World Health Organization
Eswatini

COUNTRY COOPERATION STRATEGY
2022–2026 ESWATINI

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List of Acronyms

AEFI:	Adverse Events Following Immunization
AfDB:	Africa Development Bank
AIDS:	Acquired Immunodeficiency Syndrome
BADEA:	Arab Bank for Economic Development in Africa
CCS:	Country Cooperation Strategy
CHAI:	Clinton Health Access Initiative
CHD:	Child Health Days
CMIS:	Client Management Information System
COVID:	Corona Virus Diseases
CRVS:	Civil Registration and Vital Statistics
CSO:	Central Statistics Office
DCI:	Development Cooperation Instrument
DRR:	Disaster Risk Reduction
EDF:	European Development Fund
EIS:	Event Information Site
EU:	European Union
EWARS:	Early Warning, Alert and Response System
FCTC:	WHO Framework Convention on Tobacco Control
GAP:	Global Action Plan (for Healthy Lives and Well-being for All)
GDP:	Gross Domestic Product
GEF:	Global Environmental Facility
GPW 13:	13th General Programme of Work
GSWCA:	Global Strategy for Women, Children and Adolescents
HiAP:	Health in All Policies
HIS:	Health Information System
HIV:	Human Immunodeficiency Virus
HMIS:	Health Management Information System
HRH:	Human Resources for Health
HRIS:	Human Resources Information System
IA 2030:	Immunization Agenda 2030
ICCC:	Inter-Country Certification Committee
ICD:	International Classification of Diseases
IDSR:	Integrated Diseases Surveillance and Responses
IHR:	International Health Regulations
ISO:	International Organization for Standardization
JEE:	Joint External Evaluation
JICA:	Japan International Cooperation Agency
MEPED:	Ministry of Planning and Economic Development
MICS:	Multiple Indicator Cluster Survey
MOH:	Ministry of Health
MOHA:	Ministry of Home Affairs
MOV:	Means of Verification
MPNDSR:	Maternal, Perinatal, and Neonatal Death Surveillance and Response

List of Acronyms

MSF:	Médecins Sans Frontières
NAPHS:	National Action Plan for Health and Security
NCD:	Non-Communicable Diseases
NDC:	Nationally Determined Contribution
NDS:	National Development Strategy
NGOs:	Non-Governmental Organization
NHA:	National Health Observatories
NHSSP:	National Health Sector Strategic Plan
OFID:	OPEC Fund for International Development
OPEC:	Organization of the Petroleum Exporting Countries
PEI:	Polio Eradication Initiative
PEPFAR:	The United States President's Emergency Plan for AIDS Relief
PHC:	Primary Health Care
PHEOC:	Public Health Emergency Operation Centres
PIRI:	Periodic Intensification of Routine Immunization
PMO:	Program Management Officer
QMS:	Quality Management System
RED:	Reaching Every District
RMNCAH:	Reproductive Maternal, New-born, Child, Adolescent Health
SADC:	Southern African Development Community
SDG:	Sustainable Development Goals
SHIES:	Swaziland Household and Expenditure Survey
SID:	Strategic Information Department
SOP:	Standard Operating Procedure
STEPS:	STEPwise approach to NCDS risk factor surveillance
TNC:	Third National Communication
UAE:	United Arab Emirates
UHC:	Universal Health Coverage
UK:	United Kingdom
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UNCT:	United Nations Country Team
UNDAF:	United Nations Development Assistance Framework
UNDP:	United Nations Development Program
UNFCCC:	United National Framework Convention on Climate Change
UNFPA:	United Nations Population Fund
UNGA:	United Nations General Assembly
UNICEF:	United Nations Children's Fund
UNSDCF:	United Nations Sustainable Development Cooperation Framework
USA:	United States of America
WCO:	WHO Country Office
WFP:	World Food Programme
WHO:	World Health Organization
WHO AFRO:	WHO Regional Office for Africa

Foreword from the Minister of Health

The signing of the fourth Country Cooperation Strategy 2022–2026 reaffirms the strength of the relationship between the World Health Organization, as part of the wider United Nations system, and the Government of the Kingdom of Eswatini. It advances the World Health Organization's long history of collaboration with the country and underscores their mutual commitment to work together towards agreed priorities of greater importance and relevance to the people of the Kingdom of Eswatini, as envisioned in the Government's National Development Plan (2019-2022), the National Health Policy (2016), the National Health Sector Strategic Plan (NHSSP 2019-2023) and the Sustainable Development Goals (SDGs).

The Government of the Kingdom of Eswatini is committed to improving the health and well-being of people of Eswatini by providing preventive, promotive, curative and rehabilitative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable. Eswatini also adopted Sustainable Development Goals (Goal 3) – ensuring healthy lives and promoting well-being for all at all ages. The Government recognizes that improving health outcomes will be achieved through strengthening health systems towards Universal Health Coverage, addressing socioeconomic and environmental determinants of health as well as protecting people from health emergencies, leaving no-one behind.

The Ministry of Health welcomes the fourth Country Cooperation Strategy 2022–2026 which is aligned to the World Health Organization's 13th General Programme of Work 2019-2025. It paves the way for a new level of collaboration that is strategically focused, results-oriented, and built on longstanding partnerships.
I wish to pledge the support of the Ministry of Health to ensure the implementation of WHO's fourth Country Cooperation Strategy 2022-2026 towards achieving good health and well-being for all people in the Kingdom of Eswatini.

Minister of Health
Eswatini

Message from the WHO Regional Director for Africa

The World Health Organization's (WHO) revised Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly to strengthen WHO's capacity and ensure that its delivery better meets the needs of countries. It reflects the transformation agenda of the African Region as well as the key principles of the Thirteenth General Programme of Work (GPW13) at the country level. It aims to increase the relevance of WHO's technical cooperation with Member States and focuses on identifying priorities and effectiveness measures in the implementation of WHO's programme budget. The role of different partners, including non-state actors, in supporting governments and communities is highlighted.

The objective of the CCS is to make WHO more effective in its support to countries, through responses tailored to the needs of each country.

The revised third generation CCS builds on lessons learned from the implementation of the earlier generations of the country cooperation strategies; the countries' priorities reflected in the national policies, plans and priorities; and the United Nations Sustainable Development Partnership Frameworks (UNSDCFs). These CCSs must also align with the global, continental and regional health context and facilitate the acceleration of investments towards Universal Health Coverage (UHC). It incorporates the fundamental principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008) and Busan (2011) Declarations on Aid Effectiveness. Its implementation will be measured using the Regional Key Performance Indicators, which reflect the country focus policy and the strengthening of the decision-making capacity of Governments to improve the quality and equity of public health programs.

The evaluation of the Third Country Cooperation Strategy (CCS 3) highlighted the progress made, the constraints and obstacles encountered, drew lessons and made recommendations to improve the Fourth Country Cooperation Strategy 2022-2026.

Progress towards Universal Health Coverage requires an approach that improves quality of services, ensures integration of intervention, is people-centered and inclusive and provides affordable health services. To achieve this, I urge WHO offices to effectively use the strategies in operational planning, sustained advocacy, improved resource mobilization, strengthening partnerships and justifying country presence.

I commend the effective and effective leadership role played by governments in the process leading to the development of the new CCS including conducting CCS 3 review exercise. I call on all WHO staff, and in particular WHO country representatives, to redouble their efforts to ensure the effective implementation of the programmes described in this document in order to improve health and wellbeing of the population, which are essential elements for the economic development of Africa.

I recognize that increased efforts will be needed in the coming years, but I remain convinced that with strong leadership by Governments and stronger, transparent, and more resolute collaboration between technical and financial partners, together we can work towards the achievement of national, regional, and continental health objectives. For my part, I can reassure you of the full commitment of the WHO Regional Office for Africa to provide the necessary technical and strategic support for the achievement of CCS 4 objectives with a view to achieving the "triple billion" goals and the Sustainable Development Goals.

Dr Matshidio MOETI
WHO Regional Director for Africa

Message from the WHO Representative Eswatini

The World Health Organization fourth Country Cooperation Strategy 2022-2026 is an outcome of a consultative process with inputs from Ministry of Health, various agencies in the health sector and other relevant stakeholders. It has been developed to provide strategic direction and support towards achieving the priorities of the Government of the Kingdom of Eswatini. It is designed to support strengthening of health systems and services towards attainment of Universal Health Coverage (UHC) and the Sustainable Development Goals targets.

The CCS 2022-2026 also presents the collaborative agenda between the Kingdom of Eswatini and the three levels of WHO, aligns with the strategic priorities of WHO's 13th General Programme of Work (2019 – 2025), as well as Eswatini's United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025.

The following fourth CCS 2022-2026 strategic priorities emerged from a critical analysis of the health system which identified current epidemiological, disease burden and health systems challenges, and key strategies designed to support the Government of the Kingdom of Eswatini in the attainment of the national health goals and targets:

i. Strengthening quality service delivery;
ii. Addressing communicable and non-communicable disease prevention and control;
iii. Promoting equitable and integrated health services across the life course;
iv. Promoting multisectoral approaches for healthier populations; and
v. Enhancing health security and disaster preparedness and response.

WHO is fully committed to implementing the fourth CCS through collaborative effort with all stakeholders. The CCS will be jointly monitored by the Ministry of Health and WHO throughout its implementation, and any adjustment will be made to respond to emerging needs.

We look forward to further strengthening the partnership between WHO and the Kingdom of Eswatini

WHO Country Representative
Eswatini

Executive Summary

The fourth World Health Organization Country Cooperation Strategy 2022–2026 (CCS) for Eswatini sets out how WHO will work with the government over the next five years – in accordance with the National Development Plan 2019-2022. The CCS 2022-2026 aligns with the National Health Sector Strategic Plan 2019-2023 whose overarching goal is to ensure that all citizens – regardless of age, gender, socioeconomic status, or cultural background – can lead healthy lives with equal access to quality health services and articulates the national vision of "A healthy and productive Emaswati population that live long, fulfilling and responsible lives".

The CCS 2022-2026 is guided by and is aligned with the Sustainable Development Goals, the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 and the WHO Thirteenth General Programme of Work 2019-2025.

Eswatini has made significant progress in health outcomes and health services coverage over the last 20 years. Life expectancy has increased to 60 years, up from 54 years in 1990, Maternal Mortality Ratio fell from 593 per 100,000 live births in 2012 to 452 in 2019, Child survival improved, with the under-five mortality rate falling from 97.4 deaths per 1,000 live births in 2010 to 70.4 in 2016 and Eswatini registered 40% reduction in HIV incidence among those aged 15-49 years from 2.9 (2011) to 1.36 (2016) (SHIMS2). Maternal and child health services have improved, with more children living beyond infancy, and a larger number of women delivering in health facilities with more births attended by professional service providers than ever before. Access to and provision of preventive, diagnostic and treatment services for communicable diseases have also improved. Initiatives to reduce illness and death due to non-communicable diseases and injuries are gradually being scaled up.

Despite this progress, achievements in health have not been uniform and challenges persist, with inequities between population groups continuing and preventable mortality remaining high. The significant decline in common communicable diseases, including malaria, HIV, tuberculosis, and vaccine-preventable diseases is coupled with an existing triple burden of diseases (communicable diseases, non-communicable diseases, and maternal and child health issues), with prevalence of non-communicable diseases increasing.

Sustainable financing for health remains a challenge, which undermines the sector's ability to provide equitable access to good-quality preventive and responsive health services. There is still a need to strengthen inter-sectoral collaboration and shared responsibility for health.

This Country Cooperation Strategy (CCS) 2022-2026 defines WHO Eswatini's strategic agenda for addressing country-specific bottlenecks to health and development, while leveraging resources and partnerships for health in Eswatini. It provides a high-level overview of WHO's role at its three levels (global, regional and country) and outlines WHO's commitment to achieving impact at the country level.
The strategic priorities specified in the CCS are the outcome of a series of consultations with the Ministry of Health and other stakeholders and are based on critical analysis of the country's needs and WHO's comparative advantage for addressing those needs. The Ministry of Health and WHO are both invested in the development and implementation of this CCS and are accountable for its results.

The five strategic priorities are –
vi. quality service delivery;
vii. communicable and non-communicable disease prevention and control;
viii. an equitable, integrated health service across the life course;
ix. multisectoral approaches for healthier populations; and
x. enhanced health security and disaster preparedness and response.

The Focus areas under each Strategic priority are highlighted below:

Quality service delivery

- National policies and strategies
- Integrated people-centered health services
- Health information systems and evidence

Communicable and non-communicable disease prevention and control

- Delivery of well-coordinated comprehensive communicable and non-communicable disease prevention and control services
- Provision of technical guidance towards the development and implementation of national strategies and guidelines for communicable and non-communicable diseases

Equitable and integrated health services across the life course

- Reproductive, maternal, newborn, child and adolescent health
- Improving population immunity (through vaccination) throughout the life course
- Strengthening integration of services in sexual and reproductive health

Multisectoral approaches for healthier populations

- Addressing the social, environmental and economic determinants of health
- Reducing risk factors for non communicable diseases
- Reducing malnutrition-related complications

Health Security and disaster preparedness and response

- Detecting and responding to public health emergencies
- Early warning, risk assessment, prepraredness, and emergency response to disasters

Using an integrated approach with dialogue and complementarities across programmes, disciplines, and sectors, the CCS 2022-2026 will be operationalized through biennial results-based planning and programming processes with a clear results framework focusing on achieving impact and based on the budget envelope required to implement each of the strategic priorities. WHO will harness global knowledge to help deliver evidence-informed, context-specific, and innovative solutions that will benefit all Emaswati, working closely with development partners and other stakeholders. As a learning organization, WHO will use the 13th General Programme of Work (GPW13) “triple billion” targets (aligned to national strategic priorities) to monitor performance and adapt the way it works in Eswatini to maximize its contributions.

Under the leadership of the WHO Country Representative, the CCS will be monitored and evaluated jointly with the Ministry of Health and partners. A mid term review of the CCS will be conducted in 2024 and the final evaluation will be conducted in 2026.

1. Introduction

The fourth WHO Country Cooperation Strategy 2022-2026 is the medium-term strategy that will guide the application of WHO's expertise and comparative advantage in support of the development priorities determined by the Government of the Kingdom of Eswatini.

In Eswatini, the Country Cooperation Strategy (CCS) (2022-2026) was initiated in line with the country's National Development Plan (2019-2022), National Health Policy (2016), and National Health Sector Strategic Plan (2019-2023), as well as the 2030 Sustainable Development Agenda and Eswatini's United Nations Sustainable Development Cooperation Framework (UNSDCF) (2022-2026). It sets out a strategic framework for working with the Kingdom to improve stewardship of the health sector, reduce morbidity and mortality due to high disease burden, and improve the responsiveness of WHO to country needs. It is the key instrument for guiding the work of the WHO in Eswatini, and the main instrument for harmonizing WHO's cooperation with other United Nations agencies and development partners.

It is in this context that this CCS was developed as a continuum of the previous country cooperation strategies implemented by WHO in consultation with the Ministry of Health of Eswatini and other strategic partners, including United Nations organizations, development partners, NGOs, civil society, and the private sector.

The process involved a critical analysis of the health situation in Eswatini, a mapping of health and development challenges and extensive dialogue with government and other stakeholders for consensus on the following five broad strategic priority areas:

Strategic Priority 1:	Quality service delivery
Strategic Priority 2:	Communicable and non-Communicable disease prevention and control
Strategic Priority 3:	Equitable, integrated health service across the life course
Strategic Priority 4:	Multisectoral approaches for healthier populations
Strategic Priority 5:	Enhanced health security and disaster preparedness and response.

The CCS 2022-2026 strategic priorities also reflect the transition from WHO's Twelfth General Programme of Work (GPW12) (2014-2019) to WHO's Thirteenth General Programme of Work (GPW13) (2019-2025) which seeks to address complex health challenges such as rising health care spending, changing disease burden, changing demographics, aging populations, rising inequalities, climate change and rising risk of emerging and re-emerging diseases. GPW 13 champions health in the Sustainable Development Goals (SDGs) - ensuring healthy lives and promoting well-being for all at all ages, leaving no-one behind.

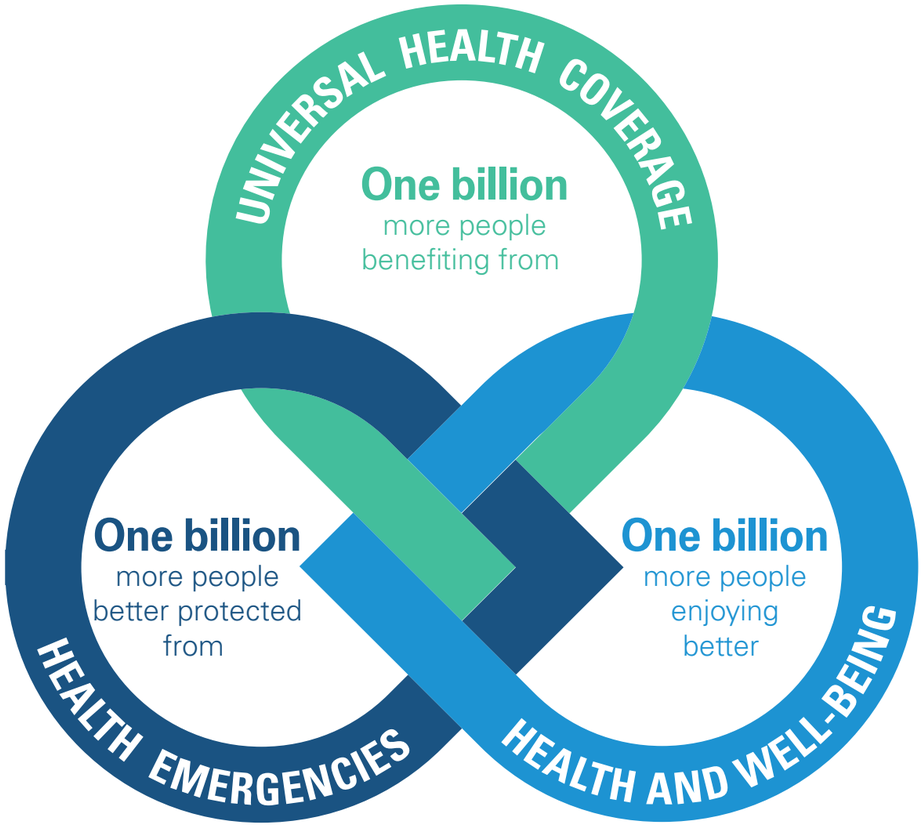


Fig 1: GPW 13 triple billion priorities

The 13th General Program of Work (GPW13) for WHO focuses on three interconnected strategic priorities: achieving universal health coverage (UHC), addressing health emergencies, and promoting healthier populations and sets goals of 1 billion people for each of its strategic priorities, which are: 1) one billion more people to benefit from universal health coverage (UHC); 2) one billion more people to be better protected from health emergencies; and 3) one billion more people to enjoy better health and well-being.

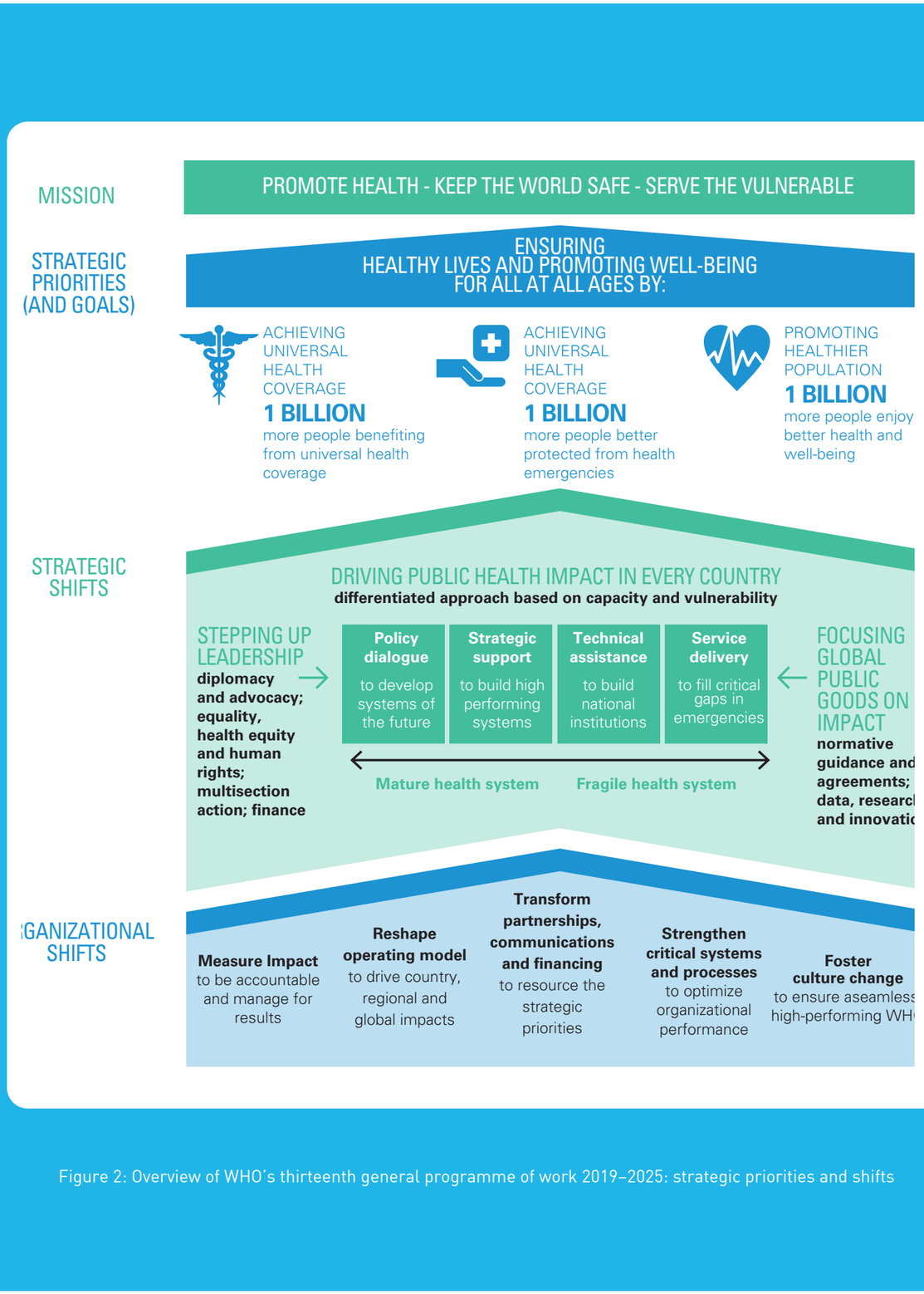


Figure 2: Overview of WHO's thirteenth general programme of work 2019–2025: strategic priorities and shifts

2. Health and Development Context

The Kingdom of Eswatini is a small (17,364 km2) lower-middle income landlocked country in sub-Saharan Africa bordered by the Republic of South Africa and Mozambique.

2.1. Political, demographic, socioeconomic, environmental and legislative context

This section covers the political, demographic, social, economic, environmental, and legislative context of Eswatini.

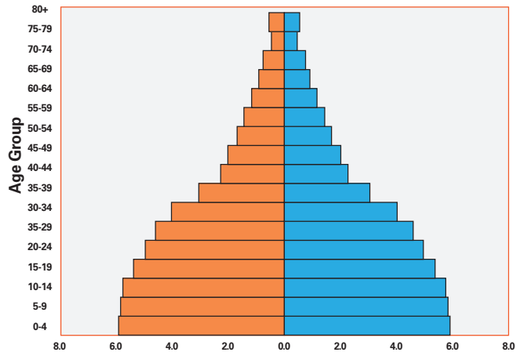
Political context

Eswatini is an absolute monarchy with constitutional provisions and Swazi Law and Custom. The King is head of state. The country is divided into 4 administrative regions, 59 political administrative constituencies (Tinkhundla) and 365 Chiefdoms, providing a structure for electoral processes and for implementation of national development initiatives and programmes. These structures also provide a link between governmental and traditional institutions for decentralized service delivery and community mobilization.

The head of government is the Prime Minister, who is appointed by the King after the election of a new parliament. The Prime Minister serves a five-year term and as head of government, also chairs cabinet meetings. Executive power is exercised by the Government, while legislative power is vested in both Government and Parliament. The Ministry of Health has primary responsibility for health care in Eswatini, while the Ministry of Housing and Urban Development, which deals with infrastructure, waste and sewage, plays a key role in promoting environmental health.

Demographic context

In 2017, Eswatini had a population of just under 1.1 million (531,111 males and 562,127 females), with over 40 per cent under the age of 15 years (Figure 1). Seventy-seven per cent of the population resides in rural areas and 23 per cent in urban settlements. Fertility was 3.3 children per woman in 2014. Eswatini has a youthful population with 56 per cent below 25 years of age in 2017. The country is going through a demographic transition, with an increase of 74,789 persons compared to 2007. The population aged 15-64 years was 56.8 per cent in 2007 and increased to 59.9 per cent in 2017.



Source: Kingdom of Eswatini 2017 Housing and Population Census

Figure 3: Population pyramid of Kingdom of Eswatini, 2017

Social context

The UNDP Human Development Index for Eswatini remains low, (rank 140 out of 187 countries). In the 2001 and 2010 Swaziland Household and Expenditure Surveys (SHIES), huge regional differences were observed in the prevalence of poverty. The driest regions of the country (Lubombo and Shiselweni) are the poorest. The Hhohho and Manzini regions – which include the major urban centres of Mbabane and Manzini respectively – have the lowest poverty rates. Female-headed households are poorer than male-headed households, with 67 per cent of the former considered poor compared to 59 per cent of the latter. It has also been observed that rural households involved in non-commercial farming activities derive about 12 per cent of their income from these activities and are the poorest. They are followed by households with self-employed heads.

Despite the enactment of the Sexual Offences and Domestic Violence Act in 2018, gender-based violence remains a major challenge in Eswatini. The last national study, conducted in 2007, indicated that one in three women in Eswatini are likely to have suffered sexual violence by the time they are 18 years of age. Measures put in place to address this include development of national regulations to accelerate implementation. With concerted advocacy efforts, the Act will go a long way towards protecting the rights of marginalized groups in society.

Economic context

Eswatini is a lower-middle-income country with a gross national income of US$4.30 per capita in purchasing power parity (PPP) in 2021. The fiscal deficit was 8.6 per cent of GDP in 2020, up from 5.3 per cent in 2019, prompting the government to approach international financial institutions for budgetary support. Gross public debt, which includes domestic arrears, rapidly rose to nearly 48 per cent of GDP in 2020 from 38 per cent in 2019, well above the government's threshold of 35 per cent of GDP. Eswatini's economy contracted by an estimated 3.2 per cent in 2020 after growing by 2.2 per cent in 2019. Eswatini's unemployment rate for 2020 was 23.4 per cent, a 1.16 percentage point increase from 2019.

48% of GDP
in 2020 from
38% in 2019

1.1 million
(531,111 males and **562,127** females),

Eswatini remains low,
rank **140 out of 187** countries

Legislative and policy framework

In 2005 Eswatini adopted a Constitution with a Bill of Rights entrenching basic human rights of Emaswati. Amongst other provisions, the Constitution has entrenched the basic human rights of vulnerable groups such as women, children, and persons with disabilities. It has provided for an equality clause and women's human rights, for the first time, empowering women to have a choice whether to consent to practices they may not be agreed to. It should be noted, however, that the Constitution does not include socio-economic rights.

Under the Bill of Rights, the right to health is categorized as a non-justiciable directive principle of state policy. Section 60(8) the Constitution provides as follows: "The state shall take all practical measures to ensure the provision of basic health care services to the population." Under Section 30(1)" Persons with disability have a right to respect and human dignity and the government and society shall take appropriate measures to ensure that those persons realize their full mental and physical potential." Under Section 30(2) Parliament shall enact laws for the protection of persons with disabilities to enable those persons to enjoy productive and fulfilling lives.

The country adopted the Sexual Offences and Domestic Violence Act (2018) which is intended to address the alarming incidence of gender-based violence at national level. Several institutions are supporting programmes towards implementation of this legislation. However, more needs to be done to educate the public and law enforcers about the Act including unpacking the provisions in the language that would be understood by all, including local communities and people with disabilities. The country continues to have escalating numbers of cases of gender-based violence.

The Disability Act of 2019 provides for access to health for persons with disabilities. Section 33 of the Act provides that: (1) Persons with disabilities have the right to the enjoyment of health on an equal basis with persons without disabilities; it also provides for essential health services. The language barrier for persons with disabilities remains a challenge for accessibility of health-care services, as there are no interpreters in health facilities in general. Physical infrastructure deters those requiring wheelchairs; education for persons with disabilities is a challenge and violations of the right to information occur, an integral aspect of the right to health.

The Child Protection Act of 2012 provides for children to access health services on their own from the age of 12 years. The Act also provides that "A child with disability has a right to special care, medical treatment, rehabilitation, family and personal integrity, sports and recreation, education and training to help him enjoy a full and decent life in dignity and achieve the greatest degree of self-actualization, self-reliance and social integration possible.

The Medicines and Related Substances Act of 2016 is another important legislation as it standardizes treatment for all, at primary, secondary and tertiary health-care levels.

The rights enshrined in all the policies and laws in Eswatini require the implementation of advocacy measurers and education to benefit the marginalized in society. To ensure provision of quality health services, as a human rights principle, Eswatini developed standards and guidelines for service provision across all the thematic health areas. The Ministry of Health is implementing a Quality Management System (QMS) Standard (ISO 9001:15), and other relevant health standards. This standard focuses on specific health rights for Emaswati accessing health services. As a result, the country has committed to: ensuring the development of a plan (part of the facility quality improvement plan) to address patients' and family rights; developing standard operating procedures (SOPs) for responding to clients' complaints; and also committing to act on recommendations for clients.

Climate and environment

Eswatini's adaptation strategies to climate change have been identified in its Third National Communication (TNC) to the United Nations Framework Convention on Climate Change (UNFCCC) (2016) and its Nationally Determined Contribution (NDC) submitted in 2016. Eswatini has identified four key sectors at risk to climate change which have been prioritized in adaptation strategies: agriculture, water, biodiversity and ecosystems, and health.
Eswatini is at high risk of natural hazards – including seasonal flooding and periods of drought – which are expected to primarily affect the agricultural sector. The country experiences natural hazards, such as violent storms and persistent drought, which are further exacerbating the country's existing challenges of food insecurity and the ability to attain development goals.

2.2. Health system in the Kingdom of Eswatini

Life expectancy at birth for the Kingdom of Eswatini is 60 years (2019), which is less than the global average of 72.2 years (2019). Due to HIV/AIDS, Swaziland has seen its average life expectancy drop over the past 10 years. Data from various sources show that females live far longer than male in Eswatini: life expectancy for females is 65 compared to 56 for males.

Box 1: Trends in key health outcomes

- Maternal Mortality Ratio fell from 593 per 100,000 live births in 2012 to 452 in 2019.
- Child survival improved, with the under-five mortality rate falling from 97.4 deaths per 1,000 live births in 2010 to 70.4 in 2016
- 40% reduction in HIV incidence among those aged 15-49 years from 2.9 (2011) to 1.36 (2016) (SHIMS2)
- Attainment of the 2030 95-95-95 HIV targets 10 years ahead of time.
- Maintained above 95% coverage of prevention of mother-to-child transmission of HIV services.
- Tuberculosis incidence declined by 30%.
- The tuberculosis treatment success rate increased from 80% in 2017 to 86% in 2020.
- Attained 92% malaria case reduction between 2002 and 2016 (Malaria Annual Reports)
- Zero cases of polio, disability and death from diphtheria, tetanus, whooping cough, measles and rubella since 2017.

2.2.1. Universal Health Coverage

Eswatini's health care system is divided into five health service delivery levels (EHCP 2016) which are Level 1 (community level); Level 2 (primary health care facilities, comprising Clinic Type A, Clinic Type B and Public Health Units); Level 3 (Health Centres); Level 4 (Regional Referral Hospitals); and Level 5 National Referral Hospitals. Health service coverage improved with the number of health facilities from 287 in 2013 to 327 in 2017.

In 2017, total expenditure on health in the kingdom of Eswatini was approximately SZL 4,428.11 billion: 10.3 per cent of annual GDP (NHA 2017/2018). Of the total health expenditure, 48 per cent was contributed by the government and 28 per cent by donors. The proportion of total health care spending out of pocket (on supplementary and parallel services, consumption items and co-payments) is very low, at 1.15 per cent (NHA 2017/2018). The percentage of the population whose out-of-pocket health expenditure exceeds 40 per cent of non-food expenditure stood at 2.7 per cent (EHIES, 2017). The Abuja Declaration benchmark of 15 per cent of the national budget to be allocated to health has not yet been achieved due to economic constraints. The national budget for 2018/2019 was 10.1 per cent of the total national budget.

Data from 2013 indicate that physician density per 1,000 population is 0.39, while that of nurses is 2.8. The region with the highest level of staffing is Hhohho (86 per cent) followed by Lubombo region (73 per cent). Manzini region has the lowest (65 per cent) level of staffing followed by the Shiselweni region (72 per cent).

Key health system indicators

6.78% of total GDP spent on health (2019)

1.5 physicians per 1,000 population (NHSSP 2019)

1.7 nurses and midwifery personnel per **1,000 population** (NHSSP 2019)

The access of young women and girls to health services is an important aspect of a gender-responsive health sector. Although reports indicate that adolescents and young women are receiving health services, there are still barriers in some facilities that do not have youth-friendly departments.

Early childbearing is a challenge in the country. In 2010 and 2014 the proportion of 15–19 year-old girls and women who had stated they had given birth remained the same at about 17 per cent. It is however higher among the poorer (25 per cent) and lowly educated females in this age group (26 per cent). In 2014 more affluent 15–19 year-old females (17.4 per cent) in the fourth quintile reported giving birth. Adolescent fertility rates are high in the country in 2014 the adolescent birth rate was 87 per 1,000 girls and women in this age group (MICS, 2014). Of all births in Eswatini, about 20 per cent are to adolescents. The unmet need for family planning, and particularly to child spacing, is highest among this group.

The National Health Strategic Plan was first developed in 1983, with primary health care as the cornerstone of service delivery. The current National Health Sector Strategic Plan 2019-2023 focuses more on achieving universal health coverage, as set out in the SDG agenda.

Despite the achievements in health outcomes, there is need to strengthen the health system to make it more resilient and adaptable to changing conditions and growing needs of the health sector. The areas of focus for the next years include improving the efficiency of the health system, addressing barriers to equitable access to health services, strengthening health information systems, digitalization, promoting ehealth and innovations. The increasing burden of non-communicable diseases calls for a holistic, integrated approach and strengthening primary health care to delivery of quality people-centered health services

2.2.2. Emergency preparedness and response

Eswatini is implementing the International Health Regulations (IHR) and Integrated Disease Surveillance and Response (IDSR) since 2010 to prevent, detect and respond to public health events of international concern. The Joint External Evaluation (JEE) for the country's ability to implement the International Health Regulations (IHR) 2005 was conducted in 2018 which led to the development of the National Action Plan for Health Security (NAPHS) 2020 to 2024 which is in process of finalization.

The recommendations of the JEE provided Eswatini with opportunity to strengthen health systems to address emerging and re-emerging diseases.

The Coronavirus disease 2019 (COVID-19) pandemic has posed a severe threat to health security, impacting every population and economy at the global, national and regional levels. On 30 January 2020, the Director-General of WHO declared the coronavirus disease 2019 (COVID-19) outbreak a public health emergency of international concern (PHEIC) under the International Health Regulations (IHR 2005), following advice from the IHR Emergency Committee. On 14th March 2020, Eswatini reported the first case of Covid-19. A summary of the response to covid-19 from 2020 to 2021 is presented in Box 2.

Box 2: Kingdom of Eswatini's Response to Covid-19 Pandemic 2020-2021

Eswatini reported its first case of COVID-19 on 14th March 2020. His Majesty King Mswati III and Ingwenyama invoked section 29 of the Disaster Management Act 2006 and declared the COVID-19 pandemic a National Emergency in the Kingdom of Eswatini from 17 March 2020. By the end of 2021, the country had recorded 64,381 cases and 1,272 deaths with a case fatality ratio of 2.0%. COVID-19 vaccination was deployed in March 2021 and 25% of the population was fully vaccinated by December 2021.

Since the first imported case was reported in the country, the country developed operational response plan, conducted risk assessments and different strategies addressing all the pillars have been put in place to combat the spread of pandemic. Public health measures were implemented to mitigate the impact and prevent health problems while ensuring that everyone has access to essential health care.

From 2020-2021, Eswatini experienced three waves of the covid-19 pandemic driven by different variants. A majority (60%) of these cases reported from the beginning of the pandemic had mild disease at diagnosis, with only 2% with severe disease. Preliminary analysis of the deaths indicates that a majority of the deaths are amongst the elderly population (60+), with males mostly dying compared to their female counterparts. A consistent trend has been noted is that those who are more likely to die from COVID-19 are those with comorbidities compared to those without. The leading comorbidity among the deaths were hypertension, diabetes and HIV.

The country adopted the Incident Management System to guide the response. The Public Health Emergency Operation Centre was operationalized, and Rapid Response Teams were trained and deployed. There was effective and successful prevention and control of COVID-19 strategies in many of the key pillars, which included the timely detection of the situation and reporting of confirmed cases, and implementation of an integrated approach with the engagement of key stakeholders from government, implementing partners and the private sector. The successful implementation was underpinned by the political commitment and strong leadership that responded to best scientific evidence, a robust underlying public health system, and a strong collaboration with funding and implementing partners.

Based on lessons learnt from COVID-19 response, there is still need to:

- Continue strengthening the structures for coordination, planning and response
- Strengthening surveillance in the context of IDSR to ensure timely health information for decision making, track disease trends, data quality, interpretation of data, and timely information sharing for public health action at all levels
- Build capacity of laboratories at the national and sub-national levels
- Build capacity of health workers in emergency and critical care as well as mental health and psychosocial support

The scale and nature of health issues facing the country is immense and tackling them will require all partners to work closely together, assisting and complementing each other following the One Health approach which recognizes the importance of man–animal–ecosystem interface in disease prevention. All the country's focus and actions will be driven by evidence.

2.2.3. Promoting a healthier population

People's health is strongly influenced by the way that the settings in which they live, grow up, learn, work and play are governed, designed, developed, and regulated. A fundamental goal of health promotion is to enable people to take control over their health. Enabling environments help people to better achieve this goal.

Drought and extreme weather predisposes populations to food insecurity with risk of malnutrition. According to the annual Vulnerability Assessment Analysis Report 2022, between June and September 2022, over 182, 600 people (16% of the population) are estimated to be facing acute food insecurity and requiring urgent humanitarian assistance. The impact of COVID-19, emerging pandemics, and the ongoing Russian/Ukraine conflict, coupled with underlying food insecurity challenges will increase vulnerability in the livelihood zones during the projected period. The number of people that will be food insecure is likely to increase to 258 800 (22% of the population). The Swaziland Comprehensive Health and Nutrition assessment undertaken in 2016 revealed Global Acute Malnutrition of 3.1% and Severe Acute Malnutrition of 2.5%. The stunting prevalence of 21.1% and underweight 5.5% were classified as medium and low respectively. Screening data and nutrition program admission data also indicated an increase in acute malnutrition cases during the drought period compared to the period prior to the drought.

According to the STEP survey 2014 prevalence of smoking among the adult population was 6% and on average the starting age of smoking was 19 years. MoH established the Tobacco Control Unit and the National Tobacco Control Focal Point was appointed. Additionally, Eswatini

established the first multisectoral National Coordinating Mechanism (NCM) for tobacco control which facilitated the development of key legislative and administrative documents such as the National Tobacco Control Policy, the National Tobacco Control Regulations as well as a National Tobacco Control Action Plan, all of which address various elements of the demand for and the supply of tobacco products. Awareness-raising campaigns on the dangers of tobacco use were conducted, targeting school children as well as out-of-school youth.

Alcohol consumption defined as consuming alcohol in the past 30 days was 13%, and in all the age groups there was a high rate of women who reported not doing enough physical activity as per WHO recommendation (20.5% for 15–29, 19.6% for 30-44 and 22% for 45-69) (STEPS Report 2014).

Addressing known, modifiable disease risk factors can promote health and prevent premature deaths. This includes reducing prevalence of, and exposure to, risks such as unhealthy diets, tobacco use, harmful use of alcohol, drug use, insufficient physical activity, obesity, hypertension and violence and injuries. A multisectoral approach is needed to influence public policies in trade, social development, transport, finance, education, agriculture, and other sectors.

The most effective interventions for tackling the social determinants of health and disease risk factors require engagement outside the health sector. WHO's actions will help promote health settings and the Health in All Policies approach (HiAP). There is need build organizational and personal capacity for HiAP and a healthy settings approach.

2.3. The next five years: Key health systems and services issues and challenges to consider

While Eswatini has made progress in key health outcomes and the provision of essential health services across all age groups, the COVID-19 health crisis threatens to reverse these gains and impede further progress. The pandemic revealed health system weaknesses and exacerbated challenges related sexual and reproductive health services as well as mental and psychosocial health. In order to address barriers to equitable, accessible, available, non-discriminatory health care in Eswatini, as well as address the health system challenges, the following issues to address are highlighted:

- Strengthening health systems to improve access to quality essential health services for all leaving no-one behind
- Address health systems constraints in health financing, human resources for health, quality of care, health regulation, health supplies and referral systems
- Build on the lessons from covid-19 to strengthen health security through implementation of the International Health Regulations (2005)
- Promote integrated people-centered care across the life course, addressing both communicable and non-communicable diseases paying attention to the emerging challenge of mental health and psychosocial support
- Tackle risk factors through a multisectoral approach for healthier populations
- Strengthen health information systems to generate real time information for policy and decision making and promoting digitalization, ehealth and innovations

3. Development partners

3.1. Main health and development partners in Eswatini

The key health development partners providing development assistance in Eswatini include United Nations organizations, bilateral and multilateral agencies, global health partnerships and initiatives, development banks and international financial institutions, civil society and non-governmental organizations, community groups, academic institutions and collaborating centres (Table 1). Development assistance is both technical and financial.

Table 1: Eswatini's development partners, 2021

	Education & training	Health	Water & sanitation	Agriculture	Fuel & energy	Infrastructure	Governance	ICT	Climate change	Social protection	Capacity building	Trade	Multi sector
AfDB			X	X		X							
BADEA													
European Union			X	X			X			X	X	X	X
GEF													
Germany				X									
Global Fund		X											
India		X	X	X				X					
Italy					X								
Japan	X	X	X										X
Kuwait						X							
OFID						X							
Republic of China		X	X	X	X	X		X					
UAE						X							
United Nations	X	X		X			X		X	X			X
United Kingdom												X	
United States	X	X											X
World Bank		X	X		X								
Total number of partners	3	7	6	6	3	5	2	2	1	2	1	2	4

Source: External Assistance to Eswatini Report 2021

According to the Ministry of Economic Planning and Development's External Assistance Report (2021), the partners of the Kingdom include the African Development Bank (AfDB), the Arab Bank for Economic Development in Africa (BADEA), the European Union (EU), Germany, the Global Environmental Facility, the Global Fund, India, Italy, Japan, Kuwait, the OPEC Fund for International Development (OFID), the Republic of China, the United Arab Emirates (UAE), the United Kingdom, the United Nations, the United States and the World Bank. There are eight multilateral partners, of which only five have in-country presence namely: the EU, the Republic of China, the United Kingdom, the United Nations, and the United States.

The main partners in the health sector include the Global Fund to Fight AIDS, Tuberculosis and Malaria, India, Japan, the Republic of China and United Nations entities including the WHO.

The EU is one of Eswatini's largest development partners and provides grant funding through several instruments and modalities, but primarily the European Development Fund (EDF) and the Development Cooperation Instrument (DCI). The main focal areas of development cooperation with the EU include education, health care, water and sanitation, agriculture, trade and business development, poverty alleviation, and capacity development of both the public sector and non-state actors. In health, the EU supports projects in Eswatini addressing HIV/AIDS and tuberculosis, as well as water and sanitation.

The Republic of China has a bilateral cooperation agreement/protocol with Eswatini, and Eswatini-Republic of China cooperation is focused in several areas, including agriculture, rural electrification, rural water supply and health care.

The Japan International Cooperation Agency (JICA) – in the framework of a bilateral agreement between the governments of Japan and Eswatini – covers a number of areas, including education, agriculture; food aid, the establishment of the Eswatini Integrated and Geospatial Information System; and capacity development programmes for governmental and private institutions. The World Bank supports the health system through the HIV, AIDS and Tuberculosis project, with the major objectives of improving access to and the quality of health services in Eswatini with a particular focus on primary health care, maternal health and tuberculosis, and increasing access to the social safety net for orphans and vulnerable children.

United Nations (UN) cooperation is focused mainly on poverty reduction, HIV/AIDS, and gender issues. It is channelled through key UN agencies operating in Eswatini: the United Nations Development Programme (UNDP); the United Nations Children Fund (UNICEF); the United Nations Population Fund (UNFPA); the World Health Organization (WHO); and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The Global Fund to fight AIDS, Tuberculosis and Malaria is a financing mechanism aimed at securing, managing and disbursing resources to reduce incidence of HIV/AIDS, tuberculosis and malaria in Eswatini and to mitigate the impacts on those infected and affected by these diseases. Other global health partnerships such as the United States' President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, the Health Metrics Network and the Clinton Health Access Initiative (CHAI), Médecins Sans Frontières (MSF) Switzerland and Holland continue to support various aspects of health.

Other partners that have supported Eswatini in previous years include but are not limited to the Government of Canada and the Government of Sweden.

3.2. Collaboration with the United Nations system at country level

The United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 is the most important instrument for planning and implementing United Nations activities at country level in support of Agenda 2030. The UNSDCF guides the country programme cycle of United Nations agencies at country level. WHO is part of the United Nations Country Team (UNCT) and recognizes the UNSDCF as the main instrument for coordinating efforts. The CCS elaborates the strategic health priorities for WHO, while the UNSDCF guides partnership on issues beyond the health sector. The CCS facilitates implementation of UNSDCF-defined health priorities. WHO is critical for implementation of the UNSDCF Priority II, which covers health, education, vocational training, gender equality and human rights and specifically Outcome 2: "By 2025 boys, girls, women and men, especially the most vulnerable, benefits from equitable access to inclusive, gender transformative, effective and efficient quality social services, life long-learning and market related skills". WHO contributes to Outputs 2.1: "Institutional capacity to develop costed policies and plans in the health sector" and Output 2.2: "Communities empowered to demand quality and relevant health, nutrition, HIV and NCD care".

With the launch of the Global Action Plan for Healthy Lives and Well-being for All (GAP) at the United Nations General Assembly in September 2019, 12 multilateral health, development and humanitarian agencies have committed to better supporting countries to accelerate progress on the health-related SDGs and to deliver on other major commitments for health (including universal health coverage and primary health care). In Eswatini, the CCS will take the GAP forward, coordinating implementation with the United Nations agencies and partners under one of the key commitments outlined below.

The Global Action Plan is based on four key commitments by the heads of signatory agencies to:

- Engage with countries better to identify priorities in health and plan and implement together;
- Accelerate progress in countries through joint action under specific programmatic themes and on gender equality and the delivery of global public goods;
- Align in support of countries by harmonizing their operational and financial strategies, policies, and approaches; and
- Account, by reviewing progress and learning together to enhance shared accountability.

The Global Action Plan broadly complements the United Nations System-wide Strategic Document, which describes the work of the United Nations Development System to support implementation of the 2030 Agenda for Sustainable Development.

4. WHO and Eswatini - A collaborative history (2014-2019)

4.1. WHO's work in Eswatini

4.1.1. Country Presence

WHO established an office in Eswatini in 1973. WHO's objective is the attainment by all peoples of the highest possible level of health. Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. The WHO Country Office provides leadership on matters critical to health. It engages in partnerships where joint action is needed and provides technical support, catalysing change and building sustainable institutional capacity.

4.1.2. Country Cooperation Strategy 2014-2019

In the previous Country Cooperation Strategy (2014-2019), WHO supported the country under the following priority areas:

- Communicable diseases
- Non-communicable diseases
- Promoting health through the life course
- Health systems
- Preparedness, surveillance, and response

WHO supported the government to reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases. WHO has also supported a reduction in the burden of noncommunicable diseases – including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental disorders, as well as disability, violence and injuries – through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors. Promoting good health at key stages of life, considering the need to address social determinants of health (the societal conditions in which people are born, grow, live, work and age) and gender, equity and human rights is another focus of WHO. WHO also supports reduction of mortality, morbidity and societal disruption resulting from epidemics, natural disasters, environmental and food-related emergencies, through prevention, preparedness, response and recovery activities that build resilience and use a multisectoral approach.

WHO supported the government to strengthen its health systems through primary health care, towards universal health coverage. It has supported the development of evidence-based national health policies, strategies and plans, as well as provision of integrated, people-centred health services with improved access to medicines and health technologies. It has contributed towards strengthening the regulatory capacity of the health systems as well as improved information and evidence generation and sharing (Table 2).

Table 2: Key achievements over the last CCS period

Technical focus	Achievements
Communicable diseases	• WHO supported the development of an operational plan and the clinical implementation guidelines for pre-exposure prophylaxis (PrEP) provisions in Eswatini in 2019 • WCO supported the MOH with the development of the His Majesty Correctional Services (HMCS) HIV and Wellness policy and strategy for 2021-2024. • A costed National TB and Control strategy 2020-2023 was developed after extensive stakeholder consultations and is currently being used to guide implementation. As a result, the drug-resistant tuberculosis (DR-TB) success rate improved from 74% in 2018 to 79% in 2021, a figure that is higher than the global treatment success rate of 59% (Global TB report 2021). The lost to follow-up also improved from 6% to less than 2%. • WHO supported the Malaria Programme Review whose findings were used to develop the National Malaria Elimination Strategy 2021-2023 • The population covered by neglected tropical diseases interventions (mass drug administration) increased from 76% in 2016 to 98% in 2019.
Non-communicable diseases	• Since the NCD Strategic Plan (2016-2020) ended, a review was conducted, and the findings were used to develop an action plan covering 2021 to 2023. • Package of Essential NCD Interventions for Primary Care in Eswatini and Kingdom of Eswatini Clinical Guidelines for the Management of NCDs at Secondary and Tertiary Care were printed and disseminated to facilities across all levels of care. • The NCD Program undertook a comprehensive national quantification of essential NCD drugs and diagnostics for 2021 to help ensure an uninterrupted supply of these key commodities for the coming year. • Cancer screening Standard Operating Procedures (SOPs) were developed along with desk guides and cancer screening registers to capture the 6 screenable cancers. Health facility assessment was also done to develop a cervical and breast cancer screening baseline for the unit, which in turn aided in the identification of gaps and development of targets.
Promoting health through the life course	• WHO supported Eswatini to introduce new vaccines, including Rota, Rubella and IPV, conducting nationwide measles-rubella campaign targeting children between 9 to 59 months integrated with Vitamin A supplementation and deworming. • The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) were developed, and health workers were trained on the guidelines. • Guiding documents on infant nutrition were also developed in line with WHO recommendations. The guidelines adapted the WHO guide for breastfeeding in the context of COVID-19 pandemic. • Strategic Assessment on Unintended Pregnancy, Contraception, and Abortion in Eswatini • WHO supported the development of the national guidelines on the management of infertility which were developed during the South-South collaboration with South Africa • WHO supported the integration of sexual reproductive health (SRH) services within SRH services and other programmes. • Family planning guidelines were reviewed and integrated cervical cancer screening, STI management and HIV counselling on pre-exposure prophylaxis. In collaboration with UNAIDS, the National Sexual Reproductive Health and Rights guidelines for women living with HIV were developed.
Health systems	• WHO supported the country in efforts to revitalize Primary Health Care (PHC). A baseline assessment was completed. • The Essential Healthcare Package was reviewed and guided the development of a strategy for the continuity of Essential Health Services during the COVID-19 pandemic. • WHO supported the establishment of the Board of Directors for the National Regulatory Unit
Preparedness, surveillance, and response	• The Joint External Evaluation (JEE) for implementation of the International Health Regulations (IHR) 2005 was completed in 2018 and led to the development of the National Action Plan for Health Security (NAPHS). • The annual reports on IHR (2005) for 2020 and 2021 using the SPAR tool were submitted on time. • WHO supported the emergency preparedness and response for covid-19 pandemic across all the pillars – including conducting Intra Action Reviews to inform the response to the covid-19 waves driven by various variants

During the CCS 2014-2019, the WHO Country Office (WCO) had a cordial relationship with the Ministry of Health, development partners and other stakeholders. This created a very favourable environment for WHO to deliver on its mandate. The WCO was able to draw on its technical expertise at regional and HQ levels to support the country's efforts. Improvements in the connectivity of the WCO made it easier to communicate with other levels of the organization. Financial resources were allocated according to focus areas. The total budgetary allocation for the implementation of the CCS was US$3.6 million, of which US$1.2 million (32 per cent) was used to implement Health System Strengthening, US$1 million (28 per cent) Health promotion and USD$900,000 (25 per cent) Communicable diseases.

4.1.3. Lessons learned and opportunities

- Adequate human resources (quality and quantity) at the Ministry of Health and WCO are essential for delivering results that support all the needs of the sector.
- Delayed disbursement of funds negatively affects implementation of key activities.
- Collaboration with development partners creates a very favourable environment for WHO to deliver on its mandate.
- The ability of the WCO to draw expertise from various levels contributed greatly to the implementation of many activities and covered the human resources gap in the office.
- A monitoring and evaluation focal person is essential for monitoring and reviewing the implementation of workplans.

4.2. The Kingdom of Eswatini's contribution to the regional and global health agenda

Eswatini, as a WHO Member State, participates in the World Health Assembly and the Regional Committee for Africa as well as the African Union. Eswatini joins other countries in discussing and setting the global health agenda. As a member of the Southern African Development Community (SADC), Eswatini participates in discussions on health issues affecting the regional bloc, for example, tuberculosis in the mining sector and HIV and AIDS prevention and control in most-at-risk populations (sex workers and long-distance truck drivers). Lesotho, Namibia, Botswana, South Africa and Eswatini have formed an inter-country certification committee (ICCC) to discuss activities in the Polio Eradication Initiative (PEI).

Eswatini played a key advocacy role for accelerating action towards attainment of SDG 3 in SADC. The country is also advocating for a malaria elimination strategy through the Elimination 8 (E8) initiative for countries in Southern Africa, and through Elimination by 2025 (E25), a global initiative targeting malaria elimination in 25 countries around the world. Through this participation the country was able to share experience and technical expertise with other countries. Through the WHO Regional Office for Africa (WHO AFRO), the country is implementing the AFRO 2 Project to demonstrate the effectiveness of diversified, environmentally sound and sustainable interventions, and to strengthen national capacity for innovative implementation of integrated vector management for disease prevention and control in the WHO AFRO region.

Eswatini is one of the countries prioritized for eliminating cervical cancer as a public health problem by 2030. In addition, Eswatini is receiving support from the WHO Framework Convention on Tobacco Control (FCTC) through the FCTC 2030 Project to strengthen tobacco control efforts.

CCS was **US$3.6 million,** of which
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5. Setting the strategic priorities

This section presents the strategic priorities for WHO's cooperation with the Kingdom of Eswatini for the period 2022-2026. The priorities have been identified through a consultative process at country level with all stakeholders and through evaluation of implementation of the previous CCS. The prioritization also took into consideration documents such as the NHSSP 2019-2023, the GPW 13 priorities and the UNSDCF 2021-2025.

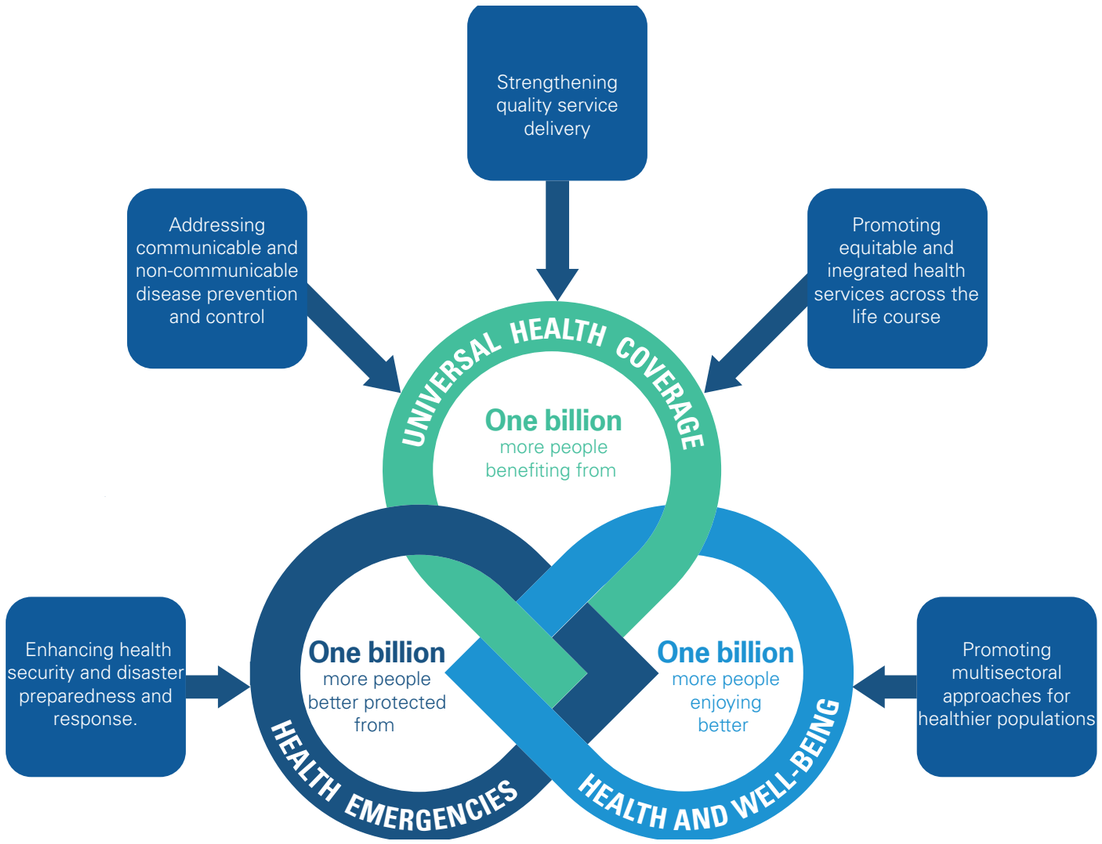

Figure 4: Linkage between CCS strategic priorities and GPW 13 priorities

Strategic priority 1: Quality service delivery

This strategic priority area focuses on supporting the provision of people-centred, quality, comprehensive, essential health services using a primary health care approach.

Focus area 1.1: National policies and strategies

A good health system is one that delivers equitable quality services to all the people at the time and place when the service is required. In the NHSSP the government has committed to delivering the best possible care to patients at all levels of the health care system.

WHO will:

- Engage in an end term review of the existing NHSSP 2019-2023
- Support the development of new National Health Sector Strategic Plan for 2024-2029
- Support the development of programme-specific policies, strategies and guidelines

CCS deliverables:

- End term review of NHSSP 2019-2023 report and new development of NHSSP 2024-2029
- National strategic policies and strategies are developed and implemented to strengthen health systems towards Universal Health Coverage

Focus area 1.2: Integrated people-centred health services

In a people-centred approach the person is placed at the centre of the service and treated as a person first. The focus is on the person and what that person can do, not the person's condition or disability.

WHO will:

- Strengthen the primary health care (PHC) system based on the findings of the already-initiated baseline assessment. Use the global PHC framework to align the primary health care approach in the whole service delivery system during the development of the NHSSP 2024 to 2029. A costed PHC service advocacy tool will be used to mobilize more resources to strengthen PHC.
- Work with the quality team in the Ministry of Health to createthe a system and monitor the quality of services like patient satisfaction.
- Support the Ministry to develop a mechanism to monitor community engagement in planning and implementation of health-related programs.
- Support strengthening and human resources for health (HRH) through the scaling up of human resources information system (HRIS) for HRH, building the capacity of mid-level managers, and supporting capacity development of the health care workforce to provide people-centred health services.
- Support the conducting of the National Health Account (NHA) and institutionalization of the NHA and conduct NHA 2018/2020.
- Strengthen the national blood transfusion system to improve the availability of the required quality and quantity of blood and blood products to provide people-centred quality services.
- Strengthen radiology and imaging in the areas of policies, strategies, and guidelines.
- Strengthen quality supply chain management and procurement for medical technologies.
- Strengthen the national pharmacovigilance system.

CCS deliverables:

- Roadmap and investment case for primary health care
- PHC approach embedded in the new NHSSP
- An innovative way to make service delivery responsive to people's needs to meet quality standards
- Health expenditure data regularly collected and analysed
- Better organized and staffed radiology and imaging unit
- Accredited and strengthened national blood transfusion system
- Availability of safe medicines and health technologies for essential health service delivery

Focus area 1.3: Health information systems and evidence

The Kingdom of Eswatini has invested enormously in health information systems (HIS) as a critical component of its response to the rising trends of demand for health care in aspiring to universal health coverage. In the past two decades, there has been great progress in both paper-based and electronic systems with regards to standardization, usability, integration and availability.

Essential health information is generated from a range of data sources, and a wide array of stakeholders is involved in different ways with each of these sources. Some of the information is generated beyond the Ministry of Health, such as vital Statistics (Ministry of Home Affairs), and population censuses and household survey data (Central Statistics Office). Health information also cuts across the six building blocks of Health systems (human resources, finance, information, service delivery, medicines and supplies, and leadership/governance).

WHO will:

- Support strengthening of the health information system through HIS strategy implementation and monitoring of key health indicators. Interoperability between the Client Management Information System (CMIS) and District Health Information Software version 2 (DHIS-2) will also be supported.

Strengthen the civil registration and vital statistics (CRVS) system.

- Establish and strengthen a National Health

Observatory.
- Support the Ministry of Health Strategic Information Department (SID) on disease-specific interventions; and strengthen the collection, analysis, and use of routine programme data (including research, scorecards, dashboards, and disease mapping) to support disease-specific interventions that improve responses.
- Promote local research for evidence-based programming.
- Strengthen data management in emergencies and Ddevelop a robust surveillance system in the context of IDSR.

CCS deliverables:
- The development of a A five-year CRVS strategy
- Transition from International Classification of Diseases 9th Revision to 11th Revision (ICD 9 to ICD 11)
- Strategic plan evaluation and programme review reports for disease-specific interventions
- An improved health information system, to provide quality, complete and timely information to support evidence-based decision making.
- Establishment of a functional and regularly updated National Health Observatory System
- A robust data management and surveillance system to monitor the control, elimination, and eradication of prioritized diseases.

Strategic Priority 2: Communicable and non-communicable disease prevention and control

This strategic priority area is about providing quality, equitable, integrated and patient-centred communicable and non-communicable disease prevention and control services at scale remains a priority in Eswatini.

Focus area 2.1 Delivery of well-coordinated comprehensive communicable and non-communicable disease prevention and control services

The focus is strengthening health systems to ensure universal demand for and access to affordable quality services for communicable and non-communicable disease prevention and control.

WHO will:
- Advocate for improved and sustainable financing for the prevention and control of communicable and non-communicable diseases
- Improve equity in the distribution of resources and health services related to communicable and non-communicable disease prevention and control.
- Scale up delivery of integrated health services on communicable and non-communicable diseases in health care facilities.
- Improve collaboration, accountability mechanisms and engagement of communities and other non-health actors for implementation of quality patient-centred communicable disease and non-communicable disease prevention and control interventions
- Ensure availability, access and affordability of essential medicines and health technologies in primary health-care facilities

CCS deliverables:
- Coordination and accountability mechanism between stakeholders, including communities and non-health sectors, reviewed and improved.
- Well-capacitated health workforce and communities for successful delivery of patient-centred communicable and noncommunicable disease prevention and control services
- Documented examples of innovative, effective and efficient integrated service delivery and monitoring models for communicable and noncommunicable diseases

Focus area 2.2 Provision of technical guidance towards the development and implementation of national strategies and guidelines for communicable and non-communicable diseases.

WHO will:
- Conduct programme reviews to inform development of evidence-based policies and plans
- Provide technical assistance to facilitate timely development and implementation of evidence-based national policies, strategies, action plans, guidelines, norms and standards and innovations for the prevention, control and elimination of conditions and diseases.
- Develop a monitoring and evaluation framework for tracking progress towards achieving programmatic targets and objectives

CCS deliverables
- Programme reviews and national health survey reports for communicable and non-communicable diseases
- Up-to-date national strategic plans, operational plans, and guidelines for communicable and non-communicable diseases
- An improved health information system for reporting on equitable and integrated service delivery for communicable and non-communicable diseases.

Strategic Priority 3. An equitable, integrated health service across the life course

This strategic priority area is about bringing together evidence-based strategies to improve health across the life course, from preconception, pregnancy and childbirth to infancy, childhood, adolescence, adulthood, and older age, as well as across generations.

Focus area 3.1: Reproductive, maternal, newborn, child and adolescent health

This area focuses on strengthening capacity to reduce risk, morbidity and mortality and improving reproductive, maternal, newborn, child and adolescent health (RMNCAH). WHO as the lead for H6 partners will strengthen delivery of RMNCAH services in this area.

WHO will:
- Adapt, implement, and review evidence-informed global strategy guidelines, and plans for expanding access to – and improving the quality of – interventions to end preventable deaths.
- Build capacity for improving health information on maternal and perinatal health, and maternal and perinatal death surveillance and response; and scale up related interventions through adoption of a multi-sectoral approach
- Strengthen national capacity for collection, analysis, dissemination and use of data on maternal and newborn health, and institute regular programme reviews, including documentation of best practices, to improve access to, and the quality of, interventions.
- Work with partners, including the Global Health Partners (H6) to mobilize resources to end preventable maternal and newborn deaths and prevent mother-to-child transmission of HIV.

CCS Deliverables
- Policies, strategies, guidelines and plans updated
- Strengthened sSurveillance systems in place
- Partnerships coordination's strengthenedforums
- Skilled health care workers with adequate skill mix and distribution

Focus area 3.2: Improving population immunity (through vaccination) throughout the life course

Vaccines are critical to the prevention and control of communicable diseases and therefore underpin the county's security. Vaccines must be equitably delivered, and thus there is a need to understand the causes of low vaccine use and address any issues of demand and supply. In addition, surveillance for adverse events following immunization (AEFI) is an integral part of the National Immunization Programme and reinforces the safe use of all vaccines in the country while also helping to maintain public confidence in the immunization programme.

WHO will:
- Support implementation of the Immunization Agenda 2030 (IA2030)
- Support use of innovative strategies to reach targeted populations (Reaching Every District – RED; Periodic Intensification of Routine Immunization – PIRI; and Child Health Days – CHDs)
- Advocate for the introduction of new vaccines as they become available for all ages
- Support vaccine safety and adverse events following immunization (AEFI) surveillance

CCS deliverables:
- Innovative strategies used to increase population immunity through implementation of Immunization Agenda 2030 (IA2030)
- New vaccines introduced as they become available
- AEFI surveillance system improved

Focus area 3.3: Strengthening integration of services in of sexual and reproductive health services throughout the life course including other vulnerable groups, (family planning, sexually transmitted infections, infertility and sexual dysfunction,and healthy ageing)

This area includes contraception and family planning, maternal and perinatal health, preventing unsafe abortion, sexually transmitted infections, reproductive tract cancers, linkages between sexual and reproductive health and HIV, infertility, adolescent sexual and reproductive health, female genital mutilation, digital health innovations, measuring and monitoring of sexual and reproductive health indicators.

WHO will:
- Support a multistakeholder/partnership approach when adapting strategies and guidelines on sexual and reproductive health with linkages to HIV, congenital syphilis, hepatitis C and adolescent health, with a focus on decreasing inequalities in sexual and reproductive health.
- Support implementation and monitoring interventions related to sexual and reproductive health, post-abortion care, sexually transmitted and other reproductive tract infections and cancers of reproductive organs, and prevention and management of gender-based violence
- Strengthen linkages with other programme areas, such as communicable and noncommunicable diseases.
- Introduce programs for sexual reproductive interventions for the elderly, marginalised and vulnerable populations
- Conduct equity analysis on provision of SRH services in the country

Deliverables
- Policies, strategies, guidelines and plans developed and implementation monitored
- Strengthened sSkilled health-care workers in skill mix and equitable distribution
- Monitoring and evaluation reports produced for sexual health interventions
- Improved capacity to deliver services for elderly, marginalised and vulnerable groups

Strategic Priority 4: Multisectoral approaches for healthier populations

Focus area 4.1: Addressing the social, environmental and economic determinants of health.
The focus is on addressing the broad determinants of health and risk factors through a multi sectoral approach towards improved health outcomes.

WHO will:
- Engage at high level with non-health sectors to address the impact of policies on health
- Develop an advocacy strategy for promoting Advocate for the Health in All Policies approach
- Advocate for increased domestic and development financing for scaling up action on health promotion and the disease-related Sustainable Development Goals.
- Strengthen partnerships and engagement with other development partners to address multi sectoral determinants and risk factors.
- Implement the key actions specified in the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (2016) and in international law to make settings healthy through partnerships and collaboration

CCS deliverables:
- Advocacy strategy developed and implemented
- High-level national coordinating mechanism created for addressing the determinants of health
- Multisectoral implementation framework created for addressing the determinants of health

Focus area 4.2: Reducing risk factors for non-communicable diseases
Reducing the major risk factors for non-communicable diseases (NCDs) – tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol – is the focus of WHO's work to prevent deaths from NCDs.

WHO will:
- Implement the WHO-recommended 16 cost-effective, affordable, and evidence-based "best buys" for noncommunicable diseases and 70 "good buys"
- Develop multisectoral action plans to reduce health risk factors and create health-supportive environments, taking into consideration WHO-recommended interventions
- Establish a multisectoral forum for NCDs
- Empower and strengthen civil society, communities, and private sector in service delivery, in the areas of public health, health promotion and prevention, and control of communicable and non-communicable diseases
- Develop and implement public-focused campaigns aimed at behavioral change towards reducing risk factors like "know your numbers" campaign

CCS deliverables:
- Multisectoral action plans developed and implemented for addressing NCD risk factors
- Communities empowered to address risk factors for NCDs
- Multisectoral forum for NCDs is established and functional
- STEPS survey conducted

Focus area 4.3: Reducing malnutrition-related complications
This focus area will support initiatives in nutrition such as formulating evidence-informed guidelines, strengthening nutrition surveillance, scaling up action on nutrition, promoting child growth standards, complementary feeding, and strengthening capacity in the management of severe acute malnutrition in infants and children through multi-sectoral mechanisms, promoting healthy diets, implementing effective nutrition actions, and monitoring progress towards achievement of global nutrition targets.

WHO will:
- Support initiatives in nutrition, such as formulating evidence-informed guidelines, promoting, protecting, and supporting appropriate infant and young child feeding practices
- Advocate for establishment of a nutrition program and coordination mechanism
- Build capacity for prevention and management of complications of nutrition focusing on severe acute malnutrition in infants, and children through multi-sectoral mechanisms
- Scale up interventions for addressing malnutrition including micronutrient supplementation throughout the life-course

CCS deliverables:
Standards and guidelines for nutrition interventions
National surveillance system for nutrition
Improved coordination in nutrition programs amongst stakeholders

Strategic Priority 5: Enhancing health security and disaster preparedness and response.
Strengthening national health security through implementation of the International Health Regulations (2005) is a priority. Natural disasters, disease outbreaks, severe weather and other emergencies are becoming more common, and the importance of enhancing national health security has never been greater.

Focus area: 5.1: Detecting and responding to public health emergencies
This area focuses on rapid detection and verification of health emergencies, which are essential to save lives. Accordingly, new technologies – such as the Early Warning, Alert and Response System (EWARS) – should detect and track new health events in the most difficult settings.

WHO will:
- Support the strengthening of integrated health systems and capacity-building for health emergencies in policies, programmes and sectors that contribute to health security, universal health coverage, resilience, and sustainable development.
- Assist with the establishment of a comprehensive, integrated, and sustainable National Disease Surveillance and Response System, especially for outbreak-prone infectious diseases and other public health risks.
- Strengthen public health emergency operations centres and improve compliance with the International Health Regulations (2005) in the areas of detection, verification, assessment, and communication on the Event Information Site (EIS) platform.
- Advocate for endorsement of the National Action Plan at a high-level authority
- Support implementation of the National Action Plan on Health Security, including mapping domestic and international technical and financial resources that can be used for national health security preparedness.

CCS deliverables:
Institutional and human resources capacity-building strategy completed for implementation of the National Disease Surveillance and Response System.
Functional Public Health Emergency Operation Centres (PHEOC) established at national level in the regions.
National core capacities for emergency response improved

Focus area 5.2: Early warning, risk assessment, preparedness, and emergency response to disasters
The focus is on developing an integrated system for hazard monitoring, forecasting and prediction, disaster risk assessment, communication and preparedness. The system will be composed of activities and processes that enable individuals, communities and others to take timely action to reduce disaster risks in advance of hazardous events.

WHO will:
- Strengthen the public health emergency preparedness and response system
- Strengthen the use and monitoring of risk profiles and multi-hazard early warning systems to anticipate and accelerate operational readiness activities
- Support United Nations-wide readiness by leading the health cluster within United Nations systems.
- Build national capacity to assess, monitor, analyse and report all-hazard emergency preparedness capacities for high-impact health security risks.
- Advocate for increased investment in targeted capacity strengthening, innovation and research and development for disaster risk reduction.

CCS deliverables
The legal framework for the PHEM system developed
A Standardized Framework for Assessment of Disaster Risk (Hazard, Vulnerability and Capacity) in the health sector developed.
The health sector component of the national plan for implementation of the Sendai Disaster Risk Reduction (DRR) Framework completed.

6. Implementing the CCS

The following section sets out pathways that will be used to support implementation of the CCS strategic priorities at country level. It provides details about national-level agreements coordinated by the Ministry of Health between the three levels of WHO and various partners, such as non-state actors. The focus is on WHO's comparative advantage for implementing the strategic agenda, organizational resources, and expertise to assure public health impact. WHO will emphasize the following means of implementation:

6.1. Principles of cooperation

Strategic policy dialogue and support

WHO will engage in discussions among stakeholders to raise issues, share perspectives, find common ground, and reach agreement or consensus, if possible, on policy to improve health. Strategic policy dialogue will take place among policymakers, advocates, other non-governmental stakeholders, other politicians, and beneficiaries.

WHO provides strategic coordination and support for linking back to the global policies and actions agreed at the World Health Assembly, and in cooperation with the Ministry of Health and other ministries, the United Nations system, the development partners, and various stakeholders. This strategic support includes advocacy materials, partnership coordination, strategies, and resource mobilization. WHO's comparative strength is its global platform; its reputation as an impartial convener of a range of partners; its stewardship of global standards, frameworks, and conventions; its role as a trusted and authoritative source of health information; and its technical and policy expertise.

Technical assistance

Technical cooperation from WHO to the government will focus on strengthening individual and institutional capacity and providing technical assistance. WHO provides integrated and coordinated technical guidance through contextualization of norms, standards, and guidelines, coordination and translating research initiatives to health interventions. WHO's unique strength lies in the combined expertise of its three organizational levels: country, region and global.

Service delivery

This CCS will use integrated approaches to strengthen health system responsiveness and resilience. The focus will be on ensuring that WHO support to Eswatini is sustainable and focused on long-term, gender-responsive solutions, following the principle of leaving no one behind.

WHO will support accelerated actions towards universal access to primary health care through the design and implementation of integrated people-centred delivery models. These will deliver comprehensive health services, including health promotion, disease prevention, curative care, rehabilitative and palliative care, while ensuring effective referral systems. WHO will also provide guidance to promote the active participation of all people, especially women, in the processes of developing and implementing policy and improving health and health care.

6.2. Implementation of the strategic priorities

The WHO Country Office in Eswatini will use the existing WHO-MOH monthly bilateral meetingestablish a core coordination working group, comprising staff members from WHO Regional Office, WHO Headquartersand representatives ofthe Ministry of Health. The core coordination working group for the CCS will to review implementation of the strategic agenda on an annual basis to assess progress and impact (see Tables 3, 4 and 5 below).

The core coordination working group willmeeting will adopt a principle-based approach, assessing successes and areas for improvement in the light of the principles of cooperation. The function of the working group is to ensure that strategic priorities continue to be aligned with national health policy and to assess outcomes resulting from CCS implementation. The working group will have the opportunity to reflect on the effectiveness of CCS during implementation, provide inputs for the mid-term evaluation and adjust needs prior to the final evaluation.

The CCS results framework, as displayed in Table 4 below, provides a matrix for validating the linkages between CCS strategic priorities and focus areas on the one hand, and national enabling policies and targets, GPW 13 and SDG targets on the other. Table 2 sets out WHO implementation support to the country and Table 3 lists indicators with baselines and milestones to achieve targets in the CCS.

Table 3: WHO implementation support to the country

WHO's key contributions		
Country Office	**Regional Office**	**Headquarters**
Strengthening the national capacity to detect, diagnose, treat, and manage non-communicable diseases and risk factors within the national health system; with an emphasis on primary health care to ensure universal health coverage and reduce gender and health equity gaps. Supporting health financing reforms that embrace a social health insurance model.	Boosting country office capacity to assist in adapting and strengthening health information systems to collect disaggregated data to track disease-related mortality, morbidity, risk factors and health inequities and guide future policy making. Adapting global tools to the regional context to improve health system governance including institutional, legal, regulatory and societal frameworks, and coordinating with regional partners to speed up UHC.	Developing guidance and support for improving equitable access to basic technologies and essential medicines including generics for noncommunicable diseases. Generating international best practices and developing guidance to support member states to initiate multisectoral policy dialogue and capacity building for effective development and implementation of intersectoral actions and "Health in All Policies" for UHC.

COUNTRY COOPERATION STRATEGY 2022–2026 Eswatini

Table 4: Summary of the strategic priorities and focus areas with interventions

Strategic priorities	Focus areas	Strategic approaches
Quality service delivery	National health policies, strategies, and plans	Conduct MTR Develop the next national health strategic document Develop programme-specific strategies and operational plans
	Integrated people-centred health services	Strengthen PHC Improve quality of service delivery Strengthen human resources for health Strengthen health financing schemes Strengthen the national blood bank system Strengthen radiology and imaging Strengthen quality supply chain management Strengthening national pharmacovigilance system Facilitate the introduction of new testing technologies, Integrate HIV and tuberculosis platforms at point of care Viral load EID testing and HIVDR Geno sequencing Technology
	Health information systems and evidence	Strengthen the health information system with the new strategy Scale up CMIS and its interoperability with DHIS II Strengthen CRVS Support the establishment of national Health Observatory system Strengthen programme-specific data quality Strengthen IDSR and VPD surveillance Conduct nutrition surveillance
Communicable and non-communicable disease prevention and control	Creating an enabling environment for effective leadership Uptake and implementation of policies and interventions	Support resource mobilization for the prevention and control of communicable and non-communicable diseases Improve uptake of policies, technical strategies action plans, norms and standards and innovations for the prevention, control and elimination of conditions and diseases. Scale up delivery and monitoring of quality health services Improve community engagement to strengthen the implementation of conditions and disease–specific interventions
	Providing normative guidance and evidence-based condition- and disease-specific interventions	Strengthen interlinkages, such as those between health programmes Integrate services for communicable diseases, noncommunicable diseases and mental health conditions in primary health care and universal health care essential packages Strengthen community-led and community-based health systems, including through co-creation with people living with or affected by specific diseases or impairments, in order to achieve person-centred care Improve reporting, monitoring and evaluation of integrated services for communicable and non-communicable diseases
Equitable, integrated health service across the life course	Reproductive, maternal, new born, child and adolescent health	Reduce risk, morbidity and mortality and improve health in RMNCAH Review RMNCAH policies, strategies and guidelines, and support implementation of evidence-informed interventions Develop quality improvement mechanisms / systems for the delivery of RMNCAH services, including maternal, perinatal, and neonatal death surveillance and response (MPNDSR). Improve human resource skills provision for quality RMNCAH services.
	Improving population immunity (vaccination) throughout the life course	Develop/update EPI strategic and operational plans to implement the immunization agenda (AI2030) Undertake vaccine-related reviews/evaluations to inform programming Support use of innovative strategies to reach targeted population (RED, PIRI and CHDs) Plan for and introduce new vaccines as they become available Support vaccine safety and Adverse Events Following Immunization (AEFI) surveillance
	Strengthening integration of services in sexual and reproductive health (family planning, sexually transmitted infections, infertility and sexual dysfunction, and healthy ageing)	Support strengthening capacity of health facilities to provide quality comprehensive and integrated SRH services
Multisectoral approaches for healthier populations	Addressing social, environmental, and economic determinants of health	Engage at a high level with non-health sectors to address the impact of policies on health Advocate for the Health in All Policies approach Advocate for increased domestic and development financing for scaling up action on health promotion and the disease-related Sustainable Development Goals. Strengthen partnerships and engagement with other United Nations agencies to address multisectoral determinants and risk factors Implement the key actions specified in the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (2016) and in international law to make settings healthy through partnerships and collaboration

	Reducing risk factors for non-communicable diseases	Implement the WHO-recommended 16 cost-effective, affordable and evidence-based “best buys” for noncommunicable diseases and 70 “good buys” Develop multisectoral action plans to reduce health risk factors and create health-supportive environments, taking into consideration WHO-recommended interventions Invest in and strengthen civil society and community organization actions and engage in the areas of public health, health promotion and prevention, and control of noncommunicable diseases Develop public-focused campaigns aimed at behavioural change, using various social media and traditional media channels
	Reducing malnutrition-related complications	Support initiatives in nutrition such as formulating evidence-informed guidelines, and promoting, protecting, and supporting appropriate infant and young child feeding practices Strengthen capacity for prevention and management of complications of nutrition, focusing on severe acute malnutrition in infants and children, through multi-sectoral mechanisms Scale up interventions for micronutrient supplementation throughout the life-course
Enhance health security and disaster preparedness and response.	Detecting and responding to public health emergencies	Support integrated health system strengthening and capacity building for health emergencies in health policies, and in programmes and sectors that contribute to health security, universal health coverage, resilience and sustainable development Assist in the establishment of a comprehensive, integrated and sustainable National Disease Surveillance and Response System, especially for outbreak-prone infectious diseases and other public health risks Strengthen public health emergency operations centres and improve compliance with the International Health Regulations (2005) in the areas of detection, verification, assessment and communication on the Event Information Site (EIS) platform Support implementation of the National Action Plan on Health security including mapping all available domestic and international technical and financial resources that can be used for national health security preparedness
	Early warning, risk assessment, preparedness, and emergency response to disasters	Strengthen the use and monitoring of risk profiles and multi-hazard early warning systems to anticipate and accelerate operational readiness activities Support United Nations-wide readiness through the provision of readiness support to other United Nations agencies. Build national capacity to assess, monitor, analyse and report on all-hazard emergency preparedness capacities for high-impact health security risks Advocate for increased investment in targeted capacity strengthening, innovation and research and development for disaster risk reduction

6.3. Financing the strategic priorities

The estimated budget required to implement the five strategic priorities is presented in Table 5 below

Table 5: Five-year budget estimate (2022-2026)

Five-year budget estimate (2022- 2026)			
Strategic Priority	**Estimated budget in US$**	**Anticipated funding**	**Anticipated funding gap**
Quality service delivery	$23,594,810.75	$6,190,655.00	$17,404,155.75
Communicable and non-communicable disease prevention and control	$5,605,197.14	$949,062.00	$4,656,135.14
Service across the life course	$1,516,401.86	$822,631.00	$693,770.86
Multisectoral approaches for healthier populations	$2,541,699.40	$822,631.00	$1,719,068.40
Health security, disaster preparedness and response	$2,786,708.00	$822,631.00	$1,964,077.00
TOTAL	**$36,044,817.15**	**$9,607,610.00**	**$26,437,207.15**


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7. Monitoring and evaluation

While CCS monitoring is the responsibility of the WHO Country Office, it will be conducted in collaboration with the government and health partners and will involve all three levels of WHO to encourage joint ownership of results.

7.1. Final Evaluation of the CCS Criteria

A participatory evaluation will be conducted using qualitative and quantitative methods to assess WHO's contribution to and influence on national health development agenda over the Country Cooperation Strategy (CCS) cycle. The proposed evaluation questions are shown in the below text box. Draft tools for each of the evaluation questions are also ready. The questions and the tools will be finalized by the working group. A local consultant will be sourced for the evaluation. Depending on her/his person, the same person can also be considered for the development of the new CCS. The consultant will work in close liaison with the PMO and the working group. The consultant will collect data using predefined tools and questionnaire from existing reports, GSM information, additional inputs from WCO staff on agreed templates, and interviewing both WCO staff and external stakeholders.

To reach out to wider audience, an online survey would also be conducted to get a perception about WHO's contributions and expectations in future. The consultant will produce a draft report with a set of recommendations which will be first validated by the working group and then later discussed in a consultative forum with government, health sector non-state actors and other development partners. The consultant will then finalize the CCS evaluation report in discussion with the working group. The final evaluation report will be shared with the Ministry of Health, UN, and other partners.

The monitoring and evaluation process will be as follows

Table 6: Key milestones, approach and activities

Year	Key element	Activities
2022	Launch of CCS	Establishing main health outcomes, baselines and targets for each strategic priority Ensuring that country-level data are available, or capacity is strengthened where required Resource mobilization
2023	Monitoring of implementation	Finalizing Country Work Plan 2022-2023, which defines: Country Office budget Country activities and detailed activities at all three levels of WHO for priorities Outcomes and outputs Resource mobilization strategy Annual review of CCS
2024	Mid-term evaluation of CCS	Conducting Country-Office-led evaluation of: Progress towards health outcomes Implementation of Country Work Plan 2022-2023 Annual review of CCS Developing country success stories on qualitative impact of CCS (backed up by evidence) Producing CCS progress report with recommendations (to be shared with the government, WHO and partners)
2025	Monitoring of implementation	Establishing main health outcomes, baselines and targets for each strategic priority Ensuring that country-level data are available or capacity is strengthened where required Annual review of CCS
2026	Final evaluation of CCS	Establishing main health outcomes, baselines and targets for each strategic priority Ensuring that country-level data are available or capacity is strengthened where required Annual review of CCS Publication of final evaluation of CCS Concurrently with final evaluation, either renew or extend CCS or initiate development of new CCS

7.2. CCS 2022-2026 Framework of Indicators

The indicators, baselines, target and annual milestones for the CCS 2022-2026 are summarized in Tables 7-11 below.

Strategic priority 1: Quality Service Delivery

Table 7: Strategic priority 1: Quality Service Delivery

Indicator							
Indicator	Baseline (year)	Target	Milestone Year 1	Milestone Year 2	Milestone Year 3	Milestone Year 4	MOV
National Health Sector Plan reviewed and new Plan developed	NA (2021)	1	N/A	1	N/A		
Percentage of established health professional positions filled	93.5% (2021)	98%	94.5%	95.5%	97%	98%	HRIS (Routine Data)
Density of doctors, nurses and midwives per 10,000 population	1.5 (2018)	1.56	1.75	2	2.1	2.2	NHWA (Routine Data)
Ratio of nurses and midwives per 10,000 population	1.7 (2018)	2	2.1	2.2	2.3	2.4	NHWA (Routine Data)
Proportion of health facilities that have transitioned from paper-based to electronic system (CMIS)	60% (2020)	100%	70%	80%	90%	100%	HMIS (Routine Data)
Non-measles febrile Rash (≥ per 100,000 population)	4.0 (2020)	2.0	2.0	2.0	2.0	2.0	EPI Annual Report (Routine Data)
Non-polio AFP Rate (≥ 2/100,000 population < 15 years)	2.8 (2020)	2.0	2.0	2.0	2.0	2.0	EPI Annual Report
Percent stool adequacy	100% (2020)	> 80%	> 80%	> 80%	> 80%	> 80%	EPI Annual Report (Routine Data)
Number of cases of poliomyelitis caused by wild poliovirus (WPV)	0 (2020)	0	0	0	0	0	EPI Annual Report (Routine Data)
Proportion of target population covered by all vaccines in their national programme	78.2% (2020)	90%	80%	83%	85%	90%	EPI Annual Report (Routine Data)

Strategic priority 2: Communicable and non-communicable disease prevention and control

Table 8: Strategic priority 2: Communicable and non-communicable disease prevention and control

Indicator							
Percentage of People living with HIV (receiving ART) who have suppressed viral load, disaggregated by sex and gender	2020 baseline All ages – 92% 0-14 years - 76% Female 15+ - (97%) Male 15+ (87%)	>95% 95% 100% 95%	93% 80% 98% 90%	94% 85% 99% 92%	95% 90% 100% 93%	95% 95% 100% 95%	UNSDCF HMIS (Routine Data)
Proportion of population requiring interventions against neglected tropical diseases	90% MDA (2018)	100%	95%	96%	98%	100%	NTD Annual Report (Routine Data)
Malaria incidence per 1000 population	0.49 (2021)	0.4	0.3	0.2	0.1	0	Malaria Annual Report Global Malaria Report (Routine Data)
Number of malaria deaths	13 (2021)	0	10	8	5	0	Malaria Annual report/ NHSSP (Routine Data)
Tuberculosis incidence per 100,000 population	319 (2020)	164	278	271	222	164	HMIS (Routine Data)
Tuberculosis mortality rate	230 (2020)	50% reduction by 2025 from 2020 baseline	> 10%	>20%	>40%	50%	Global TB Report (Routine Data)
Tuberculosis treatment success rate for new and relapse cases	86% (2020)	95%	88%	92%	93%	95%	Global TB Report (Routine Data)

Strategic priority 3: Service across the life course

Table 9: Strategic priority 3: Service across the life course

Indicator							
Indicator	Baseline	Target	Milestone Year 1	Milestone Year 2	Milestone Year 3	Milestone Year 4	MOV
Focus Area 3a: Reproductive, maternal, newborn, child, and adolescent health interventions							
Maternal mortality ratio	452 per 100,000 (2019)	446 per 100,000	451 per 100,000	450 per 100,000	449 per 100,000	448 per 100,000	GPW13/NHSSP (Survey Based Data)
Prevalence of malnutrition (weight-for-height ≥2 or ≤2 standard deviations from the median value of the WHO Child Growth Standards) among children aged under 5 years (overweight)	9% (2019)	<9%	8%	7%	6%	5%	Global Nutrition Target (Survey Based Data)
Prevalence of stunting (height-for-age ≤2 standard deviations from the median value of the WHO Child Growth Standards) among children aged under 5 years	25% (2019)	20%	24%	23%	22%	21%	GPW 13 /NHSSP/ UNSDCF (Survey Based Data)

Prevalence of malnutrition (weight- for-height ≥2 or ≤2 standard deviations from the median value of the WHO Child Growth Standards) among children aged under 5 years (wasting)	2% (2019)	<5%	< 2%	< 2%	< 2%	< 2%	GPW 13 /NHSSP/ UNSDCF (Survey Based Data)
Proportion of births by skilled health personnel	88% (2019)	96%	90%	91%	93%	94%	NHSSP (Routine Data)
Under-five mortality	74/1,000 (2016)	56/1,000	70/1,000	66/1,000	64/1,000	60/1,000	SDGs/GSWCA (Routine Data)
Stillbirths per 1000 births	12 (2019)	9	12	11	10	9	HMIS (Routine Data)
Neonatal mortality	20/1000 (2016)	12/1,000	18/1,000	17/1,000	16/1,000	15/1,000	Global Strategy for Women, children and adolescents (Survey Based Data)
Adolescent birth rate SDG 3.7.	76.6/1000 (2019)	66/1,000	74/1,000	72/1,000	70/1,000	68/1,000	NHSSP (Survey Based Data)

Strategic priority 4: Multisectoral Approach

Table 10: Strategic priority 4: Multisectoral Approach

Indicator							
Indicator	Baseline	Target	Milestone Year 1	Milestone Year 2	Milestone Year 3	Milestone Year 4	MOV
Age-standardized prevalence of current tobacco use among persons aged 15 years and older	6% (2014)	5%	5%	5%	5%	5%	STEPS (Survey Based Data)
Prevalence of obesity	20.5% (20194)	16%	20%	19%	18%	16%	STEPS (Survey Based Data)
Age standardized prevalence of raised blood pressure among people aged 18 and above	24.5% (2019)	16%	23%	20%	18%	16%	STEPS (Survey Based Data)
Proportion of health facilities providing cardiovascular disease diagnosis/ treatment	76% (2019)	86%	77.5%	80%	83.5%	86%	STEPS (Survey Based Data)
Proportion of health facilities providing Cervical cancer diagnosis	37% (2019)	47%	39.5%	42%	44.5%	47	STEPS (Survey Based Data)
Proportion of health facilities providing Diabetes diagnosis/ management	72% (2019)	82%	74.5%	77%	79.5%	82%	STEPS (Survey Based Data)

Strategic priority 5: Preparedness and Response

Table 11: Strategic priority 5: Preparedness and response

Indicator							
Indicator	Baseline	Target	Milestone Year 1	Milestone Year 2	Milestone Year 3	Milestone Year 4	MOV
Multi-hazard national public health emergency preparedness and response plan is developed and implemented	No (2018)	Yes	n/a	Yes	Yes	Yes	JEE Report (Survey Based Data)
Priority public health risks and resources are mapped and utilized	No (2018)	Yes	No	Yes	Yes	Yes	JEE Report (Survey Based Data)
Number of regions with functional PHEOCs	0 (2021)	4	2	2	4	4	EPR Report (Routine Data)
% of regions with disaster/emergency preparedness and response plans and that are able to handle emergencies.	0 (2021)	4	2	2	4	4	EPR report (Routine Data)

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World Health Organization
Eswatini Country Office
P.O Box 903, Mbabane, Eswatini
TEL: +268 2404 9635/ 2928
FAX: +268 2404 4566