

FOR A SAFER, HEALTHIER AND FAIRER ESWATINI



# THE WORK OF WHO IN THE KINGDOM OF ESWATINI

**Biennial Report 2020-2021**



World Health  
Organization



COUNTRY OFFICE FOR

# World Health Organization

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**Eswatini**



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## ACRONYMS

<b>AFP</b>	Acute Flaccid Paralysis
<b>AFRO</b>	Regional Office for Africa
<b>BFHI</b>	Baby friendly Hospital Initiative
<b>DTG</b>	Dolutegravir
<b>FCTC</b>	Framework Convention on Tobacco Control
<b>GEF</b>	Global Environment Facility
<b>GLASS</b>	Global Antimicrobial Resistance Surveillance System
<b>GPW</b>	General Programme of Work
<b>HAI</b>	Health Action International
<b>HCW</b>	Healthcare worker
<b>ICIPE</b>	International Center of Insect Physiology and Ecology
<b>IDSR</b>	Integrated Disease Surveillance and Response
<b>IHR</b>	International Health Regulation (2005)
<b>IMNCI</b>	Integrated Management of Neonatal and Childhood Illnesses
<b>IRS</b>	Indoor Residual Spraying
<b>JEE</b>	Joint External Evaluation
<b>MDRTB</b>	Multi-Drug Resistant Tuberculosis
<b>NAPHS</b>	National Action Plan for Health Security
<b>NCD</b>	Non-communicable Diseases
<b>NDVP</b>	National Deployment and Vaccination Plan
<b>PEN</b>	Package of Essential Non Communicable
<b>PHC</b>	Primary Health Care
<b>PHEMC</b>	Reconstituted Public Health Emergency Management Committee
<b>PLHIV</b>	People Living with HIV
<b>RMNCAH</b>	Reproductive Maternal, Neonatal, Child, and Adolescent Health
<b>SADAT</b>	Students Against Drug Abuse and Trafficking
<b>SDG</b>	Sustainable Development Goals
<b>TB</b>	Tuberculosis
<b>WCO</b>	World Health Organization Country Office
<b>WHO</b>	World Health Organization

## Message from the Country Representative



The World Health Organization (WHO) in Eswatini is pleased to share with its partners and stakeholders its 2020-2021 Biennial Report. This report covers the contribution WHO made towards ensuring that more people are benefitting from Universal Health Coverage (UHC), better protected from health emergencies, and enjoying better health and well-being.

Over the two years, the health sector made a lot of progress toward improving the health status of the people of Eswatini despite the advent of the COVID-19 pandemic. Eswatini reported its first case of COVID-19 on 14 March 2020 and by the end of 2021, the country had recorded 64 381 cases and 1 272 deaths. By December 2021, the country

had experienced four waves of transmission with vaccination drives still ongoing with 29% of the population being fully vaccinated against the virus.

Despite the COVID-19 pandemic being a challenge in the implementation of programmes in the country, the World Health Organization Country Office (WCO) made several strides worthy of celebration and all have been documented in this report.

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

**Dr Cornelia Atsyor**

*WHO Representative - Eswatini*

# 1 INTRODUCTION

The Work of WHO in the Kingdom of Eswatini: Biennial Report 2020-2021 covers the period between January 2020 and December 2021. The report highlights the work accomplished over the biennium. It covers the delivery of results achieved by WHO in collaboration with other stakeholders in supporting the Government of Eswatini in ensuring healthy lives and well-being for all people at all ages of life.

In line with WHO core functions, the organization:

1. Provided leadership on matters critical to health and engaged in partnerships where joint action was needed
2. Shaped the research agenda and stimulated the generation, translation, and dissemination of valuable knowledge
3. Set norms and standards and promoted and monitored their implementation
4. Articulated ethical and evidence-based policy options
5. Provided technical support, catalyzed change, and built sustainable institutional capacity
6. Monitored the health situation and assessed health trends.

The period 2020-2021 marks second biennium of the 13<sup>th</sup> General Programme of Work (GPW13), 2019-2023. The report is therefore focusing on triple billion targets of the GPW13. The triple billion targets are to ensure that by 2023:

- ❖ 1 billion more people benefiting from Universal Health Coverage
- ❖ 1 billion more people better protected from health emergencies
- ❖ 1 billion more people enjoying better health and well being

These targets are interconnected as highlighted in figure 1.

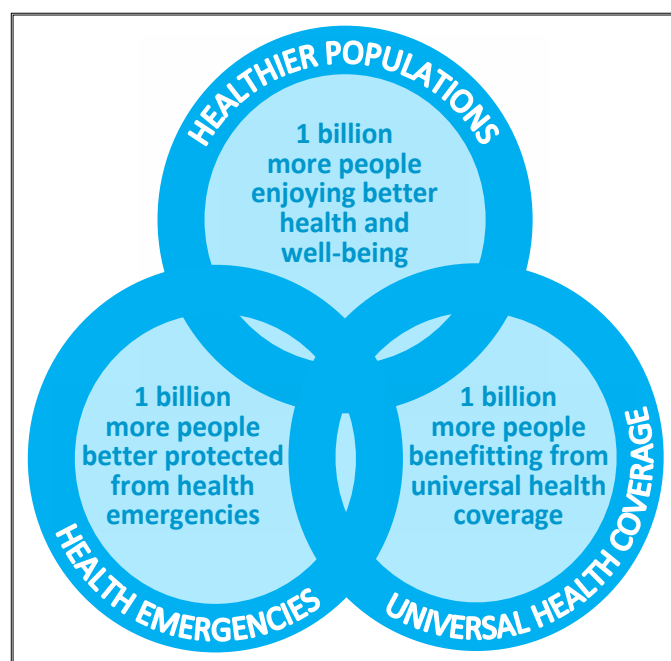


Figure 1: A set of interconnected strategic priorities

## 2 THE WORK OF WHO IN ESWATINI

The work of WHO over the biennium aimed to achieve the outcomes and outputs highlighted in table 1.

**Table 1: The outcomes and outputs guiding the work of WHO in 2020-2021**

Outcome	Outputs
<b>Achieving universal health coverage - 1 billion more people benefiting from universal health coverage</b>	
1.1. Improved access to quality essential health services	1.1.1. Countries enabled to provide high quality, people-centred health services, based on PHC strategies and comprehensive essential service packages
	1.1.2. Countries enabled to strengthen their health systems to implement condition- and disease-specific programmes
	1.1.5. Countries enabled to strengthen their health workforce
1.3. Improved availability of essential medicines, vaccines, diagnostics, and devices for primary health care	1.3.1. Provision of authoritative guidance and standards on quality, safety, and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists
	1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved
	1.3.5. Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices
<b>Addressing health emergencies- 1 billion more people better protected from health emergencies</b>	
2.1. Countries prepared for health emergencies	2.1.1. All-hazards emergency preparedness capacities in countries assessed and reported
	2.1.3. Countries operationally ready to assess and manage risks and vulnerabilities
2.2 Epidemics and pandemics prevented	2.2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative
2.3. Health emergencies rapidly detected and responded to	2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated
<b>Promoting healthier populations - 1 billion more people enjoying better health and well-being</b>	
3.2. Risk factors reduced through multi-sectoral action	3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multi-sectoral action
	3.2.2. Multi-sectoral risk factors addressed through engagement with public and private sectors as well as civil society



50.1	50.1.2. Priority given to enabling action to accelerate WHO FCTC implementation, including effective forms of technical and financial assistance to support Parties in the identified priority action areas.
<b>More effective and efficient WHO better supporting countries</b>	
4.1. Strengthened country capacity in data and innovation	4.1.1. Countries enabled to strengthen health information and data systems, including at the subnational level, and to use this information to inform policymaking
	4.1.2. WHO impact framework and triple billion targets, global and regional health trends, SDG indicators, and health inequalities and disaggregated data monitored
	4.1.3. Countries enabled to strengthen research capacity and systems, conduct, and use research on public health priorities, and scale effective innovations in a sustainable manner
<b>Outcome</b>	<b>Outputs</b>
<b>More effective and efficient WHO better supporting countries</b>	
4.2 Strengthened leadership, governance, and advocacy for health	4.2.1 Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform
	4.2.2 The Secretariat operates in an accountable, transparent, compliant and risk management-driven manner including through organizational learning and a culture of evaluation
	4.2.3 Strategic priorities resourced in a predictable, adequate, and flexible manner through strengthening partnerships
	4.2.4. Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money, and the strategic priorities of GPW 13
	4.2.5. Cultural change fostered and critical technical and administrative processes strengthened through a new operating model that optimizes organizational performance and enhances internal communications
	4.2.6. “Leave no one behind” approach focused on equity, gender and human rights progressively incorporated and monitored
4.3. Improved financial, human, administrative resources management towards transparency, efficient use of resources, and effective delivery of results	4.3.1 Sound financial practices and oversight managed through an efficient and effective internal control framework
	4.3.2. Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery
	4.3.3 Effective, innovative and secure digital platforms and services aligned with the needs of users, corporate functions, technical programmes and health emergencies operations
	4.3.4. Safe and secure environment with efficient infrastructure maintenance, cost-effective support services, and responsive supply chain, including duty of care

### 3 IMPLEMENTATION OF THE PROGRAMME BUDGET 2020-2021

The programme budget implementation covers the financial aspects.

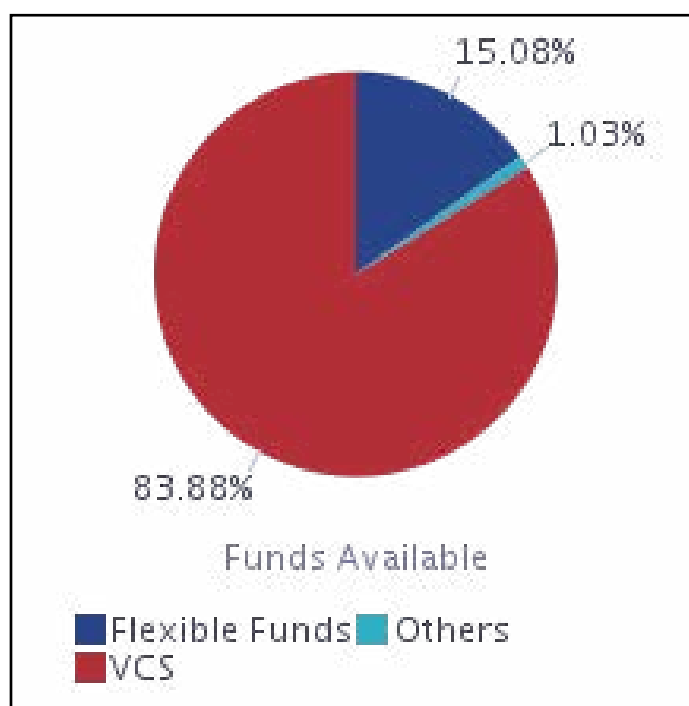
#### 3.1 ANALYSIS OF FINANCIAL IMPLEMENTATION OF THE WORK PLANS

The WCO had a budget space of \$10 571 851.00 and planned cost of \$9 601 991.00 which was 91% of the available budget space. A total of \$8 867 161.00 which is 84% of the planned cost was allocated to the WCO. The country utilised \$8 330 248.00 which is 94% of the allocated funds.

Table 2 shows the funds received by the WCO by fund type and figure 2 highlights that about 84% of the funds were Voluntary Contributions and 15% being Flexible Funding.

**Table 2: Distribution of funds received by the WCO for the biennium 2020-2021 by fund type**

Fund Type	Funds Available
Flexible Funds	1,337,600
Others	91,465
VCS	7,438,096
Grand Total	8,867,161



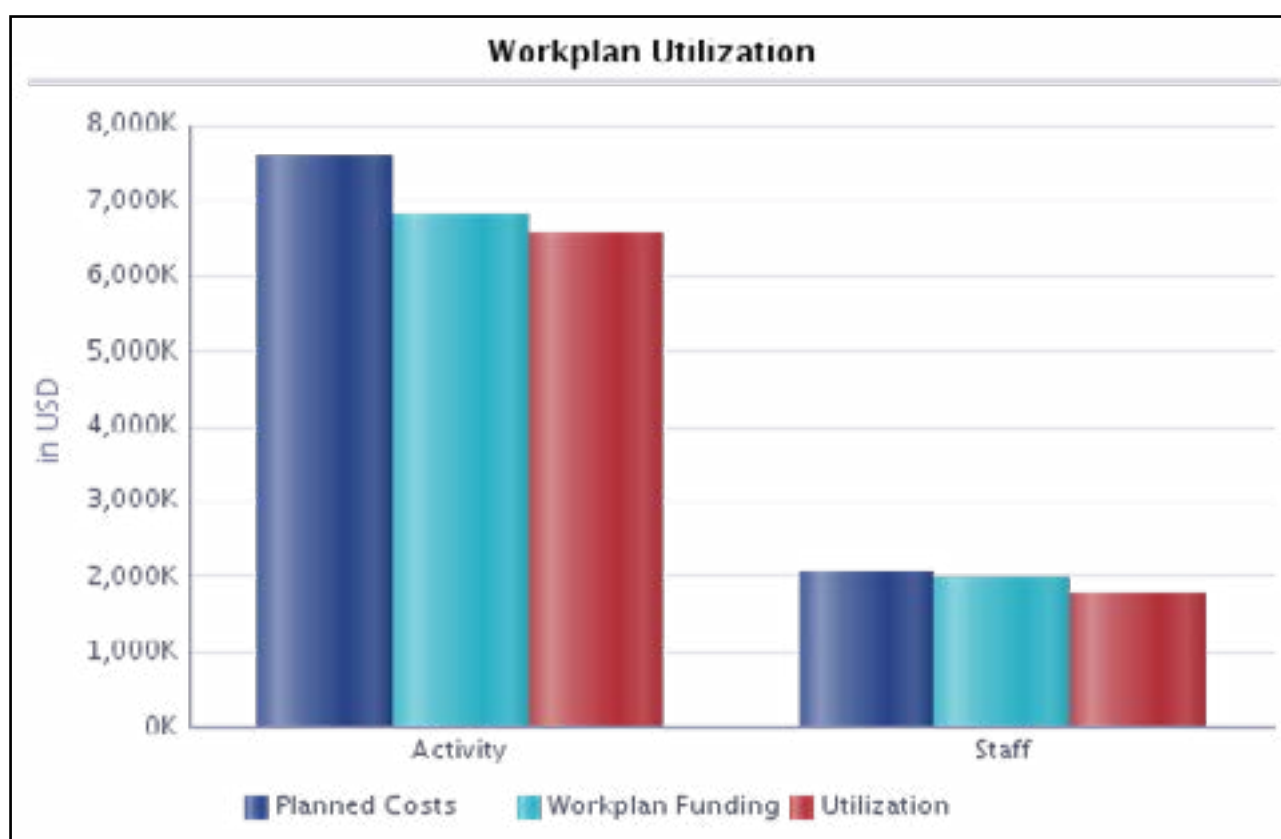
*Figure 2: Proportion of funds received by the WCO during 2020-2021 biennium by fund type*

The received funds were used to cover the activity workplan and the staff costs as summarised in table 3.

**Table 3: Distribution of funding received during the biennium by workplan type**

Workplan Type	Planned Costs	Workplan Funding	% Workplan Funding vs Planned Cost	Award Budget	Utilization	% Utilization vs Workplan Funding
Activity	7,545,238	6,808,676	90%	6,700,573	6,533,826	96%
Staff	2,056,753	1,978,290	96%	1,978,290	1,796,422	91%
<b>Grand Total</b>	<b>9,601,991</b>	<b>8,786,966</b>	<b>92%</b>	<b>8,678,863</b>	<b>8,330,248</b>	<b>95%</b>

Figure 3 summaries the budget utilisation by workplan type which highlighted that most of the funds were used for activity implementation as compared to staff costs.



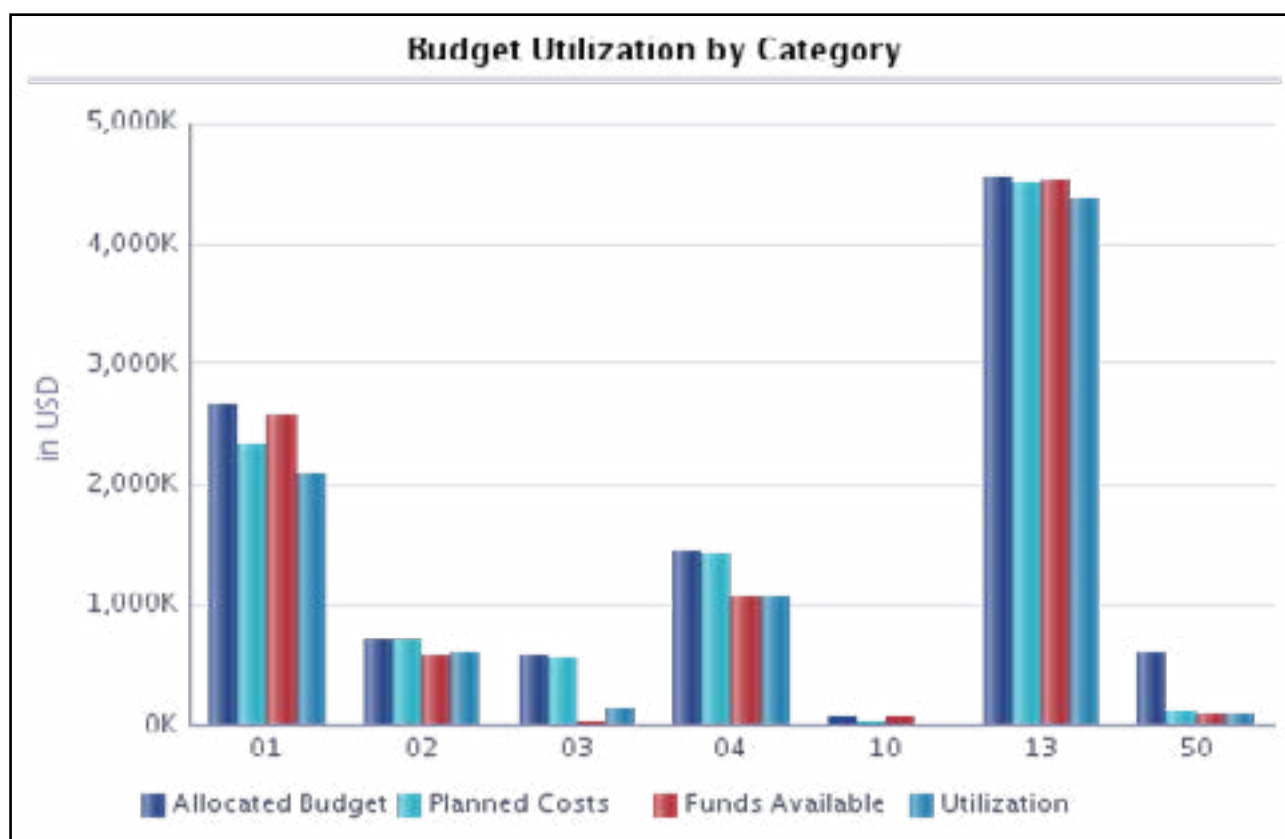
*Figure 3: Budget utilisation by workplan type for the 2020-2021 biennium*

The work of the WCO was delivered through 7 workplans under the categories 01, 02, 03, 04, 10, 13 and 50. Table 4 summaries the distribution of the funds by category.

**Table 4: Distribution of funding by category**

Category	Allocated Budget	Planned Costs	% PC vs Allocated Budget	Funds Available	% Funds Available vs Allocated Budget	Utilization	Balance of Funds Available	% Utilization vs Funds Available
01	2,658,922	2,321,928	87%	2,562,151	96%	2,087,239	474,912	81%
02	693,851	693,851	100%	571,299	82%	590,361	-19,062	103%
03	568,257	565,954	100%	29,200	5%	133,793	-104,593	458%
04	1,431,579	1,410,008	98%	1,046,808	73%	1,062,420	-15,612	101%
10	65,617	13,250	20%	65,617	100%	5,553	60,064	8%
13	4,551,625	4,497,000	99%	4,500,621	99%	4,373,991	126,630	97%
50	602,000	100,000	17%	91,465	15%	76,889	14,576	84%
Grand Total	10,571,851	9,601,991	91%	8,867,161	84%	8,330,248	536,913	94%

Category 13 received about \$4 500 621.00 followed by category 04 with \$ 1 046 808.00. Figure 4 summaries the funding utilisation by the categories.



*Figure 4: The utilisation of the funding received by category*

## 4 FOCUS ON IMPACT: SIGNIFICANT ACHIEVEMENTS.

Driving impact is the primary focus of WHO's accountability. The work of WHO was guided by the overarching principle that financial resources should not be used without an expectation of measurable results in terms of improving people's health.

Efforts focused on delivering sustainable outcomes and impacts and not merely on sustaining programmatic activities. Several achievements were delivered during the biennium as highlighted in the sections that follow.

### 4.1 MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE



The WCO ensured that more people benefitted from Universal Health Coverage. This was through improving access to quality essential health services and availability of essential medicines, vaccines, diagnostics, and devices for primary health care.

The focus was also on provision of authoritative guidance and standards on quality, safety and efficacy of health products. Address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices was prioritised.

#### 4.1.1 Provision of high quality, people-centre health services

Based on Primary Health Care (PHC) strategies and comprehensive essential service packages, high quality, people centred health services were provided leaving no one behind. Health systems were strengthened to implement condition- and disease-specific programmes.

#### 4.1.1.1 Primary Health Care and Essential Health Care Packages

The focus was integrated service delivery, with an emphasis on quality primary health care services towards improving health outcomes and reaching underserved populations to ensure no one is left behind.

#### Achievements

- The country renewed focus on 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.
- Continuity of Essential healthcare services guidelines during COVID 19 pandemic
- WHO supported the establishment of the Board of Directors for the National Regulatory Unit.

#### 4.1.1.2 Health Through the life Course



Figure 5: Promoting health through the life course

Eswatini has made significant progress towards improving indicators for women, newborns, children and adolescents and improved the sexual, reproductive, maternal, newborn, child and adolescent health and nutrition (SRMNCAH&N) indicators. With support from WHO, other UN agencies and partners, Eswatini is forging towards achieving the SDG targets specifically those of the global strategy for women's, children and Adolescents' health 2016-2030. Maternal mortality ratio reduced from 593 to 452 per 100 000 live births in 2019. The main objective is ending preventable deaths of women, newborns, children and adolescents as well ensuring that they do not only survive but also thrive. The country is focused on improving the lives of the people throughout the life course by improving the quality of services provided at all levels of care as evidenced by the development and review of guiding documents and building capacity of the service providers.

#### Achievements

- The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) were developed, and health workers were trained on the guidelines. The IMNCI guidelines include management of sick young infants with possible serious bacterial infections
- WHO supported the Improvement of quality service provision through supportive supervision which resulted in the identification of gaps that were later resolved through discussions with regional administrators and health facility supervisors
- 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.

- WHO in collaboration with UNFPA led:
  - the assessment on the availability of quality medical abortion drugs specifically the combination pack (combi-pack) of mifepristone and misoprostol
  - the 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



Figure 6: Reaching every district with vaccination.

- WHO supported the integration of 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.
- In order to achieve measles-rubella elimination status in the country, a nationwide measles-rubella campaign targeting children between 9 to 59 months was conducted. Other integrated interventions were vitamin A supplementation for children between

ages 6–59 months and deworming tablets given to children aged 12–59 months. An administrative national coverage of 97% MR vaccination, 62% vitamin A and 67% albendazole was achieved at the national level. No measles and rubella outbreaks were experienced in this biennium.

#### 4.1.2 Implementation of condition and disease specific programmes

WHO supported and promoted integration across programmes, optimize service delivery and leverage the strengths among disease control programmes.

High-impact communicable diseases, including HIV/AIDS, tuberculosis, malaria, vaccine-preventable diseases, and neglected tropical diseases were focused on.

High-impact essential noncommunicable diseases interventions – for early detection, effective management, and timely treatment – were delivered through primary health care. The focus being on Cardiovascular diseases, diabetes, asthma, cancers and mental health conditions

##### 4.1.2.1 HIV/AIDS

Eswatini has made major strides in the HIV response with the goal of ending AIDS as a public health threat by 2023. The national multisector HIV/AIDS strategic framework has been guiding the national response. The HIV prevalence has remained stable at 27% since 2007 and incidence has been on the decline. The incidence among 15-49 years declined from 2.9 (2011) (SHIMS1) to 2.23 (2013) and 1.36 (2016-17) (SHIMS2) which represents a 40% reduction.

In 2020, it is estimated that there were about 4,800 new infections. Adolescent girls and young women aged 15-39 have a comparatively higher risk of being infected.

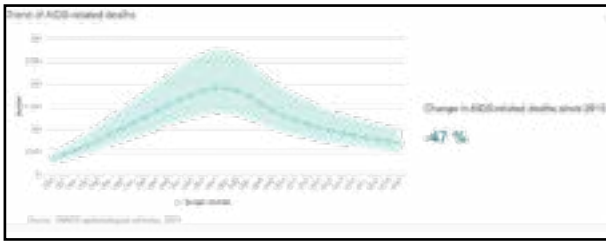


Figure 7: Trends of new HIV infections in Eswatini

Eswatini is among the 14 countries globally to have achieved the UNAIDS fast track 90-90-90 targets. Eswatini has gone further to surpass these targets by achieving the 2030 targets of 95-95-95, ten years ahead of schedule. This means that in Eswatini over 95 % of PLHIV know their HIV status, 95% are on life-saving antiretroviral treatment, and 95% of people on treatment have suppressed viral load.

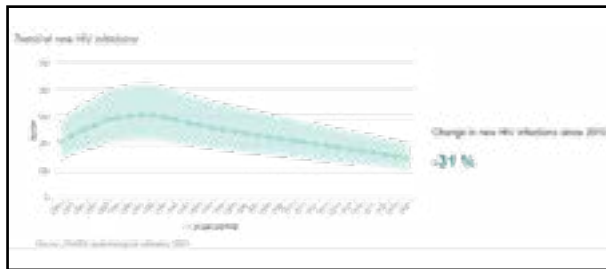


Figure 8: Trends in AIDS related deaths in Eswatini

Since 2005, HIV related deaths have been on the decline, the death rate among PLHIV was reported to be 2.16/1000 population in 2020 (UNAIDS,2021 report).



Figure 9: World AIDS Day commemoration

## Achievements

- By September 2021 the country reported that 99% of People living with HIV knew their HIV status and 99% of those who knew their HIV status were on Anti-retroviral therapy (ART) with 98% of those on ART being virally suppressed. This makes Eswatini, one of the countries to achieve the ‘95-95-95’ global HIV fast track target an entire decade ahead of the 2030 deadline.
- Through WHO support, the country adopted the use of DTG in adults, adolescents, and children under five years as well as EFV 400mg. The Dolutegravir (DTG) 10mg tablets for use in children and the Efavirenz 400 mg based Regimen (TLE 400mg) arrived in the country in July 2021 and are now being prescribed by clinicians in all ART providing facilities. Efavirenz 600 mg has been phased out completely.
- WHO supported the development of an operational plan and the clinical implementation guidelines for PrEP provisions in Eswatini in 2019 and guided implementation during this biennium (2020-2021). The facility’s PrEP provision coverage has increased from 44% (86/195) in 2019 to 98 % (191/192) in 2021. The overall initiations for 2021 show a slight increase (13595) when compared to the previous year (11950). This shows that the program was able to attain 61% (13595/22431) of the national targets. Overall, women had a high PrEP uptake of 71% when compared to men.
- WCO supported the MOH with the development of the His Majesty Correctional Services (HMCS) HIV and Wellness policy and strategy for 2021-2024



- WHO supported local adaptation and printing of 300 copies of the STI training manual. This manual was used to train 25 National trainers who will cascade training in their respective regions in 2022.

#### 4.1.2.2 Tuberculosis

The TB Burden in Eswatini has been on the decline but remains high 319/100 000 Vs. 220/100 000 (AFRO). About 65% of TB patients have HIV (largely affecting the HIV population) and about 10% of reported TB cases have Multi-Drug Resistant TB (MDRTB). The MDRTB treatment success rate has been 76 % compared to 86% among those with drug-sensitive TB (Global TB report 2021) compared.



Figure 10: Stakeholders having a discussion during World TB Day commemoration

#### Achievements

- A costed National TB and Control strategy 2020-2023 was developed after extensive stakeholder consultations and is currently being used to guide implementation.
- All oral short Multidrug-resistant TB (MDRTB) regimen is being implemented in all 14 MDRTB sites. In March 2021, the country started implementing as a pilot the all oral short regimen in 7 out of 14

MDRTB facilities in two Regions- Lubombo and Shiselweni with financial support received from MSF. In June 2021, two consultants came from the WHO Green Light Committee (GLC) to conduct a review of the MDRTB program performance in the country. At the end of the mission, the consultants recommended that the country scale up the implementation of the MDRTB regimen. In September 2021, all the 14 MDRTB facilities in all the four regions of Eswatini started providing all oral short MDRTB regimens in line with WHO recommendations. Training packages were developed and clinicians from respective facilities were trained.



Figure 11: Technicians inside an outreach TB testing site

- As a result, the 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% and even in the context of COVID-19, adherence seemed to be improving. With the adoption of the new policy MDRTB, patients are now on oral regimens with injectable regimes completely phased out.

### 4.1.2.3 Malaria

The country has reduced annual malaria incidence to 0.49 and is among 8 countries in Southern Africa and 25 countries globally with the goal of eliminating malaria before 2025.

The work of WHO is to support Eswatini achieve a malaria-free status. The goal is to reach zero indigenous malaria cases by 2023 according to the National Malaria Elimination Strategy 2021-2023.



Figure 12: Sampling water for malaria parasite testing

### Achievements

- The WCO supported the Malaria Programme Review. This involved desk review and external review conducted by a team from WHO AFRO. The findings were used to develop the National malaria Elimination Strategy 2021-2023 including the monitoring and evaluation framework.
- The country conducted annual malaria reviews resulting in the development of annual malaria reports. The country also contributed data for the Global Malaria Reports.
- The Eswatini Malaria Elimination

Advisory Group and the subcommittees provided support to the National Malaria Programme on malaria elimination covering the different thematic areas (case management, surveillance, health promotion and vector control)

- WHO engaged a STOP-malaria consultant to provide skilled technical and operational assistance to interrupt malaria transmission towards achieving malaria elimination. The STOP-malaria consultant works at the sub-national level, with an emphasis on supporting surveillance as an intervention, detailed case and focus investigations and response. The STOP-malaria consultant supported the NMP to use the Malaria Elimination Audit Tool. This tool was used to monitor progress towards implementation of the elimination strategy.
- The World Health Organization AFRO and International Center of Insect Physiology and Ecology (ICIPE) have collaborated under the Global Environment Facility (GEF) and UNEP to fund the project entitled “Demonstration of effectiveness of diversified, environmentally sound and sustainable interventions, and strengthening national capacity for innovative implementation of integrated vector management (IVM) for disease prevention and control in the WHO AFRO Region”.
  - The country received USD\$252 161 for the 2020-21 biennium activity implementation. The project has managed to achieve the following:
  - The national Integrated Vector

Management 2020-2024 in line with the Global Vector Control Response 2017-2030 was developed through multisectoral collaboration in January 2020.

- Procurement of equipment and supplies in support of the IVM Project i.e., Larval Sampling equipment and supplies (20\* 20litre Bti biolarvicide, 40 Dippers, 10 Mist blowers etc.) and Adult Mosquito equipment and supplies (20 CDC Light traps, 15 Cloth for collection cup etc.)
- Engagement of 24 field assistants to provide larval source management and adult mosquito monitoring activities in the study sites. They were provided with 24 Android tablets and 3G access to internet for data collection. They also received training on biolarvicide application as well as the project protocol standard operating procedures on use of the biolarvicide.
- A manuscript was published in the Malaria Journal in March 2021 through the project titled “Malaria in Eswatini, 2012–2019: a case study of the elimination effort”. <https://doi.org/10.1186/s12936-021-03699-x>



Figure 13: A malaria site officer doing Larvisiding

#### 4.1.2.4 Neglected Tropical Diseases

According to a mapping survey conducted in 2014, Eswatini is endemic to schistosomiasis

with a prevalence rate of 15% and soil-transmitted helminthiasis with a prevalence of 6%. With support from WHO, Eswatini increased its Mass Drug Administration (MDA) coverage for schistosomiasis and soil-transmitted helminthiasis from 76% in 2016 to 98% in 2019. However, due to the shifting of focus to the COVID-19 response, MDA was suspended in 2020 and 2021. The focus was mainly on snakebite envenoming.



Figure 14: Snakebite symposium at the Lubombo region

#### Achievements

- In line with WHO’s strategy on snakebite prevention and control, WHO collaborated with the Eswatini Antivenom Foundation (EAF) to support the Ministry of Health. This collaboration has enabled the country to make snakebite notifiable, revise the National Snakebite Management Guidelines, develop a national snakebite risk communication strategy, and reduce the mortality associated with snakebite by over 75%.
- During the 2020/21 snakebite season, EAF in collaboration with Liverpool School of Tropical Medicine, supported by The Wellcome Trust (UK), implemented an observational study at nine health facilities across Eswatini. Research assistants were employed at eight of these facilities to collect data on snakebite envenoming as well as

engage communities. Facilities with a research assistant reported improved case management and reduced deaths. Through WHO support, the assistants' contracts were extended for two months.

- WHO also supported the training of health workers on snakebite case management including hosting a snakebite symposium targeting 300 doctors, nurses, and paramedics from both public and private sectors. Due to improved case management, permanent physical disabilities and scarring have reduced from eleven (comprising nine debridements, six skin grafts, one amputation, and three fasciotomies) during snakebite season 2019/2020 to nine (seven debridements, one skin graft, two amputations, and one fasciotomy) during snakebite season 2020/21. With continued collaboration and support to the Ministry of health, more lives and

#### 4.1.3 Non-Communicable Diseases

The Ministry of Health is committed to improving the management of Noncommunicable Diseases (NCDs) in the country. The primary focus of the program is on all NCDs as outlined in the National Health Sector Strategic Plan (NHSSP) 2019-2023, with particular attention on the four high prevalent conditions namely; cardiovascular diseases, diabetes mellitus, cancers, and chronic lung diseases including asthma. The NCD programme has been structured into the following units namely:

- Prevention Unit
- NCD Clinical Management Unit
- Cancer Unit
- Mental Health Unit.



Figure 15: School children showing their pills during a mass drug administration campaign in the Hhohho region

NCD services in the country have always been centralized posing a challenge to patients in accessing the services. In an effort to address this challenge, the Ministry conducted a pilot to decentralize NCD services to the primary level facilities using the World Health Organization Package of Essential Non-Communicable (WHO PEN) diseases interventions at the primary care level. Findings from the pilot revealed that decentralization of NCD services is feasible. Hence, the programme is currently in the process of decentralizing NCD service delivery throughout the country. The work of WHO during the biennium focused on strengthening systems, processes, and tools in preparation for NCD service integration at all levels and decentralization to primary care.



Figure 16: A health workers checking Blood pressure during a wellness fair

- **Major Non-Communicable Diseases**

The focus was mainly on the four high prevalent conditions namely; cardiovascular diseases, diabetes mellitus, cancers, and chronic lung diseases including asthma.

### Achievements

- 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. The action plan included a Monitoring and Evaluation Framework and a costed operational plan to be used as a resource mobilization tool.

- Due to Covid-19, the implementation of the national decentralization operational framework had to be accelerated. An emergency decentralization protocol was developed to fast-track the above activity. The country successfully scaled up NCD services from 54 to 116 of 239 primary care facilities (with the emergency protocol that was developed) instead of the targeted 60 facilities. This represents a 32% increase in the targeted facilities and 67% coverage in the number of targeted facilities by 2021. The country plans to scale up to all primary care facilities by 2022



Figure 17: WHO Staff testing for diabetes during World Diabetes Day

- In 2020 the NCD program benefitted greatly from the COVID 19 fund as clients with NCDs were discovered to be most at risk for covid-19 hence they were a priority. Development and implementing partners continued to supplement the government budget for 2020. Mobilization of fund negotiations with the Global Fund was initiated in 2020.
- Following the emergency decentralization of NCD services to primary care facilities, mentoring and supportive supervision visits were carried out. The mentorship showed that despite the covid-19

pandemic, services were carried out efficiently. Gaps were noted during these visits and efforts were made to address these gaps and challenges.

- Package of Essential Non-Communicable Disease 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 Program has prioritized human resources, training nurses, doctors and pre-service clinicians on the new NCD guidelines. Nationally, over 300 nurses and 53 doctors were trained on the new guidelines. Trainings were also provided for healthcare workers on NCD management and Covid-19. The Program also trained 20 HMIS and M&E officers on NCD data collection tools. Furthermore, 60 NCD peer educators and 104 Lead RHM were trained on NCD screening and prevention. The cancer unit managed to conduct trainings for 8 Doctors on pre-cancerous treatment (LEEP), 40 Nurses on cervical cancer screening and pre-cancerous treatment, xxx Rural Health Motivators On health promotion.
- In order to increase access to NCD interventions, NCD interventions were integrated into the 2021-2023 National TB Control Programme strategy, and HIV guiding documents i.e. the training module. Differentiated service delivery (DSD) models for clients with NCD and HIV were developed and implemented increasing access to NCD services. The noncommunicable Diseases module was incorporated into COVID-19 case management guidelines which were distributed to 132 facilities.
- 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. Further, the Programme provided technical support and data to cost NCD activities through 2023 as part of the national costing exercise for the Extended National Health Sector Strategic Plan (NHSSP 2019-2023), as well as developed an evidence-drive, activity-based budget for NCD activities in the financial year 2021-2022.

### • **Cancer Control**

The National Cancer Control Unit (NCCU) implemented its strategic plan through different strategic activities, including expanding screening, early detection, and linkages to care.

#### Achievements

- 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.
- The NCCU further conducted regional prostate cancer awareness campaigns reaching 222 people and conducted 30 screenings and a breast and cervical cancer awareness campaign which reached 392 people.



Figure 18: Women aerobics during a cervical cancer awareness campaign

- In collaboration with UNFPA, WHO supported report writing and dissemination on the assessment of health facilities implementing the cervical cancer screening in Eswatini which led to the review of cervical cancer screening national guidelines which were piloted in a training of trainers. WHO also supported the provision of cervical cancer screening services to 7 constituencies.
- Under the Cancer Control Unit, there was the recruitment of regional coordinators to attend to regional cancer-related issues and focal persons to take lead in relation to facility cancer-related issues.

- **Mental health**

Mental health is increasingly acknowledged as an important public health concern in Eswatini. Mental disorders are highly prevalent and cause significant suffering and disease burden is high.

Untreated common mental disorders (CMD) are the leading risk factor for suicide and attempted suicide. About one in ten Swati adults have seriously considered suicide and only a quarter of these report seeking professional help. Even more alarmingly, 1 in 25 Swati adults have attempted suicide at some point in their lives, with 60% of these having done so in the last 12 months.

### Achievements

- Health care workers were capacitated in providing psychological care and support services to mitigate the impacts of COVID-19. Mental health services were decentralized to primary care facilities.
- In this biennium, the psychiatric hospital trained 110 peer educators on mental health issues including anger management, depression, substance

abuse, stress, and burnout. Moreover, training of HTS officers on depression, substance abuse, and suicide in relation to HIV was conducted.

- **Strategic information for NCDs**

The Ministry of Health recognizes the importance of reliable and high-quality health information and the need to track the burden of diseases as part of the broader strategy of achieving optimum health and wellbeing of the nation. Currently, there is a rollout of the client management systems (CMIS) into more health facilities as well as incorporating data elements required by different programs to monitor patients.

The NCD program has challenges in collecting accurate data on NCD patients. Even though there are means on the ground towards addressing these challenges, at the moment the program reports what is available as opposed to what it needs for programming

### Achievements

- In response to long-standing data gaps for NCD M&E, the NCD program successfully piloted NCD data collection tools in 19 facilities nationally to generate data to inform programming and policy decisions for the NCD program. The tools that were piloted include:
  - Enrolment registers
  - Follow up registers
  - Monthly summary
  - Chronic care file
  - Patient card
- There is also a need to generate more evidence through conducting STEPS based on the findings from the strategic plan review.

#### 4.1.4 Strengthening health systems

The focus was also on provision of authoritative guidance and standards on quality, safety and efficacy of health products. Address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices was prioritised.

##### 4.1.4.1 Strengthening health workforce

Human Resources for Health (HRH) is the foundation of the health care system that promotes a well-performing health workforce and provides support for an enabling environment. WHO has supported aspects of human resource management through the development of a standardized induction training package for newly recruited health workers and utilized the training package to induct about one hundred and fifty (150) health workers.

#### Key achievements

- Operational plans for HRH Strategic plan developed and implemented
- Supportive supervision guidelines, IPC guidelines, and employee guidelines reviewed and being used at the health facility level.
- Guidelines for recruitment and secondment for donor-funded positions were revised and implemented to guide aspects of human resource management



Figure 19: Training of Health care workers on critical care

- Research for mapping Health Workforce interventions, in the context of the COVID-19 pandemic was conducted and the report disseminated.
- Assessment of risk factors for Coronavirus disease in Health Workers conducted, report disseminated, and recommendations for intensification of infection prevention and control measures in all levels of healthcare service delivery made.
- Resilience and adaptation during COVID-19 era for frontline workers were enhanced through capacity development on basic mental health and psychological social support.
- Nurses and midwives' regulatory guidelines were revised and 500 copies of midwifery regulatory guidelines (nursing procedure manuals) printed.
- More than 5000 health workers were trained on COVID-19 through the MOH COVID-19 Academy

##### 4.1.4.2 Guidance and standards on quality, safety and efficacy of health products

WHO provided guidance on ensuring equitable access to health products and the availability, accessibility, acceptability, and affordability of safe, effective quality health products towards achieving universal health coverage.

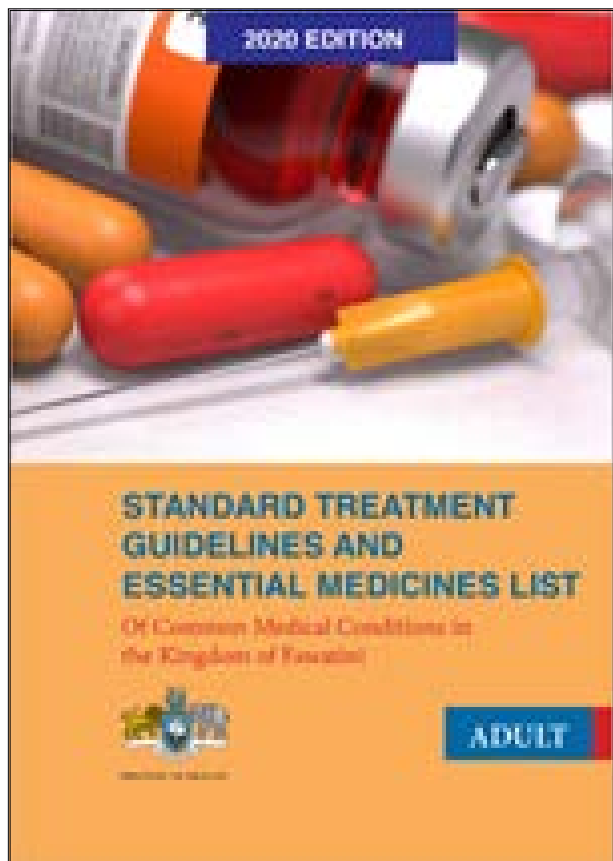
#### Achievements

- The country reviewed, printed, and disseminated the National Essential Medicines List and Standard Treatment Guidelines. The guidelines were developed with support from a team of experts from Zimbabwe through South-South collaboration facilitated by WHO. The guidelines are accessible to all health workers through an online application developed by the Ministry of Health



in collaboration with USAID and other partners.

- The county introduced new diagnostic technologies, therapeutics, and vaccines in response to the COVID 19 pandemic. WHO assisted in procurement and capacity building for the application of these technologies.



- Introduction of Polymerase Chain Reaction test for SARS CoV 2 infection. WHO supported the procurement of reagents for the test. As the pandemic evolved the country introduced the rapid test for SARS CoV 2 as well as genomic surveillance to monitor variants of the virus.

- WHO procured oxygen delivery devices as well as essential critical care medicines for the treatment of severe COVID 19 diseases
- The introduction of COVID 19 vaccines in the country was a key highlight as WCO supported the development and implementation of the National Vaccine Deployment Plan.

#### 4.1.4.3 Addressing antimicrobial resistance

Antimicrobial resistance is a growing national challenge that will have significant consequences for morbidity, mortality, and economic activity.

#### Key achievements

- The plan is being implemented in collaboration with other sectors, including the private sector ensuring antibiotic stewardship in hospitals and capacity-building of health care workers.
- A functional national antimicrobial resistance surveillance system, including the national reference laboratory which contribute data to the Global Antimicrobial Resistance Surveillance System (GLASS) was developed. An integrated antimicrobial resistance surveillance protocol for food borne bacteria across the human, animal and environment sectors was developed and validated. Six sentinel sites were set up for antimicrobial resistance surveillance in humans and animals.
- The commemoration of the World Antimicrobial Awareness Week contributed towards raising public awareness. Healthcare workers and communities were targeted.

## 4.2 MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES



WHO contributed towards operational readiness to respond to health emergencies through assessing the country All-hazards emergency preparedness capacities and capacity development for managing risks and vulnerabilities. Polio eradication and transition plans in partnership with the Global Polio Eradication Initiative were implemented towards preventing diseases outbreaks and pandemics. The country scaled up response to the COVID 19 pandemic with resurgences rapidly detected, risks assessed and communicated, and mitigation measures rapidly put in place.

### 4.2.1 Country Operational Readiness to respond to emergencies

WHO's work in emergency preparedness builds on the International Health Regulations (2005); a set of procedures to prepare for and respond to public health threats. Significant progress has been made during the biennium including follow-up actions on the voluntary joint external evaluation, Intra Action-action review for COVID 19 response, and simulation exercises.



Figure 20: JEE meeting panelists

### Key achievements

- National Action Plan for Health Security (NAPHS) was developed in line with recommendations from the Joint External Evaluation (JEE) conducted in 2018. The

plan is awaiting high level endorsement and launching.

- The annual reports on IHR (2005) for 2020 and 2021 using the SPAR tool were submitted on time.
- The 3rd edition of Integrated Disease Surveillance and Response (IDSR) guidelines and training manuals were adapted, printed, and launched. Training of trainers was conducted and 100 healthcare workers from all regions of the country participated. There will be rolling out of trainings of health workers at health facility level in 2022 with the target of reaching 40% of all health workers.
- The Public Health Emergency Management Committees (PHEMC) were reconstituted in line with the 3<sup>rd</sup> edition of IDSR guidelines. Their Terms of Reference were revised, and the committees were oriented on the incident management system which was adopted for improving the coordination of COVID-19 response at regional level.
- The country conducted Intra Action Reviews for COVID 19 response with the participation of multiple stakeholders. The reports were written and disseminated. A tabletop simulation exercise for COVID 19 vaccine introduction was conducted. The findings of all these simulation exercises were used to update the COVID 19 response plans.

### 4.2.2 Polio eradication

There is continued support for implementation of the national transition plan.



Figure 21: A child receiving polio vaccine

## Achievements

- The country has maintained the polio free status towards the global goal of polio eradication. WHO in collaboration with the Ministry of health conducted active Acute Flaccid Paralysis (AFP) surveillance in all 71 priority sites in the four regions of the country. A total of 208 health workers were capacitated on AFP surveillance on how to perform weekly retrospective record reviews. This has led to improved knowledge and maintenance of optimal AFP surveillance key performance indicators of 2/100 000 children less than 15 years in 2020 and 2021 respectively and stool adequacy above 80% nationally.
- The Polio Outbreak Preparedness and Response Plans were updated and submitted timely to the Africa regional certification committee (ARCC) as annexure of the polio annual update report.

### 4.2.3 COVID 19 Response

The World Health Organization (WHO) declared the 2019 novel coronavirus outbreak a public health emergency of international concern on 30 January 2020, with the disease later designated as COVID-19. Eswatini reported its first case of COVID-19 on 14 March 2020. By end of 2021 the country had recorded 64 381 cases and 1 272 deaths with a case fatality ratio

of 2.0%. The country had experienced four waves of transmission. Covid 19 vaccination was deployed in March 2021 and 25 % of the population was fully vaccinated by December 2021.

#### 4.2.3.1 Coordination, planning, financing, and monitoring

- The overall response employed a whole-of-society approach, with the Ministry of Health coordinating the health sector response with the declaration of the state of emergency through invoking Section 29 of the Disaster Management Act of 2006.
- The country adopted the Incident Management System to guide the response. 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.
- The country developed a health sector emergency response plan updated in July,2020. An Intra Action Review was conducted in September 2020 which informed review of the response plan. The response plan was used to mobilise resources from government, collaborating and implementing partners followed by accelerated procurement of required services and supplies. There was rapid recruitment of human resources across different key cadres.

#### 4.2.3.2 Risk communication, community engagement (RCCE) and infodemic management



Figure 22: Risk Communication campaign for COVID in Hhohho region

- Community engagement and risk communication for adoption of Public Health and Social Measures and demand creation for COVID 19 vaccination was conducted through the Risk Communication and Community Engagement Technical Working Group.
- Community engagement and social mobilisation for vaccine uptake was conducted among target groups including religious, sporting and business communities using different media platforms. Media partnership with all the country's radio stations, TV stations and newspapers resulted in free flighting of COVID 19 vaccination messages. Setting up Social Media platforms with a feedback application to address myths and rumours, increased the number of individuals reached with correct messages. Collaboration with corporate sector encouraged employees and customers to participate in COVID vaccination. Innovative public engagement such as using mobile digital advertising truck and megaphones in local busy areas help attract more people to vaccination sites.
- Teams of community volunteers were conducting door to door visits disseminating messages on prevention as well as in creating demand for vaccine uptake.
- A team of 9 community engagement officers was deployed to assist in coordinating community engagement activities in the four regions of the country.

#### 4.2.3.3 Surveillance, outbreak investigation and calibration of public health and social measures

- An effective surveillance system facilitated the dissemination of a daily situation report to guide decision making and allow two-way communication with the public, to encourage and measure compliance and delivery of targeted messages.
- Staff were trained in the delivery of services and additional staff hired to improve the response.
- The Rapid Response Teams continued with case investigation and contact tracing. COVID-19 screening was ongoing in all health facilities and workplaces with the objective of identifying suspect cases, testing, and linking them to care.
- The country also strengthened the surveillance system for monitoring SARs CoV 2 variants in the country through conducting in country genomic sequencing.

#### 4.2.3.4 Points of entry, international travel and transport, and mass gatherings

- Screening of travelers was ongoing in 8 out of 15 formal Points of Entry (PoE) by Port Health Officers (PHOs).
- There was procurement and installation of fixed scanners which are automated and effective in the high-volume POE.
- The Port Health Officers were trained to strengthen surveillance at the points of entry and on the Standard Operating Procedures for Points of Entry which include management of ill travellers.

- Public Health Emergency Contingency Plan for points of entry was also developed together with Information Education and Communication material.

#### 4.2.3.5 Laboratories and diagnostics

- The country managed to introduce real-time polymerase chain reaction (PCR) in government and four private sector laboratories. Establishment and Accreditation of the Real Time PCR laboratory in the country was on 7 April 2020.
- The government also rolled out Antigen Rapid Diagnostic Test to 94 testing sites throughout the country. COVID 19 testing was decentralised to clinics and other community-based testing sites, increasing the availability of testing services. The cumulative number of tests per 10 000 population stood at 4 025 at the end of 2021.

#### 4.2.3.6 Infection prevention and control and protection of the health workforce

- WHO facilitated the development of COVID-19 Infection Prevention and Control (IPC) Guidelines and SOPs in line with the recommended guidance from the WHO. Facility assessments were done to assess compliance and identify gaps in maintain IPC against COVID-19 including other HAI.
- IPC materials were distributed to all facilities through the push system. Following the assessments some health care facilities and prisons were provided with hand washing facilities and triage areas with the aim of reducing transmission.



Figure 23: A health personnel donning PPE in readiness to attend a patient

- Health Care Workers and Police Officers were trained in IPC on critical practices that included Donning and Doffing coupled with the rational use of PPE.

#### 4.2.3.7 Case management, clinical operations and therapeutics

- The government also set up infrastructures for isolation and care of confirmed COVID-19 cases. The country has decentralised COVID 19 treatment to regional hospitals and health centres with bed capacity of 649.
- The organised Home Care Service came in handy in managing mild cases of COVID 19, patients who did not accept admission and when the facilities were getting full due to the surge in cases.
- An effective Referral System to facilitate movement of patients from home to facilities was established.



Figure 24: An oxygen plant at the Lubombo Referral Hospital

- There was construction of oxygen generation plants at the Lubombo Referral Hospital and the Luke Commission Centre. Bulk oxygen tank were installed at one of the referral hospitals in Manzini with oxygen reticulation of the COVID 19 wards and Intensive Care Unit.

#### 4.2.3.8 Strengthening essential health services and systems

- The country decentralized service provision for non-communicable diseases with primary health care facilities refilling antidiabetic and antihypertensive medication.
- The country is also implementing community refilling of Antiretroviral

drugs and TB medication. The country is however faced with stock outs of medication for NCDs such as antihypertensives and antiepileptic drugs.

- WCO continued to prioritize and support implementation and strengthening of HIV, reproductive maternal neonatal and child health, TB, malaria, NCD and other essential services. The WCO supported the development of guiding documents for these programmes.

#### 4.2.3.9 COVID Vaccination



Figure 25: Delivery of COVID vaccines through COVAX

- The country deployed COVID 19 vaccinations from April 2021 with prioritization of the target population according to the WHO/SAGE recommendations. Multi-stakeholder involvement and implementation of the activities facilitated the vaccine rollout. Electronic Pre- registration of Covid-19 vaccine assisted the service delivery team to focus the anticipated number of people to be vaccinated.

- WHO collaborated with many stakeholders in conducting trainings of health workers on COVID 19 vaccination using different platforms at all levels e.g. physical, virtual, webinar. Standardized training information was developed and disseminated across all regions through training package and training of master trainers and regional trainers. Surge capacity for vaccination was deployed to facilitate vaccine deployment.
- Government collaborated with WHO and partners in developing a digitalized COVID-19 vaccine system for production of automated daily reports on the vaccination uptake. This promoted data use for decision making. The system also generated vaccine card and certificate with a unique QR code which provides confirmation of vaccination status.



Figure 26: A health worker administering the COVID vaccine

## 4.3 MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING

More people can enjoy better health and well-being through addressing determinants of and risks to health. These include nutrition, violence and injuries, gender, water, sanitation and hygiene (WASH), air pollution, climate, tobacco use, trans fatty acids, harmful use of alcohol, obesity, and physical activity. Addressing these determinants and risks requires multisectoral actions that are not limited to the health system alone, often using the stewardship/policy, advocacy, and regulation functions of health ministries.

The work of WHO focused on reducing risk reduced through multi-sectoral action on implementing technical global packages as well as engagement with public and private sectors as well as civil society. Priority was given to enabling action to accelerate WHO FCTC implementation.

### 4.3.1 Address social determinants of health and disease risk factors

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 that people can take control over their health. Enabling environments help people to better achieve this goal.

Reducing the major risk factors for noncommunicable diseases (NCDs) – tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol – was the focus of WHO's work to prevent deaths from NCDs.

#### Achievements

- Supported the WASH forum with the focus on improving sanitation facilities in the communities including provision of hand washing facilities in schools and

other public places as community based Infection Prevention and Control.

- Supported the implementation of multilateral environmental agreements like the Minamata Convention on Mercury. Working with Eswatini Environmental Authority, the National Action Plan (NAP) for the Minamata Convention was completed.
- The country commemorated special health days to raise awareness and empower communities to reduce risk factors to diseases. The focus was on the following : the African Vaccination Week, the Polio Day, World Cancer Day, World TB Day, World Malaria Day, World No Tobacco Day, World Blood Donor Day, World Mental Health Day, World Diabetes Day, World AIDS Day.



Figure 27: Community engagement with members of a religious group

- Information on reducing disease risk factors was disseminated to the targeted audience using print, electronic and social media. Interpersonal communication was also used to disseminate information in schools, churches, at national events and in communities through door-to-door campaigns



### 4.3.2 The FCTC 2030 project

Eswatini was selected as one of the countries to benefit from the WHO Framework Convention on Tobacco Control's (FCTC) 2030 Project in the biennium. Support for Eswatini was based on her desire to achieve the general obligations and the time-bound measures of the WHO FCTC and to implement other Articles of the Convention according to national priorities.

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, and World No Tobacco Day was also commemorated.



Figure 28: FCTC project launch

### Achievements

- With technical support from the WCO, the Tobacco Control Unit was established, furnished, and the National Tobacco Control Focal Point was appointed.
- Additionally, Eswatini established the first multisectoral National Coordinating Mechanism (NCM) for tobacco control.
- The NCM has facilitated the development of key legislative and administrative documents such as the National Tobacco

### 4.3.3 Healthy settings approach

Health determinants and risks can be improved through action in these settings, which also present opportunities for reducing health inequalities. The school health programme is a joint effort between the Ministry of Health and the Ministry of Education and Training focused on healthy learners to achieve better educational outcomes.

WHO supported the school health programme in line with the healthy schools

initiative. Routine school health activities were suspended due to COVID 19 pandemic. The focus was therefore on making schools safe in the context of COVID- 19. The mandate of the school health during the pandemic was to promote risk communication, monitor compliance and support schools on surveillance which included case investigation, contact tracing, and follow up. WHO supported with hiring of data clerks and medical officer for implementation of COVID 19 pandemic related activities.

### Achievements

- The school health team developed guidelines and Standard Operation Procedures for safe learning in

the context of COVID 19 pandemic including Information Education and Communication material. This enabled comprehensive and integrated disease prevention and wellness in schools.

- School health teams including teachers were trained on screening and recognizing ill learners as well as linking to care. The trainings were facilitated by the response to COVID 19.
- Engaged with Business Eswatini in promoting safe workplaces in the context of COVID 19 pandemic. Enforcement of Public Health and Social Measures in workplaces was introduced resulting in reducing COVID 19 transmission.



Figure 29: Community engagement on Covid prevention

## 4.4 MORE EFFICIENT AND EFFECTIVE WHO PROVIDING SUPPORT TO THE COUNTRY

The focus was the strengthening of WHO to lead and coordinate national health and enhance data and innovation to accelerate progress towards the attainment of the triple billion targets. Efforts were made to strengthen country capacity in data and innovation; leadership, governance and advocacy for health as well as financial, human and administrative resources management for efficient and effective use in a results-oriented and transparent manner.

### 4.4.1 Health information systems

Health Information Systems (HIS) offers strengthened interventions and provides support for integrating data collection, processing, reporting, and use of the information management at all levels of health services. The goal of HIS is to allow decisions to be made in a transparent way, based on evidence, to produce relevant and quality information to support decision making, and ultimately to improve the population's health status. HIS has both routine and non-routine data sources; routine sources include regularly reported health facility data, while non-routine sources include data from censuses, DHS, and civil registration systems (for birth and death records).

#### Achievements

- Landscape analysis of Civil Registration and Vital Statistics (CVRS) and transition of ICD 9 to ICD 11 was conducted in March – April 2021 and implementation milestones were developed. WHO trained 30 Trainer of Trainers (including 14 clinicians from the 7 sites and 12 regional MOH Analysts) for ICD 11 and Medical Classification of Cause of Death (MCCoD) and ICD was piloted in selected seven health facilities.
- The Kingdom of Eswatini hosted the 5th National Health Research Virtual Conference in 2021 and WHO supported pre-conference capacity development for abstract writing, presentation skills and use of virtual platforms for health workers. The conference availed a platform for disseminating research findings, sharing best practices, and translating knowledge into usable products.
- The NHRID has been supported by WHO to revise the National Health Research Agenda and guidance for research thematic areas is made available for prospective researchers.
- Open Data Kit (ODK) system for surveillance was introduced through assistance from AFRO to facilitate capturing of COVID-19 data in the initial stages of the pandemic response in order to facilitate capturing of case investigation data, case management data, contact tracing data, and Points of Entry data for epidemiological analysis and to support the availability of data to inform policy decision making processes. In addition, ODK is also used for AFP surveillance and EPI supportive supervision. The output from the ODK is used for programming and decision-making.
- The Kingdom of Eswatini was lagging behind in the health information system for international classification of diseases (ICD) since ICD 9 was in use and technical assistance from AFRO was offered to transition to ICD 11.
- WHO provided technical and financial support for facilitating the Kingdom's ability to standardize cause of death reporting and ensuring the availability of standardized data for comparison across countries. Prior to capacity development

provided by AFRO, hospital deaths were certified by medical doctors using a births, marriage, and death (BMD 10) form and completeness of death registration was at 55% and 52% of registered deaths occurred in health facilities.

- A mapping of health information systems in the country was conducted and led to the development of HIS Strategic Plan for 2021-2023.
- Capacity development and supportive supervision for utilisation of Human Resource Information Systems (HRIS) in pilot health facilities and determining the adequacy of human resources using the Ministry of Public Service Human Resource Information System was conducted. Government Establishment Register and the Staffing Norms for the Ministry of Health were developed.

#### 4.4.2 Leadership, governance, and advocacy for health

WHO promoted more effective leadership at all levels, including by strengthening country office leadership, developing a fit-

- **HR and support from the other levels**

Grade	Occupied	Vacant (Expired)	Total
G	9	1	<b>10</b>
NPO	4	1	<b>5</b>
P and above	2	1	<b>3</b>
Grand Total	15	3	<b>18</b>

WHO engaged international consultants including 7 Critical Care Nurses and 3 Critical Care doctors, 4 Biomedical technicians, and 3 Epidemiologists during this biennium.

for-purpose staffing structure, providing appropriate delegation of authority, and reengineering business processes that facilitate effectiveness and efficiency. WHO placed the country squarely at the center of its work. The country's cooperation strategies and country support plans were aligned with national priorities.

Strategic communications also improved understanding and appreciation of the role and impact of WHO. This strengthened the organization's position within the wider national health landscape to advance its normative, technical, and emergency preparedness and response work.

#### 4.4.3 Human, and administrative resources management

Management and administration enabled the implementation of the Organization's technical programmes and undergirds its ability to respond to public health emergencies. The continued improvement of administrative efficiency was an important goal of the Organization and an essential element of delivering value for money to the country and donors.

## 5 PARTNERSHIPS AND STRATEGIC COMMUNICATIONS

- World Health Organization- Eswatini continues to strengthen partnerships with the Government of Eswatini, other aid agencies, donors, and the United Nations family by actively engaging them on Health issues and how to better strengthen health systems in the country. WHO offers technical and strategic advice on specific health issues to the government to ensure that the greater population has access to better health services.
- In support of the “One United Nations”, WHO participates in an array of joint activities organized by other UN agencies. Partnerships with other UN agencies served to increase expertise in WHO’s work by ensuring efficient programming to further progress towards the achievement of the 2030 Sustainable Development Goals.
- WHO contributes to the Sisonke newsletter; a United Nations platform that showcases the work of the different agencies in the country.
- Relationships with donors have been solidified in appreciation for funding different projects in the country.
- WHO also coordinates with technical working groups on strategies to strengthen health systems.
- As a recommendation by WHO, health partners were advised to start offering TB patients food baskets since they were unable to fend for themselves and this reduced the stress burden on TB patients.
- At WHO’s request, Eswatini received support from the UK Emergency Medical Team to strengthen Risk Communication and Community Engagement (RCCE) for COVID-19. An RCCE committee was formed comprising 35 officers from government departments, different UN agencies, the PEPFAR family, and other government partners. This partnership helped in the coordination of activities whilst disseminating communication on COVID-19.



## 6 ENABLING FACTORS

There were a myriad of reasons that contributed to the successful running of the WCO including;

- Strategic guidance and support from the office of the WHO Eswatini Country Representative and support from AFRO and WHO headquarters as well.
- Availability of global technical guidelines, tools, and resources
- Adequate technical support from WHO AFRO and global headquarters
- Guidance and support from the office of the PMO in South Africa
- Collaboration and teamwork among office staff
- Collaboration and good working relationships with stakeholders and partners i.e Ministry of Health, local UN Agencies, other implementing partners
- Collaboration and support from WHO South Africa assisted with respect to ensuring the safe and clear passage of external consultants traveling into the country to support during the COVID-19 pandemic
- Availability of adequate IT support to allow for remote work by staff during the COVID-19 lockdown
- The stewardship role of the Ministry of Health in implementing health interventions



Figure 30: Dr Emmanuel Oppong (r) engaged by WHO AFRO to support COVID critical care in Eswatini

## 7 CHALLENGES IN THE COUNTRY OFFICE

- Limitations of access to some medical and logistical suppliers during the pandemic. Travel restrictions due to lockdowns compromised access to services as well as outreach programs.
- Pressure on the WCO Staff thus reducing efficiency on the continuity of essential health services.
- Repurposing of staff resulted in increased workload for staff in order to meet the demands related to the COVID-19 pandemic while ensuring continued service delivery i.e., delivery on both the regular country-office Workplan and the COVID-19 Workplan respectively; delayed implementation and completion of some planned normative activities, including difficulty with respect to representation in the formation of various control committees.
- Lack of rest and recuperation among staff due to the demands brought about by the pandemic resulted in fatigue and ultimately affected the efficiency and effectiveness in the delivery of country office results.
- Anxiety and uncertainty among staff as a result of delayed completion and approval of the functional review process to guide the HR structure of the local office
- Political unrest experienced in the country in the reporting year, 2021, caused uncertainty and anxiety among staff whilst also threatening the overall security situation in the country.
- Network disruptions were experienced for some time during the unrest thus affecting the seamless flow of work for staff including delayed reporting.
- Increased costs for setting up adequate IT infrastructure to increase efficiency in the network as staff were required to work from home due to the COVID-19 pandemic. The procurement of Mi-fi Routers including monthly data and airtime for staff and consultants engaged during the COVID-19 pandemic was effected.
- Diversion of resources to the COVID-19 response affected the seamless delivery of other essential health care services.

## 8 CONCLUSION AND LOOKING AHEAD

This biennial report highlights a number of significant achievements in the 2020-2021 biennium. WHO in the Kingdom of Eswatini is determined to continue working with the government of Eswatini and partners to help to achieve the sustainable development and other national goals.

WHO will continue to focus on:

- Quality Service delivery
- Communicable and Non Communicable Diseases Prevention and Control
- Equitable, integrated health Service across the life course
- Multisectoral approaches for healthier populations
- Enhance health security and disaster preparedness and response.

WHO will harness global knowledge to help deliver evidence-informed, context-specific, and innovative solutions that will benefit all Emaswati. WHO will continue to work closely with development partners, including United Nations agencies, and multilateral and bilateral partners. The joint work will be guided by the Sustainable Development Goals, the health sector strategic plan, the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2020–2025 and the WHO Thirteenth General Programme of Work. 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.



### INVESTING IN TOBACCO CONTROL SAVES LIVES



Tobacco use causes an undue burden to Eswatini’s economy and health system. As one of the leading risk factors for noncommunicable diseases (NCDs), tobacco use is responsible for the needless loss of lives and high health expenditures. Approximately 6% of Swazis above the age of 15 years use some form of tobacco with use by men (12%) greater than women (1%). A 2021 United Nations Development Programme (UNDP) study, the “Investment Case for Tobacco Control in Eswatini”, concluded that tobacco use kills more than 600 Swazis annually, with 66% of these deaths among individuals under age 70. Nearly one-quarter (24%) of lives lost from tobacco use are due to exposure to second-hand smoke.

Additionally, in 2017, tobacco use cost the economy SZL 684 million (roughly 46 million US dollars), equivalent to 1.1% of its gross domestic product. These annual costs

include SZL 64 million (roughly 4.3 million US dollars) in healthcare expenditures and SZL 620 million (roughly 41.6 million US dollars) in lost productive capacities due to premature mortality and disability as well as workplace smoking breaks. Left unchecked, Eswatini will face continued economic, health and societal hardship attributable to tobacco use.

*How did Eswatini do it, and how did the WHO Secretariat support Eswatini?*

WHO collaborated with the Ministry of Health to ensure that funding was available to address issues related to tobacco control. The WHO Country Office in Eswatini assisted the country to apply for funding through the WHO Framework Convention on Tobacco Control (FCTC) 2030 Project. Eswatini became one of the few countries globally to benefit from the FCTC 2030 Project

which is funded by the generous support of the Governments of the United Kingdom, Australia, and Norway. Funding started in 2020 and contributed to promoting the implementation of the WHO FCTC as part of the Sustainable Development Goal (SDG) agenda.

WHO, through its convening power, brought together relevant government sectors, international development partners, non-governmental organizations, faith-based organizations, civil society organizations, communities, and individual stakeholders to join the renewed effort to make Eswatini smoke-free. WHO played a leadership role in conducting a tobacco control needs assessment in collaboration with the WHO.

FCTC Secretariat, United Nations Development Programme (UNDP), Research Triangle Institute (RTI), and local stakeholders. The findings were used to develop and publish the first-ever investment case for tobacco control in Eswatini. WHO, together with the Government of Eswatini, widely disseminated the Investment Case for Tobacco Control report as an evidence-based advocacy tool for garnering support from stakeholders to reduce the demand for and supply of tobacco-related products.

With updated country-level data and 15-year projections on the gains that could be realized if Eswatini were to invest in tobacco control measures, the tool not only advocates

for the protection of one's own life but also for the lives of those around them. Reducing demand for tobacco products will improve life expectancy and result in fewer premature deaths for both smokers and non-smokers. Eswatini, with technical support from WHO, has since established a multisectoral National Coordinating Mechanism (NCM) for tobacco control. The NCM has facilitated the development of 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 have been conducted, targeting school children as well as out-of-school youths. Municipalities have been engaged to create smoke-free towns and cities.

Most importantly, these efforts are contributing toward a 30% relative reduction in the prevalence of current tobacco use in persons aged 15+ years and a 25% reduction in premature mortality from noncommunicable diseases by 2030 in line with the Noncommunicable Disease (NCD) Global Monitoring Framework. Investing in tobacco control will mitigate the health, social and economic impacts of tobacco use, protecting vulnerable second-hand smokers which are in some instances children and pregnant mothers.

## “WHY SHORTER TB REGIMEN IS THE MOST PREFERRED BY PATIENTS IN ESWATINI”



Siphephelosethu Ntjangase is a 21-year-old university student from Hluti village in the Shiselweni region who suffers from pulmonary drug resistant tuberculosis (DR-TB). In October 2021 before getting checked, he noticed that he was losing weight, sweating at night and had a persistent cough that had lasted over a year. From the first test, the diagnosis was not conclusive which forced him to opt for a second opinion and that is when he tested positive for tuberculosis (TB). Siphephelosethu was immediately sent into isolation at Pigg’s Peak Government Hospital to avoid infecting other people and thereafter referred to Nhlango Health Center for treatment. Nhlango Health Centre is the national designated TB treatment centre.

*“I was scared at first because I am not sickly and taking daily medication was not good at all for me. I told the people who had been near me to get tested and luckily enough no one tested positive for TB”*

Siphephelosethu had been taking his medicine religiously until the civil unrest experienced in the country in 2021 resulted in him stopping treatment for a while since he could not access the hospital.

*“At least when I started taking treatment, the effects were not as bad as I had imagined when I got diagnosed. I started gaining weight and feeling like myself again with dizziness and nausea being my only side effects. The nurse gave me tablets to take thirty minutes before taking the drug and this has really helped me”*

Previously Multi Drug Resistant TB (MDR-TB) treatment required a course of second-line drugs which included injectables for at least 24 months and up to 36 months, supported by counselling and monitoring for adverse events. Even though these regimens were effective, some patients experienced severe side effects including hearing loss, kidney,

and liver injury mainly due to injectables. The longer duration of treatment also contributed to high lost to follow up. The World Health Organization then recommended countries to forgo the non-injectable regimens, adopt all oral MDRTB treatment, shorter regimens and look at innovative approaches which included adherence enablers to support patients.

*‘Initially, I thought I would die but I am happy I never experienced any stigma from either my family or the community. My aunt even attended a family treatment support workshop where she was educated about TB and thereafter enlightened other family members. The nurses also came to my home for the same’* said Siphephelo sethu.

Dr Takudzwanashe Gwitima from Médecins Sans Frontières (MSF) says the shorter regimen that Siphephelo sethu is on is a preferred option by most patients who only use it for between nine to twelve months and has less side effects.

*“Initially, patients would come for daily injections for eight months plus tablets and tablets all through for the rest of the year(s). They would experience severe side effects like loss of hearing which in some instances would lead to deafness, kidney issues and a lot of pain from the daily injections. It used to be so traumatizing for me injecting children daily and seeing them cry was not a good feeling. At least now the mother can crush the medicine and give the baby to take”*- Dr Gwitima

In Eswatini, most patients are adhering to the oral short course therapy (OSCT) since they are tolerable with less side effects. This is evident as the treatment MDR-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% according to the Global TB report 2021. The lost to follow up improved from 6% to less than 2% and

even in the context of COVID-19 adherence seemed to be improving. Additionally, given the long duration of MDRTB treatment as well as safety precautions that TB patients must take including isolating (which often include loss of income), the WHO recommended for them to be given food baskets to cushion them from socio-economic shocks.

Multi Drug Resistant TB is of concern in Eswatini, it accounts for about 10% of diagnosed cases. Multi Drug resistant TB (DR-TB) is more difficult to treat than the drug-susceptible ones. In 2020 the new WHO DR-TB guidelines were published with Eswatini quickly adopting the guidance and reviewing the DR-TB guidelines in 2019 which recommended use of all oral regimens. The same year (2019) Eswatini with support from MSF developed a protocol for implementation of shorter all oral regimen in 2020.

Unfortunately, due to the COVID 19 pandemic, the implementation was delayed by a year. Shorter all oral regimen was later implemented in two out of the four regions under operational research. After 3 months of implementation, there was an assessment by the WHO Regional Green Light Committee consultants, and they recommended the scale up to the whole country and this was done in two months with support from President’s Emergency Plan for AIDS Relief (PEPFAR) partners.

Moving forward the country will continue to scale up use of all oral short regimens and will be training nurses to initiate these treatments to be accessible in more health facilities to further improve patient outcomes and impact. These are efforts to ensure Universal health Coverage, leaving no one behind.

## 10 YEARS WITHOUT MEASLES OUTBREAK: A STRIDE TOWARDS MEASLES-RUBELLA ELIMINATION



Eswatini embarked on a measles-rubella campaign to prevent a looming outbreak caused by not reaching every child with immunization. Follow up immunization campaign is an essential component of WHO measles elimination strategy defined to target all children from 9 to 59 months of age regardless of their immunization status or disease history. The basis of conducting this campaign was that the efficacy of the measles vaccine at 9 months is at 85%. With national coverage of 82.5% in 2019 and 76.2% in 2020 which are below 85% for the past 2 years, approximately 25% of each cohort of under ones remained susceptible (Measles rubella outbreak preparedness plan, 2020).

As each cohort's susceptible join the susceptible pool, the group vulnerable to an epidemic grows larger each year. It usually takes between 3 to 5 years for this pool to grow significantly large for an epidemic to occur. Therefore, it was justifiable for the

country to conduct the measles follow-up campaign targeting the age group 9 months to 59 months to avoid any outbreak due to the accumulation of susceptible pools over the years.

The Measles campaign was conducted during the early stages of the COVID-19 3rd wave and the rollout of the COVID-19 vaccine. In carrying out pre-implementation activities, WHO led, coordinated, and provided technical support and guided the use of COVID-19 structures including applying virtual platforms to reach all stakeholders. WHO played a critical role in convening partners for resource mobilization to ensure adequate resources were available to reach every targeted child with vaccines.

Since this campaign was executed during the COVID-19 pandemic, WHO ensured that all IPC measures were observed and followed. Use of social media particularly Facebook

and WhatsApp to reach young mothers, and elite society who do not often listen to the radio or watch TV was effective in delivering key messages. Focus group discussions undertaken during the campaign provided a platform to generate demand for the campaign and routine immunization. In order to ensure that equity is maintained, WHO provided support in the development of regional micro plans based on the urban poor, rural and hard-to-reach populations.

Engagement with community leaders, RHMS, and Municipality authorities for mapping of hard-to-reach children was done. The concept of integration adapted during the COVID-19 response facilitated quality supportive supervision and monitoring of the exercise by all WHO programme officers. Independent monitors were strategically placed in urban poor, rural and hard to reach settings to identify any missed eligible children and sites. An administrative national coverage of 97% MR vaccination was achieved at the national level.

A total of 4,008 children who were never reached with a dose of MR vaccine were vaccinated during the campaign. Inadequacies in transport logistics (vehicles and fuel) negatively affected the implementation of the campaign. Regions and the centre

attempted to mobilize vehicles from line ministries and NGOs. In some regions, nurses used their own personal vehicles to reach the vaccination sites. Strong collaboration between other partners and the Ministry of Health made the campaign a success.

Preparation for the MR campaign and COVID – 19 vaccine rollout improved the capacity of the cold chain. Timely planning of the campaign facilitated resource mobilization (technical and financial). The use of social media platforms for social mobilization led to a high turn-up of clients. Social mobilization is more effective when done one month prior to the campaign and intensified two weeks prior to implementation.

From the success of the campaign, WHO will continue to utilize a multi-sectoral national coordinating committee with relevant subcommittees both at the national and regional levels. Additionally, WHO will ensure strong coordination of national programmes and implementing partners at the regional level to avoid competition for resources. For institutional memory and data quality, WHO will continue to provide technical guidance on the digitalization of campaign data collection with full integration to HMIS.





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