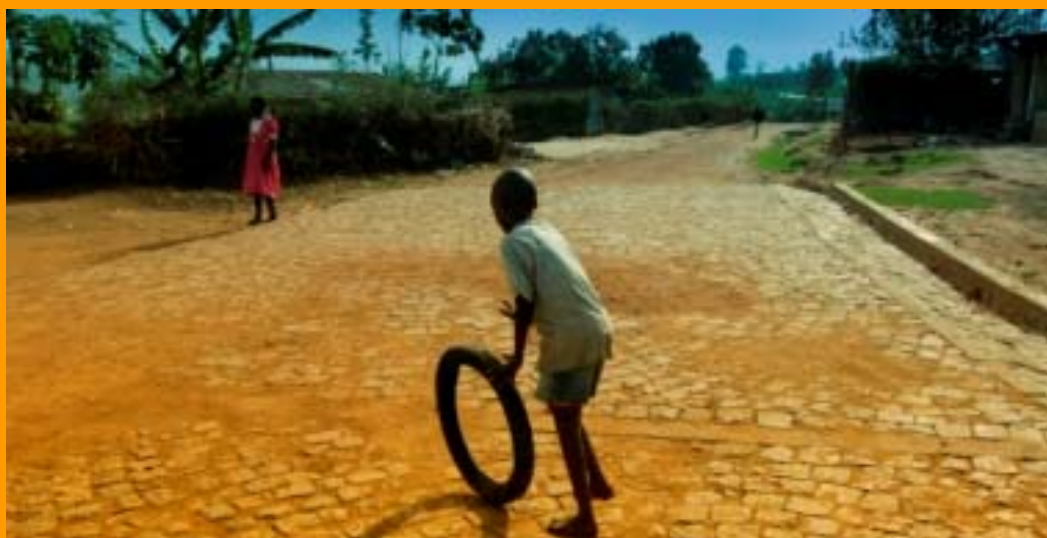




The Road towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support



Swaziland Report

November 2007

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Preface

Following the General Assembly's commitment to scale up HIV interventions in the World Summit attended by His Majesty King Mswati III in October 2005, Swaziland engaged in a consultative process of drafting a set of targets and recommendations towards universal access. The first national consultative forum was held in January 2006, and its aim was to set ambitious targets around scale up of prevention, treatment, care and support for the national HIV response to be achieved by 2008 and 2010 using UNAIDS Universal Access guidelines.

A follow up meeting was held in November 2006 and the process of setting ambitious targets through a consultative exercise of document reviews, key informants interviews and a broad stakeholder workshop commenced. This process was informed and guided by the second National Multisectoral HIV Strategic Plan (NSP), which is the backbone of the HIV response in Swaziland.

The target setting exercise focused on the Universal Access seven core indicators for the years 2008 and 2010 and it states the underlying assumptions required to realise the targets set and makes key recommendations particularly revisiting existing strategies and policies in order to achieve the set targets. Highlights coming from the report touch on improving capacity of service providers particularly the Health Sector so as to provide a holistic response to the epidemic. Also of importance is the strengthening of monitoring and evaluation efforts need to be strengthened to ensure quality reporting on the road towards universal access. The document highlights the obstacles that have emerged from implementation, and provides innovative responses for scale up.

The finalisation of the Universal Access report is a significant milestone as it gives evidence of the country's commitment to scaling up HIV interventions. The next steps following the release of the document entail reviewing of the National HIV Strategic Plan following an annual joint programme review and incorporating the Universal Access recommendations. Further, this exercise is also intended to promote greater partner alignment to the national HIV priorities, strengthen accountability and facilitate efforts by the Government of Swaziland and international partners to mobilise international support and resources.

Prime Minister

Mr Absalom Themba Dlamini

Acknowledgements

The National Emergency Response Council on HIV and AIDS (NERCHA) takes this opportunity to extend its sincere gratitude to all partners and stakeholders who have contributed to the process of setting the Universal Access targets which culminated in the writing of this report. Special appreciation to UNAIDS for providing both financial and technical support and the Ministry of Health and Social Welfare for providing the information that formed the basis of setting the targets and recommendations. Most importantly, gratitude is conveyed to the M & E Technical Working Group and the entire core team for their diligence, dedication and tireless efforts in ensuring that the work is completed in an acceptable manner. Last but not least, appreciation is extended to all the key informants and consultants for their individual and collective contributions made to this report.

NERCHA Director

Derek von Wissell

Executive Summary

The HIV epidemic in Swaziland has worsened over the years, making Swaziland the worst-affected by HIV/AIDS. The current prevalence among the reproductive age group 15-49 stands at 26 percent while prevalence among pregnant women attending ANC has risen from 3.9 percent in 1992 to 39.2 in 2006. Gender inequalities, low condom use, intergenerational sex, low HIV testing and disclosure, high levels of stigma and discrimination and multiple concurrent sexual partnerships have been identified as the key drivers of the epidemic. These are further exacerbated by high poverty levels as well as drought.

Swaziland's HIV programme dates back to 1986 following the detection of the first AIDS cases, which resulted in the formation of the AIDS Task Force. The Task force later transformed into the current Swaziland National AIDS Programme (SNAP) within the Ministry of Health and Social Welfare (MoHSW). Following His Majesty King Mswati III declaring HIV a national disaster in 1999, the crisis Management and Technical Committee was formed. With increased recognition of the multi dimensional aspects of HIV both globally and nationally, the Committee was replaced by the National Emergency Council on HIV and AIDS (NERCHA).

The Universal Access target setting process emanated from the 17th. Meeting of the UNAIDS Programme Coordinating Board (PCB) and the Gleneagles Summit where the G8 and other donors secured international commitment to universal access to HIV treatment, care and support by 2010. This was further reiterated at the UN General Assembly in September 2005 when the UN committed to scale comprehensive AIDS responses at the World Summit.

This report presents the 7 core indicators and targets for Universal Access in Swaziland and details some of the most pertinent challenges and opportunities, and recommendations regarding each target. The process of setting targets at the country level has been participatory and all inclusive and has entailed key informant interviews, national stakeholder workshops, desk review and validation work by a core group tasked to manage the process. The findings of this lengthy process are summarised in the table below.

In setting these targets, the country acknowledges that certain pertinent challenges and bottlenecks must be addressed if scale up is to be realised in all programme areas. These challenges include human resource constraints within the MOH&SW; lack of a strategy to reduce stigma and discrimination; unsustainable funding mechanisms; weak M&E; laboratory capacity; and leadership and coordination challenges.

Several strategic recommendations necessary for reaching the targets are articulated in this report. These include the development of a human resource plan for the MOH&SW; development of a strategy to counter stigma and discrimination; finalisation of the condom strategy; finalisation of the patient and drug management system; finalisation of the national blood policy and strategy; mobilisation of resources to operationalise the laboratory strategy and strengthening systems for data collection with emphasis on data use.

Universal Access Indicators and Targets for Swaziland				
Core Indicator Number	Indicator	2006 Baseline	2008 Interim Target	2010 Target
1. ART	<p>1. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy (ART) in the last 12 months.</p> <ul style="list-style-type: none"> Disaggregated by adult/child and sex 	35%	50%	60%
2. OVC	<p>2. Percentage of orphans and vulnerable children (OVCs) aged under 18 living in households where a basic external support package has been received in the last 12 months.</p> <ul style="list-style-type: none"> Disaggregated by sex 	41%	51%	61%
3. PMTCT	<p>3. Percentage of HIV-positive pregnant women receiving a course of antiretroviral (ARV) prophylaxis to reduce mother-to-child transmission (MTCT) in accordance with nationally approved protocol in the last 12 months</p>	62%	73%	80%
4. HTC	<p>4. Percentage of the general population receiving an HIV test results, and post-test counselling (in the last 12 months)</p> <ul style="list-style-type: none"> Disaggregate by sex 	15%	40%	50%
5. Condoms	<p>5. Number of male and female condoms distributed annually by the public and the private sector</p> <ul style="list-style-type: none"> Disaggregated by male/female condom, region, and public/private sector 	5.8 million condoms	10 million condoms	12 million condoms
6. Sex Before the Age of 15	<p>6. Percentage of young people aged 15 to 24 who had sex before age 15</p>	<p>7% females</p> <p>5% males</p>	<p>5% females</p> <p>4% males</p>	<p>3% females</p> <p>3% males</p>
7. Funding	<p>7. Percentage of national expenditure spent on health per year?</p>	6-7%	8%	15%

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
DBS	Dried Blood Spots
DHS	Demographic Health Survey
FLAS	Family Life Association of Swaziland
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MoHSW	Ministry of Health and Social Welfare
MTCT	Mother-to-Child Transmission
NERCHA	National Emergency Response Council on HIV and AIDS
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PLHA	People Living with HIV and AIDS
PLO	Programme Logistics Officer
PMTCT	Prevention of Mother-to-Child Transmission
RDO	Regional Distribution Officer
RHMS	Rural Health Motivators
SIPAA	Support for International Partnership against AIDS in Africa
SNAP	Swaziland National AIDS Program
SRH	Sexual and Reproductive Health
SYNC	Swaziland National Youth Council
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1. INTRODUCTION

1.1 Background

Swaziland is a small, landlocked country with a population of approximately one million people, the majority of whom are young. The population is comprised of 53% women and 47% men, with 44% of the population being under 15 years and 46% in the 15-49 year age group.

Economically, Swaziland has been classified as a middle-income country with an estimated GDP of USD 1,660 in 2004. Furthermore, the country has experienced declining levels of economic growth combined with increased public expenditure and a growing budget deficit. A significant proportion (56.4%) of the country's wealth is controlled by a mere 20% of the population, while 69% of the population is categorised as living below the poverty line.

The HIV epidemic in Swaziland has worsened over the years, making Swaziland one of the countries worst-affected by HIV/AIDS. The prevalence of HIV among pregnant women rose from 3.9% in 1992 to 42.9% in 2004 (Sentinel Surveillance Report 2006). However, a slight drop to 39.2% was observed in 2006.

The drivers of the epidemic in Swaziland have been identified as multiple concurrent partnerships, intergenerational sex, low condom use, low HIV testing and disclosure levels, and high prevalence of sexually transmitted infections. The socioeconomic effects of the epidemic at both individual and community level have been devastating.

The initial AIDS Task Force formed after the first documented case of HIV was documented in Swaziland in 1986, has developed into the Swaziland National AIDS Programme (SNAP) within the Ministry of Health and Social Welfare (MoHSW). In 1999, the Crisis Management and Technical Committee was created after His Majesty King Mswati III focused attention on the HIV/AIDS epidemic and declaring it as a national disaster. The National Strategic Plan (NSP) for 2000-2005 was developed under this committee and emphasises risk reduction, response management, and impact mitigation. The committee was replaced by the National Emergency Response Committee on HIV and AIDS (NERCHA), which was made a council in 2003. Meanwhile, the first NSP has been replaced by the 2006-2008 NSP, which focuses on prevention, impact mitigation, care and support, and coordination management of the response.

International and national commitments to scaling up for Universal Access to prevention, care, and treatment have highlighted the severity of the epidemic in Swaziland and the willingness of development partners to assist with this process. In the context of the present crisis, national concern must be met with monumental commitment and dedication. This report presents the core indicators and targets for Universal Access in Swaziland and details some of the most pertinent challenges and opportunities and recommendations regarding each target.

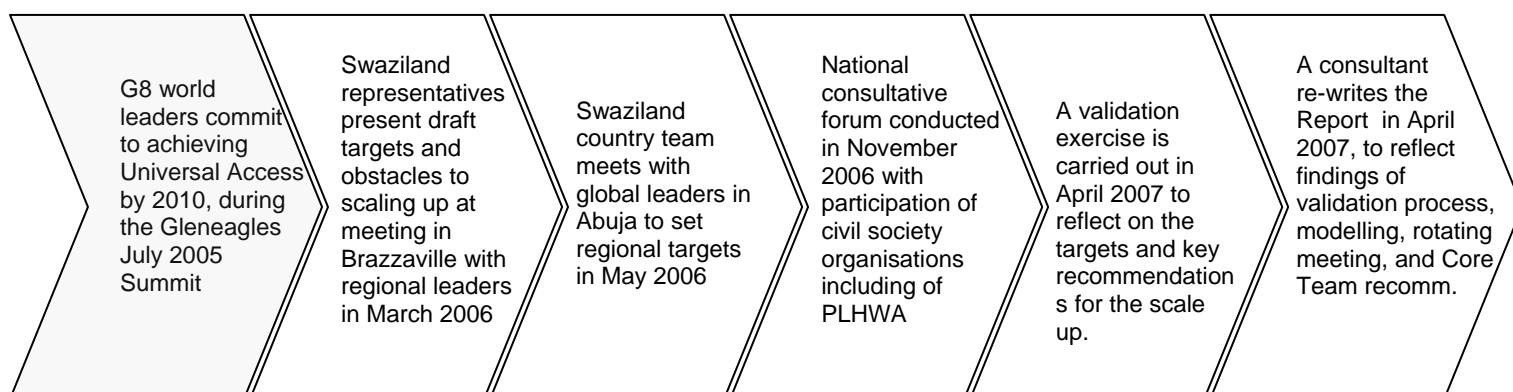
1.2 Universal Access Target-setting Process in Swaziland

The process of setting targets at country level emanated from the 17th meeting of the UNAIDS programme coordinating board in which countries were encouraged to develop evidence informed AIDS strategies including efforts towards universal access to prevention, treatment care and support services. This was further reiterated at the Gleneagles Summit where the G8 and other donors secured international commitments to universal access to HIV and AIDS prevention, treatment and care and support by 2010.

In September 2005, the General Assembly of the UN committed to the scale of comprehensive AIDS responses at the World Summit. The emphasis was on country based and country led processes involving all partners within the framework of the Three Ones, building on recommendations of the Global Task Team (GTT). Based on these recommendations, Swaziland held its first consultative forum in January 2006 and the draft targets, including obstacles to scaling up universal access, were presented in a meeting in Brazzaville with regional leaders in March 2006. Thereafter, these targets were presented to global leaders in Abuja in order to set regional targets, in May 2006. The figure below depicts the process of target-setting that has occurred in Swaziland

Following these major meetings, in November 2006, Swaziland then conducted a second consultative and all inclusive process to review initial targets and seek buy in from all partners. Key informant interviews were also conducted with HIV and AIDS programme coordinators and members of various civil society organisations. The targets and recommendations of the second consultative process underwent a validation exercise with key informants to provide a firm basis for informing the scaling up of activities.

Figure 1: Universal Access Target-setting Process in Swaziland



In this context, the scaling up for Universal Access to prevention, care and treatment is a national concern that must be met with commitment and dedication. This report presents the core indicators and targets for Universal Access in Swaziland and details some of the most pertinent challenges, opportunities, and recommendations regarding each target.

1.3 Methodology

The process of target setting in Swaziland entailed two consultative forums, extensive desk review and interviews with key informants. The consultative forums which took place in January and November 2006 involved a wide range of stakeholders including civil society organisations, private sector, development partners and government departments. This process was led by NERCHA in collaboration with the Ministry of Health and Social Welfare. There were 21 key informant interviews conducted amongst HIV focal persons, and these included the SNAP (Swaziland National AIDS Programme) and SRH (Sexual and Reproductive Health Programme) coordinators, PLHIV and representatives of Umbrella bodies. This was then followed by a validation process which took place in March 2007 which resulted in finalised Universal Access targets for Swaziland.

HIV Estimation and Projections for Swaziland

UNAIDS has over the years been publishing global estimates on a number of HIV indicators since 1998 in the AIDS Epidemic Updates and has until 2007 made major methodological

improvements in the data. This was informed by a better understanding of the HIV epidemiology through population surveys and adjustment of the models amongst other things. With the release of the first Swaziland Demographic and Health Survey (SDHS 2006-07) preliminary findings, Swaziland with support from technical experts from UNAIDS/Geneva and CDC/Atlanta, engaged in a process to undertake the necessary analysis and modelling to make available more reliable estimates of HIV prevalence, the demographic impact of the epidemic, and ART needs and service coverage using Estimation and Projection Package and Spectrum. The universal access indicators used the output from Spectrum to inform some of the data required in particular PMTCT, ART and OVC.

Previously, the country developed HIV estimates and projections by Stanecki in 2001 which the country has used in planning for HIV programmes. However, the recent methodological adjustments (calibration using population based HIV prevalence estimates) which give reduced HIV estimates and projections has since altered the projected estimates. A table detailing the HIV estimates and projections for some indicators from Spectrum is contained in the appendices. In summary, Spectrum, a projections and modelling software, was used as a key source to provide baseline data and projections for the setting of targets as well as in deriving targets until 2010. Spectrum provided estimates for baseline and future numerators and denominators for some of the indicators. It should be noted that the Spectrum output relies on adequate information to in order to produce reliable estimates. The Swaziland 2007 census results were not published at the time of developing the estimates. Therefore, it is important to emphasise the need to revise the estimates once such information is released.

2 RESULTS

2.1 Universal Access Indicators and Targets for Swaziland

The process of setting targets in Swaziland began with an examination of the internationally recommended indicators and targets. The seven core UN-recommended national indicators for moving toward Universal Access provided an entry point for country consultations. The internationally-recommended indicators were compared to the national set of indicators used for monitoring the implementation of the National Strategic Plan (NSP) which are listed in the HIV and AIDS M&E Operational Plan. The final target-setting process took into consideration previous progress, baseline data, projections and an assessment of possible progress in the coming years given known obstacles and challenges, resources, strengths, and opportunities. These considerations were the guiding factors in determining ambitious yet realistic targets for the country.

Table 1, below, presents a summary of the seven Universal Access indicators and targets for Swaziland for 2006, 2008 and 2010. Each of the ensuing sub-section outlines the background information on the indicator and target as well as challenges, opportunities, and recommendations. In setting each target, the data and projections included in the table in the Appendices were taken into account, as well as the challenges, opportunities, and recommendations detailed in each section.

The national targets were set assuming that:

1. The challenges will be met with strategic action,
2. The opportunities will be used to enhance scale-up, and
3. The recommendations will be operationalised and carried out with determination.

Table 2.1 Universal Access Indicators and Targets for Swaziland

Core Indicator Number	Indicator	2006 Baseline	2008 Interim Target	2010 Target
1. ART	1. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy (ART) in the last 12 months. • Disaggregated by adult/child and sex	35%	50%	60%
2. OVC	2. Percentage of orphans and vulnerable children (OVCs) aged 0-17 whose households received free basic external support package (in the last 12 months) • Disaggregated by sex	41%	51%	61%
3. PMTCT	3. Percentage of HIV-positive pregnant women receiving a course of antiretroviral (ARV) prophylaxis to reduce mother-to-child transmission (MTCT) in accordance with nationally approved protocol in the last 12 months	62%	73%	80%
4. HTC	4. Percentage of the general population receiving an HIV test results, and post-test counselling in the last 12 months • Disaggregated by sex	15%	40%	50%
5. Condoms	5. Number of male and female condoms distributed annually by the public and the private sector • Disaggregated by male/female condom, region, and public/private sector	5.8 million	8 million	12 million
6. Sex Before the Age of 15	6. Percentage of young men and women aged 15 to 24 who had sexual intercourse before age 15 • Disaggregated by sex	7% F 5% M	F 5% M %	F3% M 3%
7. Funding	7. Percentage of national expenditure spent on health per year	6-7%	8%	15%

2.1.1 Antiretroviral Therapy (ART)

ART			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
1. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy (ART) <ul style="list-style-type: none"> Disaggregate by adult/child and male/female 	35%	50%	60%

Background

The roll-out of the ART began in 2003, and witnessed a massive scale up of up to 19 ART sites by 2007. The WHO 3 by 5 Initiative was instrumental in the scale up of treatment, and resulted in the country achieving the 3 by 5 target of 13,000 patients initiated on ART. The ART roll out program was supported by funding from the Global Fund, WHO and US Government and other development partners, including support for the development of the patient and drug tracking. In 2006, a new protocol for the initiation of clients on ART was initiated. With a newly designated pool of doctors identified to focus on ART, medical staff were in a better position to initiate clients on ART following standard protocol.

To date, 440 nurses have been trained on provision of ART out of a pool of 3500 nurses. To cater for pre service training, a curriculum was revised to include training on the provision of ART in 2005. At the end of December 2006, 18,389 people were on ART and the cumulative number of individuals who have been enrolled on ART to date is 22,500.

Challenges and Recommendations:

a) Data Quality - The systems of monitoring patients and drugs are at an infancy stage. While data on the number of people on ART can be obtained at the end of each quarter, double counting remains an issue of concern. **Recommendation:** Plans to strengthen the ART patient and drug management system need to be accelerated, in addition to capacity building on data capture and management at facility and regional levels.

b) ART Patient Follow Up - Currently there is no mechanism to track patients who enrol in the ART programme. Given the lack of follow up in the current set up, it is difficult to determine the number and reasons for loss to follow up. **Recommendation:** There is a need to develop guidelines for a sustainable treatment supporters' programme in order to link clinics and community, thus reducing loss to follow-up.

c) Stigma, Sensitisation, and ART Literacy in Communities - In Swaziland, the ART literacy curriculum was developed with PLHIV and training has begun in some areas. The ART literacy programme is yet to reach all health workers, PLHIV and, communities. Given the potential for mismanagement of drugs by health care workers and patients, there is an urgent need for sensitisation in order to prevent drug resistance. **Recommendation:** There is need to ensure training

and sensitisation for health workers, PLHIV and the community on treatment literacy and stigma reduction.

d) Alternative Medicine – The country is faced with a proliferation of alternative healers that are claiming to cure AIDS as well as other chronic illnesses. This has resulted in patients dropping out of ART to take up other alternative treatments. **Recommendation:** *The Medical and Dental Council needs to take responsibility for addressing such malpractice, as it relates to health issues and the proper legal instruments must be put in place..*

e) Laboratory Services - Due to systemic factors, the current laboratory capacity and procedures are negatively impacting on the ART programme. The impact includes delays in receiving lab results, reagent stock outs and the inability of all patients in need of ART to receive timely CD4 counts. **Recommendation:** *The Ministry of Health and Social Welfare should expedite the finalisation of the laboratory strategy and mobilize resources to operationalise the strategy. Computerisation of the laboratory system is currently underway in order to improve the quality of lab services, including reducing delays and the mixing-up of results as well as improving the management of stocks.*

f) Human Resources – Currently there are only 15 ART doctors in the public health facilities in Swaziland, limiting the uptake of ART services as well as compromising the quality of ART services due to high doctor patient ratio. This situation is exacerbated by the limited number of health care workers trained on the provision of ART. The current indication is that only 440 have been trained on IMAI (Integrated Management of AIDS related Illnesses). **Recommendation:** *The Ministry of Public of Public Service and Information should facilitate the creation of key ART posts as requested by the MOH&SW including the absorption of externally funded posts into the establishment. A strategy to mainstream IMAI into the institution of higher learning curricula should be of priority.*

g) Funding – With the exception of funds for ARV purchasing, the current ART programme largely depends on one major source of funding, namely the Global Fund, thereby posing a major threat to the sustainability of the programme. **Recommendation:** *The ministry of Health needs to design a sustainability plan for the HR gaps created by the ART roll-out plan. There is also need to develop a health sector resource mobilisation strategy to ensure activities in the health sector response plan are implemented.*

2.1.2 Core Indicator 2: Orphans and Vulnerable Children

OVC			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
2. Percentage of orphans and vulnerable children (OVCs) aged 0-17 whose households received free basic external support package (in the last 12 months) <ul style="list-style-type: none"> • Disaggregated by sex 	41%	51%	61%

Background

It was previously projected that the number of orphans and vulnerable children will increase from the present estimate of 130,000 to over 198,000, by 2010 (*The Kingdom of Swaziland's National Plan of Action for Orphans and Vulnerable Children (2006-2010)*). The recent OVC estimated projections from the spectrum model for 2008 and 2010 are reduced to 110,460 and 113,396 respectively. In proportional terms, the preliminary findings from the first Swaziland DHS (2006/ 2007) reveal that 31 percent of children under 18 years are OVCs.

The impact of HIV and AIDS on the physical and emotional well being of children in Swaziland is extreme. The majority of these children are subjected to social and economic circumstances that heighten their vulnerability, increasing their risk of exploitation, and of adopting risky and dangerous behaviour. This in turn, increases their susceptibility to contracting HIV as well as threatening their optimal social, physical and psychological development.

The traditional network of support that has usually existed in communities has been disrupted due to the instability arising from increased illnesses and deaths. The traditional family support system has also been strained by the high disease burden, persistent drought and high levels of poverty among the rural communities in particular. The weakening of the traditional social network calls for external additional support to communities to provide for the needs of OVC and other vulnerable groups. Currently the DHS estimates that 41% of OVC's received basic external support mainly in the form of educational support in the last twelve months prior to the survey. Assuming that resources for OVC programming increases bi-annually by 10%, then it is projected that the target will increase bi-annually by the same proportion.

Challenges: and Recommendations

a) Data Collection and Quality of Data

Currently there is no system for tracking the number and status of OVC's which means the country heavily relies on estimates for planning. While attempts are made by individual NGO's to document support provided to OVC's, there is no coordinated system for OVC registration at all decentralised levels. Lack of a harmonised and coordinated system has resulted in over/under reporting of OVC's supported. At the moment, the MRDYA has recruited and trained chiefdom clerks at the community level, and it is envisaged that they will oversee the registration of OVC's at community level. Furthermore, it is anticipated that a paper based system will be available at community level through the chiefdom clerks and that the data will be extracted and exported to a national database housed at the children's unit.

Recommendations: The development of one national OVC register and accompanying tools to commence the process of monitoring OVC at the chiefdom level should be expedited and well coordinated. Stakeholder buy-in in the development and adoption of this system is paramount.

b) Leadership and Coordination

The major challenge around OVC programming is the coordination of the various implementers on the ground. This is due to the fact that Swaziland currently lacks a children's coordinating unit. Plans are, however, underway to establish a Children's Coordinating Unit in the country.

Recommendations: (1) There is need to expedite the plans for establishing a Children's Coordination Unit and ensure that it has the necessary resources to achieve its laid out mandate. (2) Coordination and implementation of OVC programmes to be strengthened by forming decentralised coordination technical committees in support of the national coordination structure. (3) Mapping of OVC services at community level needs to be conducted to inform service delivery.

c) Coverage of OVC Support: The DHS reports that most support reported to have been received by OVC is education related. This explains the government's commitment to access to education for OVC in schools. However other critical OVC needs such as shelter, psychosocial support and food are not adequate given the challenges OVC face. **Recommendation:** With the increasing need to scale up OVC interventions, Swaziland Government needs to increase its budgetary allocation in this area and mobilise additional external resources to meet the needs of OVC.

2.1.3 Core Indicator 3: Prevention of Mother -to -Child Transmission

PMTCT			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
3. Percentage of HIV-positive pregnant women receiving a course of antiretroviral (ARV) prophylaxis to reduce mother-to-child transmission (MTCT) in accordance with the nationally approved protocol in the last 12 months	62%	73%	80%

Background

The overall objective of the PMTCT programme is to integrate PMTCT within all ANC services in all health facilities. Currently, the PMTCT package is being provided in 110 out of 162 facilities in the country. In the current setup, a health facility should provide HIV testing and counselling, ARV prophylaxis (mother and infant), counselling, routine antenatal care, family planning, postnatal care, routine child welfare and advice on infant and young child feeding (IYCF). HAART has been shown to be, so far, the most effective way of reducing mother-to-child transmission of HIV. The delivery of PMTCT in Swaziland is being reorganized to be offered as an integrated package consisting of ART and paediatric care (including IYCF) at all levels of health services, which is naturally linked to HTC services. There has been a concerted effort to integrate PMTCT and ANC services. PMTCT training has been included in in-service training and its inclusion in pre-service training started in 2006.

The recommended Abuja target is that by 2010, 80% of HIV positive pregnant women should receive PMTCT services. By the end of 2006, the country had reached 62 percent of all HIV positive pregnant women and it is envisaged that the Abuja target of 80 percent will be attained, assuming the MOHSW will have the resources to scale up PMTCT services. To ensure an effective delivery of the integrated package of PMTCT, all PMTCT sites must have appropriate physical infrastructure and qualified health care workers. Furthermore, communities must be well educated on PMTCT.

Challenges and Recommendations:

a) Data Collection and Reporting: At present, out of the 110 PMTCT sites, 79 facilities are reporting regularly. Approximately 80% of reports collected at health facility level are sent to the national M&E unit, but with a lack of completeness and accuracy of data reported. There is no regional level aggregation and subsequently all reports are transmitted and analysed at national level using an excel database. Data analysis and utilisation is minimal at facility and regional levels and the extent to which data are used for performance monitoring and programme management at national, regional and facility level is limited. The existence of multiple registers and reporting requirements overburden health workers and are resulting in reduced data quality. **Recommendations:** *There is a need to adopt refined PMTCT and paediatric care and treatment indicators and to integrate them into existing registers. (2) There is also need to review and harmonise the existing registers introduced by various partners. (3) Capacity building is necessary at national, regional and facility level to support monitoring of PMTCT services.*

b) Laboratory Services: There is inadequate laboratory capacity especially in haemoglobinometers, CD4 count machines, transport of specimens and delay in returning the results, and stock outs of HIV test kits. **Recommendations:** *The Laboratory Policy to be finalised and implemented to ensure timely collection of blood samples for CD4 count and reporting of results. (2) The Govt must make resources available to MoHSW to allow for the provision of basic equipment such as haemoglobin meter to all health facilities to ensure timely assessment and initiation of HIV positive women on HAART.)*

c) Awareness Creation: At the community level there is limited information on the importance of PMTCT services. **Recommendation:** *There is need to sensitize and educate communities to effectively participate in PMTCT services.*

d) Inadequate Integration of FP (Family Planning) Counselling with PMTCT: Family planning services are not integrated into existing HTC, ART and PMTCT programs at facility level. There is also limited integration of HTC into FP and reproductive services. **Recommendations:** *Integrate FP into all ART, PMTCT and HTC; train all personnel in family and provide FP commodities; integrate HTC in all FP services.*

2.1.4 Core Indicator 4: HIV Testing and Counselling

4. HTC			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
4. Percentage of the general population over 15 years of age receiving an HIV test, the results, and post-test counselling (HTC) in the last 12 months <ul style="list-style-type: none"> Disaggregate by sex 	15% 22%-women 9% -Men	40%	50%

Background

The 2006-2008 HIV National Strategic Plan has provided that HIV counselling and testing be provider initiated and form part of the routine health visits to facilitate early diagnosis, treatment of opportunistic infections, enrolment into the pre ART program and to ensure the long term sustainability of the programme.

HIV testing and counselling started in 2002 in Swaziland. VCT sites increased from 14 in 2003 to 39 VCT sites in the country. HIV testing is monitored by the National HIV and AIDS Referral Laboratory in Mbabane. Test kits are procured centrally and supplied to government and non-government test centres. Scaling up of ART implies a scaling up of HIV testing. At present, 15 percent of the general population 15-49 have tested, with more women than men reporting to have tested (Preliminary results of the DHS 2006). The Abuja target for this indicator is that 80% of the population is tested by 2010. The country targets for 2008 and 2010 stand at 40% and 60% respectively. Out of the 15 % who have accessed HIV testing services in Swaziland, it is estimated that about 3% of cases were initiated by health care providers.

Given the current achievement of this indicator (15%), there is a need to scale up the provider initiated approach and expand mobile outreach services to reach workplaces and the rural communities. Scaling up HTC will minimize missed opportunities and institutionalize HIV testing in clinical and preventive health care services. HTC is a relatively new approach in Swaziland following the review of the VCT guidelines. The MOHSW roll out plan is that HTC/VCT services will be available in each of the 11 towns in the country, and each of these will have outreach programs in order to provide services to the surrounding communities.

Challenges and Recommendations:

a) Data Collection and Reporting:

There is currently no system for tracking and compiling data from all sites offering VCT/HTC services, resulting in under reporting in the number of people at the various sites including PMTCT. On the other hand, the current system is not able to track individuals tested but rather counts the number of tests done leading to over counting. This is due to the lack of a unique identifier system that would minimise double counting arising from one individual testing more than once in different sites. **Recommendations:** (1) There is a need for a review of data collection systems for VTC/HTC to capture data from all service delivery points such as PMTCT, medical referral, and post-exposure prophylaxis provision points. (2) A strategy to introduce identifiers for people accessing health services would enable tracking of re-tests and reduce double counting of tests and is therefore necessary.

b) Laboratory Services:

Logistical obstacles around the laboratory services in the country are major impediment to scaling up of HTC services (see ART section above). Transportation of samples, test kits stock outs amongst other issues have been cited as bottlenecks to HTC services. The Laboratory Policy still remains in draft form after over a year. **Recommendations:** *Laboratory Policy needs to be finalised and implemented.*

c) Human Resources

Sustaining human resources is a major challenge to continuing provision of VCT services in light of the current funding situation with the expiry of Global Fund round 2 grant by end of 2007. **Recommendation:** *The Ministry of Health and Social Welfare needs work with the MoPSI to ensure the absorption the health workers supported by the Global Fund to ensure the sustainability of the programme.*

d) Paediatric testing: There is a lack of timely identification of HIV infected children in need of care and treatment due to the limited availability of routine offers of testing and counselling for children, including early infant diagnosis using dried blood spots (DBS) and PCR. **Recommendation:** *Improve the identification and diagnosis of paediatric HIV infection and exposure by revising provider initiated testing guidelines and policies, ensuring the provision of training and reference materials and improving follow up of HIV exposed infants*

e) Male involvement: Studies conducted in Swaziland indicate that HIV related stigma and discrimination is widespread and often result in fear of testing and disclosure of ones HIV status. ¹ In many instances, pregnant women who undergo HIV testing may face rejection and violence from their spouses when HIV results turn out positive. A lack of male involvement in PMTCT and HIV programmes in general has contributed to this situation. **Recommendation:** *Strategies encouraging male involvement in voluntary testing and counselling and PMTCT need to be developed and implemented.*

f) Legal Framework for Youth:

Presently youth under 18 years must seek consent from a guardian or parent in order to access VCT services. **Recommendation:** *There is a need for the review of the legal framework to ensure that youth are able to access testing and counselling services.*

¹ Epidemic of Inequality: Women's rights and HIV and AIDS in Botswana and Swaziland, 2007

2.1.5 Core Indicator 5: Condoms

Condoms			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
5. Number of male and female condoms distributed annually by the public and the private sector <ul style="list-style-type: none"> Disaggregate by male/female condom, region, and public/private sector 	5.8 million condoms	8 million condoms	12 million condoms

Background

Although condoms have for many years served as a family planning method, with the advent of AIDS they have become one of the most effective methods of protection from HIV infection. The adequate supply of condoms was prioritised in 2005, and a National Condom Strategy was drafted in response to erratic condom purchasing, a stock-out situation and the need for improved supply chain management. At the end of 2006, 5.8million condoms were distributed. The 2006/7 DHS shows that about 56 percent of males and females aged 15-49 who have more than one sexual partner in the last twelve months used a condom in the last sexual encounter. The Abuja target for this indicator is that at least 80 percent of the population use a condom by 2010. This requires a massive scale of condom availability, sensitisation and campaigns. Currently, the baseline stands at 5.8 million condoms distributed from the national warehouse and this is projected to increase to 12 million by 2010.

Challenges and Recommendations:

a) Considerations Regarding Targets

The anticipated population of adults above the age of 15 in 2010 is 728, 687. If 47% of the population is comprised of men, the expected number of adult men in 2010 is 347,927. If the distribution target of 12 million condoms is reached in 2010, and every condom is used to protect partners engaging in sexual activity, this still allows for only 34 condoms per man for a period of 12 months. Upon examination of these calculations, the urgency of scaling up condom distribution is put into perspective. This is, however, based on the assumption that condom use is universally acceptable to all men and that the only impediment is access. **Recommendation:** A strategy must therefore be formed that revolves around promoting condom use, consistent condom use and partner reduction.

b) Data Collection

Information management in the condom logistics programme is poor with information on procurement and distribution maintained centrally at an aggregate level. Data on condom distribution to facilities is captured from requisition forms for contraceptives. In the baseline figure for 2006, there may have been some double-counting, as PSI does obtain some condoms from the government. Numbers of commercially distributed condoms are difficult to estimate, as pharmacies are not required to report. **Recommendations:** (1) Establish clear reporting channels for condoms distribution needs to established. (2) There is a need to urgently finalise the condom strategy. (2) The condom distribution monitoring form needs to be revised.

c) Distribution Strategy

The Condom procurement and distribution procedures are done centrally with condoms being delivered to and distributed from the Central Medical Stores centre where the conditions for storage of condoms are optimised. Four regional condom distribution centres have been constructed to support the decentralised supply chain management to the regions and improve distribution of condoms, particularly to rural areas. However, the regional condom distribution centres have not been fully utilised due to a lack of budgetary allocation for procurement of the necessary office equipment and supplies (i.e. office furniture, computers, and air conditioning systems). At present, the pull approach to distribution is more favourable given the staff shortage in this programme. This is where distributors rely on representatives from various facilities to physically collect the commodities from the warehouse when they experience stock-outs. **Recommendation:** (1) *This needs to be addressed by inclusion of condom distribution issues in the condom strategy.*

d) Regional Distribution Officers

The programme has two Regional Distribution Officers (RDOs) from the Sexual Reproductive Health Programme who are working on a contractual basis and are each responsible for two regions. However, there are no standard operating procedures on how the RDOs and the Programme Logistics Officer (PLO) relate their expectations, nor are the channels of communication among them defined. **Recommendations:** *The working relationship between the Regional Distribution Officers and the Programme Logistics Officer needs to be formalised and clearly outlined in writing (2) The current set-up where condom distribution is mainstreamed within sexual and reproductive health services and contraceptive distribution should be maintained so as not to create parallel systems, (3) The number of RDOs should be increased from two to four, allowing for one per region. Two additional vehicles will be needed and the push strategy should be used for distribution, rather than the passive pull strategy. In addition, the expectations of the PLO should be outlined, including proposed quarterly random checks on facilities to minimise the period of stock-outs.*

e) Stock-outs of Female Condoms:

Although no stock-outs for male condoms have been experienced since 2004, there was a stock-out of female condoms in 2006 and this situation has not been adequately addressed since then. **Recommendation:** *Sufficient funding for both female and male condoms must be secured to meet 2008 and 2010 targets.*

2.1.6 Core Indicator 6: Sex before the Age of 15

Sex before the Age of 15			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
6. Percentage of young women and men aged 15 to 24 who had sexual intercourse before age 15 <ul style="list-style-type: none"> Disaggregated by sex 	7% females	5% females	3% females
	5% males	4% males	3% males

Background

Swaziland has embarked on a number of mass media campaigns, targeted at youth sexual behaviour and encouraging them to preserve themselves for the future e.g. the *Likusasa ngelami* (My Future Campaign). Efforts aimed at keeping youth in school and providing life skills education as well as innovative programmes targeting out of school youth have been implemented. The delay of sexual debut is an important impact indicator as it provides a measure of the various interventions aimed at promoting abstinence. The goal of this indicator to monitor whether proportion of youth having sex before age 15 is declining over time. Results from the 2006/7 SDHS reveal that 7 percent and 5 percent of female and males aged 15-24 had sex before age 15. A scaling up of strategies targeting the youth is therefore planned through schools, youth centres and community level activities in order to reduce this indicator to 3 percent by 2010.

Challenges and Recommendations

a) Coordination

The Swaziland National Youth Council has the mandate to coordinate the HIV/AIDS response for young people but the youth council needs to strengthen its coordination role for better execution of youth related services. . Due to weak coordination among partners, different sectors produce communication campaigns independent of each other. **Recommendation:** *Initiate joint planning involving all actors in this sector.*

b) Integration

There is a national Communication Strategy of which, Behaviour Change Communication, Advocacy and Social Mobilisation are components but this is not fully implemented. In addition to the above, a youth BCC strategy is also in place but it is not well known and embraced by all stakeholders. **Recommendation:** *There is a need to realign the Communication Strategy with the NSP and create an implementation framework with inputs from all stakeholders.*

c) Leadership in National Advocacy

At present, a substantial proportion of NERCHA's efforts are directed at implementation for this programme area. **Recommendation:** *These responsibilities should be relegated to relevant partners so that NERCHA can focus on providing leadership in national advocacy, identifying best practices, and ensuring that the most effective strategies are being used.*

2.1.7 Core Indicator 7: Funding

Background

The Government of Swaziland established a budget line for HIV and AIDS in 1999 which has increased from E12 Million in 2000 to E25 Million in 2005 and goes towards sub venting NERCHA activities. In addition a separate budget of E19 million was allocated to the Ministry of Health and Social Welfare for the procurement of ARVs in 2005. On the other hand, the government allocated a budget towards orphans and vulnerable children's scholarships through the Ministry of Education of E16 million in 2004. Swaziland also received funding for HIV and AIDS from external partners such as the United Nations, Global Fund to Fight AIDS, TB and Malaria (GFATM), World Bank, Support for International Partnership against AIDS in Africa (SIPAA) and the US Government, among others. The Abuja Declaration recommends that governments allocation to Health reach 15% of total national expenditure by 2010. However, Swaziland has in the past years been moving away from and not towards this target.

Challenges:

Multiple Priorities versus Resources

Given the competing and demanding priorities in the country such as poverty, HIV, OVC, unemployment and drought, the government is challenged with how to distribute the limited resources to curb these issues. Whilst it is anticipated that the government will increase its budget to the health sector, there is uncertainty as to whether it will come close to meeting the recommended target set at Abuja. With the GFTAM providing substantial funds to the HIV response in the country, any gap or delay in funding disbursement could be devastating to programme implementation. Programmes which currently rely on GFTAM face sustainability challenges, particularly those which depend on the Global Fund for human resource support.

Recommendations: 1) A resource mobilization strategy should be developed. 2) A resource tracking system should be developed. 3) A National AIDS Spending Assessment (NASA) should be conducted.

Planning and budgeting

The MOHSW currently does not have a strategic plan, hence compromising its leadership and coordination role. The absence of a framework has promoted the development of vertical strategic plans at a programme level to fill this vacuum and vertical programming that is donor driven. These plans lack co-ordination and alignment in content and periodicity. The Health Sector Response Plan has been developed by SNAP and is aligned with the NSP, nevertheless it is not costed. The lack of a plan compromises budgeting for health programmes resulting in unfunded activities, while in other programs, unutilised funds expire. **Recommendations:** 1) Finalise the health sector strategic plan, 2) Cost the health sector response plan,

Donor Co-ordination

The many development partners in Swaziland contribute through bilateral and programmatic support. However, there is little coordination of their activities. The communication channels between government and the partners remain weak and are not conducive for coordination. **Recommendation:** There needs to be a functional donor co-ordination forum to ensure geographic equity, minimise duplication and alignment of programmes and activities.

3 CONCLUSIONS

Although Swaziland witnessed a slight drop in HIV prevalence among pregnant women attending ANC from 42.6 to 39.2 between 2004 and 2007, there is no room for complacency as the impact of this epidemic continues to ravage every sector of the economy. At this point in time the country has a wealth of information from various sources, which needs to be pooled together to make meaningful sense of key drivers of the AIDS epidemic as well as to determine where the new infections will be occurring. A focus on using evidence to inform the interventions will improve targeting and subsequently yield better results.

The process of setting targets for universal access for prevention, treatment care and support has been consultative, participatory and informative for the country. It is a significant milestone towards achieving targets set at both global and regional forums as well as evidence of the country's commitment to go to scale. This report presents these commitments and provides the recommendations which will need to be anchored into the national strategic plan during the review process. For these targets to be realised by 2010, a concerted effort should be made to mobilise additional resources both internally and externally, and improve coordination and alignment of all partnerships.

Appendices

Appendix 1: Detailed Table of Universal Access Indicators and Targets for Swaziland

Detailed Table of Universal Access Indicators and Targets for Swaziland			
1. ART			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
1. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy (ART) <ul style="list-style-type: none"> Disaggregate by adult/child and male/female <u>Definitions:</u> <ul style="list-style-type: none"> Numerator: Number of people with advanced HIV infection receiving ART (Ministry of Health M&E system data - ART Register) Denominator: Number of people with advanced HIV infection in need of ARV (Spectrum) 	35%	50%	60%
	<u>Baseline</u>	<u>Anticipated Rate of Growth Given Current Conditions</u>	
	<u>Adults:</u> 17,160 / 48,888 <u>Children:</u> 1,429 / 4,021 <u>Adults and children combined:</u> 18,389 / 52909	<u>Adults:</u> 29,012 / 58,024 <u>Children:</u> 2373 / 4,745 <u>Adults and children combined:</u> 33,757 / 62,769	<u>Adults:</u> 39,251 / 65,418 <u>Children:</u> 3,053 / 5,088 <u>Adults and children combined:</u> 42,304 / 70506

2. OVC			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
2. Percentage of orphans and vulnerable children (OVCs) aged under 18 living in households where a basic external support package has been received <ul style="list-style-type: none"> Disaggregate by sex <p><u>Definitions:</u></p> <ul style="list-style-type: none"> Numerator: Number of OVCs aged under 18 living in households where a basic external support package has been received Denominator: Number of OVCs aged under 18 (Spectrum projection, NERCHA 2007) 	41%	51%	61%
	<u>Baseline</u>	<u>Anticipated Rate of Growth Given Current Conditions</u>	
	42,965 / 104,795	56,335 / 110,460	69,171 / 113,398
3. PMTCT			

Indicator	2006 Baseline	2008 Interim Target	2010 Target
3. Percentage of HIV-positive pregnant women receiving a course of antiretroviral (ARV) prophylaxis to reduce mother-to-child transmission (MTCT) in accordance with nationally approved protocol in the last 12 months <u>Definitions:</u> <ul style="list-style-type: none"> • Numerator: Number of HIV positive pregnant women receiving a course of ARV prophylaxis to reduce MTCT in accordance with nationally approved protocol in the last 12 months (Ministry of Health M&E system data) • Denominator: Number of HIV positive pregnant women in need of PMTCT (Spectrum, NERCHA 2007) 	62%	73%	80%
	<u>Baseline</u>	<u>Necessary Progress To Meet Targets</u>	
	8,221 / 13,208 = 62.2%	9,574 / 13,115 = 73%	10,608 / 13,260 = 80%
4. HTC			
Indicator	2006 Baseline	2008 Interim Target	2010 Target
4. Percentage of the general population over 15	15%	40%	50%

years of age receiving an HIV test, the results, and 4. Percentage of the general population receiving an HIV test results, and post-test counselling in the last 12 months Disaggregate by sex <u>Definitions:</u> <ul style="list-style-type: none"> • Numerator: Number of people in the general population over 15 years of age receiving an HIV test, the results, and post-test counselling in the last 12 months (Baseline: DHS Result) • Denominator: Number of people in the general population over 15 years of age 	<u>Baseline</u>	<u>Necessary Progress To Meet Targets</u>	
	102,891 / 685,931	283,307 / 708,267	364,343 / 728,687
5. Condoms			
Indicator: Number of male and female condoms distributed annually by the public and the private sector	2006 Baseline	2008 Interim Target	2010 Target
<ul style="list-style-type: none"> • Disaggregate by male/female condom, region, and public/private sector <u>Source of data presented above:</u>	5.8 million condoms	8 million condoms	12 million condoms

<p>2006: Ministry of Health M&E system data from SNAP (Family Planning Commodities Requisition Form and Tally Sheet indicating condoms issued out from the Government National Warehouse combined with PSI distribution of condoms)</p> <p>2008 and 2010: Targets based on 20% growth per year beginning 2006-2007.</p>			
Sex before the Age 15			
Indicator 6: Percentage of young people aged 15 to 24 who had sex before age 15	2006 Baseline	2008 Interim Target	2010 Target

<u>Definitions:</u> <ul style="list-style-type: none"> • Numerator: Number of young people aged 15 to 24 who had sex before age 15 • Denominator: Number of young people aged 15 to 24 <u>Anticipated data source</u> SDHS	7% F 5% M	F 5% M 4%	F3% M 3%
7. Funding			
Indicator 7: Percentage of national expenditure spent on health per year	2006 Baseline	2008 Interim Target	2010 Target
7. Percentage of national expenditure spent on health <u>Definitions:</u> <ul style="list-style-type: none"> • Numerator: National expenditure spent on health • Denominator: National expenditure • Health: Sum of Recurrent and Capital Expenditure for the Ministry of Health and Social Welfare (NERCHA is not included) <u>Source of data presented:</u> Baseline: "The Government of Swaziland Budget	6-7%	8%	15%

Estimates for the Year from 1 st April 2007 to 31 st March 2010"			
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Appendix 2:

List of Core Team Members

Sanelisiwe Tsela (NERCHA)
Helen Odido (UNAIDS)
Faith Dlamini (NERCHA)
Clement Dlamini (CANGO)
Peter Vranken (USG)
Sibongile Mndzebele (MoHSW)

Key Informants

Derek von Wissell (NERCHA),
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Dr. Velephi Okello (SNAP)
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Nozipho Mkhathswa (NERCHA)
Patrick Dlamini (NERCHA)
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Thembi Nkambule (SWANNEPHA)
Zanele Bhembé (MoHSW)
Victor Nhlabatsi (NERCHA)
Sam Johnson (MoHSW)
Faith Dlamini (NERCHA)
Sanelisiwe Tsela (NERCHA)
Helen Odido (UNAIDS)
Clement Dlamini (CANGO)
Rudolph Maziya (AMICAALL)

Appendix 3: Stakeholder Consultative Workshop participants – November 2006 (Esibayeni Lodge)

NAME	AGENCY
1. Ms Zodwa Baartjies	Swaziland Electricity Board (SEB)
2. Dr Derrick von Wissel	NERCHA
3. Mr Vusi Bulunga	Member
4. Mr Thamsanqa Ncube	Lutheran Dulp S Service
5. Ms Lenhle Nsibandze	NATTIC
6. Mr Musa Maseko	Swaziland National Provident Fund (SNPF)
7. Ms Gcebile Dlamini	Church Forum - Anglican
8. Ms Dumile Sibandze	MOHSW
9. Mr Mduduzi Ndlovu	NERCHA
10. Mr Makhosini Mamba	UNICEF
11. Dr Jama Gulaid	UNICEF
12. Ms Futhi Dennis	NERCHA
13. Mr Bongani Langa	Church Forum
14. Ms Khetsiwe Simelane	MRYDA
15. Mr Thabo Hlophe	NERCHA
16. Dr Thilo Governder	NERCHA/UNAIDS
17. Mr Pile Lukhele	Street Vender
18. Mr Nhlanhla Mnisi	MOHSW - SNAP
19. Senator Mary Magwaza	Parliament
20. Dr Augustin Ntiliwamunda	WHO
21. Ms Thamary Silindza	FLAS
22. Ms Cecilia Pateguana	Lutsango LwakaNgwane
23. Ms Bongi B. Lukhele	Nazarene Teachers College
24. Ms Allen Nakato Waligo	EGAPAF
25. Shabangu	KSH PHU
26. Ms Bethusile Shabangu	MOHSW Manzini
27. Mr Vusi Matsebula	FBO
28. Mr Nhlanhla Nhlabatsi	HAPAC
29. Ms Thandi Mndzebele	MOHSW
30. Ms Joyce Gama	Lutsango LwakaNgwane
31. Mr Paul S. Tsabedze	MOE
32. Ms Thuli Mamba	MOE
33. Dr Thuli Nhlengetfwa	NERCHA/UNAIDS
34. Dr Mauro Almaguira	Italian Cooperation
35. Ms Jabu Dlamini	MRDYA
36. Ms Sharon Neves	MRDYA
37. Ms Sanelisiwe Tsela	NERCHA
38. Ms Cebile Manzini	NERCHA
39. Ms Beauty Khumalo	Lutsango LwakaNgwane
40. Mr Ignatius Oloyi	ICW - Women organisation-HIV&AIDS
41. Ms Tfobhi Mdluli	Lutsango LwakaNgwane
42. Ms Getrude Shiba	Lutsango LwakaNgwane
43. Mr Ewart Dlamini	SNAT-Swd Natnl Association of Teachers
44. Mr Aubrey F Sibiya	SNAC - Swd Natnl Ass of Civil Servants
45. M. Hlanze	SNAC - Swd Natnl Ass of Civil Servants
46. Ms Thobile khumalo	WILSA - Women & Law in Southern Africa
47. Senator Bellah Katamzi	Lutsango LwakaNgwane
48. Mr Sikhatsi Dlamini	Mbabane
49. Ms Jennifer Chwela	ANCEFA
50. Ms Sphiwe Sibandze	MRDYA
51. Ms Thembi Chili	TASC
52. Ms Beatrice Dlamini	SNAP
53. Ms Patience Bennett	WLSA
54. Ms Joanne Marshall Forge	TASC
55. Ms Nozipho Shongwe	Swazi TV
56. Ms Thobile D. Simelane	Swazi TV
57. Ms Rejoice Nkambule	MOHSW - SNAP
58. Mr Emmanuel Kunene	MOHSW

59. Dr Harrison Kamir	Health Swaziland
60. Mr Musa Dlamini	SNYC Council
61. Mr Bheki Mamba	NERCHA
62. Ms Thembisile Dlamine	UNAIDS
63. Ms Mulunesh Tennagashaw	UNAIDS
64. Ms Hellen Odido	UNAIDS
65. Mr Rudolph Maziya	AMICAALL
66. Dr Nhlavana Maseko	THO
67. Ms Nana Mdluli	NERCHA
68. Ms Cebisile Ginindza	MRDYA
69. Ms Lindiwe Dladla	MRDYA
70. Mr Moses M Zwane	MOJ
71. Mr Sam Dlamini	DPM's Office
72. Ms Delly Maziya	SWAPOL
73. Mr Victor Ngwenya	SWAMA
74. Mr Mshikishi Mndzebele	SWAMA
75. Ms Lineo Vilakazi	MOE
76. Ms Thembeni C. Dlamini	REO - Lubombo
77. Mr Mandla Mazibuko	Save the Children
78. Mr Sizwe Ndlangamandla	PSI Swaziland
79. Ms Connie Zambi	WFP
80. Dr Velephi Okello	MOHSW - SNAP
81. Ms Mavis P. Nxumalo	MOHSW
82. Ms Thembi Nkambule	SWANEPHA
83. Mr Sibusiso Dlamini	NERCHA
84. Ms Thuli Sibiya	MOHSW
85. Ms Bonisile Nhlabatsi	MOHSW
86. Ms Phumzile Mabuza	MOHSW
87. Mr Jabulani E Kandone	Sebenta
88. Ms Maureen Dlamini	MOHSW
89. Mr Modison Magagula	SiphilaNje Drama Society
90. Mr Peter Franken	USG
91. Ms Sibongile Maseko	MOHSW - SNAP
92. Ms Setsabile Hlophe	Hospice at Home
93. Mr Fabian Mwanyumba	UNICEF
94. Ms Zanele Nxumalo	MOJ
95. Mr Nhlanhla M. S. Dlamini	MRDYA
96. Ms Dzelisa Ntfombiyenkosi	Civil Service Unit
97. Ms Sylvia Ndlovu	MOE
98. Ms Della Nsibande	MOE
99. Ms Tizzie Maphalala	UNICEF
100. Mr Victor Dladlu	Swazi TV