

VISION

BY THE YEAR 2015, THE SECTOR SHALL HAVE DEVELOPED INTO AN EFFICIENT AND EFFECTIVE SERVICE AND SHALL HAVE GIVEN RISE TO A MANAGERIAL POPULATION OF PEOPLE THAT LIVE LONGER, HEALTHIER AND SOCIALLY FULFILLING LIVES. AS SUCH THE COUNTRY'S HEALTH AND SOCIAL WELFARE STATUS INDICATORS SHALL COMPARE FAVOURABLY TO THOSE OF COUNTRIES WITH A SIMILAR LEVEL OF HUMAN DEVELOPMENT.

MISSION STATEMENT

THE MINISTRY OF HEALTH AND SOCIAL WELFARE SEEKS TO IMPROVE THE HEALTH AND SOCIAL WELFARE OF THE PEOPLE OF SWAZILAND BY PROVIDING PREVENTATIVE SERVICES THAT ARE OF HIGH QUALITY, RELEVANT, ACCESSIBLE, AFFORDABLE, EQUITABLE AND SOCIALLY ACCEPTABLE.

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FOREWORD

The completion of this National Health Policy document comes at a critical time. The health sector is faced with growing challenges due to the ever-increasing burden of disease and newly emerging conditions. Most notably, the HIV and AIDS pandemic has undermined the sector's ability to supply health services to meet the rising health needs of the population. Against this background, this policy document will serve to guide the Ministry in effecting strategies that will be used to address recent developments, and will serve as a road map for coming years.

The previous policy has proven to be outdated in guiding the Ministry's response to current challenges. This is manifested in existing problems such as human resource shortages, overcrowded facilities, inconsistent supplies of medicines, and inadequate health service delivery, among others. The current context has implications not only on the need to respond to the expectations of the population, but also necessitates drastic changes in management to ensure that the limited financial and human resources are utilised efficiently and effectively.

This policy intends to chart a way forward to address problem areas in health service provision. The process for developing this policy involved an in-depth analysis of the national health system's responsiveness in the context of the current challenges, and key policy issues were identified. The key policy directions outlined in this document include the following: organization and management of services, coordination, human resources, quality assurance, health financing, infrastructure development and equipment management, and the provision of public health and clinical services.

The policy aims to bring about improved quality, safe, efficacious and cost-effective service delivery. The implementation of this policy provides an important opportunity to enhance the partnership between government and other major stakeholders working in this sector. The Ministry is committed to implementing this policy, and I wish to call upon all stakeholders and partners to actively support the Ministry in ensuring a concerted and smooth implementation of this policy.

I thank you.



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Minister for Health and Social Welfare

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Treatment (Therapy)
CDR	Crude Death Rate
GDP	Gross Domestic Product
GNP	Gross National Product
GOS	Government of Swaziland
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MOEPD	Ministry of Economic Planning and Development
MMR	Maternal Mortality Rate
MOAC	Ministry of Agriculture and Cooperatives
MOHSW	Ministry of Health and Social Welfare
MOF	Ministry of Finance
MTEP	Medium Term Expenditure Framework
NCD	Non-Communicable Diseases
NDS	National Development Strategy
PRSAP	Poverty Reduction Strategy Action Plan
SHIES	Swaziland Household Income and Expenditure Survey
SPEED	Smart Program on Economic Empowerment and Development
STI	Sexually Transmitted Infection
TB	Tuberculosis
U5MR	Under Five Mortality Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1

1.1. INTRODUCTION

The previous National Health Policy was published in 1983 and was founded on the concepts and principles of Primary Health Care. Specifically, it sought to provide health education, promote food supply and proper nutrition, improve access to clean water and basic sanitation, promote maternal and child health (including family planning, immunization, prevention and control of endemic diseases), improve treatment of common diseases and injuries, and provide essential drugs. The policy also sought to promote equitable distribution of health services and to coordinate the public and private sectors. After twenty-four years of implementation, it was deemed necessary to update the policy so as to align it with new national and global developments that have an impact on the health status of the country, including the Millennium Development Goals (MDGs), and for the purpose of enhancing the Ministry's ability to effectively deal with emerging health challenges. Revision of the policy was also dictated by the Constitution of the Kingdom of Swaziland, National Development Strategy (NDS), Poverty Reduction Strategy Action Plan (PRSAP), Regional Health Policy for All for the 21st Century in the African Region: Agenda 2020, and SMART Programme on Economic Empowerment and Development (SPEED).

The process for developing this policy involved an in-depth analysis of the national health system's responsiveness in the context of the burden of many global disease challenges. Key policy issues, which needed to be addressed urgently, were identified and defined. The process also involved the engagement of consultants, several in-house technical meetings, consensus-building meetings and approval by Cabinet.

1.2. CONTEXT

1.2.1. DEMOGRAPHIC AND ECONOMIC PROFILE

The economy of Swaziland is very small and highly vulnerable to external shocks, and is currently facing declining long-term growth, rising poverty, and major social challenges. Long-term per capita growth declined steadily from 4.7% in the 1980's to 1.7% in the late 1990's, and has stood at only 0.9% since 1995 (World Bank, 2006). Real GDP growth has continued to decline from 2.1% to 1.8% in the 2004 to 2005 period (World Bank 2006). Exogenous factors such as prolonged droughts, high oil prices and the loss of textile quotas in 2005, which resulted in job losses estimated at 50% in the garment sector, had drastic effects on the economy. Despite, being one of the few lower middle-income countries in Sub-Saharan Africa with a per capita income of US\$1,660, the unemployment rate is estimated at 30%. Inequality of incomes and assets is very high. As of 2001, 69% of the population lived below the food poverty line.

Administratively, the country is divided into four regions, fifty-five tinkhundla and approximately 360 chiefdoms. According to the census report of 1997, homesteads and households were respectively estimated to be 126, 414 and 172,416 and the country had a population 929, 718 people with an annual population growth rate of 2.9%. It is projected that currently in 2006 the population is approximately 1.1 million. The total fertility rate is estimated to be 3.8 live births per woman (SDHS, 2006/07). Contraceptive prevalence increased steadily over the years from 34% in 1998 to 47.7 in 2006 (SDHS,2006/07). Approximately 44% of the population is composed of children under the age of 15 years. Women of childbearing age (15-49 years) make up 26.2% of the population while all females account for 53% (GOS, 1997). About 3% of the population is over 64 years of age. Rural dwellers make up 78% of the population.

1.2.2. PROFILE OF HEALTH SERVICES

The country's health care system consists of the formal and the informal sector. The informal sector consists of traditional health practitioners and other unregulated service providers. The health service that is based on western medicine is considered to be formal and consists of public and private health services.

The formal health sector is based on the concepts of primary health care and decentralization. Its infrastructure is made up of 7 government hospitals, 2 mission hospitals and 1 industry supported hospital. There are also, 8 public health units, 12 health centers, 76 clinics and 187 outreach sites. In addition, there are 73 mission health facilities (health centers, clinics and outreach sites), 62 private clinics and 22 industry-supported health centers and clinics. Currently, there does not exist a functional referral system for rationalization of service delivery at the various levels, sometimes leading to congestion at the referral facilities with patients that could have been attended to at lower levels.

The country's health management systems, including financial management and budgeting systems, are centralized, inefficient and unresponsive to new needs. Since health services are managed at central, regional and facility levels, there is need to strengthen the coordination capacity across these levels in order to improve efficiency. Although there have been efforts to decentralize health services, such efforts have not been accompanied by decentralization of other sectors. Further decentralization efforts have to be aligned with the national decentralization policy.

The sector is serviced by a workforce of 184 doctors, 3,070 staff nurses, 275 nurse assistants, 46 pharmacists and a number of allied health professionals and support staff, whose work is supplemented by approximately 4,000 rural health motivators, home based carers and community birth attendants (WHO, 2004). The rural health

motivators, home based carers and birth attendants are trained in community health and other developmental based skills. Swaziland's health system faces intricate human resource demands, which are also characteristic of health systems in many other African countries. This is complicated by the burden of disease due to HIV and AIDS, poverty and migration of skilled health workers. The lack of comprehensive HRH data and multiplicity of disciplines involved in the provision of health and social services is a key issue hindering the formulation of strategic approaches towards addressing quality service delivery by the sector.

As mentioned above, providers of health services include government, religious organizations (mission), industry and private practitioners. It is important to note that more than 50% of nurses are employed in private facilities including mission, industrial and NGO facilities (WHO, 2004). The imbalance of staff between public and private practice and between rural and urban areas has inevitably led to shortages of staff in the public sector and difficulty in filling vacant posts. In 2005, all public health facilities with the exception of one reported vacant posts across several cadres. Almost 12% of nursing posts and 33% of all medical professional posts were vacant (HDA & JTK Associates, 2005). The involvement of multiple players in the health sector calls for a strong coordination and partnership mechanism to address these human resource imbalances and shortages.

Currently, up to 85% of the population lives within a radius of 8 kilometers from a health facility. However, the quality and availability of health services is affected by the distribution of resources. There is ample evidence to suggest that the distribution of health resources tends to favor urban over rural based populations. According to the WHO situational analysis of the health workforce in Swaziland (2004) the ratio of doctors and nurses to the population was 1: 5 953 and 1: 356, respectively. Generally, health professionals across all cadres are still in short supply. As a result,

the country competes for health professionals in the international market. According to the most recent health statistics report there are 1,619 hospital and health centre beds in the country. Projected bed needs as a consequence of HIV and AIDS already exceed this current bed capacity.

The increase in patient loads, combined with complexity of many cases associated to HIV and AIDS, has reduced the quality of health care. Long queues, extensive waiting times and shortened consultation times with physicians are among a combination of factors affecting the quality of care. There is therefore a need for quality assurance programmes to ensure quality health service delivery, as well as a monitoring and evaluation system that can track progress in service provision.

While health sector funding is limited, it has also declined over time and falls far short of the 15% of the national budget that is recommended by the Abuja Declaration of April 2001 on HIV and AIDS, Tuberculosis and other related infectious diseases. This is evident in that government allocation to the health sector has declined from 9.4% of the national budget in the eighties to an average of 7.1% in the past five years (MOF, 2005). Per capita health spending by the government declined steeply by 38% between 1998 and 2002, from US\$54 to US\$39 (World Bank, 2006).

It is important to note that investment in health is declining at a time when demand for health services is increasing as a result of the HIV and AIDS pandemic. The allocation of public health expenditures is biased in favor of less cost-effective urban-based curative health interventions, and central administration. Approximately 72% of the national health budget is absorbed by curative services in spite of a call by the 1983 National Health Policy for increased investment in preventive and promotive health activities (World Bank, 2006). Swaziland has the highest proportion of government health spending dedicated to curative services in all of Sub-Saharan

Africa. However, the newly adopted budgeting system by the Swaziland Government, the Medium Term Expenditure Framework (MTEF), is expected to gradually change the current bias towards curative services by ensuring a balanced allocation of resources to preventive, promotive and curative services.

Swaziland spends approximately 3.8% of GDP on health care (including private) of which 60% comes from Government, accounting for approximately 2% of GDP, while additional funding comes from development partners, the private sector and individuals (MOHSW, 2003). Some mission operated health facilities and NGOs also receive government funding. Households, however, are increasingly taking on a larger responsibility of funding health care as government and donor health spending has been shrinking in past years. Household health expenditures in the country are extremely high in comparison with other countries in the region. Household expenditures as percentage of total private health expenditures rose from 34.9% to 41.7% between 1998 and 2002 (World Bank, 2006).

1.2.3. PROFILE OF HEALTH STATUS

Available information shows that previous gains on the health status are being eroded by the advent of HIV and AIDS. This is evident in that life expectancy at birth increased from 44 years in 1966 to 58.8 years in 1997, but as a result of HIV and AIDS fell to 44.4 years in 2003 and continues to decline annually (MEPD, 2003). Increasing trends have been observed in the country's Crude Death Rate (CDR), Infant Mortality Rate (IMR), Under-Five Mortality Rate (U5MR) and Maternal Mortality Rate (MMR). Crude death rate per 1 000 population increased from 13 in 1990 to 26.2 in 2005 (World Bank, 2006). Infant Mortality (IMR) per 1 000 live births increased from 94.4 per 1000 in 1990 to 108 in 2005 (World Bank, 2006).

The Maternal Death Review Audit 2001 indicated that out of 16 898 live births that

occurred between January and December 2000, there were 43 maternal deaths in four regional hospitals. Direct causes of maternal deaths accounted for 48.8% of all the deaths. Malnutrition is associated with high morbidity and mortality amongst children under five, with almost 20% of children in the country found to be severely stunted and 5.1% severely underweight in 2004 (MOHSW & WHO, 2004). The interactions between nutrition and HIV and AIDS are complex, and malnutrition among adults is a growing concern. Adolescents in Swaziland continue to be victims of unprotected sex, resulting in teenage pregnancy, unsafe abortion, HIV and STI and substance abuse.

Communicable diseases continue to be a major challenge for the country. According to Health Statistics Reports, respiratory conditions account for more than a quarter of all outpatient visits, increasing from 25.3% in 1995 to 26.6% in 2002. The reasons for admission included pulmonary tuberculosis, malaria, gastro-enteritis and colitis, and pneumonia. Mortality was mostly caused by pulmonary tuberculosis, gastro-enteritis, colitis, and pneumonia. The success of the immunization program has resulted in a dramatic decrease in the incidence of vaccine preventable diseases, namely tuberculosis, diphtheria pertusis, neonatal tetanus, poliomyelitis, measles and hepatitis B. Routine immunization coverage was reported to be 82% and 72% in 1997 and 2001, respectively.

ver and above all health problems, the HIV and AIDS epidemic poses a major challenge for the country. According to sentinel surveillance data, the prevalence of HIV infection among pregnant women who attend antenatal services has increased over the years from 3.9% in 1992 to 42.6% in 2004 (MOHSW, 2004). By March 2001, the country had reported a cumulative total of 8, 458 AIDS cases. From the WHO and UNAIDS estimates, approximately 36,500 people in Swaziland are eligible to antiretroviral treatment (ART). By December 2005, over 13,000 people

had enrolled in the national ART programme, meeting the “3 by 5” target set for the country (MOHSW, 2005).

Tuberculosis has also become a very serious public health concern for the country, particularly given the high rates of HIV/TB co-infection. The incidence of tuberculosis has increased from 300 per 100,000 people in 1990 to over 1,000 per 100,000 people in 2003 (MOHSW, 2003). Malaria is endemic in selected parts of the country and is generally well managed. An analysis of the overall disease trend indicates that there has been a significant reduction in the burden of disease in the last 4 – 5 malaria transmission seasons. The number of laboratory confirmed cases has dropped from an average of 4 000 per year during the period 1995 to 2000 to less than 300 per year during 2004/2005 Malaria transmission season (MOHSW, 2005).

According to the annual statistics report for the Ministry of Health and Social Welfare 1999, out-patient data from all health facilities indicates that hypertension and heart diseases were responsible for 33,540 and 3,146 cases respectively. Forty-three percent of hypertensive cases were diagnosed in primary health care facilities, whereas 39% of heart diseases were diagnosed in tertiary health care facilities. Risk factors for non- communicable diseases (NCDs) include sedentary lifestyles, unhealthy diet, heavy alcohol consumption and smoking. In the period 1990 to 1995, a total of 503 and 317 cases of cancer were histologically diagnosed among women and men, respectively. Among women, cancer of the cervix accounted for 43.1% followed by cancer of the breast (10.2%). Among men, skin cancer was the most common (22.1%), followed by cancer of genital organs (13.9%) and oral cavity cancer (12.3%).

1.3. KEY POLICY ISSUES

The new challenges that the health sector is facing have necessitated the revision of the national health policy. This policy has been put together with intention of addressing the following key sectoral issues:

A. Health service delivery and interventions

- Managerial performance

- Balance between curative, preventive and health promotive services

- Quality of services

- Equitable distribution of services

- Coordination of sectoral activities

- HIV and AIDS

- Environmental health issues

- Decentralization of authority and decision making

- The referral system

- Supervision, monitoring and evaluation

B. Resources for Health

- Broadening the financing base for health services

- Coordinating donor activities and resource tracking

- Health and development

- Utilization of available resources

- Access to safe medicine and diagnostic technology

- Transparency and fairness in training, appointments and promotions

- Human resources for health

CHAPTER 2

2.1. VISION

By the year 2015, the sector shall have developed into an efficient and effective service deliverer and shall have given rise to a healthy population that lives longer and has socially fulfilling lives. As such, the country's health and social welfare status indicators, and its human development indicators, shall compare favourably to those of countries with a similar level of economic development.

2.2. MISSION

The Health and Social Welfare sector seeks to improve the health and social welfare status of the people of Swaziland by providing preventive, promotive, curative and rehabilitative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable.

2.3. OBJECTIVES

- 2.3.1 Reduce morbidity, disability and mortality that is due to diseases and social conditions.
- 2.3.2 Promote effective allocation and management of health and social welfare sector resources.
- 2.3.3 Reduce the risk and vulnerability of the country's population to social welfare problems as well as the impact thereof.

2.4 SCOPE

Provisions of this policy and national guidelines arising hereof, shall be binding to all individuals and entities whether government, mission, private, industrial non-governmental, or international as long as they are involved in the delivery of health related services of any kind anywhere within the Kingdom of Swaziland. The policy

shall provide guidance to all programs and departmental policies in the health sector, including those that deal with traditional, alternative and complementary health services.

CHAPTER 3

3. GUIDING PRINCIPLES

In executing its mandate, the MOHSW and all its organs and related structures shall adhere to the following fundamental principles:

- 3.1. Fundamental human rights will be respected in the course of provision of all health services.
- 3.2. The MOHSW will adhere to the principles of transparency, accountability, predictability and fairness.
- 3.3. Organization and delivery of health services shall be based on the concepts and principles of health promotion as enshrined in the Ottawa Charter and the Regional Health Promotion Strategy for Africa. This includes building healthy public policies, creating supportive environments, strengthening community action, and developing personal skills.
- 3.4. All health providers shall ensure the involvement of service beneficiaries and partners in the planning, funding, monitoring and evaluation of all health services.
- 3.5. Priority for sector funding shall be given to public health (non-personal health) and essential clinical services. These services will be accessible to all citizens and inability to pay will not deny access to these services. Investment in public health and essential clinical services shall be based on the burden of disease profile.

- 3.6. The sector, through its different departments and structures, shall ensure the participation of other sectors in the planning, implementation, funding, monitoring and evaluation of health activities when deemed necessary. Likewise, health workers shall participate in the activities of other sectors that are related to health.
- 3.7. The sector shall give priority to investment in appropriate technology that supports public health and essential clinical services.
- 3.8. Regional health management structures, hospitals and national institutions shall be accorded a degree of autonomy from the central level as reflected by set guidelines.
- 3.9. Community-based health services shall be developed as an integral part of the health system.
- 3.10. Government, the private sector, non-governmental organizations including religious organizations and individuals through collaborative efforts shall provide health and social welfare services in accordance with the national HSW policy.
- 3.11. Policy, planning and management decisions in the health sector will be made based on available evidence relevant to the country.

CHAPTER 4

4. POLICY DIRECTIONS

This section of the document outlines the structural and legislative organs that will guide and regulate the implementation and delivery of health services at national and regional levels. The main thematic areas of focus are; Organization and Management, Human Resources, Quality Assurance, Health Financing, Infrastructure Development and Equipment Management, and Service Provision.

Organization and Management of Services

- 4.1. Operation of health services shall be regulated by the Health Service Act while the protection of non-personal health (public health) shall be regulated by the Public Health Act in line with other relevant National legislation.
- 4.2. The practice of traditional medicine and other alternative health care practices shall be regulated by the Complementary and Alternative Medicine Practice Act.
- 4.3. The central level shall be responsible for overall development, management, coordination, articulation of national policy, legislation, standards, guidelines, protocols, mobilization of resources and provision of technical support to lower levels.
- 4.4. Health administrative and management structures shall be decentralized and organized at chiefdom, urban government, Inkhundla and regional levels in line with the national decentralization policy.

- 4.5. Regional health structures shall be responsible for overall coordination of regional health activities including planning, implementation, monitoring and evaluation.
- 4.6. Chiefdom and Inkhundla health committees shall be responsible for facilitating and sustaining community participation.
- 4.7. The Ministry of Health and Social Welfare shall have organizational structures with clear roles and functions at all levels.
- 4.8. Health services shall be delivered through a network of community based settings, mobile outreach sites, clinics, public health units, health centers, and regional and national hospitals.

Coordination

- 4.9. The Ministry of Health and Social Welfare shall set up standing committees and boards on specific issues of national importance in line with the national decentralization policy.
- 4.10. All development partners shall support national priorities as defined in the national strategic plan for health. Such support shall require clearance by the Policy and Planning Committee in the Ministry of Health and Social Welfare.
- 4.11. All health research activities to be conducted in the country shall be reviewed and cleared by the Health and Social Welfare Scientific and Ethics Committee.

- 4.12. All health facilities, whether government, private, mission or commercial, shall collect and report routine data in compliance with established data packages and protocols.

Human Resources

- 4.13. There shall be a Health Service Commission established in terms of Chapter X (section 172) of the Constitution that shall be responsible for all government health work force. Commissioners shall be appointed by the Minister of Health and Social Welfare for a fixed term.
- 4.14. The Ministry shall develop a sectoral human resource policy and plan to address human resource issues.
- 4.15. All appointments to management and leadership positions in the Ministry and other government-funded organizations shall be open to all cadres of health professionals based on merit and relevant qualifications.
- 4.16. Training, recruitment, deployment, promotion, discipline and dismissal of health workers shall be based on principles of transparency and fairness.
- 4.17. Human development shall be based on the needs of the sector. Government and development partners shall only support the approved Human Resource Development Plan.
- 4.18. The MOHSW, in collaboration with central agencies, shall periodically review staff establishments at all levels to effectively respond to emerging health challenges.

- 4.19. There shall be strong linkage with the Ministries of Education, Public Service and Information, and training institutions to address the training needs of the MOHSW.

Quality Assurance

- 4.20. In addition to the existing professional councils, other such councils shall be established as needed. These councils shall operate independently of the Ministry of Health and Social Welfare and their operations shall be regulated by specified legislation.
- 4.21. The Ministry of health and social welfare shall establish an accreditation system for all health service institutions in the country.
- 4.22. There shall be established national quality assurance programme for health services.
- 4.23. The license to operate a private practice shall be awarded only to health professionals who satisfy the set standards and who have worked in the country's health system for a minimum of five years.
- 4.24. Only locally registered health professionals shall be employed or allowed to practice legally in the country.
- 4.25. All health professionals in the country shall be required to engage in continuing education as a prerequisite to the renewal of practicing license. Such continuing education programs must be in accordance with the regulations set by the relevant supervisory bodies. Provisions to ensure access to such programs shall be made in accordance with the Human

Resource Development Plan.

- 4.26. In the provision of health services, all professionals shall observe and protect the basic rights of clients as provided by the bill of rights in the constitution.
- 4.27. The Medicines Regulatory Authority shall be set up in order to regulate the manufacture, importation, exportation, distribution and sale of pharmaceutical products and related commodities, and to ensure the quality and safety of medicines as well as their rational use.

Health Financing

- 4.28. Individual and community participation in the financing of health activities shall be based on the principle of pre-payment and fair contribution.
- 4.29. In order to increase revenue for health services, government-funded facilities shall commercialize some aspect of the service without rendering public health services and the essential clinical package unaffordable for the majority of the people. In commercializing such services, facilities shall be expected to comply with established guidelines.
- 4.30. Health services shall be provided free of charge to eligible children, elderly persons, orphans and persons with disability.
- 4.31. Government shall provide a subvention to non-governmental and faith based organizations that offer services that are deemed important according to established guidelines, subject to availability of resources.

- 4.32. All Non-Governmental Organizations (NGOs) dealing with health issues shall declare all funding, whether external or internal in origin, including supplies and technical assistance.
- 4.33. All NGOs, international organizations and development partners that are funding health activities shall do so in accordance with this policy and the National Strategic Plan for Health.
- 4.34. In-order to improve efficiency, government funded facilities will contract out some services according to established guidelines.
- 4.35. The MOHSW shall explore alternative financing options to ensure equity and access to services by all citizens.

Infrastructure Development and Equipment Management

- 4.36. The MOHSW shall define the minimum structural and equipment package for the different levels of service delivery.
- 4.37. There shall be an infrastructure development and maintenance plan that shall guide the construction, procurement and maintenance of health facilities and equipment in the country.
- 4.38. Construction of health facilities shall require approval of the Policy and Planning Committee in the MOHSW.
- 4.39. Designers of health buildings and providers of services shall ensure that such utilities are accessible to persons with disability.

- 4.40. Owners or providers of health services shall comply with established protocols of procurement, donation, and distribution of equipment and vehicles.
- 4.41. Owners of all health facilities shall be obliged to comply with basic security and safety requirements in line with established guidelines.
- 4.42. MOHSW shall venture into telemedicine to ensure efficiency in disease diagnosis and referral systems in health service delivery.

Service Provision: Public Health and Clinical Services

- 4.43. Health promotion shall be the cornerstone of all health care service delivery in cognizance with the national health promotion policy.
- 4.44. All public health services shall be in line with the Public Health Act.
- 4.45. Prevention and control of communicable and non-communicable diseases and other major health concerns such as HIV and AIDS, TB and Malaria shall be incorporated into the routine provision of health services.
- 4.46. The Ministry of Health and Social Welfare shall define and support the delivery of an essential health package by all service delivery levels to address common health conditions that have major contribution to the burden of disease.
- 4.47. The Ministry of Health and Social welfare shall promote environmental health programs including Safe Water Supply, Sanitation and Pollution

Control, Occupational Hygiene and Safety, Food Safety and Meat Hygiene, Nutrition, Health Care Risk/Medical Waste Management, Port Health Activities, and Safe Housing.

- 4.48. All newborn deliveries, including those that take place in the community and at home, shall be attended by skilled persons.
- 4.49. A national referral hospital shall be established and shall provide specialized services.
- 4.50. All providers of health services shall be expected to comply with established guidelines and protocols for case management and referral.
- 4.51. All health practitioners, whether government, private, industrial or mission, shall comply with the established Essential Drugs list according to WHO standards.
- 4.52. National referral and regional hospitals shall be accessed through a referral process. A fee differential shall apply in case of default.
- 4.53. All health facilities shall put in place emergency/disaster preparedness and response plans in line with the National Disaster Emergency Plan.
- 4.54. All facilities shall put in place institutional infection control measures in line with national guidelines.
- 4.55. All health workers shall adhere to health facility health measures in accordance to with the occupational health policy.

CHAPTER 5

5. POLICY IMPLEMENTATION FRAMEWORK

Implementation

- 5.1. This policy shall be translated into a national strategic plan, pieces of legislation, organizational and departmental work plans, operational protocols and guidelines.
- 5.2. The national strategic plan shall be revised after every five years, while corresponding action plans shall be prepared, implemented, monitored and evaluated annually.

Funding

- 5.3. Implementation of this policy shall be funded primarily by government, with some contribution from development partners, individuals and private sector.
- 5.4. The Ministry's budget shall reflect details of the National Strategic Plan and approved action plans. All departments and institutions at national and regional level shall prepare respective budgets.
- 5.5. The National Strategic Plan shall be costed and be used as a resource mobilization tool in the public sector, development partners and the private sector.

Monitoring and Evaluation

- 5.6. A monitoring and evaluation unit shall be established in the Ministry of Health and Social Welfare to monitor the implementation of this policy, in harmony with the Health Information System (HIS) Policy. Implementation shall be monitored through a monitoring and evaluation framework based on an agreed set of indicators. The capacity of the existing HIV and AIDS

monitoring and evaluation unit shall be strengthened, and it shall be integrated into the Ministry-wide monitoring and evaluation health information system.

- 5.7. The unit will report regularly to the Policy and Planning committee of the Ministry of Health and Social Welfare. Such reports shall be based on a standard format to be issued by the Planning Unit. A review of progress shall be undertaken at the national policy monitoring conference held annually.
- 5.8. Periodic evaluations shall be carried out after every five years to determine the extent to which policy objectives have been achieved. The outcome of evaluations shall be widely disseminated through reports, news and national conferences.

Policy Revision

- 5.9. The Policy and Planning Committee in the Ministry of Health and Social Welfare shall take the responsibility for initiating revision of this policy. The decision to do so shall be based on feedback generated from the monitoring and evaluation activities as well as in response to emerging health challenges.

CONCLUSION

The country is currently faced with formidable health challenges due to high disease burden and shortage of resources. The need to improve the health of the Swazi population is urgent, in particular for poor and vulnerable groups. The growing poor-rich divide in access to information, technology and high quality basic and specialized health care services threatens to

leave the poor even further behind. The national health system is often unresponsive to the needs of the population and contributes to their vulnerability and impoverishment. The allocation of public expenditure to health services is skewed towards less cost-effective curative services and is urban biased, fueling the view that rural health services are of poor quality. The country's health infrastructure is relatively extensive in relation to other countries in the region, but health indicators do not compare favourably to other poor and less-endowed countries in the continent. Such indicators are making it evident that the country will not meet the targets set by the millennium development goals and other global health targets.

This policy, therefore, addresses priority areas relating to health service delivery and major health interventions, and resources for health. The principal objective, over and above reducing morbidity and mortality caused by a range of diseases, is to increase the technical and allocative efficiency and equity of health care services. The policy also aims to stimulate the health care system to absorb the negative effects of epidemiological and economic transition. The Government is committed to the implementation of this policy in partnership with the development partners, private sector and other stakeholders to improve the health of the people of Swaziland.

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