



NATIONAL EMERGENCY RESPONSE COUNCIL ON HIV & AIDS (NERCHA)



Coordination Annual Report 2008 ~ 9





The National
HIV and Aids
Information
Training Centre



COORDINATION ANNUAL REPORT

April 2008 to March 2009







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Chairperson's Statement

Some five years ago NERCHA spearheaded a campaign entitled “HIV and AIDS yindzaba yeftu sonkhe” meaning – ‘HIV and AIDS is our collective concern’_. At that time it was no more than a call to all partners to recognize that they have to be involved in the response to HIV and AIDS. The message at the time was also a reminder that our involvement was also necessitated by the fact that we were all either affected or infected by the epidemic.



The years that have followed have shown that the country has risen to this call. There is evidence of scaling up in all initiatives addressing HIV and AIDS. At community level we have seen the establishment of KaGogo Social Centres in most urban and rural communities. The availability of HIV and AIDS services, especially in distant rural communities, is encouraging. However, community ownership and participation in HIV and AIDS programmes will have to be scaled up.

I also encourage my colleagues-boBabe Tikhulu (Chiefs)-to provide exemplary leadership in their communities to support the response to

HIV and AIDS. It has been shown that in communities where the Chief is involved in the HIV and AIDS programs, there has been improved management and implementation of the community response.

At the same time I encourage each and every one of us to interrogate our individual contribution to the response to the epidemic at the individual level, at home, workplace and community. In this way, united we shall conquer HIV!

May I express on behalf of myself and the Council gratitude to development partners and donors who have supported the multisectoral response and the Government who has continuously supported the response.

Partnerships are the cornerstones of a vibrant response. I urge all the stakeholders who have contributed to the progress of the response to continue with the good work that has been done.

Chief Ndzabankhulu Simelane



NERCHA Director's Report

It is amazing how the year has gone-by so fast. I am encouraged that we are slowly realizing signs of gains in the response against HIV and AIDS. I am not under estimating the challenges that lie ahead of all of us but the positives outweigh the negatives. Let me highlight just four of the successes as I see the response:



The multisectoral response has matured in the country. This is evidenced by the involvement of many sectors and increase service delivery. As a result of this gained momentum the HIV and AIDS response has reached every community in the country. I am particularly encouraged by the increased involvement of the Church as it has the potential to significantly contribute to turning the epidemic around. As individuals, no one person has a right to stand in moral judgment of another. However the Church as the custodian of moral values has that standing and authority to influence the desired behaviour change required to overcome this epidemic. Prevention remains the primary focus of our response to HIV and AIDS. I would like to encourage all our partners to support and scale up all other prevention efforts in the country.

Treatment of People Living with HIV and AIDS has been scaled up. Within the next five years almost all those who require treatment will be enrolled on treatment. This is a great achievement, and will ensure better quality of life of those who are living with HIV.

The support for Orphans and Vulnerable Children has expanded significantly. Education access, school and community feeding programmes have increased. These

programmes make it possible for orphans and vulnerable children to live positive and happy lives, whilst being supported by programmes.

Finally the multisectoral response has been embraced by all stakeholders. The coordination of the response is occurring at different levels with

synergies between the all actors. The country has been engaged with the third generation of planning processes. It has been an exciting process that started with the Joint Review of national multisectoral response culminating in the development of the National Multisectoral Strategic Framework on HIV and AIDS 2009-2014 (NSF), the Regional and National Action Plans. The NSF adopted the innovative Results Based Management Approach to planning - by setting mid-term and end- of- term targets, and aligning work plans to these targets.

I would like to express gratitude to the Prime Minister, the Government, and our Development partners, implementers, People Living with HIV and AIDS and the NERCHA team who have relentlessly supported the multisectoral response. I urge all of you to continue the good work. We can overcome HIV and AIDS and we will. I wish you all a pleasant year ahead.

Derek Von Wissell
Director: NERCHA



NERCHA Council



Chief Ndzabakhulu Simelane
Council Chairman



Ms. Thuli Dladla
Deputy Chairman



Ms. Nomathemba Dlamini
Member



Mr. Sandile Ceko
Member



Mr. Tum du Pont
Member



Mr. Phanginjobo Matisa
Member



Mr. Elliot Sihlongonyane
Member



Ms. Bongiwe Duma
Member



Mr. John Hayter
Member



Mr. Nhlavana Maseko
Member



NERCHA Council



Ms. Sonto Magagula
Member



Ms. Aylline Dlamini
Member



Ms. Grace Masilela
Member



Ms. Thandie Beames
Member



Mr. Pat Muir
Member



Mr. Dumsani Masilela
Member



Mr. Zibuse Dlamini
Member



Princess Msindvose
Member



Ms. Thandie Nhlengethwa
Member



Corporate Governance

The governing body of the NERCHA Directorate is the National Emergency Response Council on HIV and AIDS. This Council is made up of 19 non- Executive Members and one Executive Member, and met six times during this financial year. The Council's powers and functions are articulated in the NERCHA Act No. 8 of 2003 and it is accountable to the Prime Minister for its performance.

To strengthen its governance role, the Council has established two sub-committees, comprised solely of non-Executive Members. They are (a) the Appointments and Remunerations Committee and the (b) Finance and Audit Committee.

a) The *Appointment and Remunerations Committee* is mainly responsible for advising Council on matters relating to the appointment, remuneration and performance of senior management.

The Appointments and Remunerations Committee is made up of five members:

- Ms Thulisile Dladla - Chairperson
- Mr. Sandile Ceko - Member
- Mr. Patrick Muir - Member
- Ms Thandie Nhlengethwa - Member
- Ms Bongiwe Duma - Member

The Committee met five times during this financial year.

b) The *Finance and Audit Committee* oversees the financial control environment, the internal audit function, the review of reports by external auditors as well as the review of financial and management accounts prepared by Management. This committee met five times during this financial year.

The Finance and Audit Committee is comprised of five members:

- Mr. John Hayter - Chairperson
- Mr. Tum du Pont - Member
- Mr. Dumisane Masilela - Member
- Ms Thandie Beams - Member
- Mr Elliot Sihlongonyane - Member



Key Coordination Achievements in 2008-09 and Priority Actions for 2009-10

Key Achievements on Planned Priority Actions for 2008-09	Progress
• Conducted the Joint Review of the national multisectoral response to HIV and AIDS	✓
• Developed the third National Multisectoral Strategic Framework on HIV and AIDS (with priority action areas, targets and indicators)	✓
• Develop a costed National Plan of Action (based on regional multisectoral action plans)	✓
• Supported implementation of Three Ones Principles at decentralized levels	✓
• Supported coordination forums for information dissemination	✓
• Develop a resource mobilization strategy for the country	X
• Strengthened Development Partner's coordination	✓

Planned Priority Coordination Actions for 2009 to 2010
• Review Monitoring and Evaluation Framework, and supporting M&E system documents, to align with the National Strategic Framework on HIV and AIDS 2009-2014
• Realign Action Plans to Results Framework in the National Strategic Framework on HIV and AIDS 2009-2014
• Develop capacity building strategy for strengthening effective implementation of multisectoral response
• Preparation of country report to United Nations General Assembly Special Session (UNGASS)
• Develop Geographic Information System to complement management of HIV and AIDS and map community interventions on HIV and AIDS
• Develop resource mobilization strategy
• Facilitate establishment of HIV and AIDS Research Coordination function and agenda
• Development of coordination framework (document articulating coordination approach at national, regional and community level)
• Strengthen programming of HIV and AIDS interventions aligned to the Results Framework





1. The HIV epidemic in Swaziland

Nature and trends in the epidemic: The Ministry of Health released the report of the 11th Round of the Swaziland Sentinel Survey (2008) wherein the prevalence of HIV amongst pregnant women aged 15-49 was 42.0%. In 2006 and 2004 the prevalence amongst this age group was reported at 39.2% and 42.6% respectively. The indication is that the epidemic is stabilizing. Amongst the age group 15 -19 there has been a continuous decline in prevalence since 2004, signaling possible reductions in HIV incidence (new infections).

Swaziland has a hyperendemic epidemic as (a) prevalence is high and (b) HIV spread cannot be stopped by interventions amongst high risk groups only: interventions in the general population is needed to stop the spread of HIV.

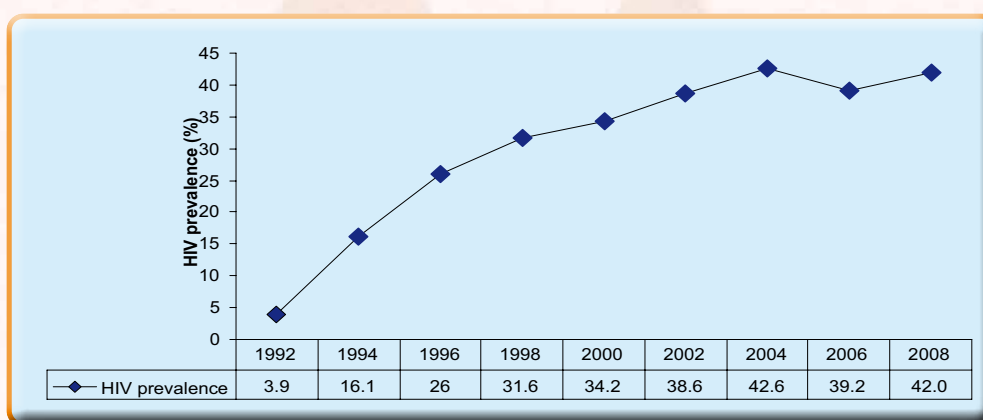


Figure 1: HIV Prevalence among Women Attending ANC, 1992-2008

Sources of new infections:

The country has conducted the Modes of Transmission study which has shown that the most at risk populations are those people above age 25 who are in long-term steady relationships and married couples who have Multiple Concurrent Partnerships (or whose partners have multiple and concurrent partnerships), migrating /mobile couples where one partner lives away from home regularly. In light of this evidence the country will develop strategies to address these priority groups. Further, the age group 15-19 has always been targeted to reduce the incidence of HIV amongst this group and delay sexual debut.

Types of and funding for prevention efforts:

The study also reported that although the country has prioritized prevention efforts in its policies and strategies, financial allocations do not reflect this policy stance. Prevention programmes have not always been implemented to scale, or focused on most at risk populations in Swaziland, or on the most effective interventions. Funding for prevention programmes lags behind funding for treatment, and it is not the most effective programmes that receive the most funding.



2. Coordination and Management of the National Multisectoral Response to HIV and AIDS

In the last year, coordination of the national multisectoral response to HIV and AIDS has been guided by the National Multisectoral Strategic Plan on HIV and AIDS 2006 to 2008 (NSP). The key achievements for the year under review are as follows:

2.1 Institutional Arrangements

The management of the response has advanced over time with the development of the multisectoral response to HIV and AIDS. Some of the milestones of coordination are demonstrated by the increased appreciation by the various stakeholders about the role of the multisectoral response. The efforts to create dialogue and information sharing have contributed to the strengthening of the national multisectoral response. Defining clear mandates, roles and responsibilities of various stakeholders will continue to be supported as this is the ideal way to build lasting partnerships for a sustained response. NERCHA, in consultation with stakeholders, have defined the coordination to occur at two levels:

- a) National coordination that is conducted at different levels by different partners; and
- b) Decentralized coordination that occurs at two levels; regional coordination and sector coordination.

2.1.1 National Coordination of HIV Response

The National Emergency Response Council on HIV and AIDS (NERCHA) is mandated by the Government of Swaziland to coordinate the multisectoral response to HIV and AIDS. NERCHA implements this role through facilitating and coordinating the implementation of the National Multisectoral Strategic Plan on HIV and AIDS. The country adopted the international accepted and UNAIDS promoted “Three Ones Principles” for promoting an effectively coordinated multisectoral response to HIV and AIDS. NERCHA has undergone an organizational review, which resulted in the introduction of three divisions to facilitate the implementation of the functions of the organization: the Response Planning and Monitoring Division, Programmes Division and Finance Division. These divisions work collaboratively.

There are also other partners who coordinate the response at the national level including the public sector (Ministry of Health, Ministry of Education and others). NERCHA is continuously strengthening links with these sectors for effective coordination.

2.1.2 Regional Multisectoral Coordination of HIV and AIDS

In partnership with the Ministry of Tinkhundla, Administration and Development (MTAD), NERCHA has institutionalized regional coordination of HIV and AIDS. Coordination of HIV and AIDS at regional level is also guided by the “Three Ones Principles”. All four regions have:

- A coordinating body, the Regional Multisectoral HIV and AIDS Coordinating Committee which meets quarterly to facilitate regional coordination of HIV and AIDS interventions.
- Established a process of regional multisectoral planning for HIV and AIDS. These regional planning processes are still at infancy stages. However the approach to be adopted as we shift implementation to the third generation of plans will strengthen the role of the



regions in planning.

- Regional monitoring and evaluation of HIV and AIDS and in particular the routine monitoring of the regional response. These processes will be strengthened to allow the regions to contribute more effectively to the response. The regions also provide forum for HIV and AIDS information dissemination.

Some of the achievements of the four regions in the last year include:

- Facilitating regional multisectoral consultative meetings for the Joint Review of the response to HIV and AIDS.
- Facilitating regional multisectoral consultative meetings for the development of the NSF as well as the accompanying Action plans.
- Dissemination of quarterly service coverage reports and information sharing.
- Training Chiefdom Multisectoral HIV and AIDS Coordinating Committees (CHIMSHACCs).
- Training of KaGogo Social Centres Managers (GCM) on coordination roles and responsibilities.

What is the road ahead for 2009 to 2010 for the regional response? The regions will be supported to strengthen their role in:

- Coordination of the regional multisectoral response
- Regional planning for HIV and AIDS. This process will be complemented by the new approach in planning of using the Results Based Planning approach. Setting clear targets for the regions will facilitate improved planning capacity for regional actors.
- Monitoring and evaluation of the HIV and AIDS response with a particular focus on routine monitoring. Reporting by regional actors will be promoted through increased mentorship and data auditing visits.

2.1.3 Sectoral Coordination of HIV and AIDS

The national Strategic Framework on HIV and AIDS 2009-2014 (NSF) has defined sectors at two levels being those in the public sector (Government ministries and departments) and the other being non Government sectors (Civil Society Sectors).

A: Government Sectors

Government sectors include the Government ministries and departments. The public sector has a role in its entirety in the response to HIV and AIDS. Each sector is supported to use its comparative advantage and initiate programmes that address both the capacity of the sector to deliver its services as well as address the impact of HIV and AIDS on the sector and its beneficiaries. There is however sectors whose role in responding to HIV and AIDS has been promoted from the early stages and these include:

A1) Ministry of Health (MOH): This sector is responsible for the clinical response to HIV and AIDS. It is recognized that other implementers who are working in partnership with the ministry to deliver services on HIV and AIDS. The multisectoral response will continue to strengthen collaboration with the health sector. The achievements of this sector appear in the monitoring and evaluation report.

A2) Ministry of Education (MOE): As a result of HIV and AIDS a large proportion of children had dropped out of school. NERCHA in collaboration with partners has worked with this ministry to facilitate Orphaned and Vulnerable Children enrollment back in school. The



school feeding programme has been introduced in both primary and secondary schools in the country. In the last year Government showed commitment towards strengthening this programme. Psychosocial Support training for teachers and students has been facilitated to equip the teacher to better manage the child who is infected or affected by HIV and AIDS in the classroom. School curriculum has been revised to include HIV and AIDS and life skills education has been introduced.

A3) Ministry of Tinkhundla and Development (MTAD)

In partnership with this sector coordination of HIV and AIDS is being implemented at regional, Inkhundla and Chiefdom levels. KaGogo Social Centres have been constructed to facilitate coordination of Chiefdom HIV and AIDS interventions and this includes structures constructed in urban areas. KaGogo Centre Managers have been appointed to facilitate coordination of HIV and AIDS activities at the Chiefdom or town levels. Implementation of Decentralization Policy of the Government of Swaziland of 2006 has been a priority area for partnership with the ministry. The multisectoral response to HIV and AIDS is facilitating implementation of the Decentralisation policy through the strengthening of regional and lower level coordination mechanisms.

A4) Ministry of Agriculture (MOAC)

Facilitating the response to food insecurity for people infected and affected by HIV and AIDS. The MOAC is coordinating implementation of food security programmes for vulnerable population affected by HIV and AIDS.

B: Non Government Sectors

The Non Government Sectors on the other hand include the following sectors:

B1) SWANNEPHA: The Swaziland National Network of People Living with HIV and AIDS is the umbrella body of organizations (including support groups) of People Living with HIV and AIDS (PLHIV) in the country. SWANNEPHA coordinates the HIV and AIDS response for PLHIV and has been able to advocate for increased involvement and support for PLHIV in the country. Swaziland adopted the international principle of Greater Involvement and Empowerment of People Living with HIV (GIEPA) and has implemented and coordinated the response guided by this principle.

B2) AMICAALL: The Alliance of Mayors Initiative for Community Action on AIDS at Local Level (AMICAALL) coordinates the HIV and AIDS response in urban areas. This sector has facilitated the development of a strategic plan which has been implemented over the past two years. A total of 38 functional KaGogo Social Centres are functional for supporting coordination of urban areas programmes in response to HIV and AIDS and provide services to over 4000 registered Orphans and Vulnerable Children.

B3) CHURCH FORUM: The Church Forum has been facilitating and coordinating the participation and involvement of the church to the response to HIV and AIDS. It has grown over time and notable achievements in coordination of the sector include the development of sector's strategic plan, constitution, organizational policies and mobilization of resources resulted in increased support and services delivered by the sector. The involvement of the church in the response to HIV and AIDS is encouraging and witnessed by the increase in



initiatives by the church to engage on issues relating to HIV and AIDS. There is need to promote capacity enhancement amongst church leaders and equip the church to not only sustain but improve on the successes already noted.

B4) SWABCHA: The Swaziland Business Coalition on HIV and AIDS (SWABCHA) coordinates the private sector response to HIV and AIDS in the country and has over 1400 companies who are affiliated to it. It brings together employers, employees and the Unions to develop collaborative framework for responding to HIV and AIDS for the private sector. SWABCHA has developed a business plan that is aligned to the NSF. The challenge facing the sector is to increase participation of the private sector in the response particularly the Small and Medium Enterprises.

B5) Public Sector HIV and AIDS Coordinating Committee (PSHACC): This sector coordinates the public sector response to HIV and AIDS. The main focus is to facilitate the internal response to the epidemic through ensuring that there is a workplace programme for employees of the government in different ministries and departments. PSHACC is at the same time focusing on ensuring that there is also the implementation of the external response which entails that a sector is mainstreaming HIV and AIDS and using its comparative advantage to respond to HIV and AIDS. This component requires all sectors to develop knowledge on the impact of HIV and AIDS on that sector. PSHACC is facilitating training of the public sector on mainstreaming HIV and AIDS.

B6) CANGO: This sector established the HIV and AIDS Consortium as a representative body for NGO's who are participating in the response to HIV and AIDS. The Consortium also developed a strategic plan on HIV and AIDS. This plan will be reviewed and aligned to the NSF. This sector has conducted Capacity Needs Assessment supported by UNAIDS and NERCHA. This exercise was in two phases being the mapping exercise of all Civil Society Organizations (CSO) working on HIV and AIDS in the country and an assessment of the capacity of CANGO to manage the Consortium. The mapping exercise revealed that there are over 180 CSOs that are contributing to the response. This information will enhance coordination efforts within the sector and beyond. The capacity assessment report of the coordination capacity of the consortium has been finalized. The Secretariat of the Consortium facilitates quarterly meetings of the Consortium to share information on HIV and AIDS and has facilitated training of its members on proposal writing to enhance resource mobilization capacity of its members. The consortium facilitated information sharing amongst those of its members who are implementing HIV and AIDS programmes supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

B7) KHULISA UMNFTWANA: This sector coordinates the traditional sector response to HIV and AIDS. This sector has been particularly keen on mainstreaming HIV and AIDS with national traditional events including Umhlanga (reed dance), Umhlanga weLutsango, Lusekwane and Incwala. The Imbali and Tingaja regiments have been targeted for increasing knowledge amongst the youth on HIV and AIDS. The sector has worked with a number of partners to support the leaders of the regiments as well as others to promote HIV and AIDS activities for the youth.

B8) MISA: MISA appointed to be the coordinator of the Media sector response to HIV and



AIDS. Training for journalists held to promote sensitive reporting in cases involving HIV and AIDS.

B9) SUSAH: The Swaziland Uniformed Services against HIV and AIDS is a body that was established to coordinate the HIV and AIDS response amongst uniformed services. There are five affiliated organizations to SUSAH. These are the Swaziland Umbutto Defense Force, the Royal Swaziland Police Force, the Swaziland Correctional Services, the Customs and Excise and the National Fire and Emergency Services. All five affiliate bodies have programmes for responding to HIV and AIDS.

B10) PARLIAMENT: This year ushered in a new Government as well as the Parliament. A new HIV and AIDS Sessional Committee has been appointed for the new Parliament. The new members have been provided with HIV and AIDS training by various organizations including capacity building on HIV and AIDS. Supported by the Southern Africa Development Community (SADC), the 8th Parliament held a consultative forum with traditional leaders and civil society on the theme: Towards a more Inclusive Political Culture and Effective HIV and AIDS Response.

B11) Traditional Healers Organization (THO): The Traditional Healers Organization has contributed to the response through coordinating the involvement of traditional healers in the response to the epidemic. A number of people in the country are attended by traditional healers. Their involvement in the response is critical for the benefit of their clients. Although partnership with this sector is gaining momentum there remains a lot of room for improving their engagement with the HIV and AIDS response.

The sectors' response to HIV and AIDS has developed over the years. The development of the sectors is varied depending on many factors but include the time when the sector was established, human and other resources available to the sector. These are some of the notable successes of the sector response over the past year:

- A number of the sectors have developed strategic plans to guide their response to HIV and AIDS.
- Some sectors have mobilized for monitoring and evaluation personnel
- Some sectors have engaged in resource mobilization initiatives and have been able to increase the implementation of sector HIV and AIDS programmes.
- There has been increased partnership with the various sectors for implementation of programmes on HIV and AIDS. However capacity support for coordination of the response has been limited.

What is the road ahead for 2009 to 2010 for the sector response?

As we look forward to increased participation and involvement of the sectors in the multisectoral response to HIV and AIDS the focus will be to support the sectors with the following:

- Facilitate harmonization of coordination approach for the sector responses
- Support sectors alignment of the strategic plans to the NSF.
- Support strengthening of monitoring and evaluation systems aligned to the national M and E framework to increase the sector involvement in monitoring sector response



- contribution to the national response.
- Facilitate training on Results Based Management approach and monitoring and evaluation for a strengthened sector response.
- Develop strategic partnerships to enhance sector capacity to coordinate the response to HIV and AIDS at the sector level.

The Sectors are providing a significant contribution to the multisectoral response and attention will be given to supporting sectors to perform these critical functions.

2.2 Community Mobilization

Community mobilization has been strengthened over the year and Chiefdom and town coordination mechanisms are functional. The regions have facilitated community mobilization and achievements appear in the Regional Coordination report.

2.3 Planning and Programme Development

The country's response to the epidemic has been guided by the National Multisectoral HIV and AIDS Strategic Plan 2006-2008 (NSP). The country engaged in the process of reviewing the response to take stock of achievements, challenges and gaps and also emerging issues in preparation for the development of new strategic framework as well as action plans on HIV and AIDS. The process of developing the new framework involved four stages:

- a joint review of the NSP
- development of the NSF
- the development of Regional Action Plans and the National Action Plan; and
- costing of the framework.

NERCHA (Council) appointed a Steering Committee whose composition was drawn from all stakeholders to manage the process from the joint review to the NSF and Action Plan development process. The process was participatory and involved different stakeholders from communities, civil society, People living with HIV (PLHIV), Traditional Health Practitioners (THP), private sector, development partners (including United Nation's agencies and donors) and government institutions. Stakeholders were involved through technical working groups, regional consultations and programme consultations.

2.3.1 The Findings of the Joint Review Report for management of the response

- The 3-Ones principles have been fully mainstreamed at national level. The decentralized regional structures i.e. REMSHACC, TIMSHACC and CHIMSHACC have been established. At regional level, One Coordinating Authority (REMSHACC) and One M&E framework are functional. The regions are yet to initiate regional planning. At sector level the three ones principles are still to be strengthened.
- 11 sub sectors have developed their strategic plans that to a large extent are aligned to the NSP. The Ministry of Health and Social Welfare strategic plan is aligned to the NSP and has been cascaded down to the regional level.
- The M&E system is functional. Stakeholders are conducting national routine HIV and AIDS reporting through the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS) for non health data, and Health sector HIV M&E system for health data.
- In the area of research and surveys the Swaziland Demographic and Health Survey, the 10th Sentinel Surveillance, Swaziland Vulnerability Assessment Report, and the Services



Availability Mapping among others have been concluded.

- Funding for HIV and AIDS increased considerably. In 2007 alone NERCHA managed more than E140 million.
- Swaziland has developed National Universal Access targets and a road map to achieve these targets.

2.3.2 Key Recommendations of the Joint Review Report 2008 for coordination of the response.

- Strengthen joint planning and budgeting at all levels. Mainstream Human Rights Based Approach to Programming and Gender frameworks in joint planning
- Consider shifting from National Strategic Plan (NSP) Framework to National Strategic Framework (NSF). The duration for the NSF is suggested to be five years.
- Strengthen mainstreaming of 3-Ones principles at regional, sector and community level. Integrate programming and M&E planning during programme development
- Mainstream HIV and AIDS in all workplace programmes and development programmes
- Develop a donor diversification strategy and plan.
- Provide funding for small grants to CBOs operating at regional and community level. Such grants could be managed by the regional coordinating structures.
- Intensify advocacy work - for increased political support and community support. Develop a national HIV and AIDS advocacy agenda and framework.
- Strengthen management capacity especially in monitoring and evaluation and develop standard curriculum to train M&E personnel.
- Strengthen community systems and institutions for HIV and AIDS planning and implementation of community based activities.
- Expand information dissemination mechanisms especially at regional and community levels.
- Develop a national M&E indicator reference Manual.
- Establish a HIV and AIDS Research Council or Unit, and develop a research agenda.
- Intensify dissemination of research and other studies data and information.
- Convert SHAPMoS to be the national data base for HIV and AIDS.

2.3.3 Development of National Strategic Framework on HIV and AIDS 2009-2014

Following the adoption of the Joint review report the country engaged in the process of developing the third National Strategic Framework on HIV and AIDS 2009-2014 (NSF). The review concluded that the high prevalence level, the devastating impacts of HIV on Swazi society and the challenges experienced during implementation of the plan necessitated a new approach. The recommendation was to shift from using strategic plan to a strategic framework. The latter was perceived as a broader approach allowing for flexibility for actors to engage and participate in the multisectoral response.

The stakeholder groups and consultations identified the priorities for the NSF based on available evidence of interventions that had the potential to:

- a) Reduce new infections and hence HIV incidence rates,
- b) Provide quality and comprehensive treatment, care and support; and
- c) Mitigate the impacts of HIV and AIDS especially among vulnerable groups.

The Technical Working Groups were involved in determining the impact, outcome and output



level results the NSF aims to achieve, using a Results Based Management (RBM) approach. NSF mid-term (2011) and final targets (2014) were developed and the NSF Results Framework was presented a wider group of stakeholders for consensus, validation and agreement. During the validation process, stakeholders also ensured that gender, human rights and strategies for community participation were adequately addressed in the NSF.

2.4 Resource Mobilization and Management

NERCHA receives a subvention from the Swaziland Government for its core mandate and also receives funds from multilateral and bilateral donors including the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) for programme activities.

The country was invited by the Global Fund to participate in the First Learning Wave of National Strategy Application (NSA). This is a learning process where Global Fund is piloting the approach of funding country strategies as opposed to the other process of submitting proposals through the Round system. A total of 22 countries were invited to submit their National AIDS strategy (including Swaziland). Only 6 of these countries will be chosen to participate in this learning wave. The Country Coordinating Mechanism (CCM), which is the body that oversees the Global Fund funded programmes, provided oversight on the NSA process.

NERCHA in her capacity as Principal Recipient of funds from GFATM received a mission from the Global Fund secretariat. The mission was successful and contributed to strengthening the country's partnership with the Global Fund. The purpose for the mission was to:

- Negotiate the smooth closure of the grants for AIDS and Malaria that had run their 5 year life, from 2003 to mid 2008.
- Consolidate the remaining AIDS grants to one grant. This is Round 4 and Round 7 which when consolidated amount to \$59 million.
- Negotiate a new grant for the Malaria National Control Programme amounting to \$5million. This grant is to prepare Swaziland for Malaria elimination by 2014.
- Meet with the Country Coordinating Mechanism, other stakeholders and Government officials relevant to the Global Fund implementation including the Ministry of Finance and Economic Planning.

NERCHA facilitated a process of conducting capacity assessment on the capacity of some implementers working on Global Fund programmes to satisfy the GFATM that the implementers have the capacity to implement the programmes for which they have been funded, manage the resources as well as report on programme performance. The assessment was to identify existing gaps and for the Principal Recipient to identify mechanism to build capacity in areas of need. The Standard Bank Swaziland Limited in collaboration with its Head Office, GFATM and NERCHA have entered into a partnership in terms of which Standard Bank will provide ProBono Services to HIV implementers to build capacity in areas identified by the implementers. For the initial stage the capacity building will focus on financial management systems.

The UNDP has provided financial resources to assist the country to develop a resource mobilization strategy. This is a priority requirement for the country as we prepare to conduct resource mobilization to fund activities of the NSF.

The resources allocated to HIV and AIDS by the Government has steadily increased over the



years. Development partner assistance has also increased over the past year. The number of development partners and donor agencies assisting the country has remained the same.

2.5 Advocacy and Communication

The quarterly Swaziland Partnership against HIV and AIDS (SPAFA) meetings has been held for facilitating information sharing with stakeholders. These dialogues bring together high-level representation from multisectoral stakeholders and in this year there were key themes including:

- Prevention
- Care and support, health care and food security and nutrition and relation with HIV and AIDS
- The last SPAFA meeting is together with the NERCHA annual general meeting.

2.6 Cross Cutting Issues

The GFATM is supporting the rollout of capacity strengthening on mainstreaming HIV and AIDS particularly in the public sector. The training is conducted by the public sector training institutions. Attention will be given to link mainstreaming with the broader development agenda of the country, the poverty reduction strategy and gender mainstreaming to adopt a comprehensive approach to mainstreaming. The National Fire and Emergency Services (NFES) HIV and AIDS policy has been finalized.

2.7 Monitoring and Evaluation

The demand for capacity building on monitoring and evaluation is increasing with the increased use of monitoring and evaluation products in the country and strengthened implementation of “Three Ones Principle”. Stakeholders are using the national monitoring and evaluation framework to guide their monitoring frameworks. Other activities include:

- The SHAPMoS has been used as the routine programme monitoring system for the country. Quarterly service coverage reports have been produced and disseminated at regional level to stakeholders. This system will be reviewed during the process of reviewing the Monitoring and Evaluation framework.
- Mentorships and data audit visits have been conducted through the year for HIV and AIDS implementers.
- UNAIDS has supported the country to develop the HIV and AIDS Estimates and Projections of prevalence of HIV and AIDS. The country report is under preparation.
- NERCHA has received support from the African Development Bank (ADB) to develop a Geographic Information System for HIV and AIDS programmes monitoring. The implementation has started and six consulting firms have been approached to submit proposals for this project.

2.8 HIV and AIDS Research

NERCHA is working on strengthening the coordination of research interventions in response to HIV and AIDS. In the meantime research coordination is facilitated by the monitoring and Evaluation Unit the following Studies have been concluded.

- The Modes of Transmission study (MOT) has been finalized. The MOT provides information that will improve understanding of the prevention response.
- The Quality of Impact Mitigation Services formative research has been concluded, the protocol designed and the country is preparing to engage in the full study. Funding gaps



for this study has been a major challenge.

- NERCHA supported the Swaziland Vulnerability Assessment Committee conduct 2008 vulnerability assessment that includes a component on HIV and AIDS.
- Research to facilitate understanding the rates of and changes in multiple and concurrent partners, is needed.

3. Coordination of HIV programmes

The NSF has introduced a new paradigm shift in the planning process for the HIV and AIDS multisectoral response. This new thinking requires that the country develop programmes that will assist the country to achieve the targets that are set in the NSF results framework. At the same time, NERCHA was appointed to be the Principal Recipient (PR) for GFATM. This role has required NERCHA not only to use its own resources in funding implementation gaps in the programmes but also to increase capacity within the office to support coordination of implementation of the HIV and AIDS programmes.

3.1 HIV Prevention Programmes

HIV prevention remains critical for the national response to the epidemic. Effective prevention has a strong and long lasting effect on HIV and AIDS response as there would be reduced new infections. The prevention interventions are designed to reduce exposure to HIV, reduce the probability of transmission when exposed, and influence change in societal norms, values and practices that tend to impact on peoples' ability to adopt key impediment behaviors. The main objective for the prevention thematic areas is to **promote safer sexual and health seeking behaviors and to delay sexual debut**

The NSF recommends the constitution of a National Prevention Technical Working Group whose key role shall be to facilitate coordination of the multisectoral prevention programme, facilitate development of prevention program policies, guidelines and standards. The Terms of Reference for the National Prevention Technical Working Group have been drafted and are in line with the NSF outcomes. It will be the responsibility of this committee to facilitate implementation of the NSF results framework.

The prevention programmes supported by the GFATM have been implemented and although there were delays in the start of the programme it is anticipated that targets set for the programme will be met within the allocated timeframes.

a) Behavioural Change Communication (BCC)

The BCC programme has worked through the BCC committee to develop the SBCC strategy. The "one-love" campaign focused on reducing multiple concurrent partnerships using multiple approaches such as mass media (billboards, radio, radio talk-shows, radio-drama series) and mobile discussions/bus rides among others; youth focused programmes in the year included the review of the youth menu programme, faith-based programme support was offered for TV programmes to address family issues and HIV and AIDS.



b) Prevention of Mother to Child Transmission (PMTCT)

The PMTCT programme is coordinated by a sub-committee alongside the Clinical TWG . Global Fund support for Round 7 is coordinated by SNAP.

c) Sexually Transmitted Infections (STIs)

This programme has maintained the service delivery in line with the national STI guidelines coordinated within the Clinical TWG.

d) Blood Safety:

Resources to support this programme are coming from the Global Fund and MOH largely for donor recruitment, procurement of reagents and supplies and human resource.

e) Condoms:

Condoms are recognized to be one of the key HIV prevention interventions. Major funding is sourced from both the UNFPA and NERCHA. Through support from UNFPA and PSI, the Ministry of Health initiated the development of the National Condom Strategy. This strategy is informed by a Rapid Needs Assessment which was conducted early in 2008. A wide stakeholder consultation, with a local consultant was implemented to inform the draft National Condom Strategy.

f) Male Circumcision (MC):

A National MC Policy has been approved by Cabinet, followed by the National MC Implementation Plan and the MC Protocols. The PSI and RFM Memorandum of Understanding has been signed and MC instruments and equipment have been supplied to this institution. Challenges experienced so far include the inadequate reporting exacerbated by the lack of the MC reporting tools that are still being developed. There are plans to establish an MC Centre of Excellence in the country.

g) Post Exposure Prophylaxis (P.E.P.)

The NSF outcome level result for PEP is that 100% of people reporting to be in need of PEP should receive these services as according to the national guidelines, by the year 2014.

h) Workplace HIV Program.

A Technical Working Group comprising of the relevant workplace stakeholders has been elected, among whose responsibilities are Coordination and Formulation of Standards. Technical Assistance will be sought to assist in the development of the National Workplace program, taking into consideration the existing workplace operational documents as well as the international or developmental partners

3.2 HIV treatment, care and support programme

The treatment, care and support thematic area's concern is ensure that people infected with HIV are cared for in order to curb morbidity and mortality due to AIDS and improve the quality of life.

1. HIV Counseling and Testing.

This programme is identified as an entry point to treatment care and support. The programme is coordinated through the Clinical TWG. Post test support groups are available at community levels to offer support to those that test HIV positive. It is observed that there is a gap to



support those who test HIV negative in order to help them stay negative.

2. ART

There is positive partner support for this area. Adherence to treatment is a major concern especially as it related to resistance; therefore the MOH is facilitating the active participation of all relevant stakeholders including PLHIV. HIV/TB con-infection is being adequately addressed within the ART guidelines and the participation of the TB programme in the clinical TWG.

3. Community Based Care and Support [CBCS (formerly Home Based Care)

A national Technical Working Group has been established to strengthen the delivery of home based care services. Regional TWG on CBCS have also been formed to coordinate and strengthen management of Home based care in the regions. Partners in CBCS are developing a national M&E tool for CBCS

4. Palliative Care

A Palliative Care Policy under the leadership of the Ministry of Health is currently being developed. A Policy Committee and a Technical Working Group has been established for this programme. The African Palliative Care Association is providing support in implementation of this programme in the country.

3.3 HIV Impact Mitigation Programme

1. Quality Impact Mitigation Services (QIMS)

The process of conceptualizing of the Quality, Relevance and Comprehensiveness of Impact Mitigation Services (QIMS) survey, developing tools that can assess the quality, relevance and comprehensiveness of the services in a standardised and population representative way so that a trend analysis can be set over time. The process was jointly funded by World Bank (GAMET), UNICEF and NERCHA.

The objective of the QIMS Survey is to measure whether: The provided services were relevant? The quality of the provided services?; The provided services were comprehensive?; and What should be done differently? The formative research has been completed.

2. National Psychosocial Support Programme for Children (PSS)

In the last year, The National Children's Coordinating Unit (NCCU) together with partners finalized the National Psychosocial Support Programme for Children. NERCHA has assisted NCCU with the recruitment a Child Psychologist and a Swazi Psychologist, who would under study the child psychologists. Further, the NCCU has established a National PSS Committee that coordinates all the children's PSS activities in the country. NERCHA is a member of this committee. A programme for caregivers to enroll in the University of KwaZulu Natal, to undertake a certificate programme in counseling for children is now available. Twenty Kagogo Centre Managers were enrolled in this programme.

3. Food Security Programme: Indlukhulu

The Indlukhulu programme has been re-conceptualised. The new programme focused a shift from communal fields to household based approach to providing farm inputs to the OVC at household level. The Indlukhulu programme document which included the monitoring tools was



finalized. Funding from GFATM has been available for this programme.

4. Early Childhood Care and Development (ECCD)

This year, two baseline surveys were undertaken to ascertain the number of and level of ECCD centres in the country. The baseline of preschools and NCPs was undertaken by the Ministry of Education ECCD Inspectorate and UNICEF together with partners. However, the ECCD strategy is still without a Monitoring and Evaluation Plan.

5. Neighbourhood Care Points (NCPs)

A National NCP strategy is under development. The purpose of the strategy is to standardize activities and provision of services to the NCPs.

4. Funding

The Council has received Grant Funds from the Swaziland Government. They have also received funding from Global Fund to fight HIV/ Aids, Tuberculosis and Malaria. Funding has also been received from bilateral, multilateral donors and others.

Funding from Government is primarily used to co-ordinate the national HIV/AIDS multi-sectoral responses, whereas grants received from donors are utilised for specific activities. Funding received during this financial year amounted to E122.4m, against E163.3m received last year. This decrease was mainly as a consequence of one of the grants from Global Fund (Round 2) reaching the end of its term. There was also an element of delayed disbursements as a result of pending conditionalities on one of the Global Fund grants.

Below is a table showing grant income received:

Figure 2: Grant Income Received

Source	Received 2006/7 (E)	Received 2007/8 (E)	Received 2008/9 (E)	% Increased
Swaziland Government	30 000 000	45 000 000	48 600 000	8
Global Fund	107 238 678	114 907 586	68 331 392	-41
UNDP		634 513	884 500	100
Interest and other income	901 683	1 771 008	2 891 459	
SIPAA	1 048 841			-100
SAFAIDS International	35 343			-100
World Bank	294 440			-100
African Alliance	500 000	35 000		-100
Young Heroes	687 917	929 284	1 672 625	80
Total Funding	140 706 902	163 277 391	122 379 975	-25
Funds Carried forward from previous year	7 731 907	31 681 748	49 980 799	58
Total funding available for the Response	148 438 809	194 959 139	172 360 774	-12

Although income from the Global Fund dropped by 41% as a result of the Round 2 grant coming to the end of its natural term, the subvention from Government and Young Heroes increased by 8% and 80% respectively.



5. UTILISATION OF FUNDS

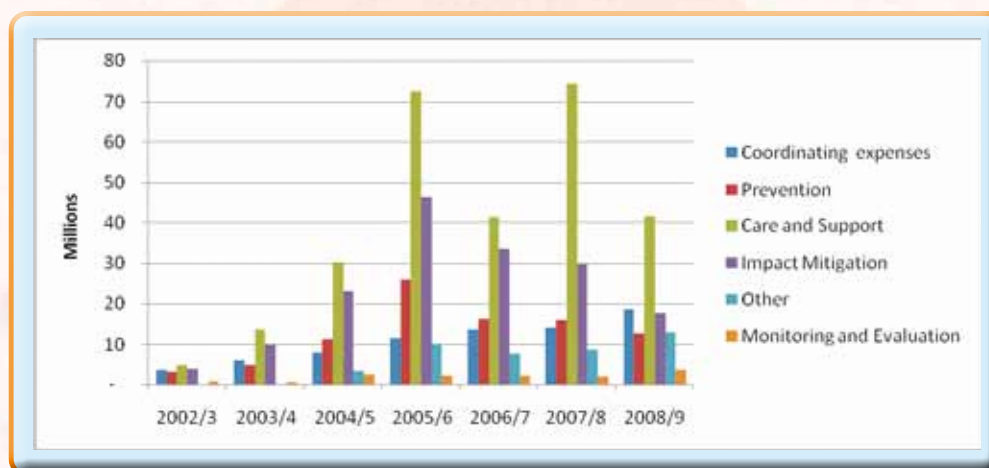
The burn-rate (utilisation of funds) decreased from 73% to 67% during the year.

Figure 3: Funds Utilised

Source	Utilised 2006/7 (E)	Utilised 2007/8 (E)	Received 2008/9 (E)	% Increased
Swaziland Government	34 757 964	35 047 020	41 110 482	17%
Global Fund	79 117 114	107 197 420	70 144 613	-35%
UNDP		93 160	2 073 949	100%
Young Heroes	409 838	845 549	1 711 711	102%
Other	1 570 462	24 184	198	-99%
Total Expenses	115 855 378	143 207 333	115 040 953	-20%
Funds Carried Forward to Next Year	32 583 431	51 751 806	57 319 821	11%
% of Funds Used	78%	73%	67%	-9%

The decrease in spending, when compared to last year, was mainly a consequence of conditionalities on Global Fund funding that took time to be resolved later in the year. Historically, over the past five years of operation, spending on treatment, care and support remains the highest, at an average of 41% of total spending.

Figure 4: The Trend in HIV/AIDS Spending





6. OPERATIONAL EFFICIENCY

In March 2009, the Council set the following efficiency ratios for the NERCHA Directorate:

- Directorate Administration Expenses to total expenditure must not be more than 15%.
- Directorate Administration Costs to total Government subvention must be maintained below 45%.
- Staff expenses should not count for more than 25% of the Government subvention.

The NERCHA Directorate Co-ordinating Expenses during the year have been maintained within these levels, except for total administration costs to total expenses. The deterioration of administration costs to total expenses ratio was mainly as a result of the temporary decrease in project expenses during the year. Staff expenses were 10% of total expenses and only 38% of the subvention received from Government was absorbed into administration costs.

Figure 5: Operational Efficiency

Year	Year End 2003	Year End 2004	Year End 2005	Year End 2006	Year End 2007	Year End 2008	Year End 2009	7 year average
Efficiency ratios:								
1. Staff costs / Total costs	12%	9%	5%	4%	7%	6%	10%	8%
2. Administration Costs/ Total Costs	22%	16%	10%	7%	11%	10%	16%	13%
3. Administration Costs/ Projects Expenses	28%	19%	11%	7%	13%	11%	19%	15%
4. Administration Expenses / Government Grant	11%	29%	40%	46%	46%	32%	38%	35%
5. Total Costs / Total Income	46%	46%	58%	96%	79%	74%	66%	67%
Proportion of Costs:								
6. Administration/ Total Costs	22%	16%	10%	7%	11%	10%	16%	13%
7. Prevention / Total Projects	20%	13%	14%	15%	13%	11%	11%	14%
8. Care and Support/ Total Projects	29%	38%	38%	42%	34%	50%	36%	38%
9. Impact Mitigation / Total Projects	24%	27%	29%	27%	28%	19%	14%	24%
10. Other Projects	0%	0%	4%	6%	7%	6%	13%	5%
11. M&E / Total Projects	4%	1%	3%	1%	2%	1%	3%	2%
12. Malaria	0%	5%	1%	0%	2%	1%	3%	2%
13. Tuberculosis	0%	0%	0%	2%	2%	2%	4%	1%





7. COUNTRY CO-ORDINATING MECHANISM

Most of the funds included in the financial statements are received from the Global Fund, to fight AIDS, Tuberculosis and Malaria.

Funds from the Global Fund are received through the work of the Country Co-ordinating Mechanism (CCM). The Global Fund requires that recipient countries and those who aspire to be recipients must establish Country Co-ordinating Mechanisms. The CCM is made up of a variety of stakeholders, each representing an active constituency with an interest in combating one or more of the three diseases: AIDS, Tuberculosis and Malaria.

The CCM in Swaziland appointed NERCHA to be the Principal Recipient of the existing Global Fund Grants. The CCM is made up of ten constituencies, including Government. Each constituency has one seat, but Government was allocated five seats. The representation is as follows:

Figure 6: Country Co-ordinating Mechanism Representation

CONSTITUENCY	REPRESENTED	MEMBERSHIP STATUS
1. GOVERNMENT:		
Prime Minister's Office	Mbuso Dlamini	Substantive (Chairman)
Ministry of Health	Dr Stephen Shongwe (PS) Ms Rejoice Nkambule	Substantive Member Alternate Member
Ministry of Economic Planning & Developmnt	Vacant Vacant	Substantive Member Alternate Member
Ministry of Housing	Vacant Vacant	Substantive Member Alternate Member
Ministry of Tinkhundla Administration & Development	Vacant Vacant	Substantive Member Alternate Member
2. NON-GOVERNMENTAL ORGANIZATIONS		
NGOs	Ms Doo Aphane Rev. Senzo Hlatshwayo	Substantive (Vice) Alternate Member
3. Academia	Dr Solomon Dlamini Dr Winnie Nhlengethwa	Substantive Member Alternate Member
4. People Living with HIV and AIDS	Mr Yusie Nxumalo Ms Thembie Nkambule	Substantive Member Alternate Member
5. Private Sector	Ms Zodwa Mabuza Ms Makhosazana Hlatshwayo	Substantive Member Alternate Member
6. Key Affected populations	Mr Maxwell Jele Vacant	Substantive Member Alternate Member
7. Faith Based Organizations	Ms Khangezile Dlamini Rev. Zwanini Tshabalala	Substantive Member Alternate Member
8. Traditional Healers Organizations	Dr Nhlavana Maseko Ms Betty Moyane	Substantive Member Alternate Member
9. Bilateral Development Partners	Dr. Jama Gulaid Dr Edward Muganu	Substantive Member Alternate Member
10. MULTILATERAL DEVELOPMENT PARTNERS		
PEPFAR	Dr George Bicego	Sub/Alternate Member
Italian Corporation	Dr Mauro Almaviva	Sub/Alternate Member
European Union	Mr Traore Amadou	Sub/Alternate Member



In addition to the ten voting constituencies, the CCM allocated non-voting seats to the following Ex-Officio members:

1. NERCHA
2. Principal Recipient
3. National Malaria Control Programme
4. National Tuberculosis Programme
5. Swaziland National Aids Programme (SNAP)
6. UNAIDS
7. AMICAALL

It is important to state that prior to the 27th February 2009, the non-voting members had voting rights and the following Ministries were not part of the CCM:

- Ministry of Economic Planning & Development
- Ministry of Tinkhundla Administration and Development
- Ministry of Housing

The CCM, during this term of office, is chaired by the Principal Secretary from the Prime Minister's Office. The position of Vice-Chairperson is held by the non-governmental constituency.

The CCM met ten times during the year and concluded, amongst other issues, the following:

1. Co-ordinated the development and submission of National Proposals under the 8th call of proposals by the Global Fund for the following components:

DISEASE COMPONENT	AMOUNT IN US\$ DOLLARS	OUTCOME
HIV/AIDS Proposal	90,214,010	Not Approved
Malaria Proposal	15,136,443	Approved
Tuberculosis Proposal	11,839,346	Approved
Health Systems Strengthening	13,880,941	Approved

Approved the Round 7 work plan consolidated by the NERCHA Directorate, Principal Recipient, in consultation with the implementers.

2. Assisted the Principal Recipient with the selection of sub-recipients for Round 7.
3. Approved the Quarterly Progress Reports on the performance of all Global Fund grants presented by the Principal Recipient (NERCHA).
4. Approved the Grant Closure Plans for Round 2 grants, AIDS and Malaria.
5. Appointed a representative of the Swaziland CCM to the Regional CCM (SADC CCM).
6. Submitted the National Strategic Framework and Action Plan for funding to the Global Fund under the National Strategic Application pilot project. The funding applied for, unfortunately, was not approved.



7. The CCM constrained for time to develop a comprehensive proposal within the available timeframe. After unfavourable results on the National Strategic Application, they resolved not to submit the Round 9 proposal to Global Fund. It was further determined that a submission will be proposed for Round 10.
8. The CCM received Capacity Development from Grants Management Solutions, a consulting firm provided by the United States Government.
9. The CCM received the Global Fund Mission led by the Global Fund Portfolio Manager from the 17th to 27th March 2009.
10. Following the Capacity Building Workshop, the CCM re-organised itself into ten constituencies and increased the seats for Government from two to five. Furthermore, the CCM established two committees, the Executive Committee and the Oversight Committee.

The Executive Committee is chaired by the CCM Chairperson and is made up of the following members:

- CCM Chairperson - Mr. Mbuso Dlamini
- CCM Vice-Chairperson - Ms. Doo Aphane
- Development Agencies - Dr. Jamal Gulaid
- PLHIV - Mr. Vusie Nxumalo

The Oversight Committee is made up of the following members:

- Development Agencies - Dr. George Bicego
- Ministry of Health - Ms. Rejoice Nkambule
- NERCHA - M&E Unit (to be advised)
- ACADEMIA - Dr. Winnie Nhlengethwa
- Private Sector - Ms. Makhosazana Hlatshwayo

Figure 7: Programme of Global Fund Grants Overseen by the CCM:

Round	Disease	Term of Grant	Amount in US Dollars				Performance Ratios	
			Total Proposal Amount	Total Grant Amount	Amount Received	Amount Spent	% Spent of Received Funds	Total of Grant Spent
Round 2	HIV/AIDS	2003-2008	52 544 145	52 544 145	49 276 920	47 878 146	97.2%	91.1%
Round 2	Malaria	2003-2008	1 820 500	1 820 500	1 431 733	1 464 327	102.3%	80.4%
Round 3	Tuberculosis	2005-2009	2 506 000	2 506 000	1 790 009	1 665 929	93.1%	66.5%
Round 4	HIV/AIDS	2005-2010	45 839 731	45 839 731	15 614 961	15 358 809	98.4%	33.5%
Round 7	HIV/AIDS	2009-2013	81 866 490	28 380 316	2 310 367	58 324	2.5%	0.2%
Round 8	Tuberculosis	2009-2013	11 839 349	-	-	-	-	0%
Round 8	Malaria	2009-2013	13 880 938	5 051 555	2 525 617	-	-	0%
Round 8	Health Systems Strengthening	2009-2013	15 136 442	-	-	-	-	0%
Total			225 433 592	136 142 247	70 423 990	66 425 535	94.3%	48.8%



NB
 * Grant agreement signed in May 2009 after financial year end and disbursement received in June 2009.
 ** Work plans for these grants were being finalised at the time of this report but will be signed before the end of October 2009.

Figure 8: HIV and AIDS Performance Indicators

Service Delivery Area	Indicator Description	Intended Target	Actual Achieved	Reason for Programmatic Deviation
Prevention: BCC- Community Outreach.	No. of trained active peer educators	900	898	Adequate numbers of peer educators have been trained but retaining these remains a challenge due to the unavailability of incentives.
	Young people (15-24) that participated in HIV prevention programmes in and out of schools.	47 387	62 750	All the youth centres are now operational; this achievement is attributed to the activities provided through these centres. The Global Fund assisted with an additional 16 centres over and above those that already existed.
Prevention: Condom distribution.	Number of male and female condoms distributed.	2 million	1 123 537	One of the condoms storage rooms was burnt down and this, inevitably, affected distribution.
Prevention: PMTCT	Percentage of HIV-Positive pregnant women receiving a course of ARV to reduce MTCT in accordance with nationally approved protocol.	76%	56%	This achievement is below target. Not all health facilities provide PMTCT, thus pregnant mothers within these facilities do not have access to PMTCT services and this negatively affects coverage.
Prevention: Blood safety and universal precaution.	Number of blood units collected and screened for HIV.	2500	2,606	The National Transfusion Services was able to meet the target for the quarter January - March 2009.
Care and Support: support for orphans and vulnerable children.	Number of community members trained in ECCD.	3600	2319	There were pending conditionalities affecting the implementation of this activity, hence there has not been any movement from what was reported last year.
Care and Support: care and support for families and communities affected.	Number of vulnerable children that receive education support in non-formal schools.	1600	3,431	These vulnerable children are reached through Sebenta.
	Number of non-formal schools for OVC and adult operational.	12	12	Eight of the schools have been fully constructed and the other four are at the stages of completion. However the initiator of this programme is using community structures (released by the Community Leaders) to provide education, hence all twelve schools are operational.



	Number of care-giver schemes established.	1200		The implementation of the care-givers scheme has been delayed by conditions imposed by the Global Fund which had not been consolidated by the end of the year. A revised strategy was submitted to the Global Fund and at the time of this report's preparation, no response has yet been received.
Care and Support: Care and Support for the chronically ill.	Number of care-givers trained in micro-finance.	8,000		Connected to the above.
	Number of care-givers benefiting from schemes.	N/A		Connected to the above.
Treatment Care and Support: Home Based Care.	Number of people receiving HBC.	48,000	5,444	An assessment carried out by the Ministry of Health revealed that there were 5443 people accessing HBC in Swaziland. The target was set before the start of the ART programme and was based on the number of people assumed to be in need of ART when the proposal was being developed.
	Number of people that have been trained in palliative care.	180	189	'Swaziland Hospice at Home' has been able to continue with training in palliative care, notwithstanding the delays in the disbursement for this activity.
Antiretroviral treatment (ARV) and monitoring	Number of people tested for HIV who have received their results and post test counselling.	30,000	25,505	The target was not met. This is an interim figure of people tested for HIV during the period.
	Percentage of health care facilities that have the capacity to provide advanced level HIV/AIDS care and support services, including ART.	30/ 30 (100%)	27/30 90%	27 sites are providing ART within their own facilities and there are more than 30 outreach sites for this service.
	Number of people receiving ARV therapy.	35,000	35,345	The rollout of ART to lower-level health facilities has contributed to achieving the target. However, the target from that of March 2009 increased by only 3000 and yet the result has increased by 9 200.



8. TB Program Commentary

Tuberculosis is one of the leading causes of morbidity and mortality among adults in Swaziland. The number of TB cases notified in Swaziland has increased six fold over the last 15 years and the country is among the highest in the world (WHO Global TB report 2008). The high TB incidence rate could be attributable to the very severe HIV epidemic and the previous poor control of the disease in the country. The National Tuberculosis Control Program (NTCP) has made significant changes in the organization of the TB control services in the country and this is highlighted in their 2008 National Annual Report.

The NTCP in collaboration with partners, such as the Swaziland National Aids Program intensified the training of all TB nurses and doctors in HIV testing and counselling and TB screening in HIV care settings. This endeavour was aimed at improving service delivery for the benefit of TB patients from the Health Treatment Centres and other related HIV care and support service points.

Tuberculosis Case Finding

During the year 2008, the NTCP adopted a strategy (case finding strategy), which is opposed to the passive (patients presenting themselves to health facilities with signs and symptoms) way of doing things. At the end of the year, a total number of 9, 656 TB cases were reported in the country versus 9, 636 in 2007, reflecting an increase of 0.2%. For a population of about 1, 018, 449 people, this corresponds to a notification rate of 966 TB cases per 100,000 population. Case detection rate improved from 57.6% among pulmonary smear positives TB cases in 2007 to 60% in 2008 and females were more affected than the at earlier ages (see figures 9, 10 and 11 below). Treatment success rate for pulmonary smear positive cases also improved significantly from 42% in 2007 to 58%

Figure 9: Distribution of AFB new smear positive TB cases by age and gender in 2008

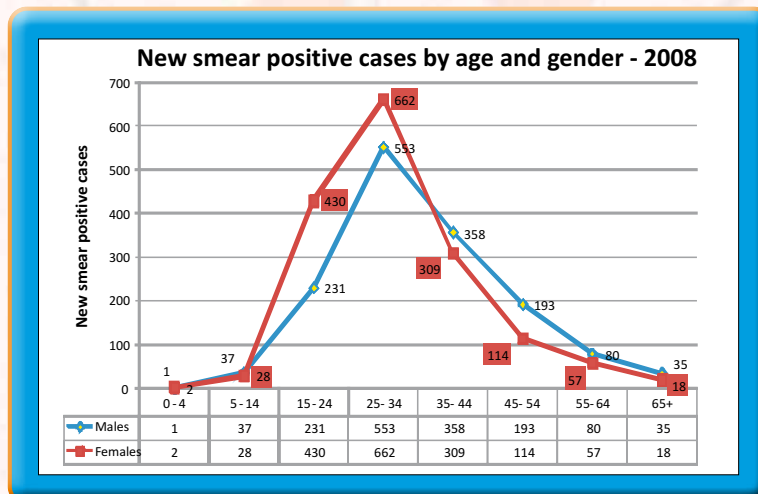




Figure 10: Case detection rate among new PTB smear positive cases reported in Swaziland from the year 2002-2008

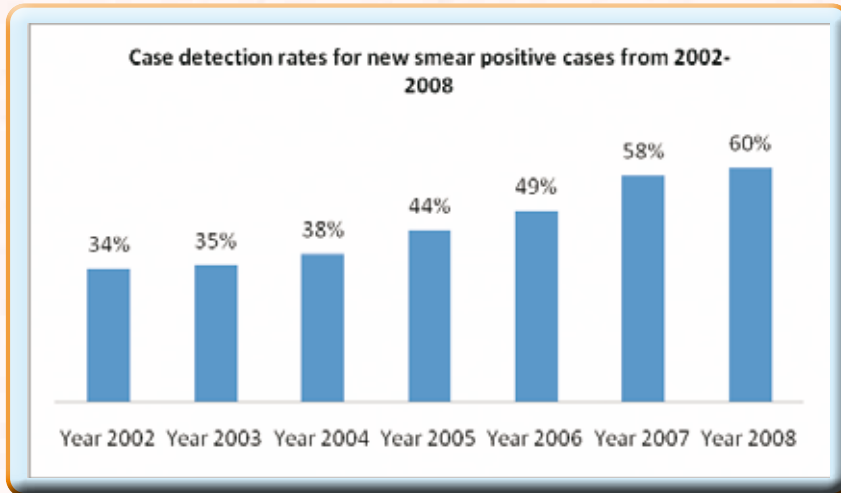
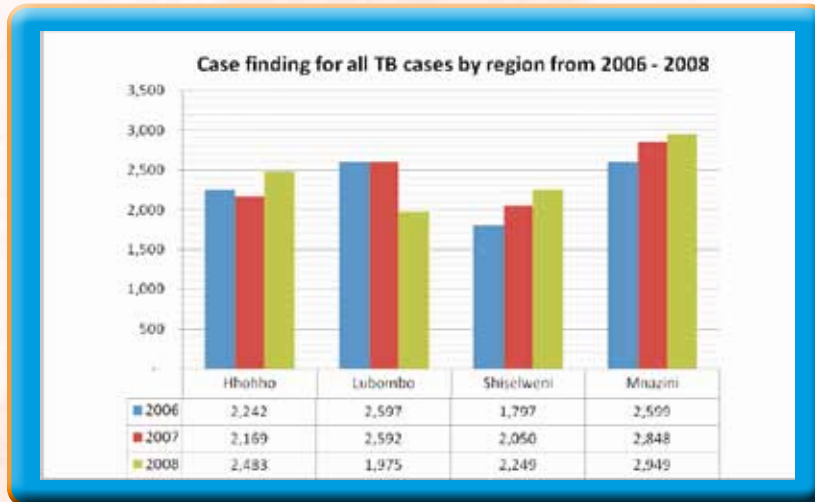


Figure 11. Trends of case finding for all TB cases per region by year



Overall, there has been an improvement in smear conversion over the year from 54% to 67% among smear positive PTB. Smear conversion remain low among retreatment cases from 44% to 55%.

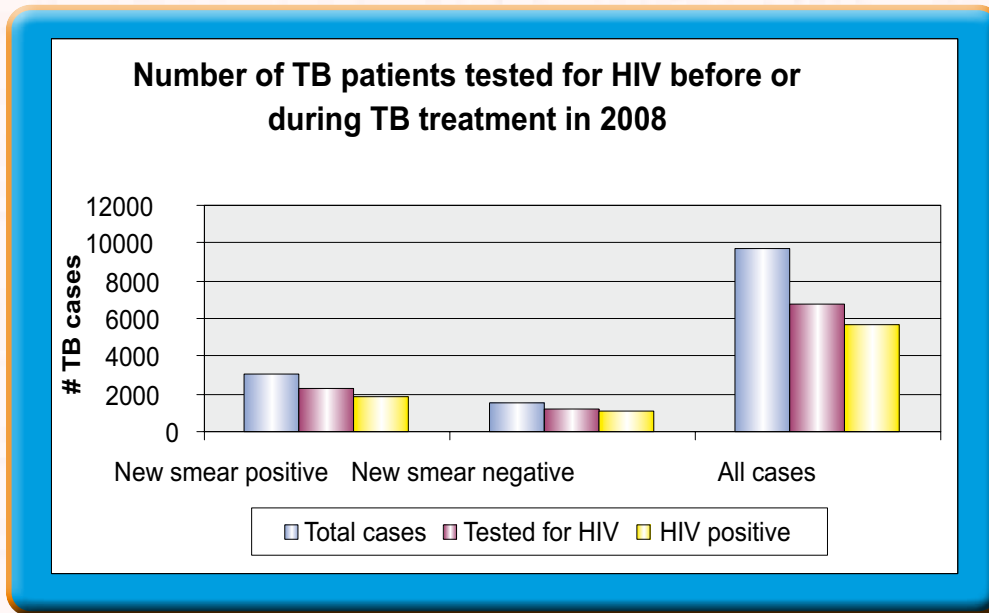




8.1 TB/HIV collaboration

According to the 10th HIV sentinel surveillance report of 2006, the prevalence of HIV among TB patients was estimated at 79.6%. A routine surveillance system for HIV infection among TB suspects and patients was started in 2007/8 and 70% of all the registered TB cases received HIV testing and counselling. Of these patients that tested for HIV, 84% came out positive.

Figure 12: Number of TB patients tested for HIV before or during TB treatment in 2008



Service Delivery Area	Indicators	Target	Achieved	Comments
TB: Identification of infectious cases	Number of nurses and doctors trained on TB case detection and treatment	850	920	Extensive training has been undertaken to TB case detection
TB: Identification of infectious cases	Number of laboratory technicians trained in sputum smear examination for TB	30	32	All laboratory technicians were trained in sputum smear examination for TB
TB: Identification of infectious cases	Number of new smear positive cases detected	3 000	3 328	Case detection through smear has improved due to indicator 1 & 2 above
Supportive Environment: Community TB Care (CBTBC)	Number of TB patients supervised during the intensive phase by treatment supporters	6 800	10 397	The program performed well on this target
Supportive Environment: Community TB Care (CBTBC)	Number of diagnostic TB facilities participating in community DOTS	20	20	More diagnostic facilities were accredited, which also includes the private sector.



TB: Timely detection and quality treatment of cases	Percentage of health facilities reporting no stock-outs of TB drugs for more than two weeks	100%	100%	All the accredited facilities keep buffer stock of drugs to avoid stock-outs
TB: Timely detection and quality treatment of cases	Number of new smear positive cases successfully treated	2 200	1 717	Measuring treatment success is still a challenge as some patients do not complete treatment due to various reasons
TB/HIV collaborative activities: Intensified case finding among PLHWA	Number of TB diagnostic facilities that offer HIV counselling and testing	20	20	All the accredited facilities offer HIV counselling and testing services
TB/HIV collaborative activities: Intensified case finding among PLHWA	Percentage of new TB cases screened for HIV			Program has a challenge because of proximity of TB centers and ART facilities





9. Malaria Program Commentary

The National Malaria Control Program (NMCP) presents an overview of the major malaria control interventions implemented during the 2007 - 2008 financial year and these are: Epidemiological Surveillance, Case Management, Vector Control, Community Mobilisation, and Program Management. The priorities for the 2008 - 2009 are also identified at the end of this report. The information cited in this report was based on routine data collection of health information, weekly surveillance system and community health surveys.

9.1 Epidemiological Surveillance

An analysis of outpatient and inpatient data during 2007-2008 indicates that there was a significant decrease in the incidence of malaria-related morbidity, admissions, and deaths, (see figures 1 and 2 below). The observed reductions could be attributable to a number of factors, including improved case management at health facilities, consistent availability of drugs in health facilities, improved health-seeking behaviour, effective implementation of other control interventions, strong regional collaboration with neighbouring countries such as through the Lubombo Spatial Development Initiative (LSDI) and unfavourable climatic and environmental conditions for malaria transmission.

Figure 13 National Outpatient Malaria Cases by Month, 2007- 2008

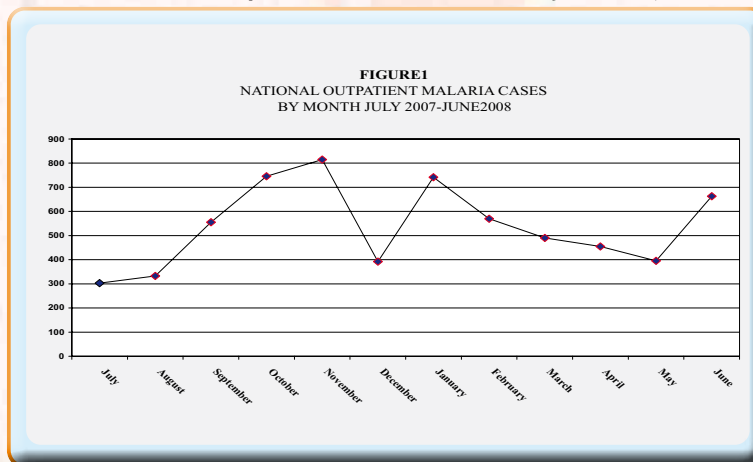
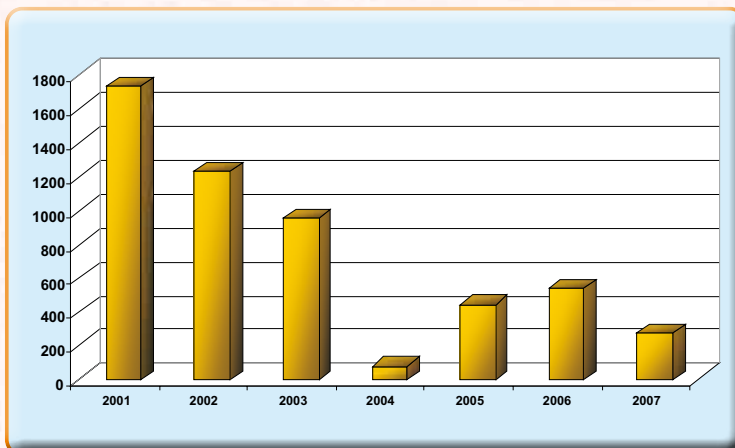




Figure 14. National Inpatient Malaria Admissions, 2001-2007



9.2 Case Management

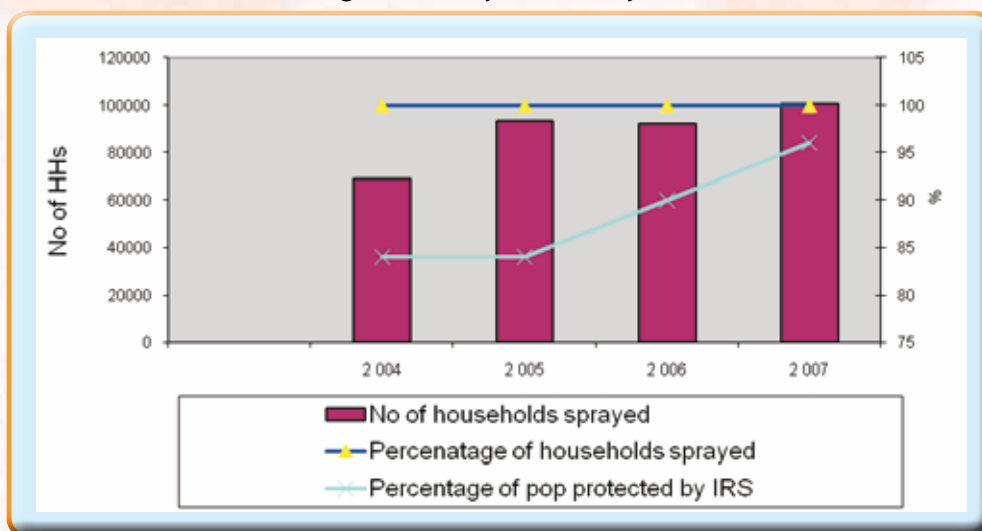
The program continued to train clinic healthcare workers on malaria case management to improve the quality of care in health facilities. The training included healthcare workers in the Lubombo, Manzini, Shiselweni, and Hhohho regions. To-date, it is estimated that 90% of health workers have been trained on management of uncomplicated and severe malaria.

The program also trained the epidemic taskforces on epidemic preparedness and response (EPR) in preparation for the oncoming malaria transmission season.

9.3 Vector Control

Vector control still remains the major approach in the reduction of malaria transmission in the country. The main interventions include indoor residual spraying (IRS) and distributing long-lasting insecticide-treated nets (LLINs) to pregnant women and children under 5 years. The program continued to maintain high IRS coverage with DDT (75% wettable powder) and pyrethroids (Icon 10 cs) of 93% and 96.4% respectively. The program continued to achieve above the 80% population protected by IRS, which is the minimum recommended by the WHO.

Figure 15 Performance of IRS





9.4 Community Mobilisation

Community mobilisation activities were undertaken during SADC Malaria Day and in preparation for the IRS campaign. The primary health promotion activities included celebration of malaria days and the dissemination of IEC materials. Messages on malaria were distributed using the electronic and print media houses. At community level, rural health motivators played a critical role in educating community members on all aspects of malaria control including the importance of early recognition of the signs and symptoms of the disease and prompt presentation to the nearest health facilities. The IRS teams continued to disseminate vector control messages in all the households that were sprayed.

A Knowledge, Attitudes, and Practices (KAP) survey was also conducted in collaboration with the South Africa Medical Research Council (MRC). A National KAP study conducted in 2007, on Malaria information and Information, Education and Communication (IEC), indicated that about 93.1% of respondents were reported to have heard information about malaria and that about (60.6%) of the respondents reported the health facility was the source of information.

9.5 Program Management

In October 2008, the program was awarded a US\$13.9 million Round 8 Global Fund grant to pursue malaria elimination in Swaziland. The major focus of the Malaria Round 8 Global Fund Grant is to roll-out Rapid Diagnostic Tests (RDTs) and Artemisinin Combination Therapy (ACTs), improve Vector Management, strengthen Surveillance, and Health Promotion.

9.6 Priorities Areas for 2008-2009

This section highlights the major priorities for the coming malaria season.

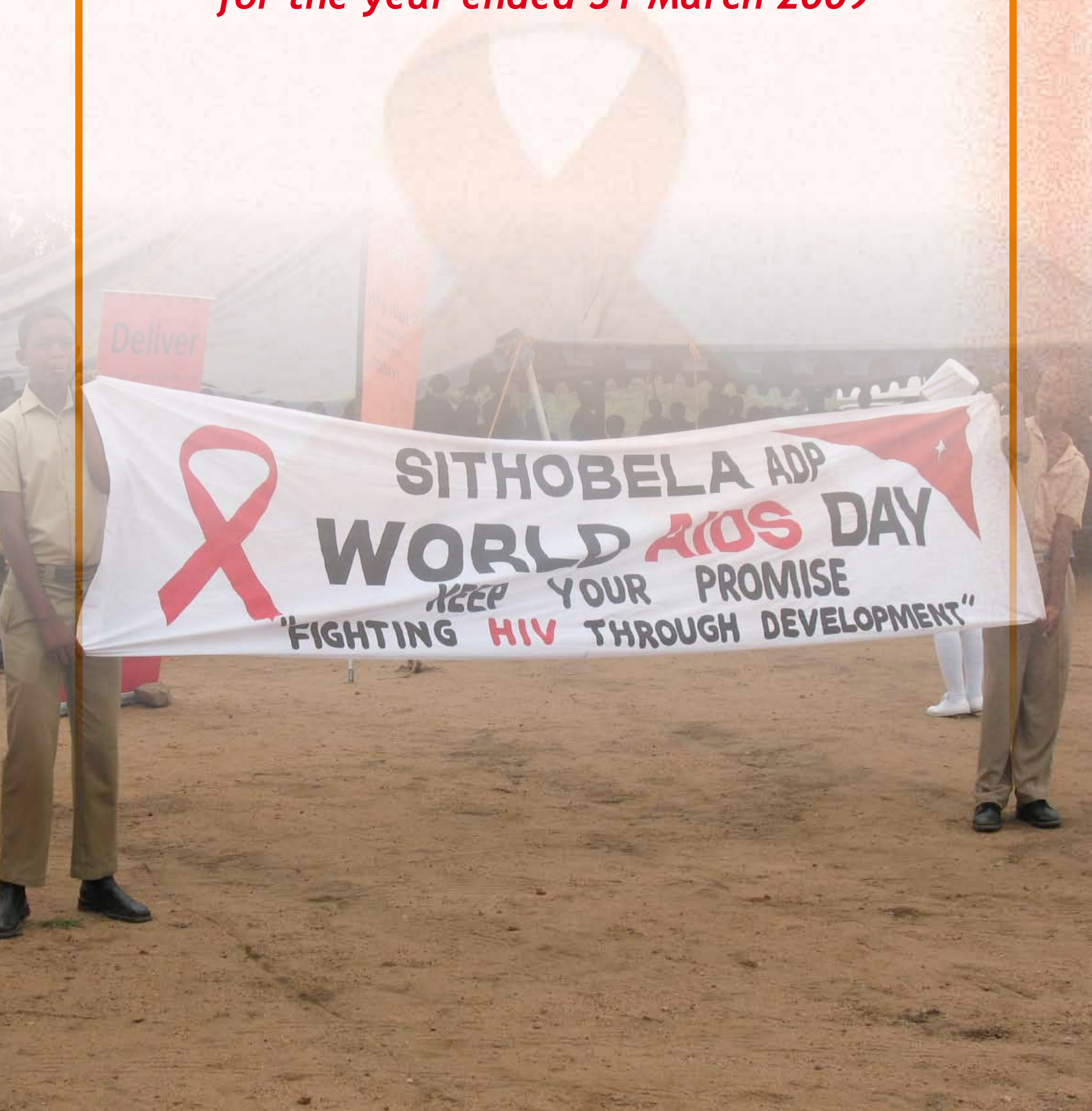
Summary of Priorities for 2008-2009

Area of Work	Priorities for 2008 -2009
Vector Control	<ul style="list-style-type: none">• Insecticide resistance management• Strengthening the GIS platform• Promotion of ITN utilisation and re-treatment• Assessment of ITNs coverage and acceptability
Case Management	<ul style="list-style-type: none">• Introduction of ACT• Development of diagnostics and treatment guidelines for ACT
Disease Surveillance and Research	<ul style="list-style-type: none">• Expand surveillance to all the health facilities
Community Mobilisation	<ul style="list-style-type: none">• Promotion of ITNs• Development of IEC materials for introduction of ACTs and RDTs
Program Management	<ul style="list-style-type: none">• Review of national malaria control policy• Development of vector control (IRS and ITNs) policy guidelines
Epidemic Preparedness and Response	<ul style="list-style-type: none">• Strengthen collaboration with meteorological services to strengthen focusing of malaria epidemics• Strengthen national epidemic task force• Extend surveillance systems outside traditional malarious areas



NATIONAL EMERGENCY RESPONSE COUNCIL ON HIV and AIDS

FINANCIAL STATEMENTS
for the year ended 31 March 2009





NATIONAL EMERGENCY RESPONSE COUNCIL ON HIV and AIDS

FINANCIAL STATEMENTS
for the year ended 31 March 2009

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COUNCIL MEMBERS' RESPONSIBILITY STATEMENT
for the annual financial statements
for the year ended 31 March 2009

The members of the Council are responsible for the preparation and fair presentation of the financial statements, comprising the balance sheet at 31 March 2009, and the income statement and cash flow statement for the year then ended, and the notes to the financial statements, which include a summary of significant accounting policies and other explanatory notes, and the Council members' report, in accordance with Swaziland and International Financial Reporting Standards and in the manner required by the National Emergency Response Council on HIV/AIDS Act, No 8 of 2003.

The Council members' responsibility includes designing, implementing and maintaining internal control relevant to the preparation and fair presentation of these financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

The Council members' responsibility also includes maintaining adequate accounting records and an effective system of risk management.

The Council members have made an assessment of the Council's ability to continue as a going concern and have no reason to believe the Council will not be a going concern in the year ahead.

The auditor is responsible for reporting on whether the financial statements are fairly presented in accordance with the applicable financial reporting framework.

Approval of the financial statements

The annual financial statements set out on pages 44 to 64 were approved by the members of the Council on 5 August 2009 and are signed on its behalf by:

.....
Member

.....
Member

5 August 2009



Report of the independent auditors

To the members of National Emergency Response Council on HIV/AIDS

We have audited the annual financial statements of National Emergency Response Council on HIV/AIDS which comprise the balance sheet at 31 March 2009, and the income statement and cash flow statement for the year then ended, and the notes to the financial statement, which include a summary of significant accounting policies and other explanatory notes, and the Council members' report, as set out on pages 44 to 64.

Council members' responsibility for the financial statements

The Council's members are responsible for the preparation and fair presentation of these financial statements in accordance with Swaziland and International Financial Reporting Standards and in the manner required by the National Emergency Response Council on HIV/AIDS Act No 8, of 2003. This responsibility includes; designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies, and making accounting estimates that are reasonable in the circumstances.

Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



Opinion

In our opinion the financial statements present fairly, in all material respects, the financial position of the National Emergency Response Council on HIV/AIDS as at 31 March 2009, its financial performance and cash flows for the year then ended in accordance with Swaziland and International Financial Reporting Standards, and in the manner required by the National Emergency Response Council on HIV/AIDS Act No 8, of 2003.

Auditors





1.1 COUNCIL MEMBERS' REPORT

The members of the Council have pleasure in presenting their report on the activities of the Council for the year ended 31 March 2009.

1. Establishment and objectives of the Council

1.1 Background

The National Emergency Response Council on HIV/AIDS is a multi-sectoral Council established in terms of the National Emergency Response Council on HIV/AIDS Act No 8, of 2003 to oversee the co-ordination of the national multi-sectoral response to HIV/AIDS and to review and adopt appropriate HIV/AIDS- related policies and strategies.

1.2 Funding of NERCHA

NERCHA is funded by the Swaziland Government and by grants from the Global Fund to fight, AIDS, Tuberculosis and Malaria ("Global Fund"), bi-lateral and multi-lateral donors and others.

2. Review of activities

The financial results of the Council are fully set out in the financial statements.

3. Management of the Council

NERCHA operates through a directorate. The Council members act in the same manner as a board of directors and guide and oversee the work of the directorate.

The NERCHA directorate is the executive office mandated to convert the National Multi Sectoral Strategic Plan for HIV/AIDS into an action plan and coordinate the implementation thereof.

3.1 The Council members during the year under review were as follows:

Chief Ndzabankhulu Simelane	-	Chairperson
Ms Thulisile Dladla	-	Deputy Chairperson
Mr Patrick Muir	-	Member
Mr John Hayter	-	Member
Mr Elliot Sihlongonyane	-	Member
Ms Bongiwe Duma	-	Member
Mr Sandile Ceko	-	Member
Ms Nomathemba Dlamini	-	Member
Dr Nhlavana Maseko	-	Member
Dr Zibuse Dlamini	-	Member



COUNCIL MEMBERS' REPORT (continued)

3.1 The Council members (continued)

Mr Dumisani Masilela	-	Member
Ms Thandi Nhlengetfwa	-	Member
Mr Tum du Pont	-	Member
Mr Phangijobo Matise	-	Member
Ms Grace Masilela	-	Member
Ms Aylline Dlamini	-	Member
Princess Msindvose	-	Member
Ms Thandi Beames	-	Member
Ms Sonto Magagula	-	Member

3.2 Directorate

Dr Derek von Wissell - National director and secretary to Council

4. Post balance sheet events

There were no significant post balance sheet events that, in the view of the Council, need to be disclosed.

5. Business and postal addresses

The registered business and postal addresses for the Council in Mbabane are

Cooper Centre
Sozisa Road
Mbabane

P O Box 1937
Mbabane
H100
Swaziland

6. Independent auditors

Auditors for the Council in the year under review are:

KPMG Chartered Accountants (Swaziland)
Ning Group Office Park
649 Somhlolo Road
P O Box 331
Mbabane
Swaziland



SIGNIFICANT ACCOUNTING POLICIES

1. Statement of compliance

The financial statements of the Council are prepared in accordance with the International Financial Reporting Standards issued by the International Accounting Standards Board (IASB), interpretations issued by the International Financial Reporting Interpretations Committee of the IASB and the provisions of The National Emergency Response Council on HIV/AIDS Act, 2003.

2. Basis of presentation

The financial statements are presented in Emalangeni, rounded to the nearest one. They are prepared on the historical cost basis, except for financial instruments which are stated at their fair values and incorporate the following principal accounting policies which are materially consistent with those adopted in the previous financial year.

3. Property and equipment

Items of property and equipment are stated at cost less accumulated depreciation.

Depreciation is charged on a straight line basis over the estimated useful lives of the assets.

The rates of depreciation used are based on the following estimated useful lives:

Computers	3 years
Leasehold improvements	5 years
Motor vehicles	4 years
Office equipment	5 years
Furniture and fittings	5 years

4. Grants

Grants are not recognised in the financial statements until there is reasonable assurance that the grants will be received by the Council and that the Council will comply with the conditions applying to the grants. Grants are recognised in the income statement on a systematic basis matching them with the related costs for which the grants are intended to compensate. The balance of grants received but not shown as income is classified as deferred income.



SIGNIFICANT ACCOUNTING POLICIES (continued)

5. Financial instruments

Financial instruments reflected on the balance sheet include cash and bank balances, accounts receivable and accounts payable. Cash and bank balances are reflected at their estimated fair values.

6. Provisions

A provision is recognised in the balance sheet when the Council has a legal and constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation.

7. Foreign currencies

Foreign currency assets and liabilities are translated into local currency at rates of exchange approximating those ruling at the balance sheet date and foreign currency transactions are translated at the rates ruling at the date of the transaction. Translation surpluses and deficits are recognised in the income statement in the year in which they occur.

8. Accounts receivable

Accounts receivable are stated at their cost less impairment losses.

9. Cash and cash equivalents

Cash and cash equivalents comprise cash balances and call deposits. Bank overdrafts that are payable on demand and form an integral part of the Council's cash management are included as a component of cash and cash equivalents for the purpose of the cash flow statement.

10. Trade and sundry accounts payable

Trade and sundry accounts payable are stated at their cost.

11. Pension and termination benefits

It is the policy of the Council to provide for retirement benefits, including those in terms of the Employment Act 1980 by payment to a separate retirement fund independent of the Council.

Obligation for contributions to the provident fund are recognised as an expense in the income statement as incurred.



INCOME STATEMENT

for the year ended 31 March 2009

	Note	2009 E	2008 E
Income			
Grant income		111 672 668	143 207 333
Donations		66 664	11 982
Interest income		2 020 344	1 755 014
Net foreign exchange gain		864 825	4 204 377
Surplus on disposal of assets		416 450	4 012
		<hr/>	<hr/>
		115 040 951	149 182 718
Expenses			
Administration expenses	1	(18 513 763)	(14 247 872)
Project expenses		(96 527 188)	(134 934 846)
		<hr/>	<hr/>
Net surplus for the year		-	-
		<hr/> <hr/>	<hr/> <hr/>

**BALANCE SHEET***at 31 March 2009*

	Note	2009 E	2008 E
ASSETS			
<i>Non-current assets</i>			
Property and equipment	2	3 569 711	1 831 814
<i>Current assets</i>			
Grants receivable	3	35 994 141	27 901 794
Other amounts receivable	4	790 581	746 416
Cash and bank balances	7.3	44 614 169	33 645 984
		<hr/>	<hr/>
		81 398 891	62 294 194
		<hr/>	<hr/>
Total assets		<u>84 968 602</u>	<u>64 126 008</u>
FUNDING AND LIABILITIES			
<i>Funding</i>			
Deferred grant income	5	57 319 823	49 980 798
<i>Current liabilities</i>			
Trade and other payables	6	22 908 906	14 145 210
Bank overdraft	7.3	4 739 873	-
		<hr/>	<hr/>
Total liabilities		<u>27 648 779</u>	<u>14 145 210</u>
		<hr/>	<hr/>
Total funding and liabilities		<u>84 968 602</u>	<u>64 126 008</u>

**CASH FLOW STATEMENT**
for the year ended 31 March 2009

	Notes	2009 E	2008 E
Cash flows from operating activities			
Cash utilised by operations	7.1	(1 107 097)	(20 172 093)
Interest received		2 020 344	1 755 014
		<hr/>	<hr/>
<i>Net cash generated/(utilised) by operating activities</i>		913 247	(18 417 079)
		<hr/>	<hr/>
Cash flows from investing activities			
Acquisition of property and equipment		(2 440 410)	(1 246 203)
Proceeds on disposal of property and equipment		416 450	17 410
		<hr/>	<hr/>
<i>Net cash outflow from investing activities</i>		(2 023 960)	(1 228 793)
		<hr/>	<hr/>
Cash flows from financing activities			
Grants received net of amount utilised to finance operations	7.2	7 339 025	18 299 049
		<hr/>	<hr/>
Net increase/(decrease) in cash and cash equivalents		6 228 312	(1 346 823)
Cash and cash equivalents at beginning of year		33 645 984	34 992 807
		<hr/>	<hr/>
Cash and cash equivalents at end of year	7.3	39 874 296	33 645 984
		<hr/> <hr/>	<hr/> <hr/>



NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 March 2009

	2009 E	2008 E
1. Administration expenses for the year		
Administration expenses for the year include:		
Auditors remuneration - fees for internal audit	150 000	66 500
- fees for external audit	250 000	169 235
Depreciation of property and equipment	702 513	684 734
Council members fees and emoluments	340 200	387 800
Operating lease payments	767 470	691 431
	<u> </u>	<u> </u>

2. Property and equipment

	Cost E	Accumulated depreciation E	2009 Net book value E
Land and buildings	1 999 754	-	1 999 754
Motor vehicles	1 175 334	(484 717)	690 617
Computer equipment	1 549 805	(1 173 438)	376 367
Office equipment	1 026 511	(714 157)	312 354
Furniture and fittings	558 057	(429 019)	129 038
Leasehold improvements	476 068	(414 487)	61 581
	<u> </u>	<u> </u>	<u> </u>
	6 785 529	(3 215 818)	3 569 711
	<u> </u>	<u> </u>	<u> </u>

	2008 Net book value E	Additions E	Depre- ciation E	2009 Net book value E
Land and buildings	551 229	1 448 525	-	1 999 754
Motor vehicles	410 887	536 294	(256 564)	690 617
Computer equipment	385 271	214 864	(223 768)	376 367
Office equipment	267 858	167 909	(123 413)	312 354
Furniture and fittings	114 964	72 818	(58 744)	129 038
Leasehold improvements	101 605	-	(40 024)	61 581
	<u> </u>	<u> </u>	<u> </u>	<u> </u>
	1 831 814	2 440 410	(702 513)	3 569 711
	<u> </u>	<u> </u>	<u> </u>	<u> </u>



NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2009 (continued)

2. Property and equipment (continued)

	Cost E	Accumulated depreciation E	2008 Net book value E
Land and buildings	551 229	-	551 229
Motor vehicles	1 014 437	(603 550)	410 887
Computer equipment	1 334 941	(949 670)	385 271
Office equipment	858 602	(590 744)	267 858
Furniture and fittings	485 239	(370 275)	114 964
Leasehold improvements	476 068	(374 463)	101 605
	<u>4 720 516</u>	<u>(2 888 702)</u>	<u>1 831 814</u>

	2007 Net book value E	Additions E	Disposals	Depre- ciation E	2008 Net book value E
Land and buildings	-	551 229	-	-	551 229
Motor vehicles	448 805	151 674	-	(189 592)	410 887
Computer equipment	247 937	382 204	(13 398)	(231 472)	385 271
Office equipment	316 258	100 458	-	(148 858)	267 858
Furniture and fittings	143 431	39 435	-	(67 902)	114 964
Leasehold improvements	127 312	21 203	-	(46 909)	101 605
	<u>1 283 743</u>	<u>1 246 203</u>	<u>(13 398)</u>	<u>(684 733)</u>	<u>1 831 814</u>



NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2009 (continued)

	2009	2008
	E	E
3. Grants receivable		
Grants receivable from Global Fund – HIV/AIDS	35 994 141	27 901 794
	<u> </u>	<u> </u>
4. Other amounts receivable		
Other amounts receivable comprise the following amounts due from grant providers in respect of expenses already incurred:		
Claypotts Trust Fund	384 228	219 167
African Alliance	-	125 359
	<u> </u>	<u> </u>
	384 228	344 526
	<u> </u>	<u> </u>
Staff study loans	53 203	47 469
Sundry debtors	142 205	109 124
Prepaid expenses	88 153	245 297
Interest receivable	122 792	-
	<u> </u>	<u> </u>
	406 353	401 890
	<u> </u>	<u> </u>
	<u> </u>	<u> </u>
	790 581	746 416
	<u> </u>	<u> </u>

**NOTES TO THE FINANCIAL STATEMENTS***for the year ended 31 March 2009 (continued)*

	2009	2008
	E	E
5. Grants		
<i>5.1 Grants received from the Swaziland Government:</i>		
Balance at beginning of year	12 409 586	2 456 606
Received during the year	48 600 000	45 000 000
Recognised in the income statement	(39 010 356)	(35 047 020)
	<hr/>	<hr/>
Balance at end of year	21 999 230	12 409 586
	<hr/>	<hr/>

Government grants are recognised as income over the period necessary to match them with the related costs which they are intended to compensate on a systematic basis. The Government has no specific period of funding.

5.2 Grants received from the Global Fund to fight AIDS, Tuberculosis and Malaria (“Global Fund”):

The Council on behalf of Country Coordination Mechanism has entered into a programme grant agreement with the Global Fund under which the Global Fund will provide funding to the Council to implement or oversee the implementation of the following:

5.2.1 Global Fund on HIV/AIDS Grant, Round 2

Balance at beginning of year	41 341 460	14 263 122
Received during the year	3 217 147	88 955 398
Recognised in the income statement	(27 085 040)	(61 877 060)
	<hr/>	<hr/>
Balance at end of year	17 473 569	41 341 460
	<hr/>	<hr/>

The coordinated country response to fight HIV/AIDS for the amount of US\$52 544 145, over a period from 1 August 2003 through to 31 July 2008.



NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 March 2009 (continued)

	2009 E	2008 E
5. Grants		
<i>5.2.2 Global Fund Malaria Grant, Round 2</i>		
Balance at beginning of year	(698 398)	654 464
Received during the year	2 324 975	-
Recognised in the income statement	(3 298 744)	(1 352 862)
	<hr/>	<hr/>
Balance at end of year	(1 672 167)	(698 398)
	<hr/>	<hr/>

The Swaziland National Malaria Control Programmes, for the amount of US\$1 820 500. Funds are to be disbursed over the period 1 October 2003 through to 30 September 2009.

5.2.3 Global Fund Tuberculosis Grant, Round 3

Balance at beginning of year	(1 870 455)	(4 003 757)
Received during the year	3 750 781	4 050 866
Recognised in the income statement	(4 608 302)	(1 917 564)
	<hr/>	<hr/>
Balance at end of year	(2 727 976)	(1 870 455)
	<hr/>	<hr/>

The coordinated country response to Tuberculosis for the amount of US\$2 506 000. Funds to be disbursed from 1 January 2005 through to 31 December 2009.

5.2.4 Global Fund on HIV/AIDS Grant, Round 4

Balance at beginning of year	(2 940 877)	17 207 736
Receivable during the year	35 994 141	21 901 322
Recognised in the income statement	(33 125 938)	(42 049 935)
	<hr/>	<hr/>
Balance at end of year	(72 674)	(2 940 877)
	<hr/>	<hr/>

Swaziland's programme to scale-up key components of the national HIV/AIDS response for the amount of US\$45 839 731 funds to be disbursed from 1 October 2005 through to 30 September 2010.



NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2009 (continued)

	2009 E	2008 E
5. Grants (continued)		
<i>5.2.5 Global Fund on HIV/AIDS Grant, Round 7</i>		
Balance at beginning of year	-	-
Received during the year	22 179 521	-
Recognised in the income statement	(831 151)	-
	<hr/>	<hr/>
Balance at end of year	21 348 370	-
<p>The seventh call for proposals: HIV/AIDS for the amount of US\$28 380 316. Funds to be disbursed from 1 January 2009 through to 31 December 2013.</p>		
	<hr/>	<hr/>
Balance at end of year	34 349 122	35 831 730
	<hr/> <hr/>	<hr/> <hr/>
5.3 Grants received from The Support to International Partnership against AIDS in Africa ("SIPAA") Programme:		
Balance at beginning of year	248 725	248 725
Received during the year	-	-
Recognised in the income statement	-	-
	<hr/>	<hr/>
Balance at end of year	248 725	248 725
	<hr/>	<hr/>
<p>The Council had entered into a financing agreement with SIPAA whereby SIPAA contributed by way of a grant from resources of a three year programme funded by the British Government's Department for International Development (DFID) and managed by Action Aid Africa. The amount of this agreement was GBP 547 000 and agreement was terminated in September 2006.</p>		
5.4 Grants received from SAFAIDS		
Balance at beginning of the year	-	277
Received during the year	3 773	-
Recognised in the income statement	-	(277)
	<hr/>	<hr/>
Balance at end of year	3 773	-
	<hr/>	<hr/>



NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 March 2009 (continued)

	2009 E	2008 E
5. Grants (continued)		
5.5 Grants received from the American Institute for Research ("AIR")		
Balance at beginning of year	550 874	539 781
Recognised in income statement	17 237	11 093
	568 111	550 874
<p>The Council has entered into grant agreements with AIR whereby AIR will contribute by way of grants amounting to US\$ 95 000 for the purposes of supporting the Council's community based intervention programs targeted at orphans and vulnerable children. The period of performance under the agreement has not been specified.</p>		
5.6 Grants received from Young Heroes:		
Balance at the beginning of the year	387 706	303 971
Received during the year	1 672 625	929 284
Recognised in the income statement	(1 284 139)	(845 549)
Balance at end of year	776 192	387 706
<p>These are donations by individuals from all over the world for the support of orphaned and vulnerable children.</p>		
5.7 Grants receivable from African Alliance:		
Received during the year	-	35 000
Recognised in the income statement	-	(35 000)
Balance at end of year	-	-

African Alliance Swaziland pledged E35 000 (2008: E500 000) to the Council for the construction of orphan houses.



NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2009 (continued)

	2009	2008
	E	E
5. Grants (continued)		
5.8 Grants received from the UNDP		
Balance at beginning of the year	541 353	634 513
Received during the year	758 000	(93 160)
Recognised in the income statement	(1 947 449)	-
	<hr/>	<hr/>
Balance at end of year	(648 096)	541 353
	<hr/>	<hr/>
5.9 Small grants received		
Balance at beginning of the year	10 824	10 824
Recognised in the income statement	-	-
	<hr/>	<hr/>
Balance at end of year	10 824	10 824
	<hr/>	<hr/>
5.10 Grants received from UNICEF		
Balance at beginning of the year	-	-
Received during the year	126 500	-
Recognised in the income statement	(126 500)	-
	<hr/>	<hr/>
	-	-
	<hr/>	<hr/>
5.11 Grants received from Claypotts Trust		
Balance at beginning of year	-	-
Receivable during the year	384 228	-
Recognised in income statement	(372 286)	-
	<hr/>	<hr/>
Balance at end of year	11 942	-
	<hr/>	<hr/>
Total grants balance	<u>57 319 823</u>	<u>49 980 798</u>



NOTES TO THE FINANCIAL STATEMENTS

For the year ended 31 March 2009 (continued)

	2009 E	2008 E
6. Trade and other payables		
Creditors and accruals	4 360 348	1 832 857
Global Fund Project creditors	495 330	6 985 849
Funds held in trust – Action Aid	52 315	52 315
Funds held in trust – Walk the Nation	-	712
Funds held in trust – Ministry of Health Information centre	17 984 669 16 244	5 273 477 -
	<u>22 908 906</u>	<u>14 145 210</u>
7. Notes to the cash flow statement		
7.1 Cash utilised by operations		
Net operating deficit for the period	-	-
Deduct interest received	(2 020 344)	(1 755 014)
Adjustment for depreciation	702 513	684 734
Less surplus on disposal of assets	(416 450)	(4 013)
	<u>(1 734 281)</u>	<u>(1 074 293)</u>
Operating deficit before working capital changes	(1 734 281)	(1 074 293)
Increase in grants receivable	(8 136 512)	(19 363 085)
Increase in accounts payable	8 763 696	265 285
	<u>(1 107 097)</u>	<u>(20 172 093)</u>
7.2 Grants received		
Grants received during the period	119 011 693	161 506 382
Utilised to finance operations	(111 672 668)	(143 207 333)
	<u>7 339 025</u>	<u>18 299 049</u>
Financing inflow	7 339 025	18 299 049
7.3 Cash and bank balances		
Closing balances		
Local currency accounts	31 071 805	18 494 690
Foreign currency accounts	13 542 364	15 151 294
	<u>44 614 169</u>	<u>33 645 984</u>
Bank overdraft	(4 739 873)	-
	<u>39 784 296</u>	<u>33 645 984</u>



NOTES TO THE FINANCIAL STATEMENTS

For the year ended 31 March 2009 (continued)

8. Related parties and related party transactions

Related parties comprise the Swaziland Government and members of the Council.

The Council received E48.6 million (2008 : E45 million) as a government grant during the year. Accounts receivable from the Swaziland Government are disclosed in note 3 to the financial statements.

Details of remuneration paid to members of the Council during the year are set out in note 1.

9. Financial instruments

The Council's financial instruments include cash and bank balances, accounts receivable and accounts payable. Accounting policies for financial assets and liabilities are set out in the statement of accounting policies.

Fair values

The fair values of bank balances, accounts receivable and accounts payable are not materially different from their carrying values.

Interest rates risk

Bank accounts attract interest at rates linked to the prime overdraft rate.

Foreign currency risk

The Council receives foreign currency denominated grants and some of the Council's bi-lateral and multi-lateral partners require the Council to keep unutilised grants in foreign currency bank accounts. As a result the Council is exposed to foreign currency risk on bank balances and grants that are denominated in a currency other than Emalangeni. The currency giving rise to this risk is US Dollars. The Council does not hedge foreign currency risk.

10. Employees

The number of employees during the year was 66 (2008: 60).

The employment costs during the year totalled E10 758 000 (2008: E9 158 389).



NOTES TO THE FINANCIAL STATEMENTS
for the year ended 31 March 2009 (continued)

	2009	2008
	E	E
11. Commitments		
Authorised and contracted for	24 419 973	88 916 981
	<u>24 419 973</u>	<u>88 916 981</u>
Commitments for future expenditure by the Council relating to project disbursements to various implementing agencies. These commitments will be financed from grants received and future grant income.		
12. Operating lease commitments		
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1 082 749	921 324
Between one and five years	5 090 790	4 669 675
	<u>6 173 539</u>	<u>5 590 999</u>

The leases are renewable at the option of the Council for a further period of between one and three years.

13. Taxation

The Council is considered to be exempt from normal income tax in accordance with the provisions of Section 12(1)(a) (vii) of the Income Tax Order 1975 as amended and Section 19 of the National Emergency Response Council on HIV/AIDS Act No 8, of 2003.



DETAILED INCOME STATEMENT
for the year ended 31 March 2009

	Swaziland Government Grants 2009 E	Global Fund on HIV/AIDS Grant Round 2 2009 E	Global Fund on Malaria Grant Round 2 2009 E	Global Fund on Tuberculosis Grant Round 3 2009 E	Global Fund on HIV/AIDS Grant Round 4 2009 E	Global Fund on HIV/AIDS Grant Round 7 2009 E	American Institute for Research Grant 2009 E	Young Heroes Grant 2009 E	UNDP Grant E	Total 2009 E	Total 2008 E
Income											
Grants recognised in income statement	39 010 356	27 085 040	3 298 744	4 608 302	33 125 940	831 151	(17 237)	1 656 425	2 073 949	111 672 668	143 207 333
Donations	66 664	-	-	-	-	-	-	-	-	66 664	11 982
Interest	1 617 012	99 832	6 199	36 829	7 651	196 896	639	55 286	-	2 020 344	1 755 014
Net foreign exchange gain	-	1 052 074	138 949	(187 929)	(155 022)	(43)	16 796	-	-	864 825	4 204 377
Surplus on disposal of asset	416 450	-	-	-	-	-	-	-	-	416 450	4 012
	41 110 482	28 236 946	3 443 892	4 457 202	32 978 569	1 028 004	198	1 711 711	2 073 949	115 040 951	149 182 718
Expenditure											
Administration expenses											
Advertising	130 996	-	-	-	-	-	-	-	-	130 996	159 282
Auditors fees	400 000	-	-	-	-	-	-	-	-	400 000	235 735
Communications and travel	946 480	-	-	-	-	-	-	-	-	946 480	773 709
Bank charges	203 691	8 528	1 204	2 628	1 497	66	198	6 201	-	224 011	140 168
Depreciation	702 513	-	-	-	-	-	-	-	-	702 513	684 733
Fund raising	397 302	-	-	-	-	-	-	-	-	397 302	173 332
General expenses	1 732 151	-	-	-	-	-	-	-	-	1 732 151	1 116 021
Professional and legal expenses	1 094 959	-	-	-	-	-	-	-	-	1 094 959	391 908
Repairs and maintenance	297 254	-	-	-	-	-	-	-	-	297 254	209 867
Rent	677 373	90 097	-	-	-	-	-	-	-	767 470	691 431
Retainer fees	206 400	-	-	-	-	-	-	-	-	206 400	206 400
Sitting allowances	133 800	-	-	-	-	-	-	-	-	133 800	181 400
Staff expenses	10 192 496	219 112	-	-	827 903	-	-	-	-	11 239 511	9 158 389
Stationery	240 916	-	-	-	-	-	-	-	-	240 916	125 497
Total	17 356 331	317 737	1 204	2 628	829 400	66	198	6 201	-	18 513 763	14 247 872



DETAILED INCOME STATEMENT
for the year ended 31 March 2009

	Swaziland Government Grants		Global Fund on HIV/AIDS		Global Fund on Malaria		Global Fund on Tuberculosis		Global Fund on HIV/AIDS		Global Fund on HIV/AIDS		American Institute for Research		Young Heroes		Total	
	2009	E	Round 2	Round 2009	Round 2	Round 2009	Round 3	Round 2009	Round 4	Round 2009	Round 7	Round 2009	Grant	Grant	Grant	Grant	2009	2008
Project expenses																		
Prevention	5 805 964		6 304 191	-	-	-	-	-	467 790	224 188	-	-	-	-	-	-	12 802 133	15 817 790
Impact mitigation	3 889 732		6 919 820	-	-	-	-	-	4 792 056	292 594	-	-	1 705 510	-	-	-	17 599 712	29 698 548
Care and support	2 136 502		13 563 279	-	-	-	-	-	25 394 977	402 547	-	-	-	-	-	-	41 497 305	74 584 678
Malaria	-		-	3 442 688	-	-	-	-	-	-	-	-	-	-	-	-	3 442 688	1 374 955
Tuberculosis	-		-	-	4 454 574	-	-	-	-	-	-	-	-	-	-	-	4 454 574	2 732 010
Administration	6 402 225		-	-	-	-	-	-	-	-	-	-	-	-	-	-	6 402 225	5 593 099
Monitoring and evaluation	506 828		1 131 919	-	-	-	-	-	1 494 346	108 609	-	-	-	416 390	-	-	3 658 092	1 967 717
Regional coordination	2 851 447		-	-	-	-	-	-	-	-	-	-	-	-	-	-	2 851 447	2 500 037
Joint review	299 775		-	-	-	-	-	-	-	-	-	-	-	-	-	-	860 865	35 247
Information Centre	1 552 331		-	-	-	-	-	-	-	-	-	-	-	-	-	-	1 552 331	630 765
National strategic framework	309 347		-	-	-	-	-	-	-	-	-	-	-	1 096 469	-	-	1 405 816	-
Total	23 754 151		27 919 209	3 442 688	4 454 574	32 149 169	1 027 938	1 027 938	32 149 169	1 027 938	-	1 705 510	2 073 949	96 527 188	134 934 846			
Total expenditure	41 110 482		28 236 946	3 443 892	4 457 202	32 978 569	1 028 004	1 028 004	32 978 569	1 028 004	198	1 711 711	2 073 949	115 040 951	149 182 718			
Net surplus for the year	-		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-



YOUNG HEROES GRANTS DETAILED STATEMENTS
for the year ended 31 March 2009

	Claypotts grant E	Young Heroes grant E	Total E
Income			
Grants recognised in income	372 286	1 284 139	1 656 425
Interest	-	55 286	55 286
	<hr/>	<hr/>	<hr/>
	372 286	1 339 425	1 711 711
Expenditure			
Administration			
Bank charges	-	6 201	6 201
	<hr/>	<hr/>	<hr/>
Total	-	6 201	6 201
Project expenses			
Impact mitigation	372 286	1 333 224	1 705 510
	<hr/>	<hr/>	<hr/>
Total	372 286	1 333 224	1 705 510
	<hr/>	<hr/>	<hr/>
Total expenditure	372 286	1 339 425	1 711 711
	<hr/>	<hr/>	<hr/>
Net surplus for the year	-	-	-
	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>



TOTAL HIV/AIDS SPENDING OVER THE YEARS 2004- 2009

Details	Year End 2004/5 Emalangeni	Year End 2005/6 Emalangeni	Year End 2006/7 Emalangeni	Year End 2007/8 Emalangeni	Year End 2008/9 Emalangeni	Year End 2008/9 %
Co-ordinating Expenses	8,028,632	11,440,840	13,718,562	14,247,872	18,513,763	30%
Interest Received	1,324,017	854,277	866,340	1,755,014	2,020,344	15%
Other Income	72,980	22,740		15,994	483,114	2921%
Revaluation Loss/Gain	(3,513,847)	(631,572)	(3,578,569)	(4,204,377)	(864,825)	-79%
Net Expenses	3,117,788	9,932,251	9,273,653	8,272,487	15,145,480	83%
Programme Expenses:						
Prevention	11,377,465	26,057,037	16,181,865	15,817,790	12,802,133	-19%
Care and Support	30,189,760	72,587,176	41,354,227	74,584,678	41,497,305	-44%
Impact Mitigation	22,954,369	46,371,074	33,284,243	28,830,336	16,266,489	-44%
Young Heroes	-	-	415,979	868,212	1,333,224	54%
Sector Support	3,523,854	6,033,002	4,810,777	5,593,099	6,402,225	14%
Monitoring & Evaluation	2,370,776	2,218,934	2,195,312	1,967,717	3,658,092	86%
Regional Co-ordination	-	-	2,169,203	2,500,037	2,851,447	14%
Strategic Planning	-	4,061,257	245,838	35,247	2,266,682	6331%
Information Centre	-	-	472,402	630,765	1,552,331	146%
Total HIV/AIDS Projects	70,416,225	157,328,480	101,129,846	130,827,881	88,629,927	-32%
Total HIV/AIDS Expenses	73,534,013	167,260,731	110,403,499	139,100,368	103,775,408	-25%
Non-HIV/AIDS Programmes						
Malaria	688,603	691,612	2,600,332	1,374,955	3,442,688	150%
Tuberculosis	128,043	3,630,844	2,851,549	2,732,010	4,454,574	63%
	816,646	4,322,456	5,451,881	4,106,965	7,897,262	92%
Total Projects	71,232,871	161,650,936	106,581,727	134,934,846	96,527,189	-28%
Net Expenses	74,350,659	171,583,187	115,855,380	143,207,333	111,672,669	-22%



Cooper Centre, bypass Sozisa Road
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Email: info@nercha.org.sz
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