World Health Organization

WHO Country Office Eswatini

2016-2017 Biennial Report


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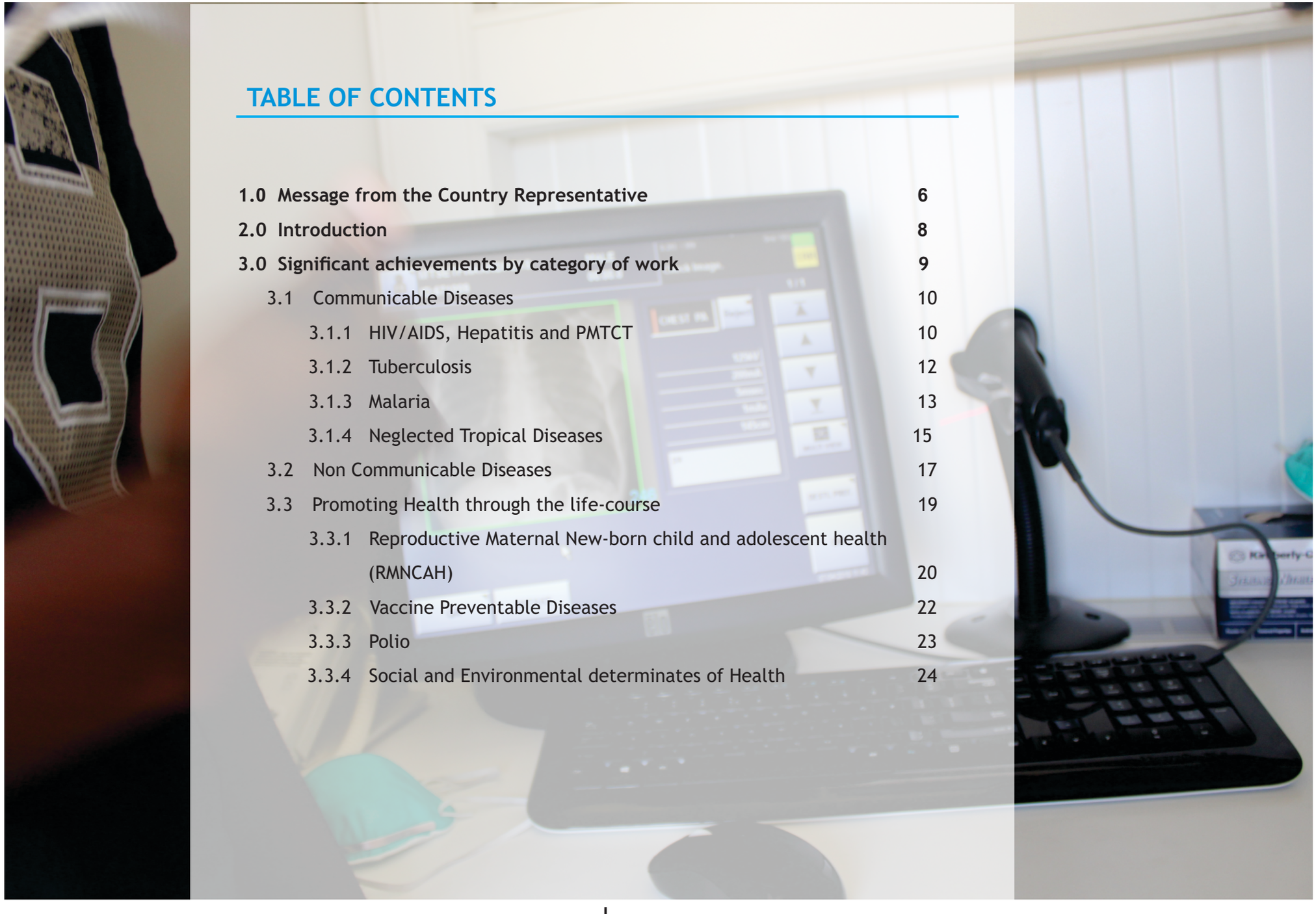

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ACRONYMS

ACSM	Advocacy, Communication and Social Mobilization
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
CCS	Country Co operating Strategy
CDC	Center for Disease Control
CHDs	Child Health Days
CMIS	Client Management Information Systemc
MYP	Comprehensive Multi Year Plan
DNA PCR	Deoxyribonucleic Acid -Polymerase Chain Reaction
DST	Drug Sensitivity Testing
EWI	Early Warning Indicators
FTCT	Framework Convention on Tobacco Control
GF-NFM	Global Fund- New Funding Mechanism
HIV	Human Immuno Deficiency Virus
HIV/DR	HIV Drug resistance
HMIS	Health Management Information System
HRH	Human Resources for Health
ICD	International Classification of Diseases
LLINS	Long Lasting Insecticide Treated Nets
MDGs	Millennium Development Goals
MDR-TB	Multi Drug Resistant TB
MOH	Ministry of Health
NCC	National Coordinating Committee
NGO	Non-Governmental Organisation
NTCP	National TB Control Programme
NTD	Neglected Tropical Diseases
PCV13	Pneumococcal Conjugate Vaccine 13
PEPFAR	President's Emergency Plan for AIDS Relief
PIN	Personal Identification Numbers
PMTCT	Prevention of Mother to Child Transmission of HIV
REC	Reaching Every Community
RHMT	Regional Health Management Teams
SEPI	Eswatini Expanded Programme on Immunization
SNAP	Eswatini National AIDS Programme
TB	Tuberculosis
UHC	Universal Health Coverage
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB

1. MESSAGE FROM THE COUNTRY REPRESENTATIVE

The World Health Organization (WHO) in Eswatini is pleased to share with its partners and stakeholders its 2016-2017 Biennial Report. This report covers the contribution WHO made towards addressing some of the health challenges and disease burden in the country. Over the period of two years, the health sector made a lot of progress towards improving the health status of the people of Eswatini.

There have been several achievements during the biennium. According to the Eswatini HIV Incidence Measurement Survey (SHIMS)II report, in 2017 HIV incidence was reduced by 46% to 1.39% from the 2.58% recorded in 2011. With support from WHO, Eswatini adapted the Test and Treat policy and achieved 85-87-95 on the 90-90-90 HIV treatment targets.

During the biennium Eswatini maintained above 95% Prevention of Mother to Child Transmission of HIV services coverage. About 94% of pregnant women were tested for HIV at antenatal clinics, 34% of them tested positive and 95% of the positive were on lifelong Antiretroviral Treatment. The Mother to Child Transmission (MTCT) rate was 2% at 6 weeks.

With support from WHO, there have been intensified efforts to reduce the burden of Tuberculosis including Multi Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB).Tuberculosis incidence declined by 46% from 733 to 397 per 100 000 population between 2015 and 2017. TB treatment outcomes were 81% cured and 86% completed for drug susceptible TB. This is attributable to rapid adaptation of TB and HIV guidelines, decentralisation and adaptation of differentiated care models and steady uptake of prevention services.

During the biennium Eswatini was ranked among 21 countries globally with the potential to eliminate malaria by 2020. Eswatini achieved 92% malaria case reduction between the years 2002 and 2016. All malaria cases received parasitological confirmatory tests and treatment according to national guidelines.

Following the relaunch of the school based Mass Medicine Administration in 2016 after 6 years suspension, Eswatini successfully conducted two rounds for Schistosomiasis and Soil Transmitted Helminthiasis with average national coverage of over 72%. According to the Mapping survey conducted in 2014, Eswatini is endemic to Schistosomiasis with prevalence of 15% and Soil Transmitted helminthiasis with prevalence of 6%.

WHO supported the strengthening of surveillance and

Dr Tigest Ketsela Mengestu
WHO Representative

provision of routine immunization services in the country. Eswatini recorded zero cases of polio, disability and death from diphtheria, tetanus, whooping cough, measles and rubella for the first time in 2017. By the end of the biennium the overall cumulative routine immunization coverage for DPT3 was 78.7% while Measles Containing Vaccine (MCV1) coverage stood at 55% nationally. The annualised Non Polio Acute Flaccid Paralysis (AFP) rate stood at 3.8 per 100,000 population less than 15 years. A 100% stool adequacy rate was achieved.

WHO supported Maternal and Neonatal Health Quality of Care (MNH QOC) assessment. By end of the biennium, maternal mortality ratio stood at 593 per 100 000 live births. Contraceptive prevalence rate was 66% and about 98% of pregnant women attended at least one antenatal clinic and 66% attended at least four clinics. About 88% of pregnant women were delivered by a skilled attendant. Child survival also improved with under-five mortality rate reduced from 97.4 in 2010 to 70.4 in 2016. Despite the drought experienced during the biennium, the number of moderate and severe malnutrition cases among the under-fives remained very low. The prevalence of stunting was 25.5%, wasting was 2% and overweight was 9%.

In line with health systems strengthening the National Health policy was finalised and a number of guiding documents were produced. Human Resources for Health was strengthened with 90% established posts filling rate and recruitment processes shortened from 6 months to 1 month. During the biennium health information generated through research was disseminated to leaders, change makers, and participants from all sectors of national health, international development, and social entrepreneurship during the biennial national Health Research Conference.

We would like to express our sincere gratitude to the Government of Eswatini, development partners, local non-governmental organizations and members of the communities for their support during the biennium. WHO Eswatini Country Office is committed to playing its leadership role in matters concerning health, providing technical support, building capacity of the health sector to deal with the health problems facing the country.

WHO Eswatini Representative Dr Tigest Ketsela Mengestu and Minister of Health Sibongile Ndlela-Simelane giving deworming tablets to school children at St' Michael's High School in June 2016

2. INTRODUCTION

This report- The Work of WHO in the Kingdom of Eswatini: 2016-2017 Biennial Report covers the period January 2016 to December 2017 and shows the work accomplished over the biennium. The report highlights the delivery of results achieved in supporting the Kingdom of Eswatini and collaborating with partners to ensure healthy lives and well-being for all people at all ages of life.

WHO provided leadership on matters critical to health and engaging in partnerships where joint action is needed; shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; setting norms and standards and promoting and monitoring their implementation; articulating ethical and evidence-based policy options; providing technical support, catalysing change, and building sustainable institutional capacity; and monitoring the health situation and assessing health trends.

The 2016-2017 is the second biennium of the 12th General Programme of Work (GPW), 2014-2019. The report is therefore presented according to the six categories of the GPW namely:

1. Communicable diseases
2. Non communicable diseases
3. Promoting health through the life-course
4. Health systems
5. WHO Health Emergency Programme
6. Corporate services and enabling functions

WHO Eswatini Representative Dr Tigest Ketsela Mengestu cuddling one of the children during the diarrhea awareness exercise at New Village in Manzini in August 2016

3. SIGNIFICANT ACHIEVEMENTS BY CATEGORY OF WORK

The WHO country office continued to provide technical and financial support towards different programmes under the Ministry of Health. These included communicable, non-communicable diseases, maternal and child health, nutrition, health promotion, health systems as well as health emergencies.

Eswatini has made tremendous strides towards the prevention and control of communicable and non-communicable diseases. The focus of WHO activities has been towards reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, Neglected Tropical Diseases (NTDs) and antimicrobial resistance as well as human health and the environment.

Efforts also targeted non communicable disease prevention and control including mental health, violence and injury, disability and rehabilitation as well as their risk factors.

Promoting health through the life course was also prioritised. Promoting good health through the life- course cuts across all areas of WHO's work including the health of women before, during and after pregnancy, and of new-borns, children, adolescents, and older people, taking into account social determinants of health, gender, equity and human rights.

Support was also provided in health systems strengthening focusing on service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. The WHO also supported the country in strengthening country Health Emergency Preparedness and the International Health Regulations (CPI), Emergency Operations, Health Emergency Information and Risk Assessments (IHM) and Infectious Hazards Management (IHM)

Key achievements during the biennium under these programmes are highlighted in the sections that follow.

3.1: COMMUNICABLE DISEASES

Communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, Tuberculosis (TB), Malaria, Schistosomiasis (SCH), and Soil Transmitted Helminthiasis (STH) continue to be major challenges in Eswatini. However Eswatini has made tremendous strides towards addressing these challenges including antimicrobial resistance related to this. The World Health Organization supported the country to scale up coverage of effective interventions for the prevention and control of communicable diseases.

3.1.1 HIV/AIDS, Hepatitis and PMTCT

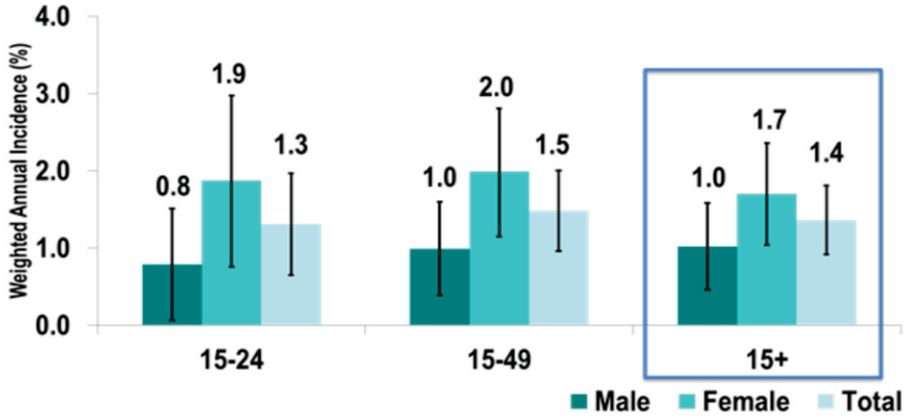
HIV prevention, treatment, care and support services were rolled out to achieve universal access to treatment for all those who need it. Following the dissemination of the WHO consolidated guidelines on HIV prevention and treatment in 2016, Eswatini adopted the "Treat All" recommendations.

UN Resident Coordinator in Eswatini Mr Israel Desselagne, UN Heads of agencies lighting the candle during the UN commemoration of World AIDS Day in December 2017.

This allowed for prompt uptake of antiretroviral treatment among HIV positive patients regardless of CD4 cell level and the rolling out of routine viral load testing. Viral load assessment was done to inform scale-up of the service.

According to the Eswatini HIV Incidence Measurement Survey (SHIMS) II report, in 2017 HIV incidence was reduced by 46% to 1.39% from the 2.58% recorded in 2011. The country also reduced AIDS-related deaths by more than 50% between 2006 and 2016. With support from WHO Eswatini adapted the Test and Treat policy and achieved 85-87-95 on the 90-90-90 HIV treatment targets. By end of 2017 about 85% of all people living with HIV knew their HIV status, 87% of all people with diagnosed HIV infection received sustained antiretroviral therapy and 95% of all people receiving antiretroviral therapy had viral suppression. By the end of biennium the total people enrolled on ART was 189, 492. Retention of people on treatment after one year stood at 93 % - one of the highest retention rates in the world.

Figure 1: HIV incidence by sex *source*: SHIMS II (2017)



During the biennium Eswatini maintained above 95% Prevention of Mother to Child Transmission of HIV services coverage. About 94% of pregnant women were tested for HIV at antenatal clinics, 34% of them tested positive and 95% of the positive were on lifelong Antiretroviral Treatment. The Mother to Child Transmission (MTCT) rate was 2% at 6 weeks.

Team of experts that conducted the Joint Programme Review for HIV, TB, PMTCT and Viral Hepatitis posing with the WHO Eswatini Officer in Charge Dr Khosi Mthethwa during a courtesy call in May 2017

Viral Hepatitis was a major under-recognised problem in Eswatini. However, as from 2017 it has received more attention.

In May 2017, Eswatini completed the first ever joint review of four programmes; HIV, TB, Viral Hepatitis and PMTCT. The findings and recommendations were used to revise the National Strategic Framework (NSF) for response to HIV and AIDS. The revision was necessary for the Global Fund Grant application processes. Eswatini received funding for HIV and Tuberculosis prevention and control activities from the Global Fund.

There is ongoing advocacy for the endorsement of Pre exposure Prophylaxis (PREP) as a prevention strategy for HIV.

3.1.2 Tuberculosis

Eswatini has a high burden in terms of incidence, prevalence and mortality of Tuberculosis including Multi Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) which is very expensive to treat. With support from WHO, there have been intensified efforts to reduce this burden.

Tuberculosis incidence declined by 46% from 733 to 397 per 100 000 population between 2015 and 2017. TB treatment outcomes were 81% cured and 86% completed for drug susceptible TB. This is attributable to the rapid adaption of the TB guidelines which were decentralised and adapted differentiated care models. The updated 2015 WHO MDR-TB guidelines were adapted and are being implemented. This led to a steady uptake of prevention, diagnosis, treatment and care services.

Capacity to detect TB has been strengthened through the rolling out of GeneXpert machines. In 2016 a total of 3806 cases were notified of which 82% were tested with rapid diagnostics at time of diagnosis. About 99% of these knew their HIV status. There was rapid initiation of patients on treatment (average 2 days) based on standardized regimens, in line with national guidelines and consistent with international recommendations. A new Drug Resistance drug - bedaquiline (BDQ) was included in the Essential Medicines List and Government tender list. The new drugs have resulted in shortening of the duration of treatment for uncomplicated MDR-TB from 24 to 9-12 months with reduced cost and improved outcomes and decreased deaths due to better adherence to treatment and reduced loss to follow up.

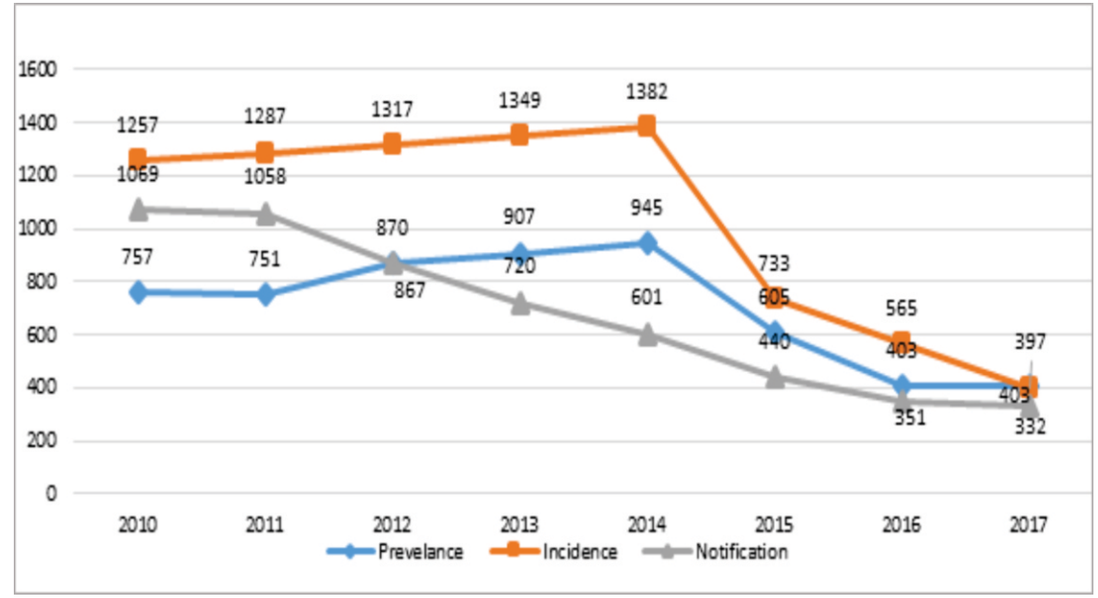


Figure 3: Trends in TB prevalence, incidence and notification in Eswatini- *source:* SHIMS II (2016)

Following adaptation of the END-TB Strategy 2016- 2035, systematic screening for active TB in Eswatini was improved, community based intensified case detection was introduced. The use of Bedaquiline for DR-TB patients program was launched to raise awareness. Capacity of the TB Drug Resistance Pharmacovigilance unit was strengthened through the procurement of hardware and software for improved efficiency in reporting adverse events.

3.1.3 Malaria

During the biennium Eswatini was ranked among 21 countries globally with the potential to eliminate malaria by 2020. Swaziland is part of the Malaria Elimination (E8) countries as well as the cross-border collaborative activities between Mozambique, South Africa and Swaziland (MOSASWA) on malaria elimination. The SADC Health Ministers Meeting held in Swaziland in November 2016 combined with the commemoration of the SADC Malaria Day raised the profile of malaria elimination on the national development agenda.

The country is therefore aiming to achieve sustainable zero incidence of indigenous malaria cases by 2020. Following a midterm review of the National Malaria Elimination Strategic Plan 2015-2020, a revision was made in line with the recommendations of the review, the WHO Malaria Elimination Framework 2017 and the Framework for implementing the Global Technical Strategy (GTS) (3 pillar).

Epidemiologist Vusi Lokotfwako looking for malaria larvae for vector control in a community in November 2017

Through the implementation of the National Malaria Elimination Strategy, Eswatini has made significant strides towards eliminating malaria. Eswatini achieved 92% malaria case reduction between the years 2002 and 2016.

The malaria diagnosis and treatment guidelines were revised in 2017 in line with the 2017 malaria elimination framework. Through annual trainings on malaria case management, all health workers in both public and private facilities are treating 100% of malaria cases according to national guidelines. All malaria cases are laboratory confirmed with Rapid Diagnostic Tests or microscopy and receive Artemether-Lumefantrine with low dose Primaquine for uncomplicated cases and Artesunate or Quinine for complicated cases.

Laboratory technologists participated in the External Competency Assessment on Malaria Microscopy for strengthening malaria diagnosis.

Spray operator spraying a structure in one the malaria at risk communities in the Lubombo Region (2016)

Surveillance agents as well as vector control officers were trained on the updated surveillance and vector control guidelines as well as on data management and use for decision making.

Eswatini experienced an upsurge of malaria cases between October and November 2017 with a total of over 200 local cases and 12 deaths. The Epidemic Task Forces and the National Malaria Programme successfully responded and controlled the outbreak. Intensified community engagement and social mobilisation contributed towards breaking the chain of transmission.

The Global funding request for Malaria was written, peer reviewed, finalized and submitted successfully and about USD4 million grant disbursed.

3.1.4 Neglected Tropical Diseases

Eswatini conducted NTDs mapping survey in 2014. The findings of the survey were disseminated through a high level meeting attended by the Ministers of Health, Education and Training and Tinkundla Administration and to the general public.

According to the mapping survey, Eswatini is endemic to Schistosomiasis with prevalence of 15% and Soil Transmitted Helminthiasis with prevalence of 6%.

The evidence generated by the survey was used to relaunch the school based Mass Medicine Administration in 2016 after 6 years of suspension. The MDA campaign was launched by the Honourable Prime Minister - Dr Sibusiso Barnabas Dlamini.

During the biennium Eswatini successfully conducted two rounds of Mass Medicine Administration for Schistosomiasis and Soil Transmitted Helminthiasis targeting 916 primary and secondary schools nationwide. The average national coverage was 72% amongst eligible school going children.

School girls posing for a photo after receiving the deworming tablets in June 2016

3.2 NON COMMUNICABLE DISEASES

The 2030 Agenda for Sustainable Development recognises Non Communicable Diseases (NCDs) as a major challenge for sustainable development. The target is to reduce by one-third premature mortality from NCDs through prevention and treatment (SDG target 3.4) by 2030. In Eswatini the probability of dying between ages 30 and 70 years from the 4 main NCDs is 21%.

There has been very slow progress towards attaining the targets outlined above. The table shows the comparison of results of the STEPs surveys done in 2007 and 2014.

Table 4: Comparison of result of the STEPs surveys 2007 & 2014

Risk factor	Prevalence	
	2007	2014
Tobacco use	7%	6%
Alcohol use	12%	13%
Raised Blood Pressure	36%	20%

With support from WHO, Eswatini developed the multisectoral National Strategy for the prevention and control of Non Communicable Disease 2016-2020 which is in line with the Global action plan for the prevention and control of NCDs 2013-2020 and the nine global targets that have the greatest impact on global NCD mortality.

Fruits and vegetables displayed at the market place in Mbabane

An external review of the Nation NCDs programme was conducted with support from WHO/AFRO. The main purpose of the review was to come up with recommendations for strengthening NCDs prevention and control in the country. A new management structure for the NCDs programme was developed and the implementation of the recommendations of the programme review was initiated.

Equipment and consumables for the diagnosis and treatment of NCDs at primary care were donated to the Government of Eswatini in support of decentralisation of services in line with WHO Package of Essential NCDs interventions at primary level (WHO - PEN).

Treatment guidelines for common mental health conditions were produced and health workers trained on the guidelines. Eswatini was selected as one of the countries for piloting data collection for the Global Dementia Observatory.

The prevention of blindness plan of action for the country has been drafted.

Eswatini established a national population based cancer registry to strengthen cancer surveillance. The establishment and functionality of the registry was facilitated by a study tour of the Zimbabwe National Cancer registry as well as evaluation by the African Association of Cancer Registries. Eswatini was invited to become a provisional member of the African Cancer Registry Network.

The Programme of Action for Cancer Therapy (impact) Mission was conducted supported by the International Atomic Energy Agency. The aim was to assess comprehensive national cancer control capacities and needs in the areas of cancer control planning, cancer information and registration, prevention, early detection, diagnosis and treatment, palliative care, education and training and civil society activities.

NCD equipment handed over to the government of Eswatini for decentralization of NCD services in August 2016.


A school health nurse examining one of the school children during the commemoration of World Hearing Day in March 2016

3.3 PROMOTING HEALTH THROUGH THE LIFE-COURSE

Promoting good health through the life-course cuts across all areas of WHO's work including the health of women: before, during and after pregnancy, and of new-borns, children, adolescents, and older people, taking into account social determinants of health, gender, equity and human rights. In line with the sustainable development agenda Eswatini is expected by 2030 to:

- Reduce the maternal mortality ratio to less than 70 per 100 000 live births;
- End preventable deaths of new-borns and children under 5 years of age;
- Reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births;
- Ensure universal access to sexual and reproductive health-care services,

WHO Eswatini Representative Dr Tigest Ketsela Mengestu posing with school girls and teachers at Somnjalose High School during the distribution of dignity packs in April 2016

3.3.1 Reproductive maternal new-born child and adolescent health (rmncah)

Health workers were capacitated on the management of severe acute malnutrition (SAM) according to national guidelines.

A Nutrition surveillance system was set up with indicators incorperated into the Health Management Information System (HMIS).

The prevalence of stunting was 25.5%, wasting was 2% and overweight was 9% among children under 5 years of age.

Guiding documents including the National Family Planning guidelines, the Sexual Reproductive Health guidelines and the cervical cancer guidelines were produced.

The Distance Integrated Management of Neonatal and Childhood Illnesses (dIMNCI) course was rolled out to health workers in the country as contribution to the delivery of child survival strategies.

A newborn baby delivered at Mbabane Government Hospital in 2017

A WHO supported Maternal and Neonatal Health Quality of Care (MNH QOC) assessment was conducted and findings informed improved care delivery.

The high HIV prevalence had an impact on maternal and infant mortality. By close of the biennium, maternal mortality ratio stood at 593 per 100 000 live births which is far from the sustainable development agenda.

Total fertility rate was at 3.3 per women and contraceptive prevalence rate was 66%. About 98% of pregnant women attend at least one antenatal clinic and 66% attend at least four clinics. About 88% of pregnant women were delivered by a skilled attendant. There was progress towards universal access to sexual and reproductive health-care services.

Child survival has improved with child mortality rate reduced from 27 in 2010 to 18 in 2014, infant mortality rate from 79 in 2010 to 50 in 2014 per 1000 live births.

Neonatal mortality rate stands at 20 per 1000 live births. These indicators are close to the sustainable development agenda targets.

These improvements can be attributed to implementation of high impact child survival strategies.

A pregnant woman waiting to deliver her baby at the Mbabane Government Hospital maternity ward in 2017

3.3.2 Vaccine preventable diseases

WHO supported the strengthening of surveillance and provision of routine immunization services in the country. Eswatini recorded zero cases of polio, disability and death from diphtheria, tetanus, whooping cough, measles and rubella for the first time in 2017. By the end of the biennium the overall cumulative routine immunization coverage for DPT3 was 78.7% while Measles Containing Vaccine (MCV1) coverage stood at 55% nationally. The annualised Non Polio Acute Flaccid Paralysis (AFP) rate stood at 3.8 per 100,000 population less than 15 years. A 100% stool adequacy rate was achieved.

The third generation Expanded Programme on Immunization (EPI) Comprehensive Multi Year Plan (cMYP) 2017 – 2021 was developed and implemented. In line with the implementation of Measles Rubella Elimination strategy, health workers were capacitated in measles surveillance. The rubella vaccine has been introduced into routine immunization and given at 9 months and 18 months. The country introduced the National Immunization Advisory Technical Group (NITAG). The EPI Advocacy, Communication and Social Mobilisation Strategic Plan (2018 – 2021) was developed.

A child receiving Inactivated Polio Virus (IPV) vaccine at Mbabane Public Health in October 2016

3.3.3 Polio

In line with the implementation of the Polio Eradication and Endgame strategic plan (PEESP) 2013 - 2018, Eswatini successfully switched from tOPV to bOPV and the Polio Outbreak Preparedness and Response Plan was developed. The country hosted the 20th Polio Inter-Country Certification Committee (ICCC) meeting. The meeting was attended by National Certification Committees (NCC) and (ICCC) from Lesotho, South Africa and Eswatini.

3.3.4 Social and Environmental determinants of Health

The context of people's lives determines their health. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors, and many others.

The implementation of Urban Health Equity Assessment and Response Tool (HEART) with Matsapha Municipality is ongoing and progress made so far has been documented. A Health Promotion Technical Working Group was formed with Terms of References finalised and adopted. The group drafted guidelines for development of IEC material in the country. The mercury initial assessment project under the Minamata Convention on Mercury was initiated and WHO is a member of the Technical Advisory Committee. An action plan for addressing adolescent health through school health was developed as follow up action from a regional consultation to take stock of progress made in school health in the African region and provide inputs into the guide to accelerate actions for the health of adolescents held in Brazzaville from 18-21 October 2016. The Technical Advisory Team meeting on the Minamata Convention on Mercury was held reviewing the national mercury stock inventory and legislation reports.

One of the informal settlements in Matsapha

3.4 HEALTH SYSTEMS STRENGTHENING

Achieving universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all is the goal of the health sector in Eswatini. The country is also working towards substantially increasing health financing and the recruitment, development, training and retention of the health workforce.

In line with health systems strengthening the National Health policy was finalised and a number of guiding documents were produced. Human Resources for Health was strengthened with 90% established posts filling rate and recruitment processes shortened from 6 months to 1 month.

A picture of Senior Nurses taken in August 2016

During the biennium health information generated through research was disseminated to leaders, change makers, and participants from all sectors of national health, international development, and social entrepreneurship during the biennial National Health Research Conference.

The following guiding documents were produced:

- National Health Policy 2016.
- e Health Strategic Plan
- Health Financing Policy
- Human Resources for Health (HRH) plan

The country adopted the ICD 10 for improving health information systems. The Client Management Information System (CMIS) was introduced in additional 15 health facilities in Hhohho, Manzini and Shiselweni Regions in collaboration with partners. A Service Availability and Readiness Assessment (SARA) was done.

WHO staff attending the conference with Dr Martin Ota representing the WHO Regional Director Dr Matshidiso Moeti during the National Health Research Conference at Ezulwini in November 2017

3.5 WHO HEALTH EMERGENCY PROGRAMME

WHO supported the Ministry of Health in strengthening capacities for preparedness and response to health emergencies. Strengthen the capacity of the country for early warning, risk reduction and management of national health risks remained a priority over the biennium.

Building of core capacities for the implementation of International Health Regulations (IHR) 2005 and combating antimicrobial resistance were put high priority on the national agenda with support from WHO. Response to disasters and disease outbreak response through the one-health approach was strengthened through the development of a Multi-hazard response plan.

Eswatini adapted the Integrated Disease Surveillance and Response (IDSR) technical guidelines in 2010 and are being implemented at all levels of the health system (Health facility, Regional and national levels) .

Eswatini experienced severe El Nino induced drought which was declared a national emergency. More than 420 000 people were left vulnerable due to unavailability of water and food and were provided with humanitarian assistance. WHO and other partners provided support through the Health and Nutrition Cluster. No diseases outbreaks or any increased number of severe malnutrition cases were reported.

Health sector emergency response capacity under IHR (2005) was strengthened through the reconstitution of National and Regional Epidemic Task Forces and Rapid Response Teams with defined and clear Terms of Reference. A National Anti-Microbial Resistance Strategic Plan was drafted.

Officers from the Emergency Medical Services during the commemoration of World Hearing Day at Nkwene in June 2017

3.6 CORPORATE SERVICES AND ENABLING FUNCTIONS

3.6.1 Corporate Services

Corporate services and organizational leadership provide the enabling functions, tools and resources that make all of the work of WHO possible. The focus areas include leadership and governance; transparency, accountability and risk management; strategic planning, resource coordination and reporting; management and administration; and strategic communications.

The Country Representative promoted WHO's leadership and governance through continued engagement with national leaders and other national and international strategic partners. Strategic communication improved through launching of the WCO Social media activities, regular updates on the visually appealing WCO website.

The operations team comprise of finance, budget, human resources, logistics, transport and information and technology. The team provided support to the technical programmes and responded to issues affecting the daily running of the office.

The WCO completed a training on compliance and GSM supported by WHO/IST and AFRO.

WHO Eswatini Representative Dr Tigest Ketsela Mengestu being interviewed by local Journalists during the commemoration of Health and Safety Day at Matsapha Town Board in August 2017

Procurement and Recruitment committees with clear Terms of References have been set up. Promotional material for the WCO which included, notebooks, wall and desk calendar, greeting cards were developed, printed and disseminated. The WCO participated in the joint UN Business Operating Strategy development. Regular media slots in both electronic and print are conducted to enhance external communication. Regular Newsflashes are shared with other levels of the organization as part of internal information sharing. Monthly presentations of ongoing innovative/strategic activities within programmes were made by staff during general WCO staff meetings.

The WCO Library services were improved through support from WHO/AFRO on cataloguing and information management.

The WHO Eswatini library after receiving a facelift through support from AFRO

3.6.2 Enabling Factors

The WHO continues to enjoy a cordial relationship with the Ministry for Health and other sectors, development partners and stakeholders.

Collaboration with other Partners, especially sister United Nations Agencies in providing harmonised support to the country. This creates a very favourable environment for WHO to deliver on her mandate.

The WCO was able to draw on its technical expertise at regional and headquarter levels to support the country efforts. The ability of the office to draw expertise from various levels contributed greatly to the implementation of many activities. Improvements in the connectivity in the WCO made it easier to communicate with other levels of the organization like through video conferencing.

Financial resources mobilized from outside WHO e.g Arab Gulf Programme for United Nations (AGFUND), USAID CDC also enabled implementation of a number of activities.

The IST team posing with the WCO staff after completion of the GSM training in Mbabane in April 2016

Capacity development for both WCO and MoH staff through workshops and training organized by IST and AFRO was very useful .There was also sharing of updated tools for adaptation at country level.

The results of the 2017 national census were released showing that the total population of Eswatini is 1.1 million.

4. IMPLEMENTATION OF THE PROGRAMME BUDGET 2016-2017

The programme budget implementation covers the financial and physical aspects.

4.1 Analysis of Financial Implementation of the work plans

The Eswatini WCO received a total of US$3,443,378.00 for the 2016-17 biennium for salaries and activities.

Of this, US$1,637,878 was from Voluntary Contributions (VC) funds and the remaining US$1,805,500.00 being Assessed Contributions (AC) funding.

A total of US$1,597,308.00 was allocated and used for salaries and US$1,846,070.00 to activities. At close of biennium encumbrances were US$127,081.00 and expenditures were US$3,278,144.44.

The implementation rate was therefore 99% against funds received.

The implementation rate against planned costs totalling US$3,917,801.00) was 87%.

Ear, Nose and Throat Specialist examining a child's ears during the World Hearing Day commemoration at Nkwene in June 2017

Table 1: shows the rate of budget implementation

Category	Allocated Budget	Planned Costs	% PC vs Allocated Budget	Funds Available	% Funds Available vs Allocated Budget	Utilization	Balance of Funds Available	% Utilization vs Funds Available
01	1,072,256	1,072,000	100%	1,148,865	107%	1,075,855	73,010	94%
02	171,000	171,000	100%	57,000	33%	57,912	-912	102%
03	418,284	418,284	100%	294,673	70%	272,398	22,275	92%
04	381,584	381,551	100%	170,137	45%	276,372	-106,235	162%
05	492,833	492,833	100%	381,244	77%	362,419	18,825	95%
06	1,382,133	1,382,133	100%	1,381,788	100%	1,359,067	22,721	98%
Grand Total	**3,918,090**	**3,917,801**	**100%**	**3,433,707**	**88%**	**3,404,022**	**29,685**	**99%**

There were wide gaps between the planned costs and budgeted funds in the work plan for all the programme areas. This impacted negatively on the work plan implementation. Due to the financial constraints, the AC funding received was mainly used for funding salaries and running of the country office leaving very little amount for activity implementation. Programme activities had to rely mainly on VC funding of which the country also received very little.

4.2 Analysis of physical implementation rates of the work plan

The implementation covers work plan implementation at products and services as well as outputs level.

Table 2: Implementation at products and services level

Programme Area	Products	In Progress	Not Started	Completed	On hold	Cancelled
Communicable Disease	66	3	2	57	4	0
Non communicable Diseases	48	2	5	38	3	0
Promoting health through the life course	56	0	6	42	8	0
Health systems	47	0	0	47	0	0
Preparedness, surveillance and response	39	0	3	35	1	0
Corporate services/enabling functions	40	0	0	40	0	0
Grand Total	**296**	**5**	**16**	**259**	**16**	**0**

Table 3: Implementation at output level

Programme Area	No. of Outputs	On Track	At Risk	In Trouble
Communicable Disease	11	8	3	0
Non communicable Diseases	11	4	7	0
Promoting health through the life course	15	8	4	3
Health systems	11	9	2	0
Preparedness, surveillance and response	14	12	0	2
Corporate services/enabling functions	15	15	0	0
Grand Total	**77**	**56**	**16**	**5**

About 88% of products and services were completed and about 5% were put on hold, another 5% not started at all and 2% were ongoing into the next biennium. At output level a total of 56 (73%) out of 77 were achieved, about 21% of the outputs were partially achieved and 6% were not achieved at all. The partially achieved and not achieved products and services as well as outputs were under the prevention and control of Non communicable Disease, Social and environmental determinants of health, environmental health, disability, violence and injury , Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH), nutrition and health emergencies.

The implementation of the work plans were negatively impacted by limited human resource capacity both in the WCO and the Ministry of Health. Technical officers were in charge of more than one programme and some public health programmes in the Ministry did not have managers. The recruitment of Short Service Appointment (SSA) staff relieved some of the human resources challenges in the office.

The WCO was also able to draw on its technical expertise at regional and headquarter levels to support the country efforts. The ability of the office to draw expertise from various levels contributed greatly to the implementation of many activities.

5.0 SUCCESS STORIES

5.1 REDUCING THE BURDEN OF VACCINE PREVENTABLE DISEASES IN ESWATINI

"Let us ensure that every child is fully immunised. Even one life lost is too many. The World Health Organization is committed to the provision of technical support to the Ministry of Health in the prevention of vaccine preventable diseases, in particular introducing new vaccines as they become available. Let us keep up the momentum and accelerate progress towards universal access to immunization"- Dr Tigest Ketsela Mengestu - WHO Representative.

A few years ago vaccine preventable diseases like polio, diphtheria, whooping cough, tetanus, measles, meningitis, pneumonia and rotavirus diarrhoea used to be of great concern for child survival in the Kingdom of Eswatini. Howeve,r over the years great strides have been made in expanding immunization as a critical component of high impact child survival strategies in the country. The WHO and UNICEF support for immunization illustrates the United Nations capacity to support the country in developing sustainable, country owned public health programmes. Immunization saves lives, makes communities more productive, and is a core component of strengthening health systems and attaining the Sustainable Development Goals (SDGs).

History of immunization in Eswatini

Eswatini initiated the Expanded Programme on Immunization (EPI) in 1979 with support from WHO and Save the Children Fund. The programme was later supported by UNICEF, Canadian Public Health Association, Rotary International and USAID. It started with very few antigens but to date the national routine immunization schedule contains 13 vaccines protecting children against infectious diseases. The introduction of new vaccines to prevent infectious diseases in Eswatini has become high priority in the health agenda. Over the last 10 years Eswatini has introduced 4 new vaccines including Haemophilus Influenzae type B, Pneumococcal Conjugate Vaccine, Rotavirus Vaccine and Inactivated Polio Vaccine (IPV). Advanced plans are in place to introduce yet another vaccine against Human Papilloma Virus (HPV) which causes cervical cancer. Cervical cancer constitutes about one third of all cancers in the country.

In line with Universal Health Coverage (UHC) the government of Eswatini, through the Ministry of Health provides vaccinations free of charge to all children regardless of sex, race or social status. This is in line with the 2016 Addis Ababa Declaration on "Universal access to immunization as a cornerstone for health and development in Africa". Eswatini is committed to increasing vaccine-related funding, strengthening supply chains and delivery systems, and making universal access to vaccines a cornerstone of health and development efforts.

WHO and UNICEF provide critical technical and financial assistance

The WHO and UNICEF has supported improved operations and systems in all areas of immunization in Eswatini. The support is provided in strengthening delivery of routine immunization services, new vaccines introduction, vaccine preventable disease elimination initiatives, data management, logistics and supply chain management as well as capacity building and implementation research.

Moving towards elimination of vaccine preventable diseases

The remarkable achievement in Eswatini of recording zero cases of polio, disability and death from diphtheria, tetanus, whooping cough, measles and rubella for the first time was made in 2017. Even though the country has been in the elimination stage of these diseases for some time now, one or two cases have been confirmed each


avacare
AUTO DISABLE SYRINGE WITH NEEDLE
Comprehensive approach to
diarrheal prevention

year during the last decade. This indeed is a clear indication that vaccines work and countless lives of children of Eswatini have been saved. It is a clear demonstration of the benefits of immunization as one of the most successful and cost-effective health interventions known.

Also of note is the fact that no case of Polio has been recorded in the country since 1989. This is in line with the Global Polio Eradication and Endgame Strategic Plan 2013-2018 whose aim is to have a polio-free world by 2018.The last measles outbreak was in the year 2010. The last rotavirus diarrhoea was in 2014 before the introduction on the rota virus vaccine. No outbreaks due to the other vaccine preventable diseases have been recorded in the last decade. There has been significant reduction the burden of vaccine preventable disease.

As a result of immunization combined with other health care and development interventions—including improved access to clean water and sanitation, better hygiene and education— the annual number of deaths among children under five years has fallen drastically. The probability per 1,000 that a new-born baby will die before reaching age five was 209.90 in 1960 before introduction of the immunization programme and has reduced to 70.40 in 2016.

Adequate and effective vaccination coverage

Coverage of vaccines that have been in use since the inception of the (EPI) has increased including the newly introduced vaccines. Annually about 90% of children are vaccinated against infectious diseases. 'Reaching Every District' (RED) strategy is used to address common obstacles to increasing immunization coverage. All health facilities in the country have the capacity to provide free vaccination services including the private sector. Outreach services are provided in "hard to reach areas". The country has been conducting the annual Africa Vaccination Week commemorations for the past 7 years to promote the use of vaccines to protect people of all ages against

disease. Catch up campaigns and national child health days are also conducted so that no child is left behind. Unvaccinated children pose a risk to all other children. An outbreak starts among unvaccinated children and spread if the community has a pool of susceptible children. Immunization does not only protect an individual's own family, but also others by helping to control serious diseases in our communities. The challenge is that there are still some communities that refuse immunization. This therefore reduces vaccination coverage and compromises the benefits of vaccination.

Future plans

The country is working towards reducing under-five mortality to at least as low as 25 per 1000 live births in line with SDG 3 target 3.2. Achieving universal health coverage is key for improved access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

5.2 INVESTING IN HEALTH WORKFORCE: THE PATH TOWARDS SUSTAINABLE DEVELOPMENT

The vison of the "Global Strategy on Human Resources for Health: Workforce 2030" is to accelerate progress towards Universal Health Coverage and the Sustainable Development Goals by ensuring equitable access to a skilled and motivated health worker within a performing health system. The Kingdom of Eswatini has set out the policy agenda to ensure a workforce that is fit for purpose to attain the targets of the Sustainable Development Goals (SDGs).

In the past few years, the Ministry of Health in Eswatini had limited institutional capacity to lead and coordinate the Human Resources for Health (HRH) planning, management and production of the health workforce in the country. These functions were fragmented in different departments and units in the Ministry. The majority of personnel involved in Human Resources (HR) activities were not adequately trained and experienced in human resources for health functions. Further, the assignment of these personnel from the Ministry of Public Service did not consider the required qualifications and experiences to undertake HRH related functions, which include health workforce planning, production and training, and management of health personnel in a health sector environment.

As a result, the health workforce planning, development and management were not clearly aligned with the needs of the health service delivery system in the country. Further, job descriptions were not responding to the emerging changes in healthcare, and tasks were not clearly assigned. The poor state of the HRH in the country was considered to be one of the major setbacks to the country's worsened health indicators, including the high Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) infection rates in the past years.

In the light of these challenges in the country, there was a need to accelerate efforts to strengthen the HRH unit of the Ministry of Health while building institutional capacity to sustain these efforts. In 2015, the World Health Organisation (WHO) country office in Eswatini, with funding from the Government of the United States of America (PEPFAR) provided technical support and guidance to transform the HRH unit. The goal was to change the relatively underperforming personnel management unit to a more strategic focused department that can effectively provide strategic direction for the health workforce in the country. According to WHO HRH Advisor Dr James Antwi, the transformation process led by the Ministry of Health involved initial engagements with personnel to review expectations and change in roles and tasks among other things. Dr Antwi noted that this has resulted in improvements in human resource functions such as recruitment, and retention, deployment, and staff development.

"Production of key health workers has improved over the last few years and most of the vacant positions have been filled. The human resource information system has been revamped to generate evidence on health workers for informed decision making" he said.

Among the achievements outlined by Dr Antwi was the formation of a Human Resource for Health Management Committee (HRHMC) at the MoH to manage the recruitment, deployment, promotion and transfer of health workers. The recruitment process which hitherto was a key bottleneck was streamlined following the development of recruitment guidelines and functionality of the HRHMC. The HRH hiring process was streamlined through tools such as applicant tracking systems and communicating with applicants and candidates about the selection process. As a result, on average, the recruitment process now takes one month to complete as compared to the 4 – 6 months as was previously the case.

The current recruitment process in the Ministry encourages fair employment practices that treat applicants equally, focusing solely on experience, expertise and qualifications. In 2016, a total of 389 health workers were recruited, accounting for approximately 10% of the total Government establishment. Majority of those recruited were for nursing, laboratory and pharmacy cadres who are instrumental in the provision of HIV/AIDS and TB services. By January, 2016 a total of 3,588 out of 4,357 established posts were filled representing an 82% filling rate of the establishment positions

In-country capacity for training has improved with increased enrollment rates and outputs for laboratory, pharmacy and nursing cadres. For example, the current nurse/midwife density in Eswatini stands at 14.6 per 10,000 population, higher than the WHO Africa region average of 10.7 per 10,000 population. However, the density of doctors, nurses and midwives currently stands at 1.66 per 1000 population, below the WHO benchmark of 2.3 doctors, nurses and midwives per 1000 population needed to provide 80% coverage of assisted deliveries. Consequently, the new five year HRH strategic plan (2018 -2022) aims at accelerating efforts in meeting the WHO benchmark.

Among other achievements was the development of systems for improving the coordination and quality of In - Service Training (IST) and currently being implemented. Further, a staff wellness program was established with dedicated wellness officers and wellness clinics have been established in hospitals and health centers.

The establishment of Human Resource Information System (HRIS) has ensured easy generation of evidence on human resource for health to inform decision making. The system ensures availability of up-to-date and accurate data on the current number of employed health workers, demographic information, where they are deployed, with what skills, as well as information on vacant positions. The HRIS has enabled the Ministry of Health to generate quarterly reports on the HRH status in the country and to assess staff development needs and consequently, plan for training and skill development activities in the country.

The transformation exercise also generated a committed Human Resource Technical Working Group (HRH-TWG) which is creating future leaders out of middle management to translate strategy to align with the future health needs of the country. The HRH-TWG was formed to provide technical guidance to the Ministry of Health for improvements in HRH in the country using local expertise. The group is made up of representatives from the WHO, the Ministry of Health, all sector Ministries involved in

healthcare activities, Regulatory Bodies, Training Institutions and Partner Agencies.

In conclusion, there is the need to continuously support the HRH unit of the Ministry of Health and consolidate the gains so far made in HRH while building institutional capacity to sustain these efforts. This is necessary for the country in the wake of progress made so far in HIV/TB prevention. The financial support by development partners especially, the United States Government was timely for the WHO to provide vital technical support to strengthen the HRH unit and implement activities to enhance HRH outcomes. This is greatly appreciated since the achievements outlined above would not have been possible without such partnership. The World Health Organisation will continue to support the Ministry of Health in pursuit of health care delivery and, ultimately, better health outcomes for the people living in Eswatini.

6.0 CONCLUSION AND LOOKING AHEAD

This biennial report highlights a number of significant achievements in the 2016-2017 biennium. WHO in the Kingdom of Eswatini is determined to continue working with the government of Eswatini and partners to help to achieve the health goals in the new era of sustainable development.

6.1 Moving forward

The WCO will continue focusing on the prevention, control and elimination of communicable and non-communicable diseases, promoting health through the life course, strengthening health systems as well as emergency preparedness and response. Main focus will be on malaria elimination and polio eradication, rolling out of HIV Test and Start within the 90-90-90 framework, adapting the Women adolescent and children strategy and development of the second Human Resources for Health (HRH) strategy. Enhancing strategic communication and focusing on the achievement of the managerial Key Performance Indicators will strengthen the enabling environment for achievement of the goals and objectives set for the next biennium.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