2014

THE SECOND NATIONAL HEALTH SECTOR STRATEGIC PLAN

2014 - 2018

Towards attainment of Universal Health Coverage

DRAFT ZERO
29 AUGUST 2014

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	Maximising level of health	Life expectancy at birth (years)	47		59
		Age-specific mortality rates			
		Neonatal mortality rate (per 1,000 live births)	19		16.5
		Infant mortality rate (per 1,000 live births)	79 (MICS)		68.7
		Under 5 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 5 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			
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		10
		Postnatal care coverage within 6 weeks of delivery	25		60
		Adolescent fertility Rate	89	82	71
	Preventing communicable & non communicable 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 non communicable conditions (per 100,000)	707		
	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 diagnostics and pathologist services			
		# 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		
		Number of people reached through outreach disaggregated by service provider			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%
		Dr 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 min for Urban (U) and 14 min in Rural (R) settings and 30 min for Aeromedical (A)	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 position in the approved organogram			
		# of national public dialogue forum 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%

Towards attainment of Universal Health Coverage. **The SECOND NATIONAL HEALTH SECTOR STRATEGIC PLAN – NHSSP II April 2014 – March 2018**

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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	Non Communicable 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 a first world status.

The theme of this strategic plan is Universal Health Coverage, which is 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 emphasizing a functional approach that has the client at the centre stage. The plan was developed in close collaboration with all stakeholders under the umbrella of SWAp including all stakeholders. The development of NHSSP II was informed by the Mid Term Review (MTR), and its priorities for health services center on the following thematic areas: promoting health through the life course, preventing communicable and non-communicable conditions, influencing health actions, managing medical and related conditions, and rehabilitation following health events to strengthen the national health systems. This plan will also implement the health financing policy.

Given the current and emerging health challenges facing Swaziland, Vision 2022 will only be realised through the implementation of a clear strategic plan, dedication and partnerships; tackling them will require that all partners work closely together, assisting and complementing each other. A strengthened collaboration, and the success of the Sector Wide Approach to Health, will therefore be vital in the implementation of the plan.

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

The NHSSP II will direct all health service interventions and allow for more effective health programming. The strategic plan should not be seen as the end 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 best and 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 prioritisation of the NHSSP II must emerge in these annual action plans (AAP) in a way that responds to the most pressing of current needs. The AAPs shall be guided by relevant criteria and evidence that meets mutual agreement of the health sector stakeholders. This prioritisation 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 World Health Organization Country Office, WHO Headquarters, the Regional and Inter-Country Office as well as the Kenya WHO Country Office, who provided constant technical and financial support.

The Ministry of Health acknowledges with appreciation the financial support provided by United Nations Population Fund (UNFPA), University Research Co. (URC), Clinton Health Access Initiative (CHAI) and 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 the consultant to lead the situation analysis, at the beginning of the process. This report assisted in the establishment of the basis for the development of the NHSSP 2.

The EU/World Bank is indebted for its financial support, during the thematic group retreats aimed at producing 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 the NHSSP 2.

The different government ministries, organizations including the private sector and civil society are highly appreciated for releasing the personnel to participate fully in this highly consultative process. These officers worked tirelessly and contributed a lot in ensuring that the strategic plan addresses almost all the current and possibly emerging health issues of the country.

The team is very grateful for the overall guidance provided by the Health Sector Wide Approach (SWAp) steering committee chairpersons for the continued support and guidance to the core team. Special mention is made to the Core Team Members for their support, as well as all the efforts they made to ensure that all necessary documents are available, arranging meetings and providing for all other logistics. The WHO Country Office is mostly appreciated for the continued valuable logistic 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 would also like to thank the chairpersons, co-chairpersons and rapporteurs of all the thematic groups, Ministry of Health Staff and Development partners who were involved in this process. All of whom gave their valuable time amidst other equally important duties.

Finally partners are urged to refer to this document for guidance on every aspect of the operations of the health sector. It is also worth noting that owning this document goes beyond participation in its formulation but its consistent utilization.

DR. SIMON M. ZWANE
PRINCIPAL SECRETARY

EXECUTIVE SUMMARY

The NHSSP II (2014-2018) ensures a comprehensive set of health services are provided that address in a holistic manner the health needs of the people in the Kingdom of Swaziland. The plan is built around a functional rather than structural approach, with the different elements interlinked and all working towards a common health agenda. The NHSSP II draws from 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 represents 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. Within this plan there is an introduction of a stronger element of client-focused and client- centered health services, a comprehensive and rationalized health systems investment focus that ensures all the critical investment needs of the health sector are being addressed. In addition it increases the level of attention to strengthening the regulation of health service provision.

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

1. Increasing the numbers of health and related services and interventions being provided across the country ***(introduction of interventions as and where needed)***
2. Increasing the coverage of populations using 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)***

The NHSSP II is structured around seven interlinked chapters

a) Chapter 1 provides the background information to the overall strategic plan – where the focus and priorities are arising from.
b) Chapter 2 provides a description of 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, for the people in the Kingdom of Swaziland
d) Chapter 4 elaborates on the health investments that are needed, to assure provision of the services as mentioned in chapter 3
e) Chapter 5 reflects on the financing measures that assure movement towards attainment of universal access.
f) Chapter 6 highlights the key implementation arrangements that the sector will use, to ensure the attainment of the targets for the health services and investments, and
g) Chapter 7 defines the monitoring and evaluation process to ensure the implementation of the NHSSP II is proceeding 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 1990-2005, a result of the HIV/AIDS epidemic, though mortality rates have declined since 2005 due to the greater 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 in favour of more efficient and effective delivery.

Shortcomings of disease focussed programming

Stand alone programs have been a predominant feature of NHSSP I in which a number of weaknesses surfaced. Deserving priorities such as Non-communicable conditions and violence / injuries related conditions were not attended sufficiently despite being major causes of disease burden. The initiatives for promoting healthy living amongst the population were limited, primarily to specific programmes with no sector-wide impacts. For example, the sedentary lifestyles and poor food habits, misconceptions on HIV transmission and gender based violence, substance abuse, suicide etc., were not being strategically addressed, as health risk factors.

Client focus, quality of care and health systems

Comprehensive look at the client pathway and ensuring required services are available at each point in the pathway to provision of care did not receive adequate attention: Access to a number of clinical services still remains rather poor. Quality of care remains an issue, with rising levels of antimicrobial resistance noted. The health service delivery systems are still not 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. The 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 harness increase in performance levels.

Despite gains made on strengthening health information, coordination is still a challenge, with different sources of information not interlinked, and capacities for analysis and use of information still weak. Overall systems for governance and regulation 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 assure health goals. Health products procurement and supply chain management systems remain inadequate, with little monitoring of rational use of health products in the country. There are limited efforts to implement a coordinated and rational approach to address health financing, as well as to ensure required resources are available and are efficiently and equitably utilised in a manner that is responsive to the expectations of the clients.

The NHSSP II emphasizes operating on a foundation of principles of social accountability, evidence and justice, people-centeredness, equity, multi-sectoral engagement, participation and efficiency. It embraces social values driven by human rights, including respect of clients, respect of culture and tradition, professionalism integrity and ethics, accountability, trust and confidentiality.

The mission embraced in this plan is “To build an efficient and equitable client-centered health system for accelerated attainment of highest standard of health to all people in Swaziland”. The overall goal is to move towards attainment of Universal Health Coverage with defined health services. Specific sector targets to set the course for reaching the 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 is aiming at maximising the available health resource for the Swazi population.
(2) Preventing diseases: These services are aimed at removing / 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 population.
(3) Prompt and effective management of medical and related conditions: These services are aimed at ensuring disease conditions are efficiently dealt with, when they occur. 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 population

(4) Rehabilitation following health events: These services are aimed at ensuring that, following a disease condition episode, clients' state of health is reverted to a status as close as it was at prior to that event.
(5) Influencing health actions in key related sectors: These relate 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 is ensuring it is influencing implementation of key actions that affect health in other sectors, and so maximising health.

In each health service thematic area the key issues, strategic areas and key innovations have been elaborated: This is followed by a table of indicators and targets and concluded by a log frame showing the outcome area 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 across six key thematic areas of investment which are:-

(1) Service delivery systems: The key investments needed to assure improved management of the process of service delivery.
(2) Health workforce: The investments relating to assuring availability of an appropriate health workforce needed for the delivery of services
(3) Health information: The investments relating to information management to guide the delivery of the defined services
(4) Health products: The 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 the 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.

As in health service areas, each of the six health system investment thematic areas is presented as key issues, strategic areas and key innovations followed by a table of indicators and targets. Each thematic area is concluded by a log frame describing 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 that aims at attaining universal coverage. Themes in financing include adequate availability of 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.

The NHSSP II shall be implemented through thematic program or system-specific service or investment areas guided by the budgeting process: Key investments that need to be considered in each budgeting period shall adhere to annual operational plans determined from NHSSP II. The Ministry of Health decentralization program shall be stressed 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 in the implementation, management, coordination, monitoring and evaluation of health services. Key strategic orientation shall include the promotion of bottom up integrated planning; capacity building and enhancement of skills of regional and community based health institutions; intersectoral coordination; and sensitization, mobilization, organization and empowerment of communities to participate in decision-making and program activities.

For effective management of the Health Sector, establishment of the Health Service Commission, subject to enactment of the Public Health Bill, establishment of the Hospital Boards in all hospitals and determining the staffing norms for health facilities will be facilitative. Promoting and managing Public Private Partnerships (PPPs), Civil Society Organizations (CSOs), and individual mission health providers through

respective forums shall encourage mutual accountability for realization of the health sector vision. Through the Sector Wide Approach (SWAp) support to the health sector shall be coordinated as per stipulations of principles of the Paris Declaration on alignment and harmonization.

The different indicators for monitoring and evaluating this NHSSP II will use data from different sources: routine HMIS, vital statistics, surveillance, surveys and research as 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 end term evaluation.

CHAPTER 1: INTRODUCTION

1.1 Country overview

The Kingdom of Swaziland is a landlocked country in Southern Africa measuring approximately 17,000 km^2. The country enjoys a sub-tropical to near-temperate climate along the western highlands, which rises 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 consumption and cash crops.

The population was estimated at 1.093 million in 2013, based on projections from the 2007 national census. Fifty-three percent of the population is female and almost half (48%) of households is headed by a woman. Swaziland has a young population with 44 percent of the population under 15 years; 4 percent is 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 a rising rate of mortality, have been responsible for the low annual rates of population growth.

Table 1: Swaziland population description

	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 a Gross National Income (GNI) of $2,860 in 2012, comfortably sits 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 economic growth has averaged 1.3 percent in the past five years, against a national target of 5 percent. Nominal Gross Domestic Product (GDP) was E32.4 billion in 2012 (around US$3.6 billion), driven mainly by manufacturing, agriculture and wholesale and retail industry. Agro-based manufacturing, specifically sugar processing, wood pulp production and food canning, contributes a growing share to 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 Africa 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 depression of prices in the agricultural sector, 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 declined from an average of 10 percent in the 1990s to 3 percent in the last ten years. Health remains a priority sector for Government: the annual budget allocation to health has increased from about 6.5% in 2002 to 12.2% in 2012 and 13% in 2013.

The African Development Bank (2011) in their analysis of Swaziland highlighted that while long-term development challenges remain unchanged, the unstable macroeconomic environment has complicated government's response. Undertaking economic and structural reforms, set out in the Fiscal Adjustment Roadmap (FAR) of 2010/11-2014/15, and the 2011 Economic Recovery Strategy have become a top priority for government in order to respond to a reduced resource envelope, following an unprecedented decline in

SACU revenue. The FAR focuses on domestic revenue enhancement, expenditure rationalisation and debt management. An Economic Recovery Strategy (ERS) 2011 was also prepared by MEPD to support the removal of long-standing impediments to economic activity which have contributed to sluggish economic growth over the past decade.

The administrative system is made up of a traditional Tinkhundla system and western-based administrative organisation. The latter is headed by the Prime Minister and made up 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 provides a foundation on which to implement government's Decentralisation Policy of 2006.

The health service delivery system in the country is structured around a four-tier system of service provision comprising 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 maternity wing) and Type B (with 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 include 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:** Regional referral hospitals provide, in addition to primary hospital services, curative and rehabilitative as well as 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 the primary health care programmes.
- **National referral hospital:** This is the highest referral level, also known as tertiary level. The kingdom has three national referral hospitals: Mbabane Government Hospital receives referrals from regional hospitals and is also used as a general hospital, while the National TB Hospital and the National Psychiatric Hospital provide specialised services.

The health services are delivered through a decentralized system of the four regions of Hhohho, Manzini, Lubombo and Shiselweni as illustrated in figure 1 below. The central level performs executive and administrative functions as well as providing strategic guidance on delivery of health care services in all the levels of care based on the Essential Health Care Package (EHCP). At 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

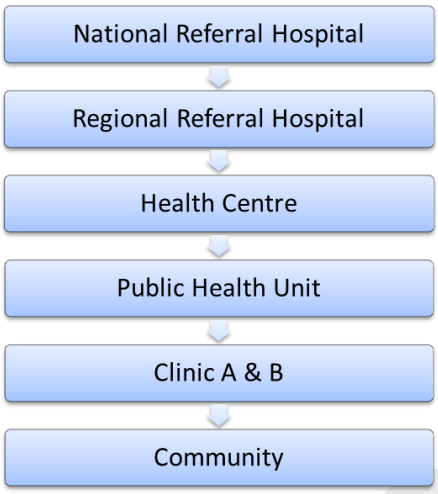


Table 2: Service delivery capacity, by region

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 guide monitoring of movement towards the Vision 2022. These, together with their targets, are shown below.

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

Focus area	Health-related Indicator	Baseline	Target for 2018	Target for 2022
	4. Child mortality ratio per 1000	80/1,000 (2012)	70/1,000	60/1,000
Service Delivery	5. Patient wait time for outpatient services	_	_	_
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%

The health targets provide a clear focus and agenda for the health sector to prioritise, if it is to contribute to the development agenda of the Kingdom of Swaziland.

1.3 Process of development of the NHSSP II

This NHSSP II has been developed over a one-year period, through a process that has drawn expertise from all stakeholders in the health sector. The extensive and prolonged process was aimed at ensuring it responds 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 NHSSP II development. It approved a concept paper for the NHSSP II development. The SHPCC developed an institutional framework within which to coordinate the development of the NHSSP II. The SHPCC also functioned as the steering committee, with a core team as the technical body leading the development process, and technical teams were constituted led by subject matter specialists as technical guidance. Each technical team was led by a government chair, together with a co-chair from one of the health partners and two rapporteurs.

Subsequent to that, a comprehensive situation analysis for health in the country was conducted. This documented the status of health, health services and health investments across the country, and laid the ground for the development of the NHSSP II strategic focus.

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

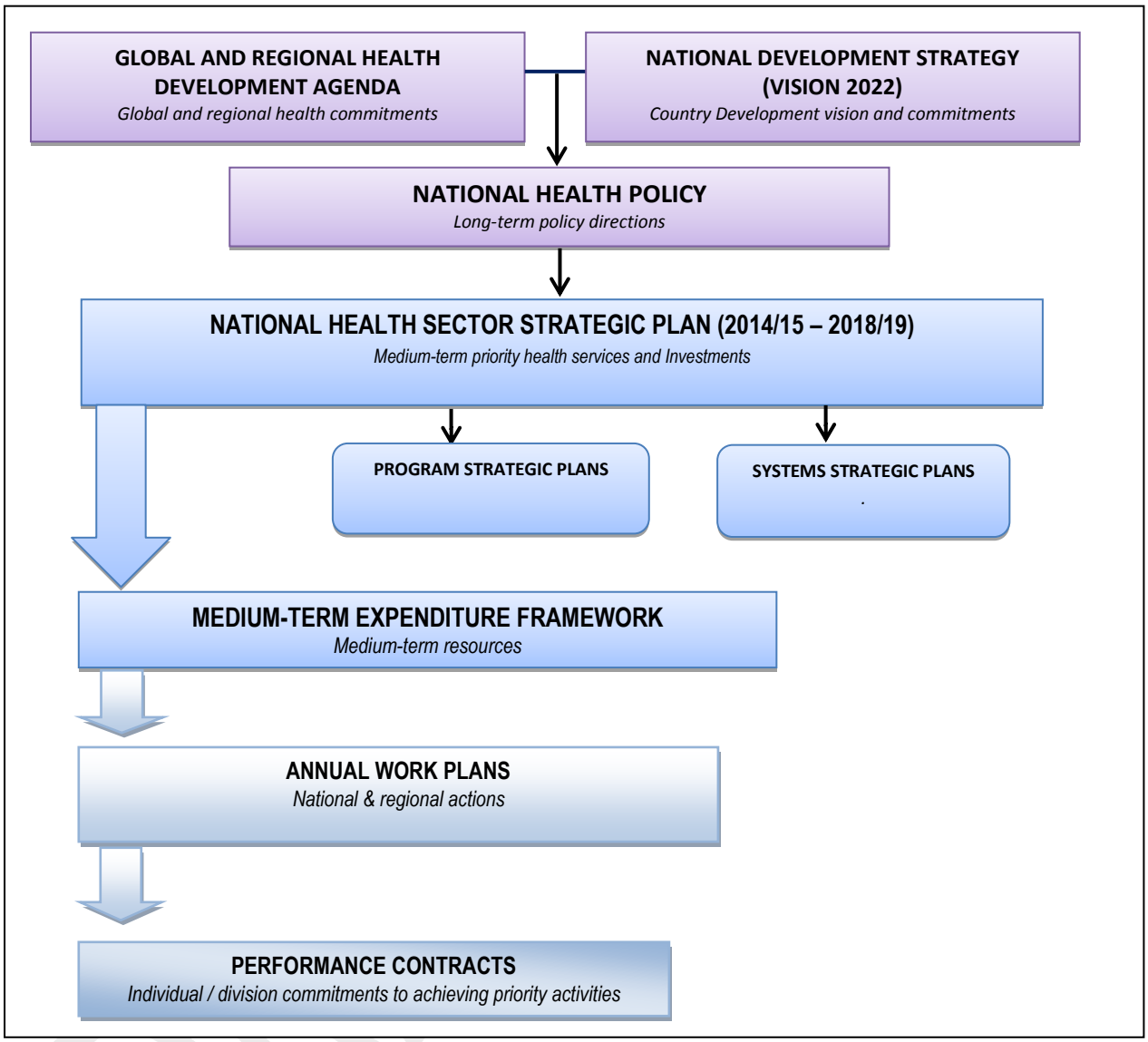
1.4 NHSSP II overview and framework

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

a) Reduce morbidity, disability and mortality that is due to disease and other social conditions;
b) Promote effective allocation and management of health sector resources; and
c) Reduce the risk and vulnerability of the country's population to social welfare problems as well as the impact thereof.

The 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



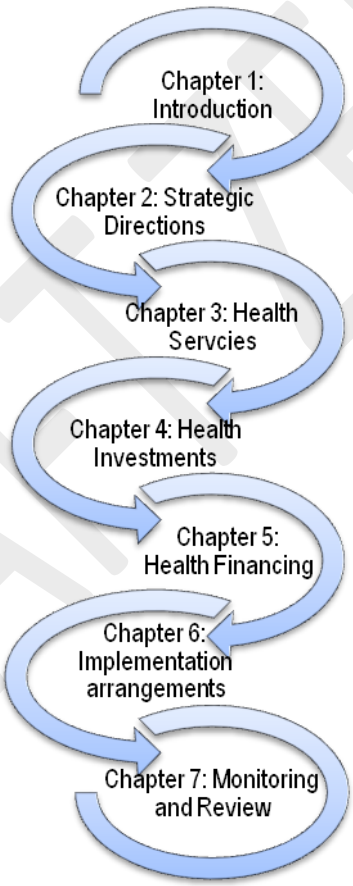
The NHSSP II draws from the National Development Strategy and the National Health Policy, which are informed by the global and countrywide health aspirations. It defines key strategic focus and interventions needed to be implemented in the medium-term, to contribute to these overall policy aspirations. The NHSSP II shall be implemented in a number of ways:

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

The NHSSP II is structured around seven chapters, which are all interlinked.

a) Chapter 1 provides the background information to the overall strategic plan – where the focus and priorities are arising from
b) Chapter 2 provides a description of 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, for the people in the Kingdom of Swaziland
d) Chapter 4 elaborates on the health investments that are needed, to assure provision of the services as mentioned in chapter 3
e) Chapter 5 elaborates on the focus for resource mobilization to assure financing of the plan
f) Chapter 6 highlights the key implementation arrangements that the sector will use, to ensure the attainment of the targets for the health services and investments, and
g) Chapter 7 defines the monitoring and evaluation process to ensure the implementation of the NHSSP II is proceeding as planned.

Figure 3: NHSSP II sections



1.5 Situation analysis

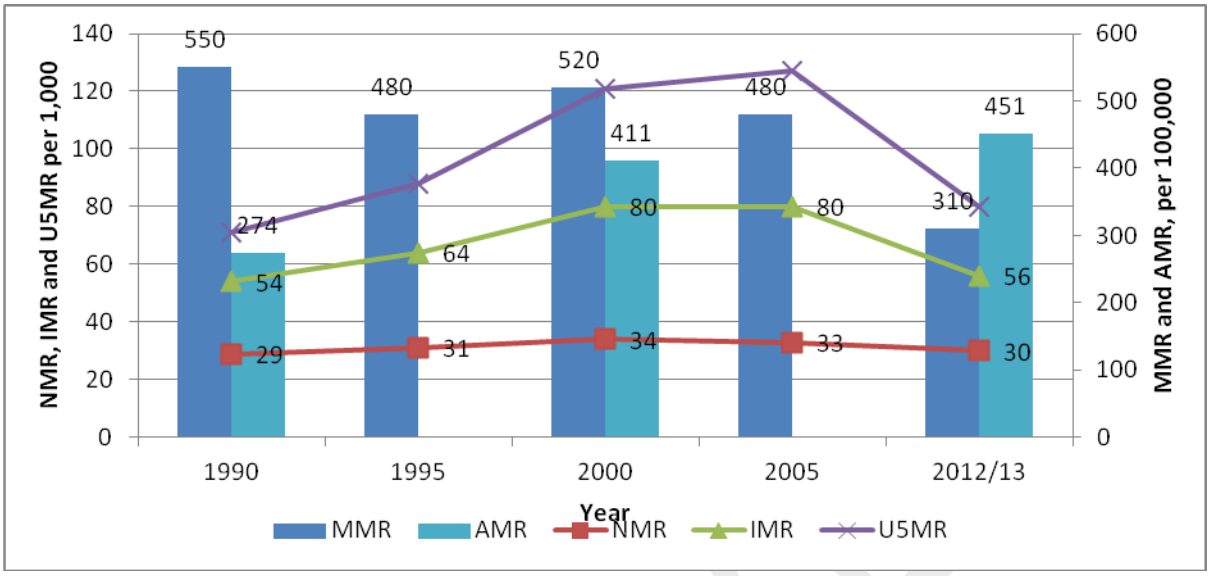
1.5.1 Health trends and distribution

The health status in Swaziland is below expectation, 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 level is very low, as compared to other middle-income countries where the expectation of life (at birth) on average ranges from 63.8 – 72 years for males, and 67.9 – 76.2 years for females. The rate is even lower than that for low-income countries (60.2 years for males, and 63.1 years for females). The rate is however higher than it was in the year 2000, when it had dropped to 48 years (48 and 49 years for males and

females respectively), though not yet at the level of 1990 where it was at 61 years (62 and 61 years for males and females respectively).

This trend in expectation of life is reflected in the mortality trends in the country, seen in the figure below.

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

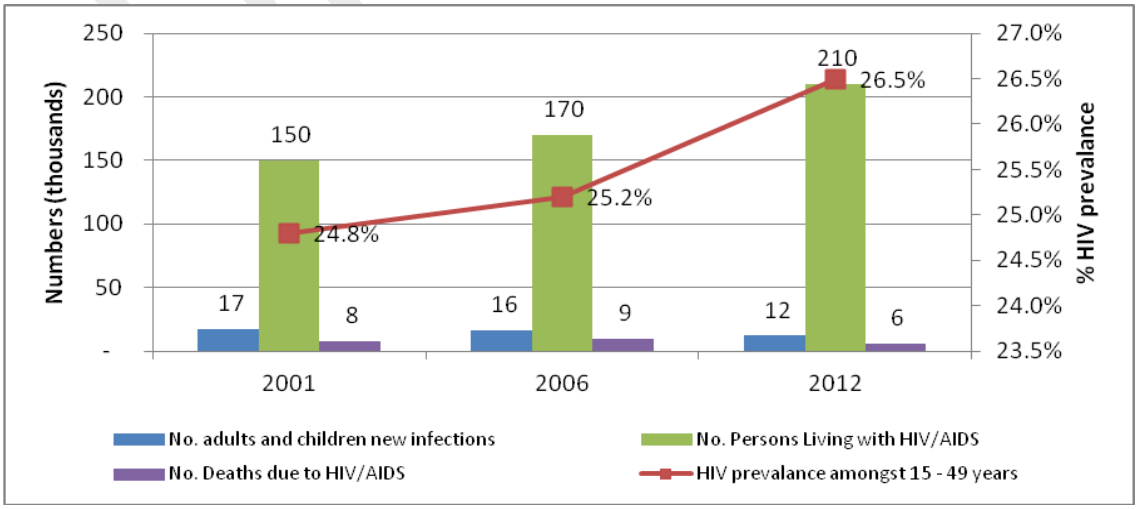


Source: Compiled from WHO World Health Statistics, 2014

All age groups have experienced significant increases in mortality in the preceding 20 years. However, apart from the adult mortality rate all the other age groups have been experiencing reducing mortality in the past 10 years. At present, though, 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 been increasing in the country, at a much higher rate than most other diseases. From 2005 onward, the decline in mortality 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

While the numbers of new HIV infections and deaths are on a downward trend, the overall prevalence remains high, due to the large population that exists with HIV/AIDS in the country. TB contribution in the Burden of Disease (BOD) can be recognized 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 during NHSSP I

The previous National Health Sector Strategic Plan (NHSSP I, 2009 – 2013) was formulated with the following overall objectives:

1) To reduce morbidity, disability and mortality that is due to diseases and social conditions
2) To enhance health system capacity and performance
3) To promote effective allocation and management of health and social welfare sector resources
4) To reduce the risk and vulnerability of the country's population to social welfare problems as well as the impact thereof

These objectives were to be attained, through implementing interventions in three strategic intervention areas of:

i. Strengthening health system capacity and performance
ii. Improving access to essential, affordable and quality public health services towards universal coverage; and
iii. Improving access to essential, affordable and quality clinical services towards universal access

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

During the NHSSP I period, findings of the Mid Term Review (MTR) highlight the following key achievements against these three strategic intervention areas are shown in the table below.

Table 4: NHSSP I Selected achievements against strategic intervention areas

Strategic intervention area	Selected achievements
Enhancing Health Systems Capacity and Performance	▪ Recruitment of HRH was accelerated, with support of partners ▪ The functionality of many facilities was improved, with required equipment purchased and deployed, and expansion of regional hospital in Lubombo region initiated ▪ There were efforts to improve capacity of staff, 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 for social health insurance done ▪ 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

Strategic intervention area	Selected achievements
Delivery of Essential Curative Health Services	▪ Introduction of telemedicine to improve efficiency in diagnosis and referral was achieved, in Mbabane Government hospital ▪ Clinical guidelines, and a national patients charter were developed ▪ Provision of specific services were expanded, such as mental health services, dental screening, eye care and prevention of blindness, automated donor blood grouping and Transfusion Transmissible Infections (TTI) testing ▪ Some specialized services were introduced in the country ▪ Infection control and risk management guidelines were put in place
Delivery of Essential Public Health Services	▪ Expansion of services for HIV prevention and control, such as PMTCT/VCT, treatment and support ▪ IMCI services were expanded, with a doubling of facilities providing these ▪ Vector control initiatives were scaled up, with ITN use amongst pregnant women and under 5s 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

As a result of the gains made, the impact on the health on the people in the Kingdom of Swaziland shows signs of improvement. The gains made should therefore be built upon, to accelerate the apparent improvements noted. There were, however, a number of issues that remained unfinished business for the sector.

With regard to health services, the services included in the NHSSP I were primarily built around stand-alone programme areas, with the NHSSP I just a collection of these 'independent' programme areas and had little inter-linkages across the different areas of the plan. As a result of this weakness, the following issues arose:

- Specific strategies addressing non-communicable conditions and violence / injuries were not given adequate priority, though these increasingly represent a major cause of disease burden
- The initiatives for promote healthy living amongst the population were limited, primarily to specific programmes with no sector-wide initiatives to facilitate this. For example, the sedentary lifestyles and poor food habits are not being 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 invested in, limiting the overall impact on the health of the people in Swaziland. Lack of a comprehensive look at the client pathway and ensuring required services are available at each point in the pathway to provision of care has led to less than desirable outcomes
- The 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 to monitor client experiences and effectiveness of care, and so align services to ensure they are responsive to expectations of the people in the Kingdom of Swaziland

On the other hand, there are still a number of system-related challenges that remain unfinished business:

- The health workforce planning, development and management is 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, with absence of norms and standards making projections of needs inaccurate, and significant amounts of infrastructure still not functional.
- There are still challenges with coordination of health information systems, with different sources of information not interlinked, and capacities for analysis and use of information still weak.
- Overall systems for governance and regulation are still inadequate to appropriately steward the health sector towards its desired goals. Improvement of the legislative and governance aspects of health need to be addressed through strengthening the Legal Department and expediting passing of the Public Health Bill.
- The health service delivery systems are still not 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 products procurement and supply chain management systems remain inadequate, with little monitoring of rational use of health products in the country.
- There were limited efforts to have a coordinated and rational approach to address health financing, to ensure required resources are available, and are efficiently and equitably utilised in a manner that is responsive to the expectations of the clients.

As a result, the key recommendations the sector will need to focus on in NHSSP II are as follows:

(1) Ensure the NHSSP II is built around a functional rather than structural approach, with the different elements interlinked and all working towards a common health agenda.
(2) Ensure a comprehensive set of health services are provided, that address in a holistic manner 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 rationalised health systems investment focus that ensures all the critical investment needs of the health sector are being addressed.
(5) Ensure 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 into which sector priorities and actions are derived. Its strategic focus is as follows:

VISION

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

MISSION

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

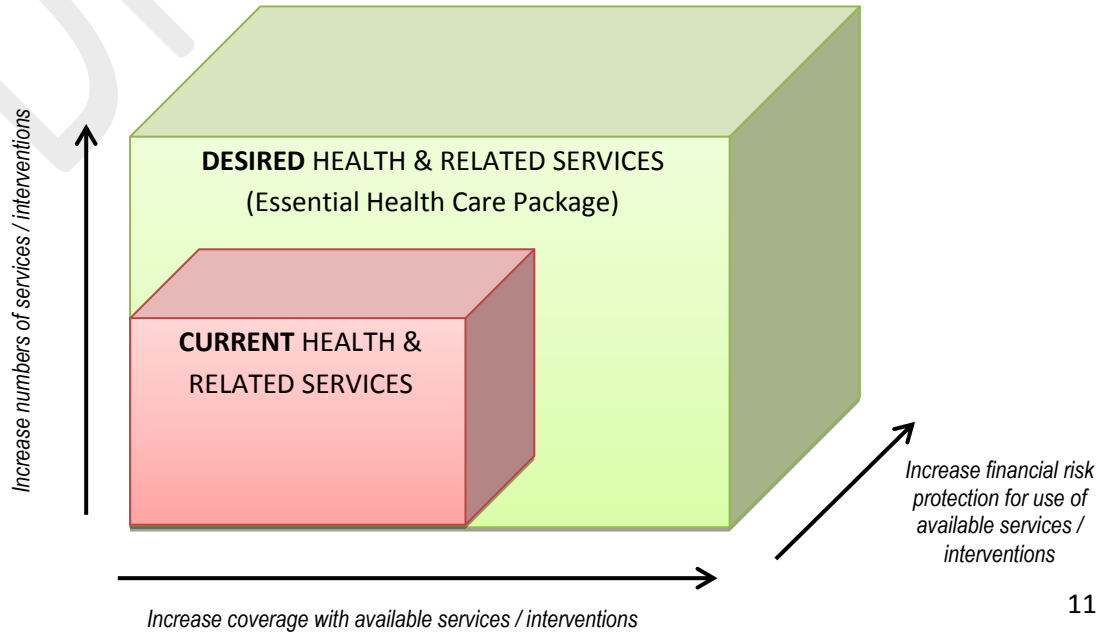
GOAL

Towards attainment of Universal Health Coverage with defined health services

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

1. Increasing the numbers of health and related services and interventions being provided across the country ***(introduction of interventions as and where needed)***
2. Increasing the coverage of populations using 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

The NHSSP II targets relate to three levels at which impact is sought:

- First level is on maximising the level of the health in the country
- Second level is on improving equity in the distribution of the available health
- Third level is on 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)	47		59
		Age-specific mortality rates			
		Neonatal mortality rate (per 1,000 live births)	19		16.5
		Infant mortality rate (per 1,000 live births)	79 (MICS)		68.7
		Under 5 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 5 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			

2.3 NHSSP II principles and values

The NHSSP II is built around principles and values that place the client in the forefront of all services provided to them. This ensures a clear focus on responsiveness to needs of the community, as services are designed and provided. The principles underpinning this NHSSP II are derived from the primary health care approach. These define how investments will be prioritized during implementation of the NHSSP II. Key principles are:

(1) **Equity:** This is to ensure all services provided avoid exclusion and social disparities. Investments are defined to ensure access to services is equitable, irrespective of a person's gender, age, race, geographical location and social class.

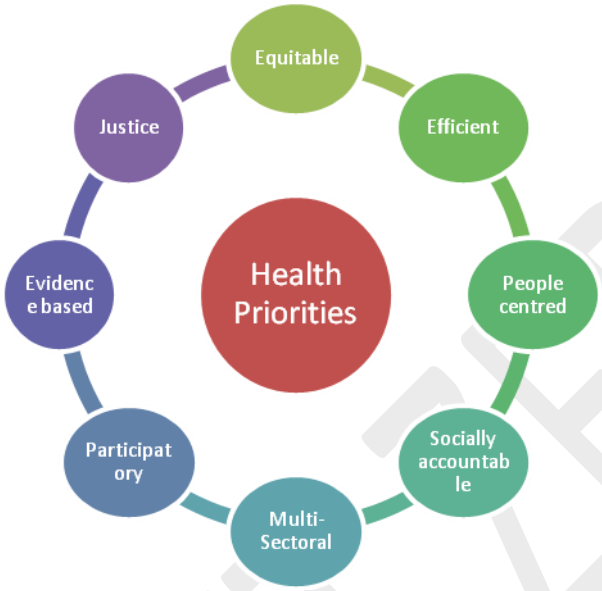
(2) **People-centred:** To ensure that health and health interventions are organized around people's legitimate needs and expectations. Interventions prioritising community involvement and participation are prioritised. The services should be designed in a manner that builds a long term relationship with the users

(3) **Participation**: Interventions involving different actors are prioritised, as they allow more scope for financing, and attainment.

(4) **Multi-sectoral approach:** This is based on the recognition that health cannot be improved by interventions relating to health services alone, but a focus of 'Health in all Sectors' is required. Interventions implemented by health-related sectors are also prioritised, as their attainment doesn't require significant health investments, but can lead to high health outcomes.

(5) **Efficiency**: To maximize the use of existing resources, interventions shall be provided in the most efficient manner. This entails implementing 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 prioritised.
(7) **Evidence based**: All focus and actions of the sector will be driven by evidence.
(8) **Justice**: All actions in the sector shall be driven by a need to ensure justice is observed

Figure 7: Key principles and attributes of health investments



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

(1) **Respect of clients:** The health sector actors will ensure the utmost levels of respect are accorded to during interaction with the clients of health services.
(2) **Respect of culture and tradition:** All stakeholders shall respect the cultures and traditions of the people 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 contained and detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.
(4) **Accountability:** At all times and at all levels, a high level of efficiency and accountability shall be maintained in the development and management of the national health system. All stakeholders shall discharge their respective mandates in a manner that takes full responsibility for the decisions made in the course of providing health care.
(5) **Trust:** The health sector shall ensure that, in all it does, it is able to build the trust and confidence of the clients of services, to ensure they are comfortable and believe in the sector's ability to deliver on their expectations.
(6) **Confidentiality:** The sector shall respect the individuality of the clients, and respect their need for confidentiality during use of health services.

CHAPTER 3: NHSSP II HEALTH SERVICES PRIORITIES

3.1 Health conditions affecting the population

Health indices and trends: After impressive improvements in health status for the three decades following independence, the country witnessed a marked deterioration in a number of health indicators in the next decade and half. 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 Country Report ICPD noted that the maternal mortality ratio has 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 to be 82% in 2010.

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

Morbidity, Mortality and Risk factors:

The top 10 causes of morbidity and mortality, as well as risk factors for morbidity and mortality, are presented in a table below. In children under five years of age, the leading conditions reported at Out Patient Department (OPD) were upper and lower respiratory infections, skin disorders, acute diarrhoea, digestive disorders, eye diseases, oral health conditions, ear problems and injuries. 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% among women aged 25-29 years. 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 an important aspect for focus considering high relative 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 impact aims at maximising the health resource in Swaziland, in an equitable manner and financed in a fair way. The country needs to move towards universal health coverage with an agreed set of health and related services that have the highest impact on the health challenges. These services should lead to the following implications on the disease burden in the Kingdom.

Table 7: Targeted health conditions affecting the Swazi population

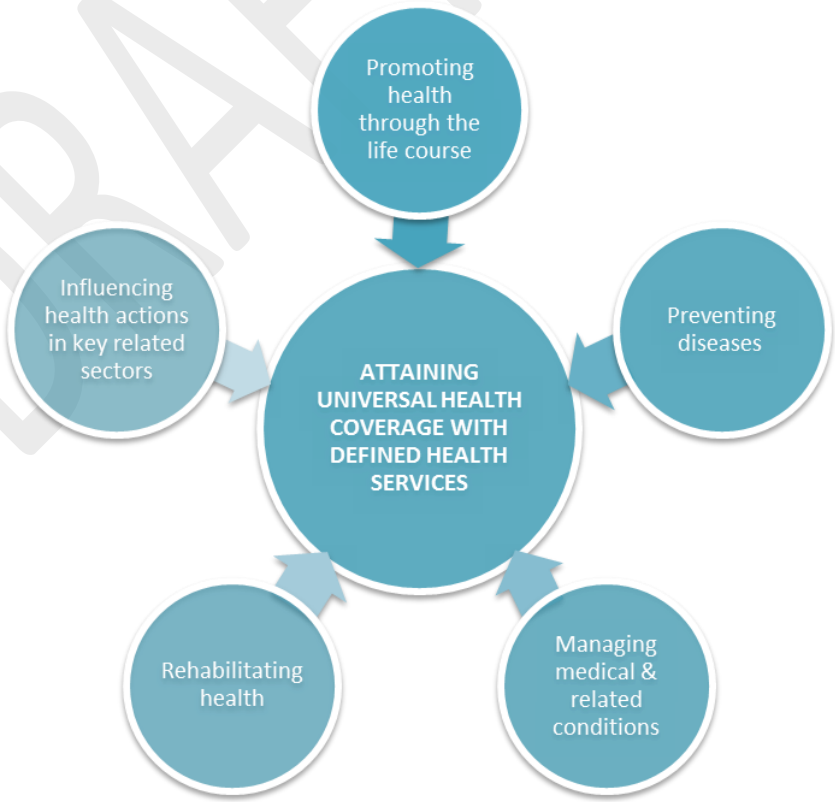
CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETED FOR ELIMINATION
1. Poliomyelitis	1. Malaria 2. Mother to Child HIV transmission 3. Maternal and Neonatal Tetanus 4. Measles 5. Neglected Tropical Conditions
CONDITIONS TARGETED FOR CONTROL	**RISK FACTORS TARGETED FOR CONTAINMENT**
1. HIV / AIDS 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 therefore the goal of moving towards 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) Prompt and effective management of medical and related conditions: These services are aimed at ensuring disease conditions are efficiently dealt with, when they occur. 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: These services are aimed at ensuring that, following a disease condition episode, clients' state of health is reverted to a status as close as it was at prior to that event.
(5) Influence health actions in key related sectors: These relate 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 is ensuring it is influencing implementation of key actions that affect health in other sectors, and so maximising 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 will maintain the existing health status amongst individuals. It is critically important for the health sector to identify and implement strategies and interventions that will help in keeping communities and individuals healthy.

A focus on promoting health through the life-course calls for addressing the barriers to good health that occur from gestation, childhood, adolescence, adulthood and elderly phases of life. At present, there are signs these challenges are significant in the population. Almost six percent of children under age five are underweight, and one in every three (31%) are stunted (MICS 2010). The same source indicates one percent 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 of mothers with lower or no education. High maternal HIV infections often lead to mothers not wanting to breastfeed or stopping breastfeeding earlier than recommended.

The MIC Survey further revealed 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 6-23 months were receiving complementary foods and breast milk at the same time. Appropriately breastfed children 0-23 months are about 40%. Child feeding frequency tends to be lower amongst poor and low education mothers. With 16% of children having had diarrhoea within two weeks before the survey and 24% of mothers having incorrect knowledge on Oral Rehydration Solution (ORS), it is not surprising diarrhoea is a leading cause of death among children under five years. 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 contribute 46% (Ministry of Health, 2011). Most maternal deaths are attributed to three factors: delay in decision-making; delay in transport to nearest health facility; and delay in service delivery at health facility level. In addition, the elderly face a number of non-communicable 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.
- 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 that aim at promoting the health of the people across the life course. The sector intends to achieve this by focusing on:

- Enhancing 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 national sustained 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. In addition, a focus across the life course of an individual presents a departure from a disease focus to a client focus – addressing the client challenges, as opposed to the disease. Through this, the sector intends to be more responsive to the health needs of the communities and individuals.

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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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		10
	Postnatal care coverage within 6 weeks of delivery	25		60
	Adolescent fertility Rate	89	82	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	1.1 Strengthening delivery of quality comprehensive Child and Maternal Survival services through enhancing 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 Reduction of teenage pregnancy and other unplanned pregnancies	2.1.1. Delay sexual debut using a cultural-rooted approach (applying rapid ethnography to source content for blending with sexuality and family health interventions).
			2.1.2. Sharing of 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 youth and adolescent comprehensive sexuality and family health services
		2.2 Promote male-involvement for enhanced reproductive and family health	2.2.1. Provide male-tailored 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-aging into health service delivery	3.1.1. Define and systematise healthy-aging in health service delivery packages
			3.1.2. Promoting understanding and practice of healthy ageing for men and women
			3.1.3 Promoting 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 Integrating mental health care, rehabilitation and counselling in service delivery	4.1.1. Package and decentralise mental health services at all levels
			4.1.2. Develop rehabilitation centres for substance abuse
			4.1.3. Strengthen empowerment approaches for clients of mental health (e.g. support groups)
		4.3 Positive engagement of all population groups (young and old)	4.3.1. Intensified promotion of sports and physical exercise for all population groups particularly adolescents and youths – Exercise

No	Outcome area	Strategies	Priority interventions
		in personal physical fitness	for All = all levels, all sectors, groups and individuals (E4A sustained campaign)
		4.4 Promoting healthy food consumption	4.4.1. Strengthen health nutrition promotion programme to target population groups particularly in and out-of-school youth
			4.4.2. Increase household consumption of iodized salt
5	Nutrition promotion	5.2 Promote availability, accessibility and utilisation 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
		5.3 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 micronutrients deficiencies	5.4.1. Integration of micronutrients indicators into existing tools e.g. ANC card, CH card
		5.5 Food and nutrition preparedness for emergencies	5.5.1 Nutrition care and support for vulnerable groups (children, women, elderly, disabled).

3.2.4 Thematic area 2: Preventing communicable, and non-communicable conditions

Key issues

The prevention of communicable and non communicable conditions remains a core function the health sector provides. Disease threats still afflict all persons, regardless of age, sex, lifestyle, background, and socioeconomic status. They cause suffering and death and impose a financial burden on society. Disease prevention strategies need to be constantly changing, due 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.

Swaziland is currently facing a double burden of communicable and non-communicable conditions. Significant efforts have mostly been focused on prevention of communicable conditions have been put in the recent 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 populations that are not receiving the interventions
- Not all communicable conditions are being prioritised. A number of neglected tropical conditions still exist, for which intervention scale up is still poor.
- The preventive strategies addressing non communicable conditions, as well as violence and injuries, are not yet significantly in place in the country.

Strategic approach

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

- Universal access to HIV and TB treatment, prevention and control in a manner that guides the national response to threats [effective antimicrobial resistance monitoring and action] shall provide better chances to monitor and implement effective surveillance on infected individuals that may endanger health among the general public.
- A systematic path to reach Malaria elimination is ready to be taken into implementation with sustained surveillance of transmission foci.
- Strengthening the quality control mechanisms to ensure food safety in the country.
- Improving response to health emergencies including emerging and re-emerging health threats
- Prevention and management of non-communicable diseases

Key innovations

A focus on universal coverage with all disease prevention 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
Preventing communicable & non	HIV incidence (adults, children)	2.22 (2.2)	2.06	1.94 (1)
	TB treatment success rate	73	82	95

communicable conditions	ART retention among adults and children			
	Deaths due to Malaria per 1000 population	0.6		0
	% population who are obese			
	Deaths due to non communicable conditions (per 100,000)	707		

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

No	Outcome area	Strategies	Priority interventions
1	Prevention of communicable conditions	1.1 Adopt broader and more inclusive treatment practices	1.1.1 Improve provision of quality holistic and integrated HIV treatment at all levels including nutrition needs.
			1.1.2 Provide tailored prevention interventions in facilities and communities.
			1.1.3 Promote supermarket delivery of services including application of rights based approach
		1.2 Advance universal access to HIV and TB prevention and control: guide the national response to threats [antimicrobial resistance monitoring and action]	1.2.1 Provide counselling, quality care and treatment to co-infection cases and those that are diagnosed with drug resistant TB.
			1.2.2 Early detection, counselling and nutrition support for people on ART/TB treatment and PMTCT
		1.3 Implement the post 2015 TB agenda	1.3.1Universal high quality TB prevention services (including DOTS - Directly Observed Treatment Strategy)
			1.3.2 Roll out integrated CSE/life-skills education for in and out of school
			1.3.3 Create healthier school environments, including healthy food options, physical activity opportunities, promotion of healthy lifestyles
		1.4 Elimination of Malaria	1.4.1 Promote usage of parasitological-based tests on all malaria cases and report immediately via the IDNS (977)
			1.4.2 Update new treatment protocols according to internationally agreed malaria elimination guidelines
			1.4.3 Intensify the mobilization of communities to actively participate in malaria elimination Interventions
			1.4.4 Establish surveillance systems to achieve certification of malaria by 2018 including active foci surveillance and their elimination
		1.5 Scale up immunization efforts	1.5.1 Vaccination for childhood illnesses (BCG, OPV, DTP, HepB, HiB, pneumococcal etc)
			1.5.2 Vaccination against cancers (e.g. HPV vaccination)
			1.5.3 Vaccination against imported diseases
			1.5.4 Monitor effectiveness and implementation of current immunization schedules and process introduction of new vaccines in accordance to existing threats (locally and internationally)
		1.6 Strengthen Prevention and Control food and water borne transmission of diseases	1.6.1 Enforce adherence to standard food handling practices: food hygiene and food safety for street food vendors.
			1.6.2 Community mobilization through the formation of Water & Sanitation Committees, PHAST training, sensitization on operation and maintenance
			1.6.3 Promote application of effective disease prevention measures at community level
			1.6.4 Determine BOD on CD NTDs to inform actions for prevention and control (e.g Schistosomiasis)
		1.7 Strengthen Health security measures and Disaster Risk Management	1.7.1 Conduct assessments, map risks, conduct profiling and scenario classification of hazards and emergencies
			1.7.2 Incorporate emergency, trauma and disaster early warning, preparedness, response and recovery into national surveillance systems
			1.7.3 Build Health facility and community resilience and preventive interventions based on disaster risk analysis and mapping
			1.7.4 Strengthen resilience building interventions in the health facilities and community level
			Promote use of Emergency Toll Free Line
		1.8 Timely Response for Emerging diseases-Public Health emergencies,	1.8.1 Strengthen epidemiological investigation and surveillance capacity for timely reporting, adherence to requirements of International Health Regulations, containment of threats, epidemics and pandemics,

No	Outcome area	Strategies	Priority interventions
		Epidemic and Pandemic threats	preparedness, and response.
2	Prevention of non communicable conditions	2.1 Accelerate implementation of Framework Convention on Tobacco Control (FCTC)	2.1.1 Empower individuals and communities to adopt a healthy lifestyle for the prevention of NCDs & lifestyle diseases
		2.2 Strengthen health systems through integration of NCD prevention and treatment	2.2.1 Implement strategies to encourage physical activity and improve diet
			2.2.2 Promote reduction of dietary salt, sugar, saturated and trans-fats and harmful use of alcohol
			2.2.3 Promote comprehensive chronic disease management and prevention programme
		2.3 Scale up prevention of NCDs	2.3.1 Provide tailored prevention interventions in facilities and communities
			2.3.2 Decentralize services of NCD and lifestyle diseases to all levels
			2.3.3 Follow up establishment and functionality of workplace programs and interventions
		2.4 Establish Mental Health & Substance Abuse prevention Programme at all levels including strengthening of Mental Health and Substance Abuse -implementation	2.4.1 Strengthen mental health screening
			2.4.2 Development of drug and alcohol abuse prevention, screening and promotional programs
			2.4.3 Adopt more effective approaches for health promotion for mental health
			2.4.4 Establishsuicide prevention programs
			2.4.5 Establish crisis intervention programs
		2.5 Provision of violence Impact mitigation and/or harm Reduction intervention in mental health	2.5.1 Establish strategies to reduce and prevent sexual abuse and gender based violence
			2.5.2 Strengthen trauma counseling and psychotherapy
			2.5.3 Strengthen international mental health awareness activities; (commemoration of World Mental Health Day, Alcohol and Substance Abuse Day and Suicide Prevention Day)
3	Prevention of violence and/or injuries	3.1 Strengthen surveillance systems	3.1.1 Enhance utilization of surveillance data to inform prevention of violence and injuries
		3.2 Create a positive safety culture	3.1.2 Provide client-focused prevention strategies

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 as where we live, the state of our environment, genetics, our income and education level, and our 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. Therefore 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, lie outside of 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 is 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 inadequate 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 influencing strategies to guide working with health related sectors that will lead to prioritization and implementation of the critical health related actions. As these actions are the mandate of other sectors, but have a significant influence on health outcomes, the health sector will build the linkages with the sectors responsible for these actions to work with them and ensure they are being implemented in a manner that will lead to better health outcomes.

This calls for multisectoral approach to harness requisite collaboration and cooperation beneficial to health. Coordination & informing national multisectoral platforms shall offer pragmatic formal engagement of other sectors.

Health Impact Assessments (HIAs) will be implemented, preferably factored into Environmental Impact Assessments (EIAs) of all projects shall bring preventive health benefits by averting what could otherwise negatively affect health in addition to effecting 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 inform promotive aspects for health and nutrition to benefit prevention and control of disease conditions.

Socializing to inform influence on behaviour through enter-educate approaches shall be tuned to needs of specific target groups for better lifestyles, safer sex and address to 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 prioritised in the sectors affecting health.

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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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			

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 Coordination & informing national multisectoral platforms	1.1.1 Establish and strengthen multi- sectoral 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 Establish Health Impact Assessment (HIA) routine 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 for household and work place production, promotion and protection of health.
		2.4 Strengthen response to injuries	2.4.1 Profile injuries & outline key interventions

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 knowledge and skills they require, as well as equipment, supplies and enabling environment.

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

Outpatient care services can be improved by reducing patient waiting time. Issues contributing to long waiting time include large numbers of patients, poor referral systems, old infrastructure affecting patient flow and weak 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 out-dated 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 to enable staff to be competent and confident in managing cases presenting at their facilities to 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.

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

Strategic approach

The health sector intends to provide high quality services by ensuring that all clients are attended to by qualified, competent, and skilled health personnel. This is coupled by having the right numbers and 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 elaborated in the below table.

Key innovations

A comprehensive focus and approach will be applied, which is patient-centred and comprehensive to ensure a full range of quality services are available to the clients. The approach is client focused, as it focuses on identifying the 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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		

**2011 figures used as baseline measurements in 2014 column*

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

No	Outcome area	Strategies	Priority interventions
1	Outpatient care	1.1 Improve the quality of outpatient care service provision	1.1.1. Upscale services at all levels through implementation of the EHCP
			1.1.2. Institutionalise quality improvement and quality management systems
			1.1.3. Develop up-to-date, adequate SOPs
			1.1.4. Scale up telecommunication services to improve patient management
		1.2 Improve patient flow to ensure patients have timely access to services	1.2.1. Improve triaging systems within health facilities (covers both clinical triage and directing staff to correct OPD room)
2	Emergency & trauma care	2.1 Increase access, scope and quality of emergency and trauma care at facilities	2.1.1. Upscale services at all levels through implementation of the EHCP
			2.1.2. Institutionalise quality improvement and quality management systems
3	Maternity care	3.1 Improve quality, access and affordability of patient centred maternity services	3.1.1. Continue to decentralise maternity services
			3.1.2. Increase number of staff trained in maternity specific services
			3.1.3. Institutionalise quality improvement and quality management systems
4	Inpatient care	4.1 Improve quality of care	4.1.1. Institutionalise supervision and mentoring systems within facilities
			4.1.2. Improve infection control measures in facilities
			4.1.3. Improve facility-level staff management
			4.1.4. Develop up-to-date, adequate SOPs
		4.2 Increase the scope of service provision	4.2.1. Implement the EHCP
			4.2.2. Ensure patients are made aware of the Patient Rights Charter and these rights are respected by health care workers
5	Operative care	5.1 Improve access and quality of operative care services	5.1.1. Decentralisation (increase access to minor surgery according to EHCP)
			5.1.2. Investigate and adopt new technologies where appropriate (best surgical practice)
			5.1.3. Institutionalise quality improvement and quality management systems
6	Diagnostics care	6.1 Improve access and availability of high-quality diagnostic services	6.1.1. Ensure patients have access to appropriate levels of diagnostic services
			6.1.2. Decentralisation of strategic diagnostic services
			6.1.3. Facilities to maintain an updated inventory of equipment
7	Pharmaceutical care	7.1 Improve access and availability of high-quality pharmaceutical services	7.1.1. Ensure patients have access to appropriate levels of pharmaceuticals, as per their required management
			7.1.2. Decentralize strategic pharmaceutical services

3.2.7 Thematic area 5: Rehabilitation following health events

Rehabilitative including palliative care services are focused on returning patients to near-normal health following an illness episode, and where not possible to restore health, to then managing that terminal illness in the most humane manner possible, for the patient, and the families. Rehabilitative services are inclusive of seven programmatic services, namely (i) Physiotherapy, (ii) Occupational Therapy, (iii) Speech Therapy, (iv) Audiology, (v) Dietetics, (vi) Orthopaedic Technology, and (vii) Podiatry. In the first NHSSP, the issues of palliative and rehabilitative care received scant attention. Though mentioned in the NHSSP I, neither of these services were defined, nor specific strategies elucidated within the strategy.

In addition, forensic services (e.g. pathology, and medico-legal services) were not included in the NHSSP I at all. Forensic services are provided primarily through forensic laboratories and pathologists, in order to provide 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 working in these units are not adequately skilled. Forensic services are primarily provided by clinical pathology departments, though generally not provided in the public sector in Swaziland – diagnosis is usually referred to laboratories in South Africa, both private and public (the National Health Laboratory Service). Pathology services are provided in the private sector.

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

The Mid Term Review of the NHSSP I conducted in 2010 noted the absence, or lack of decentralisation of rehabilitative services, and thus there was a deliberate effort in developing the NHSSP II to include these services, and provide more strategic guidance on improving access to these services. Some of these services, especially rehabilitative services, are primarily centralised, 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, podiatry, psychologist, dietetics are mainly distributed in a few hospitals hence there are few patients accessing these services. In addition, the various services are not adequately coordinated and planned for in the country such that equipment, infrastructure and personnel are inadequate to meet the demands of these programs.

The NHSSP I did make a clear commitment to decentralising services, with specific reference to clinical, palliative and rehabilitative services. There is some limited outreach, but primarily decentralisation has been hampered by health systems 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 clinical and diagnostic capacity (addressed elsewhere in the NHSSP II) to provide these services.

The Medical Imaging department uses radiation called x - rays and gamma rays, ultrasound uses very high frequency sound waves, and magnetic field (magnetic resonance imaging) in order to help in the diagnosis and treat patients for a variety of injuries and disease. They are part of a medical or surgical team, typically involved in initial patient evaluation and testing providing diagnostic and evidentiary data for 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 perform their duties in all the above mentioned sections and further, by performing other duties of a Radiologist. There are 5 qualified sonographers based in government facilities. There are 5 darkroom attendants within the public sector who process the x- ray films.

Strategic approach

The sector intends to scale up access to rehabilitative services, to ensure clients requiring these are able to use them. This requires that all facilities are able to access these services and all the infrastructure and resources required for these services are provided for. The focus is on ensuring quality rehabilitative, palliative and forensic services, and for rehabilitative and palliative care services, to ensure they are sufficiently decentralised, 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 capacity of health officials to screen patients for services such as hearing impairment, recommendations for physiotherapy etc.

Table 16: Indicators and targets for provision of rehabilitative services

Thematic area	Indicators	Baseline	Mid term	Target 2018
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 diagnostics and pathologist services			
	# of hospitals providing forensic pathology services	1		3

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

No	Outcome area	Strategies	Priority interventions
1	Rehabilitative care	1.1 Improve access to quality rehabilitative services	1.1.1. Decentralise rehabilitative services as per the EHCP[1], including outreach to clinics, and community-based services
2	Forensic services	2.1 Provide quality forensic pathology services	2.1.1. Establish a Forensic Pathology Department within the public sector to provide forensic investigations
			2.1.2. Establish clear coordination and collaboration between public and private forensic service providers to ensure greater access to forensic services
			2.1.3. Strengthen the cooperation between the Royal Swazi Police and the Ministry of Health Forensic Pathology Department
			2.1.4. Improve mortuary services at hospitals and health centres, including infrastructure investments
3	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	3.1.1. Strengthen models of quality palliative care service provision, outreach and home visit services
			3.1.2. Ensure quality of palliative care service provision at all levels of service delivery, including integration of referral and linkages between home-based care, health facilities, and hospices
			3.1.3. Strengthen palliative care knowledge and skills at all levels of the health sector
4	Medical Imaging	4.1 Improve access to quality medical imaging	4.1.1. Establish guidelines and procedures for imaging services
			4.1.2. Improve radiology services at hospitals and health centres
			4.1.3. Installation of patient archiving communication system (PACs) and radiology information system (RIS) to be in place for the storage of CT scan images and general radiographs
			4.1.4. Establish and implement radiation control measures at all service points

[1] 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 assure improved management of the process of service delivery.
(2) Health workforce: The investments relating to assuring availability of an appropriate health workforce needed for the delivery of services
(3) Health information: The investments relating to information management to guide the delivery of the defined services
(4) Health products: The 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 the 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 elaborated in this section.

4.2 Thematic area 1: Health Service Delivery Systems

Key issues

There still exist a number of challenges to the health service delivery system, impeding the capacity to deliver the required health services.

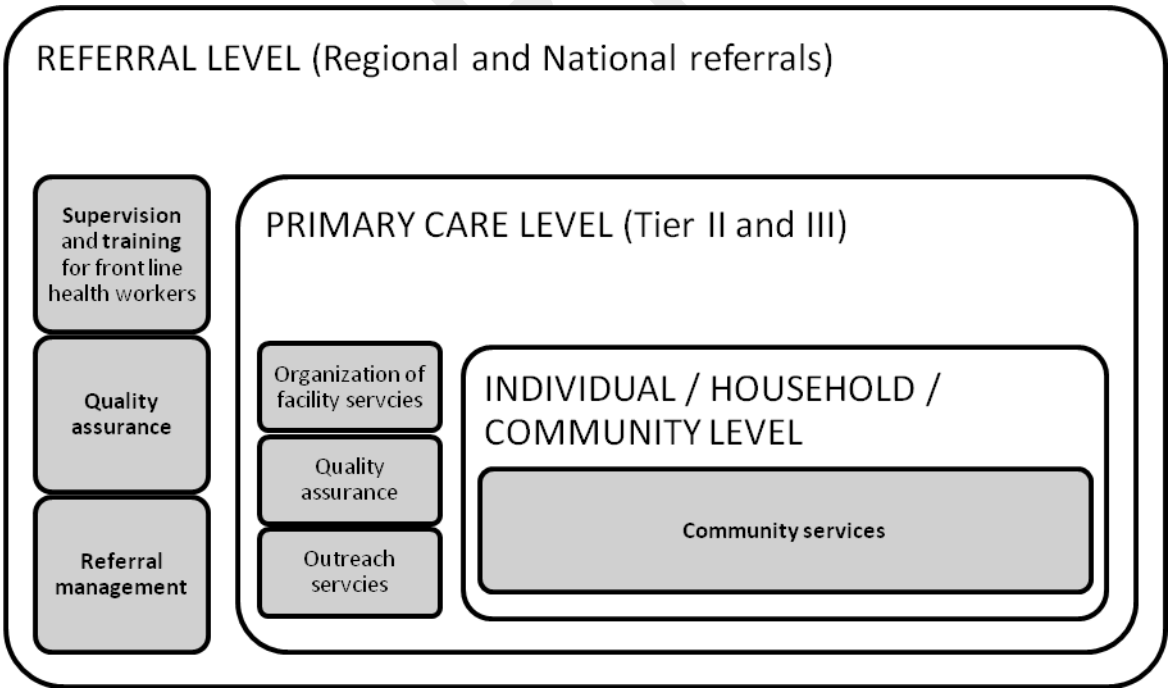
- Outreach services to the community are not structured and inaccessible to citizens in hard-to-reach areas and specialised groups. It has not been easy to cover all the designated areas, there are some underserviced communities and there are certain groups of the communities that cannot access the health 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 organised into a four tier system. For specialised 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, the EHCP implementation has significant gaps across the country, with many services not being provided, even when the capacity to provide them exists.

Strategic approach

The health sector will work towards putting in place 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 relate to how communities are able to engage in improving their health. Referral Services look at 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

supplied to communities, as per their needs. Supervision on the other hand looks at 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 the NHSSP II. This will facilitate availability of the appropriate framework needed to build capacity for other investments needed for the delivery of the health services.

Table 18: Indicators and targets for service delivery systems

Thematic area	Indicators	Baseline	Mid term	Target 2018
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		
	Number of people reached through outreach disaggregated by service provider			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%

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 of 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 no of services provided through outreaches, 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 of quality assurance and Standards	5.1.1 Support adherence to updated standard treatment guidelines
			5.1.2 Put in place quality improvement teams at each region and facility
			5.1.3 Facilitate 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 specialised 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.
- Distribution of the available health workforce is also poor, with most specialised health workers concentrated in a few, centralized facilities leaving gaps in availability of cadres at most peripheral facilities. To mitigate the current shortage, a number of donors are supporting a number of positions however the 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 as opposed to supportive. Mechanisms to motivate the workforce are limited in roll out 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 the presence of a well-motivated and productive health workforce plays on the capacity to provide health services. As such, prioritization will be given to improving the availability, and productivity of the health workforce needed to provide the defined health services.

Key innovations

A stronger emphasis on evidence based planning and management of the health workforce will be emphasized during this NHSSP II. As a result, a clear and detailed HRH strategic plan will guide HRH investments, together with operationalization of the HRH norms, and workforce projections to ensure a workforce aligned to the 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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%
	Dr patient ratio (see SAM)			

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. 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 a healthy infrastructure in good condition also shapes the public perception of good quality care and this in turn encourages utilisation of available health services. For an efficient and effective infrastructure there is need for proper planning and maintenance. At present, the sector is facing a number of challenges in this:

- There are currently lack of infrastructure norms and standards for guiding investment. As such, 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, limiting their functionality.
- Many facilities are not 'ready' to provide services. Key infrastructure required to assure readiness such as water, electricity, basic supplies, waste management are not available as expected reducing the capacity for provision of services by the facility.
- 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 capacity to respond to emergencies within the "golden hour".
- Inappropriate maintenance of existing infrastructure has led to reduced functionality, and higher inefficiencies as breakdowns are more frequent
- Absence of an 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 adequately contribute to this, the health sector needs to focus on implementation of these strategic outcomes:

- **Improving the 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 implementation of 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 improvement of the "golden" hour Emergency care intervention by providing adequate ambulances with advance life support and construction 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 of the focus in NHSSP II.

Table 22: Indicators and targets for health infrastructure

Thematic area	Indicators	Baseline		Mid term	Target 2018
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 min for Urban (U) and 14 min in Rural (R) settings and 30 min for Aeromedical (A)	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%

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

No	Outcome area	Strategies	Priority interventions
1	Infrastructure availability	1.1 Establishment of required physical infrastructure and equipment	1.1.1 Roll out physical infrastructure (facilities) as per norms and facility master plans
			1.1.2 Purchase of 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 of 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 ensured availability of functional transport services
3	Pre-hospital emergency infrastructure	3.1 Strengthening of 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 timely, complete and accurate health information plays in availing 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 the health 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 at present.

(1) There is weak / poor inter linkages across different sources of health information, limiting their usefulness. Absence of a central, and coordinated mechanism into which all health data feeds is a major contributor to 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 data base information system with a number of stand- alone information systems within the sector, each supported by a vertical program
(3) Though a national health research policy exists, research coordination is still inadequate, contributed to by an inappropriate legal environment. In addition, 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 establishment of a comprehensive, integrated health information system that integrates data from all sources, analysis this and produces health information and intelligence in a timely manner to influence decision making. It will focus on:

(1) Improving capacity for generation of integrated and comprehensive HMIS data
(2) Strengthening the coordination of health research
(3) Building surveillance systems
(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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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%

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

No	Outcome area	Strategies	Priority interventions
1	A 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 Health public dialogues
			1.1.4 Develop effective communication infrastructure
			1.1.5 Review of the HIS policy and HIS strategic plan
			1.1.6 Development of e-health policy and an e-health strategy
			1.1.7 Establish a 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 To link health and home affairs systems
		1.2 Strengthen Health Information System Coordinating	1.2.1 Review terms of reference and composition of the Health Information Coordinating Committee (HISCC)
2	Surveillance capacity	2.1 Building a robust and integrated reliable surveillance system	2.1.1 Implement IDSR strategy
			2.1.2 Implement IHR
			2.1.3 Implement GHI
		2.2 To strengthen capacity for epidemiological surveillance	2.2.1 Institutional capacity at the health facility, regional, national level in terms of information flow, definition, data analysis and outbreak response in the context of integrated disease
			2.2.2 Conduct epidemiological studies to inform policy direction through 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(decentralisation) 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 line with dictates of legislation that establish the National Research Council (NRC).
		3.2 Provide a framework that will enhance and guide capacity building	3.2.1 Build technical, technological and infrastructural capacity of the National Health Research Department so as to enable the department to provide leadership and coordination for health research
			3.2.2 Build capacity for the National Health Research Review Board to efficiently discharge its functions of reviewing protocols and promoting 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 utility of research findings and 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 systematic management research products and their regular dissemination
			3.4.3 Strengthen the national health research system to support skills and knowledge transfer

4.6 Thematic area 5: Health products, vaccines & technologies

Key issues

Health products, vaccine and technologies are key inputs in the provision of quality health services. The health sector seeks to assure that the right product is available in the right quantity, at the right place, to the right client, at a price that individuals and communities can afford. This thematic area includes selection, procurement, warehousing and distribution, and rational use of health products, vaccines and technologies.

The procurement of health products is guided by the Government of Swaziland's Public Procurement Regulations of 2012. These regulations provide guidance on how public sector procurements will be carried out. The health sector is currently in the process of developing and enacting the Medicines and Related Substances Control Bill, which will see 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 undergoing restructuring towards greater efficiencies and optimization of the limited space available. Distribution of health products is currently done from the national warehouse directly to facilities according to a predetermined scheduled.

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 standardised systems for health commodities monitoring, such as stock out monitoring, outside of standalone platforms being used to monitor antiretroviral medicines
- Weak monitoring of 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 availability of quality health products in a timely and effective manner.

Key innovations

A greater emphasis will be placed on inventory management at facility and central level, and monitoring 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
Health products	% availability of tracer classes of medicines at facility level	75	85	95%
	% of tested antimicrobials resistant to commonly used products			

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 Enforcing the use of STG/EML in the public sector and encouraging the private sector to comply
			1.1.3 Establishing a mechanism that will enable MOH to coordinate and monitor the performance of PTCs
			1.1.4 Provide support to introduce vaccines for under-5s, 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 of 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 the implementation of the NHSSP II. 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 in relation 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) with several other health regulatory frameworks awaiting approval (e.g. Public Health Bill, Nursing Bill, Medicines and Related Substances Control Bill, Pharmacy Bill, etc.). Also, 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 into leadership positions based on seniority without being prepared for the position. Additionally, people 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 on issues relevant to health, limiting information sharing and consumer feedback. The current forums (e.g. Sibaya) that do exist are 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. Additionally, the lack of clarity on decision-making structures within the MoH is affecting health service delivery. These are caused by the 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 for implementation of regulations will also be focused on, to ensure these can be 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
Governance & regulation	# of reviewed and updated health regulations	0	3	5
	# of independent regulatory mechanisms in place	3	5	6
	% of filled position in the approved organogram			
	# of national public dialogue forum conducted		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 in a staggered manner
			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 to all citizens.

5.1 Key Issues

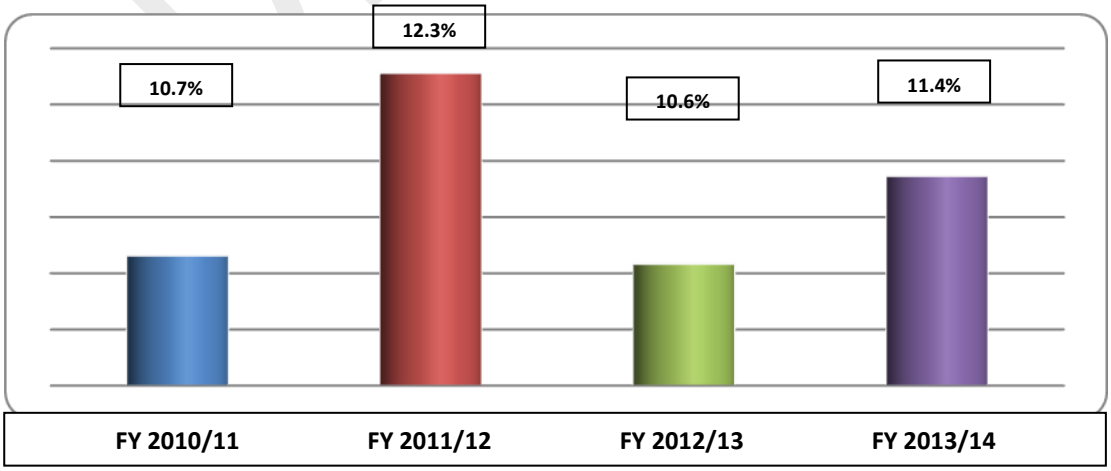
Insufficient Resources for Health

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 mobilisation 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 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 South 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 level of external resources contributing to the health sector in FY 2012/13 was estimated to be $81.4 M, which represents an increase of 17% 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 mobilised, 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 relates to financial management of health resources. Current financial management practices are characterised by limited or inadequate systems that promote 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.

While healthcare organisations' primary priority 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 Utilisation

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 v. 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), 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) in the opportunity to enjoy life and pursue one's life plans. Ultimately, every Swazi 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 $USD 57M in 2001 (or $65 per capita) to an estimated $USD 310M in 2013 (or $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, analysing 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 maximise 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. **Mobilise New Resources:** Resource mobilisation 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 mobilising domestic and international resources. By diversifying its 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 sensitise 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 mobilisation 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 applying to alcohol) and a 32.5% excise tax. These receipts 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 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 immunisations. 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. Recognising 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. **Utilisation of a Holistic Approach to Health Financing:** Utilising a holistic approach will enable the Ministry of Health to adequately address existing health financing issues and identify sustainable sources and develop key long-term strategies to financing the HSSP II. The primary focuses 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 the solid foundation to generate evidence that will be used to inform strategic planning and decision-making. The key focuses 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

Thematic area	Indicators	Baseline	Mid term	Target 2018
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%

Table 31: Strategic focus, and selected priority interventions

No	Outcome area	Strategies	Priority interventions
1	Adequate resources	1.1 Institutionalize financial processes that tracks and manages 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 mobilise resources for health
			2.1.3 Optimize the facilities fees system (e.g., user fees) in order to enable sustainable care delivery through the 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 utilisation 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 harmonisation 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 THE NHSSP II

This chapter presents the implementation arrangements of the strategic plan. It outlines the management of the health sector, roles and responsibilities of stakeholder and decentralization of health services. The focus of the 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 the 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 organisation structures, systems and processes that are responsive to the needs of the clients and will take cognisance of the resource constraints.

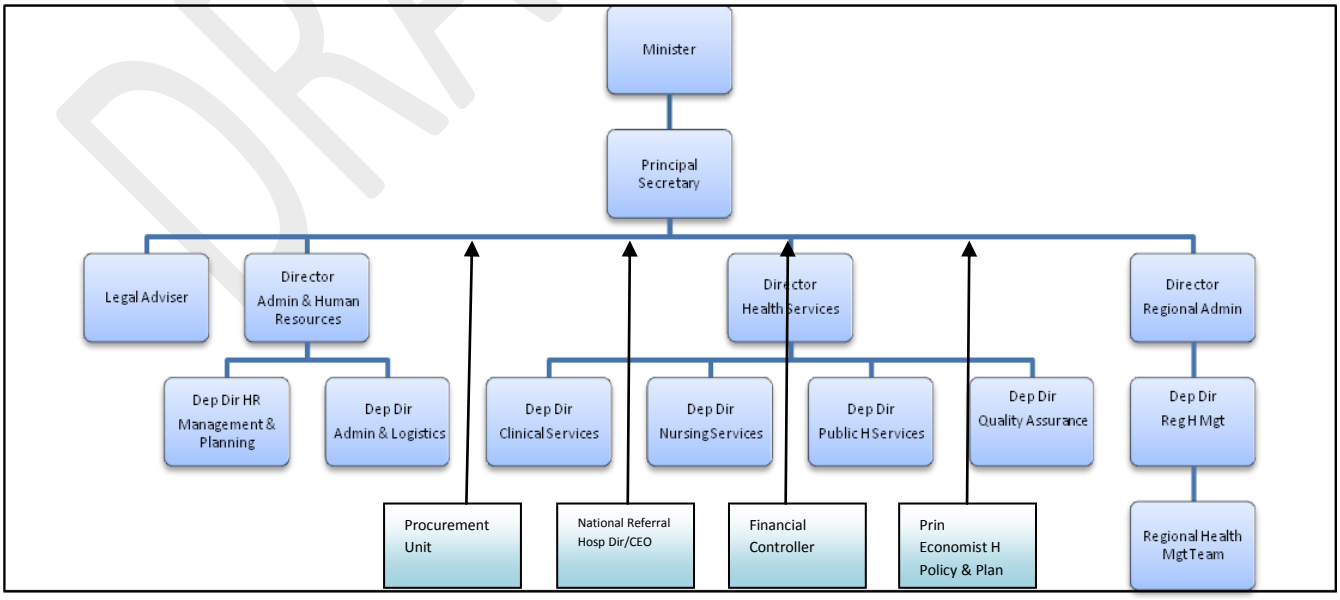
6.1 Management of the health sector

The NHSSP II aims to strengthen the governance and management capacity of MOH and 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, NGO's, the Private sector and Development partners. This is because the social determinants of health are defined in a much broader context than the health sector itself. 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 decentralisation remain the main strategy for improved health care delivery. The NHSSP II is cognisant 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 reflected 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

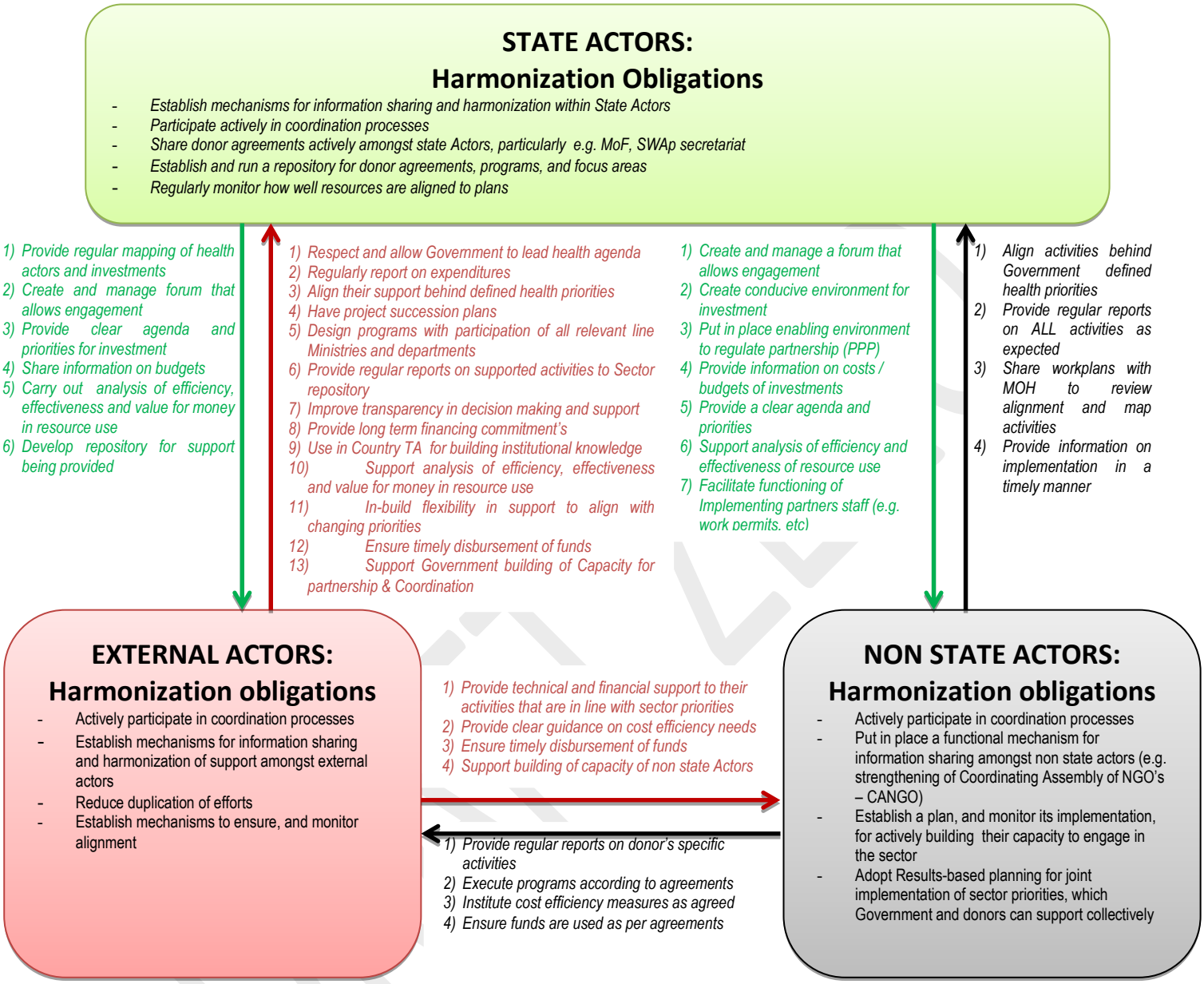
The health sector is operating under a highly supportive environment with wider stakeholder involvement and partnerships. Whilst the Ministry of health maintains its stewardship role, the stakeholders have different roles in attaining the vision, mission and strategic objectives of NHSSP II. Below is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

Table 32: Roles of different stakeholders in NHSSP II implementation

Actors	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 required guidelines and tools for improved quality of care are available iv) Ensure agreed programs / projects are appropriately designed, especially focusing on o Sustainability strategies to ensure continuity of support o Have clear hand over strategies at inception of projects v) Ensure decentralisation 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 the interventions and the provision of services ix) Facilitate the partnership process at all levels to ensure 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 sustainability is clearly designed in their support iv) Actively monitor, and ensure alignment of their support to 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 harmonization of their 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 RHMT's **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 different actors to each other

In line with the above proposed roles, the obligations of different actors 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, it is the aim of decentralization program to devolve authority and responsibility in the implementation, management, coordination, monitoring and evaluation of health services. There is need for fast-tracking the review of the Ministry of Health's 1990 Decentralization Policy.

The decentralization management structures are as follows; 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)

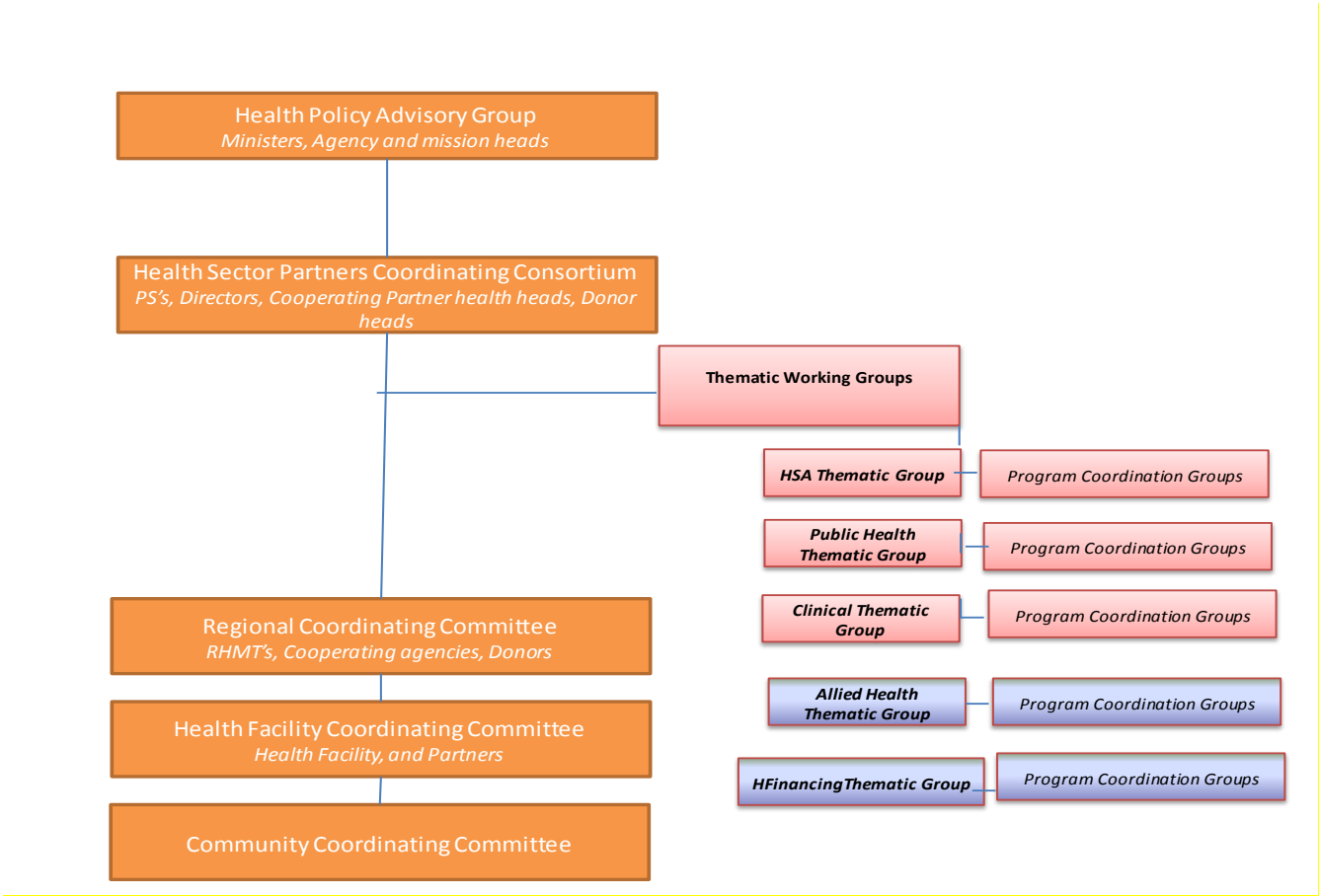
The health SWAp was established as a tool that addresses health sector planning, management, resource mobilzation and allocation.

A Sector Wide Approach is an approach to support 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 the objectives of the NHSSP II. 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 the health interventions shall support the implementation of the NHSSP II. 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 in an incremental approach.

Figure 14: Proposed SWAp Coordinating Structure (Unabridged)



6.5 Public Private Partnerships (PPPs)

The National Public Private Partnership Policy, endorsed November 2009, confirms the Government's commitment to collaborate with private stakeholders by setting a conducive regulatory and institutional framework for the policy's implementation. It focuses on putting in place 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. Limitations in resources contain government's efforts for the development of their health sectors. Difficulties persist in the provision of quality health care and the effective distribution thereof, whilst taking issues of geography, unsound infrastructure, and diversity 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 seen 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, 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 a time-frame of an initial five year period, 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.
4. A Communication Strategy for sensitization and raising awareness to 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 mobilisation, 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, 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 agreement and capacity issues in terms of personnel assigned and systems.

Regarding the policy environment, there is need to set up guidelines between MOH and donors whilst a aligning with MOEPD AID Policy 1997. Memoranda of Understanding should be in place for all donors involved and a reporting mechanism should be established. Because of the volumes of donors involved in the health sector, an external aid office within MOH through which all aid will go through.

CHAPTER 7: MONITORING AND EVALUATION OF THE NHSSP II

The Monitoring and Evaluation framework for this NHSSP II 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 different data for the identified indicators for monitoring progress in different thematic areas of the plan,
(2) The data management platform, to ensure the data is collected as and when required to inform the decision making process, and
(3) The mechanisms for the review and evaluation of progress in the 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: routine HMIS, vital statistics, surveillance, surveys and research as 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 the 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 immunised 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 & non communicable 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 non communicable 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 min for urban and 14 min in 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 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) Development of guidelines and SOPs for the different data sources, to guide them in generating and sharing of required data.
(3) Establishment of a fully-fledged IT unit within the MOH, with the IT infrastructure and staffing needed to coordinate, and support the different sources for the health data
(4) Build linkages with the related Ministries for data housed / managed outside of the Ministry of Health such as vital statistics (Ministry of Home Affairs), housing, water / sanitation.
(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 of this.

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. The performance monitoring shall be carried out at regular intervals. The different levels involved in the planning and 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 the NHSSP II objectives. The annual operational plans shall form the basis for continuous, quarterly and annual monitoring, while the 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 levels of the sector: Health facilities, regions and the national level. For each of these, a detailed breakdown of key activities against the 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 review 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 the NHSSP II, while the end term evaluation shall inform the development of the next NHSSP.

7.4 Program level strategic planning

This NHSSP II provides the platform around which programs (disease, or system based) should be elaborating their strategic approaches. To ensure clear alignment to the 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 needs 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 utilisation 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 & non communicable 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 non communicable 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 Abuse							

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Budget available	Responsible unit(s)	Key activities	Timeframe			
							1	2	3	4
			-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 development	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
			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 utilisation 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 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 utilisation 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 & non communicable 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 non communicable 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 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	

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Programme interventions
			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 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 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	

NHSSP II domain area	Thematic area	Outcome areas	Strategies	Programme interventions
			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 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 utilisation 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 therefore 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 Non-Communicable Diseases – The scope of prevention, management and control of Non-Communicable 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 organised into the following levels to distribute the above mentioned 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. The process for a 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 that are needed for the implementation of the EHCP 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 the Quality Asassurance and Standards.

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