to address low ART coverage among men 25-34 years old living with HIV who know their status, Eswatini will introduce pre-treatment VL as detailed in Section 2.5.2 Linkage and Continuity in Treatment. EID testing will remain centralized but complemented by M-PIMA testing at selected public health units and maternity wards.

A fully rolled out implementation of DNO recommendations for conventional platforms and POC multiplexing will strengthen the TB diagnosis strategy by scaling up stool-based POC test for children,

support the implementation and routinizing of HIV and TB drug resistance diagnostic and surveillance, continue decentralization of AHD testing and monitoring throughout the tiered lab network. Eswatini will continue to advocate for the establishment of Eswatini Public Health Laboratory (EPHL) to assume its core functions and national leadership and coordination role for public health laboratory activities while supporting surveillance and research. This intervention will include conducting a situation analysis of the existing surveillance activities to inform development and the implementation of the EPHL operational plan.

Program shifts in laboratory system strengthening in COP23 will focus on building EHLS national and subnational mentorship capacity to oversee implementation of LQMS within the lab network. The capacitation will also strengthen quality assurance bodies which will work collaboratively with regional regulatory bodies to ensure that the National Reference Laboratories maintain accreditation status and other identified laboratories are mentored and audited for accreditation using the SLIPTA checklist. To strengthen HIV testing services, the existing HIV testing algorithm will be revised to incorporate a tiebreaker and the HIV/Syphilis dual test used within the PMTCT program.

PEPFAR/E will continue support for a laboratory-based HIV drug resistance surveillance system to detect emerging drug resistance and to inform appropriate 2nd- and 3rd-line ARV regimens. Finally, PEPFAR/E will provide technical assistance to EHLS towards the development of the 5yr strategic plan, development of national lab quality regulatory framework and provide logistical support for national sample transport systems.

4.7 Human Resource for Health

The GKoE hiring freeze effective since 2016 has impacted all Ministries, including MOH. The PEPFAR HRH inventory and cost implications are critical to engage relevant Ministries across government. Collaboration among stakeholders outside of the health sector will be defined to support a sustained response. As prospects of lifting the hiring freeze improve, PEPFAR will be positioned to ensure that appropriately trained human capital is deployed where there are acute staff shortages and that they match the needs and priorities for health service delivery and align with government functions. In COP23, the MOH and PEPFAR, will work on the classification of project positions that are PEPFAR-funded and considered critical for the HIV/AIDS response. Aligning PEPFAR-supported salaries to government pay scales will be an important factor to inform the sustainability planning.

PEPFAR investment of the HR Information System as a planning and deployment system for HRH should be prioritized and owned by the MOH. A thorough review of the job descriptions for Eswatini National Aids Program (ENAP), National Tuberculosis Control Program (NTCP) and Sexual Reproductive Health Unit (SRHU), Rural Health Motivation (RHM) Program, and PEPFAR Lay Cadre positions supporting the HIV response will be conducted in collaboration with the Ministry of Public Service (MOPS) and Ministry of Tinkhundla and Development (MTAD) through the relevant structures in AIDS Coordination at national and regional level. These positions will also be mapped to illustrate the support of the HIV response provided over the years to inform the sustainability discussion. The Ministry of Finance and

Ministry of Economic Planning and Development (MEPD) will then be engaged following government protocol at the senior management level (US and PS level) to develop a PEPFAR HRH policy.

4.8 Strengthening National Public Health Institutions and Public Health Emergency Response Structures

Eswatini is in the nascent stage of National Public Health Institute (NPHI) development with technical support from Africa and US Centers for Disease Control and Prevention (CDC). As such, PEPFAR/E is focusing on aligning PEPFAR investments in core NPHI components such as laboratory systems and surveillance with a broader public health preparedness and response functions that can be easily transitioned to the NPHI once formally established. In the laboratory space, PEPFAR/E will support the development of an operational plan for the National Public Health Laboratory based on the framework outlined in COP22. For surveillance, PEPFAR/E will conduct a rapid assessment of existing surveillance systems to inform the development of an integrated and forward-looking public health surveillance strategy as well as support the production of the weekly public health surveillance report compiled by EDCU.

The MoH is currently exploring opportunities to further strengthen its public health workforce through the establishment of a Frontline Field Epidemiology Training Program. For the initial phases, technical leadership is being provided through the South Africa National Institute of Communicable Diseases with funding through World Bank. PEPFAR technical staff and implementing partners will serve in mentorship capacity and explore opportunities for ongoing partnership and expansion. PEPFAR played a critical role in the COVID response through participation in the public health emergency management structures and will continue to provide technical support through ongoing engagement in the National Public Health Emergency Management structures.

5.0 Pillar 4: Transformative Partnerships

PEPFAR/E benefits from remarkable access to and cooperation with the GKoE and national stakeholders on the evolution of the HIV/AIDS response. In addition to meetings and briefings with the King, Prime Minister and Cabinet, a 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, Information, Communication and Technology, as well as representation by NERCHA, PEPFAR and the Global Fund will be reinstated in 2023.

Sustaining the impact of HIV interventions will require investments that will increase domestic revenue for health alongside broad-based strengthening of the economy. PEPFAR will do its part, catalyzing innovations in the health sector that will have collateral benefits for the economy, as well as addressing high youth unemployment and related economic factors for PEPFAR beneficiaries. Addressing the

country's GBV crisis and other structural issues creating vulnerability to HIV, particularly for young women, is essential for reaching and maintaining epidemic control. Because of their destabilizing impact on development and the business climate, youth unemployment and GBV are core shared issues among development partners and the private sector. PEPFAR will work to build on new and emerging partnership opportunities with multisectoral GKoE agencies, the United Nations, diplomatic missions, and private sector partners to: (1) expand training, internship, entrepreneurship for young people; and (2) expand programming and infrastructure that addresses the immediate and long-term needs of people exposed to violence.

5.1 Government Partnership

PEPFAR's support to the GKoE is aligned with the National Multi-Sectoral Strategic Framework (NSF) for HIV and AIDS 2018-2023 objectives 2 with a shared vision on reducing HIV, incidence, and mortality. Under this framework, service delivery in Eswatini is led by multiple ministries and departments. Within the MoH, the Eswatini National AIDS Program (ENAP) leads the health sector HIV response; the Department of Social Welfare (DSW), and the Children's and Gender Units within the Deputy Prime Minister's Office (DPMO) are responsible for providing and coordinating social services to vulnerable populations, including violence prevention and response and finally within the he Ministry of Education, the Guidance and Counseling Department leads the life skills program while the Technical and Vocational Education and Training Programme contributes to the economic strengthening interventions. The Eswatini HIV response is coordinated by the Prime Minister's Office through NERCHA.

The strong partnership between PEPFAR/E and GKoE is demonstrated through formal engagements with the various ministries and departments to deliver health services under the NSF. These include regular meetings with the Senior Management Team of the Ministry of Health (MoH) and participation in several Technical Working Groups (TWG) platforms where technical assistance is provided on a range of issues on an ongoing basis.

COP23 PEPFAR/E will continue to leverage GKoE National Response by providing resources, technical assistance, and capacity-building to ensure that interventions complement and build on existing programs and provide high quality HIV and TB related services. In addition, PEPFAR/E will continue to strengthen capacity of organizations and improve an effective coordination of the HIV and TB response at central, regional and facility levels. Furthermore, PEPFAR/E will support the National Emergency Response Council on HIV/AIDS (NERCHA) mandate to facilitate, coordinate, and monitor implementation of the national multi-sectoral response. PEFAR/E will strengthen the capacity of the Deputy Prime Minister's Office (DPMO) to lead, coordinate and monitor GBV prevention and response activities.

New partnership through the MoH Cooperative Agreement award will be formed with Eswatini Standards Authority (SWASA), a parastatal entity under the auspices of the Ministry of Commerce, Industry and Trade, to support the development of a national accreditation scheme of sub-national laboratory.

With the need to evolve programming to sustain the gains and ensure a country-led ownership of the national HIV response, PEPFAR/E will build on formal discussions with GKoE on the pathway to sustainability of the national HIV response and engage various sectors of the government to develop the sustainability roadmap with a focus on HRH and clinical training and mentorship approach.

5.2 Private Partnership

In Eswatini, large local companies are organized under Business Eswatini, which represents more than 80 percent of private sector investments in the Kingdom and with which PEPFAR/E enjoys close collaboration. Numerous partnerships have been developed around HIV and COVID-19 program priorities in recent years with Business Eswatini member organizations focused on three work streams: (1) expanding vocational, digital skills, and entrepreneurship training, internships and seed capital for youth; (2) collaborating with the creative sector to promote COVID-19 vaccines and PrEP; and (3) mobilizing contributions to establish additional GBV and trafficking in persons (TIP) survivors shelters and related programming. At the height of the COVID-19 crisis, local foundations and private sector groups partnered with PEPFAR to help address Eswatini's medical oxygen shortage.

While Eswatini is a small market, it is strategically located within the Southern Africa Customs (SACU) and the Common Market for Eastern and Southern Africa (COMESA). The U.S. Embassy has prioritized promoting two-way trade and investment with U.S. businesses, particularly those already with a base of operations in neighboring South Africa. Ongoing collaborations with U.S. pharmaceutical companies aim to build on COVID-19 vaccine investments to help deploy optimized HPV vaccines regimens, injectable PrEP and, potentially, long-acting injectable ART as part of an implementation study.

More broadly, development issues negatively impacting the investment climate – power and connectivity – are limiting PEPFAR's ability to support digital transformation in the health sector. PEPFAR's significant funding to Eswatini's health sector have created platforms to attract innovations and regional market access opportunities for U.S. industries. Building on other USG investments and funding streams, PEPFAR/E is discussing a public-private partnership collaboration with Prosper Africa to deploy low Earth orbit (LEO) broadband to rural and outreach clinics to enable new telehealth and virtual mentoring applications, while improving connectivity to ensure uptime of existing health information systems.

With the current instability of the Southern Africa power market and the looming prospect of significant disruptions from 2025, PEPFAR/E is exploring several market-shaping innovations under Power Africa's global public-private partnership, the Health Electrification and Telecommunications Alliance (HETA), to catalyze the health sector's access to more affordable and dependable renewable energy sources. Pending final approvals, Eswatini has developed a proposal under State-USAID Digital Connectivity and Cybersecurity Partnership to revamp Eswatini government connectivity, including schools and clinics, with trusted networking equipment from U.S. companies. Taken together, these activities aim to develop the digital health infrastructure needed to modernize PEPFAR-supported implementation models as part of the sustainability agenda.

5.3 CSO Engagement Strategy

PEPFAR/E recognizes the critical role CSOs play in the HIV response through their understanding of the political and cultural environment; advocacy for beneficiary populations; promotion of human rights to combat stigma and discrimination against KP, PLHIV, and other vulnerable groups; advancing inclusion for people with disabilities; identifying challenges to, and gaps in, health care delivery and innovation and in providing informed views for the development of robust and responsive service delivery models and programs.

To ensure meaningful and representative participation of CSOs in the COP23 planning and development process, PEPFAR/E working with the Coordinating Assembly of Non-Governmental Organizations (CANGO), convened a group of representatives from key CSO constituencies for PLHIV; KP; AGYW/DREAMS; faith-based organizations; Men/traditional structures; youth and general CSOs. This group of representatives participated in various COP23 consultative, planning and development platforms including stakeholder consultation meetings and program task team meetings where they contributed to the formulation of COP23 strategies. This included participating in a community-led monitoring specific task team.

CSO actively engaged in the meetings to provide updates on the quarterly PEPFAR Oversight and Accountability Response Teams (POART) results and COP23 planning activities. Specifically, CSO participated in the COP23 PEPFAR Partner; Government and Stakeholder strategy input and review meetings held on February 12 and 14 2023. These meetings informed the COP23 Planning Meetings in Johannesburg held February 27, through March 03, 2023, wherein CSOs had an opportunity to further feedback on the proposed strategies and their engagement.

CSO engagement continued after the COP23 planning meetings wherein discussions and feedback were incorporated into the draft strategies in task team meetings held March 9, 2023, and a subsequent stakeholder meeting held on March 21, 2023. These meetings focused on the integration and incorporation of feedback into the COP23 Strategic Direction. Drafts of the Strategic Direction Summary (SDS) were also shared to gain their valuable feedback and input. In COP23 the PEPFAR/E small grants program will continue to prioritize implementation of the CSO CLM platform to collect community engagement in HIV services.

6.0 Pillar 5: Follow the Science

6.1. Surveillance, Surveys and Research

The Epidemiology and Disease Control Unit (EDCU) under the MOH's Strategic Information Department is mandated to manage surveillance systems in Eswatini. EDCU uses the Integrated Disease Surveillance Response (IDSR) as recommended by WHO African Region. IDSR currently monitors 20 conditions of public

health concern. EDCU currently disseminates weekly and monthly Epi bulletins as well as COVID-19 Situational Reports (SITREP). In addition, there are other surveillance systems that are managed by different programs within the MOH such as the Malaria and TB programs. Recently COVID-19 surveillance systems have also been developed. Noting the fragmented surveillance systems, MOH resolved to integrate all the surveillance systems under EDCU. 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.

In the context of addressing identified gaps, COP23 focuses on supporting the EDCU to develop an integrated national surveillance system, institutionalize HIV case surveillance with potential expansion to other areas of concern, including TB and NCDs, support for quality HIV recency surveillance implementation, improving mortality reporting, and strengthening the capacity to manage, analyze, disseminate and use surveillance data. 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 key digital health activities in COP22 such as development of a data exchange repository and Master Patient Index to increase the interoperability among various data systems.

Implementation of HIV recency surveillance represents a key element within the larger HIV case surveillance strategy contributing to the reach and sustainability of epidemic control as well as increasing our ability to respond to where new infections are happening. 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 COP18, PEPFAR/E has been supporting the scale up of recent infection surveillance from 38 health facilities towards a target of 165. In COP23, 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 groups with heightened transmission where increased number of recent infections are seen including interventions targeting AGYW such as DREAMS and prevention of new infections among PBFW. COP23 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.

In addition, COP23 will also support the updating and developing strategic documents, guidance, & policies as well as a rapid assessment of existing surveillance systems with the aim to identify opportunities for integration. The proposed review of the MOH Strategic Information Department will also strengthen the operations and functionality of EDCU. Mentorship for case surveillance monitoring data analysis and response will also continue to be provided.

Eswatini will be conducting a third Integrated Biological and Behavioral Surveillance (IBBS) Survey for KP, following the IBBS that was conducted in 2021. The IBBS will provide updated HIV prevalence and treatment cascades for KP. The survey will also include sexually transmitted infections (STI) prevalence and the status of structural barriers. The IBBS will cover MSM, FSW, TG people and PWID. Protocol development and approval by relevant IRBs will be done in FY23 to enable the survey to be completed in COP23.

Health research activities are guided by the National Health Research Agenda that was developed in 2021 and is meant to expire in 2021. The MOH National Health Research and Innovation Department (NHRID) will be supported to improve National Health Research capacity in the synthesis, dissemination, and utilization of research products. 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 broaden capacity to improve the review of research protocols & monitoring of studies. In addition, support will also be provided to increase capacity for secondary analysis of survey data (SHIMS/VACS, IBBS) to answer research questions as well as establishing a knowledge management system/platform and related guidelines/SOPs.

7.0 Strategic Enablers

7.1 Community Leadership

CLM is being implemented by CSOs under the leadership of CANGO, the umbrella body for NGOs in Eswatini and the coordinator for CLM with Community Engagement and Rehabilitation Alliance (CERA) serving as the technical Coordinator for CLM. CANGO and CERA support 4 CBOs who conduct assessments at facilities in each region. CLM oversight is carried out by a Steering committee. In FY23, CLM is focusing on KPs and the implementation of a KP services specific assessment tool at KP sites. This includes the integration of the local KP networks service delivery assessment tool into the overall CLM platform. CLM has also integrated networks of people with disabilities and provided a grant to the Bible Society to collect feedback from clients with disabilities across the four regions.

To date CLM has provided up to 19,450 clients with a platform to give feedback on service delivery at facilities. CLM data has shown that some PLHIV clients still experience stigma and discrimination and accidental disclosure of their HIV status at facilities. These incidents discourage clients from visiting facilities and accessing testing and treatment services. 0.2 percent of KP clients felt that Health care workers do not respect confidentiality and privacy and further experienced unfriendly and unprofessional services and felt unsafe in the facility. CLM highlighted the need for the program to continuously sensitize health care providers on stigma and discrimination and ensuring confidentiality of patients' HIV status. For KP, CLM has shown the need for the continuous education for healthcare providers on KP-friendly services to make every health facility accessible and user-friendly for all populations.

The consultations with CSOs and key stakeholders during FY23 revealed the following needs; 1) to strengthen the involvement of PLHIV, KP and youth-led organizations in the oversight and implementation of CLM, 2) to strengthen national level results dissemination and stakeholder engagement, 3) to improve data management and analytics for results generation, 4) to scale data collection sites and coverage of service delivery points & populations, and 5) to develop capacity to generate corrective action and formulate advocacy strategy. In COP 23, PEPFAR/E will support CANGO to improve the representation of PLHIV, KP and youth-led organizations into CLM Steering Committee and increase their continued engagement in CLM implementation.

Working in collaboration with UNAIDS, PEPFAR/E will support CANGO to strengthen stakeholder engagement and reporting at regional and national levels. This will include supporting CANGO to produce results fact sheets and quarterly reports at national and regional levels. FY25 will see the introduction of community feedback meetings at regional levels.
Aligned with improved reporting, CLM data management and analytics system will be strengthened by working with UNAIDS to support CSOs to develop and contextualize qualitative tools which will include, standardized focus group discussion guides, key informant interview guides, and observation checklists. This activity will also include training for implementing CSOs on the tools, upgrading the CLM dashboard and analytics, and supporting data analysis and visualizations capacity building through training of trainers. In FY25, PEPFAR/E will support the development of an online version of the CLM dashboard and key analytics to improve access to data for clients and other key stakeholders.

Furthermore, PEPFAR/E will strengthen partnership with the Global Fund, UNAIDS and the Global Network of PLHIV to utilize components of national CLM for broader implementation of actions. This will include building the capacity of CSOs on corrective action planning and campaign strategy development. FY25 will focus on developing a national level advocacy strategy to roll out specific campaigns for core service issues that remain unaddressed or require policy changes.

COP23/FY24 will focus on the expansion of coverage of service delivery points at appropriate frequency across programs, priority populations and facility & community sites. Activities will include scaling up of facility sites from 20 sites to 60 sites, by allocating 15 sites per region. Two data clerks will be assigned to the region and will collect data for two days in each facility on a rotational basis rather than daily data collection at fewer sites. The modification will allow for a wider reach of facilities within the same resource envelope while also alleviating the surveying fatigue reported by clients and facilities. The HR cost saving will be repurposed to cover additional travel costs to cover more sites and the recruitment of a community monitor who will cover community sites.

7.2 Innovation

PEPFAR/Eswatini is exploring technological innovations to enhance client-centered implementation models. Smart lockers were introduced to provide alternate ARV pickup points for HIV patients, with COVID-19 funds being utilized to enlarge the smart locker footprint. Planning is underway to expand use cases in support of PrEP services and delivering NCD medication. While smart lockers take advantage of PEPFAR-supported regional innovations, PEPFAR/E is working with local partners to explore the

development of 'home-grown' technologies to provide remote medicine options, including use of kiosks to provide telehealth and vending machines to dispense health commodities from secure locations. Digital health investments in biometrics and the master client index will help bridge systems and catalyze investments in non-traditional service delivery mechanisms. Using COVID-19 funds, a bot-supported WhatsApp channel, the "Health Alert" app, was created under the MOH to promote accurate information on COVID-19 management and vaccine services. Through LIFT UP funds, PEPFAR/E will support expanded use of the Health Alert app to promote additional health-related services such as PrEP and GBV prevention. Technological innovations depend on reliable and affordable connectivity and power solutions, both of which have restrained innovation and business investment in the Kingdom. As referenced in the private sector section, PEPFAR/E is developing several public-private partnerships to demonstrate connectivity and power models that will increase reliability and usability of those utilities, while lowering operating costs of the health sector to reinvest in service delivery.

The GKoE's relatively strong support for domestic HIV financing provides a solid base from which to expand resources as part of the sustainability agenda. A key component of this effort is generating data to demonstrate efficiencies in procurement systems, and the allocation and management of human resources. In support of these efforts, PEPFAR/E is collaborating with PEPFAR digital health and financing interagency subject matter experts to lay the groundwork for possible implementation of an activity-based costing and management (ABCM) model integrated into data systems to lower costs, broaden the scope, and increase the replicability of ABCM data generation. In COP23-24, PEPFAR/E will continue to explore partnerships with development banks to develop models for performance-based public-private partnerships and/or social contracting mechanisms to diversify health financing models, particularly for NGO providers constrained by operating costs or limited management systems.

7.3. Leading with Data

In FY24 and FY25 PEPFAR/E and the GKoE will build on advances in strategic information to amplify data impact on person-centered service delivery and evidence-based decisions at all levels. Through a collaborative process, Eswatini stakeholders have defined an ambitious data agenda to lead a post HIV epidemic control transition including data governance, surveillance and research capacity, health information systems, and data use at all levels for COP23. PEPFAR Eswatini investments are guided by the priorities of producing "One Truth" and supporting GKoE national integrated health sector data flows that concurrently deliver priority HIV epidemic control data requirements.

7.3.1 Governance, Policy and Guidelines

Stakeholders identified governance structure, policy and guideline gaps that impede progress on data-related priorities. The priorities identified include health workforce with requisite skills for current and future needs, guidelines to address reporting from private facilities, data access and use policies and guidelines to concurrently support evidence-based decision making, protection of client level data, and national data sovereignty. While PEPFAR Eswatini is committed to providing requisite technical and financial assistance, including support for unit institution structure reviews, these key governance, policy and guideline gaps must have GKoE leadership and commitment to achieve progress.

7.3.2 Health Information Systems,

In collaboration with the GKoE, the Global Fund, and other partners, PEPFAR/E is strengthening the national integrated health information systems. The GKoE Client Management Information System (CMIS) is actively used in 212 sites and supports 88 percent of individuals currently receiving ART. PEPFAR/E will support the GKoE's goal of expanding use of CMIS to all facilities, with technical assistance, software development support, and strengthened site-level mentorship and oversight for improving data coverage in CMIS, with a particular focus on TB and PMTCT services in COP23. While currently 95 percent of CMIS sites are able to submit data on daily basis, PEPFAR will support the introduction of measures for Point of Care (POC) system use across service points within existing sites.

As initiated in FY23, PEPFAR/E will support the National HIS to be person-centered and focus support on service delivery and programmatic challenges. In FY24 and FY25, key support will focus on integration of community and facility services, the NERCHA Community Data Action Platform (CDAP), the Ministry of Education and other non-health data flows to improve ability to integrate different data types for expanded use, to monitor effectiveness of prevention activities, and to create predictive analytics models to improve targeting of prevention services. PEPFAR Eswatini integration support will include continued support for national MOH health architecture including Health Information Exchange (HIE) and continued support to evolve and improve unique identification, including expanded use of the Master Patient Index (MPI), biometrics, and new emerging technologies such as facial recognition.

Data security requires a combination of technical, policy and capacity interventions. New dual factor authentication and other technical security improvements are being piloted but there is a need for updated policies or guidelines on access privileges of different cadres, roles and responsibilities, and health care worker training. PEPFAR regional IPs will support facility level practice and PEPFAR will continue to support improved evolution of system security according to MOH priority requirements.

7.3.3. Data Use, Integration and Analysis

FY24 and FY25 will see new emphasis on data dissemination, data repository, analytical tools, access to structured data sets curated to meet data needs, and capacity to create a conducive environment for rapid data analysis and use by different stakeholders according to mandate, levels and evolving requirements over time. PEPFAR/E will support applied use of the national data warehouse to serve specific data use cases including case-based surveillance, the ability to create and monitor custom indicators, and issue briefs or research papers for emerging programmatic questions or priorities. Taking into consideration user requirements, human and financial resources required to sustain use, PEPFAR/E will work to support a pyramid of data access, tools, and competencies. PEPFAR/E will support MOH efforts to institutionalize a MOH Strategic Information Department data product calendar and associated processes for development of analytic products.

8.0 Target Tables

Table 8.1: ART Targets by Prioritization for Epidemic Control

Target Table 1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24) *TX_CURR***	**Newly Initiated Target (FY24) *TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	**218,572**	**3,237**	**210,796**	**215,000**	**5,689**	**98.4**	**100%**
No Prioritization			**3,244**	**3.544**	**323**		
Total	**218,572**		**214.040**	**218,544**	**6.012**	**98.4%**	**100%**

Source: PAW

Table 8.2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Target Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts						
	2023		**2024**		**2025**	
Target Setting Age Bands	**Estimated Population Male**	**Current Coverage**	**VMMC_CIRC Target**	**Expected Coverage**	**VMMC_CIRC Target**	**Expected Coverage**
15-24	120,083	3%	3,449	3%	3,778	
25-34	99,336	2%	1,773	2%	1,997	
35-49	79,661	1%	760	1%	830	
50+	57,553	1%	305	1%	324	
Total	**356,633**		**6,287**		**6,929**	
15-24	0		90			
25-34	0		100			
35-49	0		20			
50+	0					
Total	**0**		**210**			

Source: PAW

Target Table 3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Table 3: Target Populations for Prevention Interventions to Facilitate Epidemic Control										
Target Population	Sex	Total Population	PLHIV		KP_PREV Target		PP_PREV Target		AGYW_PREV Target	
		2023	2024	2025	2024	2025	2024	2025	2024	2025
10-14	Female	70,647	1,700	1,634			15,833	15,833	15,791	12,633
	Male	71,193	1,710	1,645			56	56		
15-19	Female		0	0					13,718	6,828
15-24	Female	117,876	11,272	10,487			30,659	30,659		
	Male	120,083	4,420	4,312			4,550	4,550		
20-24	Female		0	0					13,809	7,002
25-29	Female		0	0					8,292	4,106
N/A	N/A		218,572	216,949	17,806	19,063				
Total		**379,799**	**237,674**	**235,027**	**17,806**	**19,063**	**51,098**	**51,098**	**51,610**	**30,569**

Source: PAW

Target Table 4: Targets for OVC and Linkages to HIV Services

Target Table 4 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC OVC_SERV Comprehensive	Target # of OVC OVC_SERV Preventative	Target # of active OVC OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files OVC_HIVSTAT
FY24 TOTAL		**61,881**	**9,328**	**8,540**	**44,705**
FY25 TOTAL		**61,881**	**9,328**	**8,540**	**44,705**

9.0 Core Standards

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
Offer safe and ethical index testing to all eligible people and expand access to self-testing	Safe and ethical index testing is being provided to all index cases including their biological children< 19 years. Intimate Partner Violence screening and adverse event monitoring are also conducted and documented. HIVST kits are distributed both at facility and community level	HTS counsellors are PEPFAR supported including trainings on ethical index testing. PEPFAR also support tracking and testing of index contacts at community level	-Maintain implementation status. -Improve tracking of contacts at community level -Use of HIVST as a screening tool in OPD and community setting for targeted populations. -Train nurses from non-PEPFAR supported sites to conduct index testing
Fully implement "test-and-start" policies.	Test and start has been rolled out. 89% receive test and same day ART initiation and an additional 8% are initiated within 2 weeks (rapid ART initiation).	>90% of TX_NEW	Maintain
Directly and immediately offer HIV-prevention services to people at higher risk.	Combination prevention services are offered to at risk population in the program prioritizing on bio medical and structural interventions	PEPFAR supports the PMO and NERCHA, DPMO, MOH, MOET, MOJ and MOSCYA to reach and provide the services to priority and key populations in 34 SNU for DREAMS and identified hotspots.	- Estimate populations at risk of contracting HIV - Finalize indicators for tracking and monitor coverage populations at risk of contracting HIV
Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic	The OVC program will continue to offer the comprehensive program to the OVC and their families focusing on priority sub-populations which includes Children and adolescents living with HIV, Survivors of sexual violence, Children of	PEPFAR supports implementation of the comprehensive OVC program in 34 SNUs providing and a modified OVC service package is provided to C/ALHIV residing outside OVC SNUs.	Maintain implementation and prioritize enrollment of children at high risk for treatment interruptions, and families experiencing challenges with continuity of treatment and ART adherence

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
interventions in support of HIV prevention and treatment outcomes.	people living with HIV, children of female sex workers, HIV exposed infants and children from child headed households. Case management approach is used to provide services to OVC and their caregivers. Services that include HIV prevention intervention and economic strengthening activities for caregivers.		
Ensure HIV services at PEPFAR-supported sites are free to the public	HIV services are provided free of charge		Maintain
Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity	Stigma and discrimination reduction activities have been implemented at community, facility levels with health care workers, law enforcement, guardians or parents and beneficiaries. The purpose is to facilitate provision of stigma free services while beneficiaries are equipped to know their rights and demand these services.	Health care workers, law enforcements and community leaders are sensitized on stigma reduction and transformative social norms	- Maintain implementation - Improve outcomes for norms change work - Improve health care workers sensitizations to standard KP competency standards
Optimize and standardize ART regimens	89% of PLHIV on treatment are on TLD. Only 5%0n TLE. 7% are on other regimens that include other DTG combinations and PIs for second line.	PEPFAR procures all Pediatric ART while the government and GF procure all adult ART	Maintain

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
Offer differentiated service delivery models	At the end of Q1 FY23, 37% of TX_CURR was on 6MMD, down from a peak of 87% in Q2 FY2. Decline has mostly been due to data challenges		Work with IPs to improve the documentation of 6 MMD in CMIS (especially capturing prescriptions and amount dispensed) Ensure that programmatically clients who are eligible for 6MMD receive it.
Integrate tuberculosis (TB) care.	All supported ART clinics have integrated TB screening services. All supported TB clinics provide HTS and ART services. Symptom based TB screening misses TB cases.	PEPFAR supported 3HP which is currently in use. PEPFAR supports national level staffing, training and mentorship on TB/HIV services.	Maintain high level of TB/HIV integration and introduce new screening and diagnostic tools to improve TB treatment coverage/ case detection.
Diagnose and treat people with advanced HIV disease (AHD).	AHD services are limited to hospitals, health centers and clinics with full time medical officers. AHD evaluation is recommended for new ART patient, those re-engaging in treatment after an interruption of $\geq$ 1 year and those with virologic failure. However, only a third of eligible patients receive CD4 testing.	PEPFAR supports procurement of CD4 count testing kits, training and mentorship on AHD services	Supporting CD4 count test kits procurement and decentralization of services to high volume clinics
Optimize diagnostic networks for VL/EID, TB, and other coinfections.	Diagnostic network optimization done for all Platforms	PEPFAR funded the Diagnostic Network Optimization for Eswatini	Implement recommendations from the Diagnostic Network optimization and

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.	SIMS is the main quality assurance tool.	Supporting QIPs at site level through EGPAF and Georgetown University Supporting QMS at the national level through MOH-COAG	Continue to improve implementation of QA at site level. Strengthen national quality TWG at national level.
Offer treatment and viral-load literacy.	Treatment literacy currently focusing on reducing repeat testing.	PEPFAR supports national treatment literacy campaigns	Refine U=U messaging targeting youth and strengthen treatment literacy among pediatric caregivers
Monitor morbidity and mortality outcome.	Updated electronic reporting for medical certificate of cause of death (MCCoD) has completed the pilot phase and roll out to prioritized public health facilities is ongoing. This includes improved capture of facility-based deaths in the national population registry as part of the CRVS system, leveraging the electronic interface with CMIS.	To date, supported the piloting of the transition from paper-based to electronic MCCoD reporting through updating of the form, trainings, and analysis/review of pilot findings to inform broader roll-out.	Continue technical and new/refresher training-related support to ensure quality implementation and increased coverage and accuracy of reporting into the system
Adopt and institutionalize best practices for public health case surveillance.	Protocol development is underway, led by MOH in collaboration with stakeholders to define CBS implementation. This is being done concurrent to and in alignment with critical COP22 key digital health activities such as development of a data	National technical support to EDCU and HMIS as key MOH SI units leading surveillance and national MOH system architecture.	Support EDCU's applied use of the data repository, MPI, and HIE in support of improved HIV case surveillance and potential expansion to include other conditions of concern, such as TB and NCDs.

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
	repository, Master Patient Index (MPI), and Heath Information Exchange (HIE) as CBS will leverage this national systems architecture.		
Enhance local capacity for a sustainable HIV response.	Technical program officers within ENAP, NTCP, and NCCP, funded by PEPFAR, drive guideline development and dissemination, coordinate technical working groups, oversee program implementation, monitor progress toward NSP targets, and run semiannual program reviews. PEPFAR has made great progress in strengthening local partner capacity, particularly in the OVC/DREAMS portfolio to lead and transition to direct awards for implementation.	A direct MoH-CDC G2G cooperative agreement supports the MoH to build organizational and technical capacity and to provide technical leadership, coordination, human resources support, and quality management of the HIV response. USAID is in process of developing a cooperative agreement with NERCHA PEPFAR/E directly funds and builds capacity of local CBOs and NGOs to implement the DREAMs and OVC programs	Mechanisms are being put in place to incrementally transition implementing partner roles (and requisite funding) to government entities as steps toward more direct program and financial oversight. This will lay the foundation for eventual transition of core program staff and activities to government once domestic or alternative resource envelopes become available. PEPFAR will continue efforts to strengthen local partner capacity to lead and transition to direct awards for the implementation of key technical areas. COP23 will see the expansion of local IPs from 4 to 6 over 2 years.
Increase partner government leadership	The GKoE provides strong political leadership in HIV/AIDS and has worked with PEPFAR/E on a strategy to support the sustained impact of the HIV/AIDS response through	A multistakeholder consultative process led by MoH and PEPFAR to develop an evolution and transition roadmap commenced in 2021 with an initial workshop to	GKoE to revitalize the higher-level Sustainability Steering Committee composed of principal secretaries from six core ministries, PEPFAR, GF principal recipients representing GF programming, WHO, UNAIDS

Core standards	Status of implementation	PEPFAR contribution	Plan for FY24/25
	a model dubbed Evolve, Achieve, Transition, and Sustain. The vision is to evolve the program as we achieve HIV epidemic control and transition components to government or other local implementers, while simultaneously strengthening the capacity of local systems and structures to sustain the gains.	establish five core working groups (program leadership/coordination, service delivery, financial management, HRH, and SI) and conduct a SWOT analysis for transition.	and CSOs. The roadmap core working groups will drive the discussions and inform decision points.

10.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR Eswatini's COP23 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, closing case-finding gaps 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 Foreign Service Nationals (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. The PEPFAR Coordinator hiring mechanism will remain with USAID secondment to PCO for COP23 (having shifted from State in COP22), impacting budget only, with the function and structure of the position remaining unchanged. The interagency Communications Officer position approved during COP22 under PCO is currently being established and classified. 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 14 staff positions: four direct hires (country director, deputy director, SI advisor, and laboratory advisor); three high level technical contractors (Care and Treatment Advisor, TB/Associate Director for Science Advisor and SI/ M&E Technical Lead), three FSN technical leads (VMMC, prevention and lab), and two FSN M&O positions (program management specialist and program management assistant). 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 FSN vacancy, the Health Systems Strengthening lead. This position has been vacant for over 18 months due to the reclassification process; recruitment for this position is ongoing.

To address recruitment and retention limitations, create additional leadership, supervision, and locally employed staff capacity building opportunities, and align technical support with the pillars of the new PEPFAR strategy, CDC is revising its organizational structure. Specifically, CDC will move from a flat to a tiered structure, forming a leadership team of five (which requires expansion of CDC's footprint by one FSN). In addition to the country director and the deputy director, this restructuring elevates the direct hire lab advisor position to an Associate Director of Pandemic Preparedness and Response with a

broader scope and supervisory responsibilities over lab and health systems strengthening, evolves the direct hire SI branch chief to an Associate Director of SI, adds a high level FSN (ideally GS-13) Associate Director for Programs position to oversee and strengthen alignment between the program technical team. The overall agency CODB increased to account for the additional FSN position and accommodate increased M&O, ICASS costs and incremental salary increases.

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. Seven of these positions are currently filled and one is actively being recruited. In addition, both the Country Director, and Director of Program and Training provide in-kind support to the PEPFAR program, funded by Peace Corps. These positions complement additional staff totaling 35 as well as up to 100 Volunteers. Volunteers are returning to the country in a phased approach, starting in September of 2022. By the end of 2023, we anticipate up to 30 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, and a logistics technician/driver. In addition, a DREAMS coordinator position will be hired by Peace Corps and seconded and 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 COP22, 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 FY23.

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.

The overall agency CODB increased slightly due to moderate increases in ICASS costs for CDC and USAID. ICASS costs remained flatlined for State Department and DOD.

APPENDIX A -- Prioritization

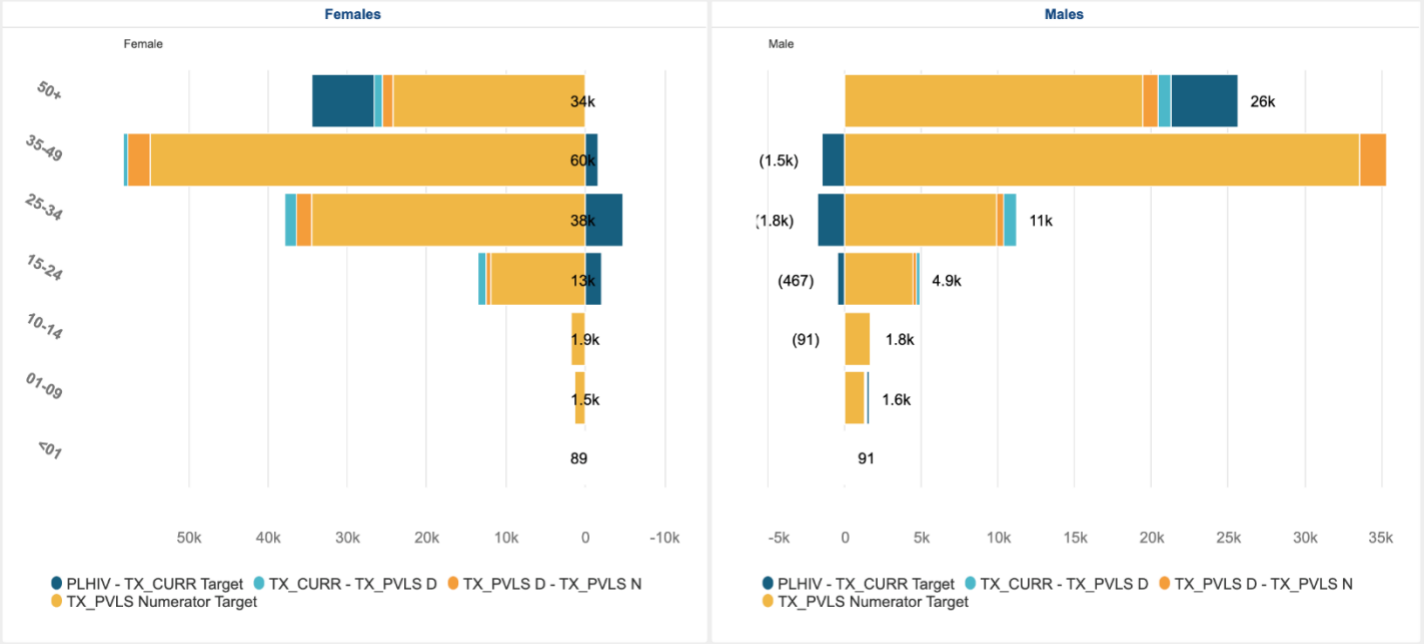

Figure 9: Epidemic Cascade Age/Sex Pyramid

Source COP23 Target Setting Tool dossier in PAW

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1: COP22, COP23/FY 24, COP 23/FY25 Budget by Intervention

Intervention	COP 2022	COP 2023	COP 2024
ASP	**$6,575,445**	**$8,542,141**	**$7,504,996**
HMIS, surveillance, & research>Non Service Delivery>AGYW	$100,000		
HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$2,144,391		
Health Management Information Systems (HMIS)>Non Service Delivery>AGYW		$300,000	$291,000
Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$982,482	$1,179,482
Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$938,092	$818,092	$818,092
Laws, regulations & policy environment>Non Service Delivery>AGYW		$235,000	$238,338
Management of Disease Control Programs>Non Service Delivery>AGYW		$500,000	$340,077
Management of Disease Control Programs>Non Service Delivery>Key Populations		$80,000	$78,000
Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$2,870,724	$2,467,899
Policy, planning, coordination & management of disease control programs>Non Service Delivery>AGYW	$150,000		
Policy, planning, coordination & management of disease control programs>Non Service Delivery>Key Populations	$80,000		
Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$2,319,962		
Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations	$638,000	$761,452	$761,452
Public financial management strengthening>Non Service Delivery>Non-Targeted Populations	$205,000		
Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Key Populations		$600,000	$0
Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$1,394,391	$1,330,656
C&T	**$25,087,364**	**$23,754,726**	**$23,463,882**
HIV Clinical Services>Non Service Delivery>AGYW	$50,000	$25,000	$25,000
HIV Clinical Services>Non Service Delivery>Key Populations		$50,000	$50,000

HIV Clinical Services>Non Service Delivery>Military	$367,127	$297,127	$356,719
HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$5,610,195	$7,349,964	$7,014,139
HIV Clinical Services>Non Service Delivery>Pregnant & Breastfeeding Women	$188,679	$188,679	$180,268
HIV Clinical Services>Service Delivery>AGYW	$268,100	$268,100	$260,000
HIV Clinical Services>Service Delivery>Key Populations	$302,408	$302,408	$294,000
HIV Clinical Services>Service Delivery>Military	$380,556	$310,489	$375,292
HIV Clinical Services>Service Delivery>Non-Targeted Populations	$7,815,530	$7,789,882	$7,747,317
HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women	$598,354	$598,354	$590,508
HIV Drugs>Non Service Delivery>Military	$24,191	$24,191	$23,505
HIV Drugs>Non Service Delivery>Non-Targeted Populations	$731,000	$731,000	$731,000
HIV Drugs>Service Delivery>Children	$971,681	$775,730	$775,730
HIV Drugs>Service Delivery>Non-Targeted Populations	$875,433	$599,356	$599,356
HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$847,639	$892,639	$891,548
HIV Laboratory Services>Service Delivery>AGYW	$37,843	$37,843	$37,843
HIV Laboratory Services>Service Delivery>Children		$76,045	$76,045
HIV Laboratory Services>Service Delivery>Military	$31,438	$31,438	$30,547
HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$3,717,524	$3,406,481	$3,405,065
Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$2,269,666		
HTS	**$2,837,666**	**$2,672,480**	**$2,660,756**
Community-based testing>Non Service Delivery>AGYW		$37,018	$37,018
Community-based testing>Non Service Delivery>Non-Targeted Populations		$96,000	$96,000
Community-based testing>Service Delivery>Key Populations	$188,739	$371,655	$362,000
Community-based testing>Service Delivery>Non-Targeted Populations	$730,402	$484,402	$484,402
Facility-based testing>Non Service Delivery>Military	$154,000	$134,303	$149,634
Facility-based testing>Service Delivery>Non-Targeted Populations	$946,067	$1,442,002	$1,431,702
Facility-based testing>Service Delivery>Pregnant & Breastfeeding Women	$107,100	$107,100	$100,000
Not Disaggregated>Non Service Delivery>AGYW	$28,669		
Not Disaggregated>Service Delivery>Key Populations	$182,916		

Not Disaggregated>Service Delivery>Non-Targeted Populations	$499,773		
PM	**$18,253,602**	**$17,779,920**	**$17,204,593**
IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$175,000	$350,842	$0
IM Program Management>Non Service Delivery>AGYW	$1,130,791	$1,164,791	$1,133,000
IM Program Management>Non Service Delivery>Key Populations	$515,000	$515,000	$500,000
IM Program Management>Non Service Delivery>Non-Targeted Populations	$7,177,840	$7,231,978	$6,925,507
IM Program Management>Non Service Delivery>OVC	$1,392,450	$553,450	$539,000
USG Program Management>Non Service Delivery>AGYW	$446,000	$446,000	$446,000
USG Program Management>Non Service Delivery>Non-Targeted Populations	$7,416,521	$7,517,859	$7,661,086
PREV	**$10,474,991**	**$10,303,001**	**$9,782,202**
Comm. mobilization, behavior & norms change>Service Delivery>AGYW	$1,391,664		
Comm. mobilization, behavior & norms change>Service Delivery>Non-Targeted Populations	$459,832		
Comm. mobilization, behavior & norms change>Service Delivery>OVC	$406,411		
Condom & Lubricant Programming>Non Service Delivery>Key Populations	$37,500	$37,500	$37,000
Condom & Lubricant Programming>Non Service Delivery>Non-Targeted Populations	$112,663	$112,500	$110,000
Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations	$499,837	$500,000	$500,000
Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$100,000	$121,456
Non-Biomedical HIV Prevention>Service Delivery>AGYW		$1,589,063	$1,565,399
Non-Biomedical HIV Prevention>Service Delivery>Non-Targeted Populations		$327,832	$320,000
Non-Biomedical HIV Prevention>Service Delivery>OVC		$643,411	$627,000
Not Disaggregated>Non Service Delivery>AGYW	$1,220,845	$1,085,845	$1,069,465
Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$300,000	$50,000	$49,000
Not Disaggregated>Service Delivery>AGYW	$915,904	$1,121,019	$1,096,115
Not Disaggregated>Service Delivery>Key Populations	$222,900	$222,900	$217,000

Not Disaggregated>Service Delivery>Non-Targeted Populations	$234,317	$294,817	$284,575
PrEP>Non Service Delivery>AGYW	$134,000	$134,000	$131,000
PrEP>Non Service Delivery>Key Populations	$745	$745	$0
PrEP>Non Service Delivery>Non-Targeted Populations	$531,812	$674,255	$537,882
PrEP>Service Delivery>AGYW	$717,435	$817,435	$711,362
PrEP>Service Delivery>Key Populations	$190,257	$190,257	$186,000
PrEP>Service Delivery>Non-Targeted Populations	$501,317	$602,884	$591,043
Primary prevention of HIV and sexual violence>Service Delivery>AGYW	$1,305,902		
Primary prevention of HIV and sexual violence>Service Delivery>Non-Targeted Populations	$172,500		
VMMC>Non Service Delivery>Non-Targeted Populations	$284,849	$285,619	$285,619
VMMC>Service Delivery>Military	$20,000	$20,000	$19,433
VMMC>Service Delivery>Non-Targeted Populations	$814,301	$836,531	$813,531
Violence Prevention and Response>Non Service Delivery>AGYW		$46,000	$46,000
Violence Prevention and Response>Service Delivery>AGYW		$495,388	$288,000
Violence Prevention and Response>Service Delivery>Non-Targeted Populations		$115,000	$175,322
SE	**$8,010,932**	**$8,012,932**	**$7,802,468**
Case Management>Non Service Delivery>OVC	$93,214	$711,682	$710,468
Case Management>Service Delivery>Key Populations		$206,000	$200,000
Case Management>Service Delivery>OVC	$1,600,906	$1,513,835	$1,471,000
Economic strengthening>Service Delivery>AGYW	$1,715,793	$1,521,793	$1,480,000
Economic strengthening>Service Delivery>OVC	$742,338	$1,017,338	$990,000
Education assistance>Service Delivery>AGYW	$737,375	$878,375	$849,000
Education assistance>Service Delivery>OVC	$885,670	$938,670	$911,000
Legal, human rights & protection>Service Delivery>Key Populations	$206,000		
Legal, human rights & protection>Service Delivery>OVC	$66,929		
Not Disaggregated>Non Service Delivery>OVC	$600,468		
Not Disaggregated>Service Delivery>Non-Targeted Populations	$7,500		
Not Disaggregated>Service Delivery>OVC	$17,500		
Psychosocial support>Service Delivery>OVC	$1,337,239	$1,225,239	$1,191,000
Grand Total	**$71,240,000**	**$71,065,200**	**$68,418,897**

Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area

Program	COP 2022	COP 2023	COP 2024
C&T	$25,087,364	$23,754,726	$23,463,882
HTS	$2,837,666	$2,672,480	$2,660,756
PREV	$10,474,991	$10,303,001	$9,782,202
SE	$8,010,932	$8,012,932	$7,802,468
ASP	$6,575,445	$8,542,141	$7,504,996
PM	$18,253,602	$17,779,920	$17,204,593
Grand Total	**$71,240,000**	**$71,065,200**	**$68,418,897**

Table B.1.3: COP22, COP23/FY 24, COP 23/FY25 Budget by Beneficiary

Targeted Beneficiary	COP 2022	COP 2023	COP 2024
AGYW	$10,350,321	$10,702,670	$10,044,617
Children	$971,681	$851,775	$851,775
Key Populations	$1,926,465	$2,576,465	$1,924,000
Military	$977,312	$817,548	$955,130
Non-Targeted Populations	$48,976,963	$48,618,984	$47,333,131
OVC	$7,143,125	$6,603,625	$6,439,468
Pregnant & Breastfeeding Women	$894,133	$894,133	$870,776
Grand Total	**$71,240,000**	**$71,065,200**	**$68,418,897**

Table B.1.4: COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative

Initiative Name	COP 2022	COP 2023	COP 2024
Cervical Cancer	$1,500,000	$1,500,000	$1,497,783
Community-Led Monitoring	$230,000	$263,906	$263,906
Condoms (GHP-USAID Central Funding)	$500,000	$500,000	$500,000
Core Program	$50,364,199	$48,564,304	$47,553,690
DREAMS	$10,209,626	$10,209,815	$9,999,617
KP Survey		$600,000	$0
LIFT UP Equity Initiative		$650,000	$0
OVC (Non-DREAMS)	$5,733,175	$6,050,175	$5,900,468
USAID Southern Africa Regional Platform	$1,203,000	$1,203,000	$1,203,000
VMMC	$1,500,000	$1,524,000	$1,500,433
Grand Total	**$71,240,000**	**$71,065,200**	**$68,418,897**

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 COP23 strategies that were agreed upon by all stakeholders. The FY22 PEPFAR Expenditure Reporting results and FY23 budget were used as a baseline

for setting the FY24 and FY25 budget. Adjustments were made for activities that will not be carried into FY24 and FY25, activities that will be implemented more efficiently and other program variations whose implementation will continue in FY24 and FY25. Estimates based on the country program's experience were used for new mechanisms that did not have historical data.

The overall funding envelope decreased by 1% from COP22 and resources have been planned in a manner that will facilitate the attainment of the 95-95-95 targets across all ages and sexes by the end of FY25 while sustainably strengthening public health systems. PEPFAR's 5x3 strategy prioritizes above site programming, which has been increased by 24% from COP22. 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 – Above site and Systems Investments from PASIT and SRE

PEPFAR/Eswatini identified key barriers and gaps to achieving epidemic control by 2025 through analysis of the SID 2021 findings, MER results, SIMS visit reports and 2023 HIV/TB/SRH joint program review. These barriers include:

1) COMMODITY SECURITY 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 GKoE 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 GKoE'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.

COP23 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 map to a section of the 2021 SID in which the country scored yellow. COP23 above site activities have measurable outcomes to ensure adequate progress towards achieving epidemic control and meeting minimum requirements.

PEPFAR/E has included in the COP23 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 the PASIT 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.

System investments in the PASIT 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. Further, PASIT and SRE activities are also aligned with civil society priorities and have been mapped and aligned with GKoE, GF and other donor investments to ensure complementarity of activities.