2014

THE SECOND NATIONAL HEALTH SECTOR STRATEGIC PLAN

2014 - 2018

Towards attainment of universal health coverage

FINAL DRAFT
MARCH 2015

Ministry of Health
Kingdom of Swaziland

Summary of Indicators and targets

Domain area	Thematic area	Indicators	Baseline	Mid term	Target 2018
Monitoring of health impact	Maximizing level of health	Life expectancy at birth (years)	47		59
		Age-specific mortality rates			
		Reduction in neonatal mortality rate (per 1,000 live births)	19		13%
		Reduction in infant mortality rate (per 1,000 live births)	79 (MICS)		13%
		Reduction in under-five mortality rate (per 1,000 live births)	104		13%
		Reduction in maternal mortality rate (per 100,000 live births)	320 (2010)		30%
		Adult mortality rate (per 1,000 adults)	451		316
	Improving equity in distribution of health				
		Variation in under-five mortality rate			50% reduction
		Variation in maternal mortality rate			30% reduction
		Variation in adult mortality rate			50% reduction
	Improving responsiveness	Improvement in numbers of clients satisfied with services			50%
Health services outcomes	Promoting health through the life course	Full immunization coverage among 1-year-olds (%)	83%	89	95%
		Stunting prevalence	30.6	26.8	23
		Unmet need for family planning	13	11	10
		Postnatal care coverage within 6 weeks of delivery	25		60
		Adolescent fertility rate	89	82	71
	Preventing communicable & noncommunicable conditions	HIV incidence (adults, children)	2.22 (2.2)	2.06	1.94 (1)
		TB treatment success rate	73	82	95
		ART retention among adults and children			
		Deaths due to malaria per 1000 population	0.6		0
		% population who are obese			
		Deaths due to noncommunicable conditions (per 100,000)	707		12% reduction
		Reduction in overall mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases	21%		25%
	Influencing health actions in key sectors	% of households with access to safe water (rural/urban)	59%/ 91.9%		85% / 95%
		% of households with access to sanitation (rural/urban)	56.7%/55.6%		80% / 75%
		% of girls attending secondary school (enrolment, completion)	24.9		
		% of businesses with appropriate workplace safety			
	Managing medical & related conditions	Number of outpatient visits (disaggregated by conditions)	2,900,000		
		Number of inpatients	58,072		
		Births attended by skilled health personnel (%)	82		
		Births by caesarean section (%)			
		Average length of stay	5.6		
	Rehabilitation following health events	# of facilities (hospitals and NGO facilities) providing palliative care services	6	10	14
		# of hospitals providing rehabilitative services	3	4	6
		## of referral hospitals with cancer diagnostics	1	2	3
		# of hospitals providing forensic pathology services	1		3
Health input / processes	Service delivery systems	% of EHCP services provided at each tier of care, as per standards	60%	70-80%	80-100%
		Outpatient waiting time	6 hours	4	2
		Proportion of people in hard-to-reach areas reached through outreach services			80%
		% of facilities receiving quarterly supervision visits	<50%	70%	100%
		% of facilities with functional quality improvement teams	<50%	80%	100%
		% of facilities accredited as per standards		15%	25%
	Health workforce	Trained nurses and midwives per 10,000 people	1.9	2.3	2.5
		% specialists available as per HRH norms (total medical officers as denominator)	17%		30%
		Doctor-patient ratio (see SAM)			
	Health information	Timeliness of submission of data (HMIS, surveillance)	74%		90%
		Completeness of data (HMIS, surveillance, vital statistics)	80%		90%
		Accuracy of data (HMIS, surveillance, vital statistics)			95%
		Health statistics annual report produced on time	0		100%
	Health infrastructure	Population within 5 km radius of a health facility	64%	75%	82%
		Percentage of tracer equipment that is functional	60%	80%	100%
		% of response time per 8 minutes for Urban (U) settings, 14 minutes for Rural (R) settings and 30 minutes for Aeromedical (A) in Emergency Medical Services	U 40%	100%	100%
			R 10%	75%	90%
			A 0%	50%	80%
		% of facilities ready to provide services (presence of 24 hour electricity, water, basic supplies, & waste management)	56.7	67	80%
	Health products	% availability of tracer classes of medicines at facility level	75	85	95%
		% of tested antimicrobials resistant to commonly-used products			
	Governance & regulation	# of reviewed and updated health regulations	0	3	5
		# of independent regulatory mechanisms in place	3	5	6
		% of filled positions in the approved organogram			
		# of national public dialogue forums conducted		5	5
Health financing		% of government health expenditure over total government expenditure	12%	13%	15%
		Total health expenditure per capita	$270	$290	$310
		% of population whose out-of-pocket health expenditure exceeds 40% of non-food expenditure			
		% of people covered under risk pooling mechanism	20%	30%	30%

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Table of Contents

Table of Figures

List of Tables

ACRONYMS

AAP	Annual Action Plan
ADSRH	Adolescent Sexual Reproductive Health
ACT	Artemisinin Combination Therapy
AGOA	Africa Growth and Opportunity Act
AIDS	Acquired Immune Deficiency Syndrome
AMR	Adult Mortality Rate
ANC	Antenatal Care
ART	Anti Retroviral Therapy
BCG	Bacille Calmete Guerin
BFHI	Baby Friendly Hospital Initiative
BOD	Burden of Disease
CBOs	Community Based Organizations
CHWs	Community Health Workers
CMS	Central Medical Store
COMESA	Common Market for Eastern and Southern Africa
COPD	Chronic Obstructive Pulmonary Disease
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DTP	Diptheria Tetanus and Pertussis
DOTS	Directly Observed Treatment Short course
E4A	Exercise for All
EHCP	Essential Health Care Package
EML	Essential Medicines List
EmOC	Emergency Obstetric Care
EPR	Emergency Preparedness and Response
ERS	Economic Recovery Strategy
eNSF	Extended National Multisectoral HIV AND AIDS Framework 2014-2018
EU	European Union
FAR	Fiscal Adjustment Roadmap
FBO	Faith Based Organization
FCTC	Framework Convention on Tobacco Control
FP	Family Planning
GHI	Global Health Initiative
HDI	Human Development Index
HepB	Hepatitis B vaccine
HIA	Health Impact Assessment
HiB	Hemophilus Influenza B vaccine
HIS	Health Information System
HISCC	Health Information System Coordinating Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HPSI	Health Promoting School Initiative
HRH	Human Resources for Health
HRWM	Health Risk Waste Management
HSC	Health Service Commission
HTC	Health Provider Initiated Testing and Counseling
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
IDNS	Integrated Domain Naming Server
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorders
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMR	Infant Mortality Rate
ITNs	Insecticide Treated Nets
IVM	Integrated Vector Management
IYCF	Infant and Young Child Feeding
JANS	Joint Assessment of National Strategies and Plans
LLN	Long Lasting Nets
LRT	Lower Respiratory Tract Infections

M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multidrug resistant TB
MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Ratio
MOA	Ministry of Agriculture
MOEPD	Ministry of Economic Planning and Development
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSS	Ministry of Labour and Social Security
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NCDs	Noncommunicable Diseases
NDPCD	National Decentralization Program Coordination Directorate
NDS	National Development Strategy
NGO	Non Governmental Organization
NHA	National Health Accounts
NHI	National Health Insurance
NHRRB	National Health Research Review Board
NHP	National Health Policy
NHSSF	National Health Sector Stakeholders Forum
NHSSP II	National Health Sector Strategic Plan 2
NMR	Neonatal Mortality Rate
NRC	National Research Council
NTDs	Neglected Tropical Diseases
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PHAST	Participatory Hygiene and Sanitation Transformation
PLWHA	People Living With HIV and AIDS
PMTCT/VCT	Prevention of Mother-to-Child Transmission/Voluntary Counseling and Testing
PPP	Public Private Partnership
QAU	Quality Assurance Unit
RDQA	Routine Data Quality Audit
RDT	Rapid Diagnostic Test
RHM	Rural Health Motivators
RHMTs	Regional Health Management Teams
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAM	Service Availability Mapping
SDHS	Swaziland Demographic and Health Survey
SDI	Swaziland Development Index
SGBV	Sexual and Gender Based Violence
SHPCC	Swaziland Health Partners Coordination Consortium
SNBTS	Swaziland National Blood Transfusion Service
SNC	Swazi National Council
STG	Standard Treatment Guidelines
SWAp	Sector Wide Approach
SHPCC	Swaziland Health Partners Coordination Consortium
TB	Tuberculosis
TTIs	Transfusion Transmittable Infections
TWG	Technical Working Group
U5MR	Under-five Mortality Rate
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Emergency Fund
VAD	Vitamin A Deficiency
VAT	Value Added Tax
WHO	World Health Organization
YoY	Year over Year
ZD	Zinc Deficiency

FOREWORD

The Ministry of Health is pleased to present the National Health Sector Strategic Plan II (NHSSP II) that was developed in line with the health sector vision and mission, as well as the country's overall Vision 2022. In order to achieve Vision 2022, the 10th Parliament called for *'development unusual'*, which is an accelerated push towards achieving first world status.

The theme of this strategic plan is **universal health coverage**, defined as "ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship" (WHO). I am pleased to inform the health sector that the strategic document has been developed with emphasis on a functional approach that focuses on the client. The plan was developed in close collaboration with all stakeholders through a sector-wide approach (SWAp). The development of NHSSP II was informed by the Mid Term Review (MTR) and its priorities for health services focus on the following thematic areas: promoting health through the life course, preventing communicable and noncommunicable conditions, influencing health actions, managing medical and related conditions, and rehabilitation following health events to strengthen the national health system. This plan will also implement the health financing policy.

Given the current and emerging health challenges facing Swaziland, Vision 2022 will only be realized through the implementation of a clear strategic plan, dedication and partnerships. Tackling these challenges will require that all partners work closely together, assisting and complementing each other. Greater collaboration and the success of the Sector Wide Approach to Health will, therefore, be crucial to the implementation of the plan.

To ensure that health service delivery obligations are honoured, it will be critical to pay attention to investment areas and how NHSSP II will be financed. The plan has been costed using the best costing models and resource tracking tools will be used to monitor the utilization of funds. It has been subjected to a Joint Assessment of National Strategies and Plans (JANS) to test its validity.

NHSSP II will direct all health service interventions and allow for more effective health programming. The strategic plan should not be seen as an end in itself, but as an ongoing catalyst for improving health outcomes. Continued dialogue, debate and innovation will be required in each of the strategic areas to ensure application of the best and most efficient techniques and optimal provision of services. Through annual reviews and action plans, the strategy will be given the flexibility to respond to the emerging challenges of the future, and the opportunity to learn from the lessons of the past. Further prioritization of NHSSP II must emerge in these annual action plans (AAP) in a way that responds to the most pressing current needs. The AAPs shall be guided by relevant criteria and evidence that meets the mutual agreement of health sector stakeholders. This prioritization is, in itself, an essential undertaking for the implementation of the strategic plan.

This plan presents the health sector with a way forward and challenges stakeholders to respond with the energy and dedication that went into its formulation. The Ministry is committed to play its stewardship role and this is reflected in the seriousness with which it proposes to tackle its institutional challenges. Partners are encouraged to align themselves with the strategic plan and work with, and alongside, Government.

I implore all health sector stakeholders and partners to play an active role in the implementation of this Strategic Plan towards the attainment of universal health coverage and the SDI as articulated in the National Programme of Action.

SIBONGILE NDLELA SIMELANE
HONOURABLE MINISTER OF HEALTH

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The development of the National Health Sector Strategic Plan 2 could not have been possible without the generous support and contributions of the many organizations and individuals mentioned below. The Ministry of Health would like to particularly thank the WHO Country Office, WHO Headquarters, WHO Regional Office for Africa, the Inter-Country Office and the Kenya WHO Country Office for providing constant technical and financial support.

The Ministry of Health acknowledges with appreciation the financial support provided by the United Nations Population Fund (UNFPA), University Research Co. (URC), Clinton Health Access Initiative (CHAI) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) towards the procurement of consultancy services to lead the writing of the Public Health, Clinical, Allied Health services and Health Financing components of the strategic plan respectively. The WHO Country Office is also highly appreciated for procuring the services of a consultant to lead the situation analysis at the beginning of the process. This report contributed to the establishment of the basis for the development of NHSSP 2.

The EU/World Bank are acknowledged for their financial support during the thematic group retreats organized to produce the first draft of the strategic plan. It is also with thanks that we acknowledge the EU/World Bank's financial and technical support for the development of the investment plan for NHSSP 2.

The different government ministries, organizations, the private sector and civil society are highly appreciated for permitting their staff to participate fully in this highly consultative process. These officers worked tirelessly and contributed a great deal to ensure that the strategic plan addresses almost all the current and possibly emerging health issues of the country.

The team is very grateful to the Health Sector Wide Approach (SWAp) steering committee chairpersons for their overall guidance and continued support to the core team. Special commendation is given to the Core Team Members for their support and the effort made to ensure the availability of all necessary documents, arrange meetings and provide for all other logistical arrangements. The WHO Country Office is mostly appreciated for the continued valuable logistical support and technical guidance. We also acknowledge with great appreciation the facilitation of meetings by CHAI, EU/World Bank, National Response Council on HIV/AIDS (NERCHA), The U.S. President's Emergency Plan for AIDS Relief / Centers for Disease Control and Prevention (PEPFAR / CDC) and World Health Organization (WHO). The Ministry also extends thanks to the chairpersons, co-chairpersons and rapporteurs of all the thematic groups, staff from the Ministry of Health and development partners who were involved in this process and who all devoted their valuable time to the exercise, despite their other equally important duties.

Finally, partners are urged to refer to this document for guidance on every aspect of health sector operations. It was important and necessary to participate in the formulation of this document, but it is even more important to own a copy and, above all, use it consistently as a guide to health sector operations.

DR. SIMON M. ZWANE
PRINCIPAL SECRETARY

EXECUTIVE SUMMARY

NHSSP II (2014-2018) ensures that a comprehensive set of health services is provided as a holistic response to the health needs of the people of the Kingdom of Swaziland. The plan is built around a functional rather than structural approach, with various interlocking elements that all work towards a common health agenda. NHSSP II draws on the Swaziland Development Index (SDI), the National Development Strategy (1999), and the National Health Policy (2007), which are informed by global and countrywide health aspirations. It constitutes the medium-term strategic focus for the health sector. The plan involves addressing health-seeking behaviours and health actions in other sectors, in addition to the traditional public health and curative services. A stronger element of client-focused and client-centered health services has been introduced into the plan, as well as a comprehensive and rationalized health systems investment focus which ensures that all the critical investment needs of the health sector are addressed. Furthermore, it focuses more on strengthening the regulation of health service provision.

NHSSP design is based on the need to attain equity of access to health and related services as defined in the Essential Health Care Package (EHCP). This implies that health sector activities during this period shall focus on:

1. increasing the number of health and related services and interventions provided across the country ***(introduction of interventions as and where needed);***
2. expanding population coverage by the various health and related services and interventions ***(scale-up of intervention use)***; and
3. reducing the household financial burden incurred at the point of access and in the use of health and related services and interventions ***(reduce catastrophic health expenditures).***

NHSSP II has seven interlinked chapters as follows:

a) Chapter 1 provides background information on the overall strategic plan – indicating where the focus and priorities lie;
b) Chapter 2 describes the overall strategic direction and focus of NHSSP II;
c) Chapter 3 defines the health services that the health sector intends to make available to the people in the Kingdom of Swaziland;
d) Chapter 4 elaborates on the health investments needed to ensure provision of the services outlined in chapter 3;
e) Chapter 5 focuses on the financing measures that ensure progress towards the attainment of universal access;
f) Chapter 6 highlights the key implementation arrangements that the sector will use to ensure the attainment of targets for the health services and investments; and
g) Chapter 7 defines the monitoring/evaluation process for ensuring that NHSSP II implementation proceeds as planned.

An integrated pro-health approach pursued in HSSPII is justified by the following key observations:

Increased burden of disease and mortality

Overall mortality rates increased from 1990 to 2005, as a result of the HIV/AIDS epidemic, although they have declined since 2005 owing to the increased availability of ARVs. Concurrent with the HIV/AIDS epidemic, a significant increase in the TB burden and the emergence of drug-resistant forms necessitates a re-evaluation of the adequacy of response strategies to ensure more efficient and effective delivery.

Shortcomings of disease-focused programming

Stand-alone programs were a predominant feature of NHSSP I which had a number of shortcomings. Deserving priorities such as noncommunicable conditions and violence/injury-related conditions were not given sufficient attention despite being major causes of the existing disease burden. Initiatives for promoting healthy living within the population were limited primarily to specific programmes with no sector-wide impact. For example, sedentary lifestyles, poor eating habits, misconceptions on HIV transmission, gender-based violence, substance abuse, suicide, etc., were not strategically addressed as health risk factors.

Client focus, quality of care and health systems

Scant attention was paid to a comprehensive review of the client pathway and ensuring that the required services are available at each point of care: Access to a number of clinical services is still rather limited. Quality of care remains an issue and rising levels of antimicrobial resistance have been noted. Health service delivery systems have still not been comprehensively rolled out across the country. There are gaps in supervision systems, outreach services provision, referral services, and other critical systems needed to organize and manage the provision of care. Health workforce planning, development and management are still not appropriately aligned to needs: Human Resources for Health (HRH) norms are not being applied, HRH motivation and retention challenges have not been tackled at an effective level to achieve an improvement in performance levels.

Despite gains made in improving health information, coordination is still a challenge, with disparate and uncoordinated sources of information, and a weak capacity to analyze and utilize information. Overall governance and regulation systems are still inadequate to appropriately steward the health sector towards its desired goals. Gaps in public health and other regulations make it difficult to enforce critical actions to meet health goals. Health products procurement and supply chain management systems remain inadequate, with little monitoring of the rational use of health products in the country. Limited effort is made to implement a coordinated and rational approach to health financing and to ensure that the required resources are available and are used in an efficient and balanced manner that addresses the expectations of clients.

NHSSP II emphasizes that operations be founded on the principles of social accountability, evidence and justice, people-centeredness, equity, multisectoral engagement, participation and efficiency. It embraces social values driven by human rights, including respect for clients, the respect of culture and tradition, professionalism, integrity, ethics, accountability, trust and confidentiality.

The mission embraced under this plan is “To build an efficient and equitable client-centered health system for accelerated attainment of the highest standard of health for all the people in Swaziland”. The overall goal is to move towards attainment of universal health coverage with defined health services. The specific sector targets for this goal have been outlined along five thematic health service areas as follows:-

(1) Promote health through the life course: These services are aimed at maintaining the health of the population at all ages. By promoting health, the health sector seeks to maximize the available health resources for the Swazi population.
(2) Prevent diseases: These services are aimed at eliminating / managing threats to the health of the population. By eliminating these health threats, the health sector seeks to reduce their impact on the health of the Swazi population.
(3) Ensure prompt and effective management of medical and related conditions: These services are aimed at ensuring that disease conditions are efficiently dealt with, when they occur. By promptly and effectively managing these disease conditions, the health sector seeks to minimize the impact of disease conditions on the health of the Swazi population.

(4) Ensure rehabilitation following health events: These services are aimed at ensuring that, after a disease condition episode, clients' state of health should revert, to the extent possible, to its erstwhile status.
(5) Influencing health actions in key related sectors: These relate to the actions that the health sector will focus on to influence the prioritization of strategies that impact on health, but which are managed in other sectors. By focusing on these actions, the health sector ensures that it influences the implementation of key actions that affect health in other sectors, and thus maximizes health.

The key issues, strategic areas and major innovations are outlined for each health service thematic area, followed by a table of indicators and targets and, lastly, a log frame presenting the outcome areas, strategies and high-level priority interventions.

The different areas of action that the health sector intends to focus on to achieve the desired health services are described in six key thematic areas of investment as follows:-

(1) Service delivery systems: The key investments needed to improve management of the service delivery process.
(2) Health workforce: The investments required to ensure the availability of an appropriate health sector workforce needed for service delivery.
(3) Health information: Investments relating to information management to guide the delivery of the defined services.
(4) Health products: Investments in medicines, supplies, vaccines, and technologies needed for the delivery of the defined health services.
(5) Health infrastructure: The physical infrastructure, equipment, transport and ICT investments needed for the provision of defined health services.
(6) Governance and regulation: The investments required for appropriate stewardship of the national health agenda to facilitate delivery of defined health services.

As was the case for the health service areas, the key issues, strategic areas and key innovations are presented for each of the six thematic health system investment areas, followed by a table of indicators and targets. Each thematic area is concluded by a log frame which presents outcome areas, strategies and high level-priority interventions. The same structure is followed in the financing chapter, where the key focus is ultimately to prepare Swaziland for the development and implementation of an equitable and sustainable health financing system geared towards universal coverage. The financing themes include availability of adequate resources, equity and efficiency in resource use, and mobilization of new resources. Ultimately, the entire Swazi population should have access to basic health services according to need, irrespective of ability to pay or geographical location.

NHSSP II shall be implemented through a thematic programme or system-specific service or investment areas guided by the budgeting process: Key investments that need to be considered in each budgeting period shall be consistent with annual operational plans designed in accordance with NHSSP II. Emphasis will be laid on the Ministry of Health's decentralization programme in order to facilitate timely, efficient and cost-effective management of the health system and delivery of health services in line with the National Decentralization Policy of 2006. Specifically, the decentralization program shall devolve authority and responsibility for the implementation, management, coordination, monitoring and evaluation of health services. The key strategic orientations shall include the promotion of bottom-up integrated planning; capacity-building and skills development for regional and community-based health institutions; inter-sectoral coordination; and sensitization, mobilization, organization and empowerment of communities to participate in decision-making and program activities.

The establishment of the Health Service Commission, subject to enactment of the Public Health Bill, the establishment of hospital boards in all hospitals and the determination of staffing norms for health facilities will facilitate efficient health sector management. The promotion and management of public-private partnerships (PPPs), civil society organizations (CSOs), and faith-based health providers through various

forums will encourage mutual accountability in the realization of the health sector vision. Through the sector-wide approach (SWAp) health sector support will be coordinated based on the principles of the Paris Declaration on alignment and harmonization.

The various monitoring/evaluation indicators of NHSSP II will use data from different sources. Routine HMIS, vital statistics, surveillance, surveys and research are the key data sources. Using a results-based approach, outputs of annual operational plans shall form the basis for continuous, quarterly and annual monitoring, while the NHSSP II biennial to medium-term targets shall be the basis for a mid-term review and an end-term evaluation.

CHAPTER 1: INTRODUCTION

1.1 Country overview

The Kingdom of Swaziland is a landlocked country in Southern Africa with a surface area of approximately 17,000 km^2. It enjoys a subtropical-to-near-temperate climate along the western highlands which rise to an altitude of over 1,800 meters above sea level, while the low-lying areas are generally hot. The climate favours the cultivation of both consumer and cash crops.

The population was estimated at 1.093 million in 2013, based on projections from the 2007 national census. Fifty-three per cent of the population is female and almost half (48%) of the households are headed by women. Swaziland has a young population, with 44% of its citizens being under 15 years and 4% aged 65 years or older. The total fertility rate was estimated at 3.8 births per 1000 women in 2007, representing a significant decline from 6.4 in 1986. Declining fertility levels, coupled with rising mortality, account for the low annual population growth rates.

Table 1: Distribution of Swaziland's population

	Population, 2007			% of population	2013 projected population	Surface area (sq km)	2013 Population density
	Females	Males	Total				
Hhohho	147,955	134,879	282,834	28%	309,184	3,562	86.8
Lubombo	107,758	99,973	207,731	20%	221,837	5,945	37.3
Manzini	169,622	149,908	319,530	31%	352,568	4,071	86.6
Shiselweni	111,786	96,668	208,454	20%	209,568	3,779	55.5
Total	**537,121**	**481,428**	**1,018,549**	**100%**	**1,093,157**	**17,357**	**63.0**

According to the World Bank, Swaziland, with its gross national income (GNI) of $2,860 in 2012, is in the lower middle-income category of countries ($1,036 to $4,085). The Swazi economy is relatively diversified compared to other small economies and has grown at an average rate of 1.3% over the past five years, relative to a national target of 5%. The nominal gross domestic product (GDP) was E32.4 billion in 2012 (approximately US$3.6 billion), driven mainly by manufacturing, agriculture and wholesale and retail trade. Agro-based manufacturing, specifically sugar processing, wood pulp production and food canning contribute to a growing share of Swaziland's gross domestic product (GDP). Supported by trade preferences, the country exports a large range of products including sugar, textiles, soft drink concentrates, canned fruit and citrus fruits. Swaziland is integrated into the global economy and is a member of the Southern African Customs Union (SACU), Southern African Development Community (SADC) and Common Market for Eastern and Southern Africa (COMESA). The country is also a beneficiary of the African Growth and Opportunity Act (AGOA), promulgated by the United States, and the Cotonou Agreement signed with the European Union (EU). However, the global economic crisis, a slump in agricultural prices, persistent drought, climate change, and the human toll of HIV/AIDS have compromised the country's ability to implement policies that will help achieve its goals for health, education, job creation, safe water, sanitation, and rural development. The economic growth rate plummeted from an average of 10% in the 1990s to 3% in the last ten years. Health remains a priority sector for the government: the annual budget allocation to health has increased from approximately 6.5% in 2002 to 12.2% in 2012 and 13% in 2013.

The African Development Bank (2011), in its analysis of Swaziland, has stated that while long-term development challenges remain unchanged, the unstable macroeconomic environment has complicated the government's response. Implementing the economic and structural reforms set out in the Fiscal Adjustment Roadmap (FAR) of 2010/2011 and 2014/2015 and in the Economic Recovery Strategy of 2011 have become a top priority for the government, which is responding to a reduced resource envelope, following an unprecedented decline in SACU revenue. The FAR focuses on domestic revenue

enhancement, expenditure rationalization and debt management. An Economic Recovery Strategy (ERS) 2011 was also prepared by MEPD to facilitate the elimination of long-standing impediments to economic activity which have contributed to sluggish economic growth over the past decade.

The administrative system comprises a traditional Tinkhundla system and western-style administrative organization. The latter is headed by the Prime Minister and composed of the Cabinet and Parliament whose members are elected and appointed. The administrative structure consists of various sectoral Ministries headed by Ministers and run by Principal Secretaries. The Tinkhundla system constitutes the foundation for implementing the government's Decentralization Policy of 2006.

Swaziland's health service delivery system is structured around a four-tier system of service provision, comprising: the community, clinics and public health units, health centres and regional referral hospitals, and national referral hospitals.

- **Community:** This level is the foundation of service delivery. Services at this level should include community-based promotion, prevention and basic curative care.
- **Clinics:** Rural clinics are categorized into Type A (without a maternity wing) and Type B (with a maternity wing). Rural clinics form the backbone of the primary health care infrastructure. They are the bases from which primary health care programmes operate and provide first-line curative and emergency interventions as well as promotive and preventive services to the rural population.
- **Public health units:** The public health services include promotive, preventive, outpatient curative, outreach health care services and interface with community-based health systems, including households and individuals.
- **Health centres:** The purpose of the health centres is to provide an intermediate range of services at this level, including promotive, preventive, outpatient curative, maternity and inpatient services as well as diagnostic services, outreach care and interface with community-based health systems.
- **Regional referral hospitals:** In addition to primary services, they provide curative, rehabilitative and selected specialist services. They are referral facilities and are responsible for providing technical support and supervision to sub-regional and primary health care facilities within their defined catchment areas. The regional hospitals also provide in-service training, consultation and research in support of primary health care programmes.
- **National referral hospital:** This is the highest referral level, also known as the tertiary level. The kingdom has three national referral hospitals: Mbabane Government Hospital receives referrals from regional hospitals and also serves as a general hospital, while the National TB Hospital and the National Psychiatric Hospital provide specialized services.

Health services are delivered through a decentralized system in the four regions of Hhohho, Manzini, Lubombo and Shiselweni as illustrated in figure 1 below. The central level performs executive and administrative functions and also provides strategic guidance on the delivery of health care services at all levels of care based on the Essential Health Care Package (EHCP). At the regional level, each region is headed by a Regional Health Administrator and supported by the Regional Health Management Teams (RHMTs). About 85% of the country's population lives within a radius of 8km from a health facility (National Health Policy, 2007).

Figure 1: Structure of the health service delivery system

Table 2: Service delivery capacity, by region

Region	Numbers of facilities				# of facilities per 10,000 population (2013)
	Total	Tier 2	Tier 3	Tier 4	
Hhohho	82	79	3	1	2.7
Lubombo	48	46	2	0	2.2
Manzini	121	117	2	2	3.4
Shiselweni	36	33	3	0	1.7
Total	**287**	**274**	**10**	**3**	**2.6**

Source: Service Availability Mapping, 2013

1.2 Overview of the National Vision

In an attempt to revisit the country's National Development Vision of 1999, the Kingdom of Swaziland is reviewing the National Development Strategy in the context of the Swaziland Development Index (SDI). As part of the review, the government has developed a customized definition of First World Status and a Vision 2022, which states: "**A first world country is one where all citizens are able to sustainably pursue their life goals, and enjoy lives of value and dignity in a safe and secure environment. This implies equitable access to sufficient resources, education, health, food security and quality infrastructure and services, as well as good governance".** Specific indicators have been defined in each of these areas to monitor progress towards Vision 2022. These indicators and their targets are presented below.

In October 2013, the 10th Parliament came into being, and the leadership called for *'development unusual',* which is an accelerated push towards achieving first world status through Vision 2022. As a result, a clear focus was defined for the various sectors, including health. This provided an overall umbrella to guide health sector focus and targets.

Table 3: Health-related indicators in the Swaziland Development Index (SDI)

Focus area	Health-related Indicator	Baseline	Target for 2018	Target for 2022
Economic prosperity	1. % of under 5s with stunted growth	40.4% (2009)	23%	15.6%
Education	*No health-related indicator*			
Health	2. Life expectancy	49 years (2011)	55 years	60 years
	3. Maternal mortality ratio per 100,000 live births	320/100,000 (2010)	220/100,000	120/100,000
	4. Child mortality ratio per 1000	80/1,000	70/1,000	60/1,000

Focus area	Health-related Indicator	Baseline	Target for 2018	Target for 2022
		(2012)		
Service Delivery	5. Patient wait time for outpatient services	6 hours	2 hours	1hours
Infrastructure	6. Trained nurses and midwives per 100,00 people	1.9/100,00	2.5/100,00	2.8/100,00
	7. % of population within 5km of a health facility	64%*	82%	95%

*SAM, 2013 does not provide this reference data

The health targets provide a clear focus and agenda based on which the health sector has to prioritize, if it is to contribute to the development agenda of the Kingdom of Swaziland.

1.3 NHSSP II development process

NHSSP II was developed over a one-year period, through a process that drew expertise from all stakeholders in the health sector. The extensive and protracted process sought to ensure that it responded to the needs of the different stakeholders, particularly the people in the Kingdom of Swaziland.

The Swaziland Health Partners Coordination Consortium (SHPCC), the overall policy organ for the Sector Wide Approach (SWAp) implementation in the country, spearheaded the development of NHSSP II. It approved a concept paper for NHSSP II development. The SHPCC developed an institutional framework within which to coordinate NHSSP II development. The SHPCC also functioned as the steering committee, with a core team that served as the technical body leading the development process. Technical teams were constituted, led by subject matter experts, to provide technical guidance. Each technical team was led by a government chair, a co-chair from one of the health partners and two rapporteurs.

Subsequent to that, a comprehensive national health sector situation analysis was conducted. It documented the status of health, health services and health investments across the country, and prepared the ground for developing the strategic focus of NHSSP II.

The SHPCC commissioned five thematic groups to lead preparation of the different elements of the health sector strategic focus for the coming period. These groups comprised representatives of all stakeholders, and involved over 150 persons from all the levels and units of the health sector.

The groups individually developed the focus areas. To ensure commonality, client focus, and a functional approach, the groups were all brought together to harmonize the strategic focus of the NHSSP II through a series of retreats.

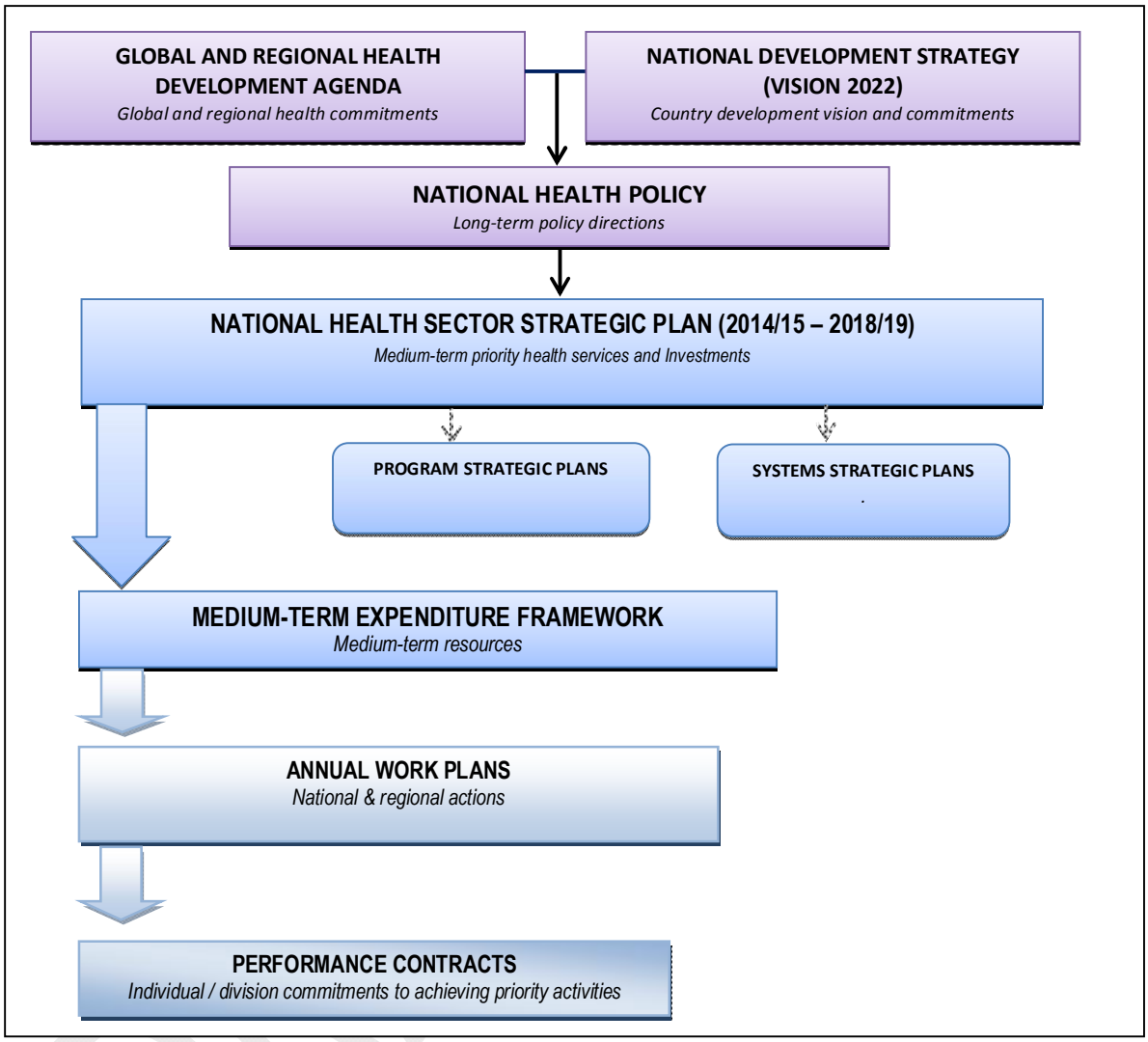
1.4 NHSSP II overview and framework

The 2007 National Health Policy (NHP) seeks to develop the health sector into an effective and efficient mechanism that gives rise to a population which lives longer, healthier and more socially-fulfilling lives. The objectives of the NHP are to:

a) reduce morbidity, disability and mortality caused by disease and other social conditions;
b) promote the effective allocation and management of health sector resources; and
c) reduce the risk and vulnerability of the country's population to social welfare problems and their impact.

NHSSP II builds on this policy and is an integral part of the overall health sector planning framework, as shown in the figure below.

Figure 2: Health sector planning framework



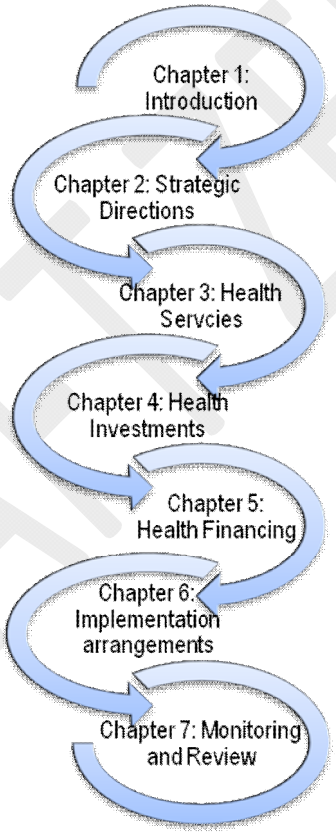
NHSSP II draws on the National Development Strategy and the National Health Policy, which are informed by global and countrywide health aspirations. It defines the key strategic focus and the interventions that need to be implemented in the medium-term to meet these overall policy aspirations. NHSSP II shall be implemented through:

- programme or system-specific service and investment plans, which elaborate key services or investments focused on a given programme area that needs to be attained;
- guidance of the budgeting process to highlight key investments that need to be considered in each budgeting period;
- annual operational plans, which define the activities that underpin NHSSP II strategies that will be implemented with available funds.

NHSSP II has seven interlinked chapters as follows:

a) Chapter 1 provides background information on the overall strategic plan – indicating where the focus and priorities lie;
b) Chapter 2 describes the overall strategic direction and focus of the NHSSP II;
c) Chapter 3 defines the health services that the health sector intends to make available to the people in the Kingdom of Swaziland;
d) Chapter 4 elaborates on the health investments needed to ensure provision of the services outlined in chapter 3;
e) Chapter 5 focuses on resource mobilization to ensure financing of the plan;
f) Chapter 6 highlights the key implementation arrangements that the sector will use to ensure the attainment of targets for the health services and investments; and
g) Chapter 7 defines the monitoring/evaluation process for ensuring that NHSSP II implementation proceeds as planned.

Figure 3: NHSSP II sections



1.5 Situation analysis

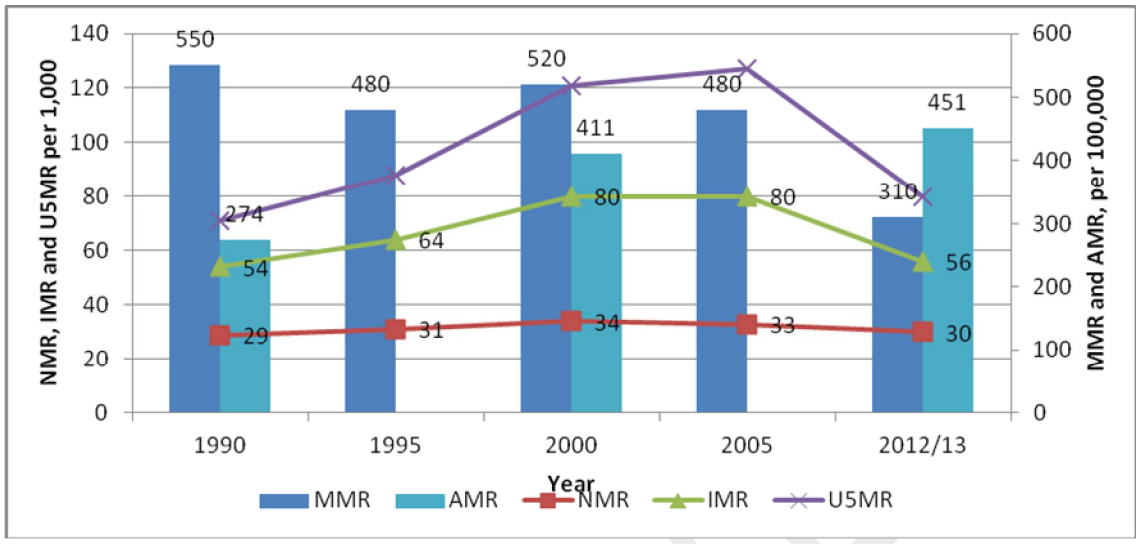
1.5.1 Health trends and distribution

The health status in Swaziland is below expectations, with life expectancy at birth estimated at only 54 years (52 years for males, and 55 years for females) according to the WHO 2014 World Health Statistics. This is very low, relative to other middle-income countries where average life expectancy (at birth) ranges from 63.8 – 72 years for males and 67.9 – 76.2 years for females. Infact this rate is even lower than that of low-income countries (60.2 years for males, and 63.1 years for females). However, although this rate has not yet attained the level of 1990 when it stood at 61 years (62 and 61 years for males and females

respectively), it is higher than it was in the year 2000, when it dropped to 48 years (48 and 49 years for males and females respectively).

This life expectancy trend is reflected in the country's mortality trends in the figure below.

Figure 4: Trends in age-specific mortality, 1990 – 2012/13

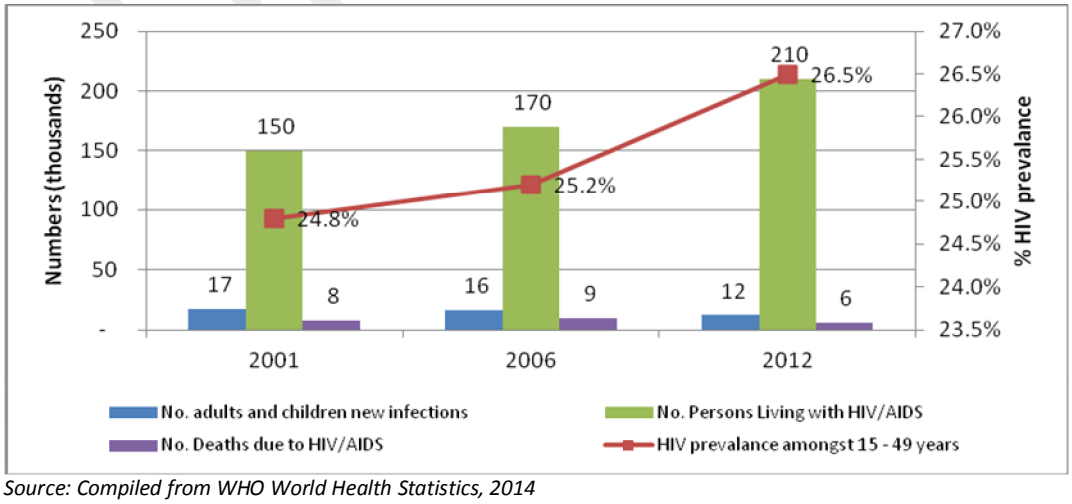


Source: Compiled from WHO World Health Statistics, 2014

All age groups experienced a significant increase in mortality in the preceding 20 years. However, apart from the adult mortality rate all the other age groups have experienced a decline in mortality over the past 10 years. Nevertheless, current mortality rates for all age groups are still higher than they were in the year 1990.

The increase in overall mortality and reduction in life expectancy from 1990-2005 has been attributed to the HIV/AIDS epidemic. HIV prevalence has increased in the country at a much faster rate than prevalence most other diseases. The decline in mortality, from 2005 onward, has been attributed to the expansion in ARV provision.

Figure 5: HIV/AIDS impact trends, 2001 – 2012



Source: Compiled from WHO World Health Statistics, 2014

Although the number of new HIV infections and deaths is on the decline, overall prevalence remains high, due to the large number of people living with HIV/AIDS in the country. TB contribution to the burden of disease (BOD) is evident considering that "in 2012 the number of people newly diagnosed with TB increased from 811 in 2010 to 1671. The increase is no doubt in part due to a six-fold increase in the TB case detection rate as well as a general increase in the TB burden..." (eNSF)

1.5.2 Key achievements of NHSSP I

The overall objectives of the previous National Health Sector Strategic Plan (NHSSP I, 2009 – 2013) were to:

1) reduce morbidity, disability and mortality caused by diseases and social conditions;
2) enhance health system capacity and performance;
3) promote effective allocation and management of health and social welfare sector resources;
4) reduce the risk and vulnerability of the country's population to social welfare problems and their impact.

These objectives were to be attained through intervention in three strategic areas, namely:

i. strengthening health system capacity and performance;
ii. improving access to essential, affordable and quality public health services with a view to achieving universal coverage; and
iii. improving access to essential, affordable and quality clinical services with a view to achieving universal access

The sector had 30 objectives and 610 tasks spread across these strategic intervention areas, to guide attainment of its objectives.

Findings of the Mid Term Review (MTR) conducted during the NHSSP I period highlight the following key achievements for the three strategic intervention areas as shown in the table below.

Table 4: Selected NHSSP I achievements in the various strategic intervention areas

Strategic intervention area	Selected achievements
Enhancing health system capacity and performance	▪ Recruitment of HRH was accelerated with the support of partners. ▪ The functionality of many facilities was improved, with the required equipment purchased and deployed and the expansion of Lubombo regional hospital initiated. ▪ There were efforts to build staff capacity, particularly in supervision, management of capital projects, M&E, and selected program interventions. ▪ Essential Health Care Package was agreed and launched in 2012. ▪ A national quality assurance program was initiated and specific initiatives to improve quality of care were introduced (for example, moving laboratory services towards ISO certification). ▪ Capacity for health financing was improved, with a feasibility study conducted on social health insurance. ▪ Improved integration of HMIS systems was attained. ▪ Active notification system was attained, including introduction of International Health Regulations. ▪ An integrated review of all health laws was initiated, with a number of new bills drafted, such as the public health bill, medicines & related substances bill, pharmacy bill. ▪ The Tobacco Products Control Act was promulgated as an Act of Parliament in 2013. ▪ Organizational structure for MOH management was approved by Cabinet in May 2010.
Delivery of	▪ Introduction of telemedicine to improve efficiency in diagnosis and referral was

Strategic intervention area	Selected achievements
essential curative health services	achieved, in Mbabane Government hospital. ▪ Clinical guidelines and a national patients' charter were developed. ▪ Provision of specific services, such as mental health services, dental screening, eye care and prevention of blindness, automated donor blood grouping and Transfusion Transmissible Infections (TTI) testing, was expanded. ▪ Some specialized services were introduced in the country. ▪ Infection control and risk management guidelines were put in place.
Delivery of essential public health services	▪ HIV prevention and control services, such as PMTCT/VCT, treatment and support were expanded. ▪ IMCI services were expanded, with a doubling of the facilities providing such services ▪ Vector control initiatives were scaled up, with ITN use amongst pregnant women and under-fives increased to near universal coverage and ACTs introduced to improve quality of treatment. ▪ Availability and quality of TB services improved, with better TB treatment completion and success rates achieved.

1.5.3 Key recommendations and unfinished business

The gains made are having a growing positive impact on the health of the people in the Kingdom of Swaziland. Consequently, there is need to build on these gains in order to accelerate the apparent improvements noted. However, a certain number of issues remain unresolved within the sector.

With regard to health services, the activities included under NHSSP I were primarily built around stand-alone programme areas. Hence, NHSSP I was just a collection of these 'independent' programme areas, with very few inter-linkages across the various segments of the plan. As a result of this shortcoming, the following issues arose:

- Specific strategies addressing noncommunicable conditions and violence/injuries were not given adequate priority, even though these are increasingly becoming a major cause of disease burden.
- Initiatives to promote healthy living within the population were limited primarily to specific programmes with no sector-wide approach to facilitate this. For example, sedentary lifestyles and poor food habits are not strategically addressed as risk factors.
- There is evidence of high rates of substance abuse, suicide, violence (including GBV), road traffic accidents and sexual abuse that are affecting health, but are not appropriately addressed.
- Allied health services were not adequately involved and this limited overall impact on the health of the people in Swaziland. The failure to conduct a comprehensive review of the client pathway and to ensure that the required services are available at each point of the care provision pathway has led to less than desirable outcomes.
- Access to a number of clinical services still remains rather poor, with scale-up beyond the tier 4 level still inadequate. Quality of care remains an issue, with rising levels of antimicrobial resistance noted.
- Quality of care initiatives are still in their infancy, with few or limited efforts made to monitor client experiences and effectiveness of care, with a view to aligning services to meet the expectations of the people in the Kingdom of Swaziland

On the other hand, a number of system-related challenges remain unaddressed:

- Health workforce planning, development and management are still not appropriately aligned to the needs of the health services. HRH norms are not being applied, and workforce projections are needed to guide development. There are challenges relating to HRH motivation and retention.

- Infrastructure and equipment planning, procurement and maintenance still remain a challenge and the absence of norms and standards results in inaccurate projection of needs, while a lot of infrastructure is still not functional.
- There are still challenges in the coordination of health information systems, with different information sources that are not interlinked, and a still weak capacity to analyse and use information.
- Overall systems for governance and regulation are still inadequate to appropriately steward the health sector towards its desired goals. The legislative and governance aspects of health need to be improved by strengthening the Legal Department and expediting the passing of the Public Health Bill.
- Health service delivery systems are still not comprehensively rolled out across the country. There are gaps in supervision systems, outreach service provision, referral services and other critical systems needed to organize and manage the provision of care.
- Health products procurement and supply chain management systems remain inadequate, with little monitoring of the rational use of health products in the country.
- There were limited efforts to develop a coordinated and rational approach to health financing, to ensure that the required resources are available, and are efficiently and equitably utilized in a manner that is responsive to the expectations of the clients.

Consequently, the key recommendations on which the sector will need to focus in NHSSP II are as follows:

(1) Ensure that NHSSP II is built around a functional rather than a structural approach, with the different elements interlinked and all working towards a common health agenda.
(2) Ensure that a comprehensive set of health services is provided, which holistically meets the health needs of the people in the Kingdom of Swaziland. This involves addressing health-seeking behaviours and health actions in other sectors, in addition to the traditional public health and curative services.
(3) Introduce a stronger element of client-focused and client-centred health services.
(4) Have a comprehensive and rationalized health systems investment focus which ensures that all the critical investment needs of the health sector are addressed.
(5) Ensure that there is a clear focus on strengthening the regulation of health service provision.

CHAPTER 2: NHSSP II STRATEGIC DIRECTIONS

2.1 Sector vision, mission and goal

This strategic plan represents the medium-term strategic focus for the health sector to support attainment of the national development agenda. It is designed to provide an overall framework from which sector priorities and actions are derived. Its strategic focus is as follows:

VISION

A healthy and productive Swazi population that lives longer, fulfilling and responsible lives

MISSION

To build an efficient and equitable client-centred health system for accelerated attainment of the highest standard of health for all people in Swaziland

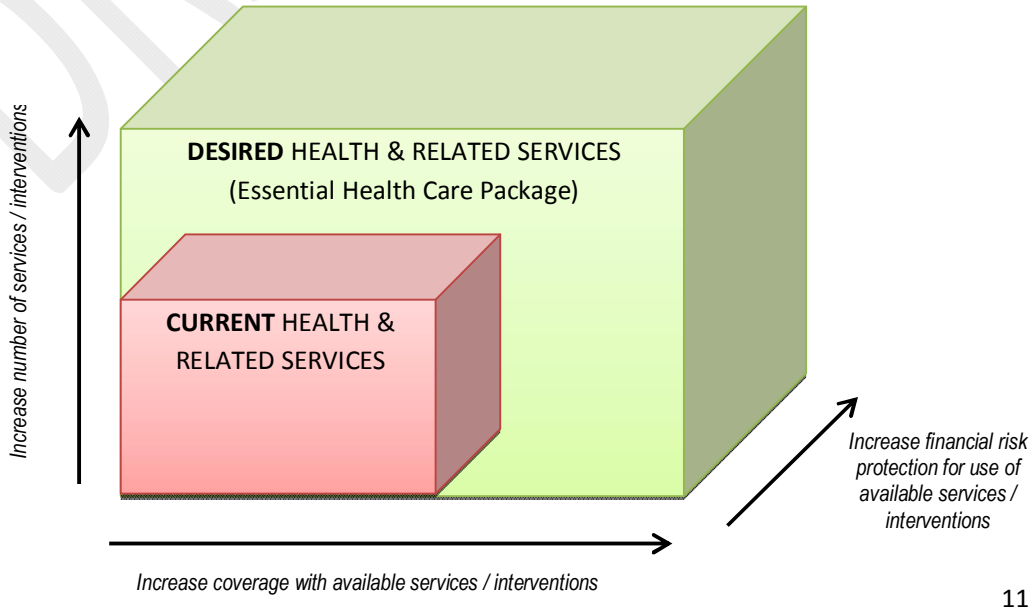
GOAL

Towards attainment of universal health coverage with defined health services

NHSSP II is designed around the need to attain universal health coverage with health and related services as defined in the Essential Health Care Package (EHCP). This implies that health sector activities during this period will focus on:

1. Increasing the number of health and related services and interventions provided across the country ***(introduction of interventions as and where needed);***
2. Increasing coverage of the population by the different health and related services and interventions ***(scale-up of intervention use)***; and
3. Reducing the household financial burden incurred at the point of access and utilization of health and related services and interventions ***(reduce catastrophic health expenditures).***

Figure 6: Towards universal health coverage with the Essential Health Care Package



2.2 NHSSP II impact targets

NHSSP II targets relate to three levels at which impact is sought, as follows:

- level I: maximising the level of health in the country;
- Level II: improving equity in the distribution of the available health;
- Level III: improving the responsiveness of services to the expectations of the people in the Kingdom of Swaziland.

The key impact targets are shown in the table below:

Table 5: NHSSP II impact targets

Domain area	Impact targets	Indicators	Baseline	Mid term	Target 2018
Monitoring of health impact	Maximising level of health	Life expectancy at birth (years)	54		59
		Age-specific mortality rates			
		Neonatal mortality rate (per 1,000 live births)	19		13%
		Infant mortality rate (per 1,000 live births)	79 (MICS)		13%
		Under-five mortality rate (per 1,000 live births)	104		90.5
		Maternal mortality rate (per 100,000 live births)	320 (2010)		147
		Adult mortality rate (per 1,000 adults)	451		316
	Improving equity in distribution of health	Mortality rates between highest and lowest poverty quintiles			
		Variation in under-five mortality rate			*50% reduction*
		Variation in maternal mortality rate			*30% reduction*
		Variation in adult mortality rate			*50% reduction*
	Improving responsiveness	Increase in numbers of clients satisfied with services			

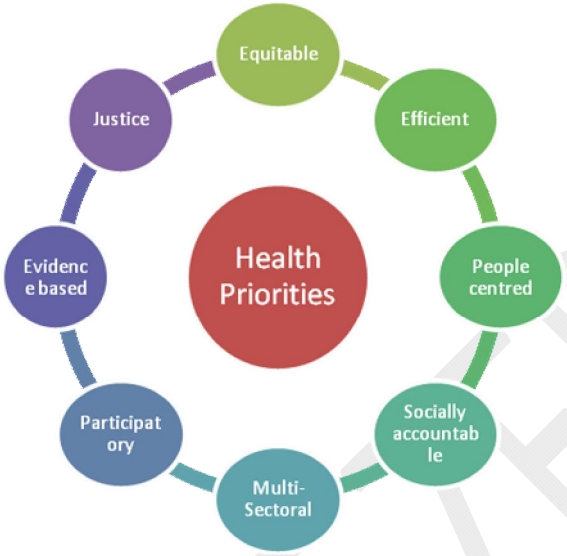
2.3 NHSSP II principles and values

The NHSSP II is built around principles and values that place the client at the centre of all services provided. This ensures a clear focus on responsiveness to the needs of the community when services are designed and provided. The principles underpinning NHSSP II are derived from the primary health care approach. They define how investments will be prioritized during NHSSP II implementation. The key principles are:

(1) **Equity:** Ensure that all services are provided without any exclusion and social disparities. Investments are designed to ensure equal access to services for everyone, irrespective of gender, age, race, geographical location and social class.
(2) **People-centred:** Ensure that health and health interventions are organized around people's legitimate needs and expectations. Give priority to interventions that emphasize community involvement and participation. The services should be designed in a manner that builds a long-term relationship with users.
(3) **Participation**: Interventions involving different actors are prioritized, as they allow more scope for financing, and attainment.
(4) **Multisectoral approach:** This is based on the recognition that health cannot be improved by interventions relating to health services alone, but that a focus on 'Health in all Sectors' is required. Interventions implemented by health-related sectors are also prioritized, since they do not require significant health investments, but can yield significant health outcomes.
(5) **Efficiency**: Maximize the use of existing resources and ensure that interventions are implemented in the most efficient manner. This entails adopting integrated approaches to service provision as much as is feasible.

(6) **Social accountability**: To improve on the public perception of health services, interventions that involve performance reporting, public awareness, transparency and public participation in decision-making on health related matters are prioritized.
(7) **Evidence based**: All focus and actions of the sector will be driven by evidence.
(8) **Justice**: All actions in the sector shall be predicated on the need to ensure that justice is done.

Figure 7: Key principles and attributes of health investments



The social values underpinning NHSSP II are driven by a rights-based approach, and will determine how the sector will review its impact on clients. These values include:

(1) **Respect for clients:** The health sector stakeholders will ensure that utmost respect is observed during interaction with the clients of health services.
(2) **Respect of culture and tradition:** All stakeholders will ensure respect for community cultures and traditions that promote health.
(3) **Professionalism, integrity and ethics:** Health, health-allied and other professionals working in the sector shall perform their work with the highest level of professionalism, integrity and ethics as stipulated in the ethics guidelines enforced by the professional bodies to which they are affiliated.
(4) **Accountability:** At all times and at all levels, a high level of efficiency and accountability will be maintained in national health system development and management. All stakeholders shall discharge their respective mandates while taking full responsibility for the decisions made in the course of providing health care.
(5) **Trust:** In all activities, the health sector shall strive to build the trust and confidence of clients and thus ensure that they are comfortable and confident in the sector's ability to meet their expectations.
(6) **Confidentiality:** The sector shall respect the individuality of the clients and cater to their need for confidentiality during use of health services.

CHAPTER 3: NHSSP II PRIORITIES FOR HEALTH SERVICES

3.1 Health conditions affecting the population

Health indices and trends: After recording impressive improvements in health status for three decades after independence, the country witnessed a marked deterioration in a number of health indicators over the last 15 years. Life expectancy at birth dropped from 60 years in 1997 to 45.3 years in 2012 and under-five mortality rate increased from 78 per 1000 live births in 1993 to 105 in 2008. The Swaziland ICDP Country Report noted that the maternal mortality ratio increased from 229 per 100,000 live births in 1991 to 589 deaths per 100,000 live births in 2007, in spite of the fact that 77% of women aged 15-49 years made at least four visits to antenatal clinics during pregnancy. The proportion of deliveries attended by skilled health workers was estimated at 82% in 2010.

The overall decline in health status can be partially attributed to the growing prevalence of HIV during the same period.

Morbidity, mortality and risk factors:

The top 10 causes of morbidity and mortality, as well as the attendant risk factors for both, are presented in the table below. In children under five years of age, the leading conditions reported by outpatient departments (OPD) were upper and lower respiratory tract infections, skin disorders, acute diarrhoea, digestive disorders, eye diseases, oral health conditions, ear problems and injuries. The leading causes of admission for this age group are gastroenteritis and colitis, upper and lower respiratory tract infections/pulmonary TB, AIDS, anaemia and nutrition-related disorders.

Compared to other diseases, HIV, AIDS and TB have imposed by far the largest burden of disease on the population. HIV prevalence among 15-49 year olds is currently estimated at 26% and is one of the highest in the world. The rate is higher among women (31%) than men (20%) (DHS 2007) and prevalence in women peaks at 49% within the 25-29 age group. Unsafe sex practices, intergenerational sex, multiple concurrent partners and misconceptions about HIV transmission account for high levels of HIV prevalence among young persons, pregnant women and other population groups. Tuberculosis constitutes a major public health problem in the country. With an estimated TB incidence rate of 1350 per 100,000 population, the country has consistently had the highest TB burden per capita in the world (WHO 2012). Compared to a 1990 level of 267 per 100,000 population, TB incidence has increased five-fold since then. The TB/HIV co-infection rate among incident TB cases has remained above 80% (TB Annual Report 2012).

The high prevalence of HIV and recent projections showing continuing new infections are most likely influenced by misconceptions of HIV among young people (only 54% have comprehensive knowledge). These facts underline the importance of reaching out more effectively to the young people with correct information and better methods of engaging them. Counselling, testing and receiving results is lowest among the youngest age group (age 15-19 years). There is a significant proportion (about 30%) of those that had sex with more than one partner who did not use a condom.

Table 6: Current estimates of major causes of morbidity/mortality and risk factors, 2014

Top 10 causes of morbidity		Top 10 causes of mortality		Top 10 risk factors to morbidity/mortality	
1	Upper respiratory infection	1	Pulmonary tuberculosis	1	Unsafe sex practices
2	Hypertension	2	Acquired immune deficiency syndrome	2	Substance and alcohol abuse
3	Musculoskeletal conditions	3	Other non-infective gastroenteritis and colitis	3	Gender-based violence
4	Skin disorder	4	Pneumomia, organism unspecified	4	Unhealthy feeding and dietary practices
5	Lower respiratory infection (mild)	5	Diabetes mellitus	5	Obesity and physical inactivity
6	Digestive disorders	6	Cardiomyopathy	6	Accidents and injuries
7	Acute watery diarrhoea	7	Meningitis of unspecified cause	7	Tobacco use
8	Diabetes mellitus	8	Chronic pulmonary heart disease	8	Sub-optimal breast feeding
9	Genito-urethral infections (STIs)	9	Heart failure	9	High blood pressure
10	Cancers and other diseases/conditions	10	Other and ill-defined cerebrovascular diseases	10	Childhood underweight

Source: HMIS data

It is important to note the youthful nature of the Swaziland population (40% below 15 years) (MICS 2010). The risk of dying is higher for a child born within two years of a preceding birth. Neonatal mortality is a major focus area, considering the relatively high proportions in some regions when compared with post-neonatal mortality (Hhohho and Lubombo) (MICS).

3.2 Addressing the health conditions in Swaziland

3.2.1 Overall health targets

The health sector seeks to maximizing the health resource in Swaziland by ensuring equitable and affordable access for all. The country needs to move towards universal health coverage with an agreed set of health and related services that have the highest impact on health challenges. These services should have the following impact on the disease burden in the Kingdom.

Table 7: Targeted health conditions affecting the Swazi population

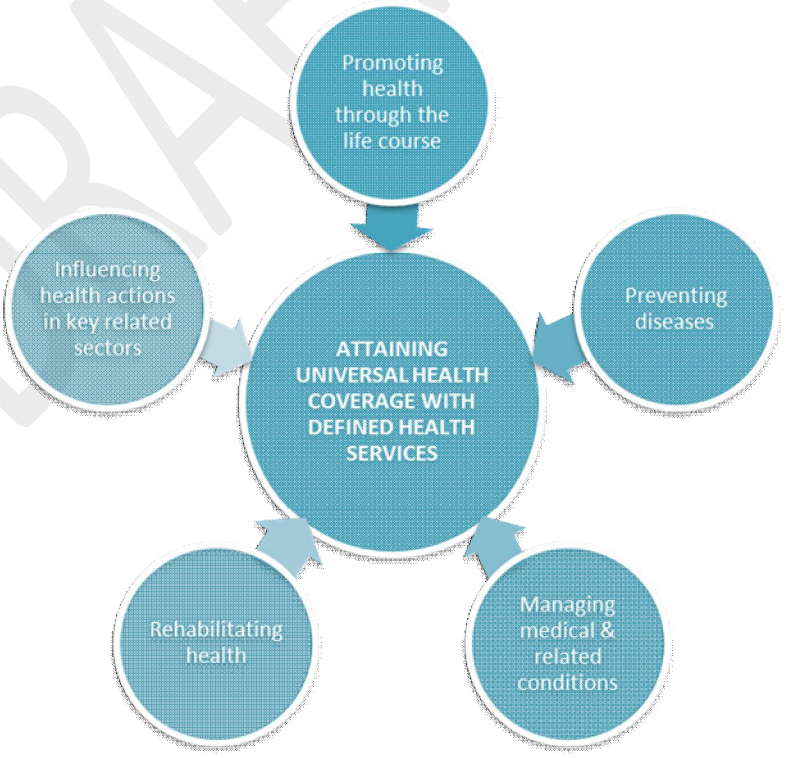
CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETED FOR ELIMINATION
1. Poliomyelitis	1. Malaria 2. Mother-to-child HIV transmission 3. Maternal and neonatal tetanus 4. Measles 5. Neglected tropical diseases
CONDITIONS TARGETED FOR CONTROL	**RISK FACTORS TARGETED FOR CONTAINMENT**
1. HIV / AIDS 2. Conditions in the perinatal period 3. Lower respiratory infections 4. Tuberculosis 5. Diarrhoeal diseases in children 6. Cerebrovascular diseases 7. Ischaemic health disease 8. Road traffic accidents 9. Violence including gender-based violence 10. Mental health disorders 11. Vaccine-preventable diseases 12. New/re-emerging infections 13. Cancers	1. Unsafe Sex 2. Unsafe water, sanitation & hygiene 3. Suboptimal breastfeeding and complementary feeds 4. Childhood and maternal underweight 5. Indoor air pollution 6. Alcohol use, Substance abuse 7. Tobacco use 8. Micronutrient deficiencies (VAD, IDD, IDA, ZD) 9. High blood glucose 10. High blood pressure 11. Lack of contraception

3.2.2 Strategic focus and thematic areas

To be able to attain these targets, and ultimately achieve universal health coverage, the health sector aims to provide services across a continuum of care that is focused on the client, by addressing health challenges that can reduce their health resource. As a result, the sector is focusing on providing health services that:

(1) Promote health through the life course: These services are aimed at maintaining the health of the population at all ages. By promoting health, the health sector is aiming at maximising the available health resource for the Swazi people.
(2) Prevent diseases: These services are aimed at removing or managing threats to the health of the population. By removing these health threats, the health sector is aiming to reduce their impact on the health of the Swazi people.
(3) Promptly and effectively manage medical and related conditions: These services are aimed at ensuring that disease conditions are efficiently dealt with, when they occur. By promptly and effectively managing these disease conditions, the health sector is aiming to minimize the impact of disease conditions on the health of the Swazi people.
(4) Rehabilitate following health events as well as reducing the impact of disability, enhancing participation and inclusion in societal roles: These services are aimed at ensuring that, following a disease condition episode, clients' state of health is reverted as close as possible to its erstwhile condition.
(5) Influence health actions in key related sectors: This relates to the actions the health sector will focus on to influence prioritization of strategies that impact on health, but are managed in other sectors. By focusing on these, the health sector seeks to influence the implementation of key actions that affect health in other sectors, and thus maximises health.

Figure 8: Health services thematic areas



3.2.3 Thematic area 1: Promoting health through the life course

Key issues

Attainment of the desired state of health is not only dependent on interventions to address ill health, but also on services and actions that maintain the existing health status of individuals. It is critically important for the health sector to identify and implement strategies and interventions that will help to keep communities and individuals healthy.

A focus on promoting health through the life-course calls for addressing the barriers to good health that occur throughout gestation, childhood, adolescence, adulthood and elderly phases of life. At present, there are signs that these challenges are significant within the population. Almost 6% of under-five children are underweight, and one in every three (31%) are stunted (MICS 2010). The same source indicates that 1% of children are wasted. It is noteworthy that education plays an important role: children whose mothers have secondary or higher education are least likely to be underweight, wasted and stunted compared to children whose mothers have little or no education. High maternal HIV infections often lead mothers to refrain from breastfeeding or stopping it earlier than recommended.

The MIC Survey further revealed that 11% of under-fives are overweight: children whose mothers reached higher levels of education are more likely to be overweight. Exclusive breastfeeding stands at 44%. Only 39% of children aged 6-23 months were receiving complementary foods and breast milk at the same time. Appropriately breastfed children aged 0-23 months constitute about 40%. Child feeding frequency tends to be lower amongst poor and undereducated mothers. With 16% of children having had diarrhoea within two weeks before the survey and 24% of mothers having incorrect knowledge of oral rehydration solution (ORS), it is not surprising that diarrhoea is the leading cause of death among under-five children. According to DHS (2007), micronutrient deficiency disorders are a key concern in the country.

Maternal deaths were attributed to preventable or treatable conditions such as haemorrhage (22%), hypertension (11%), unsafe abortion (1.6%), sepsis (12.7%), other direct causes (6.4%); and indirect causes (46%) (Ministry of Health, 2011). Most maternal deaths are attributed to three factors: delay in decision-making; delay in transportation to the nearest health facility; and delay in service delivery at health facility level. In addition, the elderly face a number of noncommunicable conditions, yet access to services addressing these conditions is limited.

The key issues hindering good health across the life course revolve around:

- weak integration and poor quality of family and child health services;
- low penetration of adolescent and youth-friendly sexual reproductive health services, child survival services, maternal and neonatal services, and health services for the elderly;
- micronutrient deficiencies and a mix of acute, moderate and chronic malnutrition; and
- inadequate male involvement in reproductive health and child health, as well as low attention to the risk factors that cause ill health among men and women.

Strategic approach

The sector intends to introduce and scale up a range of interventions aimed at promoting health throughout the life course. It intends to achieve this by focusing on:

- enhancing the integrated approach to delivery of child and maternal survival services;
- providing a male-tailored Essential Preventive Health service Package;
- promoting understanding and practice of healthy ageing for men and women;
- making physical Exercise for All (E4A) a popular sustained national campaign;
- promoting, protecting and supporting appropriate infant and young child feeding practices and behaviours with focus on the first 1000 critical days.

Key innovations

A strategic focus on promoting health is new for the health sector in Swaziland, which has in the past focused primarily on preventing, and treating diseases. Furthermore, focus on the life course of an individual constitutes a departure from emphasis on the disease to emphasis on the client; i.e. addressing the client's challenges, as opposed to the disease. Through this approach, the sector intends to be more responsive to the health needs of communities and individuals.

Table 8: Indicators and targets for promoting health through the life course

	Coverage Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	Neonatal mortality rate (per 1000)	19	17	15	13	10
2	Fully immunized children	83	86	89	92	95
3	Stunting prevalence	30.6	28.7	26.8	25	23
4	Unmet need for family planning	13	12	11	10	10
5	Postnatal care coverage within 6 weeks of delivery	24%	34%	44%	54%	60%
6	Teenage pregnancy rate (per 1000 girls aged 15-19 years)	89	85	82	78	71

Table 9: Strategic focus, and selected priority interventions for promoting health through the life course

No	Outcome area	Strategies	Priority interventions
1	Child and maternal health services Promoting good health at key stages of life	1.1 Strengthen delivery of quality comprehensive child and maternal survival services by enhancing the integration of services	1.1.1. Improve accountability on integrated family and child health services at all levels of care
			1.1.2. Generate and implement more focused and effective mitigation measures to improve neonatal and maternal health outcomes (based on assessment of disease conditions burden affecting these groups)
			1.1.3. Improve access to family and child health services at strategic service delivery points – all levels of care
			1.1.4 Promote family and child health information services at all levels (individual, family, community, health service delivery points, national)
			1.1.5. Strengthen capacity for integrated EMOC at all levels
2	Sexual and reproductive health services	2.1 Reduce teenage and other unplanned pregnancies	2.1.1. Delay sexual debut using a culturally-rooted approach (applying rapid ethnography to source content for blending with sexuality and family health interventions).
			2.1.2. Share correct information for better understanding of HIV amongst adolescents and youth
			2.1.3. Strengthen capacity of service providers on tailored SRH and family health services at all levels
			2.1.4. Promote comprehensive youth and adolescent sexuality and family health services
		2.2 Promote male-involvement for enhanced reproductive and family health	2.2.1. Provide male-tailored an essential preventive health service package (e.g. health risks reduction, regular screening for NCDs, safe sex and reproductive health, nutrition and household food security, planning for and managing family life etc.)
3	Healthy ageing	3.1 Mainstream healthy ageing into health service delivery	3.1.1. Define and systematize healthy-ageing in health service delivery packages
			3.1.2. Promote understanding and practice of healthy ageing for men and women
			3.1.3 Promote wellness as a holistic entity for various age groups (starting with schools and workplaces for immediate and intermediate term effects)
4	Managing risk factors for health	4.1 Integrate mental health care, rehabilitation and counselling into	4.1.1. Package and decentralize mental health services at all levels
			4.1.2. Develop rehabilitation centres for substance abuse

No	Outcome area	Strategies	Priority interventions
		service delivery	4.1.3. Strengthen empowerment approaches for mental health clients (e.g. support groups)
		4.3 Ensure positive engagement of all population groups (young and old) in personal physical fitness	4.3.1. Intensify promotion of sports and physical exercise for all population groups particularly adolescents and youths – Exercise for All = all levels, all sectors, groups and individuals (E4A sustained campaign)
		4.4 Promote healthy food consumption	4.4.1. Strengthen healthy nutrition promotion programme to target population groups particularly in and out-of-school youth
			4.4.2. Increase household consumption of iodized salt
5	Reduced nutritional risk factors	5.2 Promote availability, accessibility and utilization of macro and micronutrients at health facility and household level	5.2.1 Promote, protect and support appropriate infant and young child feeding practices and behaviours with focus on the first 1000 critical days
			5.2.2 Develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan
			5.2.3 Adapt and implement norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding and policy options for effective nutrition actions against stunting, wasting and anaemia
		5.3 Strengthen nutrition services and social protection in schools and communities	5.3.1. Promote dietary diversification and healthy eating habits in schools and communities
		5.4 Promote the integration and documentation of micronutrient deficiencies	5.4.1. Integrate micronutrients indicators into existing tools e.g. ANC card, CH card
		5.5 Ensure food and nutrition preparedness for emergencies	5.5.1 Provide nutrition care and support for vulnerable groups (children, women, elderly, disabled).

3.2.4 Thematic area 2: Prevention and control of communicable, and noncommunicable conditions

Key issues

The prevention and control of communicable and noncommunicable conditions remains the core function the health sector. Disease threats still afflict all persons, regardless of age, sex, lifestyle, background, and socioeconomic status. They cause suffering and death and impose a heavy financial burden on society. Disease prevention and control strategies need to be changed constantly in response to the changing nature of diseases and their management. Societal, technological, and environmental factors continue to have a dramatic effect on infectious diseases worldwide, facilitating the emergence of new diseases and the re-emergence of old ones, sometimes in drug-resistant forms. The focus of the sector in this planning period is to reduce the burden of communicable and noncommunicable diseases.

Swaziland is currently facing a double burden of communicable and noncommunicable conditions. Significant efforts have mostly focused on the prevention of communicable conditions in the past, with extensive provision of strategies to address major communicable conditions like HIV, TB and Malaria. However:

- Many of the efforts to scale up the preventive strategies have not yet reached universal coverage – there are still pockets of the population that are not receiving the interventions.
- Not all communicable conditions are being prioritized. There are still a number of neglected tropical conditions for which intervention scale up is poor.
- The preventive strategies addressing noncommunicable conditions, including violence and injuries, are not yet firmly established in the country.

Strategic approach

The health sector intends to move towards universal health coverage with critical interventions addressing communicable and noncommunicable conditions in the Kingdom of Swaziland. The focus will be on:

- Universal access to communicable disease prevention and control in a manner that guides the national response to threats [effective antimicrobial resistance monitoring and action] so as to have a better chance of monitoring and implementing effective surveillance of infected individuals who may endanger the health of the general public;
- A systematic path to address all conditions earmarked for elimination and ready to be taken to implementation with sustained surveillance of transmission foci;
- Scaling up of immunization efforts;
- Improving response to health emergencies including emerging and re-emerging health threats (epidemics and pandemics);
- Preventing and managing noncommunicable diseases.

Key innovations

A focus on universal coverage with all disease prevention and control interventions is innovative. This will ensure wide population access to these services and so move most of the targeted conditions towards effective control, prevention or elimination in the country.

Table 10: Indicators and targets for preventing communicable and non-communicable conditions

	Coverage Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	% reduction in road traffic disabilities/deaths	1	5	10	15	20
2.	TB Treatment success rate	76	79	82	85	88
3.	MDR TB Rate	56	60	62	64	66
4	HIV incidence adults (children)	2.22 (2.2)	2.13 (1)	2.06	2.0	1.94 (1)
5	Malaria slide positivity cases	35	25	12	0	0
6	Availability of affordable basic technologies and essential medicines to treat major NCDs					80%

Table 11: Strategic focus, and selected priority interventions for preventing communicable & noncommunicable conditions

No	Outcome area	Strategies	Priority interventions
1	Reducing the burden of communicable conditions	1.1 Increase access to key interventions for communicable disease prevention and control	1.1.1 Adapt and implement most up-to-date norms and standards in preventing and treating communicable diseases,
			1.1.2 Link and integrate HIV services with those of other communicable diseases and other programmes
			1.1.3 Strengthen surveillance systems, monitoring & evaluation and use of data for communicable disease prevention and control
			1.1.4 Promote supermarket delivery of services including the application of rights-based approach
			1.1.5 Ensure adequate access to new tools and guidelines for prevention and treatment of communicable diseases
			1.1.6 Reduce inequities in the provision of communicable disease prevention and control interventions
			1.1.7 Develop a national operational research agenda on identified challenges in communicable diseases prevention and control
		1.2 Control diseases earmarked for elimination	1.2.1 Implement the National Strategic Framework for Accelerated Action on the Elimination of new HIV infections among children by 2015 and keeping their mothers alive
			1.2.2 Intensify implementation and monitoring of measles and rubella elimination
			1.2.3 Establish processes for certification of polio eradication
			1.2.4 Strengthen national capacity for certification/verification of the elimination of selected communicable diseases
		1.3 Increase vaccination coverage	1.3.1 Implement and monitor the global vaccine action plan as part of the Decade of Vaccines Collaboration
			1.5.4 Monitor effectiveness and implementation of current immunization schedules and process introduction of new vaccines in accordance with existing threats (locally and internationally)
2	Reducing mortality, morbidity and societal disruption resulting from epidemics, and environmental and food-related emergencies	2.1 Strengthen alert and response capacities	2.1.1 Develop the core capacities required by the International Health Regulations (2005) for all-hazard alert and response
			2.1.2 Build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics
			2.1.3 Strengthen national capacities for all-hazard emergency and disaster risk management for health

No	Outcome area	Strategies	Priority interventions
		2.2 Adequately prepare to prevent and mitigate risks to food safety	2.2.1 Adapt and implement food safety standards, guidelines and recommendations
			2.2.2 Enhance multisectoral collaboration to reduce foodborne public health risks, including those arising at the animal-human interface
3	Reducing the burden of noncommunicable conditions	3.1 Increase access to interventions to prevent and manage noncommunicable diseases and their risk factors	3.1.1 Develop national multisectoral policies and plans for implementing interventions to prevent and control noncommunicable diseases in line with the WHO Global Action Plan for the Prevention and Control of NCDs (2013–2020)
			3.1.2 Strengthen capacity for surveillance of risk factors and for monitoring/evaluating noncommunicable disease programmes, in line with global standards
		3.2 Increase access to services for mental health and substance use disorders	3.2.1 Develop and implement national policies and plans in line with the 2013–2020 Global Mental Health Action Plan
			3.2.2 Adapt and implement mental health guidelines covering treatment, recovery, prevention and promotion
			3.2.3 Expand and strengthen strategies, systems and interventions for disorders caused by alcohol and substance use
4	Reducing risk factors for violence and injuries	4.1 Develop and implement multisectoral plans and programmes to prevent injuries	4.1.1 Develop national model programmes that focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)
			4.1.2 Develop and implement programmes and plans to prevent child injuries
			4.1.3 Develop and implement policies and programmes to address violence against women, youth and children

3.2.5 Thematic area 3: Influencing health actions in key sectors

Key issues

Many factors can affect the health of individuals and communities. Whether people are healthy or not is determined by their circumstances and environment. To a large extent, factors such place of residence, state of the environment, genetics, income, education level and relationships with friends and family, all have considerable impacts on health. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Consequently, reducing health inequities, including moving towards universal health coverage that is accessible, affordable, and good quality for all is important.

Many of these factors, which influence the status of our health, are beyond the mandate of the current health sector. However, given their significant impact on the overall health of the population, it is critical that the health sector be able to influence their implementation. At present, many of these determinants of health are significantly affecting the health status:

- Low education levels are linked with poor health, more stress and lower self-confidence. Lower educational levels also impede access to health services. Furthermore, a comprehensive school curricula that includes important health issues is an important tool. Maternal education, particularly secondary education of the girl child, is known to be a critical determinant of health outcomes during maternity, and for the family as a whole. A number of teenage girls are still not accessing adequate education, posing a significant health risk.
- Safe water and sanitation facilities have a direct effect on the health of communities, particularly in relation to water-borne diseases/conditions. Communities with limited access to safe water, and/or sanitation facilities will always be at risk from a number of communicable conditions.
- Workplaces affect health significantly, as these are areas where individuals spend a disproportionate amount of their time. Workplace health and safety measures are introduced in many formal employment areas, but most informal workplace settings are not adequately supported with strategies to improve workplace safety
- Inappropriately ventilated housing facilities affect the health of individuals and healthy lifestyles.
- Culture and traditions, when not well applied, can at times influence health outcomes. It is important to ensure these are applied in a manner that does not expose individuals and communities to health risks.

Strategic approach

The health sector intends to develop relevant strategies to guide its work with health-related sectors so as to achieve the prioritization and implementation of critical health-related actions. Since such actions fall within the mandate of other sectors, but have a significant influence on health outcomes, the health sector will build linkages with the sectors responsible for these actions so as to work with them and ensure that the actions are properly implemented to achieve better health outcomes.

This calls for a multisectoral approach to harness the requisite collaboration and cooperation that is beneficial to health. Coordination and the formation of national multisectoral platforms will create an opportunity to ensure the pragmatic formal engagement of other sectors.

Health impact assessments (HIAs) will be implemented and preferably factored into the environmental impact assessments (EIAs) of all projects. This will bring preventive health benefits by averting what could otherwise negatively affect health and also propose pragmatic measures or recommendations that address the wider climate change impacts in the Kingdom of Swaziland.

The intended social action for change agenda shall apply social marketing expertise (market research) to promote certain aspects of health and nutrition with view to ensuring the prevention and control of disease

conditions. Socializing to influence behaviour through enter-educate approaches shall adopted to meet the needs of specific target groups in terms of better lifestyles, safer sex and management of health risk factors. Pro-health behaviours need to be internalized and promoted as lifelong measures.

Key innovations

A 'health in all policies and sectors' approach is innovative in the country, and will lead to health actions being prioritized in the sectors affecting health.

Table 12: Indicators and targets for influencing health actions in key sectors

	Coverage Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	Access to safe water: Urban	91.9%	92%	93%	94%	95%
	Rural	59%	63%	70%	76%	85%
2	Access to sanitation: Urban	55.6%	60%	65%	70%	75%
	Rural	56.7%	62%	67%	73%	80%
3	Gross intake ratio in the last grade of lower secondary education	19%	20%	21%	22%	23%
4	Number of businesses (registered with SWABCHA) having appropriate workplace health and wellness programs in operation	23	28	33	38	43

Table 13: Strategic focus, and selected priority interventions for addressing health actions in key sectors

No	Outcome area	Strategies	Priority interventions
1	Multisectoral health agenda	1.1 Coordinate and form national multisectoral platforms	1.1.1 Establish and strengthen multisectoral platforms (for education, nutrition, water and sanitation, disease prevention and control, occupational and environmental safety and climate change, medico-legal and gender based violence, injury prevention & control, disaster preparedness & response)
			1.1.2 Establish a high level Accountability Commission on NCDs with cross-sector representation to monitor Summit commitments.
			1.1.3 Formalize linkages and partnerships with key stakeholders
			1.1.4 Institute routine health impact assessments (HIA) in the existing environmental impact assessments for all development projects
			1.1..5 Strengthen inter-cluster coordination mechanisms
2	Social action for change	2.1 Establish social action for change agenda	2.1.1 Adopt more effective approaches for health and nutrition promotion for disease prevention and control
		2.2 Strengthen implementation of targeted interventions	2.2.1 Develop interventions for structures that socialize & inform behaviour (family, school, community, work places)
		2.3 Advocate for pro-health programming and action	2.3.1 Enable households and workplaces to define how they would engage in pro-health behaviours to safeguard, promote and protect health.
		2.4 Strengthen response to injuries	2.4.1 Profile injuries & outline key interventions
3	Addressing Social determinants of health	3.1. Increase intersectoral policy coordination to address the social determinants of health	3.1.1 Strengthen country capacity to implement a health-in-all-policies approach, intersectoral action and social participation to address the social determinants of health
			3.1.2 Mainstream social determinants of health in all health programmes and other sectors

No	Outcome area	Strategies	Priority interventions
			3.1.3 Implement the five action areas of the Rio Political Declaration on Social Determinants of Health and other global agendas on social determinants of health
			3.1.4 Develop systems to monitor action on the social determinants of health
4	Reduced environmental threats to health	Address environmental risks to health	4.1.1 strengthen national capacity to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks
			4.1.2 Adapt and implement norms, standards and guidelines to define environmental and occupational health risks
			4.1.3 Implement agreed provisions that have implications for health in regional initiatives and multilateral agreements and conventions on environmental and sustainable development (e.g., Rio+20 United Nations Conference on Sustainable Development, Libreville Declaration on Health and Environment)

3.2.6 Thematic area 4: Managing medical and related conditions

Key issues

Many crosscutting issues contribute to the effective management of medical and related conditions. In order to deliver the best possible care to patients, clinicians must be equipped with the requisite knowledge and skills, as well as equipment, supplies and an enabling environment.

In Swaziland, the major clinical areas are outpatient care, emergency and trauma, maternity care, inpatient care, operative care, diagnostic care, psychiatric care, pharmaceutical services, forensics and podiatric services. Decentralization of all services is a key focus area and this process needs to be supported across the country.

An important component of disease diagnosis is the medical imaging department which uses radiation called x - rays and gamma rays. Ultrasound uses very high frequency sound waves, and magnetic fields (magnetic resonance imaging) for the diagnosis and treatment of patients for a variety of injuries and diseases. They are part of a medical or surgical team, typically involved in initial patient evaluation and testing to provide diagnostic and evidentiary data to physicians.

There are 11 radiology departments in the government health facilities. There are about 31 qualified diagnostic radiographers in the country who are able to work in all the above mentioned sections and also perform the other duties of radiologists. There are 5 qualified sonographers based in government facilities and 5 darkroom attendants within the public sector who process the x- ray films.

Outpatient care services can be improved by reducing patient waiting time. The issues that contribute to long waiting times include a large number of patients, poor referral systems, old infrastructure affecting patient flow, poor scheduling and deployment of trained staff.

Emergency and trauma services need to be offered across more facilities to reduce mortality rates. There is need to equip staff with skills to manage trauma cases. Current disaster preparedness is outdated and drills are not practiced on a regular basis.

The facility-based mortality rate for pregnant mothers is still high. To reduce this mortality rate, the number of trained nurses and midwives and the nurse-to-midwife ratio must increase.

The quality of care across the health care system needs improvement. Continuing professional development of existing staff needs to be encouraged so that staff can be competent and confident in managing cases presenting at their facilities and thus reduce unnecessary referrals in inpatient, maternity and trauma management. Staff supervision and mentoring is weak and lacks national oversight. Infection control processes must be improved and enforced. Diagnostic equipment needs to be made more available across the health system, and service and maintenance must improve to keep diagnostics in working order.

The operative care service needs to ensure that best practices and innovative technologies are investigated and adopted whenever possible, and the regulatory mechanism needs to be strengthened to ensure that operating procedures are uniform and in line with Medical and Dental Council guidance.

In addition, forensic services (e.g. pathology, and medico-legal services) were not included in NHSSP I at all. Forensic services are provided primarily through forensic laboratories and pathologists to determine cause of death and to aid in medico-legal investigations with the police in cases of non-natural deaths. The MoH works with the pathologists at the Royal Swaziland Police to conduct certain medico-legal investigations. The facilities currently used for this service are inadequate and do not meet the required standards. At the facilities where this service is offered, the infrastructure is inadequate and the personnel are not adequately skilled. Forensic services are primarily provided by clinical pathology departments, though generally not in the public sector in Swaziland. Diagnosis is usually referred to both private and public (the National Health Laboratory Service) laboratories in South Africa. Pathology services are provided by the private sector.

Lack of integration and decentralization of mental health services has retarded the execution of services in the country. Mental Health Services are not well integrated into the general health facilities and the national psychiatric referral hospital is used as both a screening point and a tertiary care unit. Furthermore, mental health services are not well coordinated and planned in the country.

Podiatric services were introduced in the country in 2013 and are currently provided at Mbabane Government Hospital (the National Referral Hospital). Podiatry is a medical specialty focused on the assessment, diagnosis, preventative care and management of lower limb and foot pathologies. Due to the high prevalence of diabetes mellitus and its complications in the country, there is a high rate of lower limb and foot amputations, which is a major cause of morbidity and immobility for most diabetic patients. The need for podiatry services at all levels of health service delivery to prevent foot complications is essential.

The health sector intends to provide high quality services by ensuring that all clients are attended to by a sufficient number of qualified, competent and skilled health personnel with the right skill mix. Improving infrastructure, equipment and supplies is also one area to be considered in providing quality services. The strategic approach will be informed by the strategies presented in the below table.

Key innovations

A comprehensive focus and a patient-centred and comprehensive approach will be applied to ensure that a full range of quality services are available to clients. The approach is client-focused because it focuses on identifying services and interventions from a client-pathway perspective: What are the services a client would require, irrespective of their condition, as they access and use medical care?

Table 14: Indicators and targets for managing medical and related conditions

	Coverage Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	% ART Retention (24 months)	Adults (78%) Children (77%)				Adults (95%) Children (95%)
2	Skilled attendant at delivery (%)	82	87	92	97	100

Table 15: Strategic focus, and selected priority interventions for addressing medical and related services

No	Outcome area	Strategies	Priority interventions
1	Outpatient and inpatient care including, operative care, podiatric services, emergency & trauma care	1.1 Improve the quality of care service provision	1.1.1. Improve clinical services at all levels through EHCP implementation
			1.1.2. Institutionalize quality improvement and quality management systems
			1.1.3. Develop and implement guiding documents
			1.1.4. Integrate and decentralize clinical services
2	Diagnostics care	2.1 Improve access and availability of high-quality diagnostic services	2.1.1. Decentralize strategic diagnostic services
			2.1.2. Develop and implement guiding documents for quality diagnostic care
			2.1.3. Explore and adopt innovative diagnostic procedures in the country
			2.1.4 Adhere to international diagnostic safety standards
3	Pharmaceutical care	3.1 Improve access and availability of high-quality pharmaceutical services	3.1.1. Implement guiding pharmaceutical documents
			3.1.2. Decentralize strategic pharmaceutical services
			3.1.3. Establish a Medicines and Drug Regulatory Authority
			3.1.4. Promote rational medicine-use amongst health care workers and at community level
4	Forensic services	4.1 Provide quality forensic pathology services	4.1.1. Establish a functional Forensic Pathology Department to aid forensic investigations
			4.1.2. Strengthen the cooperation between the Royal Swazi Police and the Ministry of Health Forensic Pathology Department
			4.1.3. Improve mortuary services at hospitals and health centres, including infrastructure and equipment investments

3.2.7 Thematic area 5: Rehabilitation following health events

Key issues

Rehabilitation is a set of measures that assist individuals who experience or are likely to experience disability to achieve and maintain optimal functioning in interaction with their environment. When provided on a continuum of care ranging from hospital care to rehabilitation in the community, rehabilitation can improve health outcomes, reduce cost by shortening hospital stay, reduce disability and improve quality of life for individuals and their family

es (World Disability Report 2012 Ch. 4 . pg. 96).

Rehabilitative services focus on returning patients to near-normal health following an illness episode, and where restoration to health is not possible, they help in managing the terminal illness in the most humane manner possible for the patient and the family. Rehabilitative services are inclusive of seven programmatic services, namely (i) physiotherapy, (ii) occupational therapy, (iii) speech therapy, (iv) audiology, (v) dietetics, (vi) orthopaedic technology. Under NHSSP I, scant attention was given to palliative and rehabilitative care. Though mentioned in the NHSSP I, none of these services were defined and specific strategies were not elucidated within the strategy.

Palliative care aims at improving the quality of life of patients and families facing problems associated with life-threatening illness by focusing on the prevention and relief of pain, suffering and loss of functional ability in all spheres of life.

Palliative care services are provided at facility-level and at home (home-based care), mainly through non-governmental organizations. This arrangement requires robust coordination and management between the public sector and civil society.

The Mid Term Review of NHSSP I conducted in 2010 noted a lack of decentralization of rehabilitative services. Hence in designing NHSSP II a deliberate effort was made to include these services and provide more strategic guidance on improving access to them. Some of these services, especially rehabilitative services, are primarily centralized at the Mbabane Government Hospital, which is also the main referral hospital in Swaziland, with a few available at the regional hospitals. Services such as audiology and dietetics are mainly found in a few hospitals and, consequently, few patients access them. Furthermore, the various services are not adequately coordinated and planned in the country such that equipment, infrastructure and personnel are inadequate to meet the demands of these programs.

NHSSP I did make a clear commitment to decentralising services, especially clinical, palliative and rehabilitative services. There is some limited outreach, but decentralization has primarily been hampered by health system investment gaps, e.g. policies, regulations, and health workforce, which are addressed elsewhere in the strategy. Forensic services (pathology, and medico-legal services) are essentially not provided within the public sector, and a key strategy would be to improve the clinical and diagnostic capacity (addressed elsewhere in the NHSSP II) to provide these services.

Strategic approach

The sector intends to scale up access to rehabilitative services to ensure that clients needing such services are able to access them. This requires that all facilities have access to these services as well as the attendant infrastructure and resources. The focus is on providing quality rehabilitative, palliative and forensic services and ensuring that rehabilitative and palliative care services are sufficiently decentralized, as per the Essential Health Care Package (EHCP).

Key innovations

The ministry will also make investments to provide certain services at community level and build the capacity of health officials to provide services such as screening patients for hearing impairment, recommendations for physiotherapy, etc.

Table 16: Indicators and targets for provision of rehabilitative services

	Coverage Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	Number of facilities (hospitals and NGO facilities) providing palliative care services	6[1]	8	10	12	14
2	Number of rehabilitation services provided at different levels of health care service delivery.	3	3	4	4	6

Table 17: Strategic focus, and selected priority interventions for rehabilitation services

No	Outcome area	Strategies	Priority interventions
1	Rehabilitative care	1.1 Increased access to services for people with disabilities	1.1.1. Decentralize rehabilitative services as per the EHCP[2], including outreach to clinics, and community-based services
			1.1.2 Implement the recommendations of the World report on Disability and the High-level Meeting of the General Assembly on Disability and Development
			1.1.3 Strengthen the provision of health services to reduce disability
			1.1.4 Develop guiding documents for rehabilitative care
			1.1.5 Advocate for the establishment of a national psychiatric rehabilitation centre
2	Palliative care	2.1 Ensure the provision of quality palliative care services at all levels of service delivery	2.1.1 Implement the guiding documents for palliative care
			2.1.3. Provide comprehensive clinical home-based care services

[1] Subject to operating definition of palliative care.

[2] All rehabilitative services are currently included in the Essential Health Care Package, excluding podiatry, which would need to be included in the next revision.

CHAPTER 4: NHSSP II INVESTMENT PRIORITIES

4.1 Overview of health investments

The different areas of action that the health sector intends to focus on to achieve the desired health services are described across six key thematic areas:

(1) Service delivery systems: The key investments needed to ensure improved management of the process of service delivery.
(2) Health workforce: The investments needed to ensure the availability of an appropriate health workforce needed for the delivery of services.
(3) Health information: Investments on information management to guide delivery of the defined services.
(4) Health products: Investments in medicines and supplies, vaccines, and technologies needed for the delivery of the defined health services.
(5) Health infrastructure: The physical infrastructure, equipment, transport and ICT investments needed for provision of the defined health services.
(6) Governance and regulation: The investments required for appropriate stewardship of the health agenda in the country, to facilitate delivery of the defined health services.

Figure 9: Investment thematic areas for supporting attainment of health service targets

The strategies and priority interventions across different outcome areas in these investment thematic areas are detailed in this section.

4.2 Thematic area 1: Health service delivery systems

Key issues

There are still a number of challenges to the health service delivery system that limit the capacity to deliver the required health services.

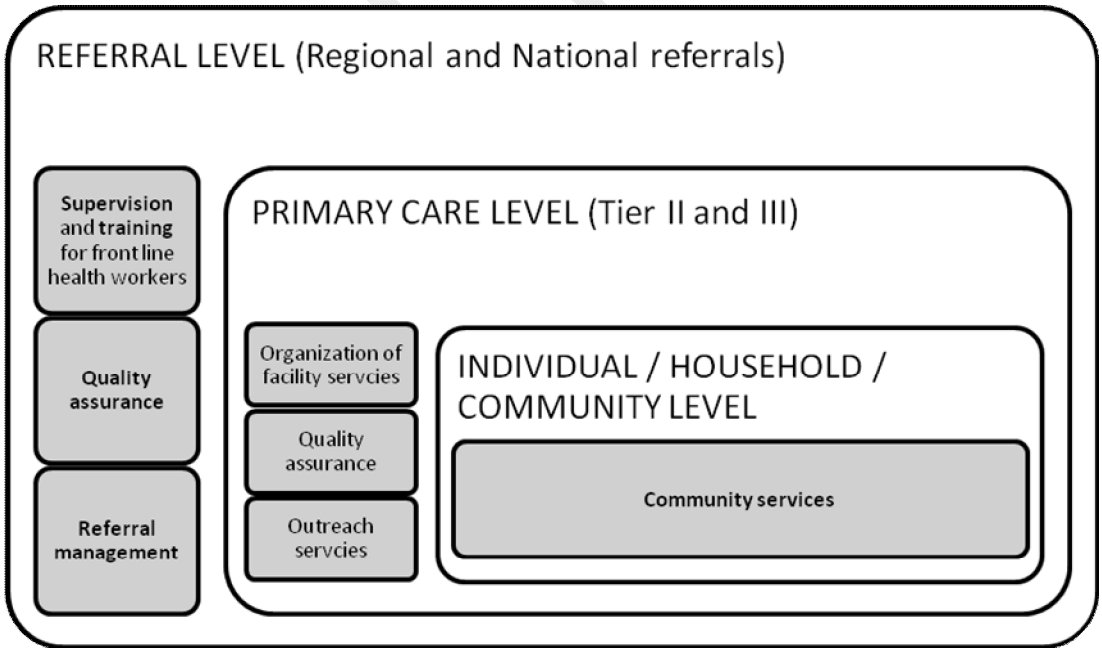
- Outreach services to the community are neither structured nor accessible to inhabitants of hard-to-reach areas and specialized groups. It has not been easy to cover all the designated areas. Some communities are underserviced and certain groups in the communities do not have access to health services.
- The referral system is weak and has been undermined by the lack of supporting policies and framework for enforcement. Although the country does not have a well-defined national referral system, it is loosely organized into a four tier system. For specialized treatment, patients are referred out of the country.
- There is currently no standard method of measuring and monitoring the quality of care given to the clients in the health facilities.
- There are no standard guidelines on supervision and guidance for facilities to follow during supportive supervision visits.

As a result of these challenges, there are significant gaps in EHCP implementation countrywide, with many services not being provided, even when the capacity to provide them exists.

Strategic approach

The health sector will work towards establishing a comprehensive and integrated service delivery system, which should facilitate effective delivery of health and related services as defined in the previous chapter. There are a number of inter-related outcome areas that relate to service delivery systems. The respective outcomes needed for such a service delivery system by level of care are shown in the figure below.

Figure 10: Service delivery system outcomes



Community services refer to how communities are able to engage in improving their health. Referral Services relates to how services are planned, and delivered across different types of facilities. The focus is on ensuring holistic delivery of services. Outreach services refer to how services (preventive and curative) are provided to communities, as per their needs. Supervision relates to how health workers are mentored and supported to continually improve their skills and expertise in providing quality services. Finally,

organization of services within facilities refers to how the facility organizes itself internally to provide and manage care delivery.

Key innovations

The sector will focus, for the first time, on an accelerated and integrated roll out of the different service delivery systems within the first two years of NHSSP II. This will facilitate availability of the appropriate framework needed to build capacity for other investments required for the delivery of health services.

Table 18: Indicators and targets for service delivery systems

	Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	% of EHCP services provided at each tier of care, as per standards	60%	65-70%	70-80%	75-90%	80-100%
2	Outpatient waiting time reduction(average disaggregated by tier of facility) - 2 hours for emergencies	0	30%	40%	50%	60%
3	% of communities receiving monthly outreaches (Hard-to-reach areas)	71	79	87	94	100
4	% of facilities receiving quarterly supervision visits	<50%	50%	70%	90%	100%
5	% of facilities with functional quality improvement teams	<50%	50%	80%	90%	100%
6	% of facilities with ISO certification	0	0	15%	20%	25%
7	% of facilities with required capacity for referral (in line with the referral linkages program)	0	60%	70%	80%	100%

Table 19: Strategic focus, and selected priority interventions for health service delivery systems

No	Outcome area	Strategies	Priority interventions
1	Organization of service delivery	1.1 Organization of service delivery (national to community service delivery)	1.1.1 Define and map service standards expected for each tier of care
			1.1.2 Induct health professionals at entry level into the system on service provision functions and responsibilities
			1.1.3 Comply with mandatory safety protocols and standards
2	Referral services	2.1 Strengthening the referral system	2.1.1 Set up filter clinics to manage referral care
			2.1.2 Set up effective triaging units within all facilities
			2.1.3 Improve communication systems across facilities
			2.1.4 Set up system for client tracking across facilities, including cross-border referrals
3	Community and outreach services	3.1 Scale-up of community services (Including outreach)	3.1.1 Scale up of services provided through RHMs
			3.1.2 Scale up number of sites reached by outreach services
			3.1.3 Increase the number of services provided through outreach, focusing on services for the elderly
4	Supervision and mentoring	4.1 Strengthening of the supportive supervision system	4.1.1 Increase the number of facilities receiving supportive supervision (focusing on clinics)
5	Quality assurance and standard setting	5.1 Improving quality assurance and standards	5.1.1 Support adherence to updated standard treatment guidelines
			5.1.2 Set up quality improvement teams in each region and facility
			5.1.3 Help facilities to attain ISO certification
			5.1.4 Facilitate accreditation of laboratories
			5.1.5 Facilitate accreditation of health facilities
			5.1.6 Orient service providers on quality improvement expectations and self-assessments for quality improvement action planning

4.3 Thematic area 2: Human resources for health (HRH)

Key issues

The country still faces acute challenges with regard to the health workforce.

- Production of the required health workforce is inadequate, and the in-country capacity to produce a number of required staff cadres (particularly specialized cadres) is poor. For instance, medical specialists currently account for only 17% of all doctors. An HRH Staffing Norms Analysis completed in 2013, quantified the gap between current and optimal levels of staffing across facilities and cadres. MOH is currently reviewing its findings and recommendations to determine appropriate strategies to achieve the optimal workforce level.
- The distribution of the available health workforce is also poor, with most specialized health workers concentrated in a few, centralized facilities leaving staffing gaps at most peripheral facilities. To mitigate the current shortage, a number of donors are supporting a number of positions. However, planning for the recruitment and absorption of these positions is poorly coordinated leading to real risks of failure to retain them.
- There are still weak management systems for the health workforce. Staff job descriptions are not aligned to their current tasks and schemes of service are outdated particularly in the public sector. Performance monitoring is weak and more punitive rather than supportive. Mechanisms to motivate the workforce are limited in rollout and scope.
- There are challenges with coordination and quality of in-service and pre-service training. There is duplication of in-service training by partners, and the training is not always facilitative of professional development in line with defined career paths of health workers and the priorities of the sector. Similarly there are challenges in coordination of pre-service training, particularly coordination between the MOH, MOET and MOLSS. Additionally, the capacity and facilities in training hospitals have been found to be inadequate for pre-service training, affecting the quality of practicum training.

As a result of these challenges, the country has an inadequate workforce that is insufficiently motivated and suffers productivity and retention challenges.

Strategic approach

The health sector recognizes the central role that a well-motivated and productive health workforce plays in health service provision capacity. Consequently, priority will be given to improving the availability and productivity of the health workforce needed to provide the defined health services.

Key innovations

NHSSP II will lay greater emphasis on evidence-based planning and management of the health workforce. As a result, a clear and detailed HRH strategic plan will guide HRH investments, together with operationalization of HRH norms, and workforce projections to ensure that the workforce is tailored to needs. Regular HRH information shall be produced, with an annual HRH status report to be developed. Mechanisms to closely monitor and correct staff performance and productivity shall be put in place. Innovative mechanisms, such as preceptorship to improve practicum training, shall be introduced.

Table 20: Indicators and targets for health workforce

	Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	Trained nurses and midwives per 10,000 people	1.9	2.1	2.3	2.4	2.5
2	Ratio of doctors, nurses and midwives to 1000 population	1.69	1.8	2.1	2.3	2.5
3	Proportion of approved staffing norms achieved	63	70	75	85	100

Table 21: Strategic focus, and selected priority interventions for health workforce

No	Outcome area	Strategies	Priority interventions
1	Improved capacity for evidence-based HRH planning	1.1 Establish a comprehensive HRH planning system	1.1.1 Operationalize needs-based sector staffing norms and standards
			1.1.2 Institute comprehensive HRH planning (recruitment and development) based on projections for all cadres
			1.1.3 Make available comprehensive HR information for HRH planning
2	Improved quality and needs-based HRH development	2.1 Strengthen systems for planning and provision of pre-service training to ensure quality and needs-based pre-service training	2.1.1Prioritize recruitment of cadres as per sector staffing norms
			2.1.2 Improve capacity of training institutes to ensure quality practicum training
			2.1.3 Strengthen coordination of the production of the health workforce across training institutions
		2.2 Strengthen the coordination of in-service training to ensure efficient and effective in-service training	2.2.1 Rationalize in-service training based on needs (not supply)
			2.2.2 Functionalize systems for coordinating and regulating in-service training
3	Strengthened HRH management systems and capacity at the MOH	3.1 Strengthen the structure and capacity for HR management	3.1.1 Monitor and improve health workforce productivity
			3.1.2 Improve attractiveness of hard-to-reach duty stations
			3.1.3 Put in place strategies for HRH retention and motivation

4.4 Thematic area 3: Health infrastructure

Key issues

Availability of a well-functioning infrastructure including physical facilities and medical and non-medical equipment, transport facilities and ICT is key to widening access to health care, ensuring the quality of care and enhancing the performance of the health system as a whole. The availability of a well maintained and functioning health infrastructure is therefore necessary in ensuring the quality of care and enhancing the performance of the health system as a whole. Having health infrastructure that is in good condition also shapes the public perception of good quality care and, in turn, encourages the utilization of available health services. Having efficient and effective infrastructure requires proper planning and maintenance. The sector is currently facing a number of challenges as follows:

- There is a lack of infrastructure norms and standards for guiding investment. Consequently, the establishment and equipping of facilities is not standards-based.
- A lack of donation standards results in various kinds of infrastructure, particularly equipment that is sometimes incompatible with other inputs, thus limiting functionality.
- Many facilities are not 'ready' to provide services. Key necessities required to ensure readiness (such as water, electricity, basic supplies, waste management) are not available as expected, thus reducing the capacity for provision of services.
- The construction and equipping of facilities needs to be guided by a clear master plan. In many instances, this is lacking or inadequate, leading to disjointed establishment of infrastructure.
- The absence of transport facilities in many areas has hampered the delivery of services, particularly supervision, and outreach services. In addition, emergency services are hampered by limited capacity to respond to emergencies within the "golden hour".
- Inappropriate maintenance of existing infrastructure has led to reduced functionality, and greater inefficiencies, such as breakdowns, are more frequent.
- There is no appropriately coordinated ICT infrastructure for network connectivity and appropriate management of facility functioning.

Strategic approach

Appropriate infrastructure remains a critical element of the country's overall Vision 2022. To contribute adequately to the resolution of this problem, the health sector needs to focus on implementing the following strategic outcomes:

- **Improving health infrastructure and equipment availability:** This entails improving physical access to health facilities to at least 5km, improving the quality and completeness of construction of facilities, and implementing a maintenance policy.
- **Improving health infrastructure and equipment management:** This entails improving functionality, and readiness of health infrastructure to support service provision.
- **Improving infrastructure for pre-hospital emergency care:** This is aimed at improving "golden" hour emergency care intervention by providing adequate ambulances with advanced life support and building of satellite stations.
- **Strengthen information communication technology infrastructure:** This entails building the capacity for coordinated and rationalized ICT use in the health sector.

Key innovations

The move towards evidence-based infrastructure planning and investment is innovative. The elaboration of norms and standards to guide establishment, maintenance and improved functionality of infrastructure will be a cornerstone in the focus of NHSSP II.

Table 22: Indicators and targets for health infrastructure

	Indicator description	Indicator targets					
			2014	2015	2016	2017	2018
1	Population within 5 km radius of a health facility		64%	66%	75%	80%	82%
2	Percentage of essential equipment that is functional		60%	70%	80%	90%	100%
3	% of response time per 8 minutes for urban settings, 14 minutes for rural settings and 30 minutes for aeromedical	U	40%	85%	100%	100%	100%
		R	10%	50%	75%	80%	90%
		A	0%	30%	50%	60%	80%
4	Proportion of facilities with waiting huts		10%	20%	40%	55%	70%
5	% of facilities with a composite of readiness to provide services (presence of 24 hour electricity, water, basic supplies, & waste management)		56.7	62	67	72	80%

Table 23: Strategic focus, and selected priority interventions for health infrastructure

No	Outcome area	Strategies	Priority interventions
1	Infrastructure availability	1.1 Establish required physical infrastructure and equipment	1.1.1 Roll out physical infrastructure (facilities) as per norms and facility master plans
			1.1.2 Purchase required equipment as per norms and donation guidelines
		1.2 Strengthen transport capacity in the sector	1.2.1 Put in place transport facilities for outreach, supervision and other mobile services as per sector norms
			1.2.2 Put in place functional referral transport facilities as per sector norms
		1.3 Assure availability of ICT infrastructure	1.3.1 Purchase required ICT infrastructure for facilities, as per sector norms
2	Infrastructure maintenance	2.1 Physical infrastructure and equipment maintenance	2.1.1 Develop and roll out application of infrastructure and equipment standards
			2.1.2 Develop a maintenance plan for all buildings and equipment
			Build bio medical engineering capacity at all levels
			2.1.3 Put in place a system for regulation of procured and donated equipment.
			2.1.4 Refurbish and construct health facilities according to standards including disability-friendliness considerations.
			2.1.5 Develop an asset management system
		2.2 Transport maintenance	2.2.1 Develop a fleet management and maintenance system within a decentralized framework that ensures availability of functional transport services
3	Pre-hospital emergency infrastructure	3.1 Strengthen pre-hospital emergency care services	3.1.1 Construct and commission the satellite stations based on standards
			3.1.2 Build capacity for basic and advanced life support amongst health workers

4.5 Thematic area 4: Health information systems

The health sector recognizes the role that timely, complete and accurate health information plays in providing the required evidence for decision making. Therefore a fully functional and resourced health information system that provides strategic information for the health sector is critical if that sector is to achieve its goals.

Health information comes from various sources:

(1) The routine health management information system, which provides client-generated data on health events, plus health management data relating to HR, infrastructure, commodities, and technology;
(2) Health research systems, which generate targeted information on selected topical issues;
(3) Surveillance systems, which collate disease specific trends and information;
(4) Vital statistics systems, which provide critical information relating to births, deaths and cause of deaths in the country.

There are currently a number of issues relating to the health information systems.

(1) There are weak/poor inter linkages across different sources of health information, thus limiting their usefulness. The absence of a central, and coordinated mechanism for storage of all health data accounts for this
(2) Efforts in the recent past to reduce parallel information systems have helped, though some of these still persist. The sector still operates a fragmented database information system and a number of stand-alone information systems, each supported by a vertical program.
(3) Though a national health research policy exists, research coordination is still inadequate due to an inappropriate legal environment. Furthermore, in-country capacity to coordinate and manage research is still poor and the MOH capacity to steward the research agenda is still being built
(4) Disease surveillance has significantly improved, with better availability of surveillance and laboratory data. However, the system is not yet vigilant enough to monitor communicable and non-communicable diseases and other emerging and re-emerging diseases/conditions.

Strategic approach

The sector intends to focus on establishing a comprehensive, integrated health information system that integrates and analyses data from all sources to produce timely health information and intelligence that influences decision making. It will focus on:

(1) improving capacity for generation of integrated and comprehensive HMIS data;
(2) strengthening health research coordination;
(3) building surveillance systems; and
(4) linking with vital statistics.

Key innovations

The sector will work towards establishing an integrated data architecture to coordinate and manage health information from all sources – routine HMIS, surveillance, research and vital statistics.

Table 24: Indicators and targets for health information

	Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	Timeliness of submission of data (HMIS, surveillance)	74%	79%	86%	89%	90%
2	Completeness of data (HMIS, surveillance)	80%	84%	86%	89%	90%
3.	Accuracy of data (HMIS, surveillance)	70%	75%	80%	89%	95%
4.	% research studies included in centralized database	0	60%	75%	90%	100%

Table 25: Strategic focus, and selected priority interventions for health information

No	Outcome area	Strategies	Priority interventions
1	Timely and reliable health information	1.1 Build and maintain a single integrated and inter-operable health information system	1.1.1 Implement the newly-developed client management information system
			1.1.2 Develop a data warehouse
			1.1.3 Establish a mechanism for public dialogues on health
			1.1.4 Develop effective communication infrastructure
			1.1.5 Review of the HIS policy and HIS strategic plan
			1.1.6 Development of an e-health policy and an e-health strategy
			1.1.7 Establish an IT service desk system
			1.1.8 Develop guidelines and SOPs for data management
			1.1.9 Establish a fully-fledged IT unit within the MOH
			1.1.10 Link health and home affairs systems
		1.2 Strengthen health information system coordination	1.2.1 Review terms of reference and composition of the Health Information Coordinating Committee (HISCC)
2	Surveillance capacity	2.1 Build a robust, integrated and reliable surveillance system	2.1.1 Implement IDSR strategy
			2.1.2 Implement IHR
			2.1.3 Implement GHI
		2.2 Strengthen epidemiological surveillance capacity	2.2.1 Build institutional capacity at the health facility, regional and national levels in terms of information flow, definition, data analysis and outbreak response for integrated disease surveillance
			2.2.2 Conduct epidemiological studies to inform policy direction through an evidence-based approach
			2.2.3 Review surveys annually in terms of relevancy and need for information
			2.2.4 Provide epidemiological expertise and training to regional levels(decentralization) and for programme managers
3	Research coordination	3.1 Ensure existence of adequate legal and policy framework for research	3.1.1 Develop legislation and guidelines that create an enabling environment for health research
			3.1.2 Formalize the existence of a National Health Research Department and National Health Research Review Board (NHRRB)
			3.1.3 Upgrade the National Health Research Department into an Institute for Health Research in accordance with the legislation setting up the National Research Council (NRC).
		3.2 Provide a framework that will enhance and guide capacity building	3.2.1 Build the technical, technological and infrastructural capacity of the National Health Research Department so that it can provide leadership and coordination for health research
			3.2.2 Build the capacity for the National Health Research Review Board to efficiently discharge its functions of reviewing protocols and promoting the ethical conduct of health research
		3.3 Guide the conduct of research	3.3.1 Facilitate and coordinate the development of a national research agenda
			3.3.2 Develop and implement guidelines for regulating research on emerging and re-emerging health issues
			3.3.3 Ensure compliance of researchers with the requirement of review and approval of all research by the National Health Research Review Board
		3.4 Promote the use of research findings in evidence-based decision making and practice	3.4.1 Develop archival and retrieval systems and repository for health research in the country that are accessible to researchers and the public
			3.4.2 Facilitate the systematic management and dissemination of research findings
			3.4.3 Strengthen the national health research system to support skills and

No	Outcome area	Strategies	Priority interventions
			knowledge transfer

4.6 Thematic area 5: Health products, vaccines & technologies

Key issues

Health products, vaccines and technologies are key inputs in the provision of quality health services. The health sector seeks to ensure that the right products are available in the right quantity, at the right place, for the right client and at an affordable price to individuals and communities. This thematic area includes selection, procurement, warehousing and distribution, and rational use of health products, vaccines and technologies.

The procurement of health products is governed by the Government of Swaziland's Public Procurement Regulations of 2012. These regulations provide guidance on how public sector procurements should be carried out. The health sector is currently in the process of developing and enacting the Medicines and Related Substances Control Bill, which will lead to the establishment of a Medicines Regulatory Authority to oversee health products management in the country. The Central Medical Store (CMS) is the national warehouse for health products, vaccines and technologies. This facility is currently being restructured to achieve greater efficiencies and optimization of the limited space available. Health products are currently distributed directly from the national warehouse to the facilities according to a predetermined schedule.

Areas of weakness include:

- vertical supply chain of health products, focusing on specific disease areas;
- inadequate capacity at facility level to accurately forecast the need for health products, which leads to poor budgeting, planning and distribution;
- no standardized systems for health commodities monitoring, such as stock out monitoring, apart from standalone platforms being used to monitor antiretroviral medicines;
- poor monitoring of the rational use of health products;
- the emergence of antimicrobial resistance.

Strategic approach

The health sector will focus on improving the overall capacity of the procurement system to ensure timely and effective availability of quality health products.

Key innovations

Greater emphasis will be laid on inventory management at facility and central level, as well as monitoring of the rational use of health products through adherence to the Essential Medicines List and Standard Treatment Guidelines of 2012.

Table 26: Indicators and targets for health products

	Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	% availability of tracer classes of medicines at facility level	75	80	85	90	95
2	% of tested antimicrobials resistant to commonly used products	70	65	55	40	45

Table 27: Strategic focus, and selected priority interventions for health products

No	Outcome area	Strategies	Priority interventions
1	Selection	1.1 Implement the Essential Medicines Program	1.1.1 Strengthen the functions of the National Essential Medicines Committee
			1.1.2 Enforce the use of STG/EML in the public sector and encourage the private sector to comply
			1.1.3 Establish a mechanism that will enable MOH to coordinate and monitor the performance of PTCs
			1.1.4 Provide support to introduce vaccines for under-fives, adolescents, and adults, including rotavirus vaccine, inactivated polio vaccine (IPV), human papilloma virus (HPV) vaccine, and measles-rubella vaccine
2	Procurement	2.1 Improve procurement of health products and technologies	2.1.1 Strengthen the quality assurance system of health products
			2.1.2 Develop and implement standards, guidelines and procedures for the procurement of health products
			2.1.3 Establish a functional procurement / supply planning system
3	Warehouse and distribution	3.1 Build and maintain capacity (human, finance, infrastructure) for the warehouse and distribution of health products, vaccines and technologies	3.1.1 Improve the logistics data management system to inform procurement and quantification
			3.1.2 Develop long-term, sustainable storage space for all health products at central and facility level
			3.1.3 Develop systems to ensure security of health products during storage and distribution
4	Rational use	4.1 Ensure availability and rational use of safe, efficacious health products	4.1.1 Regularly update treatment guidelines
			4.1.2 Monitor antibiotic use at hospitals and health centres
			4.1.3 Promote the rational use of blood products (SNBTS), medicines and laboratory supplies

4.7 Thematic area 6: Governance and regulation

Key issues

Like most sectors, the health sector requires a conducive regulatory environment with efficient governance systems in order to function smoothly. The regulations need to be comprehensive, complementary and up to date in order to support NHSSP II implementation. Subsequent to legislation being enacted, there is a need for relevant enforcement for the regulations to be effective. There is also a need to strengthen the capacity of the leaders and managers in the Ministry to ensure implementation of the strategy, coordination among the different stakeholders as well as effective delivery of health services. However, the sector still faces a number of issues and challenges relating to governance and regulation:

- **Inadequate regulation –** The existing regulatory frameworks are currently outdated (e.g. Pharmacy Act of 1929 and Public Health Act of 1969) and several other health regulatory frameworks await approval (e.g. Public Health Bill, Nursing Bill, Medicines and Related Substances Control Bill, Pharmacy Bill, etc.). Furthermore, there are inadequate and semi-autonomous professional councils that are not able to provide comprehensive and independent oversight to the relevant cadres, especially allied services.
- **Poor regulation enforcement capacities** – Despite the existence of some regulations, there is limited capacity to enforce them. This results in little public awareness of regulations. There is a need to strengthen the capacity of regulatory bodies and to ensure that regulations are widely disseminated once they are developed or reviewed.

- **Limited coordination between the government and donor partners** – Currently, coordination between the government and partners is very limited, resulting in minimal standardization and alignment in employment and procurement of health services and products.
- **Inadequate leadership and management skills amongst management –** Currently, people are promoted to leadership positions based on seniority when they are not prepared for the position. Moreover, those promoted are not well-inducted into their new roles and responsibilities.
- **Incomplete mechanisms for public involvement in health management –** Currently, there are limited platforms for public engagement in issues relevant to health. This limits information-sharing and consumer feedback. The forums (e.g. Sibaya) that do exist are located at a high level and the agenda is not determined by the health sector.
- **MOH structure and capacity limited for stewardship of some services (e.g. allied health services) –** Consolidation of several cadres under the paramedical umbrella has resulted in limited oversight of some specific services. Moreover, the lack of clarity on decision-making structures within the MoH is affecting health service delivery. These are caused by poor implementation of the approved MoH organogram.

Strategic approach

The sector intends to prioritize strengthening of sector governance systems and establishment of a comprehensive regulatory regime to facilitate adequate delivery of services.

All health-related regulations will be reviewed, and updated in line with the current health sector focus. The capacity to implement regulations will also be focused upon to ensure that they are enforced.

Key innovations

The comprehensive focus on addressing health governance and regulations is a departure from the past, when these were developed in an ad hoc manner. It is hoped that through this approach, the sector should be able to have the required framework to facilitate its health services provision.

Table 28: Indicators and targets for governance and regulation

	Indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	# of reviewed and updated health regulations	0	2	3	4	6
2	# of independent regulatory mechanisms in place	3	4	5	6	6
3	% of leaders capacitated on leadership and management	0	40	60	80	100
4	% of filled positions in the approved organogram	0	30	60	80	100
5	# of health public dialogue forums conducted	0	5	5	5	5

Table 29: Strategic focus, and selected priority interventions for governance & regulation

No	Outcome area	Strategies	Priority interventions
1	Regulation	1.1 Strengthen the regulation of health	1.1.1 Review, and update public health regulations (public health, food & nutrition, etc. bills for regulating health services)
			1.1.2 Set up key regulatory mechanisms such as a health professionals council; Food Safety Authority, and others
			1.1.3 Enforce critical existing legislations, e.g. Children's Act, Mental Health Act
2	Health governance and leadership	2.1 Build comprehensive systems for health governance and leadership	2.1.1 Establish mechanisms for public dialogue on health issues
			2.1.2 Support operationalization of institutional boards in all health units
			2.1.3 Capacity-building of management on leadership and management skills
		2.2 Strengthen the capacity of the MoH	2.2.1 Implement the approved organogram for the MoH through a phased approach
			2.2.2 Enforce the reporting structures in the existing organogram

CHAPTER 5: FINANCING OF NHSSP II

Background

The Swaziland National Health Policy (2007) identifies health financing as a key thematic area that is instrumental to achieving improved health outcomes. The policy aims to attain effective, equitable, efficient, and sustainable health care financing to ensure equal access to quality health care services for all citizens.

5.2 Key Issues

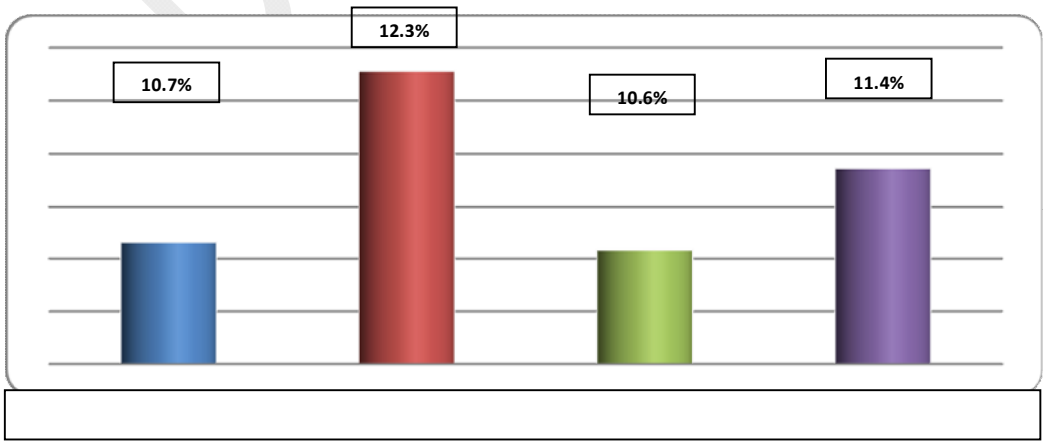
Insufficient resources for health

Analyses of key activities and interventions demonstrate that the resource envelope will need to be increased to adequately address future needs. Costed strategic, operational, and implementation plans for key programme areas in health, such as HIV/AIDS, malaria, and TB revealed financial gaps or inadequate financial resources to support the country's current and future health needs. This evidence supports the need for resource mobilization strategies to collect or generate additional revenues for health. Despite the increase in resources allocated to the health sector over the past decade, national health indicators are not meeting the country's targets, largely due to the high burdens of infectious diseases such HIV/AIDS and TB, which demand a significant portion of health resources.

The Government of Swaziland is the primary source of funding for the health sector, representing approximately 57% of total health expenditures as of FY 2012/13. While government expenditures declined by 4% from $143.6M in FY 2010/11 to $139.0M in FY 2012/13, there has been an increase in budgeted spending for FY 2013/14 at $175.5M. Approximately half of government revenues are supported by the Southern African Customs Union (SACU), a large portion of which is allocated to health. This dependence on fiscal support poses concerns for future sustainability; sudden shortfalls within the SACU could have detrimental effects on the overall health financing landscape.

From FY 2010/11 to 2013/14, government expenditures in health remained relatively consistent, representing an average of 11.2% of total national expenditures. Presently, current government health contributions account for 12.2% of overall government resources. Despite the increasing disease burden, this proportion falls short of the 15% that is recommended by the Abuja Declaration of April 2011 on HIV/AIDS, TB and other infectious diseases.

Figure 11: Health expenditures as a % of total expenditure



The contribution of external resources to the health sector in FY 2012/13 was estimated at $81.4 M, which represents a 17% increase over external funding levels of $70.1 M in FY 2010/11 and $69.7 M in FY 2011/12.

Inefficient use of resources

Efficiencies must be addressed in the way resources are mobilized, allocated and used in the health sector. Weaknesses in these areas inhibit the health system from performing at optimal levels and, ultimately compromise the provision and quality of health care. A key example is the financial management of health resources. Current financial management practices are characterized by limited or inadequate systems for promoting transparency and accountability thereby restricting the effective and efficient, use of financial resources. Responsibility centres, including medical facilities, programmes, and the MOH Planning Unit, have limited visibility into their financial and operational performances. The lack of comprehensive financial information systems and processes impedes effective management of health facilities and programs.

Although the key priority of healthcare organizations is to provide quality services rather than to make profits, there remains a need to understand their running costs from day-to-day operations. In the absence of robust financial systems and processes, as well as stakeholders trained to manage such processes, responsibility centres cannot accurately ascertain costs incurred, which makes it difficult to achieve their objectives in providing high quality care.

Inequity in resource allocation and utilization

Currently, there is little coordinated effort among the MOH and partners to ensure that resources are allocated fairly according to measurable criteria, such as urban versus rural areas or ability-to-pay. Certain financing arrangements could contribute to inequitable access to health care across the health care landscape. For example, the proportion of the population covered by insurance schemes is very low; it is estimated that only 8% of the population is covered by any form of health insurance. Further assessment is necessary to identify feasible schemes to ensure that the poor do not pay a disproportionate amount for health care.

Health inequities involve more than inequality in relation to health determinants (education, income and social status) and access to resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Thus, it is important that the reduction of these inequalities result in the elimination of differences in health status (such as disease or disability) and in the opportunity to enjoy life and pursue one's life plans. Ultimately, the entire population should have access to basic health services according to their needs, irrespective of ability to pay or geographical location.

5.2 Strategic approach

Figure 12: Focus areas for the health financing strategic approach

1. **Ensure adequate availability of resources:** Increased investments in health over the past decade have resulted in significant improvements in the provision of health services. Total spending on health has increased significantly in the past decade, from US$ 57M in 2001 (or US$65 per capita) to an estimated US$ 310M in 2013 (or US$265 per capita). Government spending has accounted for about 57% of overall health resources, with external sources making up 28% and private sources comprising the remaining 15%. Specifically, with regards to public resources, the Government of Swaziland has significantly increased allocations towards the health sector over the years, from approximately 6.5% in 2002 to 12.2% in 2012.

   Advocating for continued investment in health will be critical to improving health outcomes. However, developing a comprehensive understanding of the current and required funding envelope is equally critical to ensuring that adequate funding is available. The government will institutionalize annual processes for tracking resources, analyzing the funding gap, and other key activities necessary to inform sound decision-making with respect to the health sector.

2. **Ensure efficient use of resources:** Processes will be established for assessing and pursuing opportunities to achieve efficiency gains in the health system and maximize the impact of investments in health, via financial or operational interventions. Possible areas of investigation include fleet management, procurement, financial management, and the referral system. These opportunities have been identified by key health sector stakeholders, including the MoH, government facilities, and private health providers, but also through analyses from sources such as national health resource tracking exercises.

3. **Mobilize new resources:** Resource mobilization strategies are needed to generate additional revenues for health to meet Swaziland's health needs. Innovative financing serves as an important catalytic tool for health financing by mobilizing domestic and international resources. By diversifying their revenue sources beyond the annual budgetary allocation from the Ministry of Finance and external partners, health systems can position themselves for long-term sustainability and growth. It is, therefore, necessary to sensitize key stakeholders and to explore and implement opportunities for alternative sources of financing that will help improve and strengthen the health system.

   Potential opportunities for resource mobilization include national health insurance, sin taxes (on alcohol and tobacco products), as well as various levies including transport. For instance, with regards to sin taxes, Swazis currently pay 57.5% in total tobacco taxes, which includes a mandated 25% VAT (also applied to alcohol) and a 32.5% excise tax. These levies were reported to have generated at least $36.2 million in revenue in 2010, representing 3.8% of fiscal income. Allocating part of the revenue generated through sin taxes to the health sector could potentially increase its revenue base and

contribute to sustainable financing.

4. **Ensure equitable use of resources:** It is essential to ensure that health services are both affordable and accessible to all segments of the population. Currently, key target population groups are exempted from paying user fees in country, including the elderly over the age of 60, those requiring antenatal care, and routine immunizations. According to the most recent National Health Accounts (2010), out-of-pocket (OOP) expenditures as a percentage of total health expenditures were estimated at 14.5% and 11.6% in 2009 and 2010, respectively.

   However, though progress has been made in reducing financial barriers to obtain services, many individuals still struggle to afford services. It is imperative, therefore, to implement strategic health financing interventions to ensure access to affordable quality services based on the equity principle.

5.3 Key innovations

The key health financing innovations in the NHSSP II are twofold:

1. **Implementation of a National Health Financing Policy:** The current health financing landscape within Swaziland indicates that the government will not have the adequate financial resources to support the country's future health needs and desired health outcomes; the demand for services continue to outpace the availability. Recognizing the importance of financing to properly complement and finance health services in Swaziland, the Ministry of Health is committed to establishing a formal HF system that will be supported through the development of a national health financing strategy, policy, and implementation framework. This legislation will support and build the capacity of the health financing sub-unit within the Planning Unit, who will be empowered to advocate for sustainable health financing priorities including the effective and efficient utilization of available resource to ensure access to health services, equity, and increase in coverage of health promotion, prevention and care.

2. **Utilization of a holistic approach to health financing:** Utilizing a holistic approach will enable the Ministry of Health to adequately address existing health financing issues, identify sustainable sources and develop key long-term strategies to financing HSSP II. The primary focus actions over the next five years are to: 1) gain a detailed understanding of available and required financial resources; 2) increase the total amount of health funds through the mobilization of resources; 3) increase efficiency and effectiveness in the utilization of current resources; and 4) improve equity of access to health services. The desired outcome is to provide a solid foundation for generating evidence that will be used to inform strategic planning and decision-making. These key focus actions or pillars will ultimately prepare Swaziland for the development and implementation of an equitable and sustainable health financing system.

Table 30: Indicators and targets for health financing

	Health financing indicator description	Indicator targets				
		2014	2015	2016	2017	2018
1	% of government health expenditure over total government expenditure	12%	12.5%	13%	14%	15%
2	Total health expenditure per capita	$270	$280	$290	$300	$310
3	% increase in government year-over-year (YoY) expenditures on health	3%	3%	3%	3%	3%
4	% of population whose out-of-pocket health expenditure exceeds 40% of non- food expenditure	42.2	40	38	36	32
5	Out-of-pocket as a % of private expenditure on health	<20	18	16	14	10
6	% of people covered under risk pooling mechanism	20%	25%	30%	30%	30%

Table 31: Strategic focus and selected priority interventions

No	Outcome area	Strategies	Priority interventions
1	Adequate resources	1.1 Institutionalize financial processes that track and manage financial resources for health	1.1.1 Conduct System of Health Accounts annually
			1.1.2 Develop national health financing policy and strategy
		1.2 Strengthen capacity to utilize financing tools in the annual planning and budgeting process	1.2.1 Build capacity within the health sector to strengthen stewardship of resource tracking and use.
			1.2.2 Conduct a funding gap analysis annually
2	Mobilizing new resources	2.1 Increase overall financial resources in the Swaziland health sector	2.1.1 Conduct value for money and efficiency studies regularly
			2.1.2 Explore innovative financing mechanisms that mobilize resources for health
			2.1.3 Optimize the facilities fees system (e.g., user fees) in order to enable sustainable care delivery through adequate generation of revenue
			2.1.4 Advocate for sin taxes for health (e.g., on alcohol and tobacco) to increase tax receipts and improve public resources
			2.1.5 Review advocacy policies regarding the development and implementation of innovative financing mechanisms.
3	Ensuring efficiency in resource use	3.1 Strengthen the national capacity for allocation, management, and utilization of health financial resources.	3.1.1 Establish efficient procurement processes that will help identify the best suppliers and negotiate optimal prices for goods and services
			3.1.2 Strengthen the financial management system, including planning/budgeting, execution and monitoring processes
			3.1.3 Improve harmonization and alignment of external funding to the health sector
4	Ensuring equity in resource use	4.1 Institute a national universal health coverage system.	4.1.1 Establish a universal health insurance system
			4.1.2 Develop and operationalize a national health financing policy and implementation framework
			4.1.3 Perform an actuarial analysis of NHI
			4.1.4 Develop legal policy framework for NHI
		4.2 Improve equity and increase health care access among the poor and the vulnerable	4.2.1 Develop formula and criteria for fairness on resource allocation
			4.2.2 Conduct benefit-incidence analyses
			4.2.3 Build capacity of health financing sub-unit

CHAPTER 6: IMPLEMENTATION ARRANGEMENTS FOR NHSSP II

This chapter presents the implementation arrangements of the strategic plan. It outlines the management of the health sector, roles and responsibilities of stakeholders and decentralization of health services. The focus of NHSSP II is on the provision of quality health services in various settings of the health sector. The overall impact of the strategic plan will be the achievement of set national and health sector targets. The implementation of the strategic plan will facilitate the provision of quality health care services to the public through vibrant organization structures, systems and processes that are responsive to the needs of the clients and will take cognizance of the resource constraints.

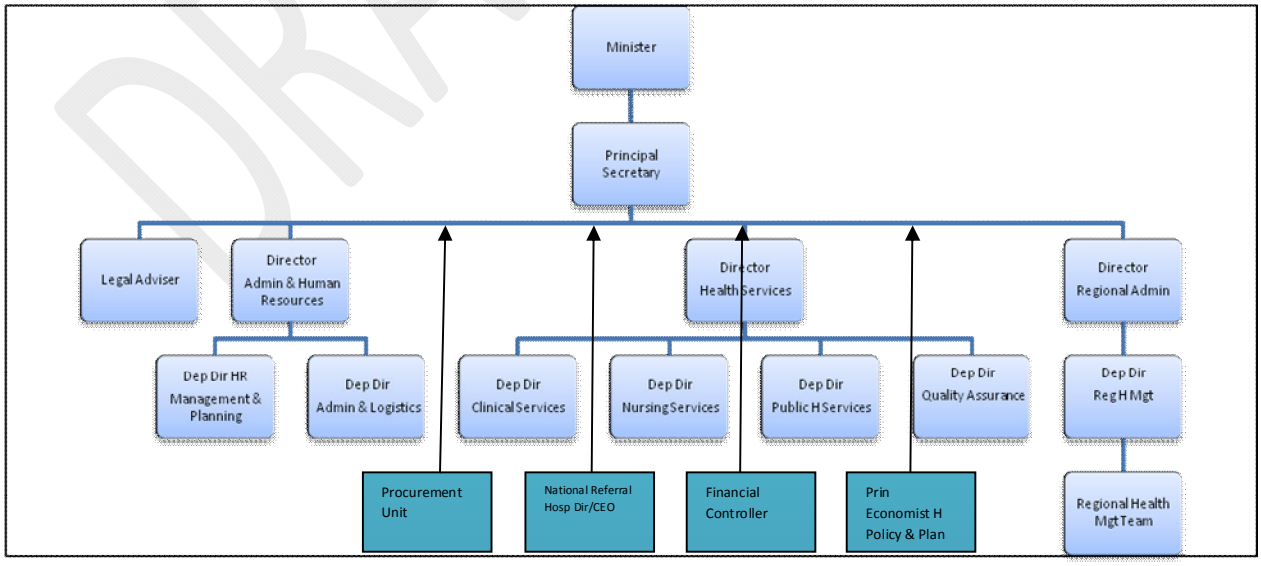
6.1 Management of the health sector

NHSSP II aims to strengthen the governance and management capacity of MOH and the health sector to effectively and efficiently perform and discharge core health sector functions. The MOH retains the stewardship of the health sector. However, there is an urgent need to strengthen collaboration with ministries, NGOs, the private sector and development partners. This is because the social determinants of health have a much broader definition that encompasses more than the health sector alone. The institutional development strategy mainly focuses on building a distinctive organizational culture, promoting values related to work processes and recognition systems, including institutional growth, efficiency, cost-effectiveness, responsiveness and sustainability. Primary health care and decentralization remain the main strategy for improved health care delivery. NHSSP II is cognizant of the direction that the Government is taking towards implementing a SWAP (sector wide approach) in the Health Sector.

The Public Health Bill calls for the establishment of the Health Service Commission, which will have responsibility over human resource matters in the Ministry of Health. The Bill also seeks to establish the Public Health Advisory Board, which will advise the Minister of Health on all matters pertaining to public health in the country. As part of institutional management, hospitals are also expected to have Hospital Advisory Boards and Health Committees that will oversee their functioning.

The current MOH organogram is presented in figure 13 below.

Figure 13: Ministry of Health Approved Organogram – 2013



With the establishment of the Health Service Commission, the above structure will be reviewed.

6.2 Roles and responsibilities of stakeholders

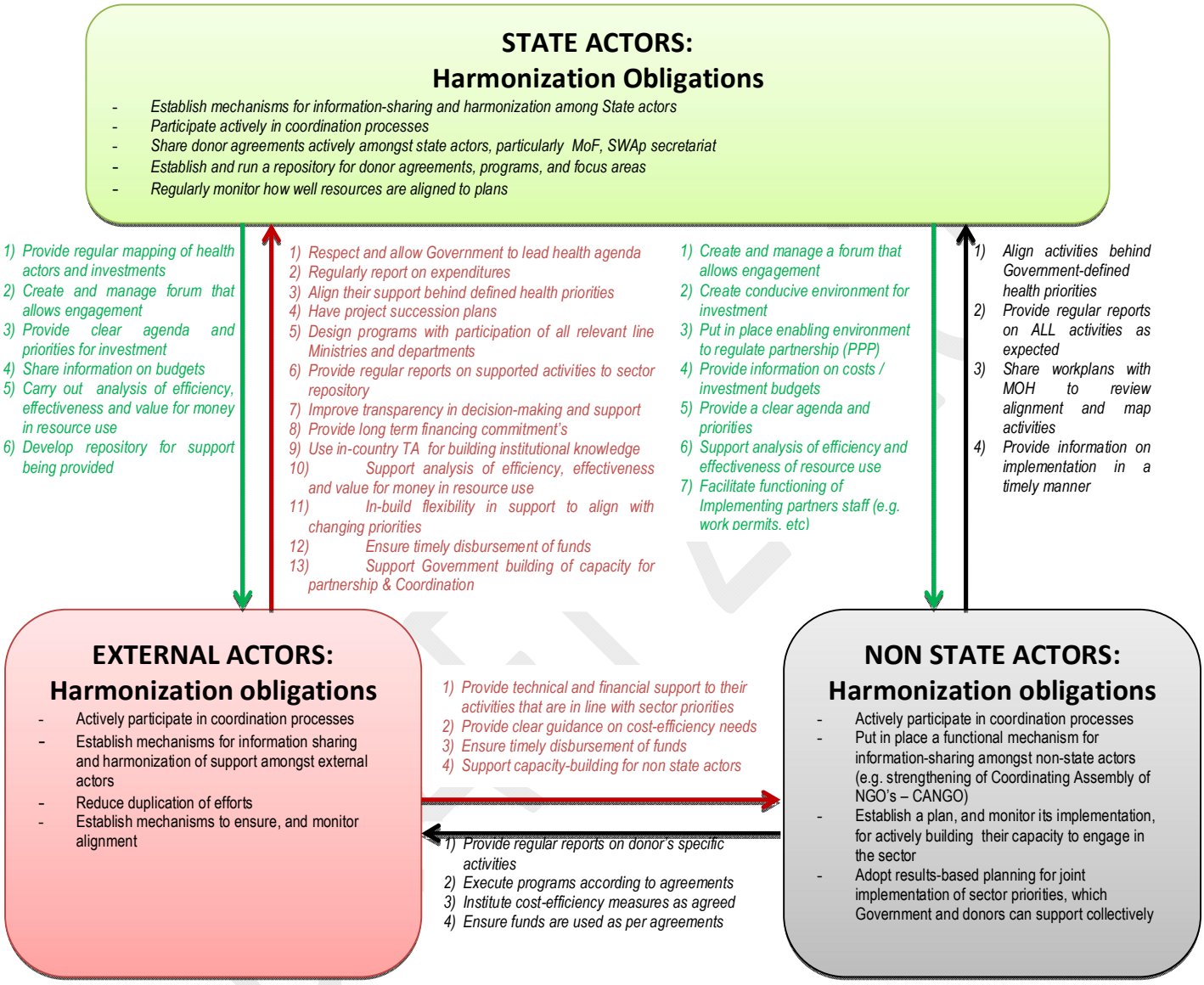
The health sector is operating under a highly supportive environment with wider stakeholder involvement and partnerships. Whilst the Ministry of health maintains its stewardship role, the stakeholders have different roles in attaining the vision, mission and strategic objectives of NHSSP II. Below is an outline of stakeholder responsibilities in realizing the defined health outcomes laid out in NHSSP II.

Table 32: Roles of the various stakeholders in NHSSP II implementation

Stakeholders	Roles
State actors	i) Provide comprehensive, and appropriate sector direction through policy, strategy and program plans ii) Provide leadership in the implementation of policies, strategies and program plans iii) Ensure that the required guidelines and tools for improved quality of care are available iv) Ensure that agreed programs / projects are appropriately designed, especially focusing on: o Sustainability strategies to ensure continuity of support; o Having clear handover strategies at the inception of projects. v) Ensure decentralization of service delivery through RHMTs vi) Provide leadership in the development of guidelines and SOPs to support implementation of programs / projects that are aligned to national priorities vii) Design, and ensure implementation of a sector-wide M&E system that comprehensively monitors implementation of ALL activities (not only those with resources) viii) Mobilize resources for the implementation of interventions and the provision of services ix) Facilitate the partnership process at all levels to ensure that all actors are meaningfully engaged x) Develop and implement strategy to improve internal expertise and soft skills in partnership and engagement
External actors	i) Provide technical support to facilitate implementation of agreed priorities ii) Provide financial support to implementation of agreed priorities iii) Ensure that sustainability is clearly factored into their support iv) Actively monitor and ensure alignment of their support with the agreed National priorities v) Support capacity-building initiatives in the health sector vi) Reduce transaction costs of Government and its service delivery in dealing with external partners, through actively ensuring the harmonization of partner support
Non-State actors	**i)** Implement, and roll out services that are in line with the agreed sector strategies /national priorities **ii)** Adhere to regulations, and decentralization expectations, e.g. report on activities through RHMTs **iii)** Adhere to good governance practices in implementation of their activities **iv)** Provide services in a coordinated manner to minimize duplication of activities **v)** Facilitate implementation of services to under-serviced populations

Obligations of the various stakeholders to each other

In line with the above proposed roles, the obligations of the various stakeholders are illustrated below.



6.3 Decentralization and health

The overall purpose of decentralization is to ensure easy access to government services and to make service delivery more efficient, effective and appropriate to the specific needs of end-users and beneficiaries. The purpose of the MOH decentralization program is therefore to facilitate equitable, timely, efficient and cost-effective management of the health system and delivery of health services in line with the National Decentralization Policy of 2006. Specifically, the aim of the decentralization program is to devolve authority and responsibility for the implementation, management, coordination, monitoring and evaluation of health services. There is need to fast-track the review of the Ministry of Health's 1990 Decentralization Policy.

The decentralization management structures are the national, regional and community levels. The Essential Health Care Package guides service delivery at all levels.

6.4 Sector-wide approach to planning and budgeting (SWAp)

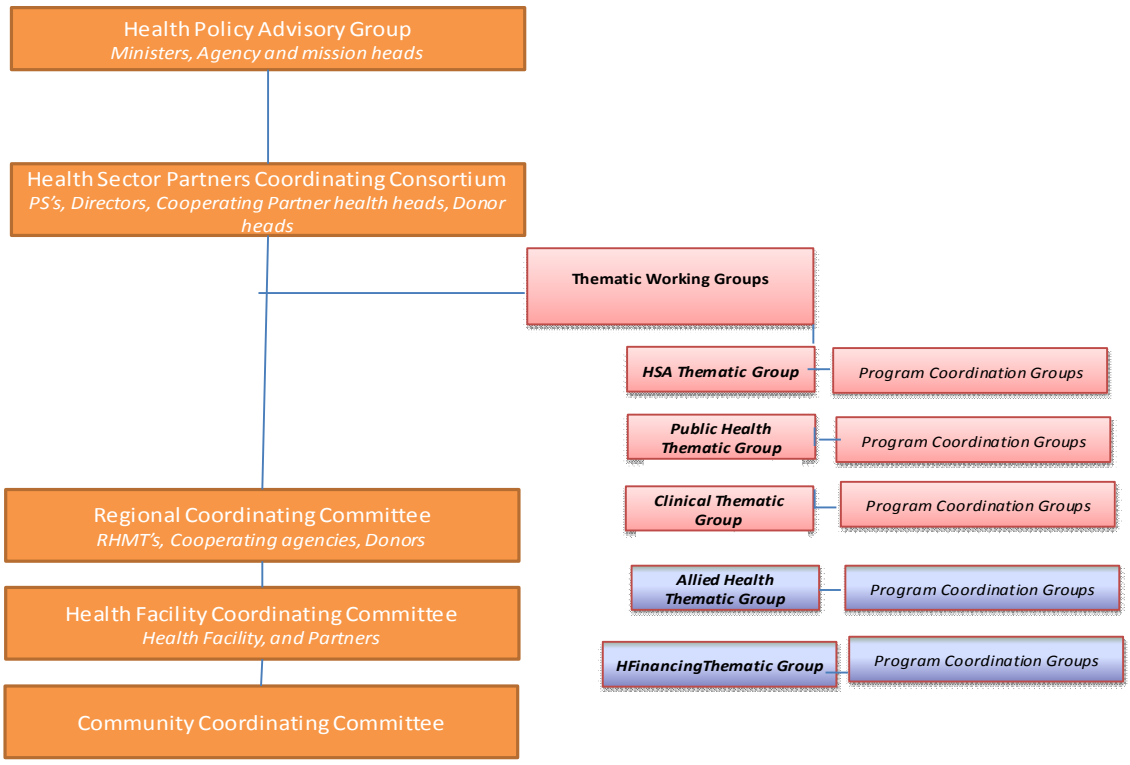
The health SWAp was established as a tool that addresses health sector planning, management, resource mobilzation and allocation.

A Sector Wide Approach is one aimed at supporting a country-led program for a coherent sector in a comprehensive and coordinated manner. It is a gradual and phased process that provides a framework for collaboration with different stakeholders. The SWAp should be the approach to health sector management and development and should be based on principles of partnership and collaboration with a common goal of achieving NHSSP II objectives. SWAp creates a forum for coordinating planning, financing and monitoring mechanisms. It is expected that all stakeholders will contribute to the development of the health sector within the SWAp framework and that the financing of health interventions will support NHSSP II implementation. The MOH, as a line Ministry dealing with health and related issues, shall maintain the responsibility of coordinating the SWAp process with support from all stakeholders.

One of the strategies in implementing SWAp is to have an instrument to govern the partnership. An unabridged structure exists for the coordination of the partnership.

The SWAp process will be implemented through an incremental approach.

Figure 14: Proposed SWAp Coordinating Structure (unabridged)



6.5 Public-private partnerships (PPPs)

The National Public Private Partnership Policy endorsed in November 2009 confirms the Government's commitment to collaborate with private stakeholders by establishing a conducive regulatory and institutional framework for the policy's implementation. It focuses on setting up a collaborative mechanism to ensure implementation through win-win strategies for the public and private sector and other stakeholders involved in PPP.

The health sector remains one of the priority areas for Government. Resource constraints undermine government's efforts to develop the health sectors. Difficulties persist in the provision and distribution of quality health care when the issues of geography, unsound infrastructure and diversity are taken into account. Against this backdrop, the emergence of the private sector, including individuals, communities, business corporations, and non-government organizations (NGOs) as a necessary partner in overcoming these difficulties has led to the effective management and provision of quality, affordable health services in many developing economies. The sector's mission is to provide basic health services. It also specifically seeks to improve partnerships between public and private sectors in the provision of health services.

The health sector will also develop an implementation framework that will include and provide for enactment of the new legislation, review of related legislation and the adoption of appropriate regulations and operational guidelines.

The scope of the implementation framework will include five key components:

1. An implementation strategy defining and detailing activities to be implemented over an initial five year period, the functions and responsibilities of implementing institutions and resource requirements;
2. Development of an institutional framework for implementation of PPPs in the health sector;
3. Legislation, regulations and operational guidelines to be developed and enacted to support implementation of PPPs in the health sector; and
4. A communication strategy for sensitization and raising awareness of the general public, beneficiaries and other stakeholders

6.6 Partnerships with external donors

The Aid Coordination and Management Section (ACMS) in the Ministry of Economic Planning Development is the designated authority for the mobilization, coordination, monitoring and evaluation of all official development assistance (ODA) received by Swaziland in the form of grants within the framework of the Swaziland Aid policy of 1997, whereas the Ministry of Finance is the custodian for loans.

The Ministry of Health also benefits from collaboration with other countries in various areas such as technical assistance as well as exchange programmes such as secondment of qualified personnel for a pre-defined period. Collaboration with multilateral agencies also expands to areas such as medical equipment and other areas where material resources are required

There is need to strengthen aid coordination within the Ministry of Health to address current challenges in aid management and administration such as: institutional challenges; delayed disbursement of funds which in turn affects agreed implementation arrangements; limited participation of policy level officials in planning, implementation, monitoring and evaluation of cooperation agreements; and capacity issues in terms of personnel assigned and systems.

Regarding the policy environment, there is need to establish guidelines between MOH and donors whilst a aligning with MOEPD AID Policy 1997. Memoranda of understanding should be instituted for all donors involved and a reporting mechanism should be established. Given the number of donors involved in the health sector, an external aid office should be established within MOH through which all aid will be channelled.

CHAPTER 7: MONITORING AND EVALUATION OF THE NHSSP II

The NHSSP II monitoring and evaluation framework is aimed at defining the process by which the plan shall be monitored, and its implementation followed up using a results-based approach. It defines:

(1) The sources of the various data for identified indicators used to monitor progress in different thematic areas of the plan;
(2) The data management platform to ensure data is collected as and when required to inform the decision making process; and
(3) The mechanisms for review and evaluation of the progress made in plan implementation.

7.1 Health data and statistics

The sections of this plan have defined the indicators, and their respective targets that will guide monitoring of progress in the respective thematic areas. The different indicators will require data from different sources, with routine HMIS, vital statistics, surveillance, surveys and research being the key data sources. The table below shows the expected primary sources of data for each of the indicators highlighted in the plan. Also highlighted is the frequency with which this data needs to be collected for it to inform plan implementation.

Table 33: NHSSP II data sources and frequency of collection

NHSSP II domain area	Thematic area	Indicators	Sources of data	Data collection frequency
Monitoring of health impact	Increasing level of health	Life expectancy at birth	▪ Central statistics office ▪ WHO health statistics	Annually
		Age-specific mortality rates	▪ Demographic & health survey	Every 5 years
	Improving distribution of health	Variation in mortality rates between highest and lowest poverty quintiles	▪ Demographic & health survey ▪ National statistics office	Every 5 years
	Improving responsiveness	Clients satisfied with services	▪ Client satisfaction survey	Annually
			▪	
Health services outcomes	Promoting health through the life course	Improve neonatal survival by 30%	▪ Central statistics office (vital statistics cause of death analysis)	Annually
		Fully immunized children	▪ Routine HMIS	Monthly
		Stunting prevalence	▪ MIC survey ▪ Demographic & health survey	Every 2 years Every 5 years
		Unmet need for family planning	▪ Demographic & health survey	Every 5 years
		Postnatal care coverage within 6 weeks of delivery	▪ Routine HMIS	Monthly
		Teenage pregnancy rate (per 1000 girls aged 15-19 years)	▪ MIC survey ▪ Demographic & health survey	Every 2 years Every 5 years
	Preventing communicable & noncommunicable conditions	% reduction in road traffic crashes	▪ Police (calculated from road traffic events data)	Monthly
		TB treatment success rate	▪ Routine HMIS	Monthly
		HIV incidence (adults, children)	▪ HIV prevalence survey (estimates)	Every 5 years
		Malaria slide positivity rate	▪ Routine HMIS	Monthly
		Deaths due to communicable conditions	▪ Central statistics office (vital statistics cause of death analysis)	Annually
		Deaths due to noncommunicable conditions	▪ Central statistics office (vital statistics cause of death analysis)	Annually
		Deaths due to violence / injuries	▪ Central statistics office (vital statistics cause of death analysis)	Annually
	Influencing health actions in key sectors	Access to safe water (rural / urban)	▪ Demographic & health survey	Every 5 years
		Access to sanitation (rural / urban)	▪ Demographic & health survey	Every 5 years
		% of girls attending secondary school (enrolment, completion)	▪ Demographic & health survey	Every 5 years
		% of housing appropriately ventilated	▪ Demographic & health survey	Every 5 years
		% of businesses with appropriate workplace safety	▪ Ministry of Labour (company registrar)	Annually
	Managing medical & related conditions	Number of outpatient visits	▪ Routine HMIS	Monthly
		Number of inpatients	▪ Routine HMIS	Monthly

NHSSP II domain area	Thematic area	Indicators	Sources of data	Data collection frequency
		% of deliveries carried out in an institution	▪ Routine HMIS	Monthly
		Caesarean sections as % of total institutional deliveries	▪ Routine HMIS	Monthly
		Facility deaths	▪ Routine HMIS	Monthly
		Average length of stay	▪ Routine HMIS (calculated)	Monthly
	Rehabilitation following health events	# of facilities (hospitals and NGO facilities) providing palliative care services	▪ Annual operational reports (Service mapping)	Annually
		# of hospitals providing rehabilitative services	▪ Annual operational reports (Service mapping)	Annually
		# of hospitals providing forensic pathology services	▪ Annual operational reports (Service mapping)	Annually
Health input / processes	Service delivery systems	% of EHCP services provided at each tier of care, as per standards	▪ Annual operational reports (Service mapping)	Annually
		Outpatient waiting time	▪ Client satisfaction survey	Annually
		% of communities receiving monthly outreaches	▪ Annual operational reports	Annually
		% of facilities receiving quarterly supervision visits	▪ Annual operational reports	Annually
		% of facilities with functional quality improvement teams	▪ Annual operational reports (quality improvement monitoring)	Annually
		% of facilities accredited as per standards	▪ Annual operational reports (quality improvement monitoring)	Annually
		% of facilities with required capacity for referral (in line with the referral linkages program)	▪ Annual operational reports (quality improvement monitoring)	Annually
	Health workforce	Trained nurses and midwives per 10,000 people	▪ Ministry of Public Service ▪ Human Resources Information System	Annually
		% specialists available as per HRH norms	▪ Ministry of Public Service ▪ Human Resources Information System	Annually
		% available HRH (public and partner) leaving the service for any reason	▪ Ministry of Public Service ▪ Human Resources Information System	Annually
	Health information	Timeliness of submission of data (HMIS, surveillance)	▪ Strategic information unit	Monthly
		Completeness of data (HMIS, surveillance, vital statistics)	▪ Strategic information unit	Monthly
		Accuracy of data (HMIS, surveillance, vital statistics)	▪ Strategic information unit	Monthly
		# research studies included in centralized database	▪ Strategic information unit (research)	Monthly
	Health infrastructure	Population within 5 km radius of a health facility	▪ Demographic & health survey	Every 5 years
		Percentage of tracer equipment that is functional	▪ Annual operational reports	Annually
		% of response time per 8 minutes for urban settings, 14 minutes for rural settings and 30 min for aeromedical	▪ Client satisfaction survey	Annually
		Proportion of facilities with waiting huts	▪ Annual operational reports	Annually
		% of facilities ready to provide services (presence of 24-hour electricity, water, basic supplies, & waste management)	▪ Client satisfaction survey	Annually
	Health products	% availability of tracer classes at facility level	▪ Client satisfaction survey	Annually
		% of tested antimicrobials resistant to commonly used products	▪ Antibiotic resistance surveys	Every 3 years
	Governance & regulation	# of reviewed and updated health regulations	▪ Annual operational reports	Annually
		# of independent regulatory mechanisms in place	▪ Annual operational reports	Annually
		% of leaders capacitated on leadership and management	▪ Annual operational reports	Annually
		% of filled position in the approved organogram	▪ Annual operational reports	Annually
		# of health public dialogue fora conducted	▪ Annual operational reports	Annually
Health financing		% of government health expenditure over total government expenditure	▪ National expenditure reports	Annually
		Total health expenditure per capita	▪ National Health Accounts	Annually
		% increase on government expenditures on health year over year (YoY)	▪ National expenditure reports	Annually
		% of population whose out-of-pocket health expenditure exceeds 40% of non- food expenditure	▪ Household expenditure & utilization survey	Every 3 years
		Out-of-pocket expenditure as a % of private expenditure on health	▪ National Health Accounts	Annually
		% of people covered under risk pooling mechanism	▪ Ministry of Labour	Annually

7.2 Data architecture

The different data sources highlighted need to ensure the information required for decision-making is available when needed.

The health sector will establish a single, integrated and inter-operable system that will coordinate and link the different data sources together to assure this. This involves:

(1) updating, and disseminating a comprehensive indicator manual, to ensure all data sources are aware of the required information and how it needs to be generated;
(2) developing guidelines and SOPs for the different data sources to guide them in generating and sharing of required data;
(3) establishing a full-fledged IT unit within the MOH, with the IT infrastructure and staffing needed to coordinate, and support the different sources of health data;
(4) building linkages with the related Ministries for data stored/managed outside of the Ministry of Health such as vital statistics (Ministry of Home Affairs), housing, water/sanitation; and
(5) building a research coordination system to capture all research being carried out in the country

The key focus in the sector will be on setting-up the required IT infrastructure to facilitate achievement the above.

7.3 Performance monitoring and review

The performance monitoring and review process will be useful for documenting lessons learnt during the implementation of the strategic plan. Performance monitoring shall be carried out at regular intervals. The different levels involved in the planning, performance monitoring and review process are:

(1) Health facilities;
(2) Regions;
(3) National level.

To facilitate the performance monitoring and review process, annual operational plans and reports, plus performance contracts shall be developed each year to set/review operational targets towards achievement of NHSSP II objectives. The annual operational plans shall form the basis for continuous, quarterly and annual monitoring, while NHSSP II shall be the basis for a mid-term review and end-term evaluation.

7.3.1 Annual operational planning and reporting

The annual operational planning shall be carried out at each of the sector levels: health facilities, regions and the national level. For each of these, a detailed breakdown of key activities against NHSSP II strategies shall be defined based on available funds from the budgeting process (see appendix 1). This, together with the indicator targets, shall form the basis for the annual operational plan.

Quarterly follow-up shall be carried out at each level (facility, region, and national levels) to monitor progress against planned activities and indicators. The reports will be discussed by the health management teams including all the stakeholders at the quarterly performance review meetings. The discussion will focus on a review of the findings and the agreed action points as well as a review of the recommendations improvement tracking plan for the previous quarter, which will be outlining the status of recommendations/action points agreed on during the previous quarterly review meeting.

Annual reports shall be informed by the quarterly reports at the facility, regional and national levels. These shall report on progress against planned activities, and indicator targets.

This operational planning and reporting process should be carried out with inputs from the different stakeholders. The annual health sector report at the regional and national levels should be presented during the public dialogues on health, for communication and feedback to the public on health sector actions.

7.3.2 Mid-term review and end-term evaluation

A mid-term review and end-term evaluation will be undertaken to determine the extent to which the subject objectives of this strategic plan are met. As opposed to the quarterly and annual reviews, the mid-term and end-term reviews will look at progress at a higher level – against strategies, and overall progress in the respective thematic areas. The information from the mid-term review shall inform a re-alignment of strategies for the 2nd half of NHSSP II, while the end-term evaluation shall inform the development of the next NHSSP.

7.4 Program level strategic planning

NHSSP II provides the platform around which programs (disease- or system-based) should be elaborating their strategic approaches. To ensure clear alignment to NHSSP II, all programs developing their strategic plans should define their priority interventions based on the relevant NHSSP II thematic areas and strategies (see appendix 2).

(1) For health service programs, the key interventions should be related to the relevant service area, plus a system review across all the system areas in terms of the investment needed to implement the strategy.
(2) For system areas, the key interventions shall be derived from the HSA areas.

Appendix 1: Annual operational planning focus

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Budget available	Responsible unit(s)	Key activities	Timeframe			
							1	2	3	4
Health Services outcomes	Promoting health through the life course	Child and maternal health services	1.1 Strengthening delivery of quality comprehensive Child and Maternal Survival services through enhancing integration of services							
		Sexual and reproductive health services	2.1 Reduction of teenage pregnancy and other unplanned pregnancies							
			2.2 Promote male involvement for enhanced reproductive and family health							
		Healthy ageing	3.1 Mainstream healthy aging into health service delivery							
		Managing risk factors for health	4.1 Integrating mental health care, rehabilitation and counselling in service delivery							
			4.3 Positive engagement of all population groups (young and old) in personal physical fitness							
			4.4 Promoting healthy food consumption							
		Nutrition promotion	5.2 Promote availability, accessibility and utilization of macro and micronutrients at health facility and household level							
			5.3 Strengthen nutrition services and social protection in schools and communities							
			5.4 Promote the integration and documentation of micronutrients deficiencies							
			5.5 Food and nutrition preparedness for emergencies							
	Preventing communicable & noncommunicable conditions	Prevention of communicable conditions	Adopt broader and more inclusive treatment practices							
			Advance universal access to HIV and TB prevention and control: guide the national response to threats [antimicrobial resistance monitoring and action]							
			Implement the post 2015 TB agenda							
			Elimination of Malaria							
			Scale up immunization efforts							
			Strengthen Prevention and Control food and water borne transmission of diseases							
			Strengthen Health security measures and Disaster Risk Management							
			Timely Response for Emerging diseases-Public Health emergencies, Epidemic and Pandemic threats							
		Prevention of noncommunicable conditions	Accelerate implementation of Framework Convention on Tobacco Control (FCTC)							
			Strengthen health systems through integration of NCD prevention and treatment							
			Scale up prevention of NCDs							
			Establish Mental Health & Substance Abuse prevention Programme at all levels including strengthening of Mental Health and Substance							

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Budget available	Responsible unit(s)	Key activities	Timeframe			
							1	2	3	4
			Abuse -implementation							
			Provision of violence Impact mitigation and/or harm Reduction intervention in mental health							
		Prevention of violence and/or injuries	Strengthen surveillance systems							
			Create a positive safety culture							
	Influencing health actions in key sectors	Multisectoral health agenda	Coordination & informing national multisectoral platforms							
		Social action for change	Establish Social action for change agenda							
			Strengthening implementation of targeted interventions							
			Advocate for pro-health programming and action							
			Strengthen response to injuries							
	Managing medical & related conditions	Outpatient care	1.1 Improve the quality of outpatient care service provision							
			1.2 Improve patient flow to ensure patients have timely access to services							
		Emergency & trauma care	2.1 Increase access, scope and quality of emergency and trauma care at facilities							
		Maternity care	3.1 Improve quality, access and affordability of patient centred maternity services							
		Inpatient care	4.1 Improve quality of care							
			4.2 Increase the scope of service provision							
		Operative care	5.1 Improve access and quality of operative care services							
		Diagnostics care	6.1 Improve access and availability of high-quality diagnostic services							
		Pharmaceutical care	7.1 Improve access and availability of high-quality pharmaceutical services							
	Rehabilitation following health events	Rehabilitative care	1.1 Improve access to quality rehabilitative services							
		Forensic services	2.1 Provide quality forensic pathology services							
		Palliative care	3.1 Improve the quality of life of patients and their families with life threatening illnesses by scaling up palliative care service provision							
Health input / processes	Service delivery systems	Organization of service delivery	Organization of service delivery (national to community service delivery)							
		Referral services	Strengthening the referral system							
		Community and outreach services	Scale up of community services (Including outreach)							
		Supervision and mentoring	Strengthening of the supportive supervision system							
		Quality assurance and standard setting	Improving of quality assurance and Standards							
	Health workforce	Improved capacity for evidence based HRH planning	Establish a comprehensive HRH planning system							
		Improved quality and needs based HRH	Strengthen systems for planning and provision of pre-service training to ensure quality and needs-based pre service training							

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Budget available	Responsible unit(s)	Key activities	Timeframe			
							1	2	3	4
		development	Strengthen the coordination of in-service training to ensure efficient and effective in service training							
		Strengthened HRH management systems and capacity at the MOH	Strengthen the structure and capacity for HR management							
	Health information	A timely and reliable health information	Build and maintain a single integrated and inter-operable Health Information System							
			Strengthen Health Information System Coordinating							
		Surveillance capacity	Building a robust and integrated reliable surveillance system							
			To strengthen capacity for epidemiological surveillance							
		Research coordination	Ensure existence of adequate legal and policy framework for research							
			Provide a framework that will enhance and guide capacity building							
			Guide the conduct of research							
	Health infrastructure	Infrastructure availability	Establishment of required physical infrastructure and equipment							
			Promote utility of research findings and evidence-based decision making and practice							
			Assure availability of ICT infrastructure							
		Infrastructure maintenance	Physical infrastructure and equipment maintenance							
			Transport maintenance							
		Pre-hospital emergency infrastructure	Strengthening of pre-hospital emergency care Services							
	Health products	Selection	Implement the Essential Medicines Program							
		Procurement	Improve procurement of health products and technologies							
		Warehouse and Distribution	Build and maintain capacity (human, finance, infrastructure) for the warehouse and distribution of health products, vaccines and technologies							
		Rational use	Ensure availability and rational use of safe, efficacious health products							
	Governance & regulation	Regulation	Strengthen the regulation of health							
		Health governance and leadership	Build comprehensive systems for health governance and leadership							
			Strengthen the capacity of the MoH							
Health Financing		Adequate resources	Institutionalize financial processes that tracks and manages financial resources for health							
			Strengthen capacity to utilize financing tools in the annual planning and budgeting process							
		Mobilizing new resources	Increase overall financial resources in the Swaziland health sector							
		Ensuring efficiency in resource use	Strengthen the national capacity for allocation, management, and utilization of health financial resources.							
		Ensuring equity in resource use	Institute a national universal health coverage system.							
			Improve equity and increase health care access among the poor and the vulnerable							

Appendix 2: Program strategic planning

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Programme interventions
Health Services outcomes	Promoting health through the life course	Child and maternal health services	1.1 Strengthen delivery of quality comprehensive child and maternal survival services by enhancing integration of services	
		Sexual and reproductive health services	2.1 Reduce teenage pregnancy and other unplanned pregnancies	
			2.2 Promote male involvement for enhanced reproductive and family health	
		Healthy ageing	3.1 Mainstream healthy aging into health service delivery	
		Managing risk factors for health	4.1 Integrate mental health care, rehabilitation and counselling in service delivery	
			4.3 Positively engage all population groups (young and old) in personal physical fitness	
			4.4 Promote healthy food consumption	
		Nutrition promotion	5.2 Promote availability, accessibility and utilization of macro and micronutrients at health facility and household level	
			5.3 Strengthen nutrition services and social protection in schools and communities	
			5.4 Promote the integration and documentation of micronutrients deficiencies	
			5.5 Ensure food and nutrition preparedness for emergencies	
	Preventing communicable & noncommunicable conditions	Prevention of communicable conditions	Adopt broader and more inclusive treatment practices	
			Advance universal access to HIV and TB prevention and control: guide the national response to threats [antimicrobial resistance monitoring and action]	
			Implement the post 2015 TB agenda	
			Eliminate Malaria	
			Scale up immunization efforts	
			Strengthen prevention and control food and water borne transmission of diseases	
			Strengthen health security measures and disaster risk management	
			Respond in time to emerging diseases, public health emergencies, epidemic and pandemic threats	
		Prevention of noncommunicable conditions	Accelerate implementation of Framework Convention on Tobacco Control (FCTC)	
			Strengthen health systems through integration of NCD prevention and treatment	
			Scale up prevention of NCDs	
			Establish Mental Health & Substance Abuse Prevention Programme at all levels including strengthening implementation of this programme	
			Provide violence impact mitigation and/or harm reduction intervention in mental health	
		Prevention of violence and/or injuries	Strengthen surveillance systems	
			Create a positive safety culture	
	Influencing health actions in key sectors	Multisectoral health agenda	Coordinate & inform national multisectoral platforms	
		Social action for change	Establish Social action for change agenda	
			Strengthen implementation of targeted interventions	

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Programme interventions
			Advocate for pro-health programming and action	
			Strengthen response to injuries	
	Managing medical & related conditions	Outpatient care	1.1 Improve the quality of outpatient care service provision	
			1.2 Improve patient flow to ensure patients have timely access to services	
		Emergency & trauma care	2.1 Increase access, scope and quality of emergency and trauma care at facilities	
		Maternity care	3.1 Improve quality, access and affordability of patient-centred maternity services	
		Inpatient care	4.1 Improve quality of care	
			4.2 Increase the scope of service provision	
		Operative care	5.1 Improve access and quality of operative care services	
		Diagnostics care	6.1 Improve access and availability of high-quality diagnostic services	
		Pharmaceutical care	7.1 Improve access and availability of high-quality pharmaceutical services	
	Rehabilitation following health events	Rehabilitative care	1.1 Improve access to quality rehabilitative services	
		Forensic services	2.1 Provide quality forensic pathology services	
		Palliative care	3.1 Improve the quality of life of patients and their families with life threatening illnesses by scaling up palliative care service provision	
Health input / processes	Service delivery systems	Organization of service delivery	Organize service delivery (national to community service delivery)	
		Referral services	Strengthen the referral system	
		Community and outreach services	Scale up community services (Including outreach)	
		Supervision and mentoring	Strengthen the supportive supervision system	
		Quality assurance and standard setting	Improve quality assurance and standards	
	Health workforce	Improved capacity for evidence based HRH planning	Establish a comprehensive HRH planning system	
		Improved quality and needs based HRH development	Strengthen systems for planning and provision of pre-service training to ensure quality and needs-based pre-service training	
			Strengthen the coordination of in-service training to ensure efficient and effective in-service training	
		Strengthened HRH management systems and capacity at the MOH	Strengthen the structure and capacity for HR management	
	Health information	A timely and reliable health information	Build and maintain a single, integrated and inter-operable health information system	
			Strengthen health information system coordination	
		Surveillance capacity	Build a robust and integrated reliable surveillance system	
			Strengthen capacity for epidemiological surveillance	
		Research coordination	Ensure existence of adequate legal and policy framework for research	
			Provide a framework that will enhance and guide capacity building	
			Guide the conduct of research	
	Health infrastructure	Infrastructure availability	Establish the required physical infrastructure and equipment	
			Promote utility of research findings and	

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Programme interventions
			evidence-based decision making and practice	
			Assure availability of ICT infrastructure	
		Infrastructure maintenance	Maintain physical infrastructure and equipment	
			Transport maintenance	
		Pre-hospital emergency infrastructure	Strengthen pre-hospital emergency care Services	
	Health products	Selection	Implement the Essential Medicines Program	
		Procurement	Improve procurement of health products and technologies	
		Warehouse and Distribution	Build and maintain capacity (human, finance, infrastructure) for the warehouse and distribution of health products, vaccines and technologies	
		Rational use	Ensure availability and rational use of safe, efficacious health products	
	Governance & regulation	Regulation	Strengthen the regulation of health	
		Health governance and leadership	Build comprehensive systems for health governance and leadership	
			Strengthen the capacity of the MoH	
Health Financing		Adequate resources	Institutionalize financial processes that track and manage financial resources for health	
			Strengthen capacity to utilize financing tools in the annual planning and budgeting process	
		Mobilizing new resources	Increase overall financial resources in the Swaziland health sector	
		Ensuring efficiency in resource use	Strengthen the national capacity for allocation, management, and utilization of health financial resources.	
		Ensuring equity in resource use	Institute a national universal health coverage system.	
			Improve equity and increase health care access among the poor and the vulnerable	

Appendix 3: The Essential Health Care Package

The EHCP policy document guides and supports the existence of the health sector and facilitates service delivery at each level within the public and private sector. It also provides the standards to be followed by all health providers. The EHCP is classified into the following major categories of services:

- **Essential public health services**
  - Family health services – The scope covers child health, neonatal care, antenatal care, intrapartum care (delivery), post-natal care, cervical cancer screening and nutrition.
  - Prevention, management and control of communicable diseases- The scope of the interventions under this cluster covers prevention, treatment, and care of the key communicable diseases in Swaziland, namely HIV and AIDS, tuberculosis, malaria, bilharzia and soil-transmitted helminths (STH).
  - Prevention, management and control of noncommunicable diseases – The scope of prevention, management and control of noncommunicable diseases covers management of mental health conditions, cardio-vascular diseases, endocrine system disorders, cancers, nutritional conditions and injuries/trauma.
  - Health promotion - Scope covers health promotion, rural health motivators, environmental health, school health and emergency preparedness response
- **Essential Clinical Care Services**
  - Oral health care
  - Eye care and prevention of blindness
  - Ear, nose and throat
  - Dermatology
  - Internal medicine clinical services
  - Intensive care/Renal care services
  - Surgical services - the scope covers surgical clinical services, orthopaedic surgery, neurosurgery, renal services and intensive care services, obstetrics and gynaecology
  - Paediatric care
  - Anaesthesia
- **Allied health services**
  - Biomedical services
  - Procurement and supply chain management
  - Laboratory services
  - Medical imaging
  - Blood transfusion services
  - Occupational health
  - Physiotherapy
  - Speech and hearing
  - Paramedical services
- **Support services**
  - Strategic information services
  - Quality assurance services
  - Epidemiology services

The Swaziland Health Sector is organized into the following levels to distribute the abovementioned services:

- National (referral) hospitals
- Regional hospitals
- Primary health care facilities
- Health centres
- Public health units

- Rural clinics and a network of outreach sites
- Community-based care where rural health motivators (RHM), faith-based healthcare providers, volunteers and traditional practitioners provide care, support and treatment.

The implementation of EHCP will only be successful with the adequate provision of enablers such as human resources, availability of supplies, information and communication technology, infrastructure and equipment among others. Full implementation of the EHCP also requires a long list of additional efforts with regard to institutional changes in the regulatory framework, reconfiguration of the network of providers and addition of financial resources. MOH has therefore developed a series of documents and processes necessary for EHCP implementation, including the Essential Medicines List/Standard Treatment Guidelines, the Referrals and Linkages Framework, the Task Shifting Framework, the Supportive Supervision and Mentoring Framework as well as Quality Asassurance and Standards.

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