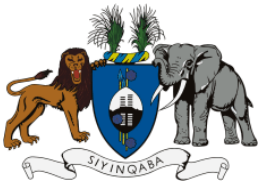
World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

SWAZILAND

World Health Organization
REGIONAL OFFICE FOR Africa



WHO COUNTRY COOPERATION STRATEGY 2008–2013

SWAZILAND

AFRO Library Cataloguing-in-Publication Data

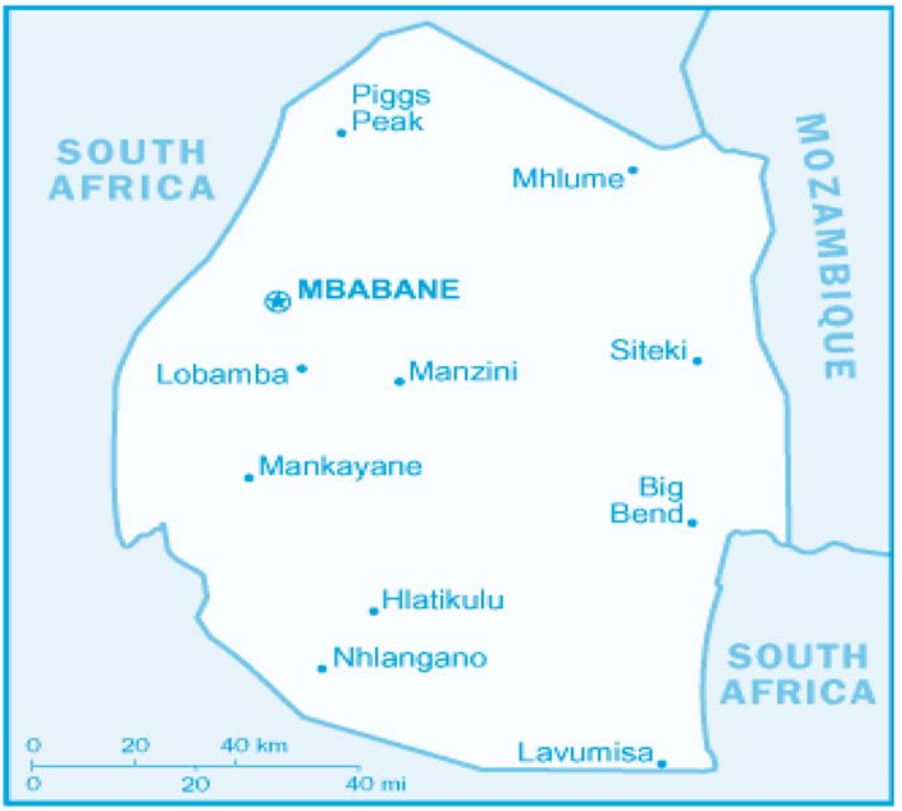
Second Generation, WHO Country Cooperation Strategy, 2008-2013, Swaziland

1. Health Planning
2. Health Plan Implementation
3. Health Priorities
4. International Cooperation
5. World Health Organization

ISBN: 978 929 023 1158 (NLM Classification**:** WA 540 HS9)

Printed in India

MAP OF SWAZILAND



CONTENTS

FIGURES

TABLES

ABBREVIATIONS

AFRO	:	World Health Organization Regional Office for Africa
AIDS	:	acquired immunodeficiency syndrome
ART	:	antiretroviral therapy
CCS	:	Country Cooperation Strategy
CDR	:	crude death rate
CSO	:	Central Statistics Office
DOTS	:	directly-observed treatment short-course
FLAS	:	Family Life Association of Swaziland
HAPAC	:	HIV/AIDS Prevention and Care
HIMS	:	Health Information Management System
HIV	:	human immunodeficiency virus
HRIS	:	Human Resource Information Systems
HSC	:	Health Service Commission
ICST	:	Intercountry Strategic Team
IEC	:	information education communication
IM	:	infant mortality
M&E	:	monitoring and evaluation
MDGs	:	Millennium Development Goals
MMR	:	maternal mortality rate
MEPD	:	Ministry of Economic Planning and Development
MOHSW	:	Ministry of Health and Social Welfare
MSF	:	*Medecins Sans Frontieres* (Doctors Without Borders)
MTSP	:	Medium Term Strategic Plan
NCD	:	Noncommunicable disease
NEPAD	:	New Partnership for Africa's Development
NERCHA	:	National Emergency Response Council
NGOs	:	nongovernmental organization
NHSSP	:	National Health Sector Strategic Plan
PMTCT	:	prevention of mother-to-child transmission (of HIV)
PRSAP	:	Poverty Reduction Strategy and Action Plan
ROC	:	Republic of China
SDHS	:	Swaziland Demographic and Health Survey
SNAP	:	Swaziland National AIDS Programme
SPEED	:	Swaziland Programme on Economic Empowerment and Development

SWAp	:	sector-wide approach
TASC	:	The AIDS Service Centre
TB	:	tuberculosis
TFR	:	total fertility rate
U5M	:	under-five mortality
UN	:	United Nations
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNGASS	:	United Nations General Assembly Special Session
UNICEF	:	United Nations Children's Fund
USG	:	United States Government
VAC	:	Vulnerability Assessment Committee
WCO	:	WHO country office
WFP	:	World Food Programme
WHO	:	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The Country Cooperation Strategy (CCS) is a medium-term vision for World Health Organization (WHO) cooperation with Swaziland. It defines a strategic framework for working with the country, articulating WHO's contribution to national health development, aligning its work with national health priorities, harmonizing with other development partners - the UN family, bilateral and multilateral agencies - to provide coherent support, contributing to poverty reduction strategies (PRS), the UN Development Assistance Framework (UNDAF) and sector-wide approaches (SWAps) and providing a basis for assessing progress and improving WHO cooperation.

The 2008-2013 CCS is a successor to the 2002-2005 CCS. The strategic agenda seeks to achieve its priorities through the following strategic directions:

(a) **Improve the health sector stewardship function of the Ministry of Health and Social Welfare (MOHSW):**

Here the CCS focuses on leadership and stewardship in the health sector and various aspects of health systems development. It supports the regulation of health practice, responsiveness of the health sector to pressing needs, effective management of human resources, increased investment in health, and management of the health information system.

(b) **Reduce excess mortality due to high disease burden:**

The focus is on disease control, child and adolescent health, and maternal and neonatal health. In this regard, efforts will be concentrated on HIV and AIDS, tuberculosis, vaccine-preventable diseases, communicable and noncommunicable diseases namely cancers, diabetes, cardiovascular diseases, mental health, and other emerging diseases.

(c) **Strengthen health systems to improve health outcomes:**

Focus will be on strengthening health systems capacity for strategic planning, implementation of plans, quality assurance, management of human resources and health facilities, and definition of essential health care packages for each of the different levels of the health care delivery system. This CCS also intends to strengthen the health information system, including development of a national health information sharing and dissemination framework.

The document was developed through a wide, rigorous, consultative and systematic process that included an analysis of the health and development challenges of the country, characterization of development assistance as well as partnerships that pertain to the country, and consideration of the policy framework of the World Health Organization at global and regional levels. A group comprising the WHO representative (WR), staff members of the WCO, and individuals from the MOHSW and civil society drove the process and did the consultations with the partners. The process also included a review of the extent to which the 2002 - 2005 CCS was implemented. It articulated a strategic agenda for the period 2008 - 2013 and description of arrangements for implementing the document. Information which forms the basis of this document was obtained through a combination of literature review and key informant interviews with partners and stakeholders representing, among others, the

health sector, civil society, international and national nongovernmental organizations, and bilateral and multilateral partners.

The literature reviewed during the process of developing this document suggests that the country is unlikely to achieve its health sector vision of "giving rise to a healthy population that will live longer and socially fulfilling lives by 2015." This is due, in part, to serious socio-economic constraints and operational challenges that the health sector is experiencing. Some of the constraints and challenges the country is facing include a declining or stagnating economy, an extensive HIV and AIDS pandemic, widespread unemployment, high levels of poverty and natural disasters.

A review of the extent to which objectives of the 2002-2005 CCS were implemented was conducted. Findings of this review indicated that implementation of the CCS was limited due to the broad nature of the CCS agenda, the delayed publication and launching of the 2002-2005 CCS document and the fact that the first generation CCS document had not been integrated into the managerial processes of WHO. As a result, its articulation with the biennial operational plans was not defined. The alignment of the second generation CCS with the Medium Term Strategic Plan of WHO (2008-2013) and its defined role *vis-a-vis* the biennial workplans should go a long way towards solving some of the perceived implementation problems.

The 2008-2013 CCS is focused on generating the desired catalytic and cascading effects on the overall performance of the health sector. It also intends to contribute to improving the stewardship function of the health sector, reducing mortality due to high disease burden and improving the responsiveness of the WHO country office. The strategic agenda of this CCS has been designed to contribute to disease prevention, management and control. Health systems development and strengthening has also been identified as key to the achievement of the set health agenda.

Section 1 of the document summarises the underlying principles and justification for updating the first CCS. Section 2 outlines the main health and development challenges and identifies areas of focus for the second generation CCS. While Section 3 discusses information on aid flow and expenditure frameworks, Section 4 states the challenges and strategic orientations of the WHO Regional Office for Africa and Headquarters. Section 5 presents the WHO Medium Term Strategic Plan as well as WHO country office presence. It outlines the support from the Intercountry Support Team including how the organization will work as one. The new strategic agenda, the strategic directions and objectives for WHO cooperation in Swaziland are set in Section 6. Section 7 spells out the country office's responsibilities as well as those of the Regional Office and Headquarters. The last section provides the monitoring and evaluation framework for CCS2.

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) is a medium-term strategic framework for collaboration between WHO and the Government of Swaziland. It is informed by national health priorities and the General Programme of Work (GPW) which is a long-term vision of WHO. The CCS is WHO's key instrument for articulating its contribution to national health development, aligning its work with national health priorities, harmonizing with other development partners – the UN family, bilateral and multilateral agencies – to provide coherent support, contributing to the Poverty Reduction Strategy and Action Plan (PRSAP), the UN Development Assistance Framework (UNDAF), sector-wide approaches (SWAps) and attainment of MDGs, and providing a basis for assessing progress and improving WHO cooperation.

This second generation CCS for Swaziland (2008-2013) is a sequel to the first CCS (2002-2005). It is aimed at addressing the gaps and pending issues emanating from the analysis of the first CCS, including the emerging national health challenges. Therefore, the strategic agenda for CCS 2 seeks to achieve its priorities through the following strategic directions:

(a) **Improve the health sector stewardship function of the Ministry of Health and Social Welfare (MoHSW):**

By focusing on leadership and stewardship in the health sector and various aspects of health systems development; supporting the regulation of health practice, responsiveness of the health sector to pressing needs, effective management of human resources, increased investment in health, and management of health information system.

(b) **Reduce excess mortality due to high disease burden:**

Attention is on disease control, improvement of maternal and neonatal health including child and adolescent health. Efforts will centre on HIV and AIDS, tuberculosis, vaccine-preventable diseases, mental health, communicable and noncommunicable diseases, and other emerging diseases.

(c) **Strengthen health systems to improve health outcomes:**

Focus will be on strengthening health systems capacity for strategic planning, implementation of plans, quality assurance, management of human resources and health facilities, and definition of an essential health care package for each of the different levels of the health care delivery system. This CCS also intends to strengthen the health information system, including development of a national health information sharing and dissemination framework.

The formulation of the strategic agenda followed a wide, rigorous, consultative and systematic process under the leadership of the WHO representative (WR). First, a multidisciplinary team was constituted with concise terms of reference, milestones and timelines. Services of a local consultant were sought to facilitate the review of the first CCS as well as national and international policy documents in order to establish country office

competencies. A SWOT analysis using focus group discussions and interviews with government, development partners, NGOs and the private sector was conducted. Information obtained was used to define strategic orientations, constraints and challenges. After gathering the required information, consensus was built among all stakeholders focusing on what WHO should concentrate on while giving support to others. Having exhausted the aforementioned steps, the document drafting process was undertaken, the culmination of which is this CCS 2 document.

SECTION 2

COUNTRY HEALTH ANDCHALLENGES

The national health policy states that the vision of the health sector is to give rise to a healthy population that will live longer and socially fulfilling lives by 2015. For this goal to be realized there is need for added efforts by the health sector to devise strategies that seek to address the emerging health and development challenges. The country's socio-economic challenges include the HIV/AIDS pandemic, TB-HIV co-infection, declining and/or stagnating economic growth, high levels of unemployment, chronic poverty and natural disasters.

2.1 ECONOMY

Swaziland is classified as a lower middle income country. However, the distribution of income is highly skewed and, as a result, the majority of people are poor. The percentage of people living below the poverty line has increased over time, rising from 66% in 1995 to 69% in 2001 (MEPD, 2001). Unemployment also depicts an upward trend, increasing from 22% in 1995 to 29% in 2002 (CSO, 2002). This has resulted in a large part of the population being dependent on food aid.

Analysts state that in the 1970s and 1980s, economic growth had been volatile but on average high. Since 1991, however, the economy has expanded at just over 3% per year on average, and the rate of growth since 2000 has fallen further to 2.4%, nearly two percentage points lower than growth in other SACU member countries. GDP per capita figures show a slight positive trend, growing at about 0.8% per year since 2000, mainly reflecting the effects of a falling population as a result of HIV/AIDS and migration to South Africa. Following a slight upturn in 2006, growth returned to 2.3% in 2007 as a result of drought which has heavily affected agricultural output, forest fires which have had a large impact on the forestry sector in particular, and deceleration in the sugar sector. The outlook over the next few years, given current policies, is for growth around 2% (World Bank, 2008).

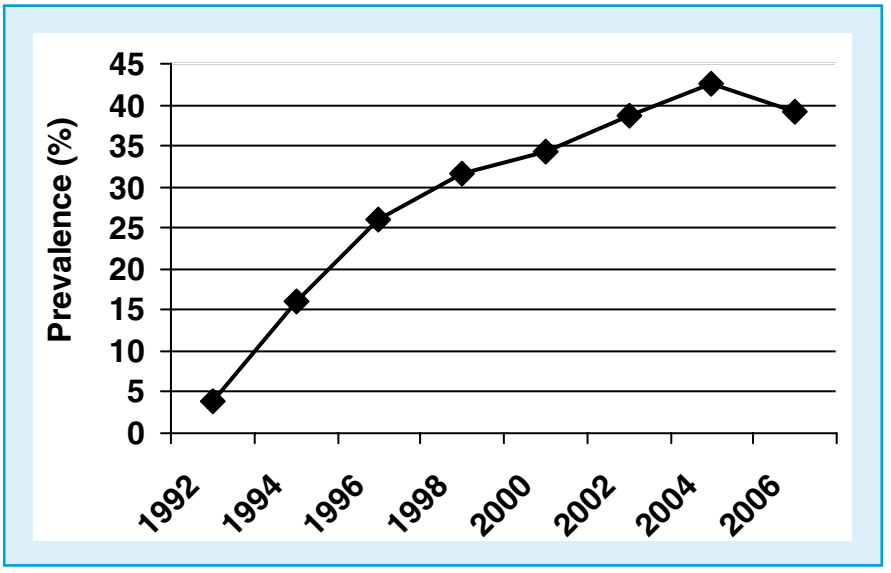
2.2 HIV/AIDS AND TB

The HIV/AIDS epidemic continues to pose a major threat to the Swazi nation and its impact is already felt in all sectors. It is estimated that about 210 000 to 230 000 (about a quarter of the population of 1.018 million) people are living with HIV/AIDS in the country. The prevalence rate among pregnant women has escalated from 3.9% in 1993 to 39.2% in 2006, having reached a peak of 42.6% in 2004, Figure 1. Tuberculosis is the leading cause of morbidity and mortality among adults in Swaziland. It is estimated that TB kills 50% of HIV- infected patients and accounts for more than 25% of all hospital admissions (MOHSW Annual Health Statistics Reports).

The HIV/AIDS epidemic has also given rise to a concurrent tuberculosis epidemic in the country, with the number of new cases reported per annum rising from less than 1 500 in 1993 to over 9 000 in 2006 as shown in, Figure 2. The level of HIV co-infection in TB cases is estimated at 80%. Progress in addressing tuberculosis in the country is slow. Implementation of the DOTS (directly-observed treatment short course) strategy is currently being rolled out

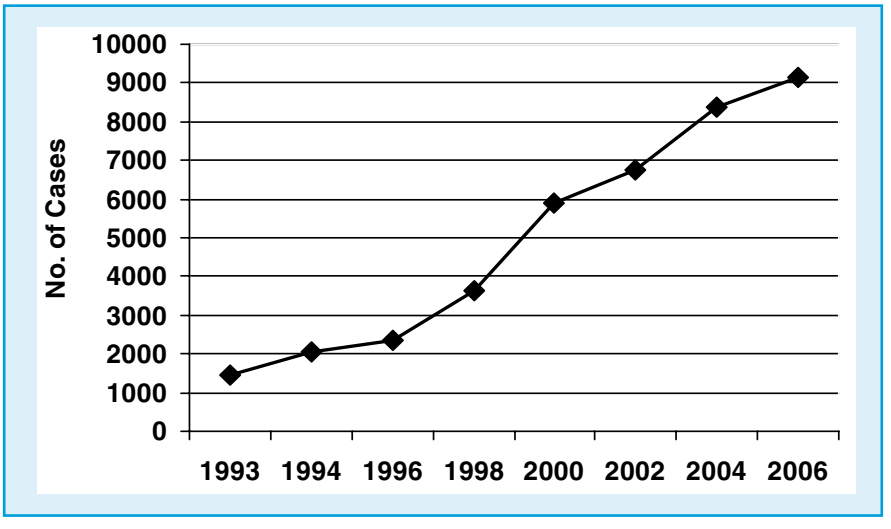
in the four regions of the country having been piloted in one region (Lubombo). The case detection rate (57%) and success rate (42%) are respectively lower than the international targets of 70% (detection rate) and 85% (cure rate). Considered against the backdrop of the trends towards the achievement of MDGs and other global targets, the country has made commendable progress in malaria control; and progress towards meeting the MDGs and Abuja targets is reasonably within reach. However, given the current trends, MDG targets for HIV/AIDS and TB are less likely to be met by 2015.

Figure 1: HIV prevalence among antenatal clients



Source: MoHSW 2006.

Figure 2: TB case notification for all cases



Source: MoHSW 2007.

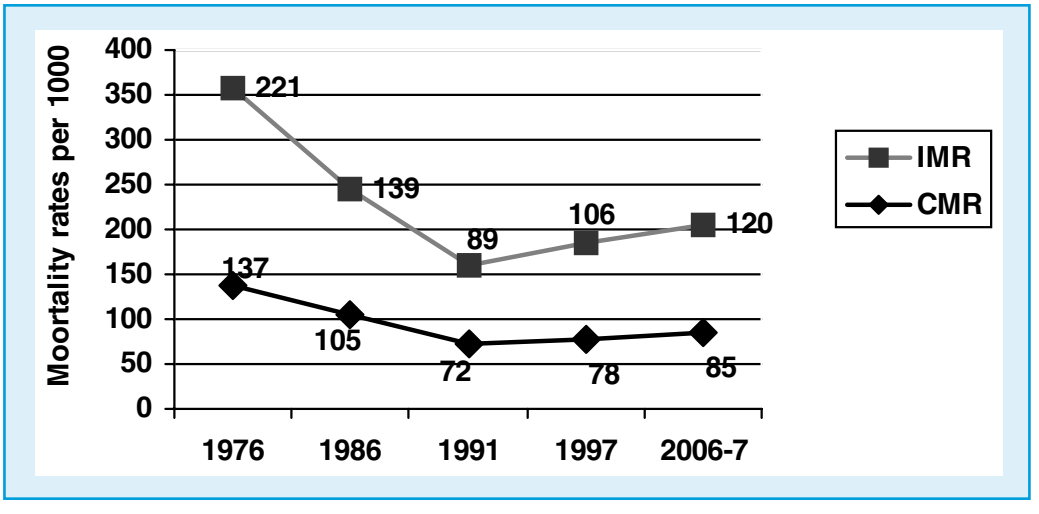
2.3 MATERNAL AND CHILD HEALTH

High maternal and neonatal morbidity and mortality is a cause for concern. It has increased in line with maturation of the AIDS epidemic and as a result the maternal mortality ratio increased from 229 to 589/100 000 (DHS 2007). The majority of maternal deaths are due to indirect causes and are attributed to medical conditions and puerperal sepsis related to HIV. Direct causes include puerperal sepsis, complications of abortions, and haemorrhage implying that the epidemiology of maternal deaths has changed due to the HIV/AIDS pandemic. Women of reproductive age are also at high risk of cervical cancer due to high prevalence of HIV and multiple sexual partners. The situation is further exacerbated by limited capacity for pathological diagnosis and effective treatment services.

The infant mortality rate increased to 85/1000 in the period 2002-2006 following a decline to 72/1000 in 1991. A similar trend was observed in the under-five mortality rate which increased to 120/1000 in the period 2002-2006, after it had declined to 89/1000 live births in 1991, from 221in 1976 as shown in, Figure 3. This is an ostensible demonstration that all gains in quality of life that had been achieved in the past have now been lost. In 2005, mother-to-child transmission of HIV infections was reported to have been reduced by 1.74% (MOHSW, 2005). Access to PMTCT has been scaled up with the result that by mid-2006 PMTCT services were available in 110 of 154 health facilities.

Maternal and child health, therefore, constitutes a serious challenge to the country, significantly reducing the prospects of achieving the health MDGs (4,5,6) and calling for specific effort in that regard.

Figure 3: Infant and under-five mortality rates



Source: *SDHS 2007*

Youth Friendly Corners were established in most health facilities and health service providers were trained on provision of youth-friendly health services. However, these services are disproportionately under-utilized, hence 27% of all antenatal care clients are adolescents. Early initiation of sex, which stands at an average of 16 years for girls and 18 years for boys, renders them vulnerable to HIV infection. Hence, HIV prevalence is high among young adults. Ostensibly, this requires concerted efforts and strategic interventions in this area (SDHS, 2007).

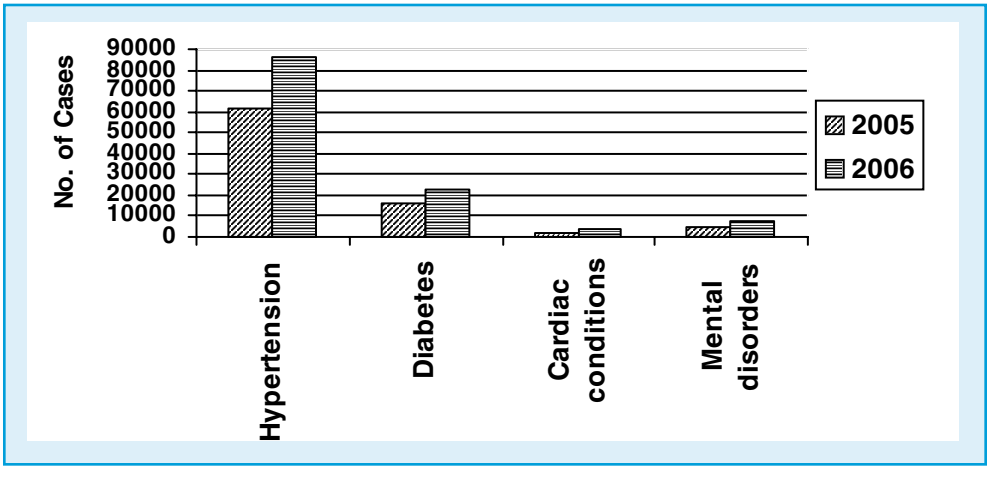
Swaziland had achieved high routine immunization coverage until the late 1990s; a fluctuation has been observed in DPT/HEP3 since 2000. Consequently, routine measles immunization coverage was 60% in 2006 while that of DPT/HEP3 was 68% in that year (MOHSW, 2007). This coverage is in contrast with the SDHS, 2007 which reported 92% for both measles and DPT/HEP3. The difference in these figures indicates inconsistency in the reporting structure, hence the need to strengthen the reporting system. Evidence also suggests that low immunization coverage combined with paediatric AIDS have reversed the gains that the country had achieved in child survival in previous years. In the light of the prevailing circumstances, the country is not poised to meet the MDGs.

The country is experiencing an increasing trend of conditions related to nutritional deficiencies. Some 29% of children under five years of age are stunted, an indication of high levels of chronic malnutrition. The high HIV prevalence has led to an increase in children with low weight for age, muscle wasting and altered metabolism requiring increased use of micronutrients. The situation is further worsened by the re-emerging nutritional deficiencies like protein calorie malnutrition and pellagra. In women of childbearing age, malnutrition is associated with most risk factors for maternal and perinatal mortality including pre-term deliveries and low birth weight.

2.4 NONCOMMUNICABLE DISEASES

Noncommunicable diseases (NCDs) have received inadequate attention, given the serious double burden of disease that prevails in the country. Out-patient data from all health facilities indicates that the country is experiencing an increase in hypertension, diabetes, cardiac conditions and mental health disorders, Figure 4. Data on cancers is not available, hence a STEPS survey is currently being undertaken with WHO support to gather baseline epidemiological data on the prevalence of NCDs in the country. It is expected that after this survey, a plan based on the WHO strategy for the control of chronic noncommunicable diseases will be developed.

Figure 4: Outpatient NCD data, 2005-2006



Source: *MoHSW 2006.*

2.5 HEALTH SYSTEMS

The country's health system is experiencing persistent challenges such as low budget, depleted infrastructure and inadequate supplies to respond to the heavy burden of disease. Health management systems, including financial management and budgeting, are centralized and mostly unresponsive to the new health development challenges at different levels of service delivery. The increase in patient loads, long queues, shortened consultation times by health care providers combined with the complexity of many cases associated with HIV and AIDS, have all militated against the quality of health care. The national capacity to effectively manage information, research and knowledge requires strengthening. National health information is not easily accessible to potential users due to uncoordinated health information systems. This leads to health information about the country being either outdated and/or unavailable in national, regional and international databases.

Swaziland's health system is faced with challenges of inadequate human resource capacity at all levels, yet the demand for health services has increased over time due to the high burden of disease. However, the budget for the sector is not enough to develop the required human resource capacity in terms of quantity and quality of personnel. The lengthy recruitment processes impact negatively on the availability of human resources for health. Although nursing vacancy rates have come down, in April 2008 the MoHSW still had vacancy rates of 36% amongst medical staff, 40% amongst dental staff, and 52% amongst pharmaceutical staff. In the medical cadre, 40% of these unfilled posts had been vacant for more than six months (MoHSW, 2008). In an effort to address these challenges, the MoHSW, with assistance from WHO, is developing a human resource management policy and plan, as well as updating the schemes of service for health personnel. The establishment of a Health Service Commission is to be implemented during the second CCS.

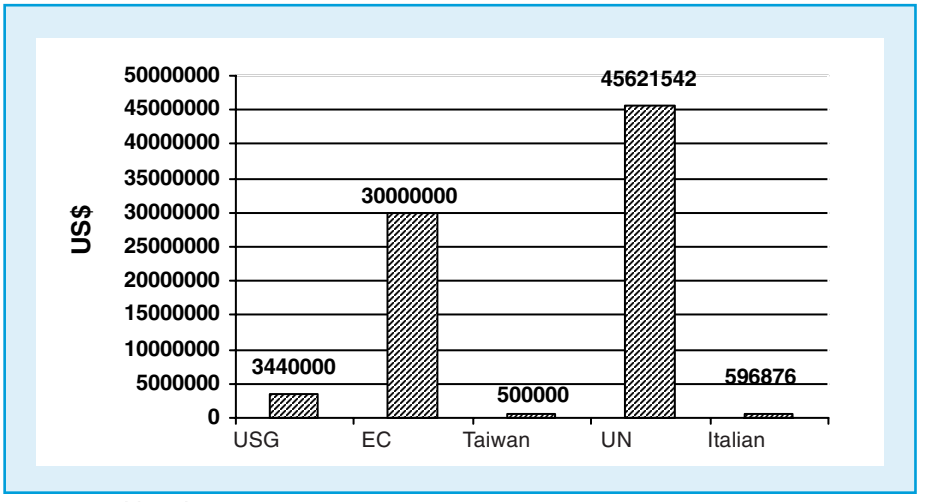
Significant progress has been made in developing an effective policy framework for health care service delivery during the life span of CCS1. The new national health policy is now in place and a number of auxiliary policies have been developed whilst others are in the process of development. The National Health Strategic Plan is nearing completion with most programmes having developed their own workplans in line with the MOHSW draft strategic plan. However, the regulatory framework and policy for different areas of the health care system still need strengthening. Policies are needed in areas such as food and nutrition, blood transfusion services, laboratory services and the health information system, while legal and regulatory frameworks are needed for various categories of health practitioners and for the control of drugs and medicines.

While the private sector is regulated to the extent that individual practitioners are required to register with statutory professional councils, there is no requirement to accredit health facilities. As a result of this limitation, the private health sector rarely complies with dictates of national guidelines and technical requirements such as reporting and continuing education. The practice of alternative medicine is currently not regulated and has remained informal.

2.6 HEALTH FINANCING

Health services in the country are mostly funded by the Government with the exception of HIV and AIDS activities which receive substantial funding from development partners such as the Global Fund, European Union, the United States Government, Italian Cooperation, Republic of China on Taiwan, and UN agencies. Contributions made by these agencies to the health sector are shown in, Figure 5.

Figure 5: Contribution of multilateral and bilateral agencies to the health sector, 2007 (US$)



Source: World Bank 2007

Health services in the country are heavily subsidized by government. The majority of clients in the country, including civil servants, pay for health services from out-of pocket. Clients in the country spend 41.7% out of pocket for private health expenditure compared to clients in Botswana (27%), Namibia (15.5%), and South Africa (17.4%) *(WHO, 2008)*. Although there has been an improvement in the budget allocated to MoHSW from 7.1% (2007/8) to 10.2% (2002/9), there is still a need to increase the national health budget to the Abuja Declaration commitment of 15%.

A large proportion of the health budget (99.9%) in 2007-2008 and (99.9%) in 2008-2009 was allocated to recurrent activities, approximately 31.5% of which is allocated to personnel emoluments. According to actual figures of the 2006-2007 health budget, a significantly higher proportion of the health budget was allocated to recurrent expenditure with a higher proportion devoted to curative services (62.1%); and only 16.6% spent on public health services. This has affected the investment made in the development and maintenance of the health infrastructure and equipment. Furthermore, it has been observed that available resources are disproportionately allocated to the response to HIV and AIDS compared to other diseases such as noncommunicable diseases (NCDs).

2.7 SUMMARY OF KEY CHALLENGES

Health service delivery in the country is currently not considered satisfactory by the public and is not commensurate with the investments made, especially in the public sector. Human resource and infrastructural constraints contribute significantly to this outcome. Leadership challenges within the Ministry of Health and Social Welfare at both managerial and programme levels also aggravate the situation. Private sector involvement in health service delivery is recognized by government. However, the stewardship role of the Ministry should be strengthened in order to harmonize the quality of service delivery.

The country's health challenges can be summarized as follows:

(a) A severe HIV/AIDS epidemic which has had a negative impact on all health indicators;

(b) High levels of poverty, estimated at 69% of the population (below the poverty line);

(c) High TB-HIV co-infection rates resulting in the highest TB notification rates in the world;

(d) Mortality rates, such as crude death rates, infant mortality rates, under-five mortality rates, and maternal mortality rates, have all risen significantly since the early 1990s;

(e) There is a growing burden of noncommunicable diseases;

(f) The interrelated effects of HIV/AIDS, high poverty levels and recurrent droughts have led to high malnutrition rates;

(g) Poor capacity in the health sector has resulted in systemic weaknesses in the health system, relating to human resources, financing , policy and planning, and service delivery;

(h) Because of its classification as a lower middle-income country, there are few donors in the health sector, and the Ministry has not yet developed the capacity to coordinate the donors and other partners.

SECTION 3

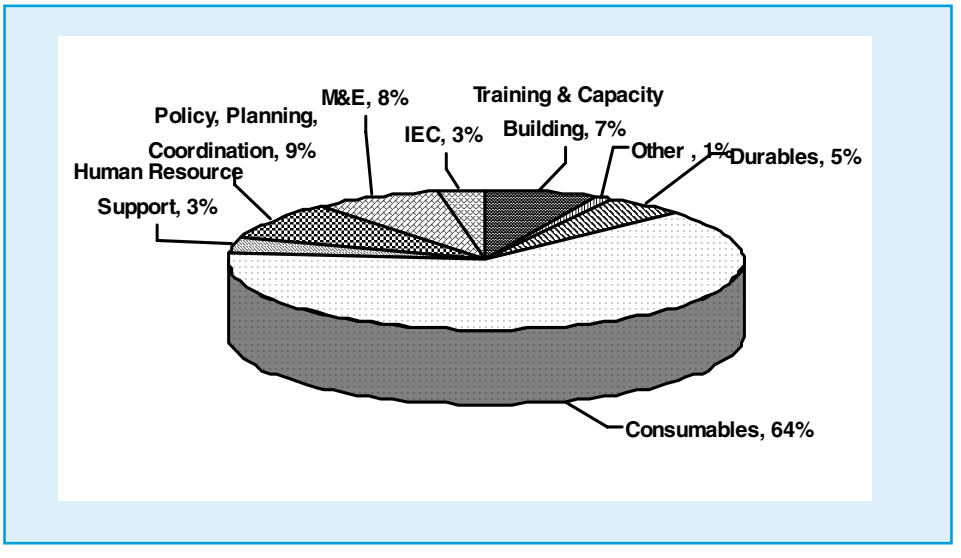
DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 INTERNATIONAL AID

External assistance in Swaziland accounts for less than 5% of GDP. In 2007, almost 80% of external support flowed into public health programmes, with approximately 60% directed to the Swaziland National AIDS Programme (SNAP), highlighting the important role that development partners have played in supporting the scaling up of the response to HIV/AIDS. Development partner support, however, comes earmarked for specific programmes and activities, disregarding other priorities (such as human resources for health, health information system, environmental health, and other health systems-related interventions).

The expenditure distribution of the support is reflected in **Figure 6.** It is worth noting that 64% of support was provided as consumables such as pharmaceuticals, other medical supplies, reagents, and other commodities. Other forms of support including development of IEC materials, durables and human resource support, as well as salaries paid to externally funded staff working within MOHSW, accounted for 12% of the total contributions.

Figure 6: External support by activity type, 2007



Source: MoHSW, 2007.

3.2 KEY INTERNATIONAL DEVELOPMENT PARTNERS

Since the expiry of the previous CCS in 2005, new aid agencies have become active in providing development assistance to Swaziland. The Global Fund to Fight AIDS, Tuberculosis and Malaria, a financing mechanism aimed at securing, managing and disbursing resources to reduce the incidence of HIV/AIDS, tuberculosis and malaria globally, and to mitigate the impact on those infected and affected by these diseases, has played a major role in Swaziland in recent years. Similarly, other global health partnerships such as The President's Emergency Plan for AIDS Relief (PEPFAR), The Bill and Melinda Gates Foundation, Health Metrics Network, Clinton Foundation, etc., continue to provide support in various aspects of health.

Other development partners that are playing an increasingly significant role in supporting the health sector in Swaziland include bilateral agencies representing specific donor countries and organizations (US Government, Italy, Canada and the European Union) as well as multilateral agencies, mainly the agencies of the UN family and international NGOs. Table 1 shows examples of the areas in which key development partners work with WHO in supporting the health sector, as well as key areas that need future support.

Table 1: Development assistance and partnerships, 2008

Name of Partner	Type of Partnership	Principal Area of Intervention	Area of Intervention	Funding (US$)
UN	Multilateral	Health Systems HIV/AIDSMaternal & Child Health	Countrywide	15,878,148
US Government Agencies	Bilateral	HIV/AIDS	Countrywide	12,700,000
Italian Cooperation	Bilateral	HIV/AIDS, TB Laboratory	Countrywide	450,857
Republic of China on Taiwan	Bilateral	Medical Equipment	Countrywide	13,000,000
European Commission	Multilateral	Health Systems HIV/AIDS	Countrywide	46,285,714
African Development Bank	Multilateral	Health Infrastructure	Countrywide	5,000,000

3.3 INTERNATIONAL FRAMEWORKS, AID MECHANISMS AND MODALITIES

All health-related activities fall under the Constitution of the Kingdom of Swaziland and should be aligned with national development policies and strategic frameworks such as the NDS, the Poverty Reduction Strategy Action Plan (PRSAP) and the Swaziland Programme on Economic Empowerment and Development (SPEED). The PRSAP commits Swaziland fully to the Millennium Development Goals and the country reports regularly to UNGASS.

The country has also committed itself to various international initiatives such as the regional Health-for-All Policy for the 21st Century in the African Region: Agenda 2020, and the Millennium Development Goals. WHO also harmonizes health-related activities with the rest of the UN family agencies within the context of the United Nations Development Assistance Framework (UNDAF). The current UNDAF (2006-2010) has five pillars *viz*., HIV and AIDS, poverty reduction, food security, basic social services, and governance.

While Swaziland has not yet adopted a sector-wide approach (SWAp) to coordinate health-related initiatives and funding (whether internal or donor), the MoHSW has expressed interest in going that direction. Adoption of SWAps will improve the coordination of donor initiatives and strengthen transparency and accountability of incoming aid and alleviate duplication of efforts by partners. Following a Partners Consultative Forum for the Health Sector in March 2008, plans for implementing the SWAp are at an advanced stage.

SECTION 4

WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and to achieve the health-related MDGs. This organizational change process has, as its broad frame, the WHO corporate strategy.

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples of the highest possible level of health". The corporate strategy, the Eleventh General Programme of Work 2006-2015 and the Strategic Orientations for WHO Action in the African Region 2005-2009 outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by core functions, which are based on the WHO's comparative advantage.

These are:

(a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;

(b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

(c) Setting norms and standards, and promoting and monitoring their implementation;

(d) Articulating ethical and evidence-based policy options;

(e) Providing technical support, catalysing change, and building sustainable institutional capacity;

(f) Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas and these include:

(a) Investing in health to reduce poverty;
(b) Building individual and global health security;
(c) Promoting universal coverage, gender equality, and health-related human rights;
(d) Tackling the determinants of health;
(e) Strengthening health systems and equitable access;
(f) Harnessing knowledge, science and technology; and
(g) Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda as follows:

(a) Health development;
(b) Health security;
(c) Health systems;
(d) Evidence for strategies;
(e) Partnerships;
(f) Improving the performance of WHO.

She has also indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The global priority areas have been outlined in the Eleventh General Programme of Work.

They include:

(a) Providing support to countries in moving to universal coverage with effective public health interventions;
(b) Strengthening global health security;
(c) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
(d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
(e) Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The WHO regional priorities have been laid out in the in the Medium-Term Strategic Plan (MTSP) 2008-2013. They have taken into account the global documents and the resolutions of the WHO governing bodies, the health MDGs, and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives. These regional priorities are also articulated in the "Strategic Orientations for WHO Action in the African Region 2005-2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in

development and other determinants of health. Other strategic objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above, the Region is committed to support countries attain the health MDG goals, and assist in tackling its human resource challenge. In collaboration with other agencies, the problem of how to assist countries in sourcing finance for the goals of the countries will be done under the leadership of the countries. To meet these added challenges, one of the important regional priorities is decentralization and the installation of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may benefit maximally from the technical support provided to them.

To effectively address these priorities, the Region is guided by the following strategic orientations:

(a) Strengthening the WHO country offices;

(b) Improving and expanding partnerships for health;

(c) Supporting the planning and management of district health systems;

(d) Promoting the scaling up of essential health interventions related to priority health problems;

(e) Enhancing awareness and response to key determinants of health;

(f) Making WHO more effective at the country level.

The outcome of the expression of WHO's cooperate strategy at country level will vary from country to country depending on the country specific context and health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization as outlined in section 5.2, may be adjusted to suit each individual country needs.

SECTION 5

CURRENT WHO COOPERATION

5.1 WHO COOPERATION OVERVIEW

The current biennial Programme Budget in Swaziland, 2008-2009, constitutes the first biennium of the second generation CCS (CCS 2) and that of the WHO Medium-Term Strategic Plan 2008-2013 to which the CCS 2 is aligned. The MTSP has thirteen strategic objectives and these have guided the selection of the priority programmes for the biennium.

5.2 THE CORE FUNCTIONS OF WHO

In discharging its functions at country level, the WHO country office (WCO) is guided by WHO core functions as set out in its corporate strategy and the MTSP. These are: providing leadership on matters critical to health and engaging in partnerships where joint action is needed; shaping the health research agenda and stimulating the generation, dissemination and application of valuable knowledge; setting norms and standards and promoting and monitoring their implementation; articulating evidence-based policy options; providing technical support, catalysing change and building sustainable institutional capacity; monitoring the health situation and assessing health trends. The MoHSW looks up to WHO as the main partner in addressing national health challenges. This second generation CCS therefore aims to build on the achievements of the last CCS (2002-2005) and to use the lessons learnt to address weaknesses identified in the latter.

5.3 LINKAGES BETWEEN THE FIRST AND SECOND GENERATION CCS (CCS 1 AND CCS 2)

The first generation CCS focused on the following areas:

(a) Strengthen disease control efforts in response to the persistent high burden of disease;
(b) Improve the performance of the health system;
(c) Address environmental, water and sanitation challenges;
(d) Develop emergency preparedness and response capacity;
(e) Maximize the contribution of health to poverty reduction;
(f) Develop partnerships.

Table 2 shows the areas of focus in CCS 1, what was achieved, and the corresponding areas of focus in CCS 2 where applicable. One of the important features of the second generation CCS is to be more focused and concentrate on fewer achievable areas.

Table 2: Linkages between CCS 1 (2002-2005) and CCS 2 (2008-2013)

Priority areas CCS 1 (2002-2005)	Areas of focus identified CCS 1	Achievements	Areas of focus for CCS 2 (2008-2013)
Strengthen disease control	**HIV/AIDS and STIs** - Development of policies and guidelines relating to health sector response; - Introduction and application of new technologies; - HIV/AIDS surveillance; - Advocacy for care and support for orphans; - Advocacy for support of national efforts aimed at preventing the spread of HIV infection; - Training of health workers in the management of HIV/AIDS ;	- Policies and technical guidelines on ART, PMTCT and HTC- M&E framework- Health sector's HIV/AIDS response strategy - 9th and 10th national sentinel surveillance reports;	- Accelerate HIV prevention- Scale up universal access- Advocacy for care and support for vulnerable groups;
	TB - Strengthening surveillance and management of TB; - Integration of TB in HIV management;	- TB strategic plan and guidelines- Drug resistance treatment plan;	- Expansion of DOTS coverage- Monitoring of drug resistance- Establishment of TB/HIV activities;
	Malaria and other communicable diseases - Strengthen malaria control and epidemic preparedness and response;	- Malaria control strategic plan- Pre-elimination plan;	- Malaria elimination- Monitoring anti-malarial drug resistance- Implementation of IHR and IDSR;
	Childhood diseases - Comprehensive review of the EPI programme, introduction of new vaccines (HIB) and development of multi-year EPI plan; - Strengthen the surveillance of vaccine- preventable diseases;	- Comprehensive Multi-Year Plan- EPI surveillance indicators met- Polio eradication certification document;	- Comprehensive review of the EPI programme- Introduction of new vaccines (HIB)- Strengthen disease surveillance for EPI target diseases - Continue support to IMCI;
	Reproductive health - Strengthen capacity to prevent and manage complications during pregnancy and child birth as well as during neonatal and postnatal periods;	- Capacity to manage complications during pregnancy, child birth and neonatal period including provision of youth-friendly health services enhanced- PMTCT programme established;	- Develop MNCH road map- Strengthen emergency obstetric care and elements of sexual and reproductive health- Continue support to IMCI;
	Noncommunicable diseases - Provision of technical guidance in epidemiological information gathering; - Development of control strategies;	- Healthy lifestyle promotion activities;	- Support the finalization of STEPS surveys - Development of control strategies for various diseases;

Priority areas CCS 1 (2002-2005)	Areas of focus identified CCS 1	Achievements	Areas of focus for CCS 2 (2008-2013)
	Mental health and substance abuse - Strengthening the mental health programme.	- Supported the establishment of a database- Mental health policy- Healthy lifestyle promotion activities;	- Integration of mental health services into general health services delivery- Updating Mental Health Act;
	Nutritional disorders - Development of nutritional surveillance system; - Development of nutrition policies in collaboration with partners such as UNICEF, WFP and FAO;	- Capacity to manage nutritional disorders associated with HIV/ AIDS and severe malnutrition enhanced- Policies and guidelines for nutrition, Infant and Young Child Feeding (IYCF);	- Revitalization of Baby Friendly Hospital Initiative (BFHI) in the context of HIV. - Establishment of routine nutrition surveillance system- Continue support for policy making and for IYCF;
Improve health systems performance	- Strengthening health systems, health information system, and human resources for health;	- National Health Policy and Strategic Plan- Draft Human Resources for Health Policy and Plan- Service Availability Mapping (SAM) report- Health Matrix Network (HMN) report;	- Institutionalization of continuing education- Development of health information system continued and other departmental action plans- Finalize HRH Policy and Plan-Support establishment of HSC- Strengthen health management systems;
Address environmental, water and sanitation challenges	- Promoting healthy environments;	- Environmental health policy- Occupational health situation analysis report;	- Strengthening of medical health care waste management;
Develop emergency preparedness and response capacity	- Strengthening capacity for EPR;	- Situation analysis report;	- Development of an EPR plan;
Maximize the contribution of health to poverty reduction	- Developing National Health Accounts (NHA);	- NHA report;	- Implementation of NHA recommendations;
Developing partnerships	- Establishing bilateral and multilateral partnerships in health development;	- Reports- MOUs;	- Support MOHSW to establish SWAp;

5.4 PROGRAMME BUDGETS DURING CCS 1

The actual programmatic activity of WHO in the life of the CCS is carried out in the context of the biennial Programme Budgets and Country Workplans. The period of CCS 1 encompassed two biennial Programme Budgets (2002-3 and 2004-5). Although the life of the CCS officially came to an end in 2005, the biennium 2006-7 was still based on it as the formulation of CCS 2 was delayed.

5.5 WORKING ACCORDING TO "ONE COUNTRY PLAN"

One of the major principles of the CCS is the application of the concept of One Country Plan. All WHO support to the country has to be delivered through the WHO country office. As a result, the country office received considerable support from ICST, AFRO and HQ in delivering support to the country based on the CCS 1. The proximity of ICST in Harare facilitates timely and consistent access to the much needed technical support.

5.6 WHO PARTNERSHIP IN HEALTH ACTION

The WHO country office enjoys a cordial working relationship with the MOHSW, other government ministries, development partners and NGOs. The need to strengthen coordination, harmonization and alignment in line with the Paris Declaration is now being strongly felt as more partners are coming into the health field. The WCO is engaged with the Ministry and the partners to develop a framework for coordination based on the sector-wide approaches (SWAp). The leadership role of WHO in health issues finds expression in various health forums and within the UNDAF in the UN system.

5.7 HUMAN RESOURCES

The WHO country office has a staff complement of twenty-two, with eight professional staff supported by fourteen general staff. In addition to the WHO Representative, the professional staff are: in HIV/AIDS (2), Family and Child Health (FHP), Health Information and Promotion (HIP), Managerial Processes (MPN), Expanded Programme on Immunization (EPI) and Administration (AO). Because the areas of work (programmes) are more than the professional staff, all the staff have tasks in programmes other than the ones suggested by their titles. A country office retreat held in 2006 to discuss reprofiling came to the conclusion that for more optimal delivery, more professional staff were needed. This situation means that the WCO will continue to be heavily dependent on the ICST and, to some extent, on AFRO and HQ to provide technical support in several critical areas.

5.8 WHO SUPPORT DURING THE FIRST GENERATION CCS (2002-2005) AND UP TO 2007

During the three biennia spanning the period 2002 to 2007, the work of the WHO country office was carried out in areas of work (AOW) that can be classified into the following categories: Disease Control; Maternal and Child Health; Health Systems; Environment; Emergency Preparedness and Response; Poverty; Country Office Operations and Partnerships. Figures 7 and 8 show the financial flows in these areas during the period.

Financial flows by main areas of focus during the CCS 1 period (2002-2007)

Figure 7: WCO Swaziland budget allocation 2002-2007

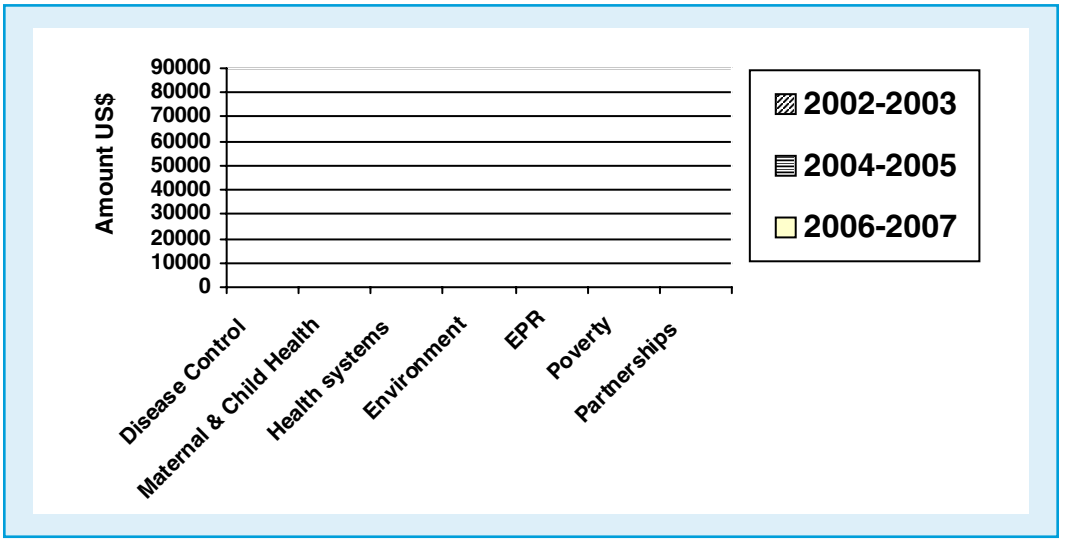
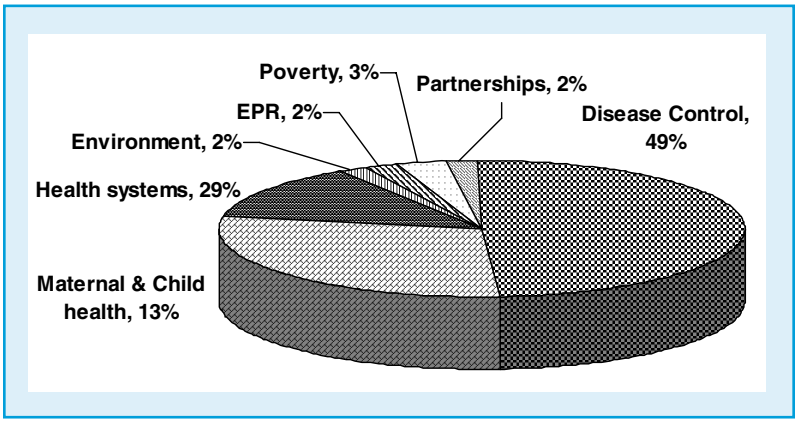


Figure 8: WCO Swaziland budget distribution 2002-2007



The Programme Budget for 2008-2009 is based on 13 strategic objectives in line with the WHO Medium Term Strategic Plan 2008-2013. The total Programme Budget for the biennium is US$ 5 932 339 divided into US$ 2 214 000 (Assessed Contributions) and US$ 3 718 339 (Voluntary Contributions).

SECTION 6

STRATEGIC AGENDA: PRIORITIES AGREED FOR WHO COUNTRY COOPERATION

The 2008-2013 CCS is premised on the recognition that previous WHO support tended to be too thinly spread over a wide array of work areas making it difficult to achieve demonstrable impact. In order to avoid this scenario, an attempt has been made to make the CCS for 2008-2013 more focused. The Swaziland WHO country office believes that such an approach is more likely to have the desired catalytic and cascading effects on the overall performance of the health sector. The agenda addresses issues from the perspectives of both the health sector and the WHO country office.

In drawing up the strategy, the commitment of the country to achieve Millennium Development Goals, especially MDGs 4, 5 and 6 which are regarded as the health MDGs, was taken into account. This was done through the alignment of the strategy to the extent possible with the PRSAP, UNDAF and other important national frameworks.

STRATEGIC AGENDA

The strategic agenda of the CCS 2 has three strategic directions: (i) Improve the health sector stewardship function of the Ministry of Health and Social Welfare; (ii) reduce excess mortality that is due to high disease burden; and (iii) strengthen health systems to improve health outcomes. Under each strategic direction there are strategic objectives and action points for the implementation of the strategic agenda as discussed below.

6.1 STRATEGIC DIRECTION 1

Improve the health sector stewardship function of the Ministry of Health and Social Welfare:

Strategic objectives

1. To contribute to efforts of the sector to improve its capacity to regulate health practice in the country.
2. To support efforts to rationalize and improve responsiveness of the management structure and organization of the health sector by:
   (a) Sharing best practices with the sector on structures and organization of health services;
   (b) Providing technical support to the process for developing a new and decentralized structure;
   (c) Providing advocacy support to the process for adopting the new structure by government;

(d) Contributing to development and implementation of an accreditation system for health facilities.

3. To assist the country in improving effectiveness of sector leadership by:
   (a) Supporting ongoing leadership capacity development activities;
   (b) Promoting a culture of strong demand and practice of good corporate governance principles;
   (c) Contributing to the development of modern corporate governance structures and guidelines at all levels.

4. To support efforts to increase investment in the health sector by:
   (a) Advocating for increased government budgetary allocation to the health sector;
   (b) Supporting the efforts of the sector to introduce a social health insurance scheme;
   (c) Contributing to efforts of the sector to introduce sector wide action planning;
   (d) Mobilizing development partners in the country to support sector-wide action planning.

6.2 STRATEGIC DIRECTION 2

Reduce excess mortality that is due to high disease burden.

Strategic objectives

1. To contribute to the reduction of mortality due to HIV and AIDS by:
   (a) Supporting development and implementation of a national plan to scale up access to antiretroviral therapy in the country;
   (b) Supporting actions to improve patient tracking and improving compliance to treatment;
   (c) Advocating for free access to medicines for managing opportunistic infections as part of comprehensive clinical management of AIDS;
   (d) Supporting implementation of Universal Access to prevention, care and treatment in the health sector;
   (e) Supporting implementation of evidence-based and cost-effective interventions in the HIV/AIDS response.

2. To contribute to the reduction of mortality that is due to tuberculosis and other communicable diseases prevalent in the country by:
   (a) Supporting the implementation of the national plan to scale up DOTS;
   (b) Supporting the response to the MDR/XDR threat;
   (c) Supporting interventions aimed at coordinating TB/HIV/ AIDS activities;
   (d) Supporting the strengthening of Integrated Disease Surveillance and Response (IDRS);
   (e) Supporting the MoHSW, especially the IHR focal point, to implement the provisions of the International Health Regulations in the country;

(f) Supporting the strengthening of control measures against communicable diseases of public health importance, including malaria.

3. To contribute to the reduction of mortality that is due to childhood conditions by:
   (a) Continuing to support the Expanded Programme on Immunization;
   (b) Supporting the scaling up of PMTCT;
   (c) Supporting efforts to increase access to ART by children, especially orphaned and vulnerable children;
   (d) Contributing to efforts for improving management of paediatric AIDS;
   (e) Supporting the scaling up of IMCI in the country;
   (f) Improving capacity for management of nutrition-related problems.

4. To contribute to reducing mortality related to childbirth and other problems related to reproductive functions by:
   (a) Supporting the country to improve access and quality of maternal and newborn health care services;
   (b) Promoting and strengthening establishment of appropriate youth-friendly health services;
   (c) Strengthening the scaling up of PMTCT services, including expansion of the more efficacious regimen;
   (d) Supporting the country's efforts to ensure that all deliveries are conducted by skilled personnel with competencies in management of emergency obstetric care and complications;
   (e) Repositioning family planning, in light of HIV/AIDS, to ensure improved access and quality of services;
   (f) Supporting the establishment of services for prevention, screening and management of cancers of the reproductive organs;
   (g) Supporting the surveillance of SRH-related morbidity and mortality.

5. To contribute to the promotion of healthy life styles and reduction of risky behaviours, including the reduction of mortality that is due to chronic noncommunicable diseases by:
   (a) Advocating for increased investment in the prevention and management of noncommunicable diseases;
   (b) Supporting assessment of disease burden from NCDs through STEPS surveys;
   (c) Supporting health promotion aimed at encouraging healthy lifestyles, e.g. diet and physical activity;
   (d) Supporting appropriate and cost-effective interventions such as screening for cervical and breast cancer, diabetes, hypertension, etc.;
   (e) Supporting efforts to establish and manage a national cancer registry;
   (f) Supporting capacity building to prevent and manage NCDs;
   (g) Supporting health promotion initiatives;
   (f) Advocating and supporting activities aimed at reducing tobacco use and substance abuse.

6.3 STRATEGIC DIRECTION 3

Strengthen health systems to improve health outcomes

Strategic objectives

1. To assist efforts of the health sector to generate and effectively manage human resources for health by:
   (a) Supporting the establishment of a human resource management system that streamlines employment procedures, thus reducing high vacancy rates and promoting retention of health workers;
   (b) Contributing to the finalization and implementation of a human resource management policy that includes a human resource development plan;
   (c) Providing fellowships in work areas that are targeted by this strategic agenda where feasible;
   (d) Supporting efforts to develop a systematic continuing education programme for the health sector;
   (e) Supporting efforts to establish registration of councils for allied health professionals;
   (f) Supporting efforts to establish standard staffing patterns and their adoption by the Ministry of Public Service and Information.

2. To support efforts for the constant availability of quality pharmaceutical and laboratory supplies by:
   (a) Improving the procurement, quantification and distribution of pharmaceutical and laboratory supplies to all health facilities;
   (b) Supporting mechanisms for guaranteeing the supply of quality assured medicine and laboratory reagents;
   (c) Supporting measures to promote rational use of medicines.

3. To contribute to efforts to improve the collection, management and use of health data for planning, budgeting and M&E purposes by:
   (a) Advocating for increased investment in HIMS, M&E and health research by both government and partners;
   (b) Supporting the development of a policy for HIMS, M&E, health research and knowledge management;
   (c) Supporting the development and implementation of a national framework for health-related HIMS, M&E, health research and knowledge management;
   (d) Support research activities in the work areas that are targeted by the strategic agenda.

4. To support the development of periodic national health information sharing and dissemination frameworks by:
   (a) Developing a framework for joint WHO/MoHSW press conferences on topical issues;
   (b) Supporting the development and implementation of a framework for hosting periodic national health and social welfare conferences;
   (c) Contributing to the strengthening of the sector's website.

6.4 LINKAGES BETWEEN WHO MEDIUM TERM STRATEGIC PLAN AND SWAZILAND CCS 2008-2013 STRATEGIC AGENDA

The Country Cooperation Strategy draws from the health challenges and intervention approaches spelt out in the National Health Policy, National Strategic Plan and Poverty Reduction Strategic Plan (PRSP), National HIV/AIDS Strategic Plan for the Health Sector, SPEED, National Development Strategy – Vision 2022(1997-2022), UNDAF and the Millennium Development Goals (MDGs). The second generation CCS is apt in responding to the health sector challenges of the country and demonstrates strong and ostensible linkages with the WHO 2008-2013 Medium Term Strategic Plan in ten areas. The CCS also links strongly with the MOHSW National Health Strategic Plan priorities and areas of focus as shown in Tables 3 and 4.

Table 3: Linkages between WHO Medium Term Strategic Plan 2008-2013 and Swaziland CCS 2008-2013

WHO Medium Term Strategic Plan and Swaziland CCS 2008-2013 strategic directions	Swaziland CCS 2008-2013 Strategic Agenda		
	(1) Improve the health sector stewardship function of MoHSW	(2) Reduce excess mortality due to high burden of disease	(3) Strengthen health systems to improve health outcomes
1. To reduce the health, social and economic burden of communicable diseases.	***	***	***
2. To combat HIV/AIDS, tuberculosis and malaria.			
3. To prevent and reduce disease, disability and premature death from chronic non-communicable conditions, mental disorders, violence and injuries.	***	***	***
4. To reduce morbidity and mortality and improve health during key stages of life.	***	***	***
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	***	***	***
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.	**	***	***
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity.	***	**	***
8. To promote a healthier environment , intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.	**	***	**
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.	***	***	***
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	***	***	***
11. To ensure improved access, quality and use of medical products and technologies.	***	***	***
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries.	***	***	***
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.	***	**	***

Table 4: Linkages between the Strategic Priorities and Focus of the National Health Sector Strategic Plan with WHO Swaziland CCS 2008-2013

MOHSW Strategic Priorities and Focus 2008- 2012	Swaziland CCS 2008-2013 Strategic Agenda		
	(1) Improve the health sector stewardship function of MoHSW	(2) Reduce excess mortality due to high burden of disease	(3) Strengthen health systems to improve health outcomes
Organization and Management of Services	***	**	***
Policy, Planning and Research	***	***	***
Delivery of Essential Public Health Services	***	***	***
Delivery of Essential Clinical Care	**	***	***
Regulations, Standards and Quality Assurance	***	***	***
Expansion of Health Service Coverage and Support Systems	***	***	***
Health Care Technology and Commodities Management	***	***	***
Laboratory Support Services and Blood Safety	***	***	***
Scaling up Investment in Health	***	**	***
Infrastructure Development	***	**	***

Key: ***: Very strong linkage; **: Strong linkage; *: Moderate linkage

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The implementation of the strategic agenda requires the effective involvement and collaboration of the three levels of WHO, namely the WHO country office, the WHO Regional Office for Africa (AFRO) and WHO Headquarters (HQ). The CCS will be the framework for support to the country from all levels of the Organization. In the spirit of "one country plan", it is expected that all support to the country will be based on the biennial programme budget, which in turn will be derived from the CCS.

7.1 IMPLICATIONS FOR WHO COUNTRY OFFICE

Implementation of the CCS at the WHO country office (WCO) needs to take cognizance of the following: expanding the use of the Country Cooperation Strategy; competencies and capacities of WCO staff; effective functioning of the country office; integrated programmatic and technical support from regional offices and headquarters; knowledge management and information and working with sister agencies of the United Nations system and development partners.

The WHO country office will ensure that the CCS is at the centre of all planning and budgeting processes. The CCS will be the basis for the WCO biennial workplans, and will also be used to foster dialogue with the stakeholders. The CCS shall be revised as required, based on appropriate consultations with all stakeholders, including Government.

Successful implementation of the CCS inherently demands that the WHO country office is not only capable but also competent to effectively and efficiently perform the WHO core functions. The strategic agenda articulates a shift in approaches and emphasis. This, therefore, must be addressed through a corresponding alignment of resource allocation, and an improved staff profile as will be evidenced by the development of new capacities and competencies in the WHO country office.

The current staff complement at the Swaziland WHO country office is inadequate; additional professional personnel in the areas of disease prevention and control and health economics are required. A reprofiling exercise to match the skills of the staff with the CCS agenda and the core functions of the WCO will be undertaken. This should lead to better targeting of staff training and development, and where funds permit, employment of more staff. It is inevitable that there will always be some multi-tasking by staff because budgetary constraints are likely to limit the employment of additional staff. In view of this, the WCO will call more and more on the ICST to provide support. Where appropriate, such support will also be sourced from AFRO and HQ.

Management of information is essential for WHO support to all programmes. All staff will be trained to be competent in knowledge management to the extent of fully utilizing resources available in WHO in this area. The library will be built up into a proper resource centre to serve both staff and outside clients, based on the Internet as there is limited space for books and periodicals. To this end, the documentalist will be given appropriate training.

An enabling working environment, with increased administrative and managerial efficiency as well as adequate logistics and field security, will help the WHO Country Team to carry out WHO core functions in line with the CCS. All staff will be provided the training needed to effectively utilize the GSM and the related information systems that support greater decentralization and increased accountability. Investments are required in strengthening the ICT infrastructure needed to support the increasing ICT needs.

The WHO country office will ensure that the CCS remains the basis for all WHO input into the UNDAF, Poverty Reduction Strategy and Action Programme and other health and development processes in the country. The CCS will also facilitate the establishment of SWAp for the health sector to strengthen the coordination of partners in health action.

The following actions will be taken to improve the responsiveness of the WHO country office to critical needs of the country's health sector:

1. Enhance the ability of the WCO to provide high quality technical support to the country's health sector by:

(a) Enhancing the human resource capacity of the country office;

(b) Cost-effective utilization of the ICST, AFRO and HQ technical support;

(c) Aligning the structure of the office with the dictates of this agenda.

2. Increase the capacity of the WHO country office to mobilize resources from partners and to enhance country support in specific areas by:

(a) Advocating for increased funding as part of WHO support to the country;

(b) Mobilizing resident and external development partners to invest in programmes targeted by this strategic agenda.

3. Contribute to partnership building in health development in Swaziland by:

(a) Assisting the MOHSW to improve partner coordination through the establishment of a health sector dialogue involving all partners in the sector, and in line with the Paris Declaration;

(b) Strengthening bilateral formal working relationships with resident development partners and participating in development partners' forums;

(c) Playing an active role in the UN Country Team, to work towards achieving the goals of "delivering as one", including active participation in the UNDAF;

(d) Establishing WHO driven periodic information sharing and exchange forum on new information that is generated by the global and regional levels of the WHO.

7.2 IMPLICATIONS FOR THE WHO REGIONAL OFFICE FOR AFRICA

Given the shortage of skills at country office level in some critical areas, the WCO will continue to solicit technical support from the Regional Office and Intercountry Support Teams (ICST). In particular, AFRO is expected to:

(i) ensure that the country office has the managerial and technical capacity required for implementation of the strategic agenda in the short term (in cases of emergency, this might require a temporary or immediate increase);

(ii) address any longer term shortfall in human and financial resources as well as infrastructure for knowledge sharing, through appropriate strategies and advocacy;

(iii) mobilize resources;

(iv) support operational planning for WHO work in and with Swaziland based on this CCS; and

(v) respond to country office requests for information, guidance and time-limited expertise.

7.3 IMPLICATIONS FOR WHO HEADQUARTERS

In line with its mandate and function, WHO Headquarters (HQ) is expected to:

(i) support the Regional Office in enhancing the capacity of the country office;

(ii) ensure adequate input into joint planning of country work;

(iii) mobilize resources and support; and

(iv) respond to specific requests of the country office that may not be handled at AFRO level.

HQ is further expected to ensure that the country priorities identified in this CCS are used as central input for the preparation of plans and budgets at AFRO and WHO as a whole.

SECTION 8

MONITORING AND EVALUATION OF THE COUNTRY COOPERATION STRATEGY

Implementation of this CCS will be measured against the three consecutive biennial programme budgets and workplans that will apply during its lifespan, including a robust monitoring framework of interventions with specific indicators. Workplan implementation progress will follow WHO's standard monitoring and evaluation processes. The country office will publish annual reports jointly with the MOHSW on annual activities that would have been implemented under the CCS. WHO will also commission a review of the progress made in the implementation of the strategic agenda in accordance with the following timeframe:

- mid-term review in 2010;
- final review in 2013; the findings will inform the development of the succeeding CCS.

This CCS will be applicable in the period 2008-2013 and will be monitored by the office of the WHO representative through a steering committee made up of representatives of the MoHSW, NGOs, private sector and development partners. Its dictates will be translated into biennium action plans which will be developed jointly with the health sector stakeholders under the leadership of the MoHSW. The country office will serve as a secretariat for biennial progress review meetings; chairpersonship will be provided by the MoHSW.

Strategic Direction 1 Indicators:

(a) New health sector organization structure;

(b) Coordination of health sector activities;

(c) Private and public sector per capita expenditure on health ;

(d) Availability and timeliness of health sector statistical and epidemiological data.

Strategic Direction 2 Indicators:

(a) Revised strategies and technical guidelines for addressing TB, AIDS, pregnancy, childbirth and neonatal-related health problems; communicable, noncommunicable and childhood diseases;

(b) Improved health indicators.

Strategic Direction 3 Indicators:

(a) New or amended regulatory frameworks in critical areas;

(b) Health Services Commission or similar mechanism for human resources management established;

(c) Accreditation system for health facilities;
(d) Revitalized Health Information Management System;
(e) Quantity and quality of human resources for health improved;
(f) Sector-wide approach framework.

CONSULTED ORGANIZATIONS

Partners consulted during the process of developing this Country Cooperation Strategy included the following locally-based agencies:

1. Centre of Excellence (Baylor College of Medicine);
2. Coordinating Assembly of Non-Governmental Organizations (CANGO);
3. Elizabeth Glazier Paediatric AIDS Foundation (EGPAF);
4. European Union (EU);
5. Food and Agriculture Organization (FAO);
6. Government of the United States of America (USG);
7. Italian Cooperation;
8. Joint United Nations Programme on HIV/AIDS (UNAIDS);
9. MoHSW (Headquarters staff);
10. MoHSW (Programme Managers, Public Health Programmes);
11. National Emergency Response Council on HIV/AIDS (NERCHA);
12. United Nations Children's Fund (UNICEF);
13. United Nations Development Programme(UNDP);
14. United Nations Population Fund (UNFPA);
15. World Food Programme (WFP);

REFERENCES

1. CSO, 1986. Swaziland population and housing census. Mbabane. Government of Swaziland.
2. CSO, 2007. Swaziland population and housing census, preliminary findings. Mbabane, Government of Swaziland.
3. CSO, 2007. Swaziland demographic and health survey 2006-7, preliminary report, Mbabane, Government of Swaziland.
4. MEPD, 1997. Swaziland national development strategy, a twenty-five year vision 1997-2022. Mbabane, Government of Swaziland.
5. MEPD, 2001. Swaziland household income and expenditure survey report. Mbabane, Government of Swaziland.
6. MEPD, 2006. Yingcamu, poverty reduction strategy and action programme 2005-2011. Mbabane, Government of Swaziland.
7. MoHSW, 2005. PMTCT report. Mbabane, Government of Swaziland.
8. MoHSW, 2006. 10th national HIV sero-sentinel survey among women who attend antenatal care. Mbabane, Government of Swaziland.
9. MoHSW, 2007. Draft national health and social welfare strategic plan 2007-2011. Mbabane, Government of Swaziland (September).
10. MoHSW, 2007. Expanded programme on immunization annual report. Mbabane, Government of Swaziland (September).
11. MoHSW, 2007. Malaria annual report 2007. Mbabane, Government of Swaziland (September).
12. MoHSW, 2007. National health policy 2007-2015. Mbabane, Government of Swaziland (September).
13. MoHSW, 2008. Human Resources Information System report. Mbabane, Government of Swaziland.
14. United Nations, 2006. United Nations development assistance framework for the Kingdom of Swaziland 2006-2010. Mbabane, United Nations.
15. UNDP, 2006. Human development report. Mbabane, UNDP.
16. UNDP, 2007. Human development report. Mbabane, UNDP.
17. VAC, 2004. National vulnerability assessment report. Mbabane, Ministry of Agriculture and Cooperatives.
18. World Bank, 2007. Swaziland public expenditure review, strengthening public expenditure and management for service delivery and poverty reduction. Washington DC, World Bank.
19. World Bank, 2008. Interim strategy note. Washington DC, World Bank.
20. WHO, 2000. World health report: improving performance of health systems. Geneva, WHO.
21. WHO, 2001. WHO country cooperation strategy 2002-2005. Mbabane, WHO.
22. WHO, 2004. 11th general programme of work 2006-2015. Geneva, WHO.
23. WHO, 2004. Strategic orientations for WHO action in the African Region 2005-2009. Harare, AFRO.
24. WHO, 2007. CCS guidelines. Geneva, WHO.
25. WHO, 2008. World health statistics report. Geneva, WHO.
26. WHO, 2008. Medium-Term Strategic Plan 2008-2013 (MTSP) and Programme Budget 2008-2009. Geneva, WHO.