Adapting for Impact: Funding Shifts and HIV Program Realignment in Eswatini

KINGDOM OF ESWATINI | MINISTRY OF HEALTH

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BACKGROUND

Maintaining Momentum

- Despite major disruptions, Eswatini sustained progress toward 95–95–95, reaching ***98–98.5–98.4*** in 2024
- Gains were threatened by service interruptions, decreased case finding and delayed data availability

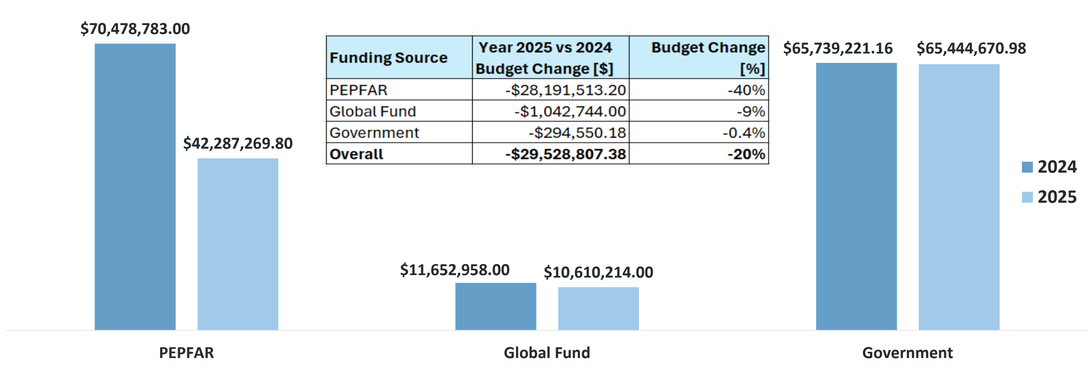
Programmatic Impact & Response

- ART coverage and viral load suppression declined by ~2% during the period Jan – Mar 2025
- Outreach for key populations halted during the Stop Work Order (SWO) period
- ~900 partner-funded staff were laid off; the HRH Strategy and reverse task shifting ensured continuity of HIV services
- The Human Resource Register under the National AIDS Program is being revised to reflect the new staffing structure

Service Delivery and Systems Adaptations

- Health information systems faced data delays and verification gaps; the MoH is strengthening data capture, reporting, and analysis
- A Quality of Care (QoC) tool is under development to enhance service standards
- Laboratory services were disrupted (30% of staff USG-funded; >50% in VL labs)
- Government assumed ARV procurement from FY27, rolled out eLMIS, and began transforming Central Medical Stores into an autonomous entity

Figure 1: Eswatini's HIV Funding Landscape FY 2024 and 2025



Funding Source	Year 2025 vs 2024 Budget Change [$]	Budget Change [%]
PEPFAR	-$28,191,513.20	-40%
Global Fund	-$1,042,744.00	-9%
Government	-$294,550.18	-0.4%
Overall	**-$29,528,807.38**	**-20%**

ADAPTIVE APPROACHES TO RESOURCE CONSTRAINTS

Issue	Mitigation Strategy	Examples
Eswatini faces major cuts of approximately, $58 million	Eswatini utilized the scenario analysis and the CQUIN-Modified TIER Tool to prioritize HIV services	• Government procured 2nd and 3rd line paediatric HIV commodities. • Implemented the Integrated Financial Management Information System (IFMIS) and developed a donor coordination mechanism and tracking system. • Deprioritizing Costly HIV outreach services for instance KP drop-in centres closed, services moved to health facilities. ART Streamlining; moving stable clients towards Multi-Month Dispensing (MMD) with only one clinical visit per year. There was no prevention services were deprioritized in either funding scenario and routine home tracing for abnormal labs or missed appointments (>28 days).
HRH loss, which led to compromised service delivery	The Human Resource Information System was utilized and the Human resource register (establishment register) under ENAP was reviewed.	• Reverse task shifting of HIV testing services from verticalized donor supported staff to facility nurses.
Poor coordinated MoH systems	Strengthening MoH ownership of the HIV program through policy reviews like updating the Medical Act, Public Health Act, Pharmaceutical Policy, and Procurement Policy to support MoH ownership.	• Refining and piloting the HIV Quality of Care tool to standardize MoH assessment tools. • Scaling-up the Integrated Chronic Disease Management (ICDM) framework • ENAP oversees policy formulation, guideline development, clinical science, research, monitoring, evaluation, and quality assurance
Fragmented community structures	Community engagement is being restructured to focused and targeted activities.	• There was transformation of Rural Health Motivators (RHMs) to Community-Based Health Promoters (CBHP), and the launch of the Community-Based Information System (CBHIS). • Promoting digital platforms for demand creation, treatment literacy, and client follow-up. Enabling Service & System Adaptations
Vertical HIV system	Government mainstreaming vertical systems back into national structures	Supply Chain & Data Systems: • Government taking up all HIV commodities and lab supplies procurement. • Implementing the electronic Logistics management Information System (eLMIS) and transforming Central Medical Stores to an autonomous entity. • Enhancing EMR capacity, piloting inpatient HMIS, reviewing HIV modules, and implementing the DHIS 2 dashboard

NATIONAL PRIORITIZED PREVENTION, TESTING, AND TREATMENT SERVICES

Figure 2: Services Prioritization Outputs

PREVENTION SERVICES		
Component	**Intervention**	**Eswatini**
Infant prophylaxis	Infant PEP HR 0–6w	
	Infant PEP HR 6–12w	
	Infant PEP LR	
PEP	Facility PEP (guidelines)	
	Community PEP (GBV/KP)	
Condoms	Facility condoms/lube	
	KP condom points	
	Community condom points	
PrEP continuation	Facility PrEP KP 3MMD/6m	
	Facility PrEP PBFW 3MMD/6m	
	Facility PrEP others 3MMD/6m	
	Annual PrEP review	
	PrEP review 6-monthly	
	Facility PrEP DSD-indiv	
	Out-facility PrEP DSD	
	Virtual PrEP refills	
	Adherence/risk counselling	
	Continue DVR PrEP	
	Continue LAI PrEP	
PrEP initiation (& re-initiation)	Start PrEP PBFW self-ID	
	Start PrEP PBFW at-risk	
	Start PrEP KP	
	Start PrEP AGYW self-ID	
	Start PrEP others self-ID	
	Test post-start 1–3m	
	PrEP demand creation	
	Continue DVR PrEP	
	Continue LAI PrEP	
	PrEP start education	
Harm reduction for people who inject drugs	Facility-first NSP+naloxone	
	Community NSP+naloxone	
	Continue OAMT refills (PWID)	
	Initiate/continue OAMT (PWID)	
VMMC	Targeted VMMC scale-up	

TESTING SERVICES		
Component	**Intervention**	**Eswatini**
Blood products	Blood product screening	
Facility-based	Symptomatic testing (entry)	
	ANC first test	
	ANC late retest	
	Postnatal PBFW 6-monthly	
	HEI 6w/6-9-18m EPI	
	HEI birth test	
	TB clients (newly diagnosed)	
	TB clients (presumptive TB)	
	STI clients (new STI)	
	Hep B/C (new)	
	Inpatient (new admission)	
	Children in malnutrition clinics	
	EPI child post-screen	
	FP initiation clients	
	FP <25 init+annual	
	FP init+biennial+change	
	FP init+annual	
	Self-initiated HIVST (annual)	
	VCT/HIVST any frequency	
	PrEP users 1m+6m	
	PrEP users 1m+3m	
	VMMC clients	
Network-based (including facility/virtual and community-based)	PN EPN +HIVST/FBT	
	PN APN +FBT (virtual)	
	PN APN +community test	
	Female index: child FBT/HIVST	
	Female index: child CBT	
	PN EPN +HIVST (VL>1000)	
	PN EPN +HIVST FP/ANC<25	
	PN EPN +HIVST (FP/ANC)	
	KP SNT +HIVST	
	AGYW SNT +HIVST	
	PN EPN +HIVST (95s STI-neg)	
	PN EPN +HIVST (STI-neg)	
	PN APN +FBT (STI-neg)	

TESTING SERVICES		
Component	**Intervention**	**Eswatini**
Community-based (virtual and in-person)	CB HIVST points >15	
	CB HIVST points 95-gap	
	CB HIVST points KP	
	HIVST digital outreach	
	KP high-volume outreach	
	KP all outreach sites	
	AGYW targeted outreach	
	Men targeted outreach	
	Men workplace testing	
	Children targeted outreach	
	Prisoners: On entry/discharge	
	Prisoners' entry/annual	
	ABYM targeted outreach	
Recency testing	Recency testing	

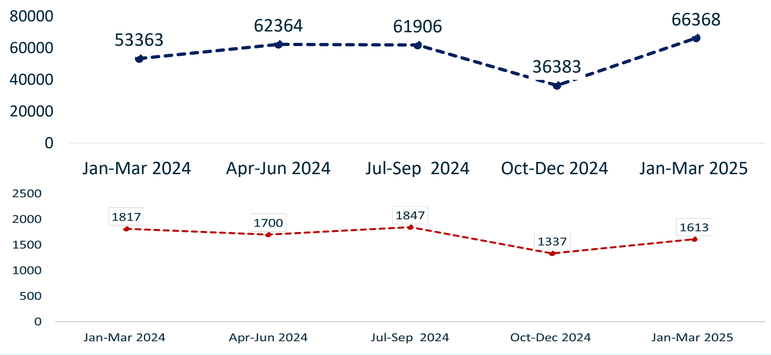
	Keep (No Change)
	Keep (Modify)
	Drop
	Not applicable
	Not Prioritized

TREATMENT SERVICES		
Component	**Intervention**	**Eswatini**
ART continuity	Uninterrupted ART for all	
	MMD 3–6 months	
	Annual clinical review	
	Enroll less-intensive DSD	
	Maintain facility DSD-indiv	
	Maintain community DSD-indiv KP	
	Maintain client-managed groups	
	Maintain adolescent groups (HCW)	
	Maintain community DSD-indiv	
	Maintain DSD groups (HCW)	
	Active transfer same-day 3MMD	
Continuity OI prophylaxis	CTX adults S3/4/CD4<350	
	CTX adults high-risk	
	CTX for HIV/TB	
	CTX for CLHIV	
	CTX for HEI	
	Fluconazole secondary proph	
ART initiation (and re-initiation)	Initiate <5 years	
	Initiate PBFW	
	Initiate symptomatic/AHD	
	Initiate all positives	
	Initiate stage3/4 or CD4 low	
	Initiate stage1/2 (CD4 high)	
Viral load monitoring	VL for suspected failure	
	Repeat VL at 3m	
	First VL by 6m	
	First VL (no prior)	
	Pregnant: VL at ANC/3m	
	Pregnant: VL 34–36w	
	Breastfeeding: VL 3m+6mly	
	LLV: repeat VL 3m	
	VL annually if suppressed	
	VL q2–3y post-2x	
	Resistance test per guidelines	

TREATMENT SERVICES		
Component	**Intervention**	**Eswatini**
OI management	TB Xpert for symptomatic	
	TB treatment	
	TPT per regimen	
	CRAG for symptomatic	
	Cryptococcal treatment	
AHD package	LAM S3/4 seriously ill	
	CRAG S3/4 IPD	
	CD4 S3/4 new or >90d	
	CD4 S1/2 new or >90d	
	LAM S1/2 CD4<200	
	CRAG S1/2 CD4<200	
	Fluconazole pre-emptive	
Integration	PAP smear never-screened	
	HPV screen never-screened	
	Hypertension integration	
	Diabetes integration	
	Family planning integration	
	VIAC annually WLHIV	
Tracking and tracing	Confirm contacts each visit	
	Phone trace abnormal labs	
	Phone trace high-risk	
	Phone trace >28d missed	
	Home trace abnormal labs	
	Home trace high-risk	
	Home trace >28d missed	
Psychosocial support/ Counseling	ART start literacy	
	Adherence assessment visits	
	VL and DSD prep	
	EAC for high VL	
	Child disclosure support	
	MH screening at start	
	MH screening high VL	
	MH screening all visits	

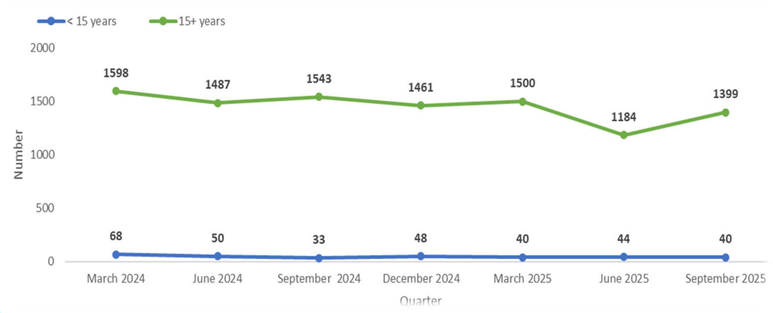
HIV SERVICE DELIVERY INDICATORS: TREND OVER TIME, 2024-2025

Figure 3: HIV Testing and Positivity Trends



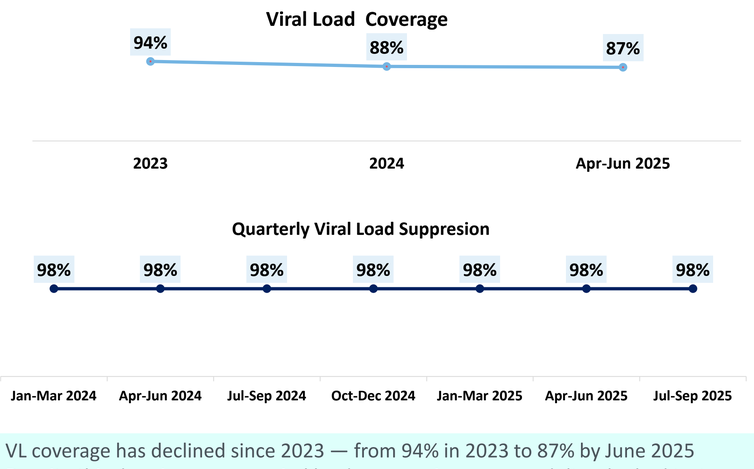
- Reduced Testing (Oct–Dec 2024): Decline due to stock-outs of testing reagents
- Testing Modalities: HIV self-testing used for OPD screening (increasing overall testing); RDTs reserved for selected populations and confirmatory testing
- Decline in HIV-Positive Cases: Reflects progress toward 95–95–95 targets, making new case identification more challenging
- Service Disruptions: SWO limited outreach and priority population testing, reducing overall HIV testing

Figure 4: ART Initiation Trend



- The graph shows a gradual decline in ART initiations over time, reflecting the success of PMTCT interventions in reducing new HIV infections
- Fewer new HIV cases have resulted in a corresponding drop in ART initiation rates across quarters
- During the Stop Work Order period, service disruptions further affected ART initiation and overall service delivery

Figure 5: VL Coverage and Suppression Trends



- VL coverage has declined since 2023 — from 94% in 2023 to 87% by June 2025
- Despite this drop in coverage, viral load suppression among adults who had tests conducted and results received remained consistently high at 98% across all quarters
- This stability in suppression rates persisted despite service interruptions, reflecting strong treatment adherence and program resilience

SYSTEMS & SERVICES ADAPTATIONS

System/Service Area	Longer-Term Adaptations and Strategies
Governance or Policy Shifts in Support of Program Continuity	❑Policies were updated to support the ownership and management of overall health services. ❑The ENAP Operational Framework was drafted to establish a structured leadership and governance model, guiding institutional arrangements and improving leadership structures to ensure effective oversight and long-term sustainability planning. ❑Developing and finalizing performance standards, updated guidelines, SOPs and data tools to enhance the quality and efficiency of HIV service delivery and strengthen monitoring mechanisms.
Financing and Purchasing: Adapting long-term financing mechanisms	❑The government is taking up the responsibility for the procurement of all HIV commodities and laboratory supplies, including 2nd and 3rd line Paediatric HIV commodities.
Service Delivery Optimization/Redesign of Service Delivery	❑Maintaining individual DSD models based at facilities, client-managed groups, and adolescent groups managed by healthcare workers, while deprioritizing community DSD models managed by healthcare workers or those not based at facilities
Community Engagement	❑Transformation of Regional Health Management Teams (RHMs) to Community-Based Health Programs (CBHP), including the launching of the Community-Based Health Information System (CBHIS).
Data Governance Across M&E Systems	❑Digital Health Rollout: Promoting the use of digital platforms for demand creation, treatment literacy, and client follow-up, specifically planning to adopt the newly developed NOTSA Health digital application for recipients of care (provides general health information and allows appointment scheduling) and linking it to the Client Management Information System (CMIS) for scheduling visits.
HRH Adaptations: Structural changes to optimize workforce	❑Implemented a Human Resource Information System (HRIS) and conducted a review of the Human Resource Register to review posts under ENAP.
Laboratory systems & Pharmaceutical systems	❑Implementation of the Electronic Logistics Management Information System (eLMIS) and transformation of the Central Medical Stores into an autonomous entity. ❑Continuing to support the National Molecular Reference Laboratory in developing its capacity for in-country HIVDR testing.

NEXT STEPS/WAY FORWARD

- ❑ Align Global Fund (GC7) realignment planning with HIV program priorities to guide resource allocation and implementation timelines.
- ❑ Reallocate resources to high-impact interventions to maximize impact and sustainability.
- ❑ Share prioritization results with key stakeholders and civil society for technical and strategic alignment.
- ❑ Implement training, supervision, and demand creation strategies aligned with national priorities and target population needs.
- ❑ Advocate for the absorption of laid-off program staff into the government system to retain capacity and ensure service continuity.
- ❑ Repeat the prioritization exercise as needed to stay responsive to evolving data and funding landscapes.