PARTNERSHIP FRAMEWORK ON HIV/AIDS

Implementation Plan 2009-2013

A collaborative effort of the
Government of the Kingdom of Swaziland
and the
Government of the United States of America

23 February 2010

FOREWORD BY THE RIGHT HONOURABLE B.S.S. DLAMINI, PRIME MINISTER OF SWAZILAND

The Swaziland Partnership Framework on HIV and AIDS 2009-2013 captures one of the most substantial and generous programmes of assistance that this country has received towards fighting HIV/AIDS. This programme, which is to be implemented in a partnership between the Government of Swaziland and the United States President's Emergency Plan for AIDS Relief (PEPFAR), provides no less than US$ 28 million for each of the next five years. That is more than E230 million per annum at present exchange rates – a very substantial programme of assistance.

It is, therefore a great honour and pleasure to place on record the Government of Swaziland's commitment to this partnership with PEPFAR as well as our profound gratitude for the generosity of the United States Government.

HIV/AIDS remains an enormous challenge to our Nation. Whilst much has been achieved over the past decade, both institutionally and in prevention, care and treatment programmes, the current prevalence figures remain less than encouraging. However, our national coordinating body, the National Emergency Response Council on HIV/AIDS (NERCHA), has led a broad consultation process to review progress, priority needs and investment areas to strengthen the national response. This has led to the National Strategic Framework on HIV and AIDS 2009-2014. It is most heartening to see the wide acceptance of this Framework as the way forward and very pleasing that the strategic agenda for cooperation in the PEPFAR partnership between our two Governments focuses on the goals of that Framework.

Furthermore, in the five key intervention areas is included decentralized, as well as improved, quality of care and treatment. In so doing, we will be in harmony with a key Government policy of improving access for all our people, through the decentralization of services.

It is further appreciated that the interventions will focus strongly on what is the national priority – HIV prevention. For in preventing infection in the first place lies the most potent weapon to securing the Nation's ultimate release from this pandemic. We need to see a more widespread acceptance of personal responsibility by individuals. Reconstitution of the National Prevention Technical Working Group should be an important catalyst in improving national prevention leadership and coordination to achieve social and individual behavioural change. And change is achievable where there is the will and confidence to do so. In the words of the new President of the United States "Yes, we can."

We are also greatly reassured by PEPFAR's entry as a new national partner in impact mitigation, with the emphasis on vulnerable children. The fabric of our society already stands vulnerable to the damage caused by the impact of the pandemic. With many thousands of children orphaned and, currently, only 22% of children growing up in two-parent families, the implications are serious. The protection, sustenance and education of our vulnerable and disadvantaged children together form one of the top priorities of this Administration.

A further high priority is the reduction of poverty. A population that is hungry does not have the emotional and physical resistance to fight disease. A population that is poor lacks the will and energy to commit to productive activities. Striking at the heart of our unacceptably high level of poverty is therefore central to this Administration's Programme of Action 2008-13.

In the first instance it is through providing a genuinely enabling environment for the creation of sustainable livelihoods that we can strike hardest at poverty. From job creation to improved health services, and from the introduction of free primary education to bigger and better-delivered grants for the elderly, His Majesty's Government has set, and is already making progress towards meeting a wide range of performance targets for its Ministries, the achievement of which will ultimately lead to a substantial reduction in poverty.

A common strand in all of these initiatives is *delivery.* Whether it is in the delivery of AIDS treatment, the support of vulnerable children or caring for the elderly and other disadvantaged, Government's goal is achieving excellence in delivery.

This Framework documents a partnership which includes many key stakeholders in addition to the two signatory governments. I urge all partners to work vigorously and collaboratively with us to make this the hugely valuable initiative that it promises to be.

It is my privilege and pleasure to thank the United States Government for this generous support to our National Strategy Framework on HIV/AIDS, through PEPFAR. The United States, through initiatives such as this, or the Peace Corps HIV/AIDS Partnership Programme, the Memorandum of Understanding which we recently signed, has shown itself to be a consistently generous and loyal partner in development, especially in the fight against HIV/AIDS.

It was an honour, on behalf of His Majesty's Government, to place my signature to the Partnership Framework Agreement and to reiterate our commitment to working closely and collaboratively with our partners and in close conformity with this Implementation Plan which represents the core of the Framework.

FOREWORD BY HIS EXCELLENCY MR. MAURICE S. PARKER
THE U.S. AMBASSADOR TO SWAZILAND

When I arrived in Swaziland in 2007, I had been briefed on the devastating effects that the HIV epidemic was having on the citizens of the Kingdom. I had heard stories of children losing their parents to AIDS and of impoverished grandmothers caring for the nation's youngest generation. I had read reports of how schools were failing because so many teachers were ill and dying and I knew that industry was faltering because workers in the prime of their life were too weak to go to work. And I was told that the budget for the U.S. Government AIDS program was at that time U.S. $8.5 million and had only three staff members dedicated full time to our program.

During the first five years of the President's Emergency Plan for AIDS Relief (PEPFAR), Swaziland was not a recipient for substantial U.S. Government funding. Yet strong partnerships with national program managers, the Global Fund leadership in Swaziland, international agencies and civil society turned a small investment into concrete accomplishments. Today, nearly 40,000 adults and children are receiving AIDS care and treatment services and are better able to lead productive lives and support their loved ones. In recognition of achievements made to date and the potential for much greater success, the U.S. Government has more than tripled its financial commitments and included Swaziland as a full PEPFAR country.

This increased investment comes with increased expectations. On the 4th of June 2009, the Right Honorable Prime Minister B.S.S. Dlamini and I signed a Partnership Framework committing the two governments to increased collaboration and investment in the HIV/AIDS response. As outlined in the Framework, our two governments will work closely together in association with other stakeholders to support policy decisions and programmatic actions that will improve the quality of life for Swazis across the nation. The political will of officials in the Government of Swaziland will drive the process to ensure that key legislative issues such as those related to male circumcision, child welfare and HIV counseling and testing will be finalized and pushed forward. We will work together to ensure that implementation efforts in prevention, care, treatment and support will be well-coordinated and rapidly scaled up. Underpinning this effort will be a strong collaboration to build the necessary capacity to ensure sustainability of our achievements.

With this document, the Implementation Plan, we now turn our attention to the details of how to operationalize the goals and objectives laid out in the Partnership Framework. Further consultations and planning have taken place between all parties in Swaziland invested in HIV/AIDS and TB programs to ensure that sound technical guidance and evidence based approaches will be used to combat the HIV/AIDS epidemic. I trust that this Implementation Plan can be used a guide for the way forward in designing, implementing and managing a robust national program.

The U.S. Government is grateful to the Government of the Kingdom of Swaziland and other stakeholders for the important work that has already been done in HIV prevention, care, treatment and support. I trust that the Partnership Framework will galvanize our energies and that through this Implementation Plan; we will work closely together to ensure that the suffering of this nation is squarely addressed and brought under control so that the Kingdom can be a glowing example of successful partnership to the world.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
BMGF	Bill and Melinda Gates Foundation
CANGO	Coordinating Assembly of Non-Governmental Organizations
CCP	Comprehensive care package
CSC	Civil Service Commission
DPM	Deputy Prime Minister
DSW	Department of Social Welfare
EID	Early infant diagnosis
FBO	Faith-based organizations
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GKOS	Government of the Kingdom of Swaziland
HCW	Health care worker
HICD	Human and Institutional Capacity Development
HIV	Human Immuno-Deficiency Virus
HR	Human resources
HRIS	Human resources information system
HTC	HIV testing and counseling
M&E	Monitoring and evaluation
MC	Male circumcision
MCPs	Multiple concurrent partners
MEPD	Ministry of Economic Planning and Development
MOET	Ministry of Education and Training
MOH	Ministry of Health
MSCYA	Ministry of Sports, Culture and Youth Affairs
MSF	Médecins sans Frontières
NCCU	National Children's Coordination Unit
NCP	Neighborhood care point
NERCHA	National Emergency Response Council on HIV/AIDS
NGO	Non-governmental organization
NPA	National Plan for Action for Orphans and Vulnerable Children 2006-2010
NSF	National Strategic Framework on HIV/AIDS 2009-2014
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PSS	Psychosocial Support
QA	Quality assurance
RHM	Rural Health Motivator
SBCC	Social and behavioral chance communication
SGBV	Sexual and gender-based violence
SDHS	Swaziland Demographic and Health Survey 2006-2007
SNAP	Swaziland National AIDS Program
TA	Technical Assistance
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on HIV/AIDS
UNICEF	United Nations Children's Fund

USG	United States Government
WHO	World Health Organization

BUILDING A SUSTAINABLE HIV RESPONSE IN SWAZILAND

On the 4th of June 2009, the Right Honorable B.S.S. Dlamini Prime Minister of the Government of the Kingdom of Swaziland (GKOS) and His Excellency Maurice S. Parker U.S. Ambassador to Swaziland signed the first ever Swaziland Partnership Framework on HIV and AIDS 2009-2013 (Framework). Through the signing of this document, the two governments agreed to a five-year joint strategic agenda, in collaboration with other key stakeholders, to strengthen, scale up and sustain key components of the HIV response and the overall health sector capacity in support of the National Strategic Framework on HIV/AIDS 2009-2014 (NSF).Developed in consultation with a wide range of public sector and non-governmental stakeholders, this corresponding Partnership Framework Implementation Plan (PFIP) provides a road map for achieving the goals of the Framework.

The overarching vision advanced in the Framework and this more detailed PFIP is to strengthen public health and community systems to support a sustained response to HIV/AIDS well beyond the lifespan of the PEPFAR program. With the highest HIV prevalence in the world, severe health sector capacity constraints and widespread poverty, the GKOS and USG recognize that this will be a long term partnership and endeavor. The diverse contributed assets of the GKOS, PEPFAR, civil society and national and international partners are dedicated to: achieving measurable results while reinvigorating the country's health infrastructure and workforce; creating efficient systems to procure and manage the equitable distribution of drugs, supplies, services and other health products; and strengthening management and governance structures for bold leadership and informed decision-making. While having HIV/AIDS as a focus, it is understood that these investments will have widely felt impacts on improved health sector function and public health outcomes. In particular, through the PFIP's emphasis on building a health work force, we address one of the most formidable challenges across the prevention, care and treatment responses. By bolstering the foundations of health and community systems at this time, we strategically position Swaziland's institutions, empower Swazi leadership, and engender ownership over the longer term.

This version of the PFIP represents one output from ongoing national strategic planning processes. As such, this plan is considered a 'living document' to be reviewed and updated as necessitated by changes in the understanding of the epidemic and by the realities of program implementation. During this first five-year period, the impetus will be on stabilizing the situation by stemming the tide of HIV through a rapid scale up of proven interventions. Cross-cutting efforts to strengthen local capacity during this time will focus on building a sufficient human and institutional base to allow for expanded service delivery. Over the course of the PFIP and subsequent to the five-year period detailed here, the partnership will shift more towards capacity building and financial sustainability as the USG gradually takes on a supportive role more focused on technical assistance than financial support.

The PFIP has been developed to fit squarely within the National Strategic Framework on HIV/AIDS 2009-2014 (NSF), which was published on September 28, 2009. The NSF represents the culmination of an extensive, widely consultative process that began with a joint review of the 2006-2008 national HIV/AIDS plan. Swaziland's one HIV/AIDS coordinating authority, the National Emergency Response Council on HIV/AIDS (NERCHA), led this process and engaged all sectors of Government along with a wide range of key stakeholders.

The strategies of the NSF are evidence and results-based and target the key drivers of the epidemic. The NSF focuses on four thematic areas:

1) **Prevention**
    a. Social and behavior change communication programs
    b. Reduction of multiple concurrent partners among sexually active population
    c. Increased comprehensive knowledge of HIV/AIDS
    d. Scaling up of PMTCT
    e. Male circumcision of HIV negative men, with a focus on the 15-24 age group. (Neonatal circumcision is also a national priority.)
2) **Treatment, Care and Support**
    a. HIV counseling and testing
    b. Pre-ART care and treatment opportunistic infections
    c. Provision of ART, including pediatric ART
    d. Provision of community-based care services, including palliative care
    e. Management of TB/HIV co-infection
    f. Care and support by Traditional Health Practitioners
3) **Impact Mitigation**
    a. Food and nutrition for vulnerable households and individuals
    b. Education support, socialization and protection for OVC
    c. Provision of psychosocial support
    d. Strengthening of community systems
    e. Strengthening of social protection systems
4) **Response Management**
    a. Coordination and partnerships
    b. Strategic and action planning, program development and project management
    c. Capacity development
    d. Mainstreaming, policy development and advocacy
    e. Resource mobilization
    f. Monitoring and evaluation

Based on PEPFAR's experience in Swaziland to date and broad consultations with GKOS, NERCHA and non-governmental stakeholders, it has been agreed that PEPFAR will target its scale up, policy reform and capacity building support on the following five 'pillar' areas prioritized within the NSF thematic areas:

- **Pillar Area 1: A coordinated and comprehensive approach to sexual prevention using.** This portfolio is a direct response to the NSF's aim of targeting the multiple drivers of the epidemic and will build capacity for national level leadership in HIV prevention.
- **Pillar Area 2: Rapid expansion of medical male circumcision to reach 15-24 year old males.** As a high impact prevention intervention, male circumcision is a top priority in the NSF prevention portfolio. PEPFAR will provide comprehensive support throughout the scale up process to ensure the back log of young men are reached with safe medical male circumcision services in the short term and that systems are put in place to sustain the practice over time on a routine basis.
- **Pillar Area 3: Decentralized and improved quality of care and treatment services for adults and children, including HIV testing and TB/HIV.** This effort will support capacity building to roll out the full continuum of HIV-related care and treatment services

in both public and non-governmental health facilities with stronger national systems and a community care component.

- **Pillar Area 4: Impact mitigation focused on vulnerable children[1] and their families.** PEPFAR will support the NSF to strengthen impact mitigation efforts by improving the policy environment, strengthening national systems and supporting accelerated, improved service delivery through existing national and community initiatives and structures.
- **Pillar Area 5: Development of human and institutional capacity** to manage an effective HIV response, including aspects of strategic information. Capacity development of both the government and non-governmental sectors will be a significant, cross-cutting focus to ensure that achievements made are sustained. In particular, there will be a heavy focus on improving human resources for health.

To harmonize programs and improve data and accountability, the PFIP emphasizes better stakeholder coordination through increased communication, joint planning, improved financial tracking and uniform monitoring of programs and policies.

COUNTRY HIV/AIDS PROFILE AND BASELINES

Know Your Epidemic / Know Your Response: HIV/AIDS epidemic, response and health systems situation assessment

With the recent PEPFAR-supported Swaziland Demographic and Health Survey and Modes of Transmission Study and the broad assessments conducted as part of the development of the NSF and the Health Sector Strategic Plan 2008-2013 (HSSP), the current knowledge base on Swaziland's HIV/AIDS epidemic, response and health care system provides a solid platform for strategic planning.

Twenty-six percent of Swaziland's adult population (aged 15-49) is infected with HIV, while HIV prevalence amongst women attending ante-natal care facilities stands at 42 percent. HIV incidence is estimated at three percent, meaning that each year three new HIV infections occur out of every 100 HIV-negative adults and also that 44 new infections occur each day in the country.[2] Women are disproportionately affected, comprising nearly 60 percent of all HIV-infected adults. Projections indicate that in 2009, out of a population of approximately 1,000,000, there are 191,000 people living with HIV/AIDS (PLWHA) in need of care and/or treatment services.[3] Various studies have identified the following main drivers of the epidemic: multiple concurrent partners (MCPs), low levels of male circumcision, low levels and inconsistent use of condoms, and long periods of premarital sexual activity. Gender-based inequalities and violence, poverty, and income disparities persist in the country and create significant barriers to effective HIV prevention interventions.

Illness and death associated with HIV/AIDS are enormous drains on the national economy, national health system, and other social support networks needed to combat the epidemic. Life expectancy at birth has fallen precipitously in the last two decades from over 60 years to

[1] In this document, the term 'vulnerable children' refers to all children 0-17 years of age who have been orphaned or otherwise made more vulnerable by the HIV epidemic. The acronym OVC is avoided both because of its potential to increase stigma and for its imprecision.
[2] NERCHA 2008
[3] NERCHA, UNAIDS and PEPFAR 2007

less than 40 years. While verifiable statistics on the numbers of fallen teachers and health workers do not exist, it is well understood that Swaziland's future is being compromised by diminished intellectual and physical health of the nation caused by weakening of the national institutions responsible for an effective response. One-fifth of the population is chronically reliant on food aid, and 30 percent of the rural population is reported to be food insecure.[4] It is estimated that nearly one third of all children in Swaziland are orphaned or vulnerable.[5] One in three female children has experienced sexual violence by the age of 18 years[6] and the number of child-headed households is increasing. The demand for child care and support well exceeds the capacity of most extended families and communities.

Significant progress has been made over the last few years in the implementation of HIV prevention, care, treatment and support programs in Swaziland. The anti-retroviral therapy (ART) program now reaches over 40 percent of the eligible population, but a third of those enrolled are lost to follow up owing to highly centralized services, ineffective adherence education and slow to develop information systems and patient monitoring. Limiting ART prescription and initiation to medical doctors is also a significant constraint to service expansion. Community-based HIV care programs lack national quality standards and are not fully developed and implemented. Diagnostic services for tuberculosis (TB) are improving rapidly, but less than 60 percent of cases successfully complete their full course of anti-TB treatment. Cases of multi-drug resistant and extensively drug resistant TB have been identified in the country. Access to HIV testing and counseling (HTC) is growing; still, the majority of Swazis have never had an HIV test. The current practice that limits the provision of testing services to nurses is a major constraint and increased demand creation activities are needed, especially to improve male participation.

According to the NSF, HIV prevention remains the national priority strategy for addressing the challenges associated with HIV/AIDS. In spite of considerable program efforts in this area, new infections continue to overwhelm the number of persons placed on ART. Although awareness of HIV is nearly universal, almost half of the adult population lacks comprehensive knowledge of means to prevent HIV transmission and half of women are sexually active before age 18. The 2008 Modes of Transmission (MOT) Study provides a roadmap for HIV prevention over the near term. The MOT study underscores the need for HIV prevention programs to transform social norms around sexual concurrency. Perhaps more than any other HIV intervention area, ongoing generation and use of data for program improvement is crucial to sexual prevention programming. As such, the PFIP supports collaboration on the design and conduct of formative, survey, and surveillance studies to inform efforts to change social and behavioral factors still fueling the epidemic.

Medical male circumcision (MC) has now emerged on the national agenda as a promising means to reduce HIV transmission. Progress has been made in the recent approval of the national MC policy and the national MC implementation plan is now being finalized. Technical and financial resources to implement the scale-up plan are largely in place.

The prevention of mother to child transmission of HIV (PMTCT) program has grown rapidly and coverage stands at over two-thirds of eligible women. The imminent challenge is to further expand access to services while improving the quality and integration of the PMTCT

[4] NERCHA 2007
[5] SDHS 2006/07
[6] UNICEF 2007

intervention with broader maternal and child health programs and with the national ART program as described in the NSF and the HSSP.

While recent increases in coverage of ART, PMTCT, TB, and HTC programs[7] are commendable and show increased commitment by the public sector to address needs, there remain an enormous number of Swazis for whom these and other critical services are currently inaccessible. The factors underlying these access challenges are social, economic and institutional. In particular, the HSSP underscores the urgent need to decentralize Swaziland's public health system, capacitate critical components of the supportive health network, and upgrade and expand its health work force, at both facility and community levels. These challenges are described in the HSSP, and it recognized that implementation of the HSSP will require significant financial and technical inputs over the next decade.

Community level initiatives to respond to HIV-related needs are numerous and creative, led by families, non-governmental organizations (NGOs), faith-based organizations (FBOs) and other community groups. It is widely acknowledged that these efforts are often fragmented and varied in terms of the quality of services delivered. Various governmental and non-governmental cadres of community-level workers exist. However, the effectiveness of this invaluable national resource could be improved if the cadres were better supported and harmonized in providing a standard package of high quality prevention and care services. It is understood that national efforts to decentralize care and treatment services, to address the needs of vulnerable children and to provide prevention interventions for young people will require assistance to communities on a much expanded and better coordinated basis.

HIV/AIDS policy reform situation assessment

The HIV/AIDS and health system policy environment were assessed as part of the preparatory work for the NSF and the HSSP. Since the adoption of a multi-sectoral HIV/AIDS policy in 2006, the policy environment in Swaziland for mounting an effective response has slowly, but steadily improved. However, the NSF, the HSSP and on-the-ground experience to date, point to key areas for improvement in both the content and implementation of national policies. This PFIP has been developed to support specific policy reforms that will help facilitate, accelerate and sustain an effective GKOS and non-governmental response to HIV/AIDS over the long term.

The status of some of the HIV-related policy areas that are critical to a successful response are described in the box below. Of particular urgency in Swaziland are policies that support effective decentralization and expansion of key services, promote human rights and address HR constraints. Framework objectives around specific policies are described in more detail in the relevant intervention areas and monitoring and evaluation sections of this PFIP.

Key Policy Areas

Human Resources for Health - The HIV response in Swaziland is severely constrained by limited human resources (HR) for health. Addressing this gap to allow for rapid decentralization of services is a top Framework priority. Finalization and approval of the Ministry of Health (MOH) HR policy, organizational structure and management plans are

[7] MOH quarterly report April 2009

targeted as early benchmarks. Of high priority within this policy are issues around task shifting and sharing, recruitment and retention and performance based supervision.

Gender - Gender norms and inequities often fuel HIV transmission; constrain both females and males from accessing needed services; and have grave consequences for vulnerable children in Swaziland. GKOS acceded to the Convention on the Elimination of All forms of Discrimination against Women in 2004 and the Constitution entrenches provisions pertaining to women's rights. A draft Gender Policy has been finalized and is awaiting approval by Cabinet. Gender issues cut across all pillars of the Framework, but will be addressed most directly within prevention and impact mitigation.

Vulnerable Children - A comprehensive National Children's Policy has just been approved by cabinet. Several other draft policies and legislation related to children await final approval. For example, GKOS is currently working to adopt a bill and ratify protocols related to human trafficking and to domestic violence and sexual abuse. Approval and implementation of these policies are critical to the Framework's agenda for children.

Access to high quality, low cost medications - The final draft of the Swaziland National Pharmaceutical Policy has as its goal to ensure "equitable access to, and rational use of quality essential medicines…at affordable cost particularly for vulnerable populations". PEPFAR has been and will continue to be a key partner in ensuring that this policy is adopted and that its objectives are met.

Stigma and discrimination - Non-discrimination and non-stigmatization of PLWHA are among the guiding principles of the 2006 HIV/AIDS Policy. The policy aims to implement measures that reduce stigma and discrimination and to develop legislation to protect the rights of PLWHAs. The Framework will support accelerated efforts to expand the involvement of PLWHAs in all aspects of service provision and to reduce stigma and discrimination in the general population.

Multi-sectoral response - A multi-sectoral response was first outlined after His Majesty King Mswati III declared HIV a National Disaster in 1999. In 2003, NERCHA was established as a statutory Council to coordinate the response. The Multi-Sectoral HIV/AIDS Policy was adopted in 2006 and calls to strengthen the AIDS response are included in both the Poverty Reduction and National Development Strategies. A major emphasis of this PFIP will be to decentralize the multi-sectoral approach to the regions.

Service Delivery - There are several policy gaps around the delivery of HIV-related services. For example, there is currently no HIV prevention policy and the nutrition policy needs to be finalized and implemented. In addition, the blood transfusion and the clinical laboratory policies await government approval and there is a need for a TB infection control policy that includes measures for MDR-TB. Ensuring that appropriate service delivery policies are in place and enforced is an important Framework agenda.

Uptake of HIV counseling and testing (HTC) - The Multi-Sectoral HIV/AIDS policy addresses HTC including promotion of couples counseling and expansion of provider-initiated HTC. Recently, finger prick testing has been taken up at the policy level. The PFIP includes efforts to promote and support HTC task shifting and sharing to phlebotomists while expanding demand creation, especially aimed at males who currently test at much lower rates than females.

HIV/AIDS financing situation assessment

In 2009, the GKOS has recently reported an increased contribution to the health sector from ten percent to 13 percent of the national budget. While short of the 15 percent benchmark established at Abuja, this would indicate a major step toward meeting the Abuja Declaration goal. The recently completed first ever National AIDS Spending Assessment (NASA) report provided estimated expenditures on HIV and AIDS for the years 2005/06 and 2006/07. In both years, the majority of funding came from the GFATM and other external sources (60 percent and 70 percent respectively). However, the NASA report noted serious challenges in obtaining the data from several key stakeholders, including GKOS, and in harmonizing financial reporting formats.

Swaziland is challenged at the moment to effectively coordinate, program and monitor the funds currently available through existing supporting institutions and funding sources. There is a great need to develop management systems, both in the public and non-governmental sector, that allow better tracking and absorption of available funds. There is also limited understanding of the costs associated with a scaled up HIV and AIDS response. Until there are stronger financial management systems in place and more robust cost estimates for planned interventions, precisely defining funding gaps and setting accurate benchmarks for financial commitments present a serious challenge. Strategically addressing these gaps through technical assistance and capacity building support is an integral part of this five-year PFIP. As an early priority, the USG with support GKOS to carry out costing exercises based on international standards and best practices.

STRATEGY AND COMMITMENTS

Partnership Framework Strategy: Institutional and Capacity Building

By 2013 through the execution of this PFIP, it is anticipated that there will be reduced HIV incidence, improved care and treatment outcomes, better quality of life for vulnerable children, and stronger local institutions for sustaining an effective HIV response. This will be accomplished through rapid scale up of HIV-related prevention, care, treatment and support services in an increasingly conducive policy environment, with a strengthened HR and institutional base and with better coordination and absorption of financial commitments from GKOS, GFATM, USG and other partners. Continued increases of GKOS financial support of the HIV response will remain a goal beyond the PFIP; however, essential capacities will be developed around human resources and service delivery within the five year period.

As described above, capacity building in both the public and non-governmental sectors is a cross-cutting priority of the Framework. Each of the intervention areas, sexual prevention, male circumcision, care and treatment and impact mitigation, are designed to build capacity while achieving measurable results. This is accomplished through support for planning, HR management and M&E among other vital gap areas. Also, laboratory services and drug procurement and management will be strengthened as key support systems for the HIV response. One pillar of the Framework is specifically devoted to human and institutional

capacity development. Under this pillar, PEPFAR will broadly support all aspects of HR management in the MOH and the Department of Social Welfare (DSW). This pillar will also support improved capacity for planning and budgeting within the MOH and strengthened national systems for strategic information and data for decision making.

Partnership Framework Gender Focus

The majority of new HIV infections (62 percent) occur in females. Prevalence among 15-49 year olds is 31 percent for females and 20 percent for males. Females are also affected at a younger age. Nearly half of all females aged 25-29 are HIV positive. HIV prevalence in males peaks at 45 percent among 35-39 year-olds. This is largely due to intergenerational sex which, along with multiple concurrent partners (MCPs), is a common practice. Sexual violence towards women is also widespread with one-third of females aged 13-24 reporting that they had experienced sexual violence before the age of 18. There are also gender inequities in HIV services. At 17 percent ever tested, males have a much lower rate of testing than females. Meanwhile, females access care and treatment services less frequently than males do. Gender-based violence and other negative outcomes for women as a result of disclosing their HIV status have been identified as barriers. The burden of care has also been unequally placed on women as they are traditionally seen as caregivers in the family.

The Swaziland PEPFAR team is committed to addressing issues of gender inequality, GBV and sexual abuse through our partners' activities and our involvement in promoting policy reforms. PEPFAR and its partners will continue to work with other donors to advocate for the approval of the National Domestic Violence and Sexual Offences Bill and the National Gender Policy. Once approved, these documents will better equip the USG and other partners to work for improvements in gender equity at all levels.

The Government of the Kingdom of Swaziland is also committed to elevating gender as a cross-cutting issue of the public sector as a whole, and has thus elevated the National Gender Unit to sit in office of the Deputy Prime Minister. Since gender is a cross -cutting issue that impacts each pillar of the PFIP, programs will mainstream gender into program activities to ensure that harmful norms that increase inequality are addressed and that male participation is increased in programs such as HTC and treatment, which have historically been accessed by women more than men. Program design will take into account that the needs of men and women differ and will find ways to meet these needs differently. Specific interventions that have a gender focus can be found in the Sexual Prevention, the Impact Mitigation and the Male Circumcision pillars. The Decentralized Care and Treatment pillar promotes an overarching family-centered approach to service provision.

Partnership Framework Service Delivery and Policy Reform

To achieve measurable results, GKOS and USG have agreed to rapidly accelerate their efforts in the five key intervention areas listed below.

- Decentralized and improved quality of *care and treatment* services for adults and children, including HIV testing and TB/HIV;
- A coordinated and comprehensive approach to *sexual prevention* using social and behavioral change communication;
- Rapid expansion of *medical male circumcision* to reach 15-24 year old males;

- *Impact mitigation focused on vulnerable children* (0-17 years) and their families; and,
- *Human and institutional capacity development (HICD)* to manage an effective HIV response, including aspects of strategic information and laboratory services.

Human and institutional capacity development is a crucial, cross-cutting focus and pillar of the Framework to ensure that achievements made are sustained. To harmonize programs and improve data and accountability, the Framework will also emphasize better stakeholder coordination through increased communication, joint planning, improved financial tracking and uniform monitoring of programs and policies.

Strategies for collaboration in each of the five pillar areas are described in the following section, and are re-summarized in the logic model on the following page. The anticipated commitments of GKOS, USG and other partners originally presented in the Framework are also described in more detail in the accompanying planning tables. Specific quantifiable objectives are further defined in the M&E section.

PILLARS AND OBJECTIVES

ONGOING PRIORITY AREAS:

PMTCT & BLOOD SAFETY

OBJECTIVES

Decentralization of Care and Treatment	Sexual Prevention	Male Circumcision	Impact Mitigation	Human and Institutional Capacity Building
Strengthen national capacity to lead, manage, and monitor roll-out of quality-assured HIV & TB care and treatment services	Strengthen the Prevention TWG to lead and coordinate national prevention policies	Strengthen national level capacity and continue to build political will to lead and manage a rapid scale up of medical male circumcision	Enhance the policy and legal environment for vulnerable children and their caregivers	Strengthen the HR capacity of the national government and key NGO providers to recruit, retain and manage a skilled health and social welfare workforce
Increase the percentage of the population that knows their HIV status, through enhanced access to quality-assured HIV Testing and Counseling (HTC) service	Improve comprehensive knowledge of HIV prevention and reduce risky behaviors within the general population	Increase the demand for medical MC	Enhance national capacity to plan, lead, coordinate, implement and monitor programs to support vulnerable children	Expedite recruitment within the ministries of Public Service, Health and the Dept of Social Welfare to fill vacancies in established positions
Increase the number of HIV infected people receiving Comprehensive Care Services	Increase correct and consistent condom use	Increase access to and national coverage of high quality MC services	Increase the percentage of vulnerable children receiving basic support services on a continuous basis	Strengthen pre-service and in-service training capacity for health and social welfare workforce
Increase the number of people receiving quality-assured ART services	Increase safe sexual behavior among young people and MARPs			Strengthen the capacity of RHMs/CHWs to deliver family-centered, HIV-related services and support
Increase TB treatment enrollment and success rates				Strengthen the capacity of local NGOs working at community level in support of the national HIV response

AREAS CROSS CUTTING THE PILLARS

GENDER

STRATEGIC INFORMATION

Pillar Area: CARE AND TREATMENT

While considerable progress has been made to respond to the sharp rise in health care needs due to HIV and TB, current care and treatment services remain largely insufficient to meet existing needs. It is understood that very substantial additional investments will be required to make services more accessible and comprehensive; to drastically improve their quality; and, to shift to a more integrated approach to service delivery.

In line with the NSF, the overall goal for this program area is to reverse the decline in life expectancy at birth and to improve the quality of life of PLWHA. This will be achieved through decentralization and improved quality of HIV-related prevention, care and treatment services within a comprehensive care package (CCP). Decentralized services will facilitate earlier diagnosis and treatment, thereby extending quality of life. The strategy for scale-up support for HIV and TB care and treatment services in Swaziland comprises policy development, institutional and leadership capacity development, program design and (costed) planning, and significant implementation support both through financial, human resource, and infrastructure support, and extensive technical assistance (TA).

Several national policies will need to be addressed in order to fully implement the strategies described below and achieve the care and treatment objectives. These include decentralization of services, task shifting, and laboratory and pharmaceutical policies among others. Additional policies and initiatives to increase the recruitment, retention, and management of the health workforce are covered under the HICD section of this PFIP.

HIV testing and counseling (HTC) remains the entry point for HIV-related care and treatment services. Support for both client-initiated and provider-initiated HTC will continue. The emphasis of the Framework will be on further scale-up and accessibility of services, through a strong and effective communication campaign, and making HTC available in every single health facility and, through outreach, to every single community in the country. Further promotion and implementation of early infant diagnosis (EID) will be part of this PFIP. Strengthening quality assurance strategies for HTC will be a very important area of focus.

With PEPFAR support, the MOH is in the process of developing a more comprehensive service model for HIV and AIDS. Implementation of the comprehensive care package (CCP) of services will be at the center of the HIV and AIDS care and treatment program. It will broaden the scope of the program from a rather exclusive treatment program to a more integrated and holistic service providing a continuum of care that starts at the time of diagnosis and caters for all the stages of the disease. This will involve expanding pre-ART interventions and early ART initiation to a more peripheral and accessible level in the formal health system. The strategy will also build upon the already existing community-based health care structures to extend the continuum of care concept into the community and increase the involvement of client families. The MOH's Rural Health Motivators and the Home-Based Carers from various community-based NGOs and FBOs will be part of the network to create stronger facility-community linkages and home-based care services. An expanded expert client program will facilitate improved patient outcomes through more effective treatment literacy, social support, and patient follow-up.

Special emphasis will be placed on the implementation of integrated TB/HIV activities. HIV testing of TB cases/suspects and TB screening of PLWHA remain the points of entry. Where

fully integrated treatment services are not yet available, proper two-way referral and feedback mechanisms will be developed to make the service as client-friendly as possible. In addition, specific strategies are being developed and implemented for TB infection control and Isoniazid preventive therapy. Importantly, the capacity of facilities and communities to address Multi-Drug Resistant (MDR) TB treatment, infection control and prevention challenges will be strengthened.

The existing ART and TB treatment facilities at hospitals and health centers will be further supported with an emphasis on improving quality of service. Support for the early initiation of ART for young children is also part of this PFIP. At the same time, a start has been made to decentralize services to the primary health care level. The essential components of CCS will be made available in every general health care facility in the country. ART and TB treatment services will be gradually introduced in selected primary health care clinics (initially through refills, then treatment initiation by visiting doctors, then initiation by clinic personnel). Support to these health facilities may include infrastructural upgrades, equipment, additional staffing, training, mentoring, and supportive supervision. Bringing the service closer to clients will facilitate earlier and increased access to HTC, prevention with positives, improved client retention, treatment adherence and, ultimately, better treatment outcomes. It is understood that addressing the emerging MDR-TB crisis must target increases in the number and performance of community-based TB treatment and infection control support workers and resources.

Through this PFIP, investments will also be made to strengthen the 11 existing public laboratories in the country, where necessary through infrastructural upgrades and additional equipment, but mainly through TA, training, and the introduction of effective quality assurance systems. For clients accessing services at the primary health care clinics, access to lab services will be secured through a combination of the assignment of lab phlebotomists at clinic level and the development of a reliable and sustainable sample transport and communication system.

Support for the consistent availability of drugs and commodities will also continue through work with the Swaziland Medicines Regulatory Authority for the approval and registration of important drugs and commodities, the Swaziland National Medicine Advisory Committee to strengthen procurement practices, and the MOH's Central Medical Stores to strengthen management, forecasting, distribution, and tracking.

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
1) Strengthen national capacity to lead, manage, and monitor roll-out of quality-assured HIV & TB care and treatment services.	a. Approve & adopt specific policies for the effective roll out of service delivery (see M&E section) b. Establish and maintain a sufficient cadre of program management personnel, and develop its leadership and management capacity c. Ensure national TWGs are coordinating the most up-to-date practices in care and treatment programming	a. Approve and adopt specific policies for the effective roll out of service delivery (see M&E section) b. Revise MOH management structure to support decentralized activities, including new hire and training of regional C&T coordinators**.** c. Update terms of reference and facilitate cross-linkages between Adult and pediatric ART, home-based care, HIV testing and counseling, TB/HIV and	a. Assist with development and advocate for approval and adoption of key policies (see M&E section) b. Support organizational, leadership and capacity development for program managers c. Provide TA and support to TWGs	a. Assist with development and advocate for approval and adoption of key policies (see M&E section) b. Provide financial and technical support to positions in the MOH re: management and coordination c. Provide TA and support to TWGs	. WHO, UNICEF, Italian Cooperation, Baylor, Clinton Foundation, MSF: Advocate for approval and adoption of key policies and provide TA . WHO: Provide technical leadership support . WHO/UNICEF: Provide TA on Quality Assurance and Monitoring and Evaluation systems

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
		laboratory TWGs.			
	d. Coordinate partners and inputs from public, NGO and external sources.	d. Establish planning and costing activities within the MOH for the decentralized care and treatment plan**.**	d. Provide TA for strategic planning, costing, technical guidelines and adoption of best practices	d. Provide TA for strategic planning, costing, technical guidelines and adoption of best practices	
	e. Establish and operate effective Quality Assurance and Strategic Information Systems in the MOH	e. Establish a QA/QI program and a Strategic Information Department within the MOH	e. Provide TA and resources to establish and operate Quality Assurance activities and a Strategic Information Dept in the MOH	e. Provide resources to hire and train QA/QI program staff and staff in the Strategic Information Dept of the MOH	
2) Increase the percentage of the population that knows their HIV status, through enhanced access to quality-assured HIV Testing and Counseling (HTC) services	a. Implement the HTC communication strategy b. Continue to support roll-out of HTC services (including early infant diagnosis)	a. Finalize and get approval for the national HTC communication strategy b. Continue to support roll-out of HTC services (including early infant diagnosis)	a. Provide TA for development and implementation of HTC communication strategy b. Provide training and on-site implementation support	a. Provide TA for development of the HTC communication strategy. Advocate for its approval. b. Provide training and on-site implementation support	i. WHO, UNICEF, Baylor, Clinton Foundation, MSF: provide TA and support HTC training ii. UNICEF, Clinton Foundation: procure commodities

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	c. Develop sufficient physical and human capacity to deliver quality-assured HTC services through introduction of task shifting and lay counselors in the services setting. d. Ensure the availability of commodities and laboratory support services for HTC	c. Complete planned site renovation, and staffing and training plan for cadres of service providers at sites delivering providing HIV care and treatment. d. Ensure planned systems upgrades at Central Medical and Central Laboratory Stores and at designated peripheral sites	c. Provide resources for decentralized service implementation (e.g., renovations, equipment, supplementary staffing, training and commodities) d. Provide technical and HR support in the delivery of HTC services through the governmental and NGO sector e. Support supply chain management and lab services for HTC, including EID	c. Provide resources for decentralized service implementation (e.g., renovations, equipment, supplementary staffing, training and commodities) d. Provide technical and HR support in the delivery of HTC services through the governmental and NGO sector	iii. UNICEF, MSF, GFATM: Provide resources for service delivery (e.g., renovations equipment, supplies, staffing) iv. MSF, Red Cross: Deliver services
3) Increase the number of HIV infected people	a. Implement the CCS through strategic planning,	a. Finalize CCS decentralization plan and receive GKOS approval to	a. Assist the MOH in the finalization, approval and roll out of the national	a. Assist the MOH in the finalization and approval of the national CCS	i. WHO, UNICEF, Italian Cooperation, Baylor, Clinton

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
receiving Comprehensive Care Services (CCS)	development of technical guidelines, staff training and on-site support.	implement	CCS decentralization plan	decentralization plan	Foundation, MSF: provide TA i. GFATM: fund training activities
	b. Strengthen linkages and referral systems among the different HIV-related and other services, emphasizing the link between facilities and community systems	b. Update and disseminate to service sites revised referral materials and methods	b. Provide ongoing TA for strengthening linkages and referral system	b. Assist in the updating and dissemination of referral materials and methods	i. GFATM, UNICEF, Clinton Foundation: support for purchasing of drugs for opportunistic infections v. Clinton Foundation: support expert client program
	c. Build sufficient physical and human capacity (including through task shifting) to deliver CCS at all public health facilities	c. MOH to develop staffing plan for all levels of public health facilities.	c. Provide training and on-site implementation support to institute a referral system linking facilities and community programs	c. Assist MOH to develop staffing plan for all levels of public health facilities.	v. MSF, Red Cross: deliver services

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	d. Ensure the consistent availability of drugs, commodities and laboratory support services for CCS	d. Renovate and provide sufficient technical resources for improved function of the Central Medical and Central Laboratory Stores.	d. Provide resources for service delivery in an expanded number of facilities (e.g., renovations, equipment, and supplementary staffing) e. Support supply chain management and lab requirements for CCS **f.** Support resources and TA for expert client program	d. Provide financial and technical support to the Central Medical and laboratory Stores infrastructure and information systems	
4) Increase the number of people receiving quality-assured ART services	a. Expand access to quality-assured ART as part of roll out of decentralized CCS b. Strengthen and expand the provision of pediatric ART by	a. Introduce ART refill service at 10 new sites, ART initiation at 5 new sites b. Introduce EID and EIT to 80 new (PHC) service sites, and establish referral	a. Provide technical and material support to expand access to quality-assured ART as part of roll out of decentralized CCS b. Support the establishment of linkages between ART and PMTCT	a. Provide technical and material support to introduce ART refill service at 10 new sites, ART initiation at 5 new sites b. Provide technical support for the expansion of EID and EIT at 80 new	. WHO, UNICEF, Italian Cooperation, Baylor, Clinton Foundation, MSF: provide TA . WHO, MSF and GFATM: fund training activities

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	strengthening linkages between ART and PMTCT programs	system to facilitate age-appropriate transfer	programs and support EID and early infant treatment (EIT) for children through PMTCT program	(PHC) sites, and to establish referral system to facilitate age-appropriate transfer	. GFATM: fund ARVs and provide resources for service delivery (e.g., renovations, equipment, and supplementary staffing)
	c. Develop and promote strong community involvement and participation in the implementation of ART program activities.	c. Strengthen community-based care and treatment staff component through hire of 1 additional community-based care specialist at SNAP and establishment of the community-based care TWG.	c. Direct support to the MOH/SNAP to strengthen the community-based care component of ART program, as part of CCS	c. Provide technical and material support to SNAP and home-based care TWG; support hire of 1 community-based care specialist	. Clinton Foundation support to the expert client program
	d. Strengthen communications to the public regarding ART and the role of community and family, to reduce stigma and improve ART outcomes	d. Incorporate guidelines on HIV and ART-related stigma reduction in beneficiary communities to the national CCP guidelines. Design a national treatment literacy and stigma reduction campaign	d. Provide technical support for ART communication strategy and implementation	d. Provide technical support to develop and implement HIV and ART-related stigma reduction strategies in beneficiary communities	. UNICEF: procure drugs and supplies and support to Baylor pediatric outreach activities . MSF, Red Cross, Baylor: deliver ART services . Clinton Foundation, WHO: Technical

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	e. Build sufficient infrastructural and human capacity to implement the decentralized ART program. f. Ensure the availability of drugs or other supplies and lab support services for ART	e. Conduct a comprehensive exercise to plan and cost the decentralized ART program. f. Establish a sustainable procurement mechanism in the MOH/GKOS for ARV and other pharmaceuticals g. Replenish the 4-month national ART buffer stock	e. Provide training and on-site implementation support for rapid roll-out of ART refill sites. f. Provide technical and material support for service expanded implementation (e.g., renovations, equipment, supplementary staffing) g. Support pharmaceutical and lab supply chain management for ART programs, including EID	e. Provide technical support to conduct a comprehensive exercise to plan and cost the decentralized ART program. f. Provide technical and material support for first phase renovations, equipment, and supplementary staffing) g. Assist the MOH to develop sound tendering and procurement mechanisms and procedures h. Provide technical and material support to bring on line drug management and patient information	assistance

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
				systems to an additional 10 ART service sites i. Assist financially and technically in the replenishment of the ART buffer stock	
5) Increase TB treatment enrollment and success rates	a. Continue roll-out of TB screening and diagnosis to all ART sites b. Build sufficient physical and human capacity to implement an expanded and quality-assured national TB program. c. Develop and promote stronger community involvement in	a. Complete introduction of TB screening and diagnosis to all ART sites b. Hire one TB/HIV specialist in SNAP to facilitate joint planning and implementation with the NTP c. Increase number of sites (to 5) with community outreach and	a. Assist in the technical support and training on TB screening, diagnostics and treatment b. Provide technical support, renovations, equipment, trainings, supplementary staffing, and on-site implementation support c. Support the development of a community-based case finding and	a. On-site technical assistance to complete introduction of TB screening and diagnosis to all ART sites b. Assist in the hire of and technical support to one TB/HIV specialist in SNAP to facilitate joint planning and implementation with the NTP c. Provide technical support and training to increase number of sites (to 5) with	i. WHO, KNCV TB Foundation, Italian Cooperation, MSF: provide TA i. WHO, MSF and GFATM: fund training activities i. GFATM (through the Green Light Committee) and MSF: fund second line TB drugs v. MSF, Red Cross,

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	TB program, integrated with the decentralized CCP and ART programs, with emphasis on MDR/XDR.	integrated with Pre-ART/ART program, including MDR/XDR components	TB treatment support program, with emphasis on MDR/XDR.	community outreach and integrated Pre-ART/ART program, including MDR components	Baylor: deliver services
	d. Develop and implement TB infection prevention and control measures, with a special emphasis on MDR-TB prevention and infection control in both facilities and communities.	d. Provide in-service training for 400 prioritized health providers on TB infection control e. Incorporate MDR-TB considerations into the national TB policy and guidelines	d. Support a comprehensive program of pre-service and in-service training for all health providers in the country on TB infection control. Facilitate incorporation of MDR-TB into national policy and guidelines	d. Technical support to provide in-service training for 400 prioritized health providers on TB infection control e. Technical support to the development of MDR-TB policy and guidelines, emphasizing isolation requirements and community-level case management	
	e. Ensure the availability of drugs, commodities & lab support for	f. Incorporate TB drugs into the overall improved drug management systems	**e.** Support pharmaceutical and lab supply chain management for TB screening,	f. Provide technical and material assistance to incorporate TB drugs into the overall	

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV Care and Treatment services to increase access and improve outcomes for PLWHA					
Key objective: By 2013, 60,000 PLWHA should be receiving high quality ART services (This objective is based on the NSF with a 2009 baseline of 38,000 from national statistics)					
Objectives	GKOS 5-year Commitments	GKOS 1-year Commitments	USG 5-year Commitments	USG 1-year Commitments	Other Partner Commitments
	TB services		diagnosis and treatment	improved drug management systems	

Pillar Area: SEXUAL PREVENTION

Despite several years of ambitious and highly visible prevention programming in Swaziland, the country continues to suffer from the world's worst HIV epidemic. Although HIV awareness is nearly universal, specific sexual behaviors continue to contribute to new infections. There is increasing recognition within GKOS and among key stakeholders that prevention efforts must move beyond individual behavior change strategies to boldly address the social and cultural norms that fuel the epidemic. Through this PFIP, GKOS, USG and other stakeholders will work together to create a unified, evidence-based national prevention program that promotes effective social and behavior change (SBCC) to reduce the spread of HIV.

All HIV prevention efforts in Swaziland have the ultimate aim of interrupting transmission and reducing the number of new HIV infections. In line with the NSF, the overall goal of the Framework in the area of prevention is to reduce HIV incidence in the general population. PEPFAR will work in collaboration with GKOS and other stakeholders to strengthen national leadership, improve prevention messaging and intensify community-level initiatives that are well-linked to mass-media campaigns.

A key component of work during the first year of the Framework will be to assist the Swaziland National AIDS Program (SNAP) and NERCHA to reconstitute the National HIV Prevention TWG. PEPFAR will provide organizational development assistance to enable the TWG to provide leadership, oversight and coordination for prevention activities country-wide. Coordination of efforts, logistics, research, strategies and cross-cutting issues, for example, male norms, sexual and gender-based violence (SGBV) and family planning, will be a key role of this group. The prevention TWG will include representatives from all relevant stakeholders and will have two subcomponents: SBCC and Biomedical. The SBCC TWG will focus on comprehensive sexual prevention while the biomedical component will focus on male circumcision, PMTCT and post-exposure prophylaxis. These TWGs will help to identify and advocate to the relevant GKOS officials for adoption and implementation of relevant HIV prevention policies.

While national mass-media campaigns around partner reduction have been a hallmark of Swaziland's prevention efforts over the last several years, there is a gap in their reinforcement at community level. Although many good prevention messages and initiatives have been promoted, coordination is often lacking and most are not sustained. The Framework will support the establishment of a system for vetting, standardizing, integrating and coordinating messages and communications around key topics including MCPs, youth and SGBV. PEPFAR will support the GKOS with the standardization of curricula and facilitation guides for FBOs, NGOs and other community-based groups to ensure evidence based messages are disseminated widely and consistently. The linking of national campaigns, such as those focused on reducing MCPs, with community level mobilization (radio, peer education, drama, and sporting activities) will serve to better saturate the country with the tools needed to address social norms and individual behaviors that lead to increased risk of HIV. The Framework will encourage the identification and fostering of National Prevention Champions to reach out to communities through traditional leaders and other influential groups.

Through this PFIP, PEPFAR will support both the public and private sector to distribute condoms and promote their use. GKOS with support from PEPFAR will finalize and disseminate the national condom strategy, expand condom distribution, intensify education on correct and consistent use of both the male and female condom and strengthen condom management systems.

HIV prevention among youth is a high priority for GKOS and PEPFAR. Messages targeted for youth will be developed and disseminated through the channels described above. PEPFAR-supported NGOs and Peace Corps volunteers will play a strong role in community-level HIV prevention activities. The Framework will engage the Ministry of Sports, Culture and Youth Affairs in sports and other development activities that can incorporate HIV and SGBV prevention. The potential for enhancing and better standardizing the life skills curriculum for school-going youth will also be explored.

Several populations and intervention activities are in need of enhanced attention. Interventions targeting couples have been shown to be effective and are in the process of being scaled up in Swaziland. SGBV is a nationwide problem that affects the impact of HIV prevention interventions. Adoption and implementation of the national Gender Policy and the Domestic Violence and Sexual Offences Bill are important PFIP benchmarks supported through both the prevention and impact mitigation pillars. The integration of strategies to address SGBV for adults and youth in prevention activities is critical. Additional prevention activities for HIV positive people should be routinely implemented. PEPFAR will continue to support prevention work with all sections of the military and other uniformed services. As guided by the NSF, PEPFAR will collaborate on feasibility studies, mapping exercises and pilot programs to assess strategies for reaching mobile populations, relevant workforce segments, commercial sex workers and other most at risk populations (MARPs). PEPFAR will work with GKOS to develop an enhanced policy environment for reaching these special populations.

Five-Year Goal for Sexual Prevention: Reduce HIV incidence by reducing behaviors that enhance the risk of HIV infection and increasing protective behaviors in the general population					
Key Objective: By 2014, no more than six per cent of males should report having multiple partners within the last 12 months (This objective is based on the NSF with a 2007 baseline of 23 per cent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
1) Strengthen the Prevention TWG to lead and coordinate national prevention policies	a. Approve national prevention policies, including SBCC, condom, youth, gender and domestic violence and sexual offences b. Ensure the Prevention TWG is coordinating implementation of the most up-to-date, evidence-driven prevention programming c. Develop and adopt a national HIV Prevention Policy	a. Identify two key national policies related to HIV Prevention to be updated b. Re-establish and operationalize the national prevention TWG c. Develop draft national HIV prevention policy	a. Advocate for approval of key policies b. Provide for leadership and management capacity development in prevention c. Support the development of the national HIV prevention policy	a. Provide technical input to edit policies related to prevention b. Provide TA and support to strengthen the national Prevention TWG c. Provide TA for the development of a national HIV Prevention Policy	i. NERCHA: Support to strengthen national capacity ii. UN Agencies: Advocate and facilitate the establishment of national prevention TWG and update the National HIV policy
2) Improve comprehensive knowledge of HIV prevention and reduce risky	a. Finalize, endorse and roll out the SBCC strategy b. Develop, cost and implement SBCC operational plan	a. Finalize and endorse the SBCC strategy b. Develop, cost and support implementation of	a. Provide TA to complete the SBCC strategy b. Provide TA to develop and cost SBCC operational	a. Print, disseminate and support launch of SBCC strategy b. Provide TA to develop and cost SBCC operational	i. ii. NERCHA, UN agencies, Southern African Development Community

Five-Year Goal for Sexual Prevention: Reduce HIV incidence by reducing behaviors that enhance the risk of HIV infection and increasing protective behaviors in the general population					
Key Objective: By 2014, no more than six per cent of males should report having multiple partners within the last 12 months (This objective is based on the NSF with a 2007 baseline of 23 per cent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
behaviors within the general population	using multiple channels c. Conduct behavioral surveillance surveys and studies to inform and evaluate programming d. Foster Champions of Prevention among traditional leaders and other influential groups	SBCC operational plan c. Establish the National Clearing House for the coordination of HIV/AIDS messages d. Develop standardized age-specific behavioral change for HIV prevention education modules e. Identify select champions to lead process	plan c. Support community-based SBCC strategies d. Provide TA and training to improve broadcast and other mass media efforts e. Support the implementation of targeted programs f. Support behavioral surveillance surveys and studies to assess program effectiveness g. Support Champions of Prevention efforts	plan c. Support the implementation of the SBCC operational plan d. Support capacity building of implementing partners to plan, implement and monitor mass media interventions e. Provide financial resources and technical input for BSS and other national surveys f. Provide training for identified champions	(SADC), The Royal Netherlands Government and the United Kingdom's Department for International Development (DFID): support SBCC programs ii. Royal Swazi Sugar and Banking Sector: Operate workplace programs v. NERCHA: Coordinate national HIV prevention efforts v. UN agencies: Support the development of an HIV prevention Toolkit
3) Increase correct and consistent	a. Finalize, approve and implement the national condom	a. Finalize and approve the national condom strategy	a. Provide TA and support for implementation of	a. Support launch and dissemination of condom strategy	i. GFATM and UN agencies: Support condom programs

Five-Year Goal for Sexual Prevention: Reduce HIV incidence by reducing behaviors that enhance the risk of HIV infection and increasing protective behaviors in the general population					
Key Objective: By 2014, no more than six per cent of males should report having multiple partners within the last 12 months (This objective is based on the NSF with a 2007 baseline of 23 per cent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
condom use	strategy b. Manage public sector condom logistics, distribution and monitoring c. Intensify and expand condom education	b. Recruit condom programmer	the national condom strategy b. Support private sector condom distribution **c.** Support NGO and community level condom logistics and distribution	b. Support recruitment and retention; support skills-based training related to condom procurement and management	ii. UN agencies: Provide Technical support to develop age –specific HIV prevention education modules to address risk behaviors in the age groups iii. The Royal Netherlands Government: Support condom procurement and programs
4) Increase safe sexual behavior among young people and MARPs	a. Address young people as a priority population in the SBCC strategy and plan b. Revise life skills curriculum to include HIV prevention and livelihood skills education in schools	a. Develop age specific HIV prevention package	a. Provide TA and support for youth programs youth, including sports and other development activities b. Provide TA to enhance life-skills curriculum for school-going youth	a. Promote youth-focused HIV prevention activities at community level b. Identify partners to collaborate on life-skills enhancement c. Provide TA to assess and develop pilot programs to	i. UN: Support in and out of school youth programs on HIV, HIV education and life skill for behavioral change to reduce the risk of HIV infection ii. GFATM, UN agencies, SADC and DFID: Support

Five-Year Goal for Sexual Prevention: Reduce HIV incidence by reducing behaviors that enhance the risk of HIV infection and increasing protective behaviors in the general population					
Key Objective: By 2014, no more than six per cent of males should report having multiple partners within the last 12 months (This objective is based on the NSF with a 2007 baseline of 23 per cent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	c. Promote efforts to keep girls in school and empower their sexual reproductive health decision making ***d.*** Support the identification, assessment and program planning for MARPs		c. Support MARPs focused assessments and pilot programs	address special needs of MARPs	youth programs iii. UNICEF and UNFPA: Support school-based and life-skills programs iv. UNFPA: Support programs for uniformed services, prisoners and commercial sex workers v. UNICEF, UNDP and the Swaziland Action Group Against Abuse (SWAGAA): Support anti-SGBV initiatives **vi.** AMICAAL: Work with MARPS

Pillar Area: MALE CIRCUMCISION

Leaders in the MOH took an early interest in research showing the HIV prevention potential of MC and together with their partners pushed forward a plan for national scale-up. As a result, Swaziland is now on the forefront of international efforts to rapidly expand MC services.

The GKOS, in partnership with PEPFAR, WHO, the Bill and Melinda Gates Foundation (BMGF) and other stakeholders, has made a commitment to reach 110,000 or 80% of all males in Swaziland, aged 15-24, with medical male circumcision services by early 2014. This effort forms part of an integrated approach to HIV prevention and will be supported by a national communication strategy to promote MC and other methods of prevention and to reduce potentially harmful misconceptions about the service. For long-term sustainability, introduction of neonatal MC with the support of UNICEF is also planned to effect circumcision of 50% of male neonates by the end of the same five-year term.

The strategy for scaling up MC services is multi-pronged in order to comprehensively address policy and planning, HR, institutional capacity, leadership development, service delivery, and communications and social mobilization. The MC Task Force will provide leadership and oversight of all elements of implementation. Advocacy and support will also focus on final approval and roll out of the MC implementation strategy, service protocol and communications plan.

To address the workforce shortage issue especially during this high intensity 5-year "catch up" phase of MC for adolescent and young adult males, three complementary strategies will be undertaken. To meet the immediate need, trained and licensed expatriate physicians will be recruited, provided with the requisite Swaziland physician registration, and placed on a limited-term basis to perform MC and other health services in Swaziland. Second, regional experts will also support a comprehensive MC training effort for local providers. Third, an assessment of MC task allocation will be conducted to explore the potential for shifting specific MC-related tasks to nurses and other health care cadres with the aim of maximizing the efficiency of physicians' time. As described in the HICD section of this PFIP, a parallel effort will be support to the government to more generally streamline and expedite recruitment, requisite registration with the Swaziland Medical and Dental Council, and competency determination of health care providers. A policy to permit and facilitate task shifting of neonatal MC to nursing cadres, as well as pre-service training programs for nurses, should also be developed to be able to better meet the projected demand of this service as scale-up rolls out.

Facilities targeted for MC service provision will be renovated and fully equipped, including support in procurement and management of needed supplies. USG and BMGF will co-fund these activities. To ensure high quality, safe MC services, protocols and quality assurance tools will be implemented in line with international guidance and standards. WHO and PEPFAR will provide technical guidance and support in these areas.

Communication and social mobilization are critical elements to the successful scale up of MC. Multiple channels will be used to reach the target population with information on the benefits of MC as part of an integrated package of prevention services and to reduce

misconceptions about MC. Community level social mobilization will be supported to engage leaders and opinion makers and to reduce the chances of any circumcision-related stigma.

Programmatic and outcome data will be collected and closely monitored to ensure service quality and coverage objectives are met, and that adverse events are well managed on both health and public relations grounds. Outcome and impact evaluations will be supported by the major partners (WHO, PEPFAR, BMGF) and coordinated by the MC Task Force.

Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males					
Key Objective: Ensure that by 2014, 80 per cent of males aged 15-24 are safely circumcised (This objective is based on the NSF with a 2007 baseline of five percent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
1) Strengthen national level capacity and continue to build political will to lead and manage a rapid scale up of medical male circumcision (MC)	a. Approve, disseminate and implement the MC policy	a. Approve, and disseminate the MC policy	a. Advocate for approval of the MC policy and support its dissemination and implementation	a. Support the policy launch of the MC policy	i. BMGF, UN agencies: Advocate for policy approval and adoption
	b. Develop, approve and implement the MC operational plan	b. Approve and disseminate the MC operational Plan	b. Participate in the development, advocate for approval and support the implementation of MC operational plan	b. Support dissemination and implementation of MC operational Plan	ii. WHO: Provide technical support on international MC guidance and standards iii. BMGF: Provide financial support to the MC Task Force
	c. Lead MC scale-up through the MC Task Force and Secretariat	c. Provide office space for the MC program Coordinator	c. Provide technical, organizational and financial support to the MC Task Force	c. Financial support for MC Program Coordinator	
	d. Empower and support the MC Program Coordinator to perform his duties	d. Strengthen national coordination of MC activities	**d.** Support MC Coordinator position at MOH		

Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males					
Key Objective: Ensure that by 2014, 80 per cent of males aged 15-24 are safely circumcised (This objective is based on the NSF with a 2007 baseline of five percent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
2) Increase the demand for medical MC	a. Finalize, approve and implement MC communications strategy b. Coordinate the communication effort using multiple channels at all levels, community-based to national	a. Approve and disseminate the MC communications strategy b. Initiate national dissemination of MC communication messages	a. Provide TA and financial resources to complete, disseminate and implement the MC communication strategy b. Support community-based communication strategies	a. Print and support dissemination of the MC communications strategy b. Support message dissemination through schools, workplaces, community agents and other venues through NGO partners	i. BMGF: Provide resources to complete the MC service and communication plans ii. WHO and UNAIDS: Provide TA and support workshops for development of the MC communications plan
3) Increase access to and national coverage of high quality MC services	a. Build physical and human capacity to deliver the minimum package of MC services at five public sites b. Link MC services to broader HIV prevention and care services c. Coordinate, manage and monitor MC training	a. Identify and mobilize three public facilities to begin minimum package of MC services b. Develop system for expedited licensing and registration of	a. Procure equipment and supplies; renovate public and NGO service sites b. Support training of public and NGO providers in MC	a. Support the three public facilities to provide the minimum package of MC services b. Advocate for the mobilization of public facility adoption of MC	i. BMGF: Provide staff support, procure equipment and supplies and renovate NGO sites ii. WHO: Provide technical guidance and QA support iii. UNICEF: Support pilot

Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males					
Key Objective: Ensure that by 2014, 80 per cent of males aged 15-24 are safely circumcised (This objective is based on the NSF with a 2007 baseline of five percent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
		short and long term professionals		minimum package	clinic, training, equipment and supplies for neonatal circumcision
	d. Establish systems to use donor funds to employ additional public sector providers and to recruit, register, and place external professionals	c. Recruit full time licensing and accreditation officer at the Dental and Medical Council to improve efficiency	c. Support GKOS to recruit, license and place short and long term external professionals to provide MC training and services d. Provide financial support to meet HR needs during initial phase	c. Support the development of recruitment system d. Support the placement of short and long term professionals	iv. BMGF: Provide resources for increased staffing needed during initial phase
	e. Assess task allocation and potential for task shifting and task sharing	d. Convene workshop of task shifting and sharing for MC services	e. Advocate for task shifting and sharing practices	e. Support a workshop on task allocation and sharing	
	f. Establish routine M&E of MC services	e. Develop standardized monitoring tools to capture patient data in public facilities	**f.** Provide TA and support for routine monitoring and program evaluation	f. Support the development and dissemination of standardized monitoring tools	
		f. Establish accreditation system for		g. Support development of certificate of accreditation	

Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males					
Key Objective: Ensure that by 2014, 80 per cent of males aged 15-24 are safely circumcised (This objective is based on the NSF with a 2007 baseline of five percent from the SDHS)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
		facilities delivering minimum package of MC services			

Pillar Area: IMPACT MITIGATION WITH A FOCUS ON CHILDREN

The needs of vulnerable children in Swaziland are immense and growing, while support and services are often fragmented and inadequate. As this strain has become more visible within society, so too has the prominence of children on the national HIV and development agendas. In the last few years, there have been some encouraging developments. A National Children's Coordination Unit (NCCU) has been established in the office of the Deputy Prime Minister (DPM) and the Department of Social Welfare (DSW) has been moved from within the MOH to the DPM's Office. The NSF prioritizes impact mitigation and children in particular as a key focus area. The policy environment is rapidly evolving with, among other developments, the recent approval by cabinet of a National Children's Policy. Six years ago GKOS introduced a budget allocation for grants to support education for orphans and vulnerable children. Although the costs of schooling are not fully covered by this grant, the national allocation has steadily increased and this year GKOS declared its intent to phase in free primary education starting in 2010.

Families and communities shoulder the burden of care for vulnerable children with numerous local efforts and a few key national initiatives that exist to support them. The National Plan of Action for Orphans and Vulnerable Children 2006-2010 (NPA) has just been evaluated and is now being updated and revised to cover the period 2011-2015. The evaluation revealed concrete accomplishments, but also tremendous need for more input and support.

It is therefore timely that the Framework engages PEPFAR as a new national partner in this program area. GKOS, PEPFAR and other stakeholders have reviewed current programs and identified important public and NGO sector opportunities for the USG to invest in to reach greater numbers of children with high quality services and support while building capacity in both the governmental and non-governmental sectors to protect and direct quality services to vulnerable children. Planned interventions will work through and improve existing mechanisms and coordination structures at national and community levels.

The overall 5-year goal for impact mitigation under the Framework is to enhance the safety, security and quality of life of vulnerable children in Swaziland. GKOS and PEPFAR in partnership with other key stakeholders will work to improve policies, strengthen national systems and support local service providers to reach significant numbers of children with a range of continuous basic support services.

The impact mitigation strategies of this PFIP are aligned with the NSF and the evolving NPA. They are designed to achieve the balance between providing growing numbers of vulnerable children with urgently needed services while at the same time building national and local capacity to sustain those services. This PFIP will provide complementary support at three levels: 1) policy development and implementation, 2) national coordination and systems strengthening, and 3) expanded, well-coordinated delivery of high quality services and support.

An important area of focus within the impact mitigation portfolio will be around approval and implementation of key policies and legislation. PEPFAR will join other development partners in advocating and supporting GKOS to implement the recently approved Children's Policy and to approve, adopt and roll out other priority policies and legal instruments, including the National Children's Protection and Welfare Bill, the Social Development

Policy, the Domestic Violence and Sexual Offences Act, and the Human Trafficking Bill. Efforts will also be made to advance the policies on Early Child Development, HIV and AIDS in the Education Sector and Gender. Emerging policy issues, including alternative care and land rights, will also be taken forward during this five year period.

Systems strengthening will focus on supporting a GKOS-led process to establish quality service standards and an effective monitoring system as well as developing human capacity. Strong agreement exists among stakeholders on the need to develop national quality service standards, service mapping and a monitoring framework for programs in support of vulnerable children. The NCCU, with support from PEPFAR and other governmental, donor and NGO partners, has initiated a process to meet this need. PEPFAR will work with Government and other stakeholders to ensure that coordination mechanisms exist at national level for effective implementation and monitoring of quality service standards. PEPFAR will also support NERCHA and GKOS to establish a monitoring framework and strengthen the evidence base on vulnerable children and the services provided to them.

As described in the HICD section of this PFIP, PEPFAR will work with GKOS to build capacity among community-level caregivers and NGOs. In particular, this PFIP will support the GFATM objectives to standardize and better compensate the work of community caregivers. NGOs working on impact mitigation will be provided with capacity building support in the areas of governance, organizational development, financial and human resources management and monitoring and evaluation.

The largest share of the impact mitigation effort will be channeled through existing structures and programs to direct services and support for vulnerable children in Swaziland. Activities in this area will be aligned with established national standards and PEPFAR guidelines. They will be developmental and designed to meet the needs of very young children, school-aged children and adolescents, including those identified as most vulnerable groups.

In line with the NPA and the NSF, core services areas will include protection, psychosocial support (PSS), health, food and nutrition, education and economic strengthening. PEPFAR will support GKOS and NGOs in implementing national initiatives, including the strategic plan for Neighborhood Care Points (NCPs), the Lihlombe Lekukhalela (shoulder to cry on) protection program and the roll out of free primary education. The NCP initiative grew out of community driven efforts to provide a hub of care and support for young, vulnerable children. Over the next five years, GKOS, PEPFAR and other donors will support a process to ensure these NCPs provide a standard quality of care, are certified as ECD centers and places where a number of basic services can be provided to young children. The Lihlombe Lekukhalela initiative is an effort to prevent and effectively respond to violence and abuse against children. Through this PFIP, community protection committees will be supported to improve and sustain their work while capacity is built among the various response agents (police, magistrates and physicians among others).

PEPFAR will also support the Peace Corps to expand the efforts of its volunteers to provide support for vulnerable children. The NGO sector will be supported to pilot and model specific interventions, including those that target teenagers, generate household-level income, provide for care-giving and socialization, and link impact mitigation with PMTCT, prevention and clinical services through a family-centered approach. Sharing lessons learned for scale up and exploring strategies to sustain these efforts will be an important focus of PEPFAR support.

To address children comprehensively, impact mitigation cannot be viewed in isolation. Prevention, care and treatment issues that are specific to children, including consent for HIV testing, male circumcision and pediatric diagnosis and treatment are addressed under those sections of this PFIP. It is also important to highlight that preventing new HIV infections and providing care and treatment for parents and caregivers are crucial to reducing the overall number of vulnerable children in Swaziland and thereby create cost savings to the national response. To ensure the full continuum of HIV prevention, treatment, care and support and to maximize benefit for children over the long term, effort will be made across all program areas to improve linkages and referrals and promote a family-centered approach.

Five-Year Goal for Impact Mitigation: Enhance the safety, security and quality of life of vulnerable children in Swaziland					
Key Objective: By 2014, 50 per cent of vulnerable children should be receiving at least three basic support services on a continuous basis (this objective was derived from NSF and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
1) Enhance the policy and legal environment for vulnerable children and their caregivers.	a. Adopt and implement the: -Children's Policy, Children's Protection and Welfare Bill; -the Social Development Policy; -the Domestic Violence and Sexual Offences Bill and the Human Trafficking Act; and -the policies on Early Child Development and HIV and AIDS in the Education Sector.	a. Adopt the national Children's Bill, the Domestic Violence and Sexual Offences Bill, Human Trafficking Act and the Social Development Policy b. Develop operational plans and mobilize resources to implement Children's policy (the NPA) and Social Development Policy (the Strategic Plan) c. Disseminate and provide training on the Children's Policy and Social Development Policy	a. Advocate for the adoption and implementation of the policies listed under GKOS 5-year commitments. b. Help to identify and provide technical and financial support to overcome bottlenecks in developing, implementing and monitoring key policies related to children	a. Advocate for the approval of the national Children's Bill, the Domestic Violence and Sexual Offences Bill, Human Trafficking Act, and the Social development Policy b. Support the development of operational plans for the Children's policy (the NPA) and Social Development Policy (the Strategic Plan) c. Support dissemination and training around the Children's Policy and the Social Development Policy	i. UNICEF, CANGO, ii. SCSWD, World Vision, and various NGOs and FBOs: Advocate for the approval and adoption of key policies and legislation related to children and their caregivers, support policy implementation and monitoring
2) Enhance national capacity to plan, lead, coordinate, implement and	a. NCCU to establish a national, multi-sectoral leadership and coordination structure, including a TWG on children's issues	a. Convene a TWG on children's issues	a. Support the establishment of an NCCU coordination structure, including a TWG on children's issues b. Support capacity	a. Participate in and support the TWG for children's issues b. Build M&E capacity and provide TA to the NCCU, DSW and NERCHA	i. ii. UNICEF, SCSWD and World Vision among others: Participate in the TWG;

Five-Year Goal for Impact Mitigation: Enhance the safety, security and quality of life of vulnerable children in Swaziland					
Key Objective: By 2014, 50 per cent of vulnerable children should be receiving at least three basic support services on a continuous basis (this objective was derived from NSF and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
monitor programs to support vulnerable children	b. Strengthen and harmonize the coordination and implementation roles of the NCCU, DSW, relevant Ministries and NERCHA in support of children		development of the NCCU, DSW and NERCHA.		Support systems development for coordination, iii. Implementation and monitoring of quality service delivery
	c. Enhance the national social protection system	b. Finalize the NPA 2011-2015 and the strategic plan for NCPs c. Finalize the Social Development Strategic Plan; establish an abuse database within DSW	c. Support the enhancement of the national social protection system.	c. Support the finalization of the Social Development Strategic plan and the establishment of the abuse database within DSW	iv. UNICEF and World Vision: Provide capacity building support for NCCU and DSW
	d. Develop and put into effect national quality service standards & an M&E framework for programs that support vulnerable children	d. Conduct a national stakeholders meeting and standards development workshop and draft standards for five core service areas	d. Provide technical and financial support for the national process to develop quality service standards and an M&E framework for programs that serve vulnerable children	d. Provide technical assistance and financial support for the national stakeholders meeting and workshop on standards setting	
	e. Conduct cost effective surveys and other data collection efforts to improve the evidence base around vulnerable children	e. Develop an M&E system and database at NCCU for children's programming f. Plan for data collection around the NSF impact mitigation indicators	e. Support efforts to strengthen the evidence base around vulnerable children.	e. TBD when data collection tools are identified and costed	

Five-Year Goal for Impact Mitigation: Enhance the safety, security and quality of life of vulnerable children in Swaziland					
Key Objective: By 2014, 50 per cent of vulnerable children should be receiving at least three basic support services on a continuous basis (this objective was derived from NSF and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
3) Increase the percentage of vulnerable children receiving basic support services on a continuous basis	a. Complete implementation of NPA 2006-2010 and begin implementation of NPA 2011-2015 and the strategic plan for NCPs b. Continue the education grant for orphans and vulnerable children while phasing in free primary education. c. Ensure a greater number of children have access to early childhood care and development. d. Implement initiatives to strengthen the capacity of all cadres of caregivers e. Guide and oversee implementation of the National PSS strategy f. Promote violence and abuse prevention and ensure sufficient protection measures for children who experience abuse or	a. Complete implementation of NPA 2006-2010 b. Begin implementation of the strategic plan for NCPs c. Support ECD services through ECD centers and NCPs Support ECD services through ECD centers and NCPs d. Implement free primary education for grades 1 and 2 starting in January 2010 e. Coordinate the efforts to train various cadres of caregivers in PSS f. Train new and existing staff in DSW and the social sectors to decentralize public sector protection services	a. Support the implementation of the NPA and the strategic plan for NCPs b. Support the roll out of the strategic plan for NCPs, including provision of ECD services c. Provide technical and implementation support for the roll out of free primary education. See HICD d. Support the national community protection committees initiative to prevent child abuse and improve the public and NGO sector	a. Participate in the process to finalize the NPA and the strategic plan for NCPs; b. Provide ECD and PSS supplies for 200 NCPs c. TBD when Free Primary Education plan and budget are available See HICD d. Provide financial support to four NGOs implementing the community protection initiative and build capacity	a. UNICEF: provide technical, financial and material support for service delivery in core service areas as defined in the NPA; train caregivers b. SCSWD, World Vision, other international NGOs and local CBOs: Support community level service delivery through NCPs, primary schools, child protection committees among others; train caregivers c. GFATM and other private and public sector donors: Provide funding for construction and support of

Five-Year Goal for Impact Mitigation: Enhance the safety, security and quality of life of vulnerable children in Swaziland					
Key Objective: By 2014, 50 per cent of vulnerable children should be receiving at least three basic support services on a continuous basis (this objective was derived from NSF and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	other violations		response	among community caregivers, the police, physicians and magistrates to respond to abuse cases	NCPs d. World Food Program: Provide food and nutrition support
	g. Strengthen referral mechanisms to ensure that children receive all needed services	g. Develop referral protocol for the prevention and management of abuse and violence against children	e. Provide technical and financial support for service mapping and to strengthen referrals for children's services	e. Support the development of the referral protocol for the prevention and management of abuse and violence against children	
	h. Coordinate and issue guidelines for the efforts of NGOs in providing services and support for vulnerable children	h. Support the Child Protection Network and other coordinating forums	f. Support NGOs to deliver quality services and support for vulnerable children in line with national plans	f. Support five NGOs to deliver services to vulnerable children at the community level.	

Pillar Area: HUMAN AND INSTITUTIONAL CAPACITY BUILDING (HICD)

Severely limited human and institutional capacity is a major constraint to scaling up the HIV response in Swaziland. The number and skill level of the current health and social welfare (SW) work force is inadequate, as is the management of human resources (HR). Public sector institutions and local NGOs lack the organizational, financial and technical wherewithal to manage rapidly scaled up programs and services. Through this PFIP, PEPFAR will continue to be a lead partner with GKOS in responding to these capacity development challenges.

The overall 5-year goal for HICD under the Framework is to create a strengthened public sector and NGO workforce and institutional base sufficient for rapid national scale up of the HIV response and with benefit across the health and SW sectors. Human and institutional capacity building cut across all program areas of this PFIP. Specific capacity development strategies, for example in decentralized care and treatment, prevention, laboratory services and pharmaceutical management, are discussed within the relevant program area sections. Outlined below are the cross-cutting strategies that will be applied to address the HR limitations in public sector and the HR and other capacity constraints of NGOs.

To ensure national level capacity for HR management, PEPFAR will support the GKOS to finalize and implement the MOH HR Policy, National Health Policy, National Health Plan and Organizational Structure with departmental functions as well as with the Department of Social Welfare (DSW), and establish the Health and SW Commission. Sufficient staffing of the MOH HR Unit will be a critical early benchmark in the Framework period. GKOS and PEPFAR will collaborate to develop and decentralize the national HR Information System (HRIS) and use the data from this system to improve all aspects of HR management. Effort will also be made to strengthen regulatory councils in Swaziland and health care professional associations, to better address HR legal and regulatory barriers.

PEPFAR will provide TA and financial support to assist GKOS to fast track recruitment to fill the more than 850 vacant posts with the current MOH and DSW, and to ensure that positions are filled in sites designated for rapidly scaled up services. PEPFAR's support for recruitment will be aligned with the priority placed on attracting Swazis back home after completing external training in health-related professions and immediately retaining new graduates from Swaziland's training schools within the public sector workforce.

PEPFAR will support GKOS to better incorporate HIV and AIDS, TB, OI management, and SW into pre-service training so that graduates will be equipped to meet the needs of their assigned communities. As many options to achieve this are available, PEPFAR will support an assessment to determine the most effective approach to strengthening pre-service training, particularly for nurses. PEPFAR will also support GKOS to better plan for and rationalize in-service training for various cadres of health care workers to ensure that they are up to date with HIV-related and other information and technologies.

GKOS, with support from PEPFAR and other stakeholders, will work towards rationalizing and standardizing the various cadres of community health workers[8] providing HIV-related services and support. This will include creating or revising written scopes of work, assessing, harmonizing and enhancing current remuneration practices, developing systems for training and accreditation and disseminating guidance to NGOs and other organizations that support CHWs.

Since inception, PEPFAR Swaziland has provided capacity development interventions for local NGOs in the areas of organizational, financial and technical management. This work will continue throughout the Framework period. PEPFAR will also provide TA and support to GKOS for the development of a national umbrella-management body and HIV-related standards and guidelines that can be disseminated to NGOs for better harmonization of the response. GKOS will develop and implement strategies to ensure adherence to these guidelines. These efforts will help to ensure that the important multi-sectoral work done by NGOs is in line with the national response and can be scaled up and sustained over time.

[8] The term Community Health Worker (CHW) is used broadly in this Plan to incorporate all cadres of community level workers engaged in the HIV response, including Rural Health Motivators (RHMs), Community and NCP Caregivers, KaGogo Center Clerks and Home-based Carers among others.

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
1) Strengthen the HR capacity of the national government and key NGO providers to recruit, retain and manage a skilled health and social welfare (SW) workforce.	a. Approve and adopt HR policies to support recruitment, deployment, task-shifting, retention and benefit packages	a. Strengthen through a revised TOR and routinize the HR TWG which is chaired by the HR/Director to direct all guidelines related to HR capacity b. The MOH will facilitate the approval process through PPCU to ensure finalization of National HR for Health Policy and National HR for Health Strategy	a. Advocate for approval and adoption of HR policies, including task shifting and accreditation required for a scaled up, efficient HIV response	a. Provide TA in finalizing the policy documents for submission to PPCU	i. WHO: Finalization and dissemination of Health Sector Service Mapping Report ii. UN Agencies, International NGOs and others: implement various, limited capacity development initiatives to support the HIV and AIDS response iii. GFATM: TA to develop a Health Commission and to develop performance-based hiring systems and retention packages; support the development of an integrated transportation and supervision program for the health sector; expansion of health workforce wellness programs
	b. Finalize, cost and budget the HR component of the HSSP, SW Strategic Plan and the MOH Organizational Structure to guide staff planning, recruitment and management	c. MOH will identify technical support required for the costing of the new MOH structure	b. Provide TA and support to develop the HR Units in the MOH and DSW	b. Provide TA in the costing of MOH/Organizational Structure and developing priority job descriptions to guide the minimum staffing norms at each level of service delivery	
	c. Build capacity, staff up	d. MOH will recruit two	c. Support and document	c. Provide TA support	

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	and train Health Planning, Strategic Information, and HR Units to ensure they are functional	positions, and the staffing in the regions; recruit the HR Director	HR systems to include career promotion structures, updated functional job descriptions, and procedures for staff deployment	to train the users (HQ senior management/other decisions makers); Health Management Teams; Purchase computer hardware for priority two regions	iv. WHO: Linkage with task shifting cadres in community health work
	d. Decentralize and utilize the HRIS to increase the efficiency and effectiveness of recruitment, training and other aspects of HR management	e. Decentralization of the HRIS in all regions; cost for networking and hardware; support of system the Government Computer Services; dedicated server for HRIS f. Absorb the HRIS Officer position currently supported by PEPFAR in the MOH Establishment Register; and create 2 Assistant HRIS Officers from two regions	d. Provide TA and support for the HRIS and use of data for decision-making	d. Develop Plan and revise the TOR for HRIS Officer to HRIS Analyst based on scope of the position and qualification	

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	e. Develop and operate effective systems of career laddering and performance-based supervision to complement GFATM support		e. Provide TA and support to develop and implement effective systems of career laddering and performance-based supervision f. Provide funding and support to the NGO sector to scale up HIV-related services and strengthen linkages between clinics and communities		
2) Expedite recruitment within the MOPS, MOH and DSW to fill vacancies in established positions	a. Establish a MOH Health Services Commission (HSC) to fast track recruitment through the Civil Service Commission b. Recruit health and SW workers according to the MOH and DSW updated	a. Facilitate the approval of HSC Act in Attorney General's Office and approval of Act; appoint commissioners, and develop an operational budget b. MOH and DSW will identify priority cadres to be recruited; DSW will identify	a. Support recruitment of current MOH and DSW vacancies with priority posting to PEPFAR-supported sites b. Support efforts to rapidly place graduates from local institutions and attract Swazis back to Swaziland after	a. Through AHP, recruit priority cadre(s) in consultation with MOH and DSW. b. Identify TA support for DSW to assist the restructuring of the DSW and recruit for the critical positions with qualified Social Workers	i. GFATM: Expedite the recruitment of MC doctors required for the national scale up ii. Nursing Council: Develop strategies to efficiently license and place new graduates and to attract Swazis back to Swaziland after

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	organizational structure, procedures of the MOPS and functional job descriptions c. Develop and implement strategies and incentives to improve retention of health and SW workers (including allowances, housing and orientation) d. Develop strategies to efficiently place local school graduates and attract Swazis back to Swaziland after external training e. Roll over short-term staffing contracts to government contract positions f.	critical positions to be hired based on the revised new structure c. Identify priority cadres to be addressed to implement a retention strategy and implications on the budget (if any). d. Facilitate absorption of short-term contracts into Establishment Register in priority cadres	external training c. Fund additional staff for short term scale up and decentralization needs or as a precursor to absorption by GKOS d. Provide TA and support for strategies to improve health and SW workforce retention	c. TA support will be provided to develop a retention strategy for Swaziland consulting with the MOH	external training iii. Medical and Dental Council: Meet regularly to expedite the recruitment and licensing of doctors iv. GFATM
3) Strengthen pre-service	a. Develop and introduce improved	a. Revise and strengthen the HR TWG TOR to	a. Provide TA and support to increase	a. Provide coordinated support in pre-service	i. Nazarene Training College,

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
and in-service training capacity for health and SW workforce	and accredited pre-service training curricula for public and NGO sector institutions in line with current health sector plan b. With MOET, arrange pre-service training scholarships allocated to MOH for HIV/AIDS training c. Rationalize accredited in-service training programs into one continuing education program for each cadre d. Improve training, mentorship and supervision programs for health and DSW e. Integrate HR performance-based promotion and career laddering f. Expand the focus for	guide pre-service and in-service training curricular and accreditation; MOH/HR Unit will chair the TWG b. Develop accreditation standards for DSW c. Facilitate retention of HCW discussion with MPS to better implement the performance based promotion system and career laddering system d. Develop a training needs analysis and skills audit that will be incorporated into MOH Training Plan and budget that will include MOH supported training and training supported by donor partners e. Finalize and adopt the	intake and incorporate HIV/AIDS in the pre-service curriculum b. Leverage regional pre-service training capacity to improve and retain qualified faculty c. Provide support to improve training methodologies, including practicum and mentorship programs for students d. Provide TA and support to improve and integrate pre-service and in-service education for the health and SW workforce e. Strengthen Swaziland Institute for Management and Public Administration (SIMPA) and the Institute of	nursing education (curriculum development and mentorship training; expanding the preceptor training; Faculty exchange visits b. Identify TA to assist DSW to develop a training program for auxiliary/Para-Social Workers and accreditation using regional experiences i.e. from Malawi that can be tailor-made for Swaziland c. Provide TA to better implement the performance-based promotion and career laddering system d. Place training Coordinator in MOH Training Unit to strengthen coordination of	ii. University of Swaziland (UNISWA), and Good Shepherd: Identify mentors, facilities, and key faculty to update the pre-service curriculum, provide pre-service training iii. SIMPA and IDM: Provide in-service training for the civil service in line with MOH training plans iv. Nursing Council: v. Improve training including, continuing education, mentorship and supervision programs for nurses vi. Medical and Dental Council: Define continuing education

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	the leadership and management training targeting all levels (senior, middle, lower) for MOH/DSW g. Strengthen the training coordination function of the HR Unit h. Recruit and retain nurse and DSW tutors for pre-service schools	draft Swaziland Nursing Council Act through PPCU	Development Management (IDM) to develop leadership and management skills for mid-level and senior managers.	training (including leadership and management training); e. Develop TIMS f. Support a training needs analysis to inform the training plan	requirements for doctors vii. GFATM - Strengthen capacity of Health Sciences faculty at UNISWA through small scale refurbishment, additional equipment and lecturers
4) Strengthen the capacity of RHMs/CHWs to deliver family-centered, HIV-related services and support.	a. Finalize the HR component of the CHW Policy and Strategic Plan to guide CHW planning, and management b. Develop and introduce standardized scopes of practice, training curricula, accreditation	a. Establish RHM/CHW Advisory and Coordination committee to streamline the cadres for uniformity and incorporate into policy b. Develop National RHM/CHW strategic plan that will influence a shift in	a. Provide TA and support for efforts to train, accredit and standardize the work and remuneration of CHWs b. Promote quality control for service delivery and job outputs through supportive supervision systems	a. Develop a strategy for linking facilities with the community in care and treatment that will assist in defining CHW scope; revise curriculum for CHW b. Provide TA in consultation with WHO, and Advisory and Coordination	i. GFATM: Provide funds for home-based care supplies; to expand the number of community caregivers; and to train and strengthen the Child Protection Committees and KaGogo centers, ii. UNICEF: Provide training and support

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	requirements and remuneration, and supportive supervision and M&E for CHWs c. Increase numbers of CHWs consistent with decentralized service provision plans d. Link CHWs to formal paraprofessional health and SW workforce positions. e. Ministry of Tikhundla Administration will formalize certification process for KaGogo Clerks and Assistant Regional Coordinator pre- and in-service training f. MOH will develop and formalize certification process for RHM and CHW pre-service and in-	curriculum that will be accredited	c. Provide non-monetary incentives to allow CHWs to perform their functions in PEPFAR supported sites d. Support GKOS to develop a standardized remuneration scheme for all cadres of CHWs e. Abide by National Labor Act terms of employment and universal precautions	Committee c. Disseminate Supervisory Manual developed through PEPFAR to Advisory & Coordination Committee and HBC/Care and Treatment TWG's d. Conduct TOT for supervisory training module (s); Train Regional Health Teams; Conduct supervisory visits in the regions e. Develop NGO Comprehensive directory starting with the project catchment area to inform more on who are the NGO's working in care and treatment	for community cadres at NCPs for service delivery and M&E

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH, DSW and NGOs to respond to the HIV epidemic					
Baseline: By 2013, 80 per cent of established positions in the MOH and DSW should be filled (This objective was jointly defined by Ministry of Public Service (MOPS), MOH, DSW and PEPFAR and the baseline is to be established)					
Objectives	**GKOS 5-year Commitments**	**GKOS 1-year Commitments**	**USG 5-year Commitments**	**USG 1-year Commitments**	**Other Partner Commitments**
	service training programs to harmonize the two cadres				
5) Strengthen the capacity of local NGOs working at community level in support of the national HIV response.	a. Establish/continue to operate forums to coordinate the work of NGOs b. Support accreditation and standard-setting for NGOs, including guidelines for NGOs that support CHWs working on HIV response c. Monitor and support the three ones including NGOs d. Ensure complementary funding for program and operational costs to NGOs	a. Establish guidelines and standards for NGOs to that work in HIV response to monitor the work they are doing to support the MOH; DSW; and other government agencies	a. Provide capacity development support to indigenous NGO-support umbrella body b. Provide training and TA to build the governance, organizational, financial, HR and technical capacity of local NGOs. c. Provide TA and support for developing national guidelines for NGOs that support CHWs d. Provide complementary funding for program and operational costs to NGOs	a. Support the Consortium for HIV to establish a forum for coordinating the work of NGOs	i. CANGO: Provides coordination mechanism for local NGOs through director's forum. Map NGO-provided services and referral mechanism and documentation ii. UNDP/UNAIDS: Support- governance strengthening in NGO community ii. NERCHA (Global Fund): Coordinate funding for systems strengthening to support government and NGOs

Ongoing Priority Areas: PMTCT and Blood Safety

The USG has made substantial investments to date in the national programs for PMTCT and to ensure a safe and adequate supply of blood. The USG plans to continue to partner with the GKOS through the Framework period to strengthen these two important program areas as described below:

- With financial and technical assistance from PEPFAR and other donors, the GKOS has achieved impressive PMTCT coverage levels (72 per cent in 2008) and completion rates. In Swaziland, PMTCT is a strong program area with good collaboration and monitoring. Although coverage is expected to further improve during the Framework period, the focus is intended to shift towards better integration of PMTCT with other HIV-related services and to transition toward greater government stewardship and financial support of PMTCT services. GKOS, PEPFAR and other partners plan to strengthen local capacity to ensure sustainability of high quality PMTCT services.
- The capacity for safe and effective blood donation has improved in Swaziland, but continues to be inadequate in relation to the national requirement. During the Framework period, GKOS and PEPFAR plan to further strengthen the capacity and quality of the national Blood Transfusion Service, with a focus on rationalized blood use policy and practice, expanding the national donor recruitment effort, and updating screening and blood banking infrastructure in the country. .

FINANCIAL ACCOUNTABILITY

The GKOS and the USG recognize that strategic investments made over the next five years in the fight against HIV and AIDS will continue to bear fruit for generations to come. The table below shows current estimates of near term commitments by external partners and the GKOS, starting in the 2008/2009 period. (Fiscal years differ so there is some overlap in annual budget periods.) These are based on preliminary results of a HIV and AIDS costing study and a funding gap analysis, both conducted by NERCHA. They include host country cost sharing requirements under U.S. foreign assistance programs whereby the GKOS will invest 25 per cent or more in cash or in kind to programs where U.S. government funds go directly to GKOS.

Adequate planning and costing of the HIV programmatic response requires trained and dedicated staff in key national institutions. A recent restructuring of the MOH has created a Planning Directorate, which will have in its purview the development of health sector budgets and harmonization of assistance partner contributions to implementation the NSP and HSSP. Through the PEPFAR-MOH cooperative agreement and other mechanisms, technical and material assistance will be delivered to facilitate the Planning Directorate's early growth and sustained development.

GKOS and the USG acknowledge that resources are limited and that proposed financial commitments are subject to annual performance reviews and the availability of funds. It is noted within the Framework that achievement of the shared goals requires resource flows beyond the ability of any one partner, and that constraints on availability of funding from either signatory or from other key partners could lead to a review and revision of the goals.

It is also important to consider that the funding gap as presented is notional in so far as Swaziland is challenged at the moment to effectively program (i.e., "absorb") the funds now available through existing supporting institutions and fund sources. Knowledge about the true cost of the planned HIV and AIDS and capacity building interventions is also limited. To ensure that the funding gap analysis is made more precise and useful, costing studies will be undertaken and effort will be made to strengthen management systems that can at once allow better absorption of available funds and permit a more precise estimate of needed resources in the context of routine health sector planning. As capacity is built to estimate costs and manage the resources, the real absorbable gap will grow perhaps well beyond the figures provided here in the out years of the Framework agreement. Therefore, at each annual review, as the financial management and tracking systems improve and as the costs of scale-up are better ascertained, the funding gap analysis will be reassessed.

Notwithstanding the potential constraints in interpreting these current data, it is clear that the GKOS has made a commitment to increase its support to the HIV and AIDS response. Yet, even with this expanded commitment, the estimated gap between needed and available funds will grow substantially to exceed $100 million by 2013.

Financial contributions to HIV and AIDS Response in Swaziland 2009-2013 in U.S. dollars

Funding Partner	Approximate Funding Level					Areas of Focus
	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	
Government (all sectors)*	$50 M	$54 M	$70 M	$82 M	$100 M	HIV Prevention, Care and Treatment (service delivery), TB/HIV, Health Systems
PEPFAR/USG	$28 M	$28 M	$28 M	$28 M	$28 M	HIV Prevention, Care and Treatment, TB/HIV, Health Systems
GFATM (Rounds 4-8)	$31 M	$25 M	$18 M	$17 M	$19 M	HIV Prevention, care and Treatment, TB, health systems grants
UN Agencies	$14 M	$14 M	$14 M	$14 M	$14 M	Impact Mitigation, PMTCT, Technical Assistance, Food and Nutrition Support
European Commission	$5 M	$5 M	$3 M	$3 M	$3 M	Impact Mitigation, Health Systems
Other External	$ 2 M	<$1 M	<$1 M	<$1 M	<$1 M	Laboratory, technical assistance
Total Projected	**$130 M**	**$126 M**	**$134 M**	**$145 M**	**$165 M**	**All areas**
Costing of Swaziland HIV AIDS Action Plan, NERCHA 2009)	**$160 M**	**$202 M**	**$220 M**	**$242 M**	**$266 M**	**All areas**
Funding Gap	**$30 M**	**$76 M**	**$86 M**	**$97 M**	**$101**	**All areas**

* Based on 2009 NERCHA gap analysis, Swaziland Government contributions include: 30% of overall curative care MOH budget, 100% of the Swaziland National AIDS Program/MOH budget, 100% of HIV prevention budget and 50% of other related budget.

MONITORING AND EVALUATION (M&E)

The Framework will be monitored and evaluated over the course of its five-year lifespan. PEPFAR Swaziland has since its inception in 2004 partnered closely with the GKOS in its support for national strategic information systems. Monitoring of the Framework will rely principally on these national systems, routine and periodic, to ensure sustainability and efficiencies in M&E implementation and to minimize transaction costs. Routine national systems in Swaziland involve both health-sector specific and multi-sector systems. The Health Management Information System is based in the MOH, collects health-related data, and reports quarterly on key national health statistics. The Swaziland HIV and AIDS Program Monitoring System (SHAPMoS) is managed by NERCHA and collects and reports quarterly on both health sector and non-health sector indicators. Both the HMIS and SHAPMoS require capacitated regional offices to provide front-line data processing and utilization activities. Periodic data systems include surveys and surveillance. Chief among these in their relevance to Framework monitoring are the HIV sentinel surveillance surveys (implemented on a biennial basis) and household surveys, e.g. Demographic and Health and other surveys (implemented every few years as needed). Both require considerable planning, financial resources, and technical capacity to ensure high quality results.

The tables following this section provide the quantitative and qualitative indicators that will be measured and tracked around each of the five pillars in the Framework Monitoring System. Indicator data will be drawn from existing M&E systems in Swaziland. Progress on the development of national policies and other qualitative benchmarks will be tracked through use of administrative records and approved policy documents. These are listed under the respective program area indicator tables below. Also provided is a monitoring table to indicate the targeted stage of reform for key policies by the end of the Framework period.

Please note that baseline or 5-year target values for a number of indicators are yet "to be established". The lack of data in these areas is in large part due to intervention standards that are non-existent, incompletely defined and/or not locally validated. During the first year of the PF implementation, a series of standards setting exercises are planned which will then permit expedited M&E instrument design and implementation. As examples the GKOS, PEPFAR and our partners will: focus on improved definition of revised scopes of practice for the health workforce under the decentralization plan; study sexual networking to create tools to measure and monitor concurrency; and collaborate in the local validation of minimum standards of care and support for vulnerable children.

Five-Year Goal for Care and Treatment: Decentralize and improve the quality of HIV care and treatment services to increase access and improve outcomes for PLWHA			
Objectives	**Indicators**	**Baseline**	**5-Year Target**
Increase the percentage of the population that knows their HIV status through increased access to high quality HTC	Provide quality-assured HIV testing and counseling (HTC) in all health facilities throughout the country by 2013. Increase percentage of people aged 15-49 tested for HIV in the last 12 months and received their test results to 50% for women and 40% for men by 2013	2009 – 178 2009 – (2007 SDHS) 22% for women, 9% for men	2013 – 223 2013 – 50% for women, 40 % for men
Increase the number of HIV infected people receiving pre-ART services as part of Comprehensive Care Package (CCP)	Increase pre-ART services to cover at least 80,000 HIV-infected people by 2013 Retain at least 80% of people on pre-ART (or ART) three years after enrolment, by 2013	2009 – to be established 2009 – to be established	2013 – 80,000 2013 – 80%
Increase the number of people receiving high quality ART services	Increase in number of people (adults and children) receiving ART from 38,000 in 2009 to 60,000 by 2013 Retain at least 85% of people on ART three years after the initiation of treatment, by 2013	2009 – 38,000 2009 – to be established	2013 - 60,000 2013 - 85%
Increase TB treatment enrollment and success	Enroll 85% HIV-infected incident TB cases on TB treatment by 2013 (NSF) Increase the overall TB treatment success rate to 85% by 2013	2009 – to be established 2008 - 58%	2013 – 85% 2013 - 85%

Policy and other qualitative benchmarks:

- National decentralization plan for HIV-related care and treatment services, including community component
- Revised ART (pediatric and adult) guidelines, including TB/HIV integration component
- User fees for HIV-related care and treatment
- Task-shifting/sharing for HTC, treatment initiation & prescription, community-based care and support, lay counsellors
- Revised essential Drug list approved; improved availability of drugs
- Implementation of the approved Pharmaceutical Policy
- Code of professional conduct and/or practise around treatment options
- Laboratory policy finalized and approved
- Nutrition policy finalized and approved
- TB infection control policy and guidelines emphasizing special measures addressing MDR-TB prevention and control

Five-Year Goal for Sexual Prevention: Reduce HIV incidence by reducing behaviors that enhance the risk of HIV infection and increasing protective behaviors in the general population			
Objectives	**Indicators**	**Baseline**	**5-Year Target**
Improve knowledge about prevention of HIV transmission within the general population	Comprehensive knowledge of HIV & AIDS among women & men aged 15-49 increased from 52% in 2007 to 78% by 2013	2007 - 52%	2013 - 78%
Reduce high risk sexual behaviors in the general population	Percent of men & women aged 15-49 with multiple partners in the last 12 months reduced from 23% to 6% for men and from 2% to 1% for women. Increase the percent of men with multiple (concurrent) partners who report using a condom during the last sex from 26% in 2007 to 70% by 2013	2007 - 23% for men, 2% for women 2007 - 26%	2013 - 6% for men, 1% for women 2013 - 70%
Increase safe sexual behaviors among young people	Percent of young people (15-24 years) who report first sex before age 15 years reduced to 2% in 2013 Per cent of young people (15-24 years) who report using a condom at first sex increase to 70% by 2013	2007 - 7% for women, 5% for men 2007 - 43% for women, 49% for men	2013 - 2% for men and women 2013 - 70% for men and women
Policy and other qualitative benchmarks: • Functional Prevention TWG • National SBCC strategy approved and implemented • National level coordination of the SBCC strategy and operational plan • National condom strategy finalized and approved • National HIV Prevention Policy developed and adopted • Gender Policy finalized and approved • Establish regular behavioral surveillance and program evaluation of HIV prevention efforts			

Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males			
Objectives	**Indicators**	**Baseline**	**5-Year Target**
Increase the demand for medical MC.	Increase in the percent of uncircumcised men aged 15-24 who want to be circumcised from 40% to 80%	2007 – 40% (SDHS)	2013 - 80%
Increased access to and coverage of MC services to meet demand.	At least 10 sites effectively delivering medical male circumcision services in line with national & international guidelines Between 2009 and 2013, 110,000 males aged 15-24 provided with high quality medical male circumcision services (cumulative, catch up)	2009 – 2 sites 2009 – est. 2,000	2013 – 10 sites 2013 - 110,000
Policy and other qualitative benchmarks: • National capacity (infrastructure and human resources) increased to manage rapid scale-up of medical MC • National MC Policy and operational plan finalized and approved • Operationalized National MC communication strategy, clinical protocol and M&E plans			

Five-Year Goal for Impact Mitigation: Improve living circumstances for vulnerable children in Swaziland			
Objectives	**Indicators**	**Baseline**	**5 Year Target**
Increase the percentage of vulnerable children receiving basic support services	Percentage of vulnerable children receiving at least 3 types of free support services from external source. Service types include: • basic health care and health care referral • education or vocational training • psychosocial • food or other nutritional • protection or legal aid • shelter and care giving • economic strengthening	2009 – To be established	2013 – 50%
Policy and other qualitative benchmarks: • Revised National Plan of Action for Children 2011-2015 • National quality standards and M&E Framework for programs in support of vulnerable children • National Children's Protection and Welfare Bill approved • National trafficking bill and ratified protocols finalized and approved • Domestic Violence and Sexual Offences Bill finalized and approved • Social Development policy and strategy finalized and approved			

Five-Year Goal for Human and Institutional Capacity Development: Improved human and institutional capacity of the MOH and NGOs to respond to the HIV epidemic			
Objectives	**Indicators**	**Baseline**	**5-Year Target**
Expedite recruitment within the MOH to fill vacancies in established staff positions	Reduce the MOH average staff recruitment time from 18 months in 2008 to 3 months in 2013	2008 - 18 months	2013 - 3 months
	Increase the percent of established MOH positions that are filled from 60% in 2008 to 80% in 2013	2009 – 60%	2013 - 80%
	Percentage of new health workers in each cadre that are registered through regulatory bodies within a year of their graduation	2009- to be established	2013- 90%
Strengthen the capacity of local NGOs working at community level in support of the national HIV response.	Number of NGOs with - budget and accounting system in place - HR management system in place - M&E plan in place	To be established	20 (above baseline)
	Indigenous umbrella NGO support agency with capacity to provide high quality technical support to NGOs in financial tracking, HR management, and M&E	None	1

Strengthened capacity of community health workers (NGO and governmental) to deliver HIV-related services.	Number of community health workers provided with comprehensive HIV and AIDS training, based on nationally recognized pre-service or, as applicable, in-service training curricula. Number (and percentage) of facility-based and community based health workers who received personal in-service supportive supervision in last six months	2009 – 0 To be established	2013 - 2000 To be established
Policy and other qualitative benchmarks: • Human resources policy, organizational structure and functional job descriptions • National HRH Policy and HRH task shifting policy approved and implemented • National HRIS System decentralized and utilized to inform HR planning • HRH implementation strategic plan developed costed and budgeted • Appropriate scopes of practice (or schemes of service) defined for all cadres • Leadership development program established for managers at relevant levels • National strategy in place for training NGOs in program management and administration			

POLICY REFORM MONITORING TABLE

Progress	HIV Prevention	Gender Policy	Male Circumcision	National Blood Transfusion Policy	National Clinical Laboratory Policy	Multi-sectoral AIDS Policy (updates on HTC)	National Pharmaceutical Policy	TB/HIV integration	Palliative Care
1. situation assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. develop policy agenda		✓	✓	✓	✓	✓	✓	✓	✓
3. develop policy		✓	✓	✓	✓		✓	(guidelines)	
4. government endorsement			✓						
5. policy implementation	**x**	**x**		**x**	**x**	**x**	**x (essential drug list)**	**x**	
6. evaluation of implementation									

Progress	National Children's Policy*	National Children's Protection and Welfare Bill*	Social Development Policy*	Domestic Violence and Sexual Offences Bill*	Human Trafficking Bill*	Human Resources Policy	National Human Resources for Health Policy	HRH Task Shifting Policy
1. situation assessment	✓	✓	✓	✓	✓	✓	✓	✓
2. develop policy agenda	✓	✓	✓	✓	✓	✓	✓	✓
3. develop policy	✓		✓	✓	✓	✓	✓	
3. government endorsement	✓				✓			
5. policy implementation	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
6. evaluation of implementation								

*** As impact mitigation focused on vulnerable children is a new program area, PEPFAR Swaziland's engagement in these policy areas is only beginning at this time.**

MANAGEMENT AND COMMUNICATION

To date, the relationship between the GKOS and PEPFAR has been one of collaboration and mutual respect. The Framework and PFIP present an opportunity and an instrument to further strengthen collaboration, coordination and accountability by ensuring a focus on key mutually defined strategies and measures of success.

Based on consultation with the USG, the Office of the Prime Minister, through a Cabinet decision, assigned the following GKOS agencies to actively partner with the U.S. inter-agency PEPFAR team on the development, implementation and monitoring of the Framework: MOH, NERCHA, the Ministry of Economic Planning and Development, the Office of the Deputy Prime Minister (National Children's Coordination Unit and the DSW), and the Ministry of Sports, Culture and Youth Affairs. Other government agencies, such as the United Swaziland Defense Forces, the Ministry of Education and Training and the Ministry of Tikhundla Administration will work closely with the USG on specific target populations and relevant issues, including the uniformed services, life skills education and decentralization.

The governance system to manage the Framework and PFIP builds on existing structures that include public and civil society representation to provide oversight for the national HIV response.

Technical Oversight and Monitoring: Within GKOS, NERCHA is expected to have primary responsibility for monitoring Framework implementation based on a mutually defined monitoring and evaluation plan. Within the USG and in each of the assigned GKOS Ministries, a point of contact is tasked as liaison to manage and routinely monitor the relevant elements of the Framework. The existing and planned multi-sectoral TWGs and coordination forums for Care and Treatment, Prevention and Impact Mitigation are intended to provide the periodic vehicle for ensuring that Framework interventions are up to date and in line with the goals of the NSF.

Strategic Oversight: In a new formalized structure, the full team of GKOS and PEPFAR management leadership intend to meet annually bringing in leadership from civil society, UN agencies, private foundations, the private sector and other bilateral assistance agencies as appropriate to discuss progress towards goals and objectives. A progress report is intended to be developed by this GKOS-PEPFAR team and disseminated to participants at the annual meeting and to all other stakeholders, including the public.

Global Fund harmonization: At the quarterly full meeting of the GFATM Country Coordinating Mechanism (CCM), members intend to review the integration of the Framework activities with Global Fund grants and national priorities.

High level oversight: This is expected to be provided through meetings between the Prime Minister of Swaziland and the U.S. Ambassador.

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