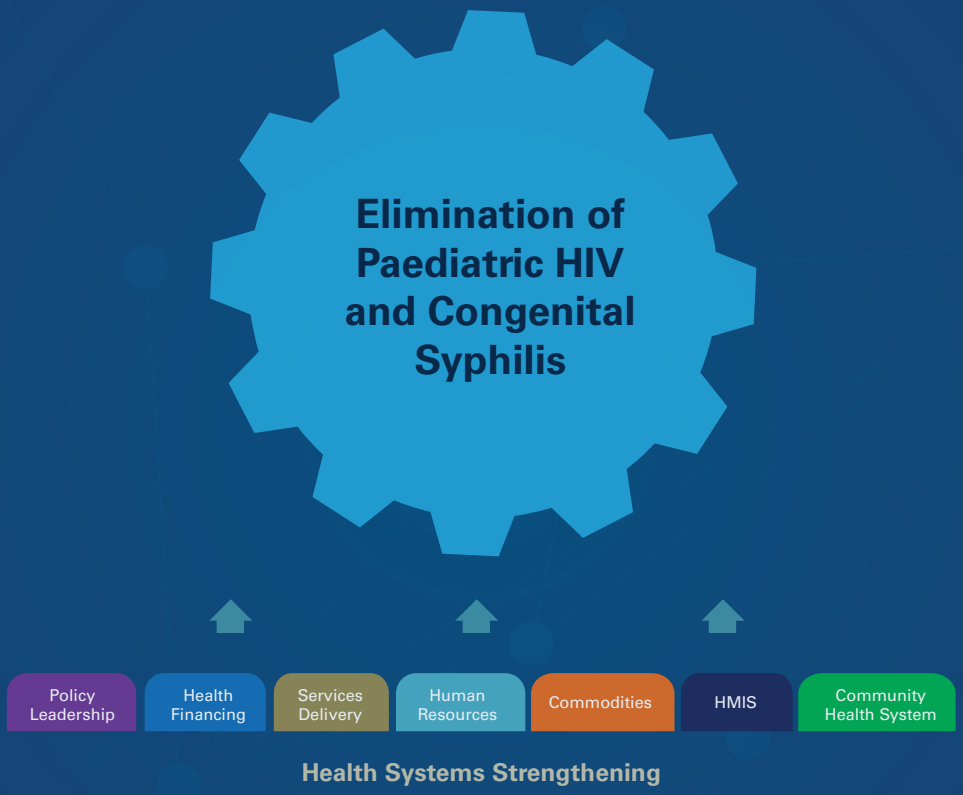
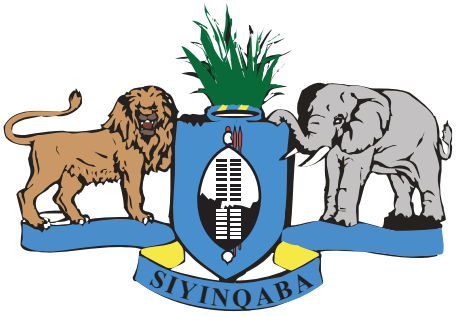
MINISTRY OF HEALTH

National Strategic Plan for Ending AIDS and Syphilis in Children (2018 – 2022)



KINGDOM OF ESWATINI



MINISTRY OF HEALTH

National Strategic Plan for Ending AIDS and Syphilis in Children (2018 – 2022)

KINGDOM OF ESWATINI

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Foreword

The HIV epidemic has remained a major public health challenge in Eswatini with significant social and economic consequences that the country continues to grapple with. Mother-to-child transmission of HIV constitutes a preventable cause of morbidity and mortality among children in the country, which justifies the prioritisation of its prevention among the high impact interventions. At the global level, Eswatini is among the 22 priority countries for elimination of Mother-to-Child Transmission of HIV.

The Ministry of Health has led the national response for elimination of mother-to-child transmission of HIV with commendable progress since 2003. In the last five years, the transmission rates at 6 weeks declined from 4.1% in 2012 to 2.1% in 2016, while the rates at final diagnosis declined from 14.8% in 2012 to 6.8% in 2016. To fast-track elimination of new infections among children, a "three frees" framework was launched in 2015 globally to guide the strategic focus of countries in line with SDGs. This strategy therefore aligns Eswatini's response to the 'Three Frees' and make a final push towards elimination of mother-to-child transmission of HIV and syphilis as well as end paediatric AIDS.

This Strategic Plan has been designed to ensure that every child is born and remains HIV and syphillis free, whilst every pregnant woman or mother living with HIV should have access to lifelong HIV treatment. In addition, every child and adolescent living with HIV should be linked to quality HIV treatment, care and support to realize their full potential without stigma and discrimination. This will be achieved through collaborative interventions with other programs and implementing partners to ensure that every child, adolescent, and women access comprehensive prevention HIV and syphillis services.

The Government of Eswatini remains committed to the fight against HIV and syphillis, and to supporting the implementation of this Strategic Plan, in partnership with key stakeholders in a collective response that is critical to the achievement of elimination targets. This will contribute to the country's vision of ending AIDS by the year 2022.

Honourable Minister of Health
Ms. Sibongile Ndlela-Simelane

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CMIS	Client Management Information System
DBS	Dried Blood Spot
DNA	Deoxy Ribo-Nucleic Acid
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
eMTCT	Elimination of Mother-to-Child Transmission (of HIV and syphilis)
eNSF	Extended National Strategic Framework
EPI	Expanded Program on Immunisation
FP	Family Planning
HEI	HIV Exposed Infants
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTS	HIV Testing Services
ICT	Information and Communication Technology
m2m	mothers2mothers
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
NGO	Non-Governmental Organisation
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Post Natal Care
POC	Point of Care
PREP	Pre-Exposure Prophylaxis
SAM	Services Availability Mapping
SDG	Sustainable Development Goal
SHIMS	Eswatini HIV Incidence Measurement Survey
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Acknowledgements

This Framework is drawn from contributions of citizens and technical experts from different organizations' across the country.

The Ministry of Health wish to thank the Prevention of Mother to Child Transmission of HIV technical working group under the leadership of the Sexual Reproductive Health Manager in MoH for steered the consultations that led to the development this framework.

We thank the following institutions for technical support during the development of the framework; **Ministry of Health** - Sexual Reproductive Health Programme, Eswatini National AIDS Programme and monitoring and evaluation unit and Regional Health Management Team; **United Nations** - UNICEF, UNFPA, UNAIDS, WHO; **US Government Agencies** and their implementing partners including EGPAF, URC, ICAP, and M2M. Your input to the framework at greatly valued.

Special thanks to, UNICEF for the financial support and technical assistance through Dr Saul Onyango (the consultant) towards the development of this strategy.

To all individuals who participated in this exercise not mentioned here, your contributions are highly appreciated.

CHAPTER 1

BACKGROUND

1.1: Country Profile

The Kingdom of Eswatini is landlocked with a surface area of 17,364 square kilometres, bordered on the north, south and west by the Republic of South Africa and on the east by the Republic of Mozambique. The Kingdom is administratively divided into four regions namely: Hhohho, Lubombo, Manzini and Shiselweni. The four regions are further sub-divided into 55 constituencies known as Tinkhundla and 360 chiefdoms and towns.

The country's projected population in 2016 based on the 2007 Population Census is about 1,093,238 people, with slightly more females (51.4%) than males. The population of Eswatini is comparatively young, with 46% under the age of 20 years. Urbanisation is still limited and more than three-quarters of the people (79%) reside in the rural areas. The literacy rate among women of reproductive age is 91%, with 59% having attained secondary level education, or higher. Selected national socio-demographic indices from the Multiple Indicator Cluster Survey (MICS) of 2014 are presented in Table 1.

Table 1: Selected Socio-Demographic Indices

Description	Value
ANC coverage at least 4 visits	76.1%
Skilled Attendance at Delivery	88.3%
Contraceptive Prevalence Rate	66.1%
Unmet Need for Family Planning	15.2%
Total Fertility Rate (15 – 49 years)	3.3
Age-Specific Fertility Rate (15 – 19 years)	87
Neonatal Mortality Rate	20
Infant Mortality Rate	50
Under-5 Mortality Rate	67
Exclusive Breastfeeding Rate (0 – 5 months)	63.8%
Full Immunization Coverage	70.7%

Source: MICS 2014

1.2: Organisation of the Health System

Eswatini has a total of 287 health facilities organized within a five-tier health care system (Figure 1):

- 1 National Referral Hospital
- 5 Regional Referral Hospitals
- 2 Specialised & 6 Private hospitals
- 5 Health Centres & 6 PHUs
- 23 Clinics with Maternity & 192 without
- 6 Specialised Clinics

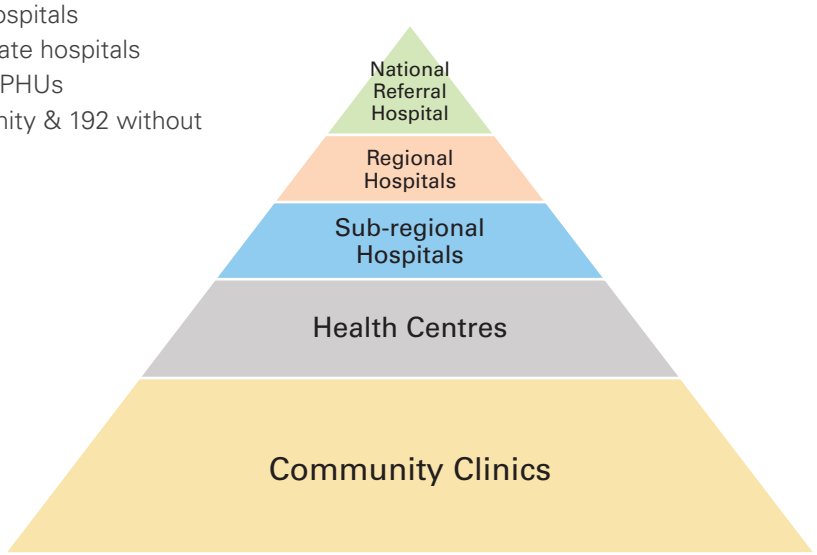

Figure 1: Health Care Delivery Structure

[1] Central Statistics Office, Mbabane: Eswatini Population Census 2017.

Overall, the health service delivery system consists of both formal and informal sectors. Under the formal sector, the system is constituted by public, private-not-for-profit and the private sectors. Through the public sector, government owns 40.1% of health facilities, 12.2% are owned by faith based institutions, 7.3% by Non-Governmental Organisations (NGO), 10.8% by industrial facilities, whilst 22.7% are privately owned by doctors and 7% by nurses. The informal sector consists mainly of traditional and alternative health care providers (SAM 2013).

Functionally, the public health system is decentralized from the central ministry to the four regional health offices, with the following roles and responsibilities:

- The central Ministry of Health performs executive and administrative functions and provides strategic guidance on delivery of the essential health care package at all levels;
- Each regional office is headed by a Regional Health Administrator and supported by the Regional Health Management Team, whose mandate is to provide technical leadership in executing policies developed by the central Ministry of Health;
- At the community level is a network of health workers, including Rural Health Motivators to promote community participation in health activities within the areas. In addition, there are health committees to support the general management of health facilities.

The health sector faces challenges in equitable deployment of human resource cadres at all levels of the health care delivery system. Over 50% of the existing workforce is deployed in hospitals located in the urban areas that serve only about 20% of the population whilst the remaining 50% serve the majority (80%) within the rural areas.

1.3: HIV and AIDS in Eswatini

The second Eswatini HIV Incidence Measurement Survey (SHIMS 2) of 2016/17 reported overall HIV prevalence of 27%, with gender discrepancy being higher among females than males (32.5% and 20.4%, respectively). In terms of geographical distribution, HIV prevalence is highest in Lubombo region (29.4%) and lowest in Hhohho region (25.7%), with Manzini and Shiselweni regions at 27.3% and 25.9%, respectively. The prevalence of HIV in 2016 based on the SHIMS 2, disaggregated by age and sex has been summarised and illustrated in Figure 2.

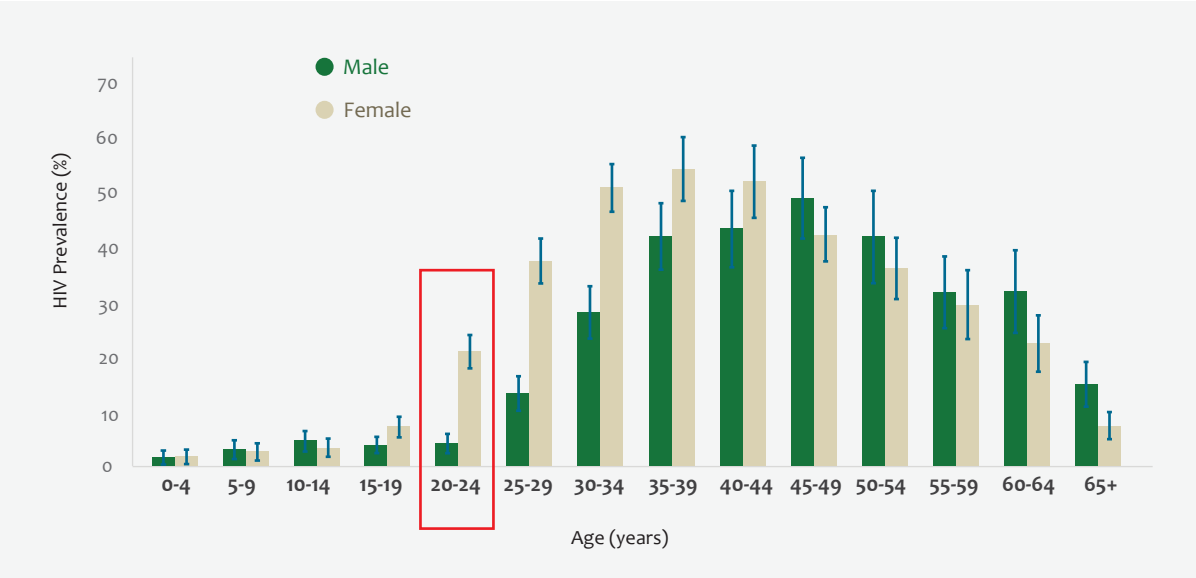

Figure 2: Prevalence of HIV in 2016 by Age and Sex (Source: SHIMS 2)

The weighted annual HIV incidence is 1.4% with relatively higher risk among females (1.7%) than males (1.0%). Its noteworthy that young females age 15 – 24 years carry higher risk of HIV infection (1.9%) when compared to males of the same age (0.8%). Decline in HIV incidence has been observed from 2.5% in 2011 to 1.4% in 2016/17, which constituted a reduction of 50% among males (1.8% to 0.9%) and 38% among females (3.2% to 2.0%).

Comparison of the HIV prevalence from SHIMS 1 and SHIMS 2 reveals a decline from 32.1% in 2011 to 30.5% in 2016/17, more notable among males (24.1% to 21.2%) than among the females (38.8% to 38.1%). The decline is not statistically significant and hence constitutes evidence of stabilisation in the HIV prevalence rather than decline. Nevertheless, over the 10-year period between 2006/07 and 2016/17 (Figure 3) there is a significant declining trend in prevalence among the young women and men.

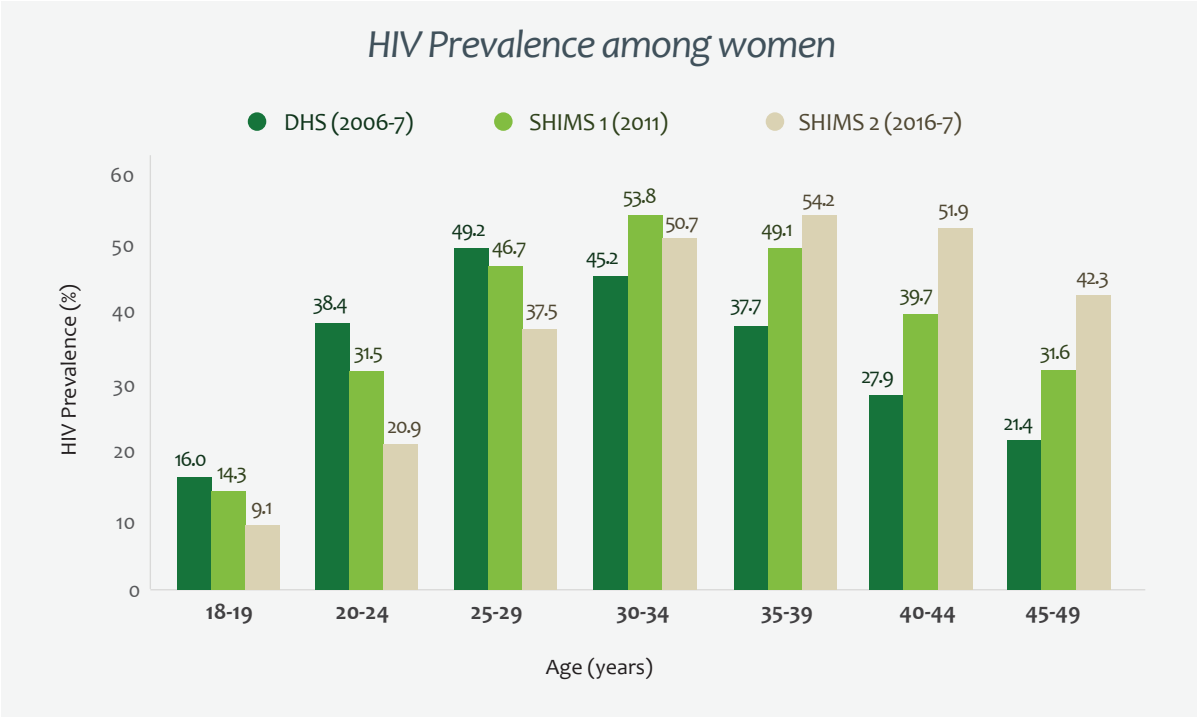

Figure 3: Prevalence of HIV among Women 18-49 Years (Source: SHIMS 2)

1.4: The PMTCT Programme in Eswatini

The PMTCT programme was officially launched in 2003 at three pilot sites, with primary support from UNICEF. The lessons from these pilots formed the basis for the national expansion from 3 sites in 2003 to an impressive 150 in 2010. In 2011, the framework for Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive (Elimination Framework) was developed to guide PMTCT implementation in the country. It reflected the national priorities for a comprehensive response to the epidemic and provided the unified platform for a strengthened and accelerated effort. The key PMTCT programme milestones are highlighted in Figure 4.

Key Milestones in the PMTCT Program

- 2002: PMTCT Guidelines 1st Edition
- 2002: PMTCT Program piloted at 3 facilities
- 2003: PMTCT Strategic Plan (2003 – 2005)
- 2006: PMTCT Guidelines 2nd Edition
- 2007: PMTCT Operational Plan (2007 – 2011)
- 2009: Early Infant Diagnosis of HIV using DNA PCR fully established in the country
- 2010: PMTCT Guidelines 3rd Edition
- 2011: Operational Plan (2011 – 2015)
- 2011: National Strategic Framework for Accelerated Action (2011 – 2015)
- 2015: Integrated HIV Management Guidelines
- 2017: Joint review of the national HIV and PMTCT programs

Figure 4: PMTCT Programme Milestones in Eswatini

CHAPTER 2

SITUATION ANALYSIS

2.1: Availability of Services at Health Facilities

On basis of the Service Availability Mapping Report of 2013, there are 287 health facilities in the country. The majority (42%) are located in Manzini region whilst Shiselweni region (13%) has the lowest with Hhohho and Lubombo regions registering 29% and 17%, respectively. Table 2 shows that 79% of all the health facilities specifically provide family health services, of which 81% and 69% offer antenatal care and PMTCT services, respectively. Family Planning is provided at different service delivery points and implementation is done using different models. A key observation is that some nurses have not been trained on the new FP guidelines. In 2016 overall 92% of the eligible 45,211 women at FP clinics were offered HTS and of those tested, 1,054 (3%) were found to be HIV positive of whom 792 (75%) were linked to HIV care and treatment services.

Table 2: Availability of Selected Services at Health Facilities by Region

Region (N)	Family Health Services	Offering HTS	Offering ART	Offering ANC	Offering PMTCT
Hhohho (82)	64	59	34	52	46
Lubombo (48)	42	44	28	38	35
Manzini (121)	87	94	44	63	53
Shiselweni (36)	34	35	27	30	28
Total (287)	**227**	**221**	**133**	**183**	**162**

Source: Service Availability Mapping (SAM) 2013 Report

2.2: Maternal PMTCT Cascade

Figure 5 illustrates the maternal cascade for PMTCT in 2016 including the gap to be bridged before reaching the estimated 33,000 pregnancies in the country. Out of the 11,000 pregnant women estimated to be in need from the Spectrum Projections in 2016, about 86% were initiated on ART. In line with the global elimination targets, the gap relates to reaching 95% of HIV positive pregnant women in the country knowing their HIV status and initiating 95% of pregnant women living with HIV on lifelong ART. It is noteworthy that some clients served through the private sector facilities may have been omitted from the cascade.

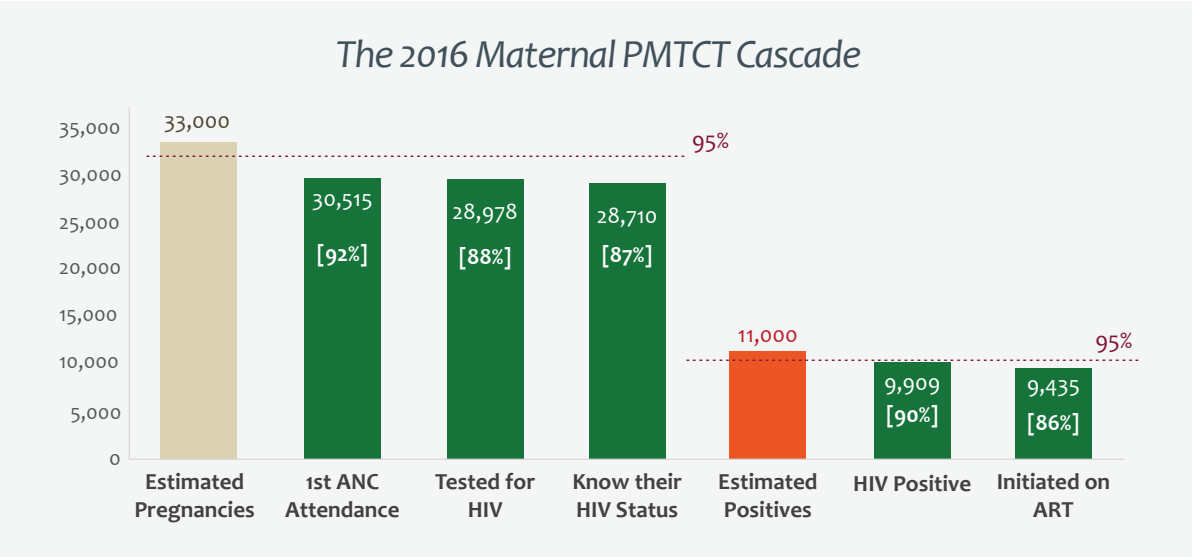

Figure 5: Maternal PMTCT Cascade in 2016 (Source: 2016 Annual Report)

2.3: Delivery, Postnatal Care and HIV Re-testing

The reported deliveries through the HMIS in 2016 constitute 80% of the estimated deliveries for the year (Figure 6) and the adolescents account for about 17% of all the reported deliveries at health facilities. The women who attended postnatal care (PNC) only constitute 63% out of all the estimated deliveries in the country. The greatest strategic gap relates to increasing uptake of PNC which is an important platform for PMTCT service delivery. In terms of regional variation, home deliveries is highest in Lubombo region (17%), but lowest in Manzini region (4%) whilst Shiselweni registered 11% and Hhohho region 8%. The critical gap will relate to improvement in the deliveries under skilled service providers, especially in Lubombo region.

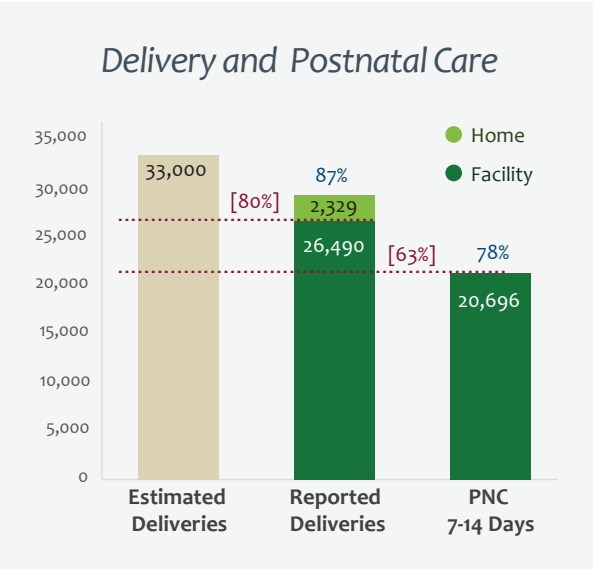

Figure 6: Deliveries and Postnatal Care from 2014 to 2016
(Source: 2016 SRH Program Annual Report)

The national HIV Guidelines promote conducting of repeat HIV tests for HIV negative women in all facilities at 8 week intervals. In addition, targeted services are provided for adolescents to prevent new HIV infections. The prevalence of HIV among those re-tested in 2016 was 1.5% at ANC, 1.3% at labour and delivery and 1.9% at PNC. The strategic gap relates to consolidation of the HIV prevention package for negative pregnant and lactating women, to sustain low levels of sero-conversion.

2.4: Uptake of Services for HIV Exposed Infants

All postnatal women and their infants are seen together regardless of their HIV status at MNCH settings, which provide daily services including ART refills and immunization. Integration of services for HIV exposed infants varies in different institutions with some having synchronized PNC, POC or DBS/PCR and EPI services. As illustrated in Figure 7, out of all the estimated births in 2016, only 79% of the infants were seen during the scheduled 6 to 8 weeks' visit. The figure further shows the gap in reaching the estimated children in need of HIV related services derived from the Spectrum Projections in 2016. The critical strategic gap relates to increase in uptake of postnatal care for infants in general, uptake of ARV prophylaxis among the HIV exposed infants and the other interventions to at least 90%. Out of the HIV exposed infants tested by PCR, 220 (2.5%) were found to be HIV positive, corresponding to 79% of the estimated number of those in need. Out of those identified through the PCR test, 150 (68%) were linked to antiretroviral treatment, implying the program initiated only about 54% of all infected children in need of ART. The strategic gaps relate to increasing proportion of HIV exposed infants who get tested by PCR and the proportion of HIV positive children who get initiated on ART.

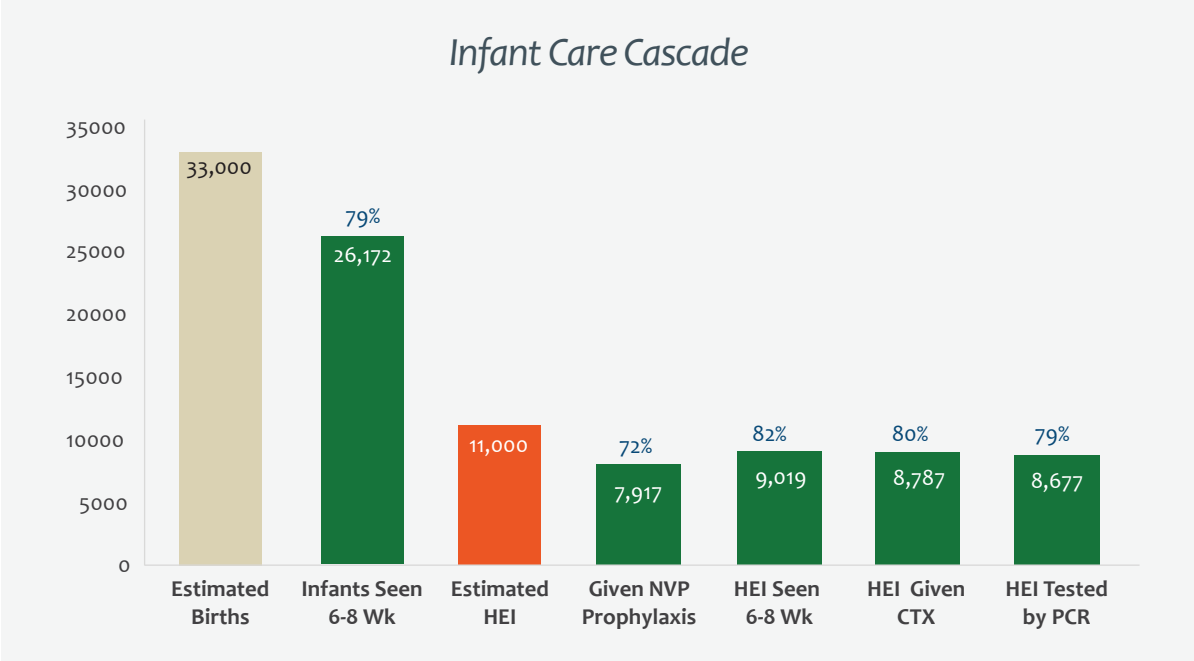

Figure 7: The Care Cascade for HIV Exposed Infants in 2016 (Source: 2016 HIV Program Annual Report)

2.5: Management of Syphilis

Figure 8 summarises the uptake of syphilis screening and treatment for pregnant women in 2016. It shows that 83% of all the estimated pregnant women (33,000) were screened and 70% (765)* of those in need were treated. It implies that about 765 would have been identified if all those in need had been screened and only 70% has been treated. Elimination of congenital syphilis in the country will among others require sustaining 95% level of screening and 95% level of effective treatment for the seropositive mothers and their partners.

*calculated based on the syphillis in ANC against estimated pregnancies

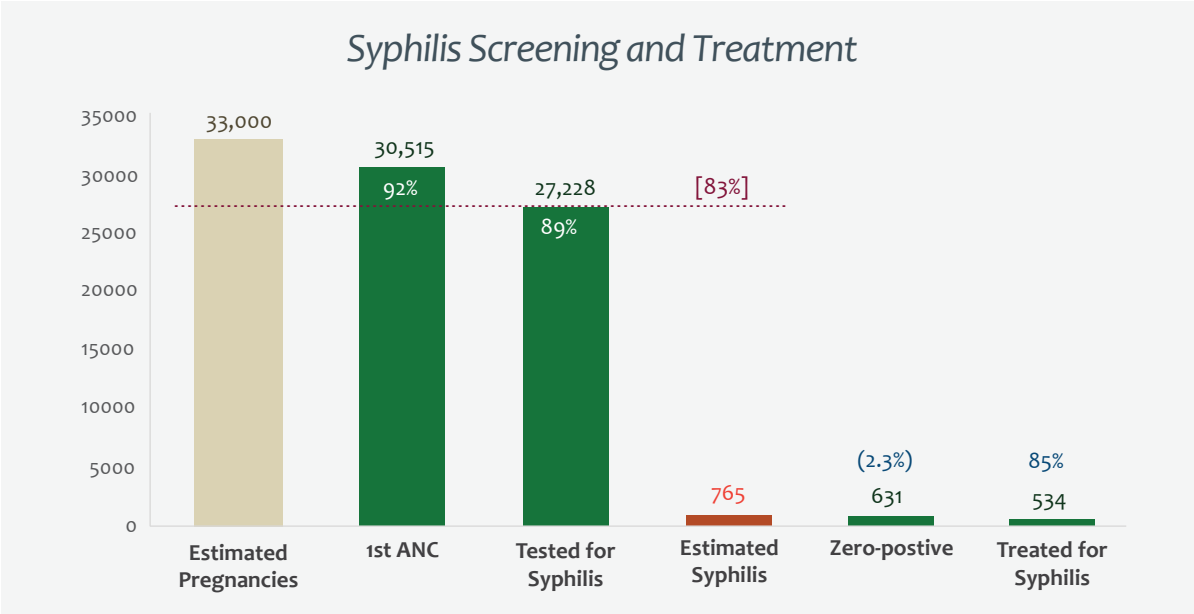

Figure 8: Syphilis Screening and Treatment in 2016 (Source: 2016 SRH Program Annual Report)

2.6: Progress of Paediatric ART Towards 90-90-90

As illustrated in Figure 9, coverage of services based on the 90-90-90 targets among young people age 0 to 14 years shows a strategic gap of 17%, 24% and 74% respectively, to attain the 90-90-90 targets for this age group. Uptake of services in the 2016 HIV Program Annual Report shows ART coverage of 58% and viral load coverage at only 22%.

The trend in antiretroviral therapy coverage shows a more consistent and sharper increase among adults (49% in 2013 to 77% in 2016) when compared to children age 0 – 14 years (43% in 2013 to 58% in 2016).

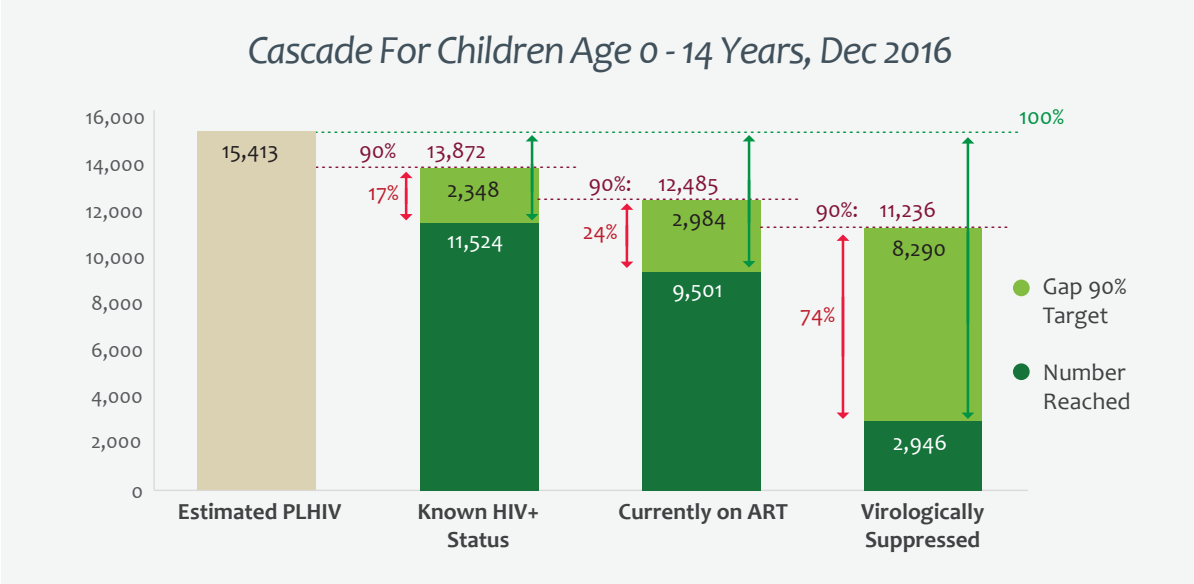

Figure 9: Achievements of 90-90-90 Targets in 2016 Source: MTR Report

More specifically out of 1,417 children initiated in 2016, there are more girls (56%) compared to the boys. In terms of geographical variation, more children are initiated from Manzini region (36%) and Hhohho region (28%) while similar proportions (18% each) are from Lubombo and Shiselweni regions. The main strategic gap relates to increase in the coverage of ART services for children age 0 – 14 years. This will involve increase the proportion tested, initiated on treatment and virologically suppressed in line with the 90-90-90 targets. There were 9,501 children living with HIV age 0 – 14 years actively on antiretroviral therapy in 2016, with slightly more girls (53%) compared to the boys (Figure 10).

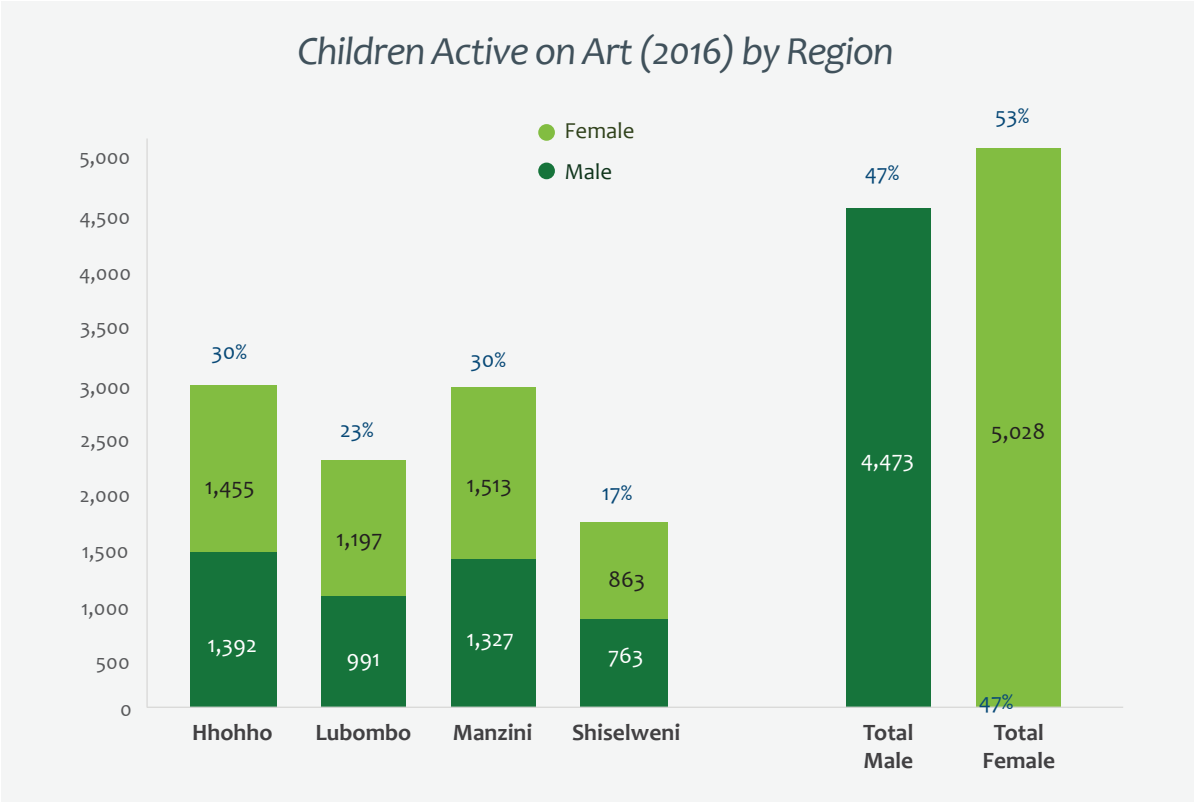

Figure 10: Distribution of Children 0-14 Years Active on ART in 2016 (Source: 2016 HIV Program Annual Report)

2.7: Cross-cutting Health Systems Strengthening

The findings in this section are predominantly from the Joint Review of the HIV and PMTCT Programs conducted in April 2017.

I. Leadership and Governance

Functionally, the regional level administration and finance is headed by the Regional Health Administrator; clinical services by the Senior Medical Officer, whilst the Senior Matron heads the nursing and public health services. Specific coordinators have been assigned at the regional level for HIV, Tuberculosis and PMTCT with clear roles and responsibilities. Strategic and operational plans were developed to guide implementation of prioritized interventions. Among the key challenges are the following:

- Irregular technical supervision from the regional and central levels, with undocumented feedback to the health facilities;
- National and regional targets are not clearly defined to managers at the health facility level.

II. Policy Leverage

The national policy guidelines have been used to influence implementation at the service delivery points. In general, most guidelines and Standard Operating Procedures (SOPs) are largely available to ensure quality service delivery. The managers displayed good knowledge of the key interventions. The following were among the major challenges highlighted:

- Whereas available, key policy documents tend to be in offices of senior management but not readily accessible to the service providers;

- Health facilities not adequately equipped with policies, guidelines and SOPs and where available, tend to keep several versions of the same guideline;
- Private health facilities not adequately equipped with policies, guidelines and SOPs.

III. Health Financing

Government resources for HIV interventions, including PMTCT are centralised and hence budgets that include the detailed activity plans, are developed by the regional coordinators in close collaboration with central level officers. In addition, implementing partners are assigned to specific regions to support interventions in a manner that limit duplication and optimally utilise the available resources. The following are among the key challenges:

- Declining funding levels for HIV-related interventions over the preceding three years;
- Central funding of activities causes delays in implementation and leads to a sense of partial ownership by the regions;
- Inadequate investment on the infrastructure to maintain delivery of quality services;
- Low economic capacity especially in the rural areas for clients to cover the out-of-pocket health-related expenses.

IV. Services Delivery

In general, the health infrastructure is relatively good with access for persons with disability at some facilities. Adoption of the 'test and treat' approach has improved initiation of women on treatment and decreased the prevalence of opportunistic infections. Integration in service delivery has been promoted with good practices such as cervical cancer screening as part of the PMTCT package, tuberculosis (TB) and HIV integrated services as well as HIV testing services for children in child welfare. Some of the main challenges include:

- Sub-optimal linkage of HIV negative clients to the available HIV prevention services;
- Few children living with HIV are being initiated on ART at the health facilities, especially those under age of 5 years;
- Limited evidence of quality improvement activities at the health facilities such as plans, journals and programme performance charts;
- Inadequate documentation for the laboratory transport system at the health facility level, including for monitoring the turn-around-time.

V. Human Resources for Health

The mandate for recruitment and management of health staff lies with the Civil Service Commission and significant investment has been made to strengthen capacity for HIV related service delivery. Contributions from implementing partners has facilitated focus on specific programmes and priorities through complementary staff recruitment at the health facility and community levels. There has been regular training of health workers to improve capacity for service provision. The following are among the key challenges:

- Inadequate numbers and skill mix of staff, especially in the rural-based facilities;
- Various positions are funded by implementing partners with risk of service interruption when partner funding gets constrained;
- Inadequate technical staff to manage medicines and commodities/ supplies with task-shifting being done to nurses despite the relatively busy clinics;
- Limited human resource capacity for data analysis and use at the health facility level.

VI. Equipment and Commodity Security

The procurement and supply chain management system has been functional with limited or no stock-outs of HIV-related medicines, including of the ARVs being reported from the service delivery points. Routine viral load tests are also regularly conducted at the health facilities. Stock cards are routinely utilised at the health facility level to monitor distribution of medicines and related commodities. The following are among the key challenges cited:

- Limited storage space for medicines at some health facilities;
- Inefficient communication with Central Medical Stores that results in relatively long tur-around time for orders placed;
- The servicing and repair of medical equipment at the health facilities not well streamlined.

VII. Health Information Management System

Health facilities have been equipped with necessary tools for monitoring PMTCT reporting, including HTS, ART, Pre-ART, ANC, PNC, FP, Child welfare registers and of recent, are linked to the CMIS. Monitoring programme performance has been regularly conducted through review meetings involving managers, stakeholders and health facility staff. Regional and cluster level meetings are conducted to discuss data quality, identify gaps and develop action plans for rectification. Some of the key challenges include:

- Too many registers that affect data completion, quality as well as service delivery;
- Possibility of double counting such as recording of clients already on ART at the time of conception as being newly initiated on ART;
- Collected data does not fully segregate age-groups in order to capture the adolescents;
- Limited or no data quality assurance initiatives at the health facility level;
- Limited analysis and use of data at health facility level.

VIII. Community Health System

Community Health Workers are constituted by various cadres such as the Rural Health Motivators, Community Expert Clients, Facility Expert Clients, mentor mothers etc. who provide health promotion, psycho-social care and support to clients and their families. The health facility cadres link up with their community counterparts to trace and follow up mothers and infants who have missed appointments. Among the key challenges are:

- Various cadres implement community level activities with possible overlap and duplication of effort;
- Difficulty in motivation of the community cadres and maintenance of the equipment supplied such as bicycles when broken down;
- Stigma and discrimination at community level still fuel provision of wrong information including addresses, by the clients;
- Inadequate documentation of the community activities and limited use of data to inform planning;
- Inadequate support groups for the pregnant and lactating women living with HIV.

CHAPTER 3

CONTEXT FOR THE STRATEGIC PLAN

3.1: Introduction

Eswatini is one of the 22 priority countries of focus for elimination of mother-to-child transmission of HIV. The United Nations developed the standardised protocol and set of impact criteria towards path to elimination of both paediatric HIV infections and congenital syphilis . The Global AIDS Community also developed the framework in 2016 to enable countries to super-fast-track ending of AIDS among children, adolescents and young women, while ensuring that children are born free of HIV and their mothers have access to lifelong antiretroviral therapy.

The National Strategic Plan for Ending AIDS and Syphilis in Children and Adolescents (2018 – 2022) is the response from Kingdom of Eswatini to the global call to give a final push towards elimination of MTCT of HIV and Syphilis. It also provides the framework to end paediatric AIDS and reduce new infections among adolescent girls and young women in the country. This will contribute to the country's vision of ending AIDS by 2022.

3.2: Policy Framework

The development process for the Strategic Plan drew heavily from the extensive consultations conducted during mid-term review of the HIV, PMTCT and TB programes in 2017. It involved support from the implementing partners and consultations with key stakeholders from national and regional levels. It has been designed to consolidate the achievements under the Framework for Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.

At the **international** and **regional** levels, the Strategic Plan builds upon the previous strategies and has been aligned to the following commitments, policies and standards among others:

- Attainment of Sustainable Development Goal 3 to ensure healthy lives and promote well-being at all ages, in particular Goal 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- Start Free, Stay Free, AIDS Free: A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020
- Guidance on global processes and criteria for validation of elimination of mother-to-child transmission of HIV and syphilis as well as related documents on pre-elimination and validation

At the **national** level, the Strategic Plan builds upon, and has been aligned to the following:

- The Extended National Multi-Sectoral HIV and AIDS Framework (eNSF) 2014 – 2018
- National Health Sector Strategic Plan II (NHSSP II) 2014 – 2018
- National Sexual Reproductive Health and Rights Strategic Plan 2014 – 2018
- Eswatini Male Circumcision Strategic and Operational Plan for HIV Prevention 2014 – 2018
- Eswatini Integrated HIV Management Guidelines (2015)
- National Policy Guidelines for Community-Centred Models of ART Service Delivery (CommART) in Eswatini (June 2016)

[2] WHO, 2014. Global Guidance on Criteria and Processes for Validation: Elimination of Mother-to-Child Transmission (EMTCT) of HIV and Syphilis.
[3] UNAIDS, PEPFAR, UNICEF, WHO, EGPAF, 2016: Start Free, Stay Free, AIDS Free.

3.3: Guiding Principles

The Strategic Elimination is consistent with the broader national HIV and AIDS response and is based on the following principles:

i. **Result-Based Management:** Planning, implementation and monitoring of PMTCT interventions at all levels with a focus on achieving stated measurable results or change;
ii. **Family Centred Approach:** Provision of a basic package of MNCH services to the pregnant and breastfeeding woman, her partner and children directly and through efficient referral services in collaboration with partner agencies and the community;
iii. **Gender Equality and Equity:** Enlisting the active participation of men and women to take greater responsibility in reducing the spread of HIV and encouraging stakeholders to address gender inequalities that fuel the HIV epidemic; as well as incorporating gender dimensions in all aspects of HIV programming to reduce gender vulnerability and improving equal access to HIV prevention, treatment and care services, especially amongst the most vulnerable;
iv. **Systems approach and Integration:** Applying a health systems' building approach to strengthen integration and linking of HIV prevention, care and treatment services within maternal, newborn, child health and reproductive health programmes, including community health systems;
v. **Promote Greater Involvement and Empowerment of People living with HIV and AIDS (GIEPA):** Embracing and operationalising the principle of meaningful involvement and participation of PLHIV in the national HIV response at all levels, particularly mentor mothers working at both the facility and community levels;
vi. **Adolescent friendly services:** Catering for, and responding to their unique health needs by recognizing that adolescents are not simply old children or young adults;
vii. **'Three Ones' Principle:** Encouraging all stakeholders to harmonise their operations under a single national (a) coordination authority, (b) strategic framework, and (c) monitoring and evaluation framework;
viii. **Community engagement and participation in, and ownership:** Supporting and empowering the communities, strengthening their systems and ensuring that interventions are community-owned and driven; as well as ensuring adequate stakeholder support, use of existing infrastructure and community solutions, equity and sustainability of interventions;
ix. **Knowledge Management:** Making deliberate efforts for stakeholders to share and learn from each other based on their "hands-on" experiences, the existing and emerging 'best' practices;
x. **Commitment to address regional and international obligations and adherence to international protocols:** Encouraging all stakeholders to take due cognisance of adapted and customised regional and international protocols, ensure compliance and thus contribute towards meeting Eswatini's regional and international commitments.

3.4: Conceptual Framework

As illustrated in Figure 11, the conceptual framework for ending AIDS and syphilis among children, adolescents and young women in Eswatini has been adapted from the "Three-Frees" framework: Start Free, Stay Free and AIDS Free. On the foundation of health systems' strengthening building blocks, there will be a three areas of focus to ensure that children start their lives free of HIV, are supported to stay free of HIV whilst those that are living with HIV are treated to stay free of AIDS and rendered less capable of further transmission.

[4] This section draws on the Guiding Principles for the Extended National Multi-sectoral HIV and AIDS Framework (eNSF) 2014-18
[5] Mothers living with HIV who are trained and employed as part of a medical team to support, educate and empower pregnant women and new mothers about health and their babies' health

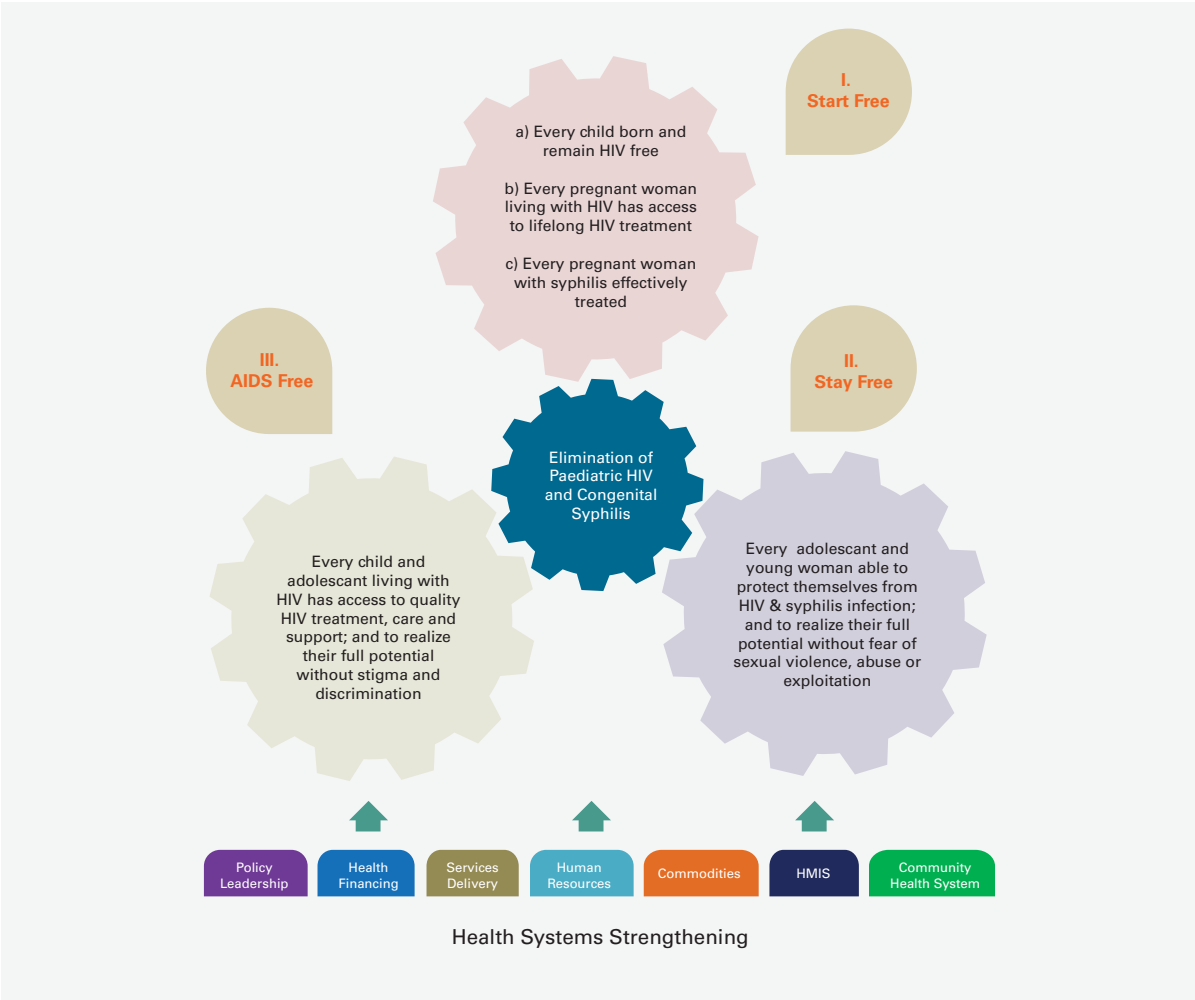

Figure 11: Conceptual Framework for eMTCT of HIV and Syphilis

"Start Free" refers to prevention of new HIV infections among children during pregnancy, birth and throughout the breast-feeding period as well as effective treatment of all identified cases of syphilis. The interventions under this Strategic Plan will primarily contribute towards "Start Free" via the 4 prongs of PMTCT

"Stay Free" refers to the prevention of new HIV infections from among the adolescents and young women as they grow up, especially those who 'started free' as a result of the interventions. Interventions will be primarily based upon the National Multi-sectoral HIV and AIDS Framework and the male circumcision Strategic and Operational Plan for HIV Prevention.

"AIDS Free" refers to the provision of HIV treatment, care and support to children and adolescents living with HIV to attain the target of at least 90% being virologically suppressed and thus contribute towards prevention of further transmission. Interventions will be based on prong IV covered under this Strategic Plan and National HIV Health Sector Strategic Plan (NHHSP).

The results framework has been summarised and illustrated in Figure 12.

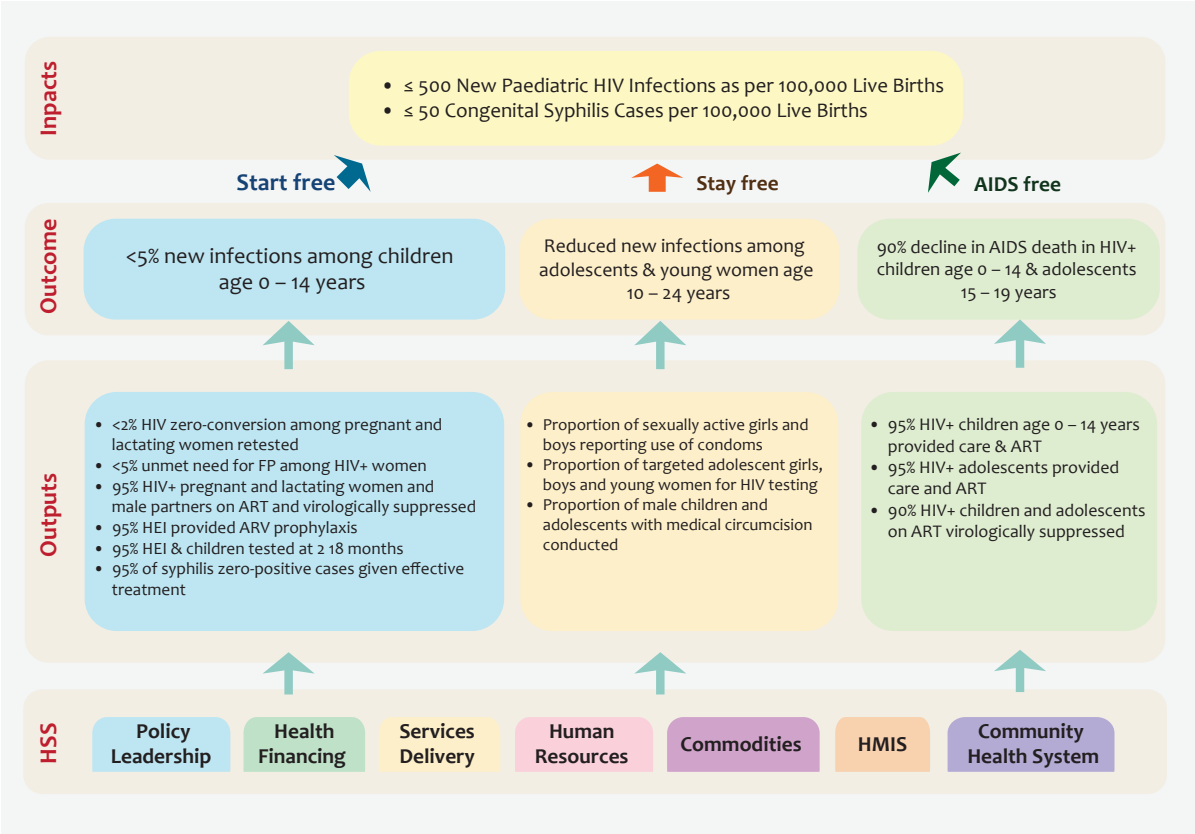

Figure 12: Results Framework for eMTCT of HIV and Syphilis

Note: The results in Figure 12 for "Stay Free" will be aligned to those in the national multi-sectoral HIV and AIDS Framework, and the male circumcision Strategic and Operational Plan for HIV Prevention.

*The silver level of the path to elimination(WHO AFRO, 2017)

CHAPTER 4

THE STRATEGIC FRAMEWORK

4.1: Strategic Vision, Mission and Goal

Strategic Vision

- Eswatini where mothers and their children are free from AIDS and syphilis

Strategic Mission

- To attain less than 500 new paediatric HIV infections, and less than 50 congenital syphilis cases per 100,000 live births, in Eswatini

Strategic Goal

- To eliminate new paediatric syphilis and HIV infections, and keep mothers alive through delivery of integrated continuum of maternal, newborn, child and adolescent health services

4.2: Strategic Objectives

By the year 2022:

1. To reduce transmission rate of HIV infections from mother to child to <5% upon cessation of breast feeding.

2. To contribute towards 50% reduction in AIDS-related death among children and their mothers living with HIV.

4.3: Results Framework

The Results Framework has been summarised and the main components as follows:

KR1 (Start Free): <5% new infections among children

- <1% HIV sero-conversion among pregnant and lactating adolescent girls and women who get re-tested for HIV (Prong I);
- <5% unmet need for family planning among adolescent girls and women living with HIV (Prong II)
- 95% pregnant and lactating adolescent girls and women living with HIV and their male partners initiated and retained on lifelong antiretroviral treatment with virological suppression (Prong III);
- 95% HIV exposed infants provided ARV prophylaxis;
- 95% identified syphilis sero-positive mothers given effective treatment.

KR2 (AIDS Free): Contribute to 50% reduction in AIDS-related deaths among the children living with HIV

- 95% HIV exposed infants (HEI) tested by PCR by age 2 months and have final diagnosis at cessation of breast feeding.
- 95% of HIV positive infants and young children are identified and linked to ART within 4 weeks of diagnosis.

4.4: Main Strategic Areas

The following are the main strategic areas for achieving the above key results;

1) Prevention of new infections among pregnant and lactating adolescents and women;

2) Prevention of unintended pregnancies among adolescents and women living with HIV;

3) Promotion of uptake, adherence and retention to care and antiretroviral treatment for pregnant and lactating adolescents and women;

4) Promotion of access to care, treatment and support for women, children living with HIV and their families;

5) Promotion of diagnosis and effective treatment of syphilis for pregnant adolescents, women and their male partners;

6) Strengthening of the health system capacity for delivery of equitable, high quality HIV-related services to children, adolescents and young women through:

   a. Policy leverage to support provision of HIV related services within the MNCH platform
   b. Leadership and governance in provision of services
   c. Financing for HIV related services
   d. Delivery of equitable and quality services
   e. Human resources for health
   f. Equipment, medicines and supplies security
   g. Health management information system, including the Client Management Information System (CMIS)
   h. Community health system

CHAPTER 5

THE IMPLEMENTATION FRAMEWORK

Strategies	Interventions	Time-Frame (Year)					Responsible
		18	19	20	21	22	
KRA 1: Reduced transmission rate of HIV and syphilis among children							
1.1: Reduce new infections among pregnant and lactating adolescent girls and women	1.1.1: Increase uptake of HIV testing among all pregnant and lactating women and their partners at health facilities	X	X	X	X	X	MoH/SNAP HTS
	1.1.2: Promote innovative condom social marketing and distribution	X	X	X	X	X	MoH/SRH
	1.1.3: Provide HIV prevention package (PREP, PEP, Condoms- dual protection, STI screening and treatment) for HIV negative pregnant and lactating women and partners	X	X	X	X	X	MoH/SNAP/SRH
	1.1.4: Strengthen HIV prevention counselling and support for HIV negative pregnant and lactating women and their partners	X	X	X	X	X	MoH/SRH
	1.1.5: Strengthen re-testing of HIV negative pregnant and lactating women and their partners	X	X	X	X	X	MoH/SRH
	1.1.6: Promote family centred approach including index testing and male partner involvement at health facility and community level targeting households with pregnant and lactating women	X	X	X	X	X	MoH/SRH/SNAP
	1.1.7: Strengthen postnatal care/ follow-up throughout the breast feeding period	X	X	X	X	X	MoH/SRH
1.2: Reduce unintended pregnancies among adolescent girls and women living with HIV	1.2.1: Integrate Family planning services into all HIV service delivery points	X	X	X	X	X	MoH/SRH
	1.2.2: Provide information and counselling in all MNCH service delivery points	X	X	X	X	X	MoH/SRH
	1.2.3: Promote dual protection family planning methods among adolescents and women living with HIV	X	X	X	X	X	MoH/SRH
1.3: Increase ARV uptake, adherence and retention in care for pregnant and lactating adolescent girls, women and HIV exposed infants	1.3.1: Increase uptake of ARV for newly diagnosed pregnant and lactating women through addressing barriers related to disclosure, stigma and poor counselling with special focus on those identified in labour and delivery	X	X	X	X	X	MoH/SNAP/SRH

	1.3.2: Improve adherence to treatment through addressing barriers related to disclosure, stigma and counselling	X	X	X	X	X	MoH/SRH/SNAP
	1.3.3: Strengthen peer support system for HIV positive pregnant and lactating women	X	X	X	X	X	MoH/SRH/SNAP
	1.3.4: Increase community awareness on eMTCT and importance of ARVs for pregnant and lactating women using evidence based	X	X	X	X	X	MoH/SRH/Health promotion
	1.3.5: Increase uptake of ARV prophylaxis for HIV exposed children through integration in MNCH	X	X	X	X	X	MoH/SRH/SNAP
	1.3.6: Increase capacity of health care workers to provide comprehensive PMTCT services	X	X	X	X	X	MoH/SRH
1.4: Increase access to care, treatment and support for women, children living with HIV and their families	1.4.1: Identify and retain breastfeeding women and their infants in the continuum of care	X	X	X	X	X	MoH/SRH
	1.4.2: Increase access to viral load testing and manage appropriately all those failing (not virologically suppressed)	X	X	X	X	X	MoH/SNAP
1.5: Increase access to syphilis testing and treatment	1.5.1: Strengthen syphilis testing and treatment for pregnant women by ensuring uninterrupted supply of syphilis test kits and drugs at all facilities	X	X	X	X	X	MoH/SRH
1.6: strengthen private sector involvement in eMTCT	1.6.1: Advocacy for private health facilities to report on MTCT and syphillis	X	X	X	X	X	MoH/SRH
	1.6.2: Engage private institutions in mobilization for eMTCT	X	X	X	X	X	MoH/SRH
KRA 2: Contribute to 50% reduction in AIDS-related deaths among children living with HIV							
2.1: Increase diagnosis for HIV exposed infants and link to ART	2.1.1: Strengthen EID and re-testing for final diagnosis for HIV exposed children after cessation of breastfeeding or at age 18 months	X	X	X	X	X	MoH/SNAP/SRH
	2.1.2: Strengthen linkages between diagnosis of HIV among children and the initiation of ART within 4 weeks of diagnosis	X	X	X	X	X	MoH/SRH/SNAP

Cross-cutting: Strengthened capacity of the health system for delivery of equitable, high quality HIV-related services							
3.1: Enhanced policy leverage for service provision within the MNCH platform	3.1.1: Review, update and widely disseminate the policy guidelines, including the use of pre-exposure prophylaxis (PREP)	X	X	X	X	X	MoH/SNAP/SRH
	3.1.2: Review, update and disseminate job-aides for eMTCT based on the "three frees"	X	X	X	X	X	MoH/SRH/SNAP
	3.1.3: Advocate for policy change to promote community based distribution of family planning service at community level	X	X	X	X	X	MoH/SRH
3.2: Good leadership and governance in service provision	3.2.1: Strengthen intra-sectoral and inter-sectoral partnerships at national and regional levels for eMTCT of HIV and syphilis	X	X	X	X	X	MoH/SRH
	3.2.2: Conduct joint planning and coordination meetings involving development and implementing partners	X	X	X	X	X	MoH/SRH
	3.2.3: Identify and map key stakeholders including networks of people living with HIV and advocate for accountability from political and civic leaders at central and regional levels	X	X	X	X	X	MoH/SNAP/SRH
3.3: Improved financing for HIV related services	3.3.1: Advocate for increased resource allocation to eMTCT activities at all levels	X	X	X	X	X	MoH/SRH
	3.3.2: Leverage existing financing mechanisms for increased access to MNCH and adolescent health services	X	X	X	X	X	MoH/SRH/SNAP
3.4: Improved delivery of quality services	3.4.1: Promote implementation of integrated HIV and syphilis service delivery models within the MNCH platform	X	X	X	X	X	MoH/SRH
	3.4.2: Engage the private sector and other stakeholders in delivery of quality eMTCT services	X	X	X	X	X	MoH/SRH
3.5: Aligned and competent human resources for health	3.5.1: Build capacity of health care providers for delivery of quality services for eMTCT of HIV and syphilis, including comprehensive family planning	X	X	X	X	X	MoH/SRH
	3.5.2: Conduct mentorship and on-job training for health workers at the implementing health facilities to cover infant ART initiation, identification of children failing 1st and 2nd line ART, Early switching etc.	X	X	X	X	X	MoH/SRH/SNAP

	3.5.3: Strengthen the pre-service curriculum to include all modules of eMTCT of HIV and syphilis	X	X	X	X	X	MoH/SRH
3.6: Improved equipment, medicines and supplies security	3.6.1: Strengthen the eMTCT commodity supply chain including tracking of condoms and other commodities	X	X	X	X	X	MoH/SRH/CMS
	3.6.2: Develop and operationalise contingency plans to address stock outs and equipment maintenance	X	X	X	X	X	MoH/SRH/CMS
	3.6.3: Improve access and turn-around time of lab tests for EID and CD4; Viral Load coverage, and access to genotyping	X	X	X	X	X	MoH/SNAP/Lab
	3.6.4: Upgrade the HIV/Syphilis diagnostic system and delivery of results through adoption of emerging technologies	X	X	X	X	X	MoH/Lab
3.7: Improved health management information system	3.7.1: Review and optimise integration of data systems for eMTCT of HIV and syphilis	X	X	X	X	X	MoH/HMIS/SRH
	3.7.2: Set priority indicators and annual targets to monitor services for children, adolescents and young women at national and regional levels	X	X	X	X	X	SRH, M&E, HMIS
	3.7.3: Conduct bi-annual data review and quality assurance meetings at regional level to improve utilization	X	X	X	X	X	SRH, SNAP
	3.7.4: Promote the use of ICT in data management	X	X	X	X	X	HMIS/M & E
	3.7.5: Strengthen the data systems to segregate and monitor indicators for both children and adolescents	X	X	X	X	X	HMIS/M & E/SRH
	3.7.6: Conduct operational and implementation research to inform decision-making	X	X	X	X	X	SRH/SI
3.8: Functional community health system	3.8.1: Review and update the communication strategy in line with the "three frees" framework	X	X	X	X	X	SRH/Health Promotion/NERCHA
	3.8.2: Promote effective advocacy interventions among community leaders and social and behavioural change interventions for eMTCT	X	X	X	X	X	SRH/Health Promotion/NERCHA/SNAP
	3.8.3: Build capacity of community health volunteers in relation to eMTCT of HIV and syphilis and strengthen partnerships with communities of women living with HIV to reduce stigma	X	X	X	X	X	SRH/Health Promotion/NERCHA/SNAP
	3.8.4: Strengthen outreach, referrals and linkage systems for eMTCT of HIV and syphilis	X	X	X	X	X	SRH/Health Promotion/NERCHA/SNAP
	3.8.5: Promote the use of e-health and m-health interventions in communication to adolescents and young people	X	X	X	X	X	SRH/Health Promotion/NERCHA/SNAP

CHAPTER 6

MONITORING AND EVALUATION FRAMEWORK

6.1: Introduction

The Strategic Plan for Preventing HIV and Syphilis in Eswatini will be the basis for development of detailed Annual Work Plans to guide implementation and provision of quality services all levels. It will be critical to continually track implementation of the annual plans using a standard integrated tool, in order to determine whether the results are aligned to the outcomes spelt out within this Strategy. Attainment of the results outlined in the implementation framework will require the contributions and collaboration from various stakeholders from the public sector, development and implementing partners, the civil society and private sector. It will also require inputs from the different levels of health care delivery system from national, regional to the sub-regional level. An agreed upon monitoring and evaluation framework will serve as the basis for all stakeholders and partners to measure achievements, identify gaps and trigger the corrective actions as appropriately as possible.

The Monitoring and Evaluation Framework has been structured to include the core set of indicators for monitoring progress towards the elimination targets. It includes process indicators to support monitoring the programme and situation-specific progress, which informs decision-making at the implementation level. The Ministry of Health will track indicators through the available Health Management Information System (HMIS) from which quarterly reports will be generated for dissemination during scheduled meetings and other related fora.

The development of this Monitoring and Evaluation Framework was through a highly participatory process with stakeholder input in its design and during the prioritisation of interventions.

6.2: Objectives of the M&E Framework

The main objectives of the Monitoring and Evaluation Framework for the Strategic Plan are as follows:

1) To provide the basis for the development of the data and information flow mechanism, indicators of progress and tools for data collection;
2) To guide all stakeholders in measuring the progress on implementation of interventions towards validation of the elimination of HIV and syphilis in the country and
3) To guide the continuous tracking of the PMTCT programme in terms of inputs, outputs, outcomes and impact.

6.3: Core Indicators for the M&E Framework

The core indicators have been selected to measure the impact and outcomes at national and regional levels. Sources of data will include the routine Health Management Information System, and the special studies and surveys such as: Demographic Health Survey (DHS), Multiple Indicator Cluster Survey (MICS) Services Availability Mapping (SAM) etc.

6.3.1: Indicators for Measuring Impact and Outcomes

The main indicators for measuring the impact and outcomes of this Strategy are summarised in Table 3.

Table 3: The Impact and Outcome Indicators

Impact indicators			End-term
1) Case rate of new paediatric HIV infections due to mother-to-child transmission (MTCT) of HIV cases per 100 000 live births;			≤500
2) MTCT rate of HIV in breastfeeding population			<5%
3) Case rate of congenital syphilis (cases per 100 000 live births)			≤50
Outcome indicators	**Baseline (2017 SRH annual report)**	**Mid-term (2020)**	**End-term (2022)**
i. Antenatal care (ANC) coverage (at least one visit)	95%	95%	≥ 95%
ii. Coverage of pregnant women who know their HIV status	96%	90%	≥ 95%
iii. Antiretroviral (ARV) coverage of HIV-positive pregnant women	93%	90%	≥ 95%
iv. Coverage of syphilis testing of pregnant women	97%	90%	≥ 95%
v. Treatment of syphilis-seropositive pregnant women	84%	90%	≥ 95%

*84% of all estimated HIV positive pregnant women but 93% of those who attended ANC

6.3.2: Indicators for Monitoring Progress at National Level

The routine health management information system will track outputs that include availability and uptake of HIV and syphilis-related services utilising the indicators summarised in Table 4.

Table 4: Indicators for Monitoring HIV and Syphilis Programs

Output indicators	Baseline (2017)	Mid-term (2020)	End-term (2022)
i. Number and percentage of health facilities providing ANC services (out of HF providing Family Health services)	227 (79%) SAM 2013		
ii. Number and percentage of health facilities providing ANC services that also provide LLAPLa	162 (88%) SAM 2013	100%	100%
iii. Number and percentage of health facilities that offer paediatric ART	85%	>95%	>95%
iv. Percentage of health facilities that reported to provide virological testing services (e.g. PCR) for diagnosis of HIV in infants on site or from dried blood spots (DBS)		>95%	>95%
v. ANC 1: Percentage of pregnant women visiting ANC clinic at least once	95%	95%	95%
vi. ANC 4: Percentage of pregnant women visiting ANC clinic at least four times	29%	50%	80%
vii. Percentage of pregnant women with early first ANC visit (within 16 weeks of gestation)	29%	50%	80%

Syphilis Indicators			
i. Percentage of ANC attendees tested for syphilis at least once	97%	100%	100%
ii. Percentage of ANC attendees tested for syphilis at first visit	97%	100%	100%
iii. Percentage of ANC attendees seropositive for syphilis	2.0%	1.8%	1.5%
iv. Percentage of syphilis-seropositive ANC attendees who receive adequate treatment	84%	>95%	>95%
v. Of infants born to syphilis-seropositive women, the percentage who receive adequate treatment	No data	TBD	TBD
vi. Percentage of ANC clinics routinely testing for syphilis	100%	100%	100%
vii. Percentage of clinics that have experienced a stock-out of syphilis testing materials in the last 6 months	NA	<5%	<5%
viii. Percentage of clinics that have experienced a stock-out of benzathine penicillin in the last 6 months	NA	<5%	<5%
HIV Programme Indicators			
i. Unmet need for family planning (all HIV positive and negative women) 15 – 49 years	15%	<10%	<5%
ii. Unmet need for family planning (HIV-positive women) 15 – 49 years	No data	TBD	TBD
iii. Percentage of pregnant women who know their HIV status	96%	>95%	>95%
iv. Seroconversion during pregnancy and post-partum period	1.6%	1.3%	<1%
v. Percentage of HIV-positive pregnant women who received LLAPLa	93%	95%	95%
vi. Percentage of infants born to HIV-positive women receiving ARV prophylaxis for prevention of MTCT in the first 6 weeks	88%	95%	95%
vii. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	96%	95%	95%
viii. Percentage of infants born to HIV-positive women started on co-trimoxazole prophylaxis within 2 months of birth	96%	>95%	>95
ix. Proportion of HIV exposed infants getting tested at 18 months	NA	80%	95%
x. Percentage of pregnant women and breastfeeding women known to be alive and on treatment 12 months after ART initiation	No data	80%	95%

6.4: The Evaluation Framework

The interventions under this Strategy will be evaluated based on an agreed set of indicators, both qualitative and quantitative. Under this evaluation framework, two main types of evaluations will be undertaken:

1. Mid-term evaluation of the Strategic Plan at the end of 2020
2. Final Evaluation of the Strategic Plan at the end of 2022

Whereas the implementing and development partners shall be actively involved, the evaluative studies will be conducted by external and independent agencies such that the process is free from bias and ensures objective as well as credible results. The objectives of the evaluation studies will focus on: accountability, learning and taking stock of results achieved. The national level Steering Committee linked to the Directorate shall have the overall responsibility of commissioning the evaluative studies.

6.4.1: Mid Term Evaluation of the Strategic Plan

The primary purpose of the mid-term evaluation will be to assess the progress made in implementation on the path towards elimination of mother-to-child transmission of HIV and syphilis in the country. The activity will provide the opportunity for recommending consolidation, modification or revision where needed, to the direction and focus of the interventions. It will also provide opportunity to revisit the goal and objectives if the circumstances so dictate. The following are examples of questions that will guide the mid-term review, which can be adjusted based on the need.

- Are there signs of advances towards the outcomes?
- What challenges are causing delays?
- What has changed in the contextual framework?
- Are there new opportunities?
- How can the challenges be overcome?
- Is it feasible to attain the ultimate results with the available resources and the existing context?

6.4.2: End of Term Evaluation of the Strategic Plan

Evaluation generates knowledge about the magnitude and determinants of programme performances, provides information about what worked well and what did not, and why. It also provides information on whether underlying programming theories and approaches used were valid. The end of term evaluation of the Strategic Plan will promote learning and accountability, providing the opportunity to, among others:

1) Measure the effectiveness, relevance, efficiency, and sustainability of the PMTCT programme;
2) Utilise the findings to guide the decision-makers in resource allocation and replication of successful strategies;
3) Share experience from the implementation with partners from the sub-Saharan Africa region as well as at the global level.

Roles and Responsibilities	
Ministry of Health	Oversee and facilitate the implementation of the eMTCT agenda
SRH/M & E	Regular review meetings at national and regional levels to monitor progress in implementation of the eMTCT framework Define and implement a monitoring system for mechanism that periodically updates the progress of the regions in meeting the validation targets Streamline and strengthen supply chain management of HIV/PMTCT commodities, laboratory support Inclusion of eMTCT as auditable public health event
eMTCT National Validation Committee	Spearhead the process of eMTCT validation in the country in line with global standards and benchmarks Consensus of proxy indicators for each of the focus areas to monitor progress and a subsequent M &E plan in line with path to validation
PMTCT Technical Working Group- National	Function as technical resource for strategic implementation for PMCT in Eswatini aiming at nationwide scale up PMCT in linkage to HIV prevention among parents including young people and strengthen follow up care and support of children affected by HIV and contribute to the achievement of eMTCT agenda. Sharing of good practices and lesson learnt especially uptake of PMTCT, referral management, decentralized actions, including greater community and PLHIV involvement; innovative means for community mobilization, male involvement, retention and paediatric HIV treatment Provide technical assistance for operationalization of PMCT technical updates, global policies and guidelines and application to country context. Monitor progress towards path to elimination of MTCT of HIV and Syphillis Periodically discuss data and apply use of national and regional dashboards focusing on validation indicators
Community health programme, Health Promotion, CBOs, NERCHA, SNAP	Institutionalize the Mentor Mothers approach in the community health programme Standardize and harmonize messaging and the scope of work for CHWs and other lay cadres, including link to facilities and inclusion of NGOs/CBOs to support PMTCT. Build capacity of networks of PLHIV to provide education, advocacy, and social mobilization to increase demand and retention to MCH and PMTCT services Strengthen outreach, referrals, and linkage systems to involve all community actors.
NERCHA/SNAP	Resource mobilization Advocacy Monitoring of the implementation
Private Sector	Funding Innovation Community data systems strengthening Strengthening supply chain and commodity management
Developmental Partners	Provide Technical oversight to the eMTCT agenda Financial support to the eMTCT activities Monitoring and evaluation of the eMTCT agenda

CHAPTER 7

BIBLIOGRAPHY

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