

# Swaziland

## U.S. Global Health Initiative

### Country Strategy

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## ACRONYM LIST

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AIDS	Acquired Immune Deficiency Syndrome	HTC	HIV testing and counseling
ANC	antenatal care	IEC	information, education and communication
ART	antiretroviral therapy	M&E	monitoring and evaluation
ARV	antiretroviral	MARP	most-at-risk-population
BSS	Behavioral Surveillance Survey	MC	male circumcision
CCM	Global Fund Country Coordinating Mechanism	MCH	maternal and child health
CDC	[HHS] U.S. Centers for Disease Control and Prevention	MCP	multiple concurrent partnerships
CHAI	Clinton Health Access Initiative	MDGs	Millennium Development Goals
CHW	community health worker	MDR	multidrug resistant
COP	Country Operational Plan	MMR	maternal mortality ratio
CSO	civil society organization	MNCH	maternal, neonatal and child health
CTX	Cotrimoxazole prophylaxis	MOH	Ministry of Health
DHS	Demographic and Health Survey	MSF	Médecins Sans Frontières (Doctors without Borders)
DoD	U.S. Department of Defense	MSM	men who have sex with men
DOL	U.S. Department of Labor	NERCHA	National Emergency Response Council on HIV/AIDS
DOS	U.S. Department of State	NCD	non-communicable disease
DSW	[Deputy Prime Minister's Office] Department of Social Welfare	NCP	neighborhood care point
FP	family planning	NHSSP	National Health Sector Strategic Plan
EC	European Commission	NGO	non-governmental organization
ECF	PEPFAR Emergency Commodity Fund	NMCP	National Malaria Control Program
ECSSA	Eastern, Central and Southern Africa Health Alliance	NRL	National Reference Laboratory
EPAS	Elimination of Pediatric AIDS in Swaziland	NSF	National Strategic Framework on HIV/AIDS
EU	European Union	OI	opportunistic infection
FBO	faith-based organization	OGAC	Office of the U.S. Global AIDS Coordinator
GBV	gender-based violence	OIG	Office of the Inspector General
GCF	Gender Challenge Fund	OVC	orphans and vulnerable children
GDP	gross domestic product	PEP	Post Exposure Prophylaxis
GHI	Global Health Initiative	PEPFAR	The United States President's Emergency Plan for AIDS Relief
GOKS	Government of the Kingdom of Swaziland	PFIP	Partnership Framework Implementation Plan
HHS	U.S. Department of Health and Human Services	PLWHA	People living with HIV/AIDS
HIV	human immunodeficiency virus	PMTCT	prevention of mother-to-child transmission
HMIS	health management information system	RFSC	Regional and Facility Support and Coordination Team
HRIS	human resources information system	RHM	rural health motivator
HRH	human resources for health	SACU	Southern Africa Customs Union
HRSA	[HHS] U.S. Health Services Resource Administration	SEC	Swaziland Scientific Ethics Committee
HDPWG	Health Development Partners Working Group	SBCC	sexual behavior change communication

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SHIMS	Swaziland HIV Incidence Measurement Survey
SI	strategic information
SID	[MOH] Strategic Information Department
STI	sexually-transmitted infections
SRH	sexual reproductive health
SWAp	Sector-Wide Approach
TB	Tuberculosis
TWG	technical working group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VMMC	voluntary medical male circumcision
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

## 1. GLOBAL HEALTH INITIATIVE VISION

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### 1.1. GOKS VISION FOR HEALTH IN SWAZILAND

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The overarching vision advanced in Government of the Kingdom of Swaziland – United States Government (GOKS-USG) joint planning is to support the transition of the Swazi public health system from an acute care to a chronic care model, while building civil society institutions to support a sustained response to HIV/AIDS well beyond the lifespan of the USG collaboration.

The Ministry of Health's (MOH) detailed vision for the health of the Swazi people is detailed in the National Health Sector Strategic Plan, 2008-2013 (NHSSP). The NHSSP centers on building the capacity of the Ministry of Health (MOH) to provide universal access to quality public health and clinical services.

### 1.2. USG VISION FOR ITS CONTRIBUTION

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While USG bilateral assistance in Swaziland is limited to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program, USG investments in supporting the national multi-sectoral HIV program have centered on strengthening the health sector as the core foundation for a sustained, generational response to the HIV/AIDS epidemic. With the world's highest HIV prevalence, significant health sector capacity constraints and widespread poverty, the GOKS and USG recognize that this will be a long term partnership and endeavor. Through the Partnership Framework (PF) and corresponding Partnership Framework Implementation Plan (PFIP), the GOKS and USG have 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/AIDS response and the overall health sector capacity in support of the National Strategic Framework on HIV/AIDS 2009-2014 (NSF). The overarching vision advanced in the PF/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.

The diverse contributed assets of the GOKS, 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. Although USG investments are limited to HIV/AIDS-centered programming, it is understood that these investments will have widely felt impacts on improved health sector function and public health outcomes. For instance, through the human and institutional capacity development pillar area, USG is helping to address one of the most formidable challenges of the health sector. By bolstering the foundations of health and community systems, USG is strategically positioning Swaziland's institutions, empowering Swazi leadership, and engendering ownership over the longer term. U.S. engagement in this fight against HIV/AIDS, in concert with the Swazi government, civil society, and international donors, is helping define the arc of Swaziland's future.

## 2. COUNTRY CONTEXT

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Swaziland is a landlocked kingdom at the epicenter of the global HIV/AIDS pandemic, struggling to mitigate the world's highest prevalence rates of HIV and TB. Twenty-six percent of Swaziland's adult population (aged 15-49) is infected with HIV<sup>1</sup>, while prevalence amongst pregnant women attending

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<sup>1</sup> CSO Swaziland, 2007, Swaziland Demographic and Health Survey

ante-natal care (ANC) facilities stands at a staggering 41 percent. HIV incidence is estimated at 2.48 percent<sup>2</sup>, meaning that over 30 new infections occur each day in the country. Life expectancy plummeted from 60 years in the 1990s to 43 years in 2007, and is estimated to have rebounded to 47 in 2009 due in large part to the success of the national anti-retroviral therapy (ART) program. The World Health Organization (WHO) estimates that 210,000 to 230,000 of Swaziland's 1,180,000 citizens are living with HIV and AIDS<sup>3</sup>. Swaziland has the highest Tuberculosis (TB) notification rate in the world at 1,155 cases per 100,000 population; approximately 80 percent of TB cases are estimated to be HIV-positive<sup>4</sup>.

**TABLE 1: KEY SOCIO-ECONOMIC INDICATORS, 1986-2009**

Indicator	1986	1997	2007	2009 Estimates
Population <sup>5</sup>	681,059	929,718	1,018,449	1,185,000 <sup>6</sup>
GDP growth rate <sup>7</sup>	14.6%	3.8%	3.5%	0.4%
GDP per capita <sup>8</sup>	\$761	\$1,690	\$2,561	\$2,478
Health Expenditure as % of GDP <sup>9</sup>		5.7%	5.9%	6.3%
Unemployment rate <sup>10</sup>	24.4%	22.8%	28.2%	
Adult literacy rate <sup>11</sup>	70.1%	81.3%	89.1%	
Life Expectancy	56	60	43	47m / 50f <sup>12</sup>

More than half of the population is under 20 and by conservative estimates more than a third of all children fit the definition of orphaned or vulnerable. Traditional family structures have all but collapsed, with only 22 percent of children raised in two-parent households. Women are disproportionately affected, comprising over 55 percent of all HIV-infected adults, and 62 percent of new infections<sup>13</sup>. Gender-based inequalities, violence, poverty and income disparities persist in the country and create significant barriers to effective HIV prevention interventions. The majority of the population (79 percent) lives in rural areas and is dependent on subsistence farming, although Swaziland's generalized epidemic does not show significant variances in HIV prevalence between rural and urban areas or among the country's four regions. Given the HIV prevalence rate, the entire country is considered at risk. TB is the leading cause of morbidity and mortality among adults. WHO estimates that TB kills 50 percent of HIV infected patients and accounts for more than 25 percent of all hospital admissions. The extreme burden of HIV, TB and other communicable diseases has severely strained the health sector's ability to tackle the growing prevalence of non-communicable diseases (NCDs). Nearly unmanageable patient loads, lack of waiting areas, deteriorating physical health infrastructure, inadequate numbers of health care providers and the complexity of providing chronic care for HIV/AIDS patients are severely straining the government's efforts to decentralize and improve the quality of health care<sup>14</sup>.

In short, the HIV/AIDS and TB epidemics are altering Swaziland's demographics at an alarming pace, cutting away at the productive core of the country and threatening to turn the country into a land of orphans and the aged. Economic growth and development have been deeply impacted by the health crisis, which literally threatens the future of the kingdom. Illness and death associated with HIV/AIDS are enormous drains on the national economy, national health system, and other social support networks

<sup>2</sup> 2010 Estimates and Projections Report

<sup>3</sup> WHO Country Cooperation Strategy

<sup>4</sup> CSO Swaziland, 2007, Swaziland Demographic and Health Survey

<sup>5</sup> Swaziland Population and Housing Census, 1987, 1997, 2007

<sup>6</sup> 2009 WHO Country Health Profile

<sup>7</sup> World Bank Country Estimates

<sup>8</sup> World Bank Country Estimates

<sup>9</sup> World Bank Country Estimates

<sup>10</sup> Integrated Labour Force Survey, 2007/2008

<sup>11</sup> Taken from 2010 MDG Progress Report

<sup>12</sup> 2009 WHO Country Health Profile

<sup>13</sup> National Strategic Framework on HIV/AIDS Mid-term Review

<sup>14</sup> WHO Country Cooperation Strategy

needed to combat the epidemic. The 2007 Demographic and Health Survey (DHS) showed chronic malnutrition to be a key problem with 29 percent of children under 5 stunted.<sup>15</sup>

<sup>16</sup>Economically, Swaziland is closely tied to South Africa, from which it receives 90 percent of its imports and a large proportion of its public sector financing through the Southern African Customs Union (SACU). Compounding the health and social strains of the Kingdom was a precipitous fall in revenue resulting from a two-thirds cut of SACU customs receipts in 2009. Despite a low debt-to-GDP ratio and a history of servicing external debts, Swaziland has only been able to raise a fraction of the revenue needed fund its national budget, which prioritizes the health and education sectors. Declining GDP growth and attraction of foreign direct investment are compounding the fiscal situation. Since Swaziland is classified as a lower middle income country, there are few development donors operating in the country. Poverty has declined slightly in recent years. However, the country's highly skewed income distribution mean that more than 60 percent of Swazis live below the poverty line; 30 percent are classified as living in extreme poverty<sup>17</sup>.

Despite the circumstances, significant progress has been made over the last few years in strengthening the Swazi health sector. With support from PEPFAR, the Antiretroviral Therapy (ART) program now reaches approximately 70 percent of the eligible population (at CD4 count threshold of 350). Eight-five percent of pregnant women attending ANC sites are reached with prevention of mother-to-child transmission (PMTCT) services. Male circumcision (MC) prevalence has increased to over 20 percent since USG began supporting the program in 2008. Increases in coverage of ART, PMTCT, TB and testing and counseling programs demonstrate the commitment by the public sector to remain resolute despite the daunting strain on the health system. 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. Under GHI, Americans are committing to support Swaziland's public and non-public sectors to bring treatment services to the community level, strengthen HIV prevention programs, scale up male circumcision, mitigate the impact of HIV on children, and build the capacity of Swazi institutions for future generations.



<sup>15</sup> Complementary Country Analysis, United Nations, April 2010

<sup>16</sup> CSO Swaziland, 2007, Swaziland Demographic and Health Survey

<sup>17</sup> Central Statistics Office, 2009/2010 Swaziland Household Income and Expenditure Survey: Poverty in a Decade of Slow Economic Growth

### 3. GOKS GHI-RELATED TARGET GOALS

The investment made by GOKS on health inputs has not resulted in improvement of some of the main health indicators. The situation has been worsened by the advent of HIV/AIDS and rising incidence of poverty. The HIV/AIDS epidemic has accelerated the parallel TB epidemic in the country, with TB now a major public health problem. It is estimated that HIV co-infection occurs in about 80 percent of all TB cases. HIV-related illnesses have become the major cause of morbidity and mortality among children under the age of five years; according to the MOH, HIV-related illnesses account for 47 percent of deaths among under-fives. Pneumonia and diarrheal diseases account for 12 percent and 10 percent respectively (DHS 2007). Limited access to clean water and sanitation, likely along with HIV infection, are probable risk factors for mortality due to pneumonia and diarrheal diseases.

Malaria continues to be a public health problem; an estimated 30 percent of the population is at risk of malaria infection. The country achieved high routine immunization coverage until the late 1990s, however a fluctuation has been observed in DPT/HEP3 since 2000. Evidence suggests that low immunization coverage in some parts, combined with pediatric AIDS, has reversed the gains that the country had achieved in child survival in previous years.

The aforementioned challenges are well recognized by the GOKS and in its National Health Sector Strategic Plan of 2009-2013. The GOKS has formulated different strategies to ensure the achievement of NHSSP goals (table 2) in GHI-related areas

Indicator	Baseline 2009	Target 2013
<b>HIV/AIDS:</b> Reduce the rate of new HIV incidence per year	3%	2.3%
<b>Malaria:</b> Reduce the number of laboratory confirmed cases per year during the malaria transmission season	300/1000 cases	30/1000 cases
<b>Tuberculosis:</b> Reduce prevalence	1,155/100,000 population <sup>18</sup>	724/100,000 population
<b>Maternal Health:</b> Reduce Maternal Mortality Ratio (MMR)	589/100,000 live births	295/100,000 live births
<b>Child Health:</b> Reduce Under 5 Mortality Rate	120 deaths per 1,000 live births	78 deaths per 1,000 live births
<b>Child Health:</b> Reduce Infant Mortality Rate	85 deaths per 1,000 live births	65 deaths per 1,000 live births
<b>Nutrition:</b> Reduce stunting prevalence rate among children under 5	29 <sup>19</sup> %	15%
<b>Family Planning:</b> Reduce Total Fertility Rate	3.8	3.0
<b>Neglected Tropical Diseases:</b> Reduce Bilharzias prevalence	55%	40%

### 4. APPLICATION OF THE GHI PRINCIPLES IN SWAZILAND

Swaziland's USG interagency team has been focused on GHI since the initiative was first announced by President Obama. This focus is reflected by the incorporation of GHI principles into the GOKS-PEPFAR Partnership Framework signed in June 2009. Because the only funding stream for U.S. global health

<sup>18</sup> CSO Swaziland, 2007, Swaziland Demographic and Health Survey

<sup>19</sup> CSO Swaziland, 2007, Swaziland Demographic and Health Survey

investments in Swaziland is the PEPFAR program, the team has worked thoughtfully and diligently to ensure that PEPFAR programming is continually enhanced to reflect the core principals of GHI.

Swaziland's GHI strategy demonstrates GHI principles by: Strengthening USG-GOKS partnership and GOKS ownership; Intensifying efforts to address cross-cutting areas of Gender and Health Systems Strengthening; Increasing efforts to integrate PMTCT and MNCH; Promoting research and innovation; Building more sustainable systems; and Strengthening donor coordination.

Due to its design as a limited-time national service delivery campaign, an important USG-financed program that will not receive focus in Swaziland's GHI country strategy is the Soka Uncobe male circumcision campaign (although MC continues to be an important PF Pillar). Soka Uncobe – “to circumcise and conquer” in siSwati – is a comprehensive package of HIV prevention, centered on MC as the entry point to services. Many thousands of Swazi are being reached with HIV prevention education, individual counseling on HIV risk reduction, HIV testing, condoms and condom education, and medical male circumcision. Those men diagnosed with HIV are being linked to a continuum of HIV care and treatment programs. The population-level impact of this program could be significant, with the potential to drop HIV incidence, and avert future treatment costs running into the hundreds of millions of dollars. The USG interagency team believes that Soka Uncobe will have a measurable impact on Swaziland's HIV epidemic, will relieve strains on the health care system and will provide a platform for invaluable operations research for bringing future MC programs to scale.

Alongside Soka Uncobe, USG has completed the initial phase of a first-of-its-kind evaluation of trends in HIV incidence, known as the Swaziland HIV Incidence Measurement Survey (SHIMS). In addition to its principle objective of evaluating the impact of male circumcision and broader HIV combination prevention efforts under “real world” conditions, the SHIMS project is building the foundation of national learning institutions around public health evaluation (see Sections 4.7 and 5.2).

Importantly, over the past two years the USG team has utilized several new central initiatives to further bolster the approach of aligning its program with GHI principles: 1) Gender Challenge Fund (described in detail in Section 4.1); 2) PMTCT Acceleration Plan (described in detail in Section 5.1); and 3) Global Fund-PEPFAR Collaboration Initiative (described in detail in Section 4.3). Overall, the USG team has redoubled its efforts to support the Swazi government's leadership on decentralizing HIV/TB care and treatment, scaling up MC programs and improving the essential drug supply chain. USG is positioning its partners to increasingly focus on building institutions through a technical assistance model, while moving away from direct service delivery.

Given the success of the PEPFAR program in Swaziland, PF alignment to national plans and high-level GOKS leadership's embracing of the PF approach, the USG interagency team is keen to build off of the platform rather than supplant it with an entirely new GHI approach. While this document focuses on new and expanded programmatic areas under GHI, the USG interagency proposes to incorporate the PF pillars into one unified programming structure as detailed in the results framework (see Section 8).



U.S. Embassy Mbabane endeavors to be a 'learning organization' and embraced participation in GHI strategic planning as a means of improving its contribution to overcoming the unprecedented health, economic and social crisis which has devastated Swaziland's health system and hampered her economy. Under the leadership of the Mission, global health investments will honor America's side of the bargain vis-à-vis the Swaziland Partnership Framework and will contribute to United States global development and diplomatic goals.

Although this document focuses on the four expanded GHI strategy areas (Integration of PMTCT and MNCH; Research for Innovation; Gender; Health Systems and Infrastructure), the achievement of the five original Partnership Framework Pillar Areas are an integral part of GHI. As part of ongoing PF implementation, and now under the GHI umbrella, the USG remains committed to (*for more information please see the PF/PFIP*):

1. Improving the quality of care and treatment services, including through stronger HIV/TB integration

In line with the NSF, the overall goal for this pillar is to reverse the decline in life expectancy at birth and to improve the quality of life of PLWHA. USG's focus is to achieve this through decentralization and improved quality of HIV-related prevention, care and treatment services within a comprehensive care package. Decentralized services will facilitate earlier diagnosis and treatment, thereby extending quality of life, and will serve to reduce HIV transmission to partners. The strategy for scale-up support for HIV and TB care and treatment services 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.

2. Strengthening sexual prevention efforts, including improved social and behavior change communication (SBCC) interventions

<sup>20</sup> 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.

A key component of initial PEPFAR work via the PF has been to assist the Swaziland National AIDS Program and NERCHA to reconstitute the National HIV Prevention TWG and to provide organizational development assistance to enable the TWG to provide leadership, oversight and coordination for prevention activities country-wide. USG's focus further includes support for: 1) the establishment of a system for standardizing, integrating and coordinating messages and communications around key topics including multiple concurrent partners (MCP); 2) 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; 3) the identification of National Prevention Champions to reach out to communities through traditional leaders and other influential groups; 4) public and private sector condom distribution and promotion; 5) strengthening the focus on key target groups including youth and couples; and 6) the inclusion of key gender issues, including gender-based violence (GBV).

### 3. Expanding access to male circumcision for adult males

The GOKS, in partnership with USG and other stakeholders, has made a commitment to reach 110,000 or 80 percent of all males in Swaziland, aged 15-24, with medical MC 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 reduce potentially harmful misconceptions about the service. USG is working hand-in-hand with the GOKS to scale up MC services through a multi-pronged strategy that addresses policy and planning, human resources (HR), institutional capacity, leadership development, service delivery, and communications and social mobilization. The National MC Task Force provides leadership and oversight of all elements of implementation.

### 4. Increasing impact mitigation efforts, including strengthening the Department of Social Welfare (DSW) and expanding social welfare and family-focused services for children

USG's focus is to expand and improve support for vulnerable children in core services areas, including health, education, protection, psychosocial support, food security and economic strengthening. A major goal is to enhance coordination and standardization of community based services. The portfolio aims to: 1) reach large numbers of children with a package of basic services; 2) support and build on existing national momentum, structures, plans and initiatives; 3) leverage additional funding and resources and improve quality and sustain services; 4) promote family-centered approaches and stronger linkages between prevention, care, treatment and support; 5) devote the bulk of funding to services and support for children through national or scalable initiatives and through NGOs that can model key aspects of impact mitigation; and 6) complement service activities with efforts to strengthen systems and improve the policy environment.

### 5. Bolstering human resources capacity in key areas such as HR management, policy reform, recruitment, retention and training as well as building institutional capacity

USG's overall goal for this pillar is to create a strengthened public sector, NGO workforce and institutional base sufficient for rapid national scale up of the HIV response and with benefit across the health and social welfare sectors. Human and institutional capacity building cut across all program areas of the PFIP. To ensure national level capacity for HR management, USG is supporting the GOKS 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 DSW, and establish the Health and Social Welfare Commission. USG is providing technical assistance and financial support to assist the GOKS 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. Direct support to the MOH facilitates the linkage of HR planning with infrastructure planning and decentralization of service delivery.

#### 4.1. FOCUS ON WOMEN, GIRLS AND GENDER EQUALITY

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USG completed a preliminary gender analysis in 2010 as part of the process of planning for the Gender Challenge Fund Issues. Gender inequity, socio-cultural norms and behaviors, and GBV all play a role in women being disproportionately affected by HIV. The 2007 DHS reported HIV prevalence among adults aged 15-49 to be 31 percent for females and 20 percent for males. Women are infected at a younger age, with HIV prevalence peaking at a nearly inconceivable 49 percent among the 25-29 year age group. The majority (62 percent) of new infections occur in females, with HIV contributing to an escalating maternal mortality rate which is now at 590 deaths per 100,000. High HIV prevalence and the differing rates between men and women can be explained to a large extent by intergenerational sex, earlier sexual debut among girls, as well as the prevailing practice of MCP. These practices are influenced by gender norms and ideals for both men and women including a tradition of polygamy and values which endorse men's power and dominance over women. GBV is a severe social and public health problem in Swaziland; a UNICEF-CDC study in 2007 documented that one third of girls aged 13-24 experienced sexual violence before the age of 18.

Women are economically and financially dependent on male partners or family members, which dramatically increases their vulnerability to HIV infection, GBV and other forms of exploitation. Women also face legal disadvantages when it comes to property ownership and rights, as well as access to financial services. Women shoulder most of the burden of caring for ill family members, yet it is common for widows and their children to be dispossessed of their property when a male head of household dies. Economic disparities and women's economic reliance on men also serve to reinforce gender stereotypes and limit women's ability to make decisions, including those related to safer sex, health care-seeking and the care and support of their children.

According to the 2007 DHS, only 22 percent of children live with both parents and one third do not live with either parent. While extended families have absorbed the vast majority of children without parents, traditional safety nets are being stretched to a breaking point as the number of children in need rises. The breakdown in family structures and lack of adult support and supervision is having a direct impact on the safety of children, particularly girls.

The 2005 National Constitution recognizes women's equal status in the economic, political and cultural spheres of life and stipulates that the state shall take all necessary steps to ensure the full integration of women into the mainstream of economic development. Furthermore, the GOKS has endorsed the importance of gender equality as a means to reducing poverty, enhancing justice and promoting sustainable development in a number of other policies, protocols and conventions.<sup>21</sup> Despite this supportive overarching framework, real progress has been slow. Several key pieces of legislation, such as the Deeds Registry Act, Marriage Act and Administrations of Estates Act, have been developed to help women to realize their economic rights as stated in the Constitution but are yet to be implemented. The

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<sup>21</sup>Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), SADC Protocol on Women and Development, Eight core ILO labor conventions, Poverty Reduction Strategy and Action Program (PRSAP), National Gender Policy, Draft Citizens Economic Empowerment Bill, Small, Medium and Micro Enterprises (SMME) Policy

Domestic Violence and Sexual Offences Bill have been in the approval process for more than 10 years. The Child Maintenance Bill is a relatively new bill but it has the potential to greatly improve the situation of single mothers and their children. At the writing of this document, the Domestic Violence and Sexual Offences and Children's Bills had been tabled and passed by the Swazi House of Parliament, and were pending passage by the Senate and approval by the King.

There is a dual legal system in Swaziland, made up of the common law and the traditional Swazi Law and Custom. Because of the lack of clarity in the legal systems around issues related to women's and children's rights and a wariness of initiatives that might compromise Swazi culture and traditions, efforts to tackle gender issues straight on have yielded limited results. It is evident that the implementation of this robust collection of policies will require coordinated and sustained efforts by government and development partners, as well as civil society advocacy to ensure advances in women's equality.

Issues of women and children in the national HIV/AIDS response, as well as in the broader areas of poverty reduction and development, have gained prominence over the past few years. The NSF identifies several drivers of the epidemic that are related to gender and economic inequality including intergenerational sex, commercial sex, mobility and migration, sexual violence and cultural norms and values that endorse men's control over women. Accordingly, gender-related issues cut across all thematic areas of the NSF and strategies to address them feature in the prevention, care and treatment and impact mitigation areas. The policy environment for children's issues also is rapidly evolving with, among other developments, the approval by cabinet of a National Children's Policy, Social Development Policy and Human Trafficking Act as well as the development of several draft documents including National Alternative Care Guidelines, Residential Care Guidelines, Referral Protocol for Sexual Abuse, Quality Service Standards for OVC Programs, Psychosocial Support Strategic Plan and Neighborhood Care Point (NCP) Strategy. While the policy environment is improving, many gaps still exist; for example as noted above, key pieces of legislation such as the Children's Welfare and the Domestic Violence and Sexual Offences Bills have yet to be passed, and the full rights of children remain unprotected.

USG recognizes the critical importance of addressing issues of gender inequality in order to maximize the impact of interventions across the five pillar areas of the PF; for this reason gender was included as a cross-cutting element in the PFIP. Current USG activities focused on women, girls and gender equality include:

- Strengthening of social welfare systems which include systems to address child abuse and GBV.
- Supporting the national Lihlombe Lekukhalela (Shoulders to Cry On) community-based child protection program to raise awareness, increase reporting of child abuse cases and making available basic psychosocial support to victims (most often girls) at the community level.
- Roll out of the National SBCC Strategy, in which the focus includes key gender-based messages such as intergenerational sex, MCPs and GBV.
- Adult and youth-focused activities such as community dialogues, mentoring and psychosocial support clubs which address norms and behaviors that make women and girls vulnerable to HIV infection, including GBV prevention (implemented in part with Gender Challenge Funds).
- Expansion of PMTCT activities as part of the PMTCT Acceleration/Virtual Elimination Plan.
- Actively involving women in the scale up of male circumcision and ensuring that the population is educated with regards to women's benefits and potential risks.
- Prioritizing attention to male involvement through community outreach, home-based and couples HIV counseling testing and PMTCT to facilitate access to care and treatment and help reduce the potential for violence. Employing a family-centered approach to care and treatment efforts; supporting women's and men's support groups.

- Technical assistance for the implementation of post-exposure prophylaxis (PEP) services for survivors of GBV.
- Women-focused savings and lending groups which integrate discourse around gender and GBV (implemented in part with Gender Challenge Funds).
- Ongoing advocacy for passage of bills (e.g. Domestic Violence & Sexual Offences, Child Welfare).
- Strengthening service data and monitoring to ensure that indicators are disaggregated by sex and gender inequities are tracked with appropriate strategies implemented in response.

Moving forward, USG envisions a continued and enhanced focus on gender mainstreaming as the mechanism for ensuring the priority needs of women and girls are addressed (see Section 5.3). A PEPFAR gender strategy will be developed with assistance from the OGAC Gender TWG, which will detail future priority actions and how the different program areas will systematically integrate gender issues. Tools such as the draft document Linking PEPFAR's Fight against HIV to Ending Gender Based Violence, and the GHI Supplemental Guidance on Women and Girls and Gender Equality will be used to guide discussions and prioritization. As part of this process, basic procedures, tools and checklists will be developed for activity managers to promote understanding of and compliance with the gender strategy. Furthermore, assisting key partners to mainstream gender within their programs is expected to be of fundamental importance. Technical assistance from the Gender TWG has already been sought for this activity, which is planned for November 2011.

The principle of women, girls and gender equality will also be demonstrated in the New Pillar Area: PMTCT and MNCH integration. Through implementation of the PMTCT Acceleration Plan, life saving interventions targeting mothers and infants will be scaled up in order to reduce HIV transmission to women and infants and reduce maternal and infant mortality (see Section 5.1).

#### 4.2. ENCOURAGE COUNTRY OWNERSHIP AND INVEST IN COUNTRY-LED PLANS

In applying the principle of encouraging 'country ownership' to the Swazi context, it is critical to do so with the understanding that the large majority of health sector financing comes from Swazi government funding streams. The GOKS national budget for health is approaching the 15 percent Abuja Declaration goal, and the health budget has been maintained despite increasing external resources and decreasing national resources. As a lower-middle income country, Swaziland finances over 40 percent of the HIV response, twice the threshold recommended by the Global Fund (USG/PEPFAR and Global Fund account for approximately 50 percent of HIV financing). Investments and technical support from bilateral and multilateral stakeholders – including USG, the World Bank, the European Commission (EU/EC), the UN family, the Republic of China on Taiwan, the Global Fund, Médecins Sans Frontières (MSF), the Clinton Health Access Initiative (CHAI) and several international NGOs – are on balance supporting national systems rather than setting up parallel vertical programs. While international partner programming is largely focused on direct support to the HIV/AIDS and TB response, there are projects supporting malaria, children's feeding programs, social welfare, health infrastructure, microenterprise and livelihoods, social transfers, family planning and agricultural development.

In a scenario of sustained national and regional macroeconomic growth, Swaziland might be considered a candidate country for a transitional USG health investment strategy toward a more limited, technical collaboration-only model. However, as detailed in Section 2, the country's current fiscal position raises serious questions of whether Swaziland's national social investments are at risk in the near term. Elderly pensions, OVC school grants and school feeding programs were all in danger of being reduced at the writing of this document. While the U.S. Mission remains focused on capacity building and the principle

of country ownership, it also recognizes the need to work with national stakeholders to plan contingencies for humanitarian interventions should the national context deteriorate.

A strong example of maintaining the balance between facilitating country ownership and responding to humanitarian issues is the USG’s support through the PEPFAR Emergency Commodity Fund (ECF) to replenish Swaziland’s ‘buffer’ stock of ARVs. USG shared the costs of the Swazi government’s ECF request by reprioritizing budgetary ‘pipeline’. The primary goal of the ECF donation was to help the MOH safeguard the approximately 70,000 Swazis currently on ARVs and to avoid interruption in the uptake of HIV testing and counseling and linkage into care and treatment programs. Just as important was the secondary goal of assisting the Swazi government in meeting its commitment to fully manage and finance the national ARV supply chain. This is no easy task, due in large part, paradoxically, to the tremendous success of the national ART program. As the Swazi government faces increasingly difficult budget decisions, Embassy Mbabane judged that it was a smart investment to endorse and cost share the Government’s ECF request, and is optimistic that it will assist the Swazi Cabinet in maintaining funding for lifesaving health programs.

The USG health development model in Swaziland was shaped by its late scale up under the PEPFAR program. Not designated as one of the original ‘focus’ countries under PEPFAR I and implemented principally through a regional platform, USG health investments did not increase significantly until fiscal year 2009. As such, programmatic activities were developed around a limited ‘technical assistance’ and systems building model. As the program has been brought to scale, it has retained a highly collaborative model of working almost exclusively through and in support of national systems.

While the only funding stream for U.S. global health investments in Swaziland is the PEPFAR program, the team has worked thoughtfully and diligently to ensure that PEPFAR programming is continually enhanced to reflect the core principals of GHI. Even though the PF was developed to fit squarely within the NSF, the GHI principle of building health systems for country ownership was elevated to a pillar of the PF strategy and will retain its centrality under GHI. Also, given the impact of HIV on nearly every aspect of the health system, the scope of USG HIV programs is logically pulled toward a broader, more integrated approach to programming that favors technical collaboration over direct service delivery. Accordingly, the breadth of USG investments in core health systems is evidenced by the number of key objectives under the three ‘Strategic Thrusts’ of the NHSSP for which USG programs are playing an important role. Table 3 below illustrates that a majority of NHSSP key objectives are supported by USG programs, in collaboration with MOH and development partners.

TABLE 3: INTERNATIONAL PARTNER SUPPORT FOR NHSSP KEY OBJECTIVES				
1. <b>Strengthening health system capacity and performance:</b> To ensure that the MOH effectively executes its core health sector policy, regulatory, administrative, technical and health service delivery functions, efforts will be directed at:				
			 	a. Restructuring and rationalizing the functions and task structure of the MOH
			 	b. Strengthening governance and management capacity of the MOH
			 	c. Strengthening regulatory, policy and planning capacity of the MOH
				d. Improving research and quality management capacity and M&E systems of the MOH

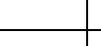
TABLE 3: INTERNATIONAL PARTNER SUPPORT FOR NHSSP KEY OBJECTIVES					
					e. Strengthening the decentralization processes of the health system
					f. Construction of MOH National and Regional Offices
<b>2. Improving access to essential, affordable and quality public health services towards universal coverage.</b> The following strategies will be implemented:					
					a. Delivery of quality maternal, neonatal, nutrition and child health services
					b. Prevention and control of communicable and non-communicable diseases
					c. Delivery of quality Environmental Health Services
					d. Promotion of healthy lifestyle
					e. Involvement of communities in health service delivery
					f. Development of capacity to manage Emergency Preparedness and Response
<b>3. Improving access to essential, affordable and quality clinical services towards universal access.</b> The MOH will work with all partners in implementing the following:					
					a. Delivery of essential curative, diagnostic and rehabilitative health services
					b. Training, continuing education and capacity building
					c. Establishment of functionally efficient and effective referral system
					d. Development of collaborative mechanisms with traditional practitioners
					e. Building of skills and capacity to manage health facilities
					f. Establishment of quality assurance standards and benchmarks
					g. Strengthening of the essential health commodities management system
					h. Support to NGOs, local authorities, private sector and mission health care providers
					i. Identification of viable telemedicine services appropriate to Swaziland
					j. Establishment of the Swaziland Medicines Control Authority to be the strategic procurement and regulatory unit for the health sector

TABLE 3: INTERNATIONAL PARTNER SUPPORT FOR NHSSP KEY OBJECTIVES					
					k. Rehabilitation and upgrading of health facilities;
					l. Rehabilitation and upgrading of Mbabane Government Hospital
					m. Construction of a national referral hospital
					n. Standardization of medical equipment and furniture for the different types of health facilities
					o. Standardization of staffing norms and patterns

#### 4.3. STRENGTHEN AND LEVERAGE KEY MULTILATERAL AND BILATERAL INVESTMENTS

As health sector financing is increasingly constrained by Swaziland’s fiscal crisis, alignment, coordination and harmonization of development partner programs has gained heightened importance. While Table 3 above is not indicative of the magnitude of external financial support, it does illustrate the relative success national stakeholders have achieved in aligning programs to national planning. Overall, GOKS, with support from USG and international partners, is moving towards a more systematic, better coordinated approach to health systems and its HIV response. USG provides direct support to the MOH Planning Unit to enhance institutional capacity in areas in which USG has a comparative advantage of technical expertise, including: strengthening laboratory systems, strategic information, blood safety, pre-service training for key cadres of health care workers, strategic planning and policy development. With USG assistance, the MOH established a Strategic Information Department (SID), and is making strides in using data to improve the quality and delivery of services. USG continues to support the MOH human resource information system and the development of workforce data for recruiting, retaining and training skilled health care professionals. Technical support for health sector coordination and planning activities, such as the Health Sector-Wide Approach (SWAp), is included in the CDC-MOH Cooperative Agreement. USG is also contributing technical officers and financial support to the NHSSP mid-term review.

A growing focus of the USG team is support to Global Fund governance and oversight structures, risk management, proposal development (including alignment with PEPFAR programming) and grant implementation. USG helped establish the Country Coordinating Mechanism (CCM) governance structure and funded the creation of one of the first CCM Secretariats in the world. USG is a voting member of the CCM, and USG team members help staff the CCM Executive Committee, Oversight Committee and Proposal Development Team. USG technical officers and implementing partners play key roles in Global Fund grant development and improving grant performance. Recently, Swaziland was awarded funding under the PEPFAR-Global Fund Collaboration Initiative to enhance ongoing technical assistance activities with the CCM, NERCHA (a principal recipient) and to augment capacity-building efforts with civil society to be effective USG and Global Fund implementers. Under this approach, local NGOs are being jointly capacitated to meet international standards for program management and implementation, an effort that should strengthen Swaziland’s civil society as a whole. Importantly, USG and its implementing partners are leading contributors to addressing conditions precedent and findings raised by a recent Global Fund Office of Inspector General (OIG) report.

To improve donor coordination, the USG team founded the Health Development Partners’ Working group to ensure that development partners are appropriately leveraging their position within bilateral and multilateral forums. USG has partnered with UNICEF to fund the HIV component of its national Prevention, Wash, Health and Immunization program, and is collaborating closely with UNFPA on the national PMTCT program. USG has worked closely with WHO, MSF and CHAI to champion task

shifting/sharing activities, which led to nurse-initiated ART (NARTIS). To operationalize USG program coordination with national stakeholders and ensure accountability against mutual commitments, the USG/PEPFAR interagency management team holds monthly GHI/PF management meetings with the directorates of MOH, NERCHA and WHO. In early 2012, USG is hosting a national stakeholders meeting, chaired by MOH and NERCHA, to reprioritize the national HIV response in light of changes to Global Fund financing and technical approach.

#### 4.4. IMPROVING USG HEALTH PROGRAM IMPACT THROUGH STRATEGIC COORDINATION AND INTEGRATION

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The USG health program, funded through PEPFAR, is the flagship foreign assistance program of the Mission. The Ambassador, Deputy Chief of Mission, Public Affairs Officer and Political/Economic Officer are integral members of the expanded interagency team. PEPFAR funding is the sole foreign assistance being implemented by USAID, HHS/CDC, HHS/HRSA and DOL in Swaziland, and the major program for DoD and Peace Corps. USG health activities are closely linked to the Mission strategic goals of building institutional capacity in the health sector and encouraging sustainable economic development.

The key to the success of USG health development programming in Swaziland has been the robust “one USG” approach, which leverages the comparative strengths of the various USG agencies. For instance, implementation of PEPFAR activities involves true cross-agency management and puts the diplomatic mission of the United States and the health outcomes of the Swazi people at the fore of program strategy. For instance, CDC, USAID and DoD officers are expected to provide strategic input into and, in several cases, act as the activity managers for projects funded through each other’s agencies. The USG interagency health team is co-located in one office, with technical staff co-mingled by function rather than by agency affiliation. Under GHI and the PEPFAR PF, that spirit of collaboration is the basis for engaging all national stakeholders.

A strong example of cross-agency management and collaboration are the monthly Regional and Facility Support Coordination (RFSC) Team meetings convened for all USG implementing partners to work through issues related to the decentralization and transference of facility-based programming to the government. The meetings enable the USG team and its partners to speak with one voice when engaging the health sector at all levels and in far reaches of the country. This initiative is operationalizing a decentralized, high-quality essential package of health care services that is implemented in all health facilities and whose clinical mentoring, strategic planning and support services will be fully absorbed by the MOH.

#### 4.5. BUILD SUSTAINABILITY THROUGH HEALTH SYSTEMS STRENGTHENING

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USG/Swaziland has embraced the GHI principle of “Building Sustainability through Health Systems Strengthening” as critical in its approach to addressing HIV/AIDS prevention, care, and treatment. USG works closely with its partners and the GOKS to ensure that all components of a comprehensive health system - information, procurement, governance, and human resources - are strengthened and coordinated to more effectively deliver a sustainable national response to HIV and AIDS and other basic health services.

##### 1. Information Systems Strengthening

The current health system has been doubly handicapped by an increasing demand for services associated with HIV/AIDS and ongoing problems in the recruitment and retention of qualified health care workers.

There is a severe shortage of personnel in the country who are trained in the management and use of strategic information (SI), critical for monitoring of and responding to epidemic. Although the MOH currently houses the SID, a lack of clarity in its role and management structure have impeded the hiring of a sufficient number of qualified senior staff members and the effectiveness of its overall planning and budgeting processes. The Swazi government's fiscal crisis has constrained resources for improving the infrastructure and human resources related to SI systems, which as limited improvements in IT infrastructure and country-ownership of critical research and evaluation.

In order to address these challenges, USG is supporting the MOH and its partners in a number of key SI target areas. Central among these targets is the development of a decentralized health management information systems (HMIS) and patient MIS (ART, chronic care) system to improve patient follow up and overall site and program management. USG is ensuring that the various elements of HMIS, driven by development partners and regional sites, are integrated within the MOH's overall SI framework. USG also plans to support the coordination and integration of HMIS within the MOH through the provision of short- and longer-term technical assistance in collaboration with international partners such as WHO, UNICEF, CHAI, and regionally-platformed academic institutions. Such assistance will focus on improving the quality of data collected from routine HMIS, advancing the skills of SI staff in epidemiology, M&E, and research through advanced training, and strengthening the overall research capacity of the MOH through partnership with key international organizations.

In support of these aims, USG has identified a number of specific SI strengthening interventions to address the current gaps. For example, support for program evaluations will target areas of linkage to care, ART program outcomes, costing and PMTCT to build capacity and enhance the culture of data use for program improvement. Activities will target the expansion and enhancement of MOH HMIS and QA/QI systems. USG will also support the establishment and institutionalization of a Data Use and Research Development Committee (DURDC), which will focus on training and mentoring of selected individuals and institutions. This Committee will assume a leadership role for overseeing a national research agenda, and support selected research efforts. USG will also assist in the recruitment of a senior SI liaison with the MOH Health Services Directorate to guide and support the SID during transition to self sufficiency.

## 2. Supply Chain Systems Strengthening

USG acknowledges the complexity of components and coordination involved in effectively functioning supply chain systems. A gap in any one of these components - human resources, information systems, governance, financial - may lead to a breakdown of the overall supply chain system. In Swaziland, challenges in many of these areas impede the effectiveness of local procurement. For example, there is currently a shortage of pharmacy professionals and the GOKS has been unable to task shift to lower level cadres. Local information systems are often inadequate to assist in forecasting needs, and governance structures offer inadequate regulation of pharmaceuticals and pharmacies. The MOH's procurement unit has experienced delays in developing and overseeing sufficient standard operating procedures. Most challenging at this time, however, is the fiscal crisis affecting the GOKS' ability to pay for essential medicines and commodities. In order to address these challenges, USG is supporting multiple strategies with the overall goal of avoiding future stock outs of key medications and commodities at public facilities. Of primary importance is the integration of forecasting into one MOH system with support from all development partners. USG supported the recent establishment of a national Supply Chain Technical Working Group, and is supporting the placement of a senior advisor at the MOH to act as a Regulatory Affairs Pharmacist in improving regulatory and governance structures.

### 3. Strengthening the National Health Sector Strategic Plan and Governance

Ongoing gaps in governance have hindered effective implementation of Swaziland's NHSSP. The lack of clearly delegated decision-making authorities within the MOH has hampered strategic and operational planning, resource allocation efficiencies, uptake of international normative health policy guidelines, and consistent application of a human rights agenda in health sector coordination. In order to address governance challenges, USG's support to the GOKS and its partners focuses on strengthening institutional capacities for good governance, supporting prudent fiscal management and enforcement of related laws. Specific focus is placed on promoting participatory decision making processes, decentralization of executive powers, and capacity development of modern and traditional Swazi institutions to better respond to the needs of the poor. For example, USG is supporting the establishment of the Human Rights and Public Administration Commission in Swaziland and encouraging the GOKS' participation in numerous global and regional conventions and treaties on human rights. These targeted interventions, in synergy with other development partners' support, will help achieve the National Development Plan goal of improving governance and service delivery.

### 4. Human Resource Strengthening

USG is pursuing several key policy opportunities to expand the implementation of HR strengthening. A more efficient and effective workforce is expected from joint USG and GOKS policies addressing retention, task-shifting, posting, and supportive supervision. The PEPFAR PF complements the NHSSP and focuses on strengthening the health system's capacity and performance in developing skills in the health, social work, and community workforce to address skills shortages, improve recruitment, retention, and training of the health and social welfare workforce (formal and informal). The GOKS has prioritized the restructuring of the MOH and DSW, processes which will allow the USG further opportunity to improve the governance and management capacities of these bodies in support of better health services.

With the goal of increasing impact through strategic coordination and integration, USG is supporting a number of new national programs. The East Central and Southern Africa (ECSA) Human Resources Alliance for Africa (HRAA) project will establish an HRH advisory group, composed of key stakeholders, including line ministries and development partners, to guide development of an HR policy and implementation (see Section 5.4). This will encourage country ownership of the program and ensure that USG investments are aligned to country-led plans. Further, USG will assist in the restructuring of the DSW and implementation of the Nursing Council's professional development program.

#### 4.6. PROMOTE LEARNING AND ACCOUNTABILITY THROUGH MONITORING & EVALUATION

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The recently-established MOH SID aims to strengthen the generation and use of high-quality data for needs-based prioritization of resource allocation and to stimulate a learning and accountability culture within the Ministry. Supported by the USG and built upon internationally recognized HIS policies, standards and principles (e.g., Health Metrics Network), it is recognized that sustained investments in both SI infrastructure and SI human resources are crucial to a more integrated, efficient health service delivery system. It is further understood that maturation of the strategic information context is an essential element which will directly influence Swaziland's near-term efforts to combat the HIV/AIDS epidemic and in the longer term ensure that HIV/AIDS investments are positioned to provide sector-wide benefits. Given the significant challenges in Swaziland, it will continue to be imperative that the GOKS-USG partnership, embodied in the PF, maintains its focus on developing a single national MIS and avoiding duplicate, parallel M&E systems. Despite the short-term challenges inherent in "one M&E" system and the

occasional resistance observed from partners, USG is committed to keeping its limited SI resources invested in this aim.

Under GHI, USG will continue to partner with the GOKS to strengthen health and social sector wide strategic information systems on three integrated axes. First, the basic architecture and human resource foundation for routine *management information systems* in Swaziland continues to be generally weak and will thus continue to be a major ongoing focus under GHI. Initial USG investments to strengthen the ART-related, electronic medical record systems will be expanded and better integrated to include links with TB data and data generated at the MCH and reproductive health facilities. Second, Swaziland's *surveillance systems* are crucial, especially in regards to tracking and response to trends in the HIV and emergent MDR-TB epidemics. USG will continue to emphasize these surveillance activities and build expertise in public health surveillance and related public health laboratory science in the MOH. Lastly, developing the human and institutional expertise to design and manage program *monitoring and evaluation* systems will continue to be a high priority under GHI. While few "quick wins" are available, there are numerous opportunities to partner closely with the GOKS programs to strengthen the analysis of data and routinize the communication of MIS and surveillance data to program decision-makers.

#### 4.7. ACCELERATE RESULTS THROUGH RESEARCH AND INNOVATION

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The interface of information generated as part of a strategically designed and implemented HIS (described above in Section 4.6) with research is key. The MOH recognizes that questions regarding the quality and coverage of programs, the cost and effectiveness of innovative interventions and empirical assessment of public health impact under "real world" conditions must be encouraged, and allocated technical and financial resources by USG to create and nurture a learning environment which will attract and mold the future public health leadership in Swaziland. USG has thus begun over the past year a more concerted effort to strengthen this environment as evidenced in the new GHI pillar "Research for Innovation" (see Section 5.2).

As noted earlier, USG has completed the initial phase of a groundbreaking evaluation of HIV incidence trends - the Swaziland HIV Incidence Measurement Survey (SHIMS). SHIMS aims to evaluate the impact of male circumcision and broader HIV combination prevention efforts including ART on the rate of new HIV infection. In-line with GHI principles, the SHIMS project is building the foundation of national learning institutions around public health evaluation. The study targets significant capacity building needs of health systems, including laboratory science and research data processing and data utilization. In addition to SHIMS, USG is currently supporting an active research agenda, looking at key questions in the areas of prevention, care, treatment and systems strengthening. Some examples are outlined below.

The current ART outcomes and costing study is a facility based evaluation of clinical outcomes (enrolment, morbidity and mortality, clinical indicators) associated with the national ART program scale up (2004-2010). Importantly, the study also looks at costs for ARV care. Another study is assessing linkages to care, and if the recently developed Standard Operating Procedures (SOPs) for referring HIV-positive persons (from SHIMS and Soka Uncobe testing) to care is having the intended impact. This study includes a pilot project to improve the SOPs dependent on survey outcomes. USG is currently undertaking a study which examines the social and structural factors associated with HIV-related risk behaviors and prevalence among most-at-risk populations (MARPs). The goal of this study is to provide a comprehensive set of data that can be used by municipal and national governments in Swaziland to design evidence-based HIV prevention programs for MARP populations. Other studies include 1) assessing the "proof of concept" around nurse-initiated ART, 2) assessing the utility of expert clients in increasing ART retention and adherence, and 3) evaluation of PMTCT outcomes.

GHI presents the USG team with the opportunity to further strengthen the national research agenda, bolster country research capacity, ensure that research links back to program implementation, support capacity building for the Swaziland Scientific Ethics Committee (SEC). (See also Section 5.2).

## 5. NEW GHI PILLARS AND CROSS-CUTTING AREAS

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After conducting a review of existing programs and future priorities for the GOKS and USG and in consultation with the GOKS, the USG team has identified two GHI priority areas: 1) promoting PMTCT as an entry point to MNCH and 2) building a world-class research base to drive health sector innovation.

### 5.1. NEW PILLAR AREA: PMTCT & MNCH INTEGRATION

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In October 2010 PEPFAR began the 'Elimination of Pediatric AIDS in Swaziland (EPAS)' program in collaboration with the MOH, implemented by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). In June, OGAC announced that this program, known as EPAS+, was chosen to receive additional one-time funds to accelerate PMTCT in Swaziland. These additional resources will assist in introducing innovative strategies for PMTCT, while also strengthening current activities. With the recognition that bringing more women into ANC and PMTCT services has been a limiting factor in realizing this goal, USG will use these funds to target women in rural areas through community programs.

The current focus on PMTCT has also offered USG a critical entry point for strengthening maternal, neonatal and child health (MNCH) services and for supporting family interventions at facility and community levels more broadly. Importantly, this new pillar fits under the GOKS's new strategy to eliminate pediatric AIDS and keep mothers alive. The EPAS+ Plan is based on the four-pronged approach which prioritizes prevention, care and support activities: 1) Prevention of HIV in Women; 2) Prevention of Unintended Pregnancies among HIV-positive Women; 3) Prevention of Mother-to-Child Transmission of HIV; and 4) Care and Support for HIV-positive Women, Infants, and Families. While the goals of the Plan focus on increasing HIV testing and linkages to PMTCT care among pregnant women, each prong also incorporates activities - outlined below - that specifically target the improvement and expansion of MNCH services. Linkages with family planning (FP) are seen as integral to MNCH. Furthermore, the EPAS+ Plan affords USG with an exciting opportunity to expand its focus on the health of infants and young children including through improved nutrition, immunization opportunities, and stronger linkages to other services such as neighborhood care points, including for OVC.

#### Prong 1: Prevention of HIV in Women

The PEPFAR Combination Prevention Program currently supports enhanced awareness and education efforts for HIV prevention, including youth life skills programs for in- and out-of-school youth. It also implements innovative sexual behavior change communication (SBCC) messaging to reduce GBV and risky sexual behavior. The majority of sexual prevention activities are currently funded and managed separately from PMTCT programs and partners. Under the framework of accelerating PMTCT and integrating MNCH, USG will work to strengthen coordination among partners working at facility- and community-levels to increase collective impact.

Mass media campaigns have often been used in Swaziland to target MCP reduction or MC programs, but to date none have focused on maternal health, PMTCT and safe labor and delivery (L&D) options for pregnant women. A mass media campaign will be undertaken to encourage more women not only to attend ANC services, but also to come early and come often during their pregnancies. These messages will promote the positive health benefits of regular ANC visits, and will underscore the importance of safe

facility deliveries. Highlighting the holistic benefits of this care will also address the concerns of health care workers in ANC/L&D settings who often feel marginalized by campaigns which focus only on HIV and do not highlight the positive aspects of safe motherhood services.

### Prong 2: Prevention of Unintended Pregnancies among HIV-positive Women

There is currently poor joint planning between partners implementing FP, MNCH, and PMTCT, resulting in the low quality and/or unavailability of FP services at many ART sites. This has contributed to significant unmet need for FP reported in the country (24 percent) and a high number of HIV-positive women having unintended pregnancies. Currently, PEPFAR does not support FP services in Swaziland; however, FP counseling and other services will be integrated as part of the PMTCT Plan. For example, training of lay counselors on referral and counseling of women on FP will be enhanced and USG will introduce nurse mentorship training at health facilities to improve attitudes of nursing personnel towards patients and offer comprehensive HIV and FP services.

The EPAS+ Plan will also improve linkages and coordination between USG PMTCT activities and MNCH/FP support provided by other donors. Under the leadership of the MOH, the United Nations Population Fund (UNFPA) will support FP services in Swaziland. The World Bank is also launching a new program which will contribute to the reduction of maternal mortality through the provision of transport vouchers to pregnant women traveling to birthing facilities. USG and its partners will work with these donors through the MOH/Sexual and Reproductive Health Unit and the national Technical Working Groups to coordinate all activities.

USG will also strengthen infrastructure and human capacity for the delivery of integrated PMTCT and MNCH/FP services. USG will support the training of lay counselors and nurses on FP referral and counseling. UNFPA will assist in the procurement of FP commodities and condoms. USG will support the provision and dissemination of IEC materials on FP in health facilities and communities as well as FP provision in ART and post-partum clinics to reduce unintended pregnancies in HIV-positive women.

### Prong 3: Prevention of Mother-to-Child Transmission of HIV

The new WHO 2010 PMTCT guidelines have created opportunities for integrating PMTCT into MNCH activities to provide more comprehensive services to mothers and subsequently to mother-child pairs. In line with these guidelines, USG will support *increased utilization of MNCH Services* (ANC initial attendance, repeat ANC visits, deliveries in facilities) through community mobilization and the engagement of traditional structures and the Royal family. The high coverage rate (97 percent) of first ANC visits completed by pregnant women demonstrates strong motivation for attending ANC services. However, this ANC coverage falls to only 47 percent in the fourth visit. In order to mitigate this subsequent fall in coverage, USG will build the capacity of the MOH's existing cadre of Rural Health Motivators (RHMs) who are equipped to identify pregnant women and to link them to ANC service sites throughout the country. Swaziland's network of traditional chiefs and royalty exercises significant authority at the community level – members of this network will be motivated to engage their communities in supporting safe motherhood, involving men in counseling and testing, and understanding the benefits of MC and couples counseling. Members of the Royal household have the capacity (and have expressed willingness when approached) to act as Patrons for such outreach campaigns.

PEPFAR's EPAS+ Plan will also focus on *increasing facility deliveries with a skilled birth attendant*. The Global Fund and World Bank will both contribute resources to the infrastructure and equipment needed at maternity sites. USG will augment these resources with support for renovations and equipment in maternity departments to improve the quality of health facilities. USG will also support the training of

midwives on quality of care and patient-centered delivery to improve health services available to pregnant women.

USG recognizes the importance of *male involvement in creating a supportive environment for the health of their female family members and communities*. USG will support RHM activities, such as family days and community testing, that target male partners and broader communities and help to normalize HIV and reduce stigma. Mass media campaigns, with Royal patronage, will also be supported to promote positive health messaging for pregnant women. Male involvement has been a hallmark of the PEPFAR Swaziland program and good synergies have been made in the past through involving testing and counseling, prevention and PMTCT partners in these efforts. USG will work with partners to strengthen the integration of primary prevention within PMTCT programs by focusing on reaching male partners through couples counseling and family interventions at facility and community levels.

The *PMTCT service plan provides a continuum of opportunities to integrate MNCH services* such as Family Planning, nutrition (messaging on exclusive breast feeding (EBF) and weaning), immunization, STI, TB screening and provision of Co-trimoxazole (CTX). The standard six week immunization visit scheduled for newborns presents an important opportunity for providing additional maternal and infant care. This is also the point where HIV exposed infants may be identified and tested by PCR to confirm their HIV status. Health care workers at facility and community levels may also require printed work aids and IEC material on EBF, hygiene, linkage and adherence to care to distribute to mothers. The work of Rural Health Motivators will be expanded and revitalized to target MNCH/PMTCT and infant nutrition. Neonatal MC is also being scaled up in Swaziland and will form part of all counseling mothers receive at pre and post natal visits. USG will support activities such as training for providers that address these needs and capitalize on each opportunity for improving care and follow-up services received by women and their children.

#### Prong 4: Care and Support for HIV-positive Women, Infants, & Families

Despite efforts made by the GOKS to improve the health of pregnant women, the country is still faced with a high Maternal Mortality Ratio (MMR), which has been estimated as high as 589 maternal deaths/100,000 births. Almost half (46 percent) of these deaths are attributed to underlying HIV infection. In order to increase the number of eligible pregnant women on ART, USG has supported provision of ART to these women at the MNCH facilities. However, not all MNCH are providing these services due to either staff shortage or lack of minimum standards of a facility to offer such. There is also inadequate referral of pregnant women from PMTCT facilities which do not offer ART to ART care and treatment sites. This has resulted in some eligible pregnant women failing to access life-saving ART in time. A significant proportion (26 percent) of pregnant women express preference for delivering at home based on negative reported experiences at birthing facilities among other reasons, thereby placing themselves at a higher risk of complications. There has also been poor messaging about the need for ongoing follow-up of the mother-infant pair after delivery. This has resulted in loss to follow-up of mothers who would have benefitted from early treatment. The loss to follow-up of exposed infected infants/children can also be attributed to weak pediatric and adolescent care services in the country.

In an effort to address these gaps, USG is supporting the *expansion of provision of ART services at MNCH/PMTCT facilities countrywide*. Recently, USG started supporting the training of Swazi Nurses to initiate ART in ANC, Labor and Post Natal Clinic sites. Previously, doctors were the only health cadres allowed to start a client on ART. USG is currently advocating for an improved system of infant follow-up and making sure that all exposed infants get their DNA PCR results. Post natal follow-up of women and their HIV-exposed infants is also currently being strengthened; USG plans to establish a HMIS to follow mother-infant pairs to 18 months of age. Apart from treatment and prophylaxis support offered during

infancy, USG is advocating for the introduction of a comprehensive package of support for HIV-positive children. USG “positive prevention” activities will be expanded to ensure the full package of support for HIV-positive adults and children, including opportunities to link with food and nutrition services. Given that malnutrition is a serious issue for HIV-positive infants, USG will address infant and young child health issues through information and counseling and the facility and community levels on key issues (e.g., EBF, appropriate complementary feeding, importance of growth monitoring, immunizations, etc.).

## 5.2. NEW PILLAR AREA: RESEARCH AND EVALUATION FOR INNOVATION

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Perhaps nowhere else is the need for innovative, cost-effective models of public health programming more urgently felt than in Swaziland. Superimposed onto an already struggling response to twin HIV and TB epidemics are emergent socio-economic trends which threaten to weaken the country’s ability to sustain, let alone further advance, hard-won service delivery gains observed in the past couple of years. Understanding this context, USG is partnering with key Swazi, regional and international research institutions to strengthen the public health and social research foundations serving to guide and evaluate effective national responses. Research and evaluation findings generated and used here will support improved health programming not just in Swaziland but in the region and globally.

Under this new pillar area USG will leverage the research assets of globally recognized public health research institutions to build capacity and create valued “space” within key Swazi institutions for evidence-based priority setting and improved planning and management based on what works best in delivering improved health outcomes. While the current focus of USG research efforts has been on HIV and TB programming, USG will continue to emphasize the building of human and institutional capacity and promote the application of the principles of intervention science to other public health problems. As part of the GHI Country Strategy, USG is currently in discussions with the MOH to establish a center for health intervention science. The proposed mission of the Centre is to provide a capacity-building environment in which applied health evaluation research can be conducted by national institutions, including MOH and NERCHA, with support leveraged from USG partnerships.

As one example, USG has established a strong platform for the evaluation of combination HIV prevention through the SHIMS. This is a first of its kind national population-based, serial cohort study of changes in HIV incidence in relation to the scale-up of key HIV prevention interventions: medical male circumcision, ART treatment, and sexual behavior change programming. Led by the MOH in close technical partnership with USG, this platform will serve the country and the region as a “learning environment” for years to come.

USG will further support the GOKS to prioritize operations research studies that addresses key programmatically-relevant issues around PMTCT, HIV care and treatment, and MC programs regarding costs-efficiencies and best practices to reach national public health goals. The current ART outcomes and costing study is a facility based evaluation of clinical outcomes (enrolment, morbidity and mortality, clinical indicators) associated with the national ART program scale up (2004-2010), including costs for ARV care. USG is currently undertaking a study which examines the social and structural factors associated with HIV-related risk behaviors and prevalence among most-at-risk populations (MARPs). The goal of this study is to provide a comprehensive set of data that can be used by municipal and national governments in Swaziland to design evidence-based HIV prevention programs for MARP populations.

Additionally, the MOH in partnership with USG is currently in the process of establishing and evaluating innovative activities to improve the linkage and retention of HIV individuals to HIV care services under the chronic care model. Underlying these targeted research projects is the need and the USG response to

strengthen health information systems and surveillance activities which provide “dashboards” for timely definition of public health problems and tracking of the public health response. Other studies include 1) assessing the “proof of concept” around nurse-initiated ART, 2) assessing the utility of expert clients in increasing ART retention and adherence, and 3) evaluation of PMTCT outcomes.

USG will assist the GOKS to be proactive in the dissemination of research and evaluation findings so as to advance understanding of the most effective implementation of prevention, care, and treatment programs. Key to effective utilization of research findings and other information products is that they be targeted to the right audience. USG will emphasize this aspect of the strategy to ensure selected units and individuals within the relevant national institutions, especially the MOH, are supported with required training and mentored through workshops, publication and dissemination activities by supporting institutions (e.g., Johns Hopkins University, Columbia University, CDC, FELTP - Field Epidemiology and Laboratory Training Program - and others).

### 5.3. CROSS-CUTTING STRATEGIC GROWTH AREA: GENDER

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Recognizing the fundamental role gender norms play in the vulnerability of women and girls to HIV infection and other diseases, as well as the immense burden of care placed on women in southern Africa, gender will be a cross-cutting strategic growth area for USG in Swaziland.

The USG team will develop a gender strategy (planned for FY 2012) which will articulate specific priority actions and how gender will be further mainstreamed across all program areas (see Section 4.1 for examples of current activities). The USG team believes that the program as a whole will benefit from a more detailed gender analysis and strategizing process, and it is reasonable to expect that a certain amount of adjusting to make the program more gender sensitive can be done without additional resources. The strategy will also allow the USG team to be strategically placed to quickly program any additional resources for gender should they be made available. Implementing partners will be provided with training and technical assistance to ensure that gender is appropriately mainstreamed in existing work plans and in all new activities. Basic tools will be developed to assist activity managers to monitor and support partners’ compliance the country gender strategy.

Two PEPFAR special initiatives, the PMTCT Acceleration Plan (see Section 5.1) and the PEPFAR Gender Challenge, have afforded the USG with an excellent opportunity to expand its work benefiting women, girls and gender equality. Additionally, USG prevention/SBCC programs will continue to proactively address harmful gender norms and ensure that mass media, community outreach and interpersonal communication activities facilitate the adoption of more positive gender norms.

The forthcoming integrated Community-based Livelihoods Development (C-BLD) program is based on the concept that economic empowerment is one of the most effective ways of improving the status of women. Increasing household income has been demonstrated to have numerous positive effects on care seeking behavior, child health outcomes and access to education, nutritional status, among other outcomes. Vulnerable women such as single mothers, older adolescent girls, and female caregivers are among the target populations. C-BLD aims to: 1) improve the livelihood capabilities of vulnerable households; 2) strengthen the capacity of local organizations to provide effective economic strengthening and livelihoods services; and 3) promote equal economic status among women and men, and protect the rights of women and children. The program is in the competitive process and is expected to begin in early FY 2012.

Gender equality is also about men, which is especially relevant for the Swaziland context where data indicate that men access health services less frequently than women. Fewer men test for HIV; there are

thus fewer opportunities for men to be linked into HIV care and treatment. With the acceleration of the national MC plan, and enhanced strategies to engage men in testing, the expectation is that more men will undergo HIV testing, and with strong referral protocols in place, be linked into care. Health facilities are also beginning special initiatives such as men's health days, employing male expert clients and adjusting opening hours to fit men's work schedules in order to make services more appealing to men.

A groundbreaking 2007 UNICEF-CDC study documented high rates of sexual violence among girls in Swaziland - one third of girls aged 13-24 experienced sexual violence before the age of 18. Since this study, the GOKS and other stakeholders have worked to strengthen the national response to addressing GBV; however progress in study follow-up has been slow. USG activities include supporting the delivery of care, support and legal aid services for survivors of GBV, advocacy and GBV prevention activities, technical assistance for the implementation of PEP services for survivors of GBV, and the integration of gender/GBV issues into the forthcoming C-BLD activity. Additional USG activities will further integrate GBV prevention and mitigation aspects; should future funding become available the USG team is well-placed to expand these activities.

A key feature of activities moving forward will be the more systematic inclusion of mechanisms to measure gender-related outcomes. The gender equitable men (GEM) scale will be piloted among a small group of partners implementing gender-focused community dialogues, and provided the pilot is positive, scaled up across relevant activities. As appropriate, programs will integrate indicators that seek to demonstrate change in women's control over household resources, household decision-making practices, attitudes around GBV, health and nutrition outcomes, care-seeking behavior, etc. As the evidence base grows, those activities that are demonstrating the strongest results will be well positioned to scale up should additional resources be made available, or as mainstreaming into ongoing activities allows. USG will continue to closely monitor sex-disaggregated program targets and results to ensure that any disparities are identified and that mechanisms are put into place to address them.

#### 5.4. CROSS-CUTTING GROWTH AREA: HEALTH SYSTEMS STRENGTHENING & INFRASTRUCTURE

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Through this cross-cutting strategic growth area, USG will support the GHI principles of: increasing impact through encouraging country ownership and investing in country-led plans; strengthening and leveraging other efforts; increasing impact through strategic coordination and integration; building sustainability through health systems strengthening; and promoting learning and accountability through monitoring and evaluation.

Health systems strengthening is particularly important in Swaziland, with the highest HIV rate in the world. The need to provide chronic care services for this lifelong disease increases daily, however, much of Swaziland's health resources remain directed at the requirements of a few decades ago: acute primary health care aimed at treating simple infections and tertiary care for people who require hospitalization. USG is supporting the MOH to make this key transition to the provision of high quality longitudinal services in all areas of the country. The transition requires attention to each of the WHO's six building blocks for health systems - leadership and governance; health information system; health financing; human resources for health; essential medical products and technologies; and service delivery. USG current and planned support to the MOH will continue to facilitate the interaction between the first three of these building blocks (leadership, information and financing) to produce a system that enables the second three (human resources, commodities, and especially service delivery) to succeed. In short, USG is helping the MOH improve the collection and use of data to make informed decisions regarding all aspects of the health system.

Recognizing that strong systems - for everything from patient care to capital projects - require strong central coordination and accountability in planning and monitoring, USG directs a key part of its support directly to the MOH through a formal cooperative agreement. A portion of these funds are utilized by the MOH Planning Unit whose role is to examine the health system's current functions, infrastructure development and provide guidance on the way forward. Specifically, USG supports the MOH with financial and technical assistance in the following areas:

1. Coordinating resources and developing new partnerships

USG will support the Planning Unit to plan and budget for the Sector Wide Approach process (SWAp), including funding the development of a SWAp website and its management. USG is also funding capacity building for MOH Management and Secretariat to strengthen the stewardship role for MOH officials at all levels. USG is supporting the Planning Unit to develop a health sector resource tracking system which will monitor financial inflows into the health sector, irrespective of the source of funds. The tracking of resource inflows will also assist in the monitoring of health policy objectives to ensure that they are utilized in line with the national health policy/ NHSSP aspirations.

USG is also working through its implementing partners to strengthen administrative, planning and financial management skills of the Regional Health Management Teams (RHMTs) (which have, to date, been marginalized from these processes) so they can provide key inputs to the MOH. The vision is to ensure that the RHMTs are able to prioritize and manage their own activities in a financially prudent manner.

Finally, Swaziland currently lacks a legal framework for a government entity to enter into a partnership contract with a private provider. USG funds will be used by the Planning Unit to assess the legal and policy environment and institutional capacity in the health sector for implementing public-private partnerships (PPPs) and then develop a framework/strategy under which PPPs could be introduced and managed in the country. Within one to two years, USG hopes to see the first PPP operationalized within the health system.

2. Accountability in planning and implementation at national, regional and facility level

USG will work toward increased accountability through four interventions: 1) establishing national standards to re-define the health system to meet current needs; 2) building capacity of the National Quality Management Program; 3) inaugurating national RHMT review meetings; and 4) establishing Regional Clinical Mentoring Teams (RCMTs).

Over the last two years USG has supported efforts to rethink the documents that form the foundation of the public health system: an Essential Health Care Package, Standard Treatment Guidelines, Essential Medicines List, Referrals and Linkages Guidelines, Task Shifting Framework, and Mentoring and Supervision Framework. In collaboration with the GOKS, USG will work to develop new national standards which meet current needs for the health system. In addition, USG and its partners will continue to assist the MOH in the drafting of a Quality Management strategic plan, the application of the above standards to the health system, and a means of sustainably promoting/implementing quality assurance and quality improvement activities.

Activities related to inaugurating RHMT Review Meetings and Intra-regional Facility Review Meetings will strengthen the engagement of the regions and the central level in an ongoing process to create a planning and budgeting framework. Through these forums the MOH expects to strengthen the ability of the four

regions in planning and management and improve communication between the parties. Twice a year, each region will meet with all of its facilities to discuss progress on key indicators and share challenges and best practices. The RHMT will then take these data, lessons and resulting plans to meetings with the rest of the regions and the MOH directorate to inform the next round of planning and implementation. The process is expected to lead to substantive improvements in the capacity of the Directorate, the RHMTs and the facilities to plan, manage, and be accountable for the quality of service delivery.

In addition to these initiatives to improve country ownership, governance and accountability, USG is working to institutionalize data use for quality management at the facility level. Working through implementing partners, USG has established Regional Clinical Mentoring Teams (RCMTs) who support data-based quality improvement efforts. These teams of health professionals were created in coordination and collaboration with the MOH and they have been integrated into the pre-existing MOH RHMTs. Each RCMT is made up of a combination of existing and new MOH employees that cover the spectrum of vertical and cross-cutting programs—HIV, TB, lab, pharmacy, M&E, MCH, etc. (The new posts—such as TB Coordinator, Regional Laboratory Advisor receive salary support from PEPFAR or Global Fund until they can be absorbed into the MOH ranks.) Until now, the RHMT provided only scant clinical mentoring to health care providers; the RCMTs' role is to fill this gap, providing on-site clinical mentoring to all health facilities where they will develop and empower facility-based multi-disciplinary teams. The long term goal is for the RCMTs' quality improvement/mentoring activities to be adopted as a core government activity. USG has received positive indications that the MOH will eventually take responsibility for their salaries and management. That moment will mark a successful transition of the responsibility for providing clinical mentoring at public health facilities from USG to the MOH. USG teams would then be free to focus on the facilities which are facing the most difficulties in providing quality service.

As additional support to the national planning process, USG will support the MOH to develop a prioritized list of necessary infrastructure expansions and upgrades in line with standard packages, as well as facility-based maintenance plans for building. Simultaneously, USG support to the MOH Biomedical Engineering Department will help establish sustainable systems to manage the maintenance of medical equipment. These upgrades are essential to provide the basic foundation of a health care system that is now responsible for caring for its outpatients on a continuous basis. To achieve this goal, Swaziland needs functional equipment, staff housing to incentivize health care workers to live in rural areas, as well as renovations to health facilities such as properly ventilated waiting areas, larger dispensaries, laboratories and record rooms,. It is expected that this planning process will provide strategic direction for the use of USG and other national and partner funding to meet this needs.

### 3. Addressing limited human and institutional capacity

Severely limited human and institutional capacity is a major constraint to scaling up the response to HIV/AIDS in Swaziland. The number and skill level of the current health and social welfare work force is inadequate, as is the management of human resources. USG will provide technical and financial support to assist the GOKS 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. USG'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.

In line with the GHI principles, USG will use the key interventions mentioned in the four sections above to help the MOH transition its health system to meet the needs of its patients. It will facilitate this evolution

by aligning resources to identified priorities and promoting a culture of data use to improve the quality of service delivery and accountability.

## 6. GHI IMPLEMENTATION ARRANGEMENTS

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PEPFAR Swaziland is comprised of six U.S. agencies reporting to the Chief of Mission, U.S. Ambassador Earl Irving. PEPFAR Swaziland's core staff from USAID, CDC, DoD and State are co-located within the U.S. Embassy and are supported by the State Department. The USAID program is considered "limited-presence" (or "LPC") and receives acquisition, contracting, technical and staffing support from the regional USAID Mission in Pretoria. The CDC program receives support from the CDC Global AIDS Program in Atlanta, although it is staffed with grants officers and provides discretionary budget oversight in-country. The DoD program is primarily engaged with the Umbutfo Swaziland Defence Force; DoD technical guidance/oversight is provided through the DHAPP program in San Diego, while procurements are arranged through San Diego, Naples and Embassy Mbabane. Peace Corps Swaziland currently has volunteers engaged in PEPFAR-related programming and is located in its own facility off of the Embassy campus. DOL maintains a small ILO-implemented program but does not have a field presence. The State PEPFAR program manages coordination and shared administration functions for the PEPFAR interagency team.

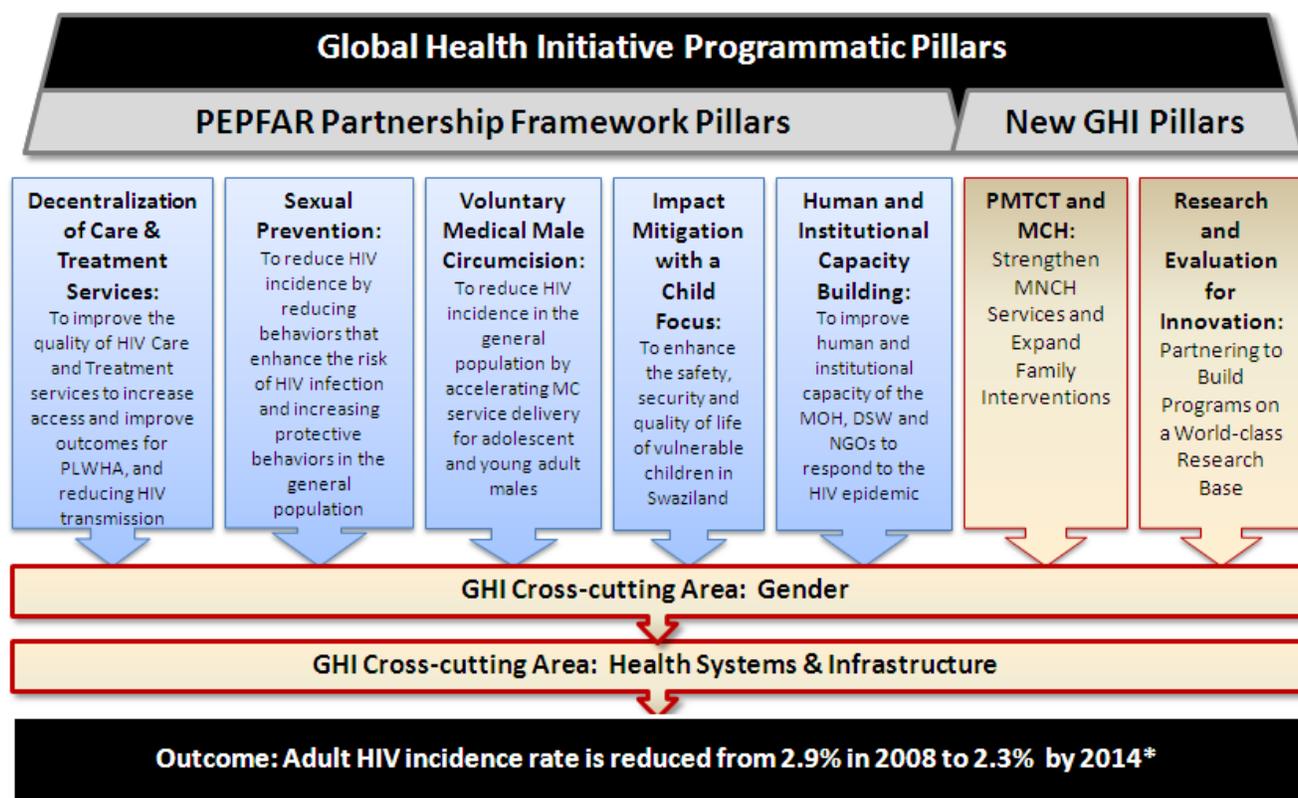
While all PEPFAR Swaziland agencies report to the Chief of Mission, the program receives interagency programmatic, technical and financial guidance from the State Department's Office of the U.S. Global AIDS Coordinator (OGAC). All interagency communications are communicated from the OGAC Country Support Team Lead to the PEPFAR Country Coordinator. Each agency has its own direct supervisory reporting lines to its respective headquarters office in the U.S.; the USAID program also reports to USAID/Pretoria. The PEPFAR country coordinator reports to the Deputy Chief of Mission; the DoD specialist's local supervision is the PEPFAR country coordinator.

Using the ongoing USG planning and monitoring structures, regular national stakeholder meetings are held to engage on the strategic direction of GHI Country Strategy and PEPFAR Partnership Framework implementation. Internally, USG staff will continue strong interagency collaboration and coordination in the implementation and monitoring of the GHI strategy. To maintain day-to-day coordination with national stakeholders and ensure accountability against mutual commitments, the USG/PEPFAR interagency management team will continue to hold monthly GHI and PEPFAR Partnership Framework monitoring meetings with the directorates of MOH, NERCHA and WHO. In addition, the Embassy PAO team will support PEPFAR in a communications and outreach strategy to ensure integration of GHI communications are part of ongoing USG public diplomacy efforts.

## 7. MONITORING & EVALUATION

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The Results Framework below outlines expected GHI Strategy outcomes. The existing PFIP indicators (see Appendix) will form part of the GHI M&E strategy, with additional indicators below for the new Pillars and Strategic Growth Areas. Where possible, USG will report on, and utilize, indicators from existing GOKS systems, in line with the "one M&E system" approach.



\*Outcome indicator taken from Swaziland National Strategic Framework on HIV/AIDS.

Monitoring of the GHI Strategy will thus rely principally on national systems, routine and periodic, to ensure sustainability and efficiencies in M&E implementation and to minimize transaction costs. The HMIS collects health-related data, and reports quarterly on key national health statistics. SHAPMoS collects and reports quarterly on both health sector and non-health sector indicators. Existing research and data collection, such as the SDHS will provide important data on progress, in addition to key ongoing studies such as SHIMS.

<b>Goal for PMTCT &amp; MNCH integration PILLAR: Elimination of Pediatric AIDS in Swaziland</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target 2015</b>
Prevention of HIV in Women	New HIV infections among women attending MNCH services	7-10%	5%
Prevention of Unintended Pregnancies among HIV-positive Women**	FP unmet need	24%	12%
	Unintended pregnancies in HIV-positive women of child bearing age	36.9%	20%
Prevention of Mother-to-Child Transmission of HIV	Proportion of pregnant women presenting during first trimester	25%	50%
	Proportion of pregnant women who visit ANC at least 4 times	47%	75%
	Number of pregnant women with known status includes women who were tested for HIV and received their results	20,686	26,779
	Proportion of women delivering in health facilities	74%	90%
	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother to child transmission.	7 560	9 780

<b>Goal for PMTCT &amp; MNCH integration PILLAR: Elimination of Pediatric AIDS in Swaziland</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target 2015</b>
	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	83%	94%
Care and Support for HIV-positive Women, Infants, & Families	Increase percentage of eligible pregnant women enrolled on ART	TBD	TBD
	Increase percentage of exposed infants who remain in care at 6, 12 & 18 month	TBD	TBD
<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>Development and approval of the national PMTCT M&amp;E tools - Registers (ANC, L&amp;D and PNC/FP), Monthly Reporting form, hand held ANC and child health cards- 2011/2012</li> <li>Development and approval of National Strategic Frame work to Eliminate New HIV infections among Children and keeping their Mothers alive (2011-2015)</li> <li>Development and approval of PMTCT job aids on the new guidelines such as NVP dosage table, ARVs algorithm, HTC for PMTCT support tools</li> <li>Development and approval of FP/ART SOP</li> </ul> **To be revised based on national MTCT elimination plan			

<b>Goal for Research and Evaluation for Innovation Pillar: Strengthen the public health and social research foundations to guide and evaluate effective national responses</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target</b>
Increased number and quality of information products which meet widely accepted quality standards and support the priorities of policy & program decision-makers.	Number of high-quality information products which meet widely accepted quality standards, to include National Health Statistics Report, Quarterly HIV/AIDS Program Report (4), National ART Program Outcomes Evaluation Report, National PMTCT Outcomes Evaluation, SHIMS reports, and other scheduled priority surveillance reports and national disseminations.	Nil	4, first year 6, each subsequent year
Increased use of knowledge in policy and program decision-making	Existence of a strategy to communicate key national and international research and evaluation findings	No	Yes
	Communication strategy milestones reached on schedule, including publications; non-published dissemination materials and events; advocacy events & processes.	N/A	Milestones reached
	Maintain bi-annual national health research meetings	2010	2012?
<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>Development of Health Research and Evaluation Capacity-Building Strategic Plan/Agenda</li> </ul>			

<b>Goal for cross-cutting area for Gender: Enhance positive gender norms in Swaziland</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target</b>
Develop and implement the gender strategy for USG health investments	Reduce gender gap in access to HIV/AIDS health services including access to ART and HTC (national level)	TBD	TBD
	Implement Gender-Equitable Men Scale (GEM Scale) among partner specific target population	TBD	TBD
<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>Support development of national gender strategies</li> </ul>			

<b>Goal for cross-cutting area for Gender:</b> Enhance positive gender norms in Swaziland			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target</b>
<ul style="list-style-type: none"> <li>• Passage of Domestic Violence and Sexual Offence Bill</li> <li>• Passage of Child Welfare Bill</li> <li>• Partner Specific Gender Mainstreaming Periodic Audits</li> </ul>			

<b>Goal for cross-cutting area for Health Systems and Infrastructure:</b> Strengthen health systems through encouraging country ownership, investing in country plans; supporting strategic coordination and integration			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>Target</b>
Coordinate resources and develop new partnerships	Health sector resource tracking system developed and institutionalized	Nil	Yes
	Regional Health Management Teams (RHMTs) annual administrative and financial plans are developed and implemented	Nil	Yes
	PPPs Framework and strategy developed and implemented	Nil	Yes
Ensure accountability in planning and implementation at national, regional and facility level	National standard established for planning and implementation at national, regional and facility level	TBD	TBD
	Capacity of National Quality Management Program improved (based on a checklist)	TBD	TBD
	Prioritized list of necessary infrastructure expansions and upgrades established and coordinated with development partners	Nil	Yes
Address limited human and institutional capacity	Number of vacant posts within the MOH and DSW	850	100
<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>• Included above</li> </ul>			

## 8. APPENDIX 1: PFIP MONITORING & EVALUATION FRAMEWORK

<b>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</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>5-Year Target</b>
<b>Increase the percentage of the population that knows their HIV status through increased access to high quality HTC</b>	Provide quality-assured HIV testing and counseling (HTC) in all health facilities throughout the country by 2013.	2009 – 178	2013 – 223
	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 – (2007 SDHS) 22% for women, 9% for men	2013 – 50% for women, 40 % for men
<b>Increase the number of HIV infected people receiving pre-ART services as part of Comprehensive Care Package (CCP)</b>	Increase pre-ART services to cover at least 80,000 HIV-infected people by 2013	2009 – to be established	2013 – 80,000
	Retain at least 80% of people on pre-ART (or ART) three years after enrolment, by 2013	2009 – to be established	2013 – 80%
<b>Increase the number of people receiving high quality ART services</b>	Increase in number of people (adults and children) receiving ART from 38,000 in 2009 to 60,000 by 2013	2009 – 38,000	2013 - 60,000
	Retain at least 85% of people on ART three years after the initiation of treatment, by 2013	2009 – to be established	2013 - 85%
<b>Increase TB treatment enrollment and success</b>	Enroll 85% HIV-infected incident TB cases on TB treatment by 2013 (NSF)	2009 – to be established	2013 – 85%
	Increase the overall TB treatment success rate to 85% by 2013	2008 - 58%	2013 - 85%
<b>Policy and other qualitative benchmarks:</b>			
<ul style="list-style-type: none"> <li>• National decentralization plan for HIV-related care and treatment services, including community component</li> <li>• Revised ART (pediatric and adult) guidelines, including TB/HIV integration component</li> <li>• User fees for HIV-related care and treatment</li> <li>• Task-shifting/sharing for HTC, treatment initiation &amp; prescription, community-based care and support, lay counselors</li> <li>• Revised essential Drug list approved; improved availability of drugs</li> <li>• Implementation of the approved Pharmaceutical Policy</li> <li>• Code of professional conduct and/or practice around treatment options</li> <li>• Laboratory policy finalized and approved</li> <li>• Nutrition policy finalized and approved</li> <li>• TB infection control policy and guidelines emphasizing special measures addressing MDR-TB prevention and control</li> </ul>			
<b>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</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>5-Year Target</b>
<b>Improve knowledge about prevention of HIV transmission within the general population</b>	Comprehensive knowledge of HIV & AIDS among women & men aged 15-49 increased from 52% in 2007 to 78% by 2013	2007 - 52%	2013 - 78%

<b>Reduce high risk sexual behaviors in the general population</b>	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%
<b>Increase safe sexual behaviors among young people</b>	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
<b>Policy and other qualitative benchmarks:</b>			
<ul style="list-style-type: none"> <li>• Functional Prevention TWG</li> <li>• National SBCC strategy approved and implemented</li> <li>• National level coordination of the SBCC strategy and operational plan</li> <li>• National condom strategy finalized and approved</li> <li>• National HIV Prevention Policy developed and adopted</li> <li>• Gender Policy finalized and approved</li> <li>• Establish regular behavioral surveillance and program evaluation of HIV prevention efforts</li> </ul>			
<b>Five-Year Goal for Male Circumcision: Reduce HIV incidence in the general population by rapidly expanding MC services for young adult males</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>5-Year Target</b>
<b>Increase the demand for medical MC.</b>	Increase in the percent of uncircumcised men aged 15-24 who want to be circumcised from 40% to 80%	2007 – 40% (SDHS)	2013 - 80%
<b>Increased access to and coverage of MC services to meet demand.</b>	At least 10 sites effectively delivering medical male circumcision services in line with national & international guidelines	2009 – 2 sites	2013 – 10 sites
	Between 2009 and 2013, 110,000 males aged 15-24 provided with high quality medical male circumcision services (cumulative, catch up)	2009 – est. 2,000	2013 - 110,000
<b>Policy and other qualitative benchmarks:</b>			
<ul style="list-style-type: none"> <li>• National capacity (infrastructure and human resources) increased to manage rapid scale-up of medical MC</li> <li>• National MC Policy and operational plan finalized and approved</li> <li>• Operationalized National MC communication strategy, clinical protocol and M&amp;E plans</li> </ul>			
<b>Five-Year Goal for Impact Mitigation: Improve living circumstances for vulnerable children in Swaziland</b>			
<b>Objectives</b>	<b>Indicators</b>	<b>Baseline</b>	<b>5 Year Target</b>
<b>Increase the percentage of vulnerable children receiving basic support services</b>	Percentage of vulnerable children receiving at least 3 types of free support services from external source. Service types include: <ul style="list-style-type: none"> <li>• basic health care and health care referral</li> <li>• education or vocational training</li> <li>• psychosocial</li> <li>• food or other nutritional</li> <li>• protection or legal aid</li> <li>• shelter and care giving</li> <li>• economic strengthening</li> </ul>	2009 – To be established	2013 – 50%

<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>• Revised National Plan of Action for Children 2011-2015</li> <li>• National quality standards and M&amp;E Framework for programs in support of vulnerable children</li> <li>• National Children's Protection and Welfare Bill approved</li> <li>• National trafficking bill and ratified protocols finalized and approved</li> <li>• Domestic Violence and Sexual Offences Bill finalized and approved</li> <li>• Social Development policy and strategy finalized and approved</li> </ul>			
<b>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</b>			
Objectives	Indicators	Baseline	5-Year Target
<b>Expedite recruitment within the MOH to fill vacancies in established staff positions</b>	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
<b>Policy and other qualitative benchmarks:</b> <ul style="list-style-type: none"> <li>• Human resources policy, organizational structure and functional job descriptions</li> <li>• National HRH Policy and HRH task shifting policy approved and implemented</li> <li>• National HRIS System decentralized and utilized to inform HR planning</li> <li>• HRH implementation strategic plan developed costed and budgeted</li> <li>• Appropriate scopes of practice (or schemes of service) defined for all cadres</li> <li>• Leadership development program established for managers at relevant levels</li> <li>• National strategy in place for training NGOs in program management and administration</li> </ul>			