FAMILY HEALTH INTERNATIONAL

Impact Implementing AIDS Prevention and Care Project

Swaziland

Assessment Of Existing STI Care Services And Recommended Strategies To Improve STI Care For Selected Target Groups

Regional HIV/AIDS Program

Southern Africa

United States Agency for International Development

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Summary

Swaziland is among the countries with the highest HIV prevalence. One of the factors contributing to the high transmission rate of HIV is the mobility of the population. This includes men seeking employment as migrant labourers in South Africa, taxi drivers, soldiers and industrial workers as well as women seeking employment in factories or self-employed as informal traders. Employment opportunities for women are scarce so that women often have to rely on sex work for additional or only income.

Swaziland has adopted the syndromic approach to manage STI in public and private health facilities during the nineteen nineties. Although the principles of syndromic STI management are well understood by most health workers, there is not a coherent system in place with clear, uniform guidelines, reliable supply of drugs and efficient reporting of STI cases and their partners.

While several non-governmental health facilities provide STI services of high standard, a similar standard is not reached in most public health facilities. Of particular concern are the quality of STI services provided by the two main public services in Mbabane and Manzini, where monthly over 1,500 STI patients are treated. This is more than in all other governmental and non-governmental health facilities in Manzini, Mbabane and the immediate border sites together. Staff of these services is committed, but the number of staff allocated is entirely insufficient to adequately handle the patient load considering that each patient should be examined and counselled. Moreover, the staff has apparently not received the necessary training and supportive supervision to ensure an appropriate quality of services. In addition, the clinic space in Manzini is inadequate for STI patient examination.

The laboratory services in Mbabane have the infrastructure and technical capacities to provide the necessary laboratory services for referred STI cases and simple studies on the prevalence of STI in specific population groups. This capacity was confirmed during the successful implementation of the 2001 HIV sero-survey. At present, however, the laboratory is mainly used by the STD clinic of the Mbabane hospital of carry out routine urine test of STI patients with no diagnostic value.

The Municipalities of Mbabane and Mazini have plans to establish municipal clinics that could provide the appropriate infrastructure and staff for STI management. Both municipalities are already involved in outreach programmes for high-risk populations and welcome the cross border initiative. The construction of the municipal clinics in Manzini and Mbabane will take at least another 1-2 years. In the mean time, alternative solutions for STI service provision for the target population should be found.

In Mbabane, the Municipality already provides services for high-risk population at a clinic within the Municipal building. Outreach programmes by FLAS could therefore refer the target population to this clinic. In Manzini the FLAS clinic would currently be the most appropriate facility for referral of the target population. However, the cost of the services at the FLAS clinic is too high for most of the target population. To cover these costs, a system could be introduced whereby FLAS outreach workers and peer educators distribute vouchers to members of the target population requiring services.

The clinics in the border areas of Ngweya and Lavumisa can provide adequate services once issues of drug supply, syndromic reporting and supervision have been addressed. This may require the provision of some security stock of drugs to

overcome logistical problems. For all staff involved in the programme, additional training is needed to ensure uniform treatment, counselling practices, and reporting.

Educational materials that are specifically adapted to the different target groups should be produced to facilitate patient management and promote treatment-seeking behaviour and risk reduction. Sufficient quantities of these materials should be produced in order to ensure uninterrupted availability of these materials.

All key informants raised the context of the specific culture in Swaziland as the main obstacle for behavioural change. According to this cultural context, multiple sexual partnerships are considered as the norm for men and monogamy as the norm for women. In this context, women have no power to reduce their risk for STI, including HIV.

Within this cultural context the fact that the number of men and women affected by HIV and AIDS is about equal seems to be to be ignored. Although men have the power within sexual relationships, they are apparently trapped within their perceived cultural role. While many women are eager to change this situation, their influence is very limited. There is therefore an urgent need for men who have realised the situation of HIV/AIDS and have adapted their sexual behaviour accordingly, to speak out in order to influence other men.

Behavioural change communication is likely to be most effective and sustainable when it is implemented within the wider framework of the community. In Ngweya at the Swaziland-South African border a local traditional leader (and former Minister) has initiated a programme to assist women seeking employment. Health staff of the local clinic are also involved in this initiative. Collaboration between RHAP and this initiative may provide a good opportunity to ensure involvement of the target community as well as traditional leaders. In Mbabane, Manzini and possibly Lavumisa, collaboration with the municipalities is likely to provide the required framework for the establishment of sustainable programmes.

Syndromic management of STD and behavioural change communication are probably insufficient to rapidly reduce STD prevalence in the high-risk population, as asymptomatic infections are frequent in both men and women. Presumptive Periodic Treatment could boost the effect of the programme on STI prevalence and could also reduce the incidence of serious complications such as pelvic inflammatory disease.

The introduction of this strategy would require a baseline biological assessment and further biological monitoring, for which links need to be established with laboratories outside the country to carry out specific assays. It should be therefore only considered within an overall action plan to strengthen STI services in the target areas.

Strengthening of syndromic STD management and promotion of safer sex through peer education could entirely be covered through the existing RHAP agreement. For the implementation of Periodic Presumptive Treatment, however, additional resources should be mobilised. Due to USAID restrictions on drug supply, RHAP may have to link-up with other partners to ensure long-term drug supply if this intervention is considered. Regular biological assessments should be considered to be an integral component to monitor the effect of this innovative approach.

Based on the types of interventions that are considered and the available resources, a detailed action plan and budget should be developed with the partners identified.

List of Acronyms

AMICAAL	
FHI	Family Health International
FLAS	Family Life Association of Swaziland
IMPACT	Implementing AIDS Prevention and Care (Project)
MHSW	Ministry of Health and Social Welfare
NGO	Nongovernmental organization
PSI	Population Services International
RHAP	Regional HIV/AIDS Program
SACU	South African Customs Union
SAIMR	South African Institute of Medical Research
SNAP	Swaziland National AIDS Programme
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SZL	Swaziland Lilangeni (1 USD = 10 SZL)
TB	Tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

There is growing recognition that interventions for highly HIV vulnerable communities are vital, even in a mature HIV epidemic. The link between mobility and HIV vulnerability is also increasingly recognized, and highways and borders have been identified as environments of elevated HIV vulnerability.

Southern Africa is the world's region most severely affected by the HIV epidemic. Border posts and truck stops play an important role in the spread and maintenance of the epidemic. Because migration transcends national and international boundaries, HIV/AIDS interventions for mobile populations require a regional approach. Recognizing the importance of regional cooperation, the U.S. Agency for International Development (USAID) and partner governments and organizations initiated the "Corridors of Hope Initiative." This project seeks to promote practical regional collaboration. The program started in 1999 along the Durban-Lusaka highway, southern Africa's major transport corridor linking South Africa, Zimbabwe and Zambia. It has since been extended to include Malawi, Swaziland, Lesotho, and Namibia. The main population groups targeted by the program include long distance truck drivers, taxi drivers, migration officers, moneychangers, sex workers, vendors, low-income women, and youth living within the intervention area. A first rapid assessment was carried out in Messina in northern South Africa, Beitbridge in southern Zimbabwe, Chirundu in northern Zimbabwe and Chirundu in southern Zambia.

The main focus of the project is behaviour change through peer education. It also includes a component of improving STI care and prevention.

The current STI assessment is carried out to strengthen this last component, with the purpose to develop a coherent strategy addressing the main challenges for improving STI care and prevention for the target populations in all the sites covered by RHAP.

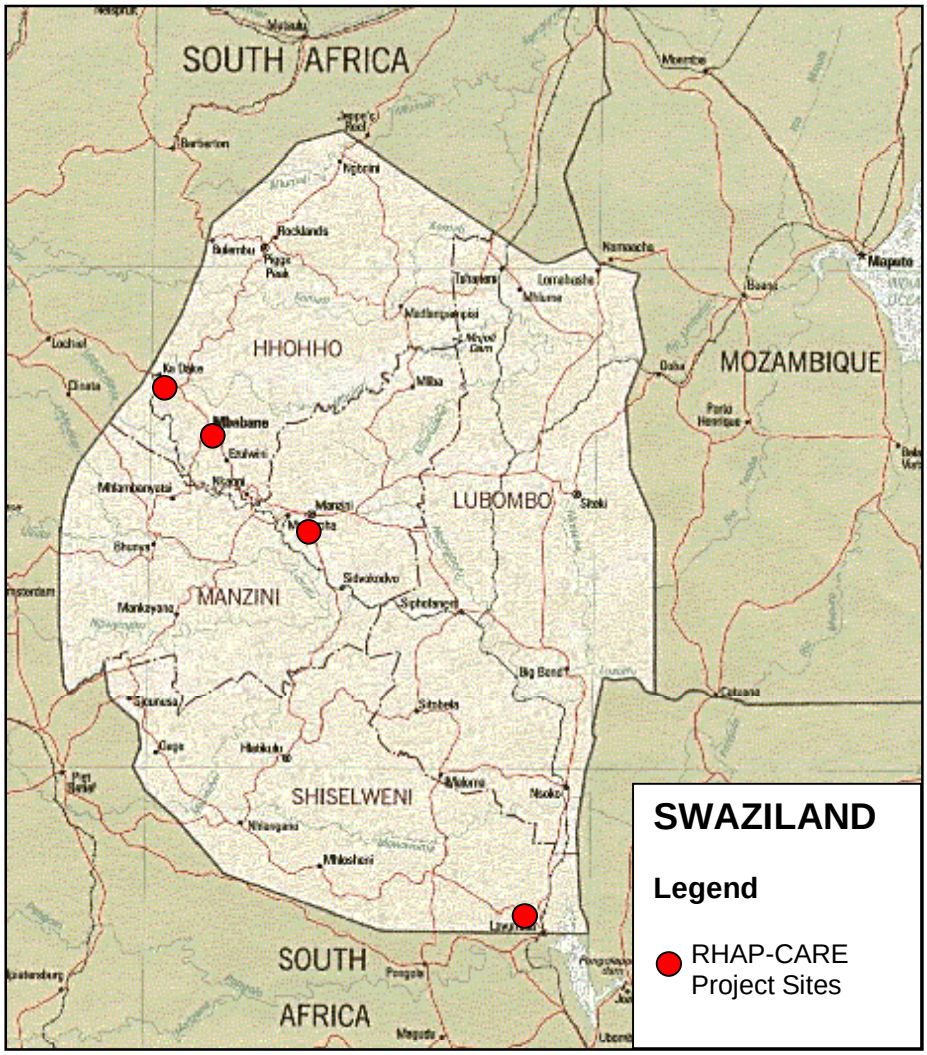
Fig. 1: Map of RHAP border sites

Corridors of Hope in Swaziland

An assessment of the situation of cross border migrant population specific risk situations was carried out in Swaziland in mid 2000. According to this assessment, efficient custom procedures of the Southern African Customs Union (SACU) between South Africa and Swaziland reduced the high-risk situations that were found along the borders between South Africa, Zimbabwe and Zambia. High-risk situations were found, however, in towns, industrial settlements, sugar estates and industries close to the border, such as Ngwenya, Mbabane, Manzini and Lavumisa. It was therefore decided to focus the interventions on mobile population groups, border officials, low-income women, sex workers and youth in these two areas.

The program is implemented by the Family Life Association of Swaziland (FLAS) through a sub-agreement and with technical support from Family Health International (FHI).

FIGURE 1: RHAP INTERVENTION SITES IN SWAZILAND



Objectives of the assessment

1. **To assess existing STI care services in multiple project sites in Southern Africa funded by USAID/RHAP through FHI.**

The assessment consists of:

- Assessment of STI management in all clinics in the project catchment sites
- Key informant interviews starting at the local level and progressing through the Health Departments
- Inventory using a standard inventory checklist, which captures information on drug availability, use of syndromic management protocols, and staff training.
- Interviews with health care providers in the public and private sector
- Interviews with mobile teams
- Site visits with peer educators to meet the target populations

2. **To recommend STI case management strategies for target groups.**

The findings and recommendations should be written in the final report for each assessment. The recommendations should cover strategies to improve STI care for each target group.

Methodology

The assessment consisted of (1) interviews of key informants from the Ministry of Health and Social Welfare, other organizations at the national level and with health staff at H.S.A. and district level, (2) visiting health facilities in the project area using a standardized inventory check list as much as possible, (3) interviews with health care providers of the public and private sector, (4) meeting with sex workers to discuss the main issues regarding STI services. The list of people met and sites visited is provided in annex 1.

Interviews with key informants

Demographic situation

Swaziland has a total population of about 1 million people. About 75% of the population of Swaziland is rural. There are four regions. The Hhohho region in the north-western part of the country, which includes Mbabane the Mazini region in the centre and southeast, the Lebombo region in the northeast and the Shiselweni region in the southwest. The capital city Mbabane has an estimated urban population of about 70,000 inhabitants. The City Council also serves an additional 103,000 people in the surrounding areas. Manzini is the largest city of Swaziland with a population of about 95,000 inhabitants. Manzini is also the economic centre of the country, where most production and trade takes place.

The situation of HIV, AIDS and STI in Swaziland

The HIV epidemic in Swaziland is closely linked to the situation in South Africa. The epidemic started later than in other countries in the region, such as Zambia, Zimbabwe and Malawi.

The epidemic has spread rapidly, however, reaching national HIV prevalence levels among pregnant women of 34% that are among the highest in the world. The highest prevalence of 41% is observed in Manzini. The lowest prevalence of 27% is observed in the Shishelweni region.

Table National HIV Prevalence in ANC clients, STI and TB patients and TB patients 1992 - 2000

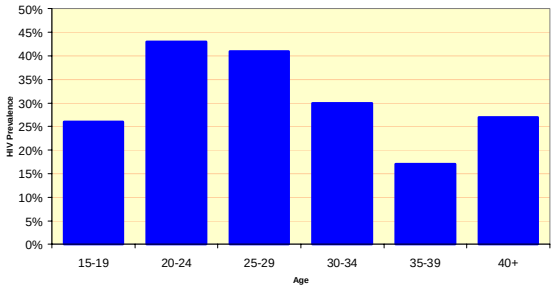
	1992	1994	1996	1998	2000
ANC	4%	16%	26%	32%	34%
STI	11%	27%	37%	48%	50%
TB	19%	31%		58%	79%

Source: 7th HIV Sentinel Serosurveillance Report, Ministry of Health and Social Welfare, Mbabane, Swaziland, Dec. 2000

The highest HIV prevalence in pregnant women is observed in the age group between 20 to 24 years

The vast majority (85%) of pregnant women tested reported only one sexual partner. HIV prevalence was 32% in this group. Among women reporting 2 or 3 partners, HIV prevalence was 45%. Among the 1% of the women reporting having 4 or more HIV prevalence was 64%.

Age Secific HIV prevalence in ANC clients Swaziland 2000



Of all pregnant women tested, 19% had experienced STI related symptoms in the last year. HIV prevalence was higher women who reported having STI symptoms (45%) than in those who did not report symptoms (32%). The overall prevalence of active syphilis among pregnant women was 6%.

HIV Prevalence in ANC clients and STI Patients per Region

	ANC	STI
Shishelweni	27%	52%
Hhohho	32%	49%
Lubombo	34%	49%
Manzini	41%	51%

Source: 7th Sentinel Surveillance Report, Dec. 2000

HIV prevalence among STD patients is 50%, with an almost equal distribution among STI patients throughout the country. The high prevalence of 79% among TB patients reflects the high rate of HIV/TB co-infection, showing the impact of HIV on the TB epidemic and emphasizing the importance of appropriate management of TB in persons with HIV.

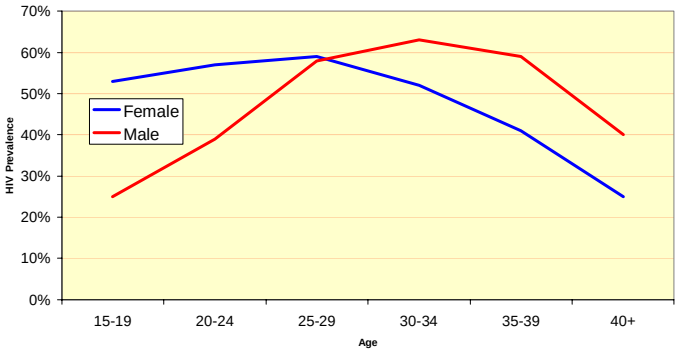
There are important differences in HIV prevalence among male and female STI patients in different age groups. This difference is most pronounced in the age group 15-19 years with 53% of female and 25% of the male STI patients testing HIV positive. This difference has disappeared in the age group 25-29 years. The highest HIV prevalence of 62% is observed in men aged 30-34 years.

The majority (59%) of 2,221 STI patients enrolled in the survey were women. Female patients were more likely to be HIV positive (52%) than males (48%).

There was no significant difference in HIV prevalence between those with no or only primary school education (48%) and those with secondary and higher education (52%).

Overall prevalence of active syphilis in STI patients was 7% with little difference among age groups.

HIV prevalence in Female and Male STI patients, Swaziland 2000



The findings of the survey suggest that the HIV epidemic in Swaziland is fuelled by a high number of men who have several sexual partners and transmit HIV to their mainly monogamous sexual partners. A low number of women report several sexual partners and higher levels of HIV. HIV transmission in women occurs at a young age, as indicated by the high prevalence of HIV among female STD patients (52%) and pregnant women under the age of 20.

Co-ordination of the Health Response to HIV/AIDS

The Swaziland National AIDS Programme (SNAP) is part of Ministry of Health and Social Welfare (MHSW) and is in charge of co-ordinating the National Response towards HIV/AIDS.

The National STD Programme

There is no specific STD programme in Swaziland. During the early nineteen nineties an STD programme manager was appointed. She received training in STD management in the UK and several nurses received in-service training in Zambia. Syndromic reporting was introduced in several clinics and draft national guidelines were developed. After transferring the programme manager, the position was not filled by a clinician with a similar background. With support of WHO, the existing draft guidelines were revised and treatment algorithms were prepared. These algorithms are similar to those used in other countries in the region and were published as posters and trainings were conducted. Syndromic reporting, however, was not introduced nationwide and was only continued by some NGOs (such as FLAS) for internal use. No national statistics on the number of patients attending OPD services for STI related complaints and referred partners are therefore available.

There are currently no national guidelines for the clinical management of HIV disease and AIDS. These are expected to be developed in the near future.

Supply of drug and condoms

Drugs and condoms for the public sector are purchased and supplied by the MHSW. Stocks of supplies at the central medical stores seem to be sufficient. Supplies are supposed to be delivered on a monthly basis. Transport is, however, unreliable and many stock outs are reported. In absence of syndomic reporting it is difficult to monitor drug use and assess drug needs.

Business sector response

There is a well-run private occupational health service that provides clinical care to workers of a range of companies that have bought into their programme. Previously the occupational health service was involved in and STI prevention programme. This programme stopped when external funding for this programme was discontinued. The occupational health services reach about 1,500 workers and 8,500 students and could provide opportunities for preventive initiatives.

Health Service assessment in Mbabane

Clinical services in Mbabane

There is one public hospital and there are no public clinics in Mbabane. The main NGO clinics providing STI services are the Salvation Army clinic that provides general outpatient services as well as home-based care and the FLAS clinic that provides reproductive health services.

Mbabane Hospital STI clinic

The STI clinic at the Mbabane hospital sees approximately 750 patients per month. There is one doctor working at the clinic who mainly sees referred patients with HIV related illness. There are two nurses in the clinic of which one was present on the day of the assessment. STI patients are managed according to the syndromic management guidelines. Recording is done, however, on the basis of “clinical” diagnosis (including gonorrhoea, syphilis, Chancroid, genital herpes, candidiasis, trichomoniasis, etc. All men and women are referred to the lab for midstream urine microscopy, a diagnostic test that is indicated for urinary tract infection, but for STI management. Syphilis serology is done for patients with ulcers, although this is not required as all these patients receive treatment for syphilis according to the syndomic management guidelines and syphilis serology might be false negative in ulcer patients. Patients requiring speculum examination are usually referred to the gynaecology department. Patients are said to be counselled on risk reduction, compliance and partner notification. No contact slips are available. Patients are told to give their health card to their contact and go for treatment. This practice, however, excludes multiple partners and is unpractical for casual partners. The cost per consultation is 10 SZL and the cost of laboratory examinations is 3 SZL. Drugs and HIV testing are free of charge.

Salvation Army Clinic

The Salvation Army clinic is an efficiently run health facility that provides outpatient services (including curative care and MCH/ANC/FP services) and home based care. Staff of the clinic includes 3 qualified nurses, 2 nurse assistants/counsellors for home-based care and one general manager. There are 3 consultation rooms and one room for ANC. The consultation rooms are adequate with appropriate privacy. No speculum is available at the clinic. Only one copy of the poster for syndromic management is available at the clinic. Patients are managed according to the syndromic management guidelines. The respondent has been trained but does not know how many of the other staff are trained in syndromic STI management. All relevant drugs for STI treatment are available with the exception of Spectinomycin for treatment of vaginal discharge in pregnant women, which is currently out of stock. Condoms are not available in the clinic but are available for the community outreach programme. Blood is taken for syphilis screening of pregnant women. Results are returned by the Mbabane hospital laboratory for treatment at the clinic during the next visit. The cost of the consultation is 14 SZL for adults. Drugs are charged separately and cost between 10 to 20 SZL for most STD syndromes.

FLAS Clinic

The FLAS clinic is situated in pleasant premises on a hill close to the business centre of Mbabane. At the waiting room there are a variety of educational materials available on reproductive health issues. The consultation rooms are spacious. The clinic was visited twice but the assessment had to be cancelled at both occasions due to urgent other arrangements. The qualifications of staff, training in STI management, drug supply, syndromic reporting, counselling of patients, partner referral systems, cost of consultation and availability of educational materials are similar in the FLAS clinics of Mbabane and Manzini and are discussed under the Manzini service assessment.

City council clinic

The public health and social welfare unit of the Mbabane city council has a clinic that is dedicated to specific high risk groups for car washers, street kids, sex workers and can collectors. The unit also does some outreach work. So far 15 sex workers at highest risk are identified and 34 street kids. The clinic has its own budget for the supply of STI drugs. The city council has allocated land to construct a filter clinic next to the market that should be operational within 2 to 3 years. This clinic will continue to provide specific services for high-risk populations. The public health and social welfare unit of the Mbabane city council is eager to work together with the cross border initiative.

Laboratory services in Mbabane

The laboratory services at the hospital are situated within the hospital building. Despite the limited space, the premises seem to be appropriate and equipment seems adequate for the operation of essential hospital laboratory services. The laboratory would have the capacity to carry out routine tests for referred STI patients and to contribute to operational biological research for STI. Unfortunately, the laboratory is mainly used by the STD clinic to examine urine samples that are routinely taken from all STI patients and have no diagnostic value. In order to upgrade their capacity the lab would need assistance in establishing Standard Operational Procedures and support for the supply of reagents. Shortage of skilled manpower might become a problem if the workload due to STI or HIV related work would be considerable. The laboratory would be keen to link up with other laboratories in the region.

CD4 testing for HIV is not available at the laboratory and in general clinicians request very little specific laboratory examinations for persons with HIV (which is likely to be related to the absence of national guidelines for HIV disease management).

Health Service assessment in Ngwenya

Ngwenya is situated close to the South African border at 26 from Mbabane. Ngwenya's population is about 8,000 inhabitants. At the border there is a bar where sex workers and clients tend to meet. There are several permanent sex workers and varying number of transient sex workers. There are many women seeking employment in the Ngwenya area, of which some are involved in sex work or have sex in exchange for material support. At the time of the assessment construction works were carried out on the road between Mbabane and Ngwenya, increasing the demand for casual and commercial sex.

Clinical services in Ngwenya

The only clinic in the Ngwenya area is the Motshane clinic. The clinic has 2 qualified nurses, 2 nursing assistants, 1 dental hygienist, and 2 environmental health staff. All 4 nurses providing STI care have been trained in syndromic management in 1999 and 2000. There is a poster on syndromic treatment and South African STI guidelines in the clinic. The consultation rooms provide sufficient privacy and are adequately equipped. There are speculums but no autoclave. Speculums are therefore not used. Erythromycin and Nystatin are not available. The previous month there were stock outs of Metronidazole and Erythromycin for 3 weeks. Health workers have some problems with the management of combined syndromes (such as genital discharge and sores) and would need guidance on these. Frequency of Herpes seems to be increasing. There are sufficient supplies of condoms.

Community initiatives in Nwenya

Teenagers in the Moshane community have already been trained by FLAS as peer educators and distribute condoms in the community. A local traditional leader (who is the current regional governor and a former Minister) has initiated a programme to assist women seeking employment: This programme, named MHAPI (Moshane HIV/AIDS Programme Initiative) aims to create opportunities for self-employment for women (such as crafts) and to stimulate mutual support by women to address the needs of orphans and vulnerable children through a variety of community based initiatives (including gardening and collecting clothing). The management of this organization includes a woman with HIV and the nurse in charge of the clinic. Collaboration between FLAS and initiative may provide a good opportunity to ensure involvement of the target community as well as traditional leaders.

Health Service assessment in Manzini

Introduction

The Manzini region is the most populated region in the country. As the economic centre, it attracts many migrant workers, truck driver, job seekers, merchants and informal traders. Military headquarters are also based in Manzini. The Manzini city council has a health and social welfare department consisting of a public health nurse (and former FLAS director) and a recently employed social worker. The social worker is expected to look (among other issues) into addressing the needs of street children. One of the worrying reports to the city council is that male street children are increasingly involved in paid sex with truck drivers. There seem to be only very few female street children, possibly because abandoned children may be taken into households for domestic work where they may also be subject to abuse.

The city council has provided the land for a new filter clinic that is expected to be opened by the end of the year 2002. This clinic will replace the current Mposa clinic.
The city council is currently collaborating with a number of activities, including initiatives of AMICAAL. The city council is eager to work together with FLAS in the implementation of the cross border initiative as well as in strengthening links between the filter clinic and the FLAS clinic.

Clinical services in Manzini

Nazarener Hospital

The Nazarener mission hospital is the only hospital in Manzini. This hospital provides outpatient services and hospital care of high quality. Consultations are carried out by doctors trained in syndromic management of STI. All drugs required for STI management are available. For the majority of poor inhabitants of Manzini, the cost

of the services is a major limiting factor for access. The Nazarener mission also runs 19 rural clinics throughout the country. These clinics also provide syndomic treatment of STI and are regularly supervised by hospital staff.

Mposa clinics

The busiest clinic in Manzini is the public Mposa clinic. Consultations and treatment here are for free (1.50 SZL is charged for registration). There are 6 qualified nurses and 5 nurse assistants in this clinic. One qualified nurse is seeing all STI patients, about 40 per day or 800 per month. Although she has not been trained in STI management, patients receive syndromic treatment, as indicated on the wall chart at the clinic. The consultation room is small and does not have an examination couch. Nystatin pessaries and Erythromycin were not available during the visit. Last month, Nystatin, Metronidazole and condoms were out of stock. Patients only receive group education prior to the consultation. Condom use among clients of the clinic is considered to be very low. There is no register for patients. There are no contact slips or educational materials available in the clinic. Clinic staff do not know if there are sex workers among their patients. No outreach activities are carried out from this clinic. Pregnant women are tested for syphilis. Blood is taken for this purpose at the first ANC visit and sent to Manzini. Treatment is given at the next follow-up visit at the clinic. A new building for this clinic is under construction and staff is expected to move "soon" to this new building.

Lobamba clinic

The Lobamba clinic is situated in the Manzini region between Mbabane and Manzini. The clinic has 7 qualified nurses (one of which provides home based care) and 3 nursing assistants. Two qualified nurses have been trained in syndromic STI management. The consultation room with a couch is appropriate and provides adequate privacy. No speculum and light are available. Handouts on syndromic management are displayed on the wall of the clinic for easy reference.

Blood for syphilis testing of pregnant women is taken at the clinic and tested at the laboratory in Manzini. Results are returned within a week to the clinic. At the time of the assessment, only ciprofloxacin and male condoms were available for STI management. There is also a shortage of other drugs: the only drug available is panadol. This situation was said to be caused by the limited transport capacities of the central medical stores (only one truck for the entire country to distribute all supplies). There are no contact slips nor educational materials. Patients are told to give their patient card to their partner(s) and refer these to the clinic for treatment.

FLAS clinic

The FLAS clinic is situated in a new and spacious building at walking distance from the Manzini business and shopping centre. In the same building there is a clinic for adults, a clinic for adolescents and office space. There are 2 qualified nurses and 2 nurse assistants working at the 2 clinics. Monthly a total of about 100 STI patients are managed. There are 2 consultation rooms for adults and 2 for adolescents. The consultation rooms are well equipped (couch, gloves, speculum, light), and provide adequate privacy. There is a small lab that carries out tests including pregnancy tests, syphilis serology, HIV testing. All drugs required for STI management are available and have not been out of stock in the previous month. Patients are individually counselled on all relevant aspect of STI treatment and risk reduction. Materials on reproductive health are available, but no specific materials on STI. Contact slips are used to refer partners. A register is kept and monthly reports are prepared to monitor syndromic management and drug requirements. The respondent

was not aware of any annual reports on STI syndromes that have been compiled. The cost of the consultation and drugs varies according to the required medication between 35 and 60 SZL.

Occupational Health Clinic

The Occupational Health Service is a privately owned health service provider founded in 1979. Companies can buy the services at a fixed rate per employee per month. The type of services provided depends on the type of agreement between the employer and Occupational Health Services. An annual contribution per capita is charged to the employer for treatment of all illnesses except diabetes and hypertension. Three doctors, 6 qualified nurses and 5 nurse assistants work for occupational health services. Occupational health services run 9 company clinics throughout the country. The majority of employees in the factories are women. These clinics receive drugs through occupational health services. Patients needing referral are seen by general practitioners at the occupational health services headquarters. Drugs are bought in bulk (among others from Echo in the UK). All cost of STI management is covered by the employer.

South African STI management guidelines, similar to the Swaziland guidelines have been distributed to the nurses in the factories and are used by the staff in the centre. The respondent did not have statistics on the number of STI patients per month. All relevant drugs for STI management except Ceftriaxone and nystatin/clotrimazole pessaries are available and have not been out of stock in the previous month. Peer education used to be done previously but has been stopped due to a shortage of funding. Prophylaxis for opportunistic infections with co-trimoxazole is provided to workers known to be HIV positive. No INH prophylaxis is given, as this is not foreseen in the national TB policy. The death rate among workers is reported to be high. There is currently no liaison between occupational health services, the MHSW, municipality or any NGO.

Swaziland Defence Forces Health Department

The Swaziland Defence Forces provide health services to all their personnel. STI are the fourth health problem according to OPD frequency after respiratory disorders, diarrhoea and skin diseases. According to the head of the health department, especially the soldiers along the borders are at risk for STI. STI are managed syndromically. The reporting system of the MHSW is used for OPD. The Defence Force therefore also lacks detailed information on the type of STI syndromes treated. Drugs are purchased by the Defence Force. Shortages of STI drugs occur due to insufficient funding for drugs or inefficiency in the logistical system.

The Defence Force is supported by a project financed by the US DOD. This project focuses on behavioural change communication and does not cover support for STI drugs. This project mainly uses educational materials that have been designed by FHI. Training and educational materials on STI, such as books, leaflets, slides and CD-ROMs are lacking. Although the military leadership is supportive for the army HIV prevention programme, there seems to be a shortage of role models among the defence force leadership that are willing and capable of addressing directly the importance of safe sexual behaviour and need to support HIV positive defence force members and their families as a national security priority. Moreover, there are no guidelines for management and support of HIV positive soldiers, and no known HIV positive soldiers are working in the prevention programme.

Public Health Laboratory in Manzini

The Public Health Laboratory in Manzini was briefly visited. The badly maintained building is not conducive for efficient laboratory work. Equipment is cramped together within a small space. This laboratory used to carry out the HIV test for blood transfusion services and for the national HIV sero-surveys. These are now carried out at the blood transfusion services and the laboratory in Mbabane. Syphilis tests for pregnant women from surrounding clinics are done at this laboratory. The laboratory does not seem to have potential to make a significant contribution to STI surveillance and research in the context of the RHAP project.

Health Service assessment in Sishelweni

Lavumisa clinic

The Lavumisa clinic is situated in the village of Lavumisa along the road at about 100 m from the border post with South Africa. The clinic has one consultation room and an examination room. The rooms provide adequate privacy. There are 2 qualified nurses and 1 nursing assistant working at the clinic. The respondent, a registered nurse, has been trained in syndromic STI management at the nursing school. Other staff have probably not received training in STI management. The staff does not know of any sex worker among their clients. Truckers come for various complaints to the clinic, including STI. Most truckers are from South Africa. The clinic sees about 60 patients per day and about 50 STI patients per month. All permitted STI drugs for clinics are available with the exception of Nystatin, which has been out of stock for several months. There are sufficient condoms. Women attending for ANC services are referred to the Health Centre for syphilis screening (at 30 minutes by car). No statistics are kept on how many of them tested positive and received treatment.

Ndezvane clinic

The Ndezvane clinic is situated along the road between Manzini and Lavumisa. The clinic is situated in a building close to the road. Staff consists of 3 qualified nurses and 3 nursing assistants. Three of them attended a training course on STI management, including the nurse providing MCH/FP services. The consultation room is adequate to examine STI patients. A speculum is not available, as the sterilizer is not working due to lack of water (for more than one month). Nystatin pessaries and Erythromycin were out of stock. During the entire previous month, Benzathine Penicillin, Nystatin, Erythromycin and Metronidazole had been out of stock.

Discussion

STD treatment guidelines, reporting and monitoring

All services visited during this assessment apply syndromic treatment. Several treatment guidelines with similar treatment protocols were found in the facilities during the assessment. Public services do not record keep records of syndromic diagnosis, so it was impossible to verify the quality of services. The Mbabane hospital is the only public facility that keeps detailed records. Although correct syndromic treatment is provided in most cases, the reporting is done according to a "clinical diagnosis", which is known to be unreliable. Until a filter clinic is operational, the STI clinic needs to consider using different protocols for untreated and referred patients. Additional staff is needed to provide adequate counselling and appropriate management of patients with HIV.

Drug supply in all public clinics is problematic. Some drugs, such as Nystatin are out of stock at the central medical store for several months. Other drugs, such as

Podophillin and Ceftriaxone are unavailable for clinics, even if they have a high patient load and referral services are unavailable. Various drugs are out of stock because insufficient quantities are ordered or delivered, or because delivery is delayed.

Several non-governmental health facilities that work on a non-profit basis such as FLAS, the Nazarener hospital and clinics, and the Salvation Army clinic provide STI services of high standard. Of these organizations, FLAS provides the most comprehensive STI services. FLAS also has a syndromic reporting system in place that can easily by used by other facilities. For many persons of the RHAP target population, the cost of the services offered by these organizations is prohibitive.

RHAP initiatives should therefore aim at improving the public services as these provide care for the majority of the population and at increasing access by the target population to services offered by NGOs, in particular FLAS clinics. In Manzini and Mbabane, collaboration with the City Councils are likely to be successful in mobilising local resources and reaching high-risk populations (including street children).

In Mbabane, the Municipality already provides services for high-risk population at a clinic within the Municipal building. Outreach programmes by FLAS could therefore refer the target population to this clinic. In Manzini the FLAS clinic would currently be the most appropriate facility for referral of the target population. However, the cost of the services at the FLAS clinic is too high for most of the target population. To cover these costs, a system could be introduced whereby FLAS outreach workers and peer educators distribute vouchers to members of the target population requiring services. These vouchers could be provided for free or at a very low cost. This system would facilitate the referral of patients and the documentation of referrals.

The Occupational Health Service, a private health services provider, offers STI services to an important number of low-income women and students and should therefore be invited to participate in RHAP initiatives, such as training and exchange of information.

The laboratory services in Mbabane have the most appropriate infrastructure and technical capacities to collaborate with biological studies on STI prevalence in specific population groups. For this purpose, the laboratory should work together with other experienced laboratories, preferably in the Southern African region.

The clinics in the border areas of Ngweya and Lavumisa can provide adequate services once issues of drug supply, syndromic reporting and supervision have been addressed. This may require the provision of some security stock of drugs to overcome logistical problems. For all staff involved in the programme, additional training is needed to ensure uniform treatment, counselling practices, and reporting.

Educational materials on HIV, STI and reproductive health are only available in FLAS clinics. Materials that are specifically adapted to the different target groups are currently not available and are likely to facilitate health seeking behaviour and behavioural change communication. Sufficient quantities of these materials should be produced in order to ensure uninterrupted availability of these materials.

All key informants raised the context of the specific culture in Swaziland as the main obstacle for behavioural change. According to this cultural context, multiple sexual partnerships are considered as the norm for men and monogamy as the norm for women. In this context, women have no power to reduce their risk for STI, including HIV.

Within this cultural context the fact that the number of men and women affected by HIV and AIDS is about equal seems to be to be ignored. Although men have the power within sexual relationships, they are apparently trapped within their perceived cultural role. While many women are eager to change this situation, their influence is very limited. There is therefore an urgent need for male role models. However, there seem to be only few men who have realised the situation of HIV/AIDS, who have adapted their sexual behaviour accordingly and who are prepared to speak out in order to influence other men (it was a hopeful sign that one health worker mentioned that he used his position as male health worker and royal guard to share his concerns about HIV/AIDS).

Behavioural change communication is likely to be most effective and sustainable when it is implemented within the wider framework of the community. In Ngweya at the Swaziland-South African border a local traditional leader (and former Minister) as initiated a programme to assist women seeking employment. Health staff of the local clinic is also involved in this initiative. Collaboration between this RHAP and initiative may provide a good opportunity to ensure involvement of the target community as well as traditional leaders. In Mbabane, Manzini and possibly Lavumisa collaboration with the municipalities is likely to provide the required framework for the establishment of sustainable programmes.

Syndromic management of STD and behavioural change communication are probably insufficient to rapidly reduce STD prevalence in high-risk populations, as asymptomatic infections are frequent in both men and women. Presumptive Periodic Treatment could boost the effect of the programme on STI prevalence. The introduction of this strategy would require a baseline biological assessment and further biological monitoring, for which links need to be established with laboratories outside the country to carry out specific assays.

Strengthening of syndromic STI management and promotion of safer sex through peer education could entirely be covered through RHAP. For the implementation of Intermittent Epidemiological Treatment, however, additional resources should be mobilised. Due to USAID restrictions on drug supply, RHAP will have to link-up with other partners to ensure long-term drug supply if this intervention is considered.

Based on the types of interventions that are considered and the available resources, detailed action plan to reduce the burden of STD in the target population, a detailed action plan and budget should be developed with the partners identified.

Recommendations

- A meeting of local stakeholders in the RHAP target areas should be convened by FLAS in co-operation with SNAP to agree about STI reporting, provision of training in STI management, ensuring of drug availability, mechanisms for monitoring and supervision of services, and to define modalities to refer symptomatic members of the target population for syndromic management.
- Staff all clinics in the target areas should receive refresher training on STI management and receive full information on the rationale and objectives of the RHAP project.
- Educational materials on STI and HIV/AIDS should be produced and made widely available.
- Supported supervision of public clinics in particular by staff of referral STD clinics should be strengthened. This staff should also be involved in the refresher training of clinic personnel.
- Outreach programmes of the cross border project should strengthen their links public health services in the project areas and referral STD clinics.
- Stock outs of essential supplies in particular condoms should be eliminated as these are extremely disruptive and affect the credibility of the entire cross border programme.
- For outreach activities and behavioural change communication, partnerships with municipalities and local initiatives should be established or strengthened.
- A biological assessment among the target groups to assess the baseline STI prevalence would be useful for evaluation of the impact of the programme and to assess the possible benefits and target groups for Periodic Presumptive Treatment. Standard protocols exist for the implementation of these assessments. The choice of the methods to be used and the practical organization should be further developed.
- Periodic presumptive treatment might be considered if a well-defined target population can be defined that is likely to benefit of such an intervention.
- Where possible, technical assistance should be provided to improve access to VCT and strengthen HIV disease management, care and support for the target population.

Annex 1: List of people met and sites visited

Monday 29 April			
Beatrice Dlamini	Head of SNAP	Ministry of Health and Social Welfare	
Dr. Austen Ezegu	Senior Medical Officer-Superintendent	Mbabane Hospital	
Dr. Priyani S. Mahaliyana	Medical Officer in charge of STI and HIV Clinic	Mbabane hospital	Tel.: +268-4043182 E-mail: psdissanayake@africaonline.co.sz
Sr. Dlamini	Qualified Nurse in charge of STI clinic	Mbabane Hospital	
Brenda Greenidge Lindokuahle Sitole Dlamini	Chief Administrator Qualified Nurse	Salvation Army Clinic, Mbabane	
Tuesday 30 April			
Richard Walwema	Head of Laboratory	Mbabane Hospital	
Ms. Thelma Fakudze	Acting Nurse in Charge	Lobamba Clinic	
Santebo Sonti	Qualified Nurse in Charge	Mliba Clinic	Interviewed while attending a meeting at the Nazarener Hospital in Manzini
Dr. Ndukwe	Medical Officer	Nazarener Hospital, Manzini	
Ms. Zodwa V. Dlamini	Research and Evaluation Manager	FLAS	E-mail: zodwadlamini@yahoo.com
Dr. Qhing-Qhing Dlamini	Managing Director	QQ Consultancy Services	Tel/Fax: +27-11-7022126 E-mail: qhingqhing@qqconsultancy.com qhing44@hotmail.com
Mayor Makong	Head of Health Department	USDF (Defence Force)	

Wednesday 1 May			
	Public Holiday		
Thursday 2 May			
Gcinile Buthelezi	Public Health and Social Welfare Unit	City Council of Mbabane	Tel.: E-mail: clinic@mbacity.org.sz
Sindie Dlamini	Qualified Nurse in Charge	Motshane Clinic (near Ngweya Border post)	
Thelma Fakudze	Acting nurse in Charge	Lobamba Clinic	
Anna Mngometulu Hypatia Manana	Acting nurse in Charge Qualified Nurse	Ndezvane Clinic	
	Qualified Nurse	Lavumisa clinic	
Friday 3 May			
Laetitia Dlamini	Registered Nurse	FLAS Clinic, Manzini	
Nomsa Hlope Prudence Hlatsshwayo	Public Health Officer Social Welfare Officer	Manzini City Council	
	Qualified Nurse at STI OPD	Clinic Manzini	
Dr. Manners	Medical Practitioner	Occupational Health Service	
Dorica Mndzebele	Acting Senior Technologist	Public Health Laboratory, Manzini	
Ms. Zodwa V. Dlamini	Research and Evaluation Manager	FLAS	

Annex 2: Approaches to STI management

In addition to interventions to reduce the risk of STI by behaviour change, there are three approaches to address STD:

1. Through **syndromic management** treatment is provided to persons seeking care on the basis of symptoms and signs. All relevant agents, including sexually transmitted infections as well as other reproductive tract infections that may cause the syndrome in the particular epidemiological setting are treated. This approach is very effective in treating patients with symptoms and can efficiently be carried out as no laboratory examinations are used.
2. Persons who have unprotected sex with many partners are likely to have a high prevalence of STI. They will only benefit from syndromic STD management when they have symptoms and seek treatment. However, many will have asymptomatic or unrecognised infections. An additional approach is therefore needed to reduce the level of STI in this population group. One additional strategy is called **Periodic Presumptive Treatment.** In certain research settings this strategy has contributed to a reduction of STI prevalence in sex workers and a reduction in reported STI cases among their clients. Adequate implementation of this strategy requires regular epidemiological assessment of the STI prevalence in this group to determine the most appropriate treatment and the duration of the interval between treatments, as well as close monitoring of the adherence to treatment by group members.
3. The third strategy is **diagnostic STI management**. Hereby a diagnosis is made on the basis of laboratory testing for each person and treatment is given accordingly. This means that at least 2 visits are required. The first for examination and sampling, the second to provide treatment on the basis of the laboratory results. Diagnostic management is often less efficient and more costly for patients with symptoms as laboratory examinations are relatively expensive, require time and sometimes fail to detect an existing infection. For clients without symptoms, diagnostic management has the advantage that specific treatment is given only to those persons requiring medication. It also makes clients aware of their health (and risk) status and supplies data on prevalence of STIs in those seeking care. The cost of laboratory diagnosis is high as compared to syndromic management and periodic presumptive treatment.

Annex 3: Characteristics of Health Facilities visited

Name of facility		**STD clinic**	**Salvation Army**	**Municipality**	**Motshane Clinic**
	Site	Mbabane	Mbabane	Mbabane	Ngweya
	Type	Public Hospital	Public Hospital	Municipal clinic	Public clinic
	Respondent	Doctor	Qualified Nurse	Qualified Nurse	Qualified Nurse
	Estimated No. STI patients/mo	750		50	60
Staff	Docters	1		0	0
	Qualified Nurse	2	3	1	2
	Nurse Assistant		2*	0	2
	Other			0	0
	Total staff	**3**	**3**	**1**	**4**
Manage STD	Docters	1		0	0
	Registered Nurse	1	3	1	2
	Nurse Assistant		2	0	2
	Other			0	0
	Total staff	**2**	**5**	**1**	**4**
Trained	Doctors	0		0	0
	Registered Nurse	1		1	2
	Nurse Assistant			0	2
	Other			0	0
	Total staff	**1**	**Does n't know**	**1**	**4**
Equipment	Examination couch	Yes		Yes	Yes
	Speculum	Yes	Yes	Yes	Yes
	Light	Yes	No	Yes	Yes
	Penis model	Yes	Yes	Yes	No
	OPD book				Yes
Guidelines	STD guidelines	No	No	Yes	Yes
Flow chart	Poster	Yes	Yes	No	Yes
Privacy	Adequate	Yes	Yes	Yes	Yes
	Insufficient				
Syphilis screening	in facility	Yes			
	sent to lab		Yes	N.A.	Yes
	not available				
Health education	Compliance	Yes	Yes	Yes	Yes
	Contact	Yes	Yes	Yes	Yes
	Risk reduction	Yes	Yes	Yes	Yes
	Condom use	Yes	Yes	Yes	Yes
	STD/HIV		Yes	Yes	Yes
Supplies available	Benzathine Penicillin	Yes	Yes	Yes	Yes
	Ceftriaxone	Yes	No	No	No
	Ciprofloxacin	Yes	Yes	Yes	Yes
	Nystatin pessaries	No	Yes	Yes	No
	Doxycycline	Yes	Yes	Yes	Yes
	Erythromycin	Yes	Yes	Yes	No
	Metronidazole	Yes	Yes	Yes	Yes
	Podophyllin	Yes	Yes	No	Yes
	Condoms	Yes	No	Yes	Yes

Name of facility		STD clinic	Salvation Army	Municipality	Motshane Clinic
Stockout last month	Benzathine Penicillin	0	0	0	0
(Days)	Ceftriaxone	0	N.A	N.A	N.A
	Ciprofloxacin	0	0	0	0
	Clotrimazole or Nystatin pessaries	30	0	0	0
	Doxycycline or Tetracycline	0	0	0	0
	Erythromycin	0	0	0	20
	Metronidazole	0	0	0	20
	Condoms	No		0	0
Supportive materials	Contact slips	No	Yes	No	No
	STD Leaflets	No	No	No	No
	Facts on AIDS	Yes	No	No	No
	Other	Yes	No	No	No
Register book	Sydromic reporting	No	Yes		Yes
	Syndromic treatment	Mostly	Yes		Yes
Cost of consultation and Tx		10 R (incl. Tx)	12 R (+10-15)	0	
Comments treatment		Carry out urine microscopy for all patients	2 nurse assistants/counsellors for HBC+D30		Current shortage of essential drugs: e.g. Co-timoxazole, Aspirin
Comments from respondent		Recommends patients to give their health card to partners	Condoms available in outreach programme	City Council clinics follows-up marginalised groups: 15 SW, 34 street kids, can collectors and car washers	Speculum for IUD, not in use due to failure of autoclave
Other comments		About 50 patients per month are referred to doctor (mainly for HIV)	Have stock of spectinomycin	Municipality workers also go out for outreach	South African STD guidelines (essential drug programme)
		Lab test 3R			Ran out of condoms 2 month ago

Name of facility		**FLAS Clinic**	**Occupational Heath Clinic**	**Lobamba Clinic**	**Nazarener Hospital**
	Site	Manzini	Manzini		
	Type	NGO clinic	Private clinic	Pubic clinic	NGO Hospital
	Respondent	Qualified Nurse	Doctor	Qualified Nurse	Doctor
	Estimated No. STI patients/mo	100	No statistics	No statistics	No statistics
Staff	Docters	0	3	0	4
	Qualified nurse*	2	6	7	
	Nurse Assistant	2	5	3	
	Total staff	**4**	**14**	**10**	**4**
Manage STD	Docters	0	0		4
	Registered Nurse	2	1	6	
	Nurse Assistant	2	0	3	
	Other	0	0	0	
	Total staff	**4**	**1**	**9**	**4**
Trained	Docters	0	3	0	4
	Registered Nurse	2	6	2	
	Nurse Assistant	2	5	0	
	Other	0	0	0	
	Total staff	**4**	**14**	**2**	**4**
Equipment	Examination couch	Yes	No	Yes	Yes
	Speculum	Yes	?	No	Yes
	Light	Yes	?	No	Yes
	Penis model	Yes	?		Yes
	OPD book	Yes	No	No	No
Guidelines	STD guidelines	Yes		Handouts on wall	Yes (RSA)
Flow chart	Poster	Yes		No	Yes
Privacy	Adequate	Yes		Yes	Yes
	Insufficient	N.A.			
Syphilis screening	in facility	Yes	No	No	Yes
	sent to lab	N.A.	Yes	Yes	
	not available	N.A.			
Health education	Compliance	Yes	Yes	Yes	Yes
	Contact	Yes	Yes	Yes	Yes
	Risk reduction	Yes	Yes	Yes	Yes
	Condom use	Yes	Yes	Yes	Yes
	STD/HIV	Yes	Yes	No	Yes
Supplies available	Benzathine Penicillin	Yes	Yes	No	Yes
	Ceftriaxone	Yes	Yes	N.A.	Yes
	Ciprofloxacin	Yes	Yes	Yes	Yes
	Clotrimazole or Nystatin pessaries	Yes	Yes	No	Yes
	Doxycycline or Tetracycline	Yes	Yes	No	Yes
	Erythromycin	Yes	Yes	No	Yes
	Metronidazole	Yes	Yes	No	Yes
	Podophyllin	Yes			Yes
	Male Condoms	Yes	Yes	Yes	Yes
	Female Condoms	Yes	No	No	Yes

Name of facility		FLAS Clinic	Occupational Heath Clinic	Lobamba Clinic	Nazarener Hospital
Stockout last month (Days)	Benzathine Penicillin	0	0		0
	Ceftriaxone	0	Not ordered		0
	Ciprofloxacin	0	0		0
	Clotrimazole or Nystatin pessaries	0	Not in stock		0
	Doxycycline or Tetracycline	0			0
	Erythromycin	0			0
	Metronidazole	0			0
	Condoms	0		0	0
	Female Condoms	0	Not ordered	N.A.	
Supportive materials	Contact slips	Yes		No	Yes
	STD	No		No	
	AIDS	Yes		No	
	Reproductive Health (incl. STD/HIV)	Yes		No	
	Other			No	
Register book	Sydromic reporting	Yes	No register book	No register book	No register book
	Syndromic treatment	Yes	Yes (not checked)	Yes	
Cost	* No distinction is made between qualified and double qualified nurses	35-60	Covered by employer	1.5 registration	Consultation + drugs
Comments treatment			Some ulcers do not respond to Cipro	Drugs should arrive by 3rd week but delivery is often late. Only have panadol at present	
Comments from respondent			Write prescriptions for Nystatin for several months	No Contact slips, use patient's OPD card for referral	Ceftriaxone only for specific use. Patients pay for it.
Other comments		Youth clinic and adult clinic	Only ANC room has examination couch	Rarely have educational materials	Treatment prescribed by doctors, counselling done by nurses
		Provide also HIV testing, Pap smears, pregnancy testing	Provide Co-trimoxazole prophylaxis for HIV+ workers		19 clinics depend on hospital and are regularely visited by doctors
		No knowledge about sex workers among clients	No knowledge about sex workers among clients		HIV Elisa done in Hosp. Lab. Cultures availble but not done for STD

Name of facility		**Lavumisa Clinic**	**Ndezvane Clinic**
	Region	Shiselweni	Shiselweni
	Site	Lavumisa	
	Type	Public clinic	Public clinic
	Respondent	Qualified Nurse	Qualified Nurse
	Estimated No. STI patients/mo	50?	
Staff	Docters	0	0
	Qualified nurse*	2	3
	Nurse Assistant	1	3
	Total staff	**3**	**6**
Manage STD	Docters	0	0
	Registered Nurse	2	3
	Nurse Assistant	1	3
	Total staff	**3**	**6**
Trained	Docters	0	0
	Registered Nurse	2	3
	Nurse Assistant	0	2
	Total staff	**2**	**5**
Equipment	Examination couch	Yes	Yes
	Speculum	Yes	No
	Light	Yes	No
	Penis model	Yes	No
	OPD book	No	
Guidelines	STD guidelines	No	Yes
Flow chart	Poster	Yes	Yes
Privacy	Adequate	Yes	Yes
	Insufficient	N.A.	
Syphilis screening	in facility	No	No
	sent to lab	No	No
	not available	N.A.	No
Health education	Compliance	Yes	
	Contact	Yes	
	Risk reduction	Yes	
	Condom use	Yes	
	STD/HIV	Yes	
Supplies available	Benzathine Penicillin	Yes	Yes
	Ceftriaxone	N.A.	N.A.
	Ciprofloxacin	Yes	Yes
	Nystatin pessaries	No	No
	Doxycycline or Tetracycline	Yes	Yes
	Erythromycin	Yes	No
	Metronidazole	Yes	Yes
	Male Condoms	Yes	Yes
	Female Condoms	No	No

Name of facility		**Lavumisa Clinic**	**Ndezvane Clinic**
Stockout last month	Benzathine Penicillin	0	28
(Days)	Ceftriaxone	N.A.	N.A.
	Ciprofloxacin	0	0
	Clotrimazole or Nystatin pessaries	30	28
	Doxycycline or Tetracycline	0	0
	Erythromycin	0	28
	Metronidazole	0	28
	Condoms	0	0
	Female Condoms	N.A.	
Supportive materials	Contact slips	No	No
	STD	No	No
	AIDS	No	No
	Reproductive Health (incl. STD/HIV)	No	No
	Other	No	No
Register book	Sydromic reporting	No	No
	Syndromic treatment	Yes	
Cost			
	* No distinction is made between qualified and double qualified nurses		

Comments treatment		Guidelines in store room (not in use)
Comments from respondent	Does not know SW	
Other comments	Patients sent to HC at 30' (4 R Fare one way)	