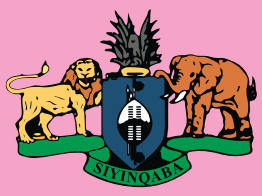

MDG ACCELERATION FRAMEWORK

SWAZILAND

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Country Action Plan for Accelerating Progress Towards Improving Maternal Health

SWAZILAND

MDG ACCELERATION FRAMEWORK

COUNTRY ACTION PLAN FOR ACCELERATING PROGRESS TOWARDS IMPROVING MATERNAL HEALTH

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMICCALL	Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Anti Retroviral
ASRH	Adolescent Sexual and Reproductive Health
BBA	Born Before Arrival
CAP	Country Action Plan
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CARMMS	Campaign for Accelerated Reduction of Maternal Mortality in Swaziland
CBOs	Community-Based Organizations
CHAI	Clinton Health Access Initiative
CHIMSHACC	Chiefdom Multi-Sectoral HIV and AIDS Coordinating Committee
CMS	Central Medical Stores
CNO	Chief Nursing Officer
CSE	Comprehensive Sexuality Education
CSO	Central Statistical Office
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DPMO	Deputy Prime Minister's Office
EGPAF	Elizabeth Glassier Pediatric AIDS Foundation
EIB	European Investment Bank
EmONC	Emergency Obstetrics and Neonatal Care
ERS	Economic Recovery Strategy
EU	European Union
FAR	Fiscal Adjustment Roadmap
FBOs	Faith Base Organizations
FLAS	Family Life Association of Swaziland
FP	Family Planning
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoS	Government of Swaziland
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counselling
HW	Health Worker

IBRD	International Bank for Reconstruction and Development
ICAP	International Centre for AIDS Prevention
IFAD	International Fund for Agricultural Development
IMAI	Integrated Management of Adult Illnesses
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
MAF	MDG Acceleration Framework
MCIT	Ministry of Commerce, Industry and Trade
MDGs	Millennium Development Goals
ME&NR	Ministry of Environment and Natural Resources
MEPD	Ministry of Economic Planning and Development
MHA	Mental Health Association
MICS	Multiple Indicator Cluster Survey
MISA	Media in Southern Africa- Swaziland Chapter
MMR	Maternal Mortality Ratio/Rate
MNH	Maternal and Newborn Health
MNHC	Maternal, Newborn and Child Health
MNRE	Ministry of Natural Resources and Energy
MOA	Ministry of Agriculture
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOWT	Ministry of Works and Transport
MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
MTCT	Mother to Child Transmission
NARTIS	Nurse Led ART Initiation in Swaziland
NDS	National Development Strategy
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Governmental Organizations
NSF	National Multisectoral Strategic Framework on HIV and AIDS
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PHU	Public Health Unit
PITC	Provider Initiated Testing and Counselling
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PRSAP	Poverty Reduction Strategy and Action Programme
PSHACC	Public Sector HIV/AIDS Coordinating Committee
PSI	Population Services International
REMSHACC	Regional Multi-Sectoral HIV and AIDS Coordinating Committee

RFMH	Raleigh Fitkin Memorial Hospital
RHM	Rural Health Motivator
RHMT	Regional Health Management Team
RHR	Reproductive Health and Rights
SACU	Southern African Customs Union
SAM	Service Availability Mapping
SBCC	Social Behaviour Change Communication
SCATA	Swaziland Commercial Transport Authority
SDHS	Swaziland Demographic and Health Survey
SERA	Swaziland Energy Regulatory Authority
SHIES	Swaziland Household Income and Expenditure Survey
SME	Small and Medium-sized Enterprise
SNAP	Swaziland National AIDS Programme
SNNC	Swaziland National Nutrition Council
SNYC	Swaziland National Youth Council
SPHC	Swaziland Population and Housing Census
SPTC	Swaziland Post and Tele Communication
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SRHU	Sexual and Reproductive Health Unit
SRN	State Registered Nurse
STI	Sexually Transmitted Infection
SWADE	Swaziland Water Agriculture Development Enterprise
SWSC	Swaziland Water Services Corporation
TB	Tuberculosis
TBA	Traditional Birth Attendant
THO	Traditional Healers Organization
TIMSHACC	Tinkhundla Multisectoral HIV and AIDS Coordinating Committee
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNISWA	University of Swaziland
URC	University Research Council
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WVI	World Vision International

FOREWORD

This is the first MDG Acceleration Framework (MAF), which gives the country a guide on how, as a sector, it is expected to perform in order to achieve the Millennium Development Goal 5, set for 2015 and beyond. In 2012, Swaziland, along with five other countries in Eastern and Southern Africa, took part in the preparation of the MDG Acceleration Framework (MAF) Country Action Plan (CAP), following the rollout of the MAF in 10 pilot countries including 4 in Sub-Saharan Africa (i.e., Ghana, Tanzania, Togo and Uganda). Swaziland selected MDG 5—Improve Maternal Health—for acceleration, given the importance of overcoming setbacks in this area. This is a major milestone for Swaziland, as we were able to develop this document with minimal external support.

The commitment and determination of the Ministry of Planning and Development in collaboration with UN and the financial and technical support from the other partners and stakeholders is much appreciated. It is through their massive contribution that the document was completed.

The MAF is not another analysis of the causes of the country's high maternal mortality. It rather aims to identify the bottlenecks and highlight why some of the identified interventions have not been implemented or have not achieved the desired impact. More specifically, the MAF exercise aims at supporting the Government and stakeholders to better understand the key bottlenecks in improving maternal health and to formulate an effective action plan to reduce/remove the obstacles hindering the progress.

The MAF is an important and valuable tool in the management of a pregnant woman in an effort to ensure she and the baby are alive before and after delivery.

The MAF is fully integrated into the overall national plan to be delivered as one. It will not only facilitate decision making and planning processes but also serve as an advocacy tool for the Government and its partners development partners. Through the framework, government and partners are informed of the sectors' performance, which facilitates evidence-based decisions for areas of support. In this regard, I appeal to our international and national partners to fully support this initiative that has shown its valuable and determinant role in facilitating the attainment of Millennium Development Goal 5.

With your support, the Ministry of Economic Planning and Development will be able to regularly and effectively monitor and assess all sectors and, at the opportune moment, take all necessary corrective measures for their strengthening in order to achieve the MDG 5 set for 2015. I would like to take this opportunity to congratulate all stakeholders and sectors involved in this framework for their good work, as demonstrated in this document. Since the MAF will be implemented in 2014 and beyond, I encourage all sectors to fully engage themselves and actively participate so that the country's vision to reduce maternal mortality by 2015 is realized.

Prince Hlangusempi
Hon. Minister MEPD

Israel Dessalegne
UN Resident Coordinator/UNDP
Resident Representative

ACKNOWLEDGEMENTS

The Government of Swaziland recognises the importance and crucial role women play towards its inclusive and sustainable development. The pertinence of addressing the high mortality rate of 320 for every 100,000 live births receives the high priority of the Government, which identified MDG 5, maternal mortality, as the most lagging MDG in the country. To this effort, this MAF serves as a reference tool in addressing maternal mortality in a collective and concerted fashion by all sectors, thus rendering it a national document.

The Government commends the UN system in Swaziland, under the leadership of the Resident Coordinator Israel Dessalegne, for their ingenuity, passion and unwavering support for the MAF and drive to addressing maternal mortality in the country. The leadership of WHO in the MAF under the Resident Representative Dr. Owen Kaluwa and the inputs of the UN technical team is highly acknowledged. Special appreciation to the Ministry of Health for their technical leadership through the able guidance of the Deputy Director of Public Health Services, Rejoice Nkambule and her team. This multi-sectoral process would not have been possible without the untiring coordination of the Principal Secretary of the Ministry of Economic Planning and Development, Bertram Steward and team. Special gratitude to the leadership of all Ministries/sectors and their technical officers for their commitments and participation in the consultation sessions. Sincere thanks go to civil society under the headship of CANGO for its dedication to the process.

The MAF benefitted from the insightfulness and competence of the consultants Akua Dua-Agyeman and Mavis P. Nxumalo. Preparatory training on the MAF was conducted in collaboration with the UNDP Regional Service Centre who continue to be involved in the review of the draft reports. The valuable inputs of Mr. Osten Chulu; RSC, Ms. Auxilia Ponga, RSC; Mr. Elvis Mtonga, UNDP; Ms. Eunice Kamwendo, RBA; Mr. Jonas Mantey, RBA and Mr. Shadrack Tsabedze UNDP Swaziland and former UNDP Swaziland Economic Advisor Zuzana Brixiova are well acknowledged. Administrative support provided by Ms. Nonhlanhla Bhiya, Ms. Nandipa Bujela and Ms. Zanele Shongwe of UNDP Swaziland are also well valued.

The oversight and quality assurance provided by the United Nations Development Group through the Regional Bureau for Africa (RBA) MDG Advisor Mr. Ayodele Odusola; and the UNDP Swaziland Economic Advisor, Ms. Fatou Leigh is highly commendable.

The United Nations Communications Group (UNCG) in Swaziland is appreciated for providing pictures for the report.

EXECUTIVE SUMMARY

Introduction/background

The MDG Summit, in September 2010, concluded that the eight development goals (MDGs) are achievable, if supported by the right set of policies, targeted technical assistance, institutional capacity, adequate funding, and strong political commitment. In 2012, Swaziland, along with five countries in Eastern and Southern Africa, took part in the preparation of the MDG Acceleration Framework (MAF) Country Action Plan (CAP), following the rollout of the MAF in 10 pilot countries including 4 in Sub-Saharan Africa (i.e., Ghana, Tanzania, Togo, and Uganda). Swaziland selected MDG 5—which seeks to improve Maternal Health—for acceleration, given the importance of overcoming setbacks in this area.

The MAF Action Plan for Accelerated Progress on Maternal Health is not aimed at replacing existing interventions but to complement them. It also seeks to contribute to operationalizing the EMTCT and other similar Frameworks/Plans of Action by identifying in a comprehensive manner the bottlenecks and focusing on prioritised solution. More specifically, the MAF aims at supporting government and stakeholders to better understand the key bottlenecks in improving maternal health and to formulate an effective action plan to reduce the obstacles hindering progress.

Rationale

Swaziland's decision to participate in the MAF CAP formulation was guided by the country's National Development Strategy (NDS) review, which allows decisions to take into account the current challenges and opportunities. The Government has also clearly articulated its interventions in improving maternal health, which is enshrined in policy documents, national frameworks and plans of actions. It is also hoped that the MAF will boost the ongoing efforts of the development partners supporting the health and non-health sectors as the diagnostic analysis of bottlenecks and recommended solutions will corroborate their work in the sectors and unleash the full power of partnership. Furthermore, it will hasten the great strides in the implementation of prevention of mother-to-child transmission (PMTCT) to keep over 59 percent of the 13,563 infants born to HIV-positive mothers free from infections, further evidence of the Government's commitment to accelerate actions to reduce maternal, newborn and child mortality.

The objective of the MAF is to identify the bottlenecks and highlight why some of the identified interventions have not been implemented or have not achieved the desired impact. More specifically, the MAF exercise aims at supporting government and stakeholders to better understand the key bottlenecks to improving maternal health and formulate an effective action plan to reduce/remove the obstacles hindering progress.

Suitability of the MAF on MDG 5 in Swaziland

The MAF establishes a strong operational focus in bringing together existing strategies and policies in innovative ways and drawing on international best practices. The MAF is thus particularly suitable for accelerating MDG 5 in Swaziland, given the country's existing strategies and policies, which co-exist with challenges on the implementation side. Some important documents and initiatives that support the MAF process are the following:

- National Health Sector Strategic Plan (HSSP), 2008–2013;
- HSSP Mid-Term Review Report, March 2012;
- The National Strategic Framework for Accelerated Action on Elimination of Mother-to-Child Transmission, 2011–2015;

- The NDS, PRSAP, 2007 Health Sector Policy, HSSP and other supplementary documents provide sources for the MAF diagnostic analysis to identify bottlenecks and solutions to accelerate MDG 5;

- The efforts of development partners supporting the health sector are already budgeted for and will form the initial basis for action;

- The ongoing review of the NDS and the proposed review of the PRSAP will allow the health sector to incorporate the suggested MAF interventions, including funding;

- The fiscal crisis of 2011 has interrupted social expenditures, including in the health sector. The relatively high Southern African Customs Union (SACU) revenues in 2013/14 provide an opportunity to put health financing on sustainable footing. This situation calls for innovation and 'business unusual'; and

- By embarking on accelerating MDG 5 through the MAF at a somewhat later stage than the pilot countries, Swaziland can benefit from their experiences and best practices in other African countries, including utilizing modern technology (e.g., m-technology, ultrasound).

Strategic Areas of Interventions

A. Improving HIV Management before, during and after pregnancy;

B. Improving Access to modern family planning (FP) methods by HIV-positive women and their partners plus adolescents/youths;

C. Improving Quality of Skilled Birth Attendance during labour, delivery and post-delivery and access to skilled attendance and quality of MNCH services;

D. Improving access to Quality Skilled Birth Attendance;

E. Promotion of early and appropriate Health Seeking Behaviour;

F. Poverty Reduction/Cross-cutting Issues/Reduce Food Insecurity at household level; and

G. Conduct monitoring and evaluation.

Methodology

The preparation of the MAF Country Action Plan occurred in three parts and was participatory in all stages of development. It was guided by MAF guidelines. The development of the CAP was conducted under the leadership of the Ministry of Economic Planning and Development (MEPD) and Ministry of Health (MOH) in collaboration with UN partners.

Key steps in the development included development of the concept paper, desk review, validation field visits, advocacy meetings, wide consultation with policy makers and stakeholders and the national MAF Technical Task Team.

One-day workshops were held to identify bottlenecks and solutions as well as to conduct costing and monitoring and evaluation. Finally, a validation meeting was held with stakeholders to finalize the document. The document was submitted to a regional expert who reviewed it and provided comments that were then incorporated into the document.

MAF Costing

The MAF CAP was costed and showed the estimated costs of the interventions to be US$2,992,952.29.

Results

Maternal Health MDGs have been lagging behind, with the maternal mortality ratio (MMR) rising to an estimated 589/100,000 (SDHS 2007). The outcomes of the two major targets of MDG 5

(i) MMR by three quarters between 1990 and 2015, and (ii) achieving universal access to reproductive health by 2015 are uneven. The observable positive performance indicators such as high ANC attendance, PMTCT coverage, facility deliveries, birth attendance by skilled personnel and women on full course of ART prophylaxis does not compare with the MMR. Pregnant women continue to die of post-delivery severe bleeding, hypertensive disorders and unsafe abortions. Deaths are also attributable to non-pregnancy related conditions such as advanced AIDS and TB. Other noted factors include inadequate institutional and human capacity to facilitate integration of services such as PMTCT/ART/FP, etc. Coordination, supervision and mentorship were identified as challenges. Community participation, lobbying and advocacy to enforce programme ownership were also lacking. Information management was deemed ineffective for monitoring essential commodities.

The assessment noted other obstacles linked to various ministries and sectors, among others: poverty, unemployment and drug abuse; poor roads, bridges and public transport; socio-cultural factors such as myths and misconceptions; erratic power supply; absence of waiting huts; decision making about attending ANC; and health facility delivery.

Conclusion

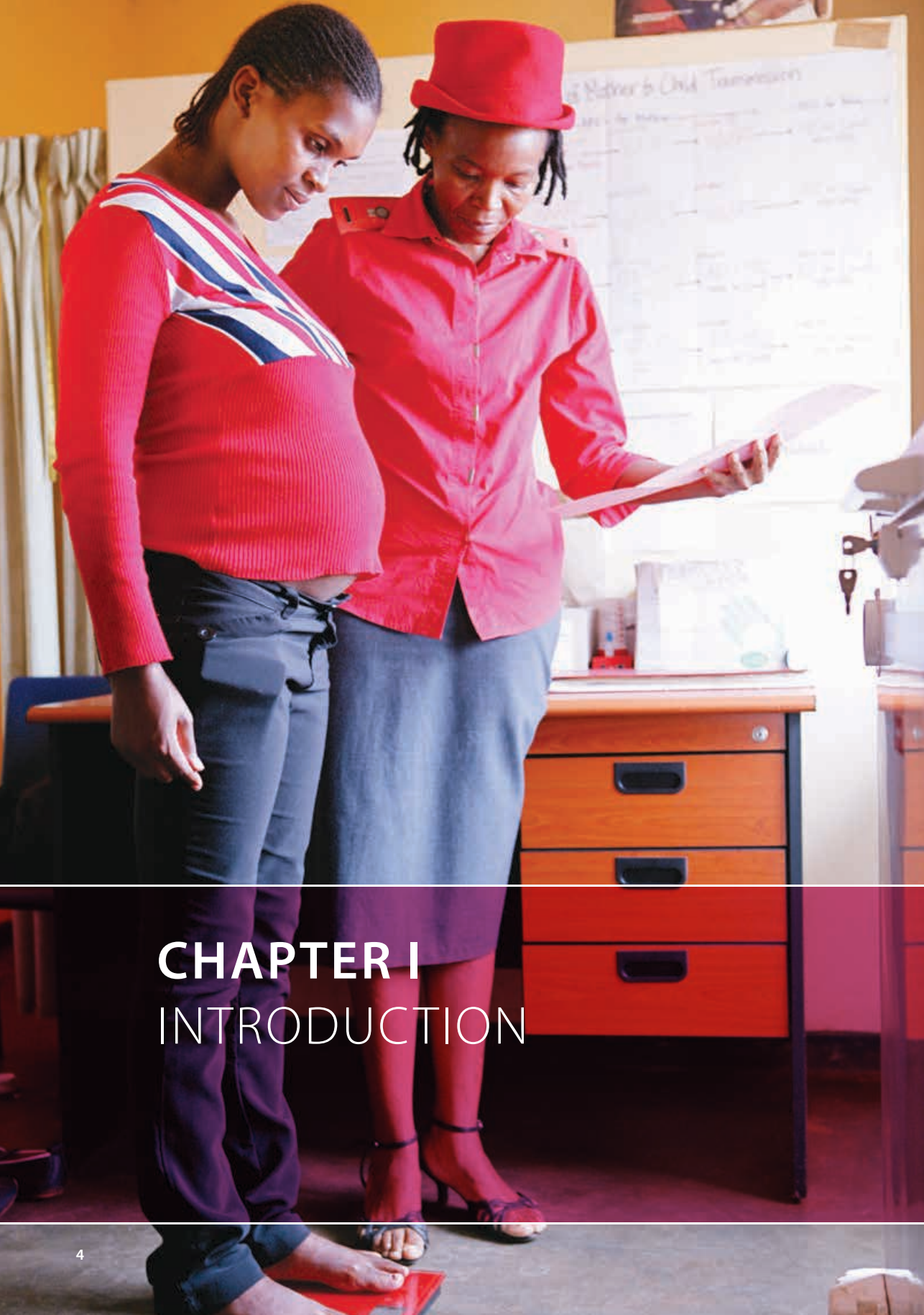
MDG 5 is achievable, if supported by the right set of policies, targeted technical assistance, institutional capacity, adequate funding and strong political commitment. Swaziland selected to strengthen MDG 5—which seeks to improve Maternal Health—for acceleration, given the importance of overcoming setbacks in this area.

The MAF Action Plan for Accelerated Progress on Maternal Health aims at complementing existing interventions. It also seeks to contribute to operationalizing the EMTCT and other similar Frameworks/Plans of Action by identifying in a comprehensive manner the bottlenecks and focusing on prioritised solutions. The MAF assessment aimed at supporting government and stakeholders to better understand the key bottlenecks in improving maternal health and formulate effective action plans to reduce the obstacles hindering progress. It was observed that the country's MMR is high in the country despite notable good indicators such as high ANC attendance, ART prophylaxis uptake, health facility deliveries, PMTCT uptake, etc. This is attributable to direct and indirect maternal health causes, among others: severe bleeding, pre-eclampsia, advanced AIDS and TB as well as poverty, unemployment and inaccessibility to health facilities due to poor roads, bridges and public transport and many more.

The development of the MAF Country Action Plan was participatory in all the stages of development, and was successful, demonstrated by the achievement of the planned objectives.

This is confirmed by the following:

- Relevant literature was reviewed and strategic interventions were identified.
- Key bottlenecks for the acceleration of maternal health programs were identified, which were beyond the Ministry of Health.
- Key indicative solutions to address bottlenecks were identified across all sectors using the MAF solution criterion tool based on impact (magnitude, speed, sustainability and adverse impact).
- The compact country Plan of Action was produced.



CHAPTER I
INTRODUCTION

1.1 Background

Maternal mortality in Sub-Saharan Africa remains high, despite an observed decline of 41 percent (i.e., from 850/100,000 live births in 1990 to 500/100,000 in 2010). This decline did not occur in all countries. From 1990 to 2000 Swaziland, along with Botswana, Lesotho, Namibia and South Africa, saw the maternal mortality rate (MMR) increase, mainly as a result of the HIV epidemic. In Swaziland, the MMR rose from 110/100,000 to 589/100,000 live births between 1990 and 2006/07.[1] The country has been classified among 10 countries (Botswana, Cameroon, Chad, Congo, Lesotho, Namibia, Somalia, South Africa, Swaziland and Zimbabwe) in Sub-Saharan Africa as making "no progress" in reducing MMR.[2] In 2012, Swaziland chose to participate in the second-generation MAF CAP formulation, focusing on MDG 5: Improve Maternal Health. The high MMR in Swaziland has been studied extensively, the main challenges identified and several recommendations proposed. The National Development Strategy (NDS), Poverty Reduction Strategy and Action Programme (PRSAP), 2007 Health Sector Policy, Health Sector Strategic Plan (HSSP) 2008–2013, auxiliary policies and strategic plans and project documents outline specific interventions. However, implementation has been lagging, with less than desired impact on the MMR.

Prior to the adoption of the Millennium Declaration in 2000, Swaziland had developed the Vision 2022 and the National Development Strategy (NDS) of 1997–2022, aimed at reducing poverty and inequalities with the overarching goal of becoming among the top 10 percent medium human development countries by 2022. The policy frameworks following the NDS integrated the MDGs at all levels; progress was monitored across the sectors through periodic MDG reports. The specific policy documents included the Prioritized Action Programme on Poverty Reduction of 2002; Social Protection of Vulnerable Children Including Orphans 2002; and the Poverty Reduction Strategy and Action Programme (PRSAP) 2008–2013 seeking to attain: (i) macro-economic stability and sustainable economic growth; (ii) a more equitable pattern of growth to benefit the poor; (iii) quality human resource development; (iv) improved quality of life for the poorest and most vulnerable through social protection; (v) increased impact of policies for poverty reduction by governance institutions; and (vi) transparency and accountability.

As a response to fiscal crisis challenges and declining growth, the country has developed additional policy frameworks, i.e., the Fiscal Adjustment Roadmap (FAR) 2010/11–2014/15 and Economic Recovery Strategy (ERS). The NDS is currently undergoing review to take into account the new development challenges. The PRSAP is also expected to be reviewed thereafter.

1.2 Rationale

Swaziland's decision to participate in the MAF CAP formulation was guided by the country's NDS review, which allows decisions to take into account the current challenges and opportunities. The Government has also clearly articulated its interventions in improving maternal health, enshrined in policy documents such as the National Health Sector Strategic Plan (HSSP) 2008–2013, which offers the roadmap for realizing the 2007 National Health Policy. It is also hoped that the MAF will boost the ongoing efforts of development partners supporting the health and non-health sectors as the diagnostic analysis of bottlenecks and recommended solutions will corroborate their work in the sectors and unleash the full power of partnership. Furthermore, it will hasten the great strides in the implementation of PMTCT to keep over 59 percent of the 13,563 infants born to HIV-positive mothers free from infections, evidence of the Government's commitment to accelerate actions to reduce maternal, newborn and child mortality.

[1] SHDS, 2007

[2] WHO et al. 2012

1.3 Objective

The MAF aims to identify the bottlenecks and highlight why some of the identified interventions have not been implemented or have not achieved the desired impact. More specifically, the MAF exercise aims at supporting Government and stakeholders to better understand the key bottlenecks in improving maternal health and formulate an effective action plan to reduce/remove the obstacles hindering progress.

Specific Objectives

- Review and identify strategic interventions
- Identify key bottlenecks to implementation of the maternal health programme in Swaziland
- Elicit key solutions from stakeholders that will address the collectively identified bottlenecks
- Develop an implementation compact with key stakeholders that deepens ownership and buy-in

Key steps in developing the MAF Country Action Plan

- Development of the concept paper
- Desk review
- Validation field visits
- Advocacy meetings, wide consultation with policy makers and stakeholders and the national MAF Technical Task Team

1.4 Strategic Areas for Interventions

A. Improving HIV Management before, during and after pregnancy;

B. Improving Access to modern family planning (FP) methods by HIV-positive women and their partners plus adolescents/youths;

C. Improving Quality of Skilled Birth Attendance during labour, delivery and post-delivery and access to skilled attendance and quality of MNCH services;

D. Improving access to Quality Skilled Birth Attendance;

E. Promotion of early and appropriate Health Seeking Behaviour;

F. Poverty Reduction/Cross-cutting Issues/Reduce Food Insecurity at household level; and

G. Conduct monitoring and evaluation.

1.5 Methodology

The preparation of the MAF Country Action Plan occurred in three parts and was fully participatory. After the concept note, a background paper was prepared followed by the development of the MAF. The Background Paper started with the desk review of secondary data and literature, including reports and project documents as well as national policy documents. This provided background to consultative meetings with the national MAF Technical Task Team including the UN Inter-Agency Technical Team, and key officials of the Ministry of Economic Planning and Development (MEPD), National Emergency Response Council on HIV/AIDS (NERCHA), the Ministry of Health (MOH) and World Bank. The team members also took field visits to three Government Health Facilities: Lobamba and Motshane Clinics and Mankayana to validate and update available information (Annex A).

The development of the Country Action Plan (CAP) was conducted under the leadership of the Ministry of Health through the Sexual Reproductive Health Unit (SRHU) and under the guidance of the Deputy Director of Health Services. The UN Inter-Agency Team (World Health Organization, United Nations Population Fund and Joint United Nations Programme on HIV/AIDS) provided technical support in the CAP design. UNDP Regional Service Centre for Eastern and Southern Africa also provided technical backstopping in a three-day workshop to orient the MAF Technical Team on the tools and methodology for the identification and prioritization of interventions, the bottlenecks impeding on the implementation and the solutions to unlock the bottlenecks. The workshop outcomes were further reviewed and reprioritized to identify the high-impact interventions contributing to the implementation of the EMTCT Accelerated Action Plan and SRH Integrated Plan of Action towards reducing maternal and neonatal mortality (Annex B - MAF Preparation Process).

The Swaziland MAF Country Action Plan was subjected to technical expert review, which revealed that the document lacked multisectoriality. This necessitated conducting a follow-up process to engage other stakeholders towards identifying non-health-sector-based bottlenecks and solutions. The identification of non-health sectors was preceded by field visits in eight hard-to-reach communities (Kasiko, Lufafa, Mkhiweni, Bhahwini, Mhlabeni, Bhandeni, Tholulwazi 2 and Kholwane 2) to validate information received from reports. Findings of the validation exercise revealed non-health sector issues related to access to health care, which included poor road infrastructure, inadequate communication network, myths and misconceptions as well as poor and inappropriate health seeking behaviour and delayed decision-making. In all the stages of identification of solutions to bottlenecks, stakeholders from all identified sectors and NGOs participated in the workshops through the leadership of MEPD. This was followed by the development of a monitoring and evaluation framework and the costing of the document. Next, a validation meeting was held that was also participatory, and lastly, the document underwent expert review, producing additional input.

1.6 Limitations

The lack of a comprehensive centralized database on maternal health hampers the complete development of the Action Plan and, more generally, the progress with MDG 5. The available data varies for the same indicator in many reference documents, making comparability a challenge. For example, the Swaziland Demographic and Health Survey (SDHS) 2006/07 estimated MMR at 589/100,000 live births while WHO et al. estimated MMR at 420/100,000 live births in 2008. It is thus difficult to have a common basis to measure maternal mortality ratio in Swaziland. Table 1 on the quantifiable progress towards achieving the MDGs therefore drew on various data sources including the MICS, SDHS, UN Stats online data, SAM, SHIES and poverty maps.

Similarly, most reference documents/strategies (e.g., EMTCT framework 2011–2015 and SRH framework and Plan of Action 2012–2017) drawn up to develop MAF Action Plan are not costed. Annual work plans have not been adequately articulated and/or consolidated to show a composite costing/budgeting. Available costing are only in draft, not consolidated and not finalized for approval. For example, the SRHU is now in the process of compiling the budget for the Integrated Strategic Plan of Action. The EMTCT 2011–2015 is also not costed. Furthermore, attempts at costing were hampered by the need to assess distances on site for water installation and telephone services. Data was therefore not available to cost the MAF Compact and to assess the resource need for the MAF.

The timing of the latter part of the MAF assessment to identify the non-health-sector-based bottlenecks coincided with national elections for the tenth Parliament, hence the limited availability of key persons.

1.7 Report Structure

The report is organized as follows: The next section is devoted to the national context. Chapter 2 presents the status of MDG 5; the policy and strategic frameworks that create the enabling environment for maternal health care, the linkage with sexual reproductive health, the health delivery system supporting maternal health services, challenges and constraints; and the outline of the strategic interventions and stakeholders. Chapter 3 looks at the priority interventions; Chapter 4 deals with the bottlenecks; while Chapters 5 and 6 are dedicated to the solutions and the acceleration plan, respectively. The implementation and monitoring plan is provided in the final section.

FIGURE 1: **POLITICAL MAP OF SWAZILAND SHOWING REGIONS AND TINKHUNDLA**

1.8 National Context

Swaziland is a small landlocked kingdom in Southern Africa, covering a surface area of 17,364 square kilometers. The country is almost entirely surrounded by the Republic of South Africa except on the east where it shares a border with the Republic of Mozambique. According to the 2007 population census, the population of Swaziland is 1,018,449, comprising 53 percent women and 47 percent men, with 44 percent of the population being under 15 years and 46 percent in the 15–49 years age category. The estimated population growth rate is 3.8 (CSO, 2008). The projected population for 2010 was 1,046,197. About 79 percent of the people live in rural areas and depend on subsistence farming for their livelihoods (CSO, 2008). Residents of Swaziland are homogeneous in their language, culture and tradition. They speak either siSwati, or siSwati and English, which are considered official languages.

The country is divided into four agro-ecological zones each with distinctive climatic conditions, resources and potential for development. The Highveld is a mountainous region in the west with an altitude of 1200 m and plenty of rainfall, rich asbestos deposits and large commercial forests. The Middleveld, with an altitude of 700 m, has a warm climate, a fair amount of rainfall and soil amenable to mixed farming of maize, tobacco, citrus fruits and irrigated rice. The Lowveld with an altitude of 200 m, is a savannah-like region in the east; it has rich fertile soil, a hot climate, erratic rainfall (thus making it the driest of the zones) and large coal deposits. The Lubombo range is a plateau separating Swaziland from the Mozambique coastal plain. Its climate is similar to that of the Middleveld and only a small area of the land is arable. Because of these variations in the landscape and climate, certain diseases have become uniquely linked to some zones and seasons. It is important to note also that Swaziland is divided into four ad-

ministrative regions namely Hhohho, Lubombo, Manzini and Shiselweni and into 55 Tinkhundla (constituencies).

Swaziland is predominantly rural accounting for about 75 percent of the national population (CSO, 2011). The population of Swaziland is generally young, with 47 percent of the total under 18 years (CSO 2007). The total fertility rate was 3.95 in 2007, a drop from 4.5 in 1997 and inter-censal population growth rate between 1997 and 2007 was 0.9 percent annually, down from 2.9 percent a decade earlier. This decline is partly attributed to the increase in contraceptive prevalence rate from 17 percent in 1990 to 50.6 percent in 2007 and an unexpected increase in mortality.

The MMR has remained high, increasing from 370 in 1995 to 589/100,000 live births in 2007 (SDHS 2006–07). The IMR and MMR have also increased as a result of the HIV/AIDS epidemic. Despite the drop in total fertility rate and increase in the CPR, the unmet need for family planning remains high at 13%. Early sexual debut among youths is still high (25 percent), and 25 percent of all institutional deliveries are by adolescent girls. There is poor or no integration of services such as FP, HIV/AIDS, STIs and MNCH.

Gender-based violence and sexual dysfunctions are common social and medical conditions. The complex interactions among all the stated issues contribute to high morbidity and mortality. Average population density is estimated at 61.4 persons per square kilometer (World Bank, 2012). Females account for 53 percent of the population, while 44 percent is under the age of 15 years and another 46 percent is in the 15–49 years age group.[3] Christianity and a form of Zionist are the main religions, constituting 57 percent and 40 percent respectively. The remaining 3 percent are filled by Muslim and Bahai religions.

Notwithstanding Swaziland's middle-income status (with GDP per capita at US$2,667.9),[4] poverty and inequality are high with a 63 percent poverty rate and Gini Coefficient of 0.51, respectively, in 2010. Over 70 percent of Swazis depend on agriculture for livelihoods. The Swaziland Human Development Index value of 0.522 ranked the country 140 out of 187 countries in 2011.

Swaziland has one of the highest rates of HIV in the world and the highest incidence of TB. The 2006/07 DHS estimated HIV prevalence at 26 percent among the 15–49 years age group. The case notification rate for all TB cases was 860/100,000 in 2011 (having declined from 1048/100,000 in 2010 and 1057/100,000 in 2009).[5] With HIV and AIDS, life expectancy at birth declined from 60 years in 1997 to 46 years in 2009.[6] HIV prevalence among women attending antenatal clinics also increased from 3.9 percent in 1992 to 41.1 percent in 2010.[7] HIV accounts for 46 percent in maternal deaths and 47 percent in under-five mortality in Swaziland. HIV prevalence is evenly distributed across the country. Women aged 15–49 are more likely to be HIV positive than men (31 percent and 20 percent respectively) and the prevalence peaks earlier among women (25–29 years) than among men (35–39 years). HIV prevalence is higher among the urban population than the rural populations (DHS 2006/07).

The country's HIV situation:

- 19% prevalence among the 2 years and older
- 26% among sexually active adults (31% for women and 19% for men) (CSO 2007) Early sexual debut among youth is 25%
- 41.1% among antenatal care clients (2010 HIV ANC Serosurveillance)

[3] Swaziland Mid-Year Population Projections 2007–2030

[4] http://data.un.org/Country Profile.aspx?crName=Swaziland.

[5] Swaziland Annual Health Statistics Report 2011

[6] World Bank, World Development Indicators 2009

[7] 12th National HIV SeroSurveillance among ANC clients 2010 - Ministry of Health, Swaziland

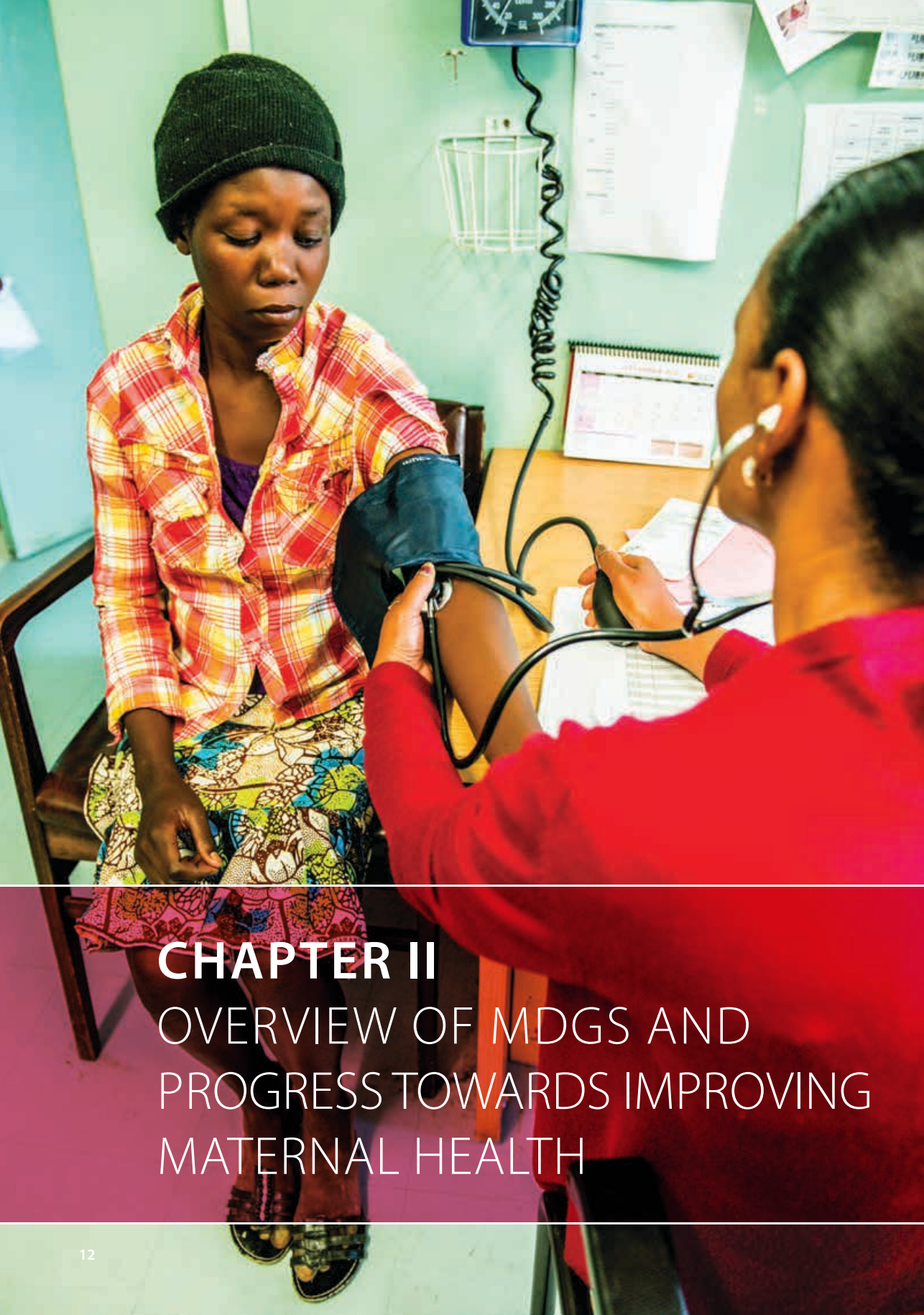
1.9 Summary of the Financial Crisis and Fiscal Situation in Swaziland

The World Bank classifies the country as a lower middle-income country with a GDP per capita income of US$5100 for 2009. Despite being perceived as having a reasonable resource base compared to many developing countries, the majority of people (69 percent) in the country are classified as poor (Swaziland Household Income and Expenditure Survey (SHIES), 2001. Through the implementation of the Poverty Reduction Strategy and Action Plan (PRSAP, 2006), the Government of Swaziland is committed to reducing poverty levels from 69 percent in 2001 to 30 percent by 2015 with the possibility of eradicating poverty by 2022. While the country appears to have made significant economic development progress in the past, there is no doubt that these achievements are being significantly curtailed by the effects of the AIDS epidemic and difficulties in attracting meaningful foreign direct investment.

The country's economy is based on agriculture (which accounts for 70 percent), mining, food processing and manufacture of clothing and light consumer goods. Surrounded by the Republic of South Africa except for a short border with Mozambique in the east, the country is heavily dependent on South Africa, which provides over nine-tenths of its imports and to which it sends 60 percent of its exports. Swaziland's currency is pegged to the South Africa rand, subsuming Swaziland's monetary policy to South Africa.

The country's economic growth rate rose faster in the late 1980s, at an average of 9 percent. In recent years however, the pace of economic growth has severely slowed down, reaching an average of only 3.1 percent during the fiscal year 2007, and there is evidence of deepening poverty and hunger in the population, with an unemployment rate currently estimated at 40 percent. The economic slowdown has been largely due to erratic climatic conditions and changes in prices of agriculture products in the world market due partly to the global economic meltdown experienced in the past two to three years. This had a negative impact on Southern African Customs Union (SACU) receipts. The economy has also been affected by a persistent drought that has affected agricultural production. This fall contributed to a sharp deterioration of the country's fiscal balance from a surplus of 10 percent (as a share of GDP) in 2006–07 to a deficit of almost 15 percent in 2010–11. The ensuing liquidity squeeze further hampered growth (falling from 1.9 percent in 2008 to 1.3 percent in 2011), employment as well as progress towards the Millennium Development Goals.

While the notable increase in SACU revenues will turn the fiscal situation around in 2012/13 and 2013/14, the underlying structural weaknesses—namely high current expenditures and insufficient investment combined with over-dependence on SACU revenues—remain. Addressing them is key for putting public finance on a sustainable path and ensuring adequate fiscal space for financing MDGs.



CHAPTER II
OVERVIEW OF MDGS AND PROGRESS TOWARDS IMPROVING MATERNAL HEALTH

2.1 Overview of the MDGs progress in Swaziland

The achievement of MDGs is central to the Government's poverty reduction programme enshrined in the Vision 2022, NDS 1997–2022 and the PRSAP 2008–2013. The progress so far has been mixed. Two MDGs (2 and 3) are achievable by 2015 while the remaining ones are not likely to be achieved in full. MDG 2 (universal primary education), MDG 3 (promote gender equality and empower women) and part of MDG 7 target (C) have made steady progress over the years while MDGs 1, 4, 5 and 6 have struggled and made no or limited progress. The period between 2006/07 and 2010 has shown positive outcomes for several MDGs (Annex C) though the progress has been uneven, and inequalities and regional and rural/urban disparities still remain. Maternal health (MDG 5) has been lagging alongside the high under-five child mortality rates and HIV prevalence. The reduced effectiveness of the immune system in most pregnant women link maternal death and HIV/AIDS prevalence, which is strongly correlated with child mortality rates as well.[8] The country has adopted an integrated approach in addressing pregnancy among HIV-infected women in order to reduce the high MMR being experienced.

2.2 Status of Maternal Mortality in Swaziland

The outcomes of the two major targets for MDG 5 assessment: (i) MMR by three quarters between 1990 and 2015; and (ii) achieving universal access to reproductive health by 2015 are uneven, thus becoming a great concern to decision and policy makers, especially in light of the good performance on some indicators such as the ANC attendance, skilled birth attendance, facility deliveries and reduced mother-to-child transmission (MTCT). ANC attendance for the first visit is 97 percent, birth attendance by skilled personnel 82 percent, facility deliveries 80 percent and PMTCT coverage 88 percent, reaching most of the delivery facilities with 76 percent of the 13,536 HIV-positive pregnant women receiving full course of ARV prophylaxis. Yet, the maternal mortality ratio has not been evolving in line with the positive results seen above. The 2006/07 Swaziland Demographic and Health Survey estimated the maternal mortality ratio (MMR) at 589 per 100,000 live births.[9] WHO et al. pitched it at 420 per 100,000 live births in 2008.[10] The uncertainty surrounding qualifications of 'skilled' health personnel and the adequacy of facilities together with high HIV rates and high unmet need for family planning among HIV-positive women help explain this divergence. Moreover, the drivers of the MMR extend beyond the health sector. It includes poverty, social norms and women's empowerment, thus calling for a multi-sectoral approach to address the issues.

The global estimates for reducing MMR in Sub-Saharan Africa is not encouraging. Between 1990 and 2010, it is estimated that the average global maternal deaths decreased by 47 percent (from 543,000 in 1990 to 287,000 in 2010) resulting in an annual rate of decline at 3.1 percent. However, Sub-Saharan Africa accounted for only 2.6 percent. This was far behind WHO et al. (2012) estimates where a reduction rate of 5.5 percent annually between 1990 and 2015 is required to achieve the MMR reduction of 3/4 (75 percent) by 2015. In the Swaziland situation, it has experienced rising maternal deaths from

[8] In fact, the 2012 WHO et al. report found that 67.3 percent of maternal deaths in Swaziland is related to HIV.

[9] The figure has not since been revised.

[10] The trend is comparable to Botswana, Lesotho, Namibia, South Africa and Zimbabwe in the Southern African region. For example, Lesotho MMR increased from 520 per 100,000 live births in 1990 to 750 in 2005 before dropping to 620 in 2010. Similarly, Namibia recorded MMR of 310 in 2005 from 200 in 1990. Malawi, on the other hand, showed a consistent decline from a high level of 1,100 maternal deaths per 100,000 in 1990 to 460 in 2010.

110 to 589/100,000 between 1990 and 2006/07. Pregnant women continue to die from the four major preventable causes: severe bleeding after childbirth, infections, hypertensive disorders and unsafe abortions. This is a great disparity with the target set by the country to achieve by 2015 i.e., 92 per 100,000 (**Table 1, Figure 2**).

FIGURE 2: TRENDS OF MATERNAL MORTALITY RATE BY TARGET DATE - 1990–2015

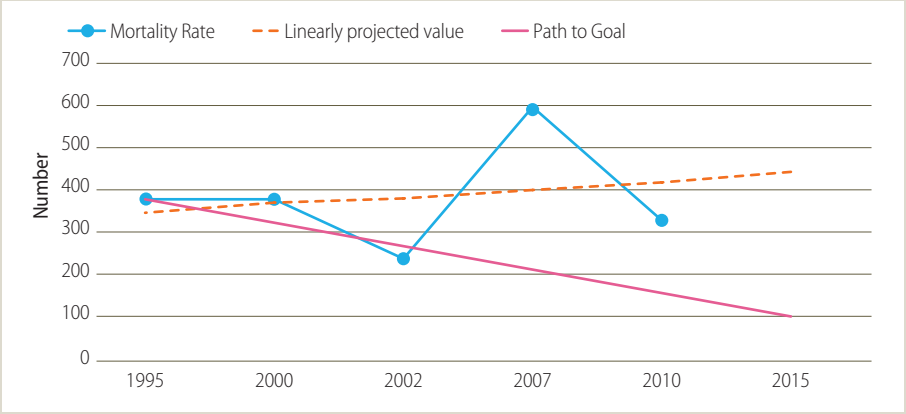
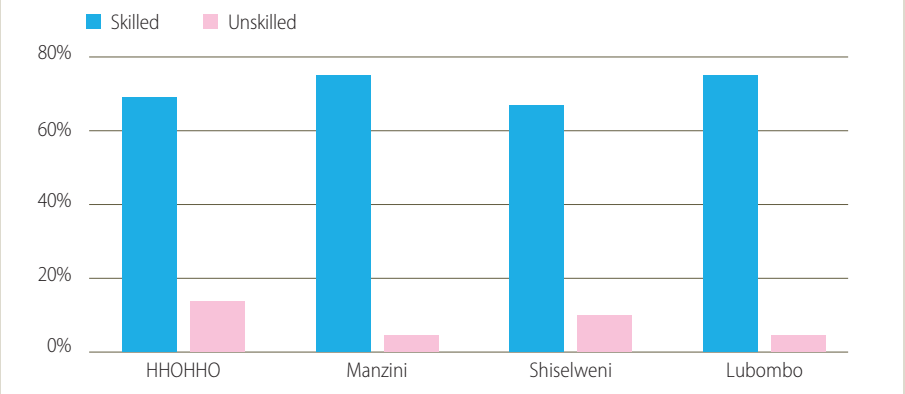


TABLE 1: PROGRESS TOWARDS ACHIEVING MDG 5 - 1990–2015

Goal/Targets/Indicators	Indicators	Indicator Status						Target Year
		1990	1995	2000	2005	2007	2010	2015
Goal: MDG 5-Improve Maternal Health								
Target 5A: Reduce by 3/4 between 1990 and 2015, the maternal mortality ratio	2015	110 (1991)	370	229 (2001)	325	589	320	92
	5.2 Proportion of births attended by skilled health personnel (%)	–	56 (1994)	70	74 (2002)	74.3	82	100
Target 5B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate (%) among married women 15–49 years	–	–	27.9	–	59.3	65.2	100
	5.4 Adolescent birth rate per 1000 women	134 (1991)	–	102.8	–	111	89	–
	5.5 Antenatal care coverage (%):							
	- at least one visit	–	–	97	–	97	97	100
	- at least four visits	–	–	–	–	–	76.6	–
	5.6 Unmet need for family planning (%)	–	–	–	–	24	13	–

Source: Swaziland Multiple Indicators Cluster Survey (MICS) 2000 & 2010; National MDG Reports, 2003, 2007, 2010 & 2012; http://mdgs.un.org/unsd/mdg/Data.aspx

FIGURE 3: MATERNAL MORTALITY RATE BY DELIVERY ATTENDANT AND BY REGION



Swaziland is classified among 10 countries in Sub-Saharan Africa making 'no progress' in reducing MMR by the 3/4 by the target year 2015. The major cause behind the increase in MMR, observed also in other countries (Botswana, Lesotho, Namibia, South Africa and Zimbabwe) in the region is the high HIV prevalence. According to the WHO et al. 2012 study, 67.3 percent of maternal deaths in Swaziland are HIV/AIDS related.

In 2007, the Government made maternal deaths a notifiable event and established a committee to oversee a National Confidential Enquiry Review/Audit into maternal deaths. The Committee's first report (2008–2010 Triennial Report), June 2011 covered a review of 63 deaths from Government-owned delivery facilities in a three-year period (2008, 2009 and 2010) and found that the most frequent underlying cause of death is non-pregnancy related infections (including advanced HIV/AIDS with opportunistic infections such as TB). With the combined direct and indirect causes (54 percent and 46 percent respectively), HIV/AIDS accounted for 25.4 percent, hemorrhage (antepartum and post-partum) 22.2 percent, pre-existing maternal diseases 14.5 percent, sepsis 12.7 percent, pre-eclampsia/eclampsia 11 percent and anemia 6.3 percent. Three-fifths of all deaths occurred in pregnant women aged 21–30 years with severe cases of HIV/AIDS and non-pregnancy related infections. The 2010 MICS revealed that in Manzini Region, 90 percent of women deliver in health facilities. Of these, only 82 percent was assisted by a skilled person, of which 75 percent was conducted by a midwife, whilst 4.5 percent was conducted by a relative. In the Hhohho Region 81.1 percent of women delivered in health facilities, 78.4 percent was conducted by a skilled person of which 69 percent was conducted by a midwife and 13.7 percent conducted by a relative. In Shiselweni Region 78.1 percent of deliveries occurred in health facilities by 82.2 percent skilled health worker of which 66.8 percent was a midwife and 9.9 percent conducted by a relative. In Lubombo Region 66.5 percent occurred in health facilities of which 90.2 percent was conducted by a skilled person of which 75 percent was a midwife and 4.5 percent delivered by a relative. However, it could not be established why the most (41.3 percent)

Update on CARMMS activities:

a) Establish community Midwifery Committees and restructure operations in maternity wards: Established and fully functioning;

b) Deploy at least two qualified maternity care providers: 50% of health facilities has two mid-wives;

c) Ensure availability of supplies and equipment for emergency obstetric care: 80% of health facilities provided with adequate; and

d) Step up in-service training on risk identification and management: 60% of health workers trained

deaths occurred in Manzini Region followed by Hhohho with 36.5 percent, Shiselweni with 12.7 percent and Lubombo 9.5 percent, mainly at the referral hospital level. Additional data from HSSP 2008–2013 also noted the contribution of severe malnutrition to perinatal and maternal deaths at 20 percent and 10 percent, respectively.

The Government of Swaziland is committed to the response to the HIV/AIDS menace and ensuring quality health care for all citizens and reducing maternal deaths from pregnancy complication and childbirth. This is evidenced in the number of regional and national strategies the country has embarked upon to scale up comprehensive sexual reproductive health, elimination of mother-to-child transmission, repositioning of family planning, the campaign for accelerated reduction of maternal mortality, strengthening the MNCH platform, formulating and training health care workers on service guidelines and standard operational procedures and establishing the confidential enquiry into maternal deaths, among others.

Following the regional launch of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) by the African Union in May 2009 to create national awareness and mobilize domestic partners and resources for MNHC, Swaziland was among the few countries to implement CARMMA, launching CARMMS (Campaign for Accelerated Reduction of Maternal Mortality in Swaziland) in October 2009. CARMMS is in line with the six CARMMA pillars to: (i) improve quality MNHC service delivery; (ii) promote MNH; (iii) generate and share evidence-based research to inform policy/programmes; (iv) establish leadership/ good governance; (v) increase domestic resource mobilization to fund MNHC; and (vi) strengthen community mobilization in MNHC. The launch and implementation of CARMMS is championed by Her Royal Highness Inkhosikati Make La Mbikiza. CARMMS set out activities to: (i) establish community Midwifery Committees and restructure operations in maternity wards; (ii) deploy qualified maternity care providers; (iii) ensure availability of supplies and equipment for emergency obstetric; and (iv) step up in-service training on risk identification and management. The death of a mother while giving life is not acceptable. Children whose mothers pass away are said to be 10 times more likely to die within two years of their mother's death than those whose mothers are alive. Furthermore, the death of a mother lowers productivity and greatly aggravates poverty in the family, especially if she was the head of household. The extremely close interrelationship between MDGs 5, 1, 4 and 6 cannot be overemphasized.

2.3 Constraints to Achieving MDG 5

2.3.1 Policy Framework Supporting Improved Maternal Health Care

The health sector in Swaziland operates in a favorable legal and policy framework. The provision of basic health care services to the population of Swaziland is enshrined in the National Constitution as well as the NDS and PRSAP. The 1983 Health Policy and revised 2007 National Health Policy have all provided the legal and regulatory framework for the sector to perform its mandate founded on the concepts and principles of Primary Health Care. The National Health Sector Strategic Plan (HSSP) 2008–2013 offers the roadmap for realizing the 2007 National Health Policy. One of the HSSP Strategic Operational Objectives is to ensure access to the widest possible package of reproductive and maternal health care in order to significantly reduce maternal and neonatal morbidity and mortality.[11] The indicative cost for implementing the HSSP for the five-year period was estimated at US$147,665,841. The 2012 HSSP mid-term review report reveals 46 percent (11) of the 24 strategic interventions planned "to ensure access to the widest possible package of reproductive and maternal health care in order to significantly reduce maternal and neonatal morbidity and mortality" was attained by 2011, 29 percent (7) was in progress while 25 percent (6) was not done. Among the major programme services are safe motherhood, family planning, PMTCT, adolescent and youth; SRH, gynecology and geriatrics services.

The health sector relies heavily on Government funding to finance the health interventions. The proportion of Government budget allocated to the health sector averaged 8 percent between 2009 and 2011 against the Abuja Declaration target of 15 percent (**Table 2**). A provision for an additional E92 million in the 2012/2013 budget brings Government total allocation to E1.1 billion for the 2012/13 fiscal year. Personnel emolument and other recurrent costs is estimated at 60 percent of total budget to the sector. Relative to some other Sub-Saharan African countries, these are substantial allocations though, and a key challenge is then to utilize them effectively.

TABLE 2: TRENDS IN KEY HEALTH FINANCING INDICATORS

No.	Indicator	2007/08	2008/09	2009/10	2010/11
1.	Proportion of GDP spent on health (%)	2	3	7	7
2.	Proportion of Government budget allocated to health (%)	8	7	9	8
3.	Proportion of allocated funds disbursed (%)	95	86	98	80
4.	Total Public Expenditure on health (Emalangeni)	577,398,382	728,428,999	962,391,383	926,746,225
5.	Total MOH Budget (Recurrent and Development including Donor) (Emalangeni)	610,565,591	845,036,362	983,322,222	1,153,606,000
6.	Per capita (Public) expenditure on health		567	729	683

Source: HSSP 2008–2013 MTR Report 2012

[11] Sectoral strategies and policies are listed in the Executive Summary and in Section 4.1.

Strengths of Family Planning

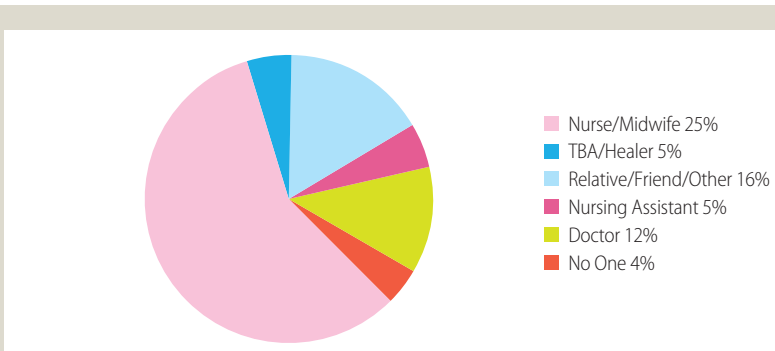
- Repositioning of family planning
- Development of FP guidelines
- Training of service providers
- Method mix has expanded to include implant
- 72.5% of facilities offer FP

2.3.2 Linkage between Sexual Reproductive Health and Maternal Mortality

Changes in reproductive patterns like the use of contraceptive methods, inter-pregnancy intervals, maternal age, high unmet need for contraception, antenatal and postnatal care, unsafe abortions, skilled delivery with well-equipped health facilities and skilled health personnel are expected to have an impact on maternal health in general and maternal mortality in particular. In Swaziland, most of these indicators have improved. Nevertheless, the maternal mortality trends have deteriorated.

Contraceptive use in Swaziland increased from 59.3 percent in 2007 to 65.2 percent in 2010. According to the 2007 SHDS, knowledge of family planning methods is universal (99.7 percent among women and 99.5 percent among men aged 15–49 years). The most frequently used contraceptive methods by women aged 15–49 years are male condoms, 13.6 percent; injectables 12 percent; and pills 5.9 percent. The long-term methods such as implants and intrauterine device are not used much. Distribution of contraceptive methods is 45 percent by government hospitals, health centres and clinics, while private hospitals and NGOs offer 14 percent and 24 percent respectively (2006/07 DHS). Contraceptive use is highest among married women living in Hhohho (51 percent), with tertiary education (72 percent) and lowest among married women in Shiselweni (42 percent) and with no education (26 percent). Urban women tend to use contraceptives more than their rural counterparts.[12]

FIGURE 4: TYPE OF ASSISTANCE DURING DELIVERY



[12] These figures are slightly below those in the 2010 MICS report, which found that 65 percent of married women in Swaziland use some form of contraception, in contrast to 51 percent of married women reported in SHDS 2007. Correspondingly, unmet needs for family planning reported in the 2010 MICS report were also below those in the SDHS 2007, with the unmet need being the lowest in Manzini (11 percent).

Average unmet need for family planning among married women decreased from 24 percent to 13 percent between 2007 and 2010. However, significant disparities exist among HIV-positive women (37 percent), HIV-positive ANC clients on ART (65.3 percent) and regions ranging from 20.3 percent for Hhohho region and 28 percent in Lubombo. Women who are young, adolescent, rural and/or uneducated are also affected by unmet need for family planning. In sum, despite their knowledge, many Swazi women still do not have sufficient access to family planning services.

The total fertility rates among Swazi women have fallen over the years by almost 50 percent from 6.4 in 1986 to 3.7 children per woman in 2010. Disparities exist by residence, region, education and economic status. Women in urban areas tend to have fewer children (about 3) than women in rural areas (4.2 children). The regional difference is highest in Shiselweni (4.3 children) and lowest in Hhohho (3.6 children). Women with tertiary education have on average 2.4 children; while non-educated will typically have more than 4. The poorest women have almost 5.5 children, more than twice the children of women from the wealthiest households (2.6). Early childbearing is prevalent among the poor. About 47 percent of the poorest 20–24-year-old women have had a child before turning 18.

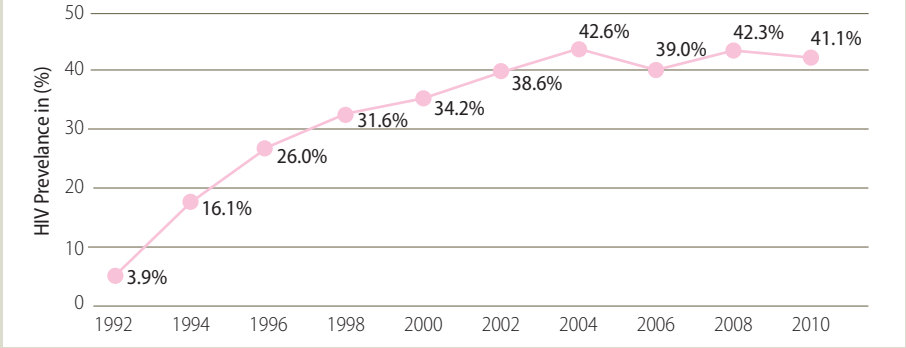
Even though antenatal care coverage is estimated at 97 percent in 2010 (33,916) only 26 percent of the pregnant women attended antenatal care services by the first trimester, whereas 76.6 percent went for the recommended four ANC visits. The MNCH programme has not been able to track the remaining 20.4 percent clients for all services and ensure women adhere to their drug regimens throughout their pregnancy. With high HIV prevalence among pregnant women in Swaziland, early ANC booking in the first trimester of pregnancy and adherence of the clients to the recommended four visits are crucial for timely enrolment into the PMTCT programme and also early detection of complication to improve the survival rate of the mother and newborn. Between 2011 and the third quarter of 2012, 62 percent of maternal deaths occurred post-partum.[13] Yet just 25 percent of mothers avail themselves for postnatal care (PNC) services within the recommended six weeks. With this situation, sepsis/infections and other obstetrics complications put mothers at risk.

Swaziland has a significant high attendance (82 percent) by skilled personnel, with 80.4 percent of women delivering at health facilities in 2010. Of these total deliveries (23,962), the National EMTCT Strategic Framework notes that 88 percent occurred in hospitals, 9 percent in health centres and 3 percent in clinics, while 5 percent delivered on the way to a health facility. When it comes to the categorization of health personnel giving assistance during delivery, doctors and nurses/midwifes constitute 70 percent and nursing assistants 5 percent.[14] Some 25 percent was assisted by a traditional birth attendant (TBA)/healers, an untrained relative/friend or self (**Figure 3**). Home deliveries are said to be common in the rural areas at 29 percent of all deliveries and 11 percent in urban areas. Among the challenges around labour and delivery are the inadequate health facility infrastructure, lack of obstetric care equipment and supplies and shortages in skilled human resources.

[13] Presentation by the Confidential Enquiry into Maternal Deaths Committee, 2011–2013 at the Swaziland Research Day, 6–8 November 2012

[14] This figure is below the 2010 MICS figure of 82 percent skilled attendance at delivery.

FIGURE 5: **TRENDS IN HIV INFECTION AMONG ANC CLIENTS (15–49 YEARS) FROM 1992–2010**



Use of antenatal care is free of charge, but this is not the case with delivery. Mothers pay up to E33 (US$3.30) for delivery in public facilities, E5,400 (US$540) or more in the private-sector facilities and up to E1,800 (US$257) in religious mission health facilities. Fees for cesarean deliveries amount to between E25–50 (US$3.60–7.10) in public and E877 (US$125) in private facilities. The private sector is more costly because it is not subsidized by the Government; hence they buy most of the commodities themselves.

The 41.1 percent HIV prevalence (**Figure 5**) among the 33,916 ANC clients in 2010 translated into some 13,536 pregnancies or HIV-exposed infants. Through the PMTCT intervention, 40 percent (5,425) infants born to HIV-infected mothers were free from HIV infections. From the initial 3 PMTCT pilot sites in 2003, the programme expanded covering 88 percent (150) of the 177 delivery facilities. The regional coverage of services also ranges from 77 percent in Manzini region to 97 percent in Lubombo, based on the four-pronged approach on:

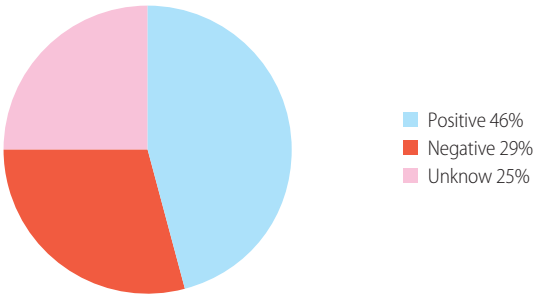
- Primary prevention of HIV infection among women of childbearing age to keep women from acquiring HIV infection;
- Preventing unintended pregnancies among HIV-positive women;
- Improving the quality of care during pregnancy, labour and breastfeeding; and
- Standardizing care, treatment and support for HIV-positive mothers and their infants.

The PMTCT services are not yet completely integrated with other HIV, MNCH, FP, TB and ART services to provide a 'one-stop shop' comprehensive package to clients. Knowledge of HIV status among pregnant women is high in Swaziland (**Figure 6**): 46 percent know they are positive and 29 percent, negative, while just 25 percent[15] of ANC clients do not know their HIV status. Nevertheless, HIV continues to be linked to the majority of maternal deaths.

Health delivery in Swaziland operates on a five-tier health care system with well-defined responsibilities at each level. The Service Availability Mapping (SAM 2010) identified 265 health facilities operating in the country compared to the 154 in 2008. Government ownership is 44.8 percent, and facilities privately owned by doctors or nurses is

[15] SRHU, MOH

FIGURE 6: KNOWLEDGE OF HIV STATUS AMONG PREGNANT WOMEN



22.4 percent, faith-based organizations (FBOs) is 14.8 percent, industrial facilities is 12.6 percent and NGOs is 5.4 percent. The rural clinics, classified Type A and Type B, account for 80 percent (211) of all the facilities. Of these, 88 percent (186) are Type A, i.e., clinics without maternity units and 12 percent Type B (with maternity units), managed and run by a State Registered Nurse. The next in the rung are Public Health Units (eight) and Health Centres (five), followed by four regional hospitals and three referral hospitals. The public health system is decentralized and headed by a Regional Health Administrator supported by the Regional Health Management Team (RHMT) to provide technical leadership in executing Ministry of Health policies in all the four regions. The health system is further supported by a network of community health workers including the 5,000 rural health motivators (RHMs) who sensitize and promote community participation in health activities.

2.4 Challenges and Constraints to Maternal Health

Capacity issues pertaining to staff numbers, knowledge, skills, equipment, supplies, facility availability, etc. constrain health service delivery, as recorded in the 2009 Maternal Health Situational Analysis and 2011 Competency-Based Midwifery Training Assessment Report. The total number of health sector personnel increased from 2,880 in 2008 to 4,545 in 2010; the number of health workers who received (pre-service) training also increased from 159 to 363. The number of doctors and midwives per 100,000 population increased from 19.7 to 23 and 90.53 to 93.5, respectively, and the number of nurses declined from 28 to 25 per 100,000. Nevertheless, inequity exists in the distribution of health personnel. Over 50 percent of the existing workforce is deployed in hospitals located in urban areas, serving about 20 percent of the population, while the rural areas, with 80 percent of the population, are served by 50 percent of the workforce.[16] Of the 80 percent rural population, 85 percent reside within the recommended 8-kilometer radius from a health facility. Of concern is the 15 percent which is in hard-to-reach areas serviced by a monthly outreach programme. With deliveries taking place mainly at the health center and hospital level, it has been found that

[16] EMTCT, National Strategic Framework for Accelerated Action, 2011–2015

distances and transportation to facilities is greater than the recommended 8-kilometer radius for many of the rural pregnant women. Thus the under-developed road infrastructure in rural areas can make reaching hospitals challenging and/or contribute to poor health seeking behaviour. Getting the referral system (communication, ambulance services) to function is also another challenge. There is inadequate safe running water in 16 health facilities, while 20 other health facilities experience erratic power supply. The means of communication remain poor in 34 health facilities, and poor physical infrastructure limits accessibility to health centres—physical infrastructure and fencing is poor at 32 facilities. Moreover, most referral facilities have no waiting huts. And of the 62 ambulances nationwide, only 17 were available to the 186 Type-A clinics (without maternity units) (SAM, 2010).

Lack of adequate experience to recognize risks and manage obstetric complications during labour, delivery and post-delivery is another challenge. These three delays also aggravate complications i.e., (i) delay in recognition of a problem by the pregnant woman to seek timely and appropriate professional assistance; (ii) delay in arriving at a health facility; and (iii) delay within the health facility.

Other constraints are caused by sociocultural and religious factors, e.g., limitations on male involvement in reproductive health issues including myths and misconceptions, women's limited empowerment to make decisions regarding their sexual reproductive health rights and choices and, church prohibitions on the use of western medicine. Lastly, relevant reproductive health indicators are either poorly defined and/or collected to generate sufficient information for policy direction.

Taking a broader view, poverty—which in Swaziland has a female face—is a key factor behind poor maternal health. In 2010 Swaziland had an overall 63 percent poverty rate (living on an equivalent of US$1.25 a day or less), with 67 percent of female-headed households living in poverty, relative to 59 percent of male-headed households (Government of Swaziland, 2011). Similarly, while in 2007 the unemployment rate for men (of all ages) was 'only' 24 percent, it was 30 percent for women of all ages and 55 percent for women aged 15–24. Delivery in hospitals and other professional facilities thus may be out of reach for a number of pregnant women: mothers tend to pay up to E33 (US$3.70) for delivery in public facilities, E5,400 (US$540) or more in the private facilities and up to E1,800 (US$257) in religious mission health facilities. Fees for cesarean deliveries amount to between E25–50 to E70.00 (US$2.55–7.00) in public and E877 (US$87.70) in private facilities.

The importance of women's empowerment as a driver of improved maternal health cannot be emphasized enough. Reduced maternal deaths among educated women could improve human capital of the young population, as the link between mothers' education and child's health and education outcomes is well established. Additionally, improved maternal health would undoubtedly contribute to women's economic and overall empowerment. In 2012 on the Organisation for Economic Co-operation and Development (OECD) Social Institutions and Gender Index, Swaziland ranked 74 out of 86 non-OECD countries. According to the index, Swazi women experience limitations on their reproductive rights.[17] Women's access to family planning services should also improve to meet their demand. Stronger advocacy could help counter negative attitudes among a substantial number of men towards women's use of contraceptives.[18]

[17] Abortions are illegal except in a case of rape, mental retardation or if the health of mother is at risk.

[18] http://genderindex.org/country/swaziland

2.5 Strategic Interventions Supporting the Achievement of MDG 5

2.5.1 Overview of National Interventions

Swaziland is embarking on a number of interventions with the overarching goal of increasing access to comprehensive sexual reproductive health and reducing maternal and neonatal mortality. The key SRH components informing the interventions are: Safe Motherhood; FP; Adolescent Sexual and Reproductive Health; Management and Coordination; Male Involvement; and Community Mobilization and Participation in SRH. Safe Motherhood and FP interventions are also appropriate for Adolescent Sexual Reproductive Health. Similarly, interventions for Community Mobilization and Participation and Male Involvement sometimes overlap. Management and Coordination interventions are cross-cutting, creating the enabling environment to attain the results. Some specific ongoing interventions are outlined in **Table 3** below.

TABLE 3: INTERVENTIONS TO REDUCE MATERNAL AND CHILD MORTALITY RATE

Intervention	Description of Interventions
Safe Motherhood	• Strengthening maternal health units in health facilities, including laboratory, blood safety and theatre, and ensuring constant availability of life-saving equipment, supplies and drugs; • Continuous capacity building for reproductive and MNHC workers on essential life-saving and referral knowledge and skills targeting health facilities and communities (nurses/midwives; RHMs); • Provision of long-lasting insecticide-treated bed nets and improving essential antenatal care (TT2 and IPT) immunization, postnatal care, child spacing and general health education services; • Integrating maternal and neonatal services with prevention, control and management of communicable and non-communicable diseases; • Integrating nutrition education into all maternal and neonatal health services; • Decentralization of PMTCT and ART services, to peripheral clinics to increase access; • Increasing Waiting Wards to bring pregnant women close to the health facility when it is term; • Maintaining the free antenatal and postnatal care for pregnant women and mothers; • Strengthening the midwifery pre-service training to meet standards stipulated by WHO and International Confederation of Midwives; • Continued development of Guidelines/Protocols/SOPs for health workers; • Strengthening supervision and equipping RHMs to increase counselling and visitations to pregnant mothers up to 11 times in a period of 24 months in accordance with the Guidelines; and • Community mobilization to encourage good health seeking behavior, e.g., early ANC bookings in the first trimester of pregnancy and also PNC.
Family Planning	• Repositioning family planning and integrating FP and SRH/HIV services into all health facilities; • Procurement of FP commodities and building capacity for logistics management, forecasting, stock monitoring and coordination; • Continuous training for staff/service providers and equipping of service sites to provide constant FP services; • Community mobilization and information education to boost FP demand; • In-depth continuous analysis of SDHS data to inform SRH programming based on population evidence; • Encouraging and supporting HIV and SRH integration through pilot centres of excellence; and • Training health workers for prevention and management of unsafe abortion and also post-abortion care.

Intervention	Description of Interventions
Management and Coordination	• Developing policies, strategic plans, Guidelines, Standards and Protocols with an impact on SRH and MNH care services, i.e.: – Sexual Reproductive Health (SRH) Policy (Final Draft); – Integrated SRH Strategic Plan 2008–2015 revised to Integrated SRH Strategic Plan of Action 2012–2015, July 2012; – The National Condom Strategy 2010–2015 'A Call for Safe Sex,' December 2010; – Elimination of New HIV Infections among Children by 2015 and Keeping Mothers Alive: National Strategic Framework for Accelerating Action, 2011–2015; – Child Survival Strategy; and – National HIV Strategic Framework. • The health sector is also guided by the 2010 National Gender policy and 2010 National Youth policy.
Health System Strengthening	• Health Facility improvement initiatives including: • Transforming Mbabane Government Hospital into a National Referral Hospital; • Developing Urban Filter Clinics in partnership with Mbabane and Manzini City Councils to improve access to health service delivery; • Construction of a regional hospital in Lubombo, rehabilitation and expansion of Mankayane, Pigg's Peak Government Hospitals and RFMH to bring services to the people; and • Equipping health centres to have operational Public Health Units for the provision of Mother and Child Health/FP, preventive, outreach and supervisory services to their established catchment area. • In addition to the special services, the regional hospitals are also being equipped to provide in-service training, consultation and research in support of the primary health care programmes.
Community Mobilization for SRH and SRHR	• Establishing community health committees and outreach sites to facilitate community participation and the interface between health facilities and community-based health service providers; • Community mobilization and continuous advocacy and sensitization campaigns to educate pregnant women and families on importance of pre-conception, antenatal and postnatal care; and • Developing and implementing Community Actions including male participation.
Other Interventions	• Strengthening the HMIS, M&E and promoting operational research; • Strengthening the midwifery award system to recognize performing midwives through initiating the "Midwife of the Year" award in institutions/facilities; • Extending maternal death review/audit to the regional facilities; • Integrating and managing Gender-Based Violence into SRH; and • Improving the national referral system (communication, ambulances, training, blood safety and availability) according to the national referral framework.

2.6 Stakeholders and development partners' support to achieve MDG 5

Government is the major source of funding for the health sector in general. Development partners over the years have also provided the sector with financial, technical and material support, as shown in the table below.

TABLE 4: DEVELOPMENT PARTNERS' CONTRIBUTION TO THE HEALTH SECTOR

No.	Development Partner	Service area	2011/12	2012/13 (indicative budget in US$)
1.	Proportion of GDP spent on health (%)	Supports Family Life Association of Swaziland	1,519,486	2,979,149
2.	Global Fund			
	a) R7 – HIV	HIV	1,458,149	1,715,525
	b) R8 – Malaria	Malaria	2,178,242	1,712,490
	c) R8 & 10 TB	TB	4,418,810	7,182,466
3.	Médecins Sans Frontières (MSF)	HIV and TB	6,542,857	10,585,714
4.	US Government/PEPFAR	HIV and AIDS coordination: • Supporting the implementation of the multi-sectoral National Strategic Framework on HIV/AIDS (NSF 2009–2014); • Improving the coverage and quality of HIV-related treatment and care; • Mitigating the impacts of HIV/AIDS with a focus on children; • Increasing access to high quality medical male circumcision; and • Building the human and institutional capacity needed to achieve and sustain these goals.	27,100,000	33,300,000
5.	UNDP	• Focusing on poverty reduction; • HIV/AIDS, governance and gender mainstreaming	22,500	12,500
6.	UNAIDS	HIV and AIDS		211,911
7.	UNFPA	Focusing on Reproductive Health and Rights (RHR) and sexual and reproductive health (SRH) programmes, i.e.: • Preventing HIV, mitigating HIV's impact and providing high-quality reproductive health services; • Training for Reproductive Health Commodity Security (FP commodity procurement); • Managing maternal and newborn health emergencies and equipping maternity units; • Supporting mobile clinic services for vulnerable groups in textile industries and in rural areas; and • Supporting research and campaigns targeting youths and health care workers to reduce maternal mortality, i.e., Maternal Death Audit.	2,436,496	1,718,900

No.	Development Partner	Service area	2011/12	2012/13 (indicative budget in US$)
8.	UNICEF	• Support the uptake of PMTCT and pediatric AIDS care services; • Improve infant feeding practices; • Improve the treatment of children suffering from acute malnutrition; • Train midwives to care for neonates and enhance girls' education; and • Improve maternal health and child survival among others.	5,672,326	570,200
9.	WB/Japanese Social Development Fund	Delivering Maternal and Child Health Care to Vulnerable Population	104,335	856,764
10.	WB/EU	• Improving reproductive, maternal and neonatal health care; and • Swaziland Health, HIV/AIDS and TB Project (2010–2015). The two main components of the project are: (i) increasing the availability of basic and comprehensive Emergency Obstetrics and Neonatal Care in public and private health facilities; and (ii) increasing the capacity for monitoring maternal and newborn health outcomes.		10,706,190
11.	WFP			6,355,000
12.	WHO	• Improving the health sector stewardship and leadership function of MOH to be efficient and effective to strategically coordinate the number of Ministries that contribute to the state of the public health sector; • Reducing high mortality due to high burden of disease; and • Strengthening health systems to improve health outcomes.	762,000	1,097,000
13.	Taiwan Medical Mission		234,286	
TOTAL			**52,449,487**	**79,003,809**

Source: 2008–2013 HSSP Mid-Term Review Report, 2012

CHAPTER III
STRATEGIC INTERVENTIONS

The Expanded MAF Technical Task Team identified and prioritized four key intervention areas from the above list in Chapter 2 for analysis during the MAF technical workshop, 4–6 March 2013 at the Sibane Hotel. These included issues of family planning, emergency obstetric and neonatal care, skilled birth attendance and medical conditions in pregnancy (i.e., HIV, TB and hypertensive disorders). Further analysis and guidance from the leadership of the MAF Technical Task Team placed emphasis on HIV with the view to align and complement the MAF to the Swaziland EMTCT Strategy. The strategic interventions in maternal and neonatal health were thus analyzed and three key priority areas were identified for acceleration. This was further followed by meetings/discussions with other sectors to identify non-health issues impacting on the maternal and newborn health care services. The four interventions also contribute directly to the HSSP 2008–2013 strategic operational objective "to ensure access to the widest possible package of reproductive and maternal health care in order to significantly reduce maternal and neonatal morbidity and mortality." The identification of the priority interventions were based on the set of criteria: Incremental outputs and outcomes; Beneficiaries (population impacted); Impact ratio (as proportion to expenditure); Speed of impact; and Evidence of impact. Strong community and family education/advocacy/engagement for demand creation and support for the interventions; difficult terrain and poor roads and infrastructure in hard-to-reach rural areas; poverty; cultural beliefs and misconceptions about HIV and MNH; and issues of mentorship, supervision, monitoring and coordination are common to all three priority areas. The prioritized strategies are mutually interlinked and complementary, reinforcing one another. They are:

A. Improving HIV Management before, during and after pregnancy;

B. Improving Access to modern family planning (FP) methods by HIV-positive women and their partners plus adolescents/youths;

C. Improving Quality of Skilled Birth Attendance during labour, delivery and post-delivery services;

D. Improving access to quality skilled birth attendance;

E. As much as these interventions are identified, their success requires that the following are accorded priority. Promotion of early and appropriate Health Seeking Behaviour;

F. Poverty Reduction/Cross-cutting Issues/Reduce Food Insecurity at household level;

G. Conduct evidence based socio-cultural research and promote knowledge management; and

H. Conduct monitoring and evaluation.

1. Improving HIV Management before, during and after Pregnancy

Effective management of HIV among women of reproductive age is very important to reducing maternal mortality. The high national HIV prevalence at 26 percent and 41.1 percent among pregnant women, make this intervention a very high priority to Swaziland. The country attained 88 percent coverage of PMTCT in 2010 with great efforts for integration into SRH and HIV. Tracking HIV and STI prevalence among pregnant women attending ANC services is universal. Guidelines and supportive tools have been developed to assist health care workers to deliver quality integrated PMTCT care. The MAF is seeking to reinforce and accelerate the ongoing national initiatives in attaining the elimination targets of reducing new HIV infections among pregnant women and women in general, providing quality comprehensive mother-to-child transmission services and

increasing the survival rates of HIV-positive pregnant women/mothers and their newborns. In this regard, issues of family support systems and structures, communication network, road infrastructure and transport network are also highlighted. The prioritized indicative interventions for analysis are:

- Strengthening capacity to deliver comprehensive HIV interventions targeting HIV-negative pregnant women and their partners and to expand and increase coverage for the HIV prevention interventions;
- Strengthening education and quality counselling for HIV-positive women and their partners on sexual reproductive health rights;
- Integrating PMTCT into all MNCH care platforms and strengthening linkages with TB, ART and other relevant programmes in all delivery facilities;
- Strengthening coordination, mentorship and supervision capacity for scaling up PMTCT;
- Enhancing community education and advocacy to improve participation and support for PMTCT and other MNCH services; and
- Strengthening family structures and systems to address HIV, teenage pregnancies and drug abuse.

2. Improving Access to modern family planning methods by HIV-positive women and their partners plus adolescents/youths

The impact of effective family planning (FP) on reducing the risk of maternal deaths from pregnancy-related complications and abortion cannot be over-emphasized. The country is embarking on multiple interrelated interventions to provide access to modern FP methods for both men and women, including HIV-positive women and their partners plus adolescent, young women. This will have a positive impact on reproductive health, education and economic outcomes. The national contraceptive prevalence of 65.2 percent and the 13 percent unmet need for FP among married or cohabiting women aged 15–49 years have significant disparities. There is high unmet need for family planning among HIV-positive women (37 percent) and pregnant women living with HIV (65.3 percent),[19] women living in rural areas, less educated and young sexually active women (CSO, 2012).[20] The high knowledge of FP methods has not created adequate demand for the long-term and permanent FP methods, such as intrauterine devices (IUDs), implants and vasectomy/sterilization to reduce unwanted pregnancies.

With the high HIV prevalence, the national FP intervention is seeking to reposition FP within HIV and MNCH services, strengthen capacity for sexual reproductive health, expand access and demand for FP methods, improve community mobilization and distribution for FP commodities, strengthen the school health programme and empower school learners on SRHR. Since 2012, the Ministry of Health Central Medical Stores (CMSs) have embarked on a harmonization drive to include reproductive health commodity supply with the MOH Logistics Management Information System to ensure that procurement and distribution of reproductive health commodities are centrally coordinated and provided optimal storage conditions, as done for other medical supplies and commodities. The Supply Chain Technical Working Group and Management

[19] Antenatal Surveillance Report, MOH 2010

[20] Market Segmentation Analysis on Family Planning, Central Statistics Office, 2012

Sciences for Health (MSH), among others things, are helping the health sector to address issues on coordination, stock management, procurement and distribution of reproductive health commodities. The National Condom Technical Working Group (TWG) chaired by the Sexual and Reproductive Health Unit (SRHU) provides technical guidance on condom programming and enhancing partners' participation in the Reproductive Health Commodity Security. With the school health programme, the Ministry of Education and Training, working with NGOs such as FLAS, are supporting students' access to FP services, according to age and need.

The outlined prioritized indicative interventions will support acceleration of the FP initiatives:

- Availability of modern FP commodities at delivery facilities at all times;
- Expanding access to modern FP commodities for women living with HIV and their partners as well as adolescent boys and girls;
- Integrating FP into ART, TB, PMTCT and MNCH services;
- Empowering communities to enhance knowledge, understanding and participation in SRH and HIV programmes;
- Improving coordination, mentorship, supervision and monitoring;
- Strengthening SRH and empowerment programmes for adolescents;
- Improving access to skilled birth attendance and quality MNCH services; and
- Strengthening the school health programme.

3. Improving Quality of Skilled Birth Attendance during labour, delivery and post-delivery

Quality skilled attendance at ANC, labour, delivery and PNC is core to reducing maternal and neonatal deaths. The notable progress in antenatal care (97 percent for one visit; 76.6 percent for four visits); health facility deliveries (80 percent); and deliveries attended by skilled health personnel (82 percent) has not reduced obstetric complications and maternal deaths. While at the same time, 20 percent of deliveries take place outside the health facilities, and 18 percent of deliveries are not attended by skilled HWs. Also 23.4 percent of pregnant women do not complete the prescribed four ANC visits. Government interventions to address the situation have included: (i) strengthening the midwifery pre-service training programme to meet the essential competencies and standards stipulated by WHO and International Confederation of Midwives. Numerous capacity building initiatives are also being rolled out, including development of additional Guidelines, Standards and Protocols for obstetric procedures so that obstetric health workers can perform quality labour, delivery and post-delivery services as well as respond effectively to basic emergency/essential obstetric procedures.[21] The World Bank (WB) is currently training doctors and midwives in antenatal, emergency obstetrics, neonatal and postnatal care and also improving access to specialized facilities.

The prioritized interventions for acceleration are:

- Strengthening capacity of doctors and midwives/nurses in regions not covered by the WB-sponsored initiatives;

[21] Assisted delivery such as vacuum, prescription labour enhancers, placenta removal, etc.

- Ensuring a stockpile of basic essential/ emergency drugs and supplies at all times in all delivery facilities;
- Strengthening use of the partogram to monitor labour; and
- Improving coordination, mentorship and supervision at all levels.

4. Access to quality skilled attendance and quality MNCH services

Access to service delivery can be a deterrent for women who seek MNCH services. Findings from the community dialogues and validation field visits confirmed that most of the road infrastructure and network is poor in some communities. For example, in Bhandeni there is no public transport and yet the walking distance to the facilities ranges from 1–5 hours, but hiring private transport ranges from E50–800.00. Other bottleneck interventions identified were as follows:

- Improving road infrastructure and transport networks in hard-to-reach rural areas;
- Improving access to safe/clean running water supply in health facilities and communities;
- Improving reliable electricity power supply to delivery health facilities especially in hard-to-reach areas;
- Improving ICT/communication network connectivity in health facilities and communities; and
- Improving security/safety in health facilities in rural areas and at community levels with records of high crimes rates.

5. Improve Early and Appropriate Health Seeking Behaviour

The community assessment found that most of the community members had socio-cultural and religious practices that hindered prompt and appropriate health seeking practices. The interventions to alleviate bottlenecks were identified as follows:

- Efforts to dispel myths and misconceptions;
- Elimination of home deliveries and use of harmful practices; and
- Empowering of women to make prompt decisions and communities to improve health seeking behaviours.

FIGURE 7: **POOR ROAD INFRASTRUCTURE TO HEALTH FACILITIES**

CHAPTER IV
BOTTLENECK ANALYSIS

The identified bottlenecks preventing the interventions in Chapter III from being implemented effectively and at scale are also highlighted in the recent health sector midterm review report. The bottlenecks relate to low coverage/accessibility to the interventions; the slow process in integrating SRH and HIV/AIDS (PMTCT/TB/ART/FP/MNCH) to provide 'one-stop shop' services; the intermittent non-availability of commodities/supplies; low capacity and capabilities of health personnel in delivering services; poor coordination; weak mentorship, supervision and monitoring as well as partnership between communities/networks and health facilities to create demand for services. Other identified bottlenecks included poor road infrastructure leading to 51 health facilities, compounded with 21 low or informal bridges and transport networks, inadequate communication services in 34 rural health facilities and at the community level and inadequate supply of safe running water in 15 health facilities and communities. Although electricity coverage in health facilities is good (90 percent), most often there are observed power outages in 20 health facilities. High levels of poverty resulting in food insecurity at the household level, social and cultural norms and beliefs and misconceptions, inadequate male involvement in SRHR, negative media influence, high level of teenage pregnancies, drug abuse, inadequate implementation of the school health programme including low coverage and lack of integration of sexuality into school curriculum to empower learners on sexuality at an early age, abortions as well as donor coordination and safety and security issues. The bottlenecks were linked to Ministries/sectors, which was then followed by an in-depth advocacy meeting with policy makers on their role in maternal mortality. The bottlenecks were identified and prioritized based on the following set of criteria (i) direct impact of the bottleneck; (ii) spillover impact; overall impact and overall near term solution for the bottleneck. The categories of bottlenecks ranged from service delivery, service utilization, policy/planning, management, budget and financing, resource mobilization, demand creation, engagement and accountability, coordination, alignment, advocacy and cross cutting issues, as shown in **Table 5**.

FIGURE 8: SUMMARY OF CHALLENGES IDENTIFIED FROM FIELD VALIDATION VISITS, CONTRIBUTING TO MATERNAL MORTALITY IN SWAZILAND

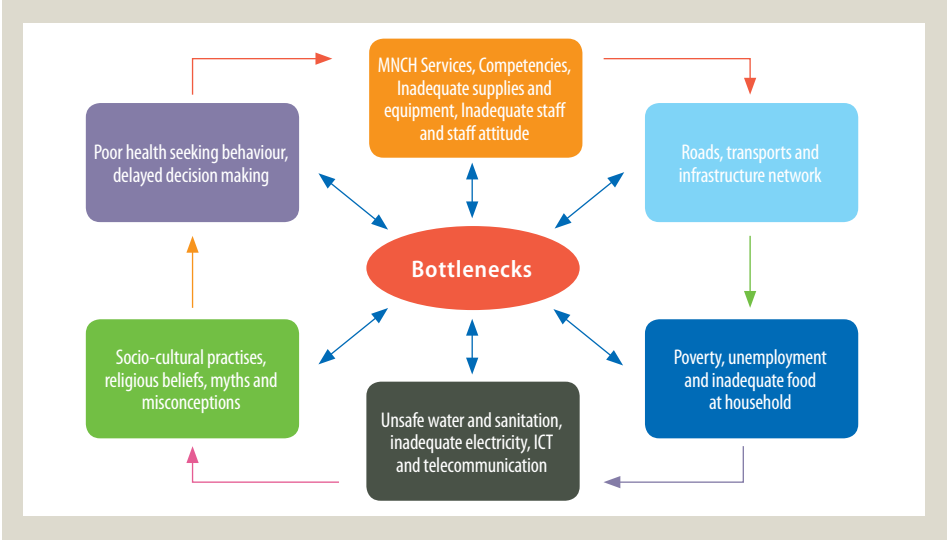


TABLE 5: IDENTIFIED MINISTRIES/SECTORS AGAINST IDENTIFIED CHALLENGES	
Identified Challenge	**Ministries and Sectors Identified**
1. Decision making about attending ANC and delivery	DPM Office-Gender Consortium and Ministry of Tinkhundla and Civil Society Organisations (CSOs)
2. Poverty, unemployment and poor crop production	Ministry of Economic Planning, Ministry of Agriculture, Ministry of Labour and Social Security
3. Teenage pregnancies and drug abuse	Ministry of Education, Ministry of Tinkhundla, FLAS, School Health Programme, civil development organisations and CSOs
4. Poor roads, bridges and public transport	Ministry of Public Works and Transport, SCATA and Road Engineering and CSOs
5. Socio-cultural and religious factors and myths and misconceptions	Ministry of Home Affairs, Ministry of Tinkhundla, Ministry of Justice, Ministry of Health, Gender Consortium, DPM's Office and CSOs
6. Erratic power supply, inadequate water and sanitation, poor communication and lack of security in health facilities	Ministry of Natural Resources, Ministry of ICT and CSOs
7. Inadequate waiting huts	MOH/MOWT, and CSOs

Cross-Cutting Bottlenecks

A. ***Capacity:*** Inadequate institutional and individual capacities exist across all interventions, slowing down integrations, e.g., HIV (PMTCT, ART/TB) and SRH (FP, MNCH) services; integration and dissemination of Guidelines; commodity stock management; and forecasting, procurement and distribution. Staff numbers are also limited at facility and community levels to deliver the integrated services.

B. ***Coordination, supervision and mentorship:*** Weak coordination, irregular supervision and mentorship of programmes at all levels (within one facility, between facilities and allied institutions) to deploy early corrective measures.

C. ***Community participation:*** Inadequate community engagement, participation and ownership of programmes was identified to be a common occurrence across the board.

D. ***Information generation and management:*** Information generation and management for effective monitoring of health commodities, supplies, etc. was a major bottleneck to all.

E. ***Lobbying and advocacy:*** Policy makers and community leaders, inadequate information clouded with misconceptions and myths and the need to instill the concept of 'Leadership for change' all contributed to bottlenecks.

CHAPTER V
ACCELERATING MDG PROGRESS: IDENTIFYING SOLUTIONS

5.1 Improving HIV management before, during and after pregnancy

- Strengthen the HIV/AIDS prevention interventions (e.g., increase number of staff/nurses, equipment/transport for the outreach/mobile programme), train staff and equip staff to improve HTC and PITC. Educate HIV-positive women on SRHR.
- Increase coverage on training for Facility Health Workers on IMAI,PMTCT, NARTIS and continuously provide supervision and mentoring to trained HWs.
- Translate revised PMTC. Guidelines into practice and develop customized communication packages, tools and standard operating procedures (SOP) on integrated services.
- Incorporate the TB Guidelines into HIV and essential Obstetric Care guidelines
- Procure PMTCT commodities and distribute to facilities.
- Mobilize retired midwives/nurses, train and support them to participate in the integrated PMTCT services (if there are no new recruits and the need is there).
- Integrate comprehensive PMTCT curriculum into pre-service training of nurses and midwives as part of the HIV curriculum.
- Advocate for persons with experience to be assigned in maternity wards for long period and promote to supervisor within the department.
- Strengthen coordination among FP stakeholders for comprehensive SRH implementation.

5.2 Improving access to modern family planning

The proposed prioritized solutions are:

- Ensure procurement and timely distribution of modern FP commodities, including condoms to all facilities.
- Scale up community-based distribution of FP commodities (including distribution of condoms by non-health distribution points).
- Scale up the integration of SRH and HIV commodities into the national medicines and pharmaceuticals supply chain management as well as training for facility pharmacists and pharmacist assistants to do proper FP stock/logistics management and forecasting to ensure supply at all times.
- Integrate FP Guidelines in the context of HIV, develop SOPs and train ART, PMTCT and other MNCH service providers for integration of FP into ART, PMTCT and MNCH (ANC, Labour/Delivery, PNC). Provide modern FP commodities to ART, PMTCT, TB sites and delivery facilities and strengthen the linkages between SRHR, HIV TWG. Develop standardized routine SRH (including FP) package after delivery and build capacity to operationalize the Manuals, Guidelines and Protocols for modern FP methods.
- Create demand for modern FP commodities especially among HIV-positive women. This will involve community mobilization targeting RHMs; adolescents, youths, women and men; PLHIV; opinion leaders; MPs; media; and couples in addition to developing an SRH promotion and marketing strategy for implementation to raise awareness about SRH, including FP.

- Provide orientation to RHMTs, TWGs and other FP stakeholders to strengthen coordination and comprehensive SRH implementation.

5.3 Improving quality of skilled birth attendance during labour, delivery and post-delivery and access to skilled birth attendance

The solutions are:

- Strengthen training, mentorship and supervision for doctors and midwives/nurses to competently address obstetric complications during labour, delivery and post-delivery. Additionally, intensify clinical orientation for newly graduated midwives/nurses and train them to properly understand the guidelines for delivery of quality maternal and newborn care services.
- Develop checklist and orient practicing midwives/nurses on use of partogram to monitor labour.
- Provide pharmacists and pharmacist assistants guidelines for procurement and distribution of essential/emergency drugs and supplies to properly manage forecasting and logistics management and also establish a dashboard for stock alerts.
- Develop supervision guidelines and orient supervisors to strengthen supportive supervision at delivery facilities.
- Develop a Life Saving Skills Manual and train community and home-based health workers in Life Saving Skills to support referrals to health facilities.

FIGURE 9: LABOUR, DELIVERY AND RESUSCITATION EQUIPMENT AND SUPPLIES

5.4 Improve access to quality skilled birth attendance and quality of MNCH services

The Prioritised Solutions are:

- Provide backup generator, solar energy and other power saving initiatives such as invertors.
- Provide Landline telephones in all identified areas, Provide official cellphone, Wireless fixed telephones and Local Area Network (LAN).
- Provide telephone coin boxes in chiefdom area and Gogo Center. Conduct Public awareness on toll free numbers.
- Drill boreholes, improve water treatment and promote water harvesting in 3 health facilities: Ndzevane, Musi, Mangweni and Siphocosini.
- Regular upgrade and maintenance of feeder gravel roads in at least 48 communities; semi-tarred road (gravelling).
- Reconstruction and upgrading of 26 low bridges to the national approved standards (Malaysian style).
- Upgrade the gravel and informal road infrastructure to attract transport operators in hard-to-reach areas.
- Provide awards for best performance in transport service delivery.
- Upgrade the gravel and informal road infrastructure to attract transport operators in hard-to-reach.

5.5 Improve early and appropriate health seeking behaviour

The Prioritised Solutions are:

- Create awareness and sensitize communities and families on SRHR (ANC and FP).
- Provide capacity building to community leaders (chiefs, opinion leaders), TBAs and FBOs on the dangers of home deliveries and non-compliance to ANC.
- Sensitize the TBAs and advocate for withdrawal of the delivery kits provided by MOH.
- Provide capacity building to community leaders (chiefs, church and opinion leaders), TBA, traditional healers, on the dangers of concoctions and unsterilized instruments.
- Provide security training and security devices for health workers in affected health facilities.
- Improve fencing in rural health facilities and provide flood lights.

CHAPTER VI
MDG ACCELERATION PLAN: BUILDING A COMPACT

Swaziland's decision to participate in the MAF CAP formulation coincides with the country's NDS review, which will take into account the current challenges and opportunities. The government has also clearly articulated its interventions to improve maternal health care in policy documents and national frameworks and plan of actions. It is also hoped that the MAF will boost the ongoing efforts of the development partners supporting the health sector and interest others as the diagnostic analysis of bottlenecks and recommended solutions will corroborate their work in the sector and unleash the full power of partnerships. The great strides in the implementation of PMTCT to keep over 59 percent of the 13,563 infants born to HIV-positive mothers free from infection is evidence of the government commitment to accelerate actions in reducing maternal, newborn and child mortality. The three prioritized interventions to address the prioritized bottlenecks are: (i) HIV management before, during and after pregnancy; (ii) family planning; and (iii) skilled birth attendance, in particular for HIV-positive clients.

Country Action Plan

This section proposes the MDG 5 Action Plan (Table 6) following the prioritized interventions, identified bottlenecks with indicative solutions and proposed implementing partners. The action plan also describes the related budgets, available resources and funding gap for resource mobilization.

Country Action Plan on MAF

■ Short term: within 3 months ■ Medium term: 6–18 months ■ Long term: >18 months ■ Short–medium/long: Ongoing

TABLE 6: COUNTRY ACTION PLAN ON MAF

Priority MDG Target	**Goal 5:** Improve Maternal Health **Target 5a:** Reduce by ¾ between 1990 and 2015 the maternal mortality ratio (92/100,000 live births) **Target 5b:** Achieve, by 2015, universal access to reproductive health			
MDG Indicators	5.1 Maternal Mortality Ratio 5.2 Proportion of births attended by Skilled Health Personnel 5.3 Contraceptive prevalence rate (%) among married women 15–49 years 5.4 Adolescent birth rate per 1000 women 5.5 Antenatal care coverage (%): at least one visit and at least four visits 5.6 Unmet need for family planning (%)			
Prioritized Interventions (Areas)	**Prioritized Bottlenecks**	**Indicative Acceleration Solution 2013–2015**	**Timeline**	**Potential Partner(s)**
A. The Prioritised Solutions are: Improving HIV management before, during and after pregnancy				
A.1 Strengthen capacity for comprehensive HIV prevention interventions for HIV-negative pregnant women and their partners (including adolescent and young women)	a.1.1 Low coverage for HIV/AIDS prevention interventions outside the MNCH platform	a.1.1.1 Strengthen the HIV/AIDS prevention interventions (e.g., increase number of staff/nurses, equipment/transport for the outreach/mobile programme), train staff and equip staff to improve HTC and PITC	Short	MOH (SNAP), NERCHA UN (UNFPA, UNICEF), PSI
A.2 Strengthen education and quality counselling for HIV-positive women on SRHR	a.2.1 Inadequate education and counselling on SRHR for HIV-positive women	a.2.1.1 Educate HIV-positive women on SRHR	Short	MOH, UN (UNFPA, UNAIDS)

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
A.3 Integrate PMTCT into all MNCH care platforms (ANC, Labour and Delivery, Postnatal) and strengthen linkages with TB, ART and other relevant services	a.3.1 Low coverage for training in Integrated Management of Adult Illnesses (IMAI), Nurse Led ART Initiation (NARTIS) and PMTCT	a.3.1.1 Increase coverage on training for Facility Health Workers on IMAI, PMTCT, NARTIS and continuously provide supervision and mentoring to trained HWs	Short to Medium	MOH (SRHU, RHMT, SNAP); UN (WHO, UNICEF), EGPAF, ICAP, Baylor
	a.3.2 Revised PMTCT Guidelines not adequately disseminated to service providers	a.3.2.1 Translate revised PMTCT Guidelines into practice and develop customized communication packages, tools and standard operating procedures (SOP) on integrated services	Short	MOH, UN (WHO), EGPAF, MSF
	a.3.3 TB Guidelines are not adequately integrated into HIV Guidelines	a.3.3.1 Incorporate the TB Guidelines into HIV and essential Obstetric Care Guidelines	Short	MOH (SRH TB Programme); WB, UN (WHO), GF, MSF
	a.3.4 Low capacity in stock management and forecasting for PMTCT commodities/Weak stock management information and distribution systems	a.3.4.1 Procure PMTCT commodities and distribute to facilities	Medium	MOH, NERCHA, GF,
		a.3.4.2 Strengthen the procurement system, management and dissemination of commodities	Medium	MOH, UN (WHO, UNICEF)
		a.3.4.3 Train pharmacists/pharmacist assistants in stock management and forecasting and provide orientation on procurement guidelines	Medium to Long	MOH, UN (WHO, UNICEF)
A.4 Strengthen capacity to deliver on integrated PMTCT services	a.4.1 Shortage of qualified staff at all facilities and high staff burn-out	a.4.1.1 Formalize task shifting/ sharing policy, train, mentor and support staff with SOP to deliver integrated package of PMTCT services	Medium to Long	MOH, UN (WHO)
		a.4.1.2 Mobilize retired midwives/ nurses, train and support them to participate in the integrated PMTCT services (if there are no new recruits and the need is there)	Medium	MOH, UN (WHO, UNICEF), EGPAF
		a.4.1.3 Integrate comprehensive PMTCT curriculum into pre-service training of nurses and midwives as part of the HIV curriculum	Short	MOH, UN (WHO, UNICEF), EGPAF
		a.4.1.4 Advocate for persons with experience to be assigned in maternity wards for long period and promote to supervisor within the department	Short	MOH (SRHU, Directorate, CNO, Hospital Matrons)
	a.4.2 Establishment Register Order is outdated, (e.g., still advocating for minimal staffing for lower level health facilities)	a.4.2.1 Review Establishment Register Order, revise placement of staff to match needs	Short to Long	MOH (Directorate, CNO); Ministry of Public Service
	a.4.3 Inadequate laboratory infrastructure and services, e.g.: • CD4 count machine only in PHUs • Inadequate transport for CD4 and TBS samples for assessment	a.4.3.1 Provision of training on laboratory management, equipment/ supplies and critical staffing at all levels of care	Short to Long	MOH (Laboratories Services Dept.)

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
A.5 Enhance community capacity to improve participation and support for PMTCT and MNCH care services	a.5.1 Lack of accurate knowledge and information on protective behaviours for HIV prevention and weak linkages/and referral mechanisms between communities and health facility-based services	a.5.1.1 Intensify advocacy on Social Behavior Change Communication (SBCC) interventions at community level	Short to Long	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI
		a.5.1.2 Sensitize HWs on effects of stigma and discrimination to health service delivery	Short to Medium	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI
		a.5.2.1 Strengthen the mobile/ outreach HTC programme to reach the communities	Short to Medium	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI, PEPFAR, NERCHA
A.6 Improve coordination, supervision and monitoring for effective implementation of the integrated PMTCT initiative	a.6.1 Inadequate coordination and supervision at all levels	a.6.1.1 Orient HWs and Coordinating Committees at all levels to improve performance management system	Short to Long	MOH, CHIMSHACC, TIMSHACC, REMSHACC, PSHACC
A.7 Improve Family Life Education	a.7.1 Destruction of family structures by HIV	a.7.1.1 Sensitization to enhance the family support systems and structures	Medium to Long	Local traditional structure; SC; WVI; Extension workers; CBOs, DPMO; MHA
		a.7.1.2 Educate families on the importance of expectant mothers and child birth	Medium to Long	
	a.7.2 Decay of social moral values	a.7.2.1 Conduct community dialogue to empower women and girls against sexual exploitation	Medium to Long	MOET, MOH; MHA; UN, MISA/ Media; CSOs-Umhlanga, Lutsango (women and girls), Lusekwane, imimemo), FBO
		a.7.2.2 Revive and preserve good cultural practices i.e., liguma Umcwasho and lutsango (puberty rights) and align with the education curriculum	Medium	MOET, MOH; MHA; UN, MISA/ Media; CSOs-Umhlanga, Lutsango (women and girls), Lusekwane, imimemo), FBO
	a.7.3 Negative influence of the media	a.7.3.1 Orientation/sensitization for the media on gender implications on adverse practices	Medium	MISA; UN; DPMO
	a.7.4 Fear of and delayed decision making in ANC enrolment and delivery	a.7.4.1 Create awareness on importance of early ANC booking, facility delivery and PNC services	Medium to Long	Local traditional structure; SC; WVI; CBO; DPMO; MHA; MOET; MOH; Media/MISA; UN; FBO- Council of Churches, Church Forums, League of Churches)
	a.7.5 Inadequate male involvement on SRH and HIV issues including voluntary counselling and testing and practicing safe sex	a.7.5.1 Create male-friendly environment in health facilities	Medium to Long	
		a.7.5.2 Capacity building to orient community leaders, opinion leaders and religious leaders to help in reducing stigma, discrimination and misconceptions related to HIV	Medium	

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
A.8 Improve road infrastructure in hard-to-reach areas to increase access to HIV outreach programmes	a.8.1 Poor road infrastructure during and after rains resulting in muddy and slippery roads in rainy season (e.g., Bhandeni, Kasiko, Bhahwini Chiefdoms)	a. 8.1.1 Regular upgrade and maintenance of feeder gravel roads; semi-tarred road (gravelling)	Medium	MOWT; Community WB; MEPD; Ministry of Tinkhundla
	a.8.2 Low and informally constructed bridges (e.g., Tholulwazi, Maphalaleni, Bhandeni, Bhahwini Chiefdoms)	a.8.2.1 Reconstruction and upgrading of bridges to the national approved standards (Malaysian style)	Medium to Long Term	MOWT; Community WB; MEPD; Ministry of Tinkhundla
	a.8.3 Inadequate community involvement in road infrastructure projects	a.8.3.1 Train communities and involve them in construction of roads and other infrastructure	Medium to Long Term	MOWT; Community WB; MEPD; Ministry of Tinkhundla
B. The Prioritised Solutions are: Improving access to modern family planning by HIV-positive women and adolescent/youth				
B.1 Ensure availability of modern FP commodities at health facilities at all times	b.1.1 Inadequate modern FP commodity supply and distribution to facilities	b.1.1.1 Procure and distribute modern FP commodities including condoms to all facilities in a timely manner	Short to Long	MOH (SRHU, CMS), NERCHA (GF), UNFPA, AIDS Health Care Foundations, population Services International (PSI), FLAS
B.2 Expand access to modern FP methods for women living with HIV, adolescents, young women and all women of reproductive age	b.2.1 Limited-community-based contraceptive distribution system	b.2.1.1 Scale up community-based distribution of FP commodities (including distribution of condoms by non-health distribution points)	Short to Long	MOH, (SRHU), CMS, NERCHA, UN (UNFPA, WHO)
	b.2.2 Inadequate skills and knowledge on SRHRs by health workers and adolescent as well as women of reproductive age respectively	b.2.2.1 Develop standardized routine SRH, (including FP) package after delivery and train HWs and adolescent/young women on SRH for modern FP methods	Short to Medium	MOH (Chief Nursing Office, SRHU facility supervisors, SRH-mentors, senior nurses); UN (UNFPA, WHO), FLAS; EGPAF
		B.2.2.2 Develop strategies geared towards the adolescents, e.g., Prong 1	Short to Medium	
	b.2.3 Low capacity in stock management and forecasting/Weak stock management information and distribution systems/Low capacity in stock management	b.2.3.1 Scale up the integration of SRH and HIV commodities (including condoms and other commodities for long-term methods) into the national medicines and pharmaceuticals supply chain management	Medium to Long	MOH (SRHU, Central Medical Stores), MSH, UNFPA
		b.2.3.2 Train facility pharmacists and pharmacist assistants on FP stock/ logistics management and forecasting to ensure supply at all times	Medium to Long	MOH (SRHU), CMS, UN (WHO)
B.3 Integrate FP into ART, TB, PMTCT and MNCH services	b.3.1 Slow integration of FP into ART, PMTCT, TB and other MNCH services (coverage)	b.3.1.1 Review FP Guidelines in the context of HIV, develop SOP and Train ART, PMTCT and other MNCH service providers for the integration of FP into ART, PMTCT, and MNCH (ANC, Labour/ Delivery, PNC)	Short to Long	MOH (SRHU, Swaziland Nation AIDS Programme –SNAP; Central medical Stores-CMS, Health Education Unit); UNFPA; FLAS; EGPAF
		b.3.1.2 Provide modern FP commodities to ART, PMTCT, TB sites and delivery facilities	Short to Long	MOH (SRHU, CMS, SNAP); UNFPA
		b.3.1.3 Strengthen the linkages of SRHR and HIV TWG	Short to Long	MOH (SRHU), EU/WB

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
B.4 Enhance Community knowledge, public awareness and understanding of SRH and HIV	b.4.1 Limited knowledge on SRH rights among communities	b.4.1.1 Mobilize Communities on FP targeting RHMs, adolescents, youth, women and men, PLHIV, opinion leaders, MPs, media and couples to create demand (including demand for long-term) FP commodities	Short to Medium	MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA
		b.4.1.2 Include SRH into PLHIV and TB treatment literacy manuals and the correct messaging for service delivery	Medium	International Centre for AIDS prevention-ICAP; MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; EGPAF
		b.4.1.3 Develop and implement SRH promotion and marketing strategy	Short	MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; CHAI
	b.4.2 Low male involvement due to misconceptions and attitude towards SRH	b.4.2.1 Develop and implement male-friendly strategies and messages to raise SRH awareness including FP	Short to Medium	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL
B.5 Improve coordination, supervision and monitoring to ensure effective implementation	b.5.1 poor coordination, supervision and monitoring	b.5.1.1 Strengthen coordination among FP stakeholders for comprehensive SRH implementation	Short	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL
		b.5.1.2 Orient HWs and RHMTs at all levels to strengthen coordination and performance management system	Short to Long	MOH and EGPAF
B.6 Strengthen provision of sexual and reproductive health and empowerment programs for adolescents	b.6.1 High level of teenage pregnancies and drug abuse among school going children	b.6.1.1 Train career guidance teachers on comprehensive sexuality education (CSE)	Medium	MOH, FLAS, UN, MOET Supper Buddies, SNYC
		b.6.1.2 Train health workers on counselling and youth friendliness to accelerate service provision and uptake	Medium	MOH, FLAS, UN, MOET Supper Buddies, SNYC
	b.6.2 Limited integration of sexuality education in school curriculum	b.6.2.1 Develop SRH/CSE materials to be used by teachers and peer educators	Long Term	MOH, FLAS, UN MOET, Ministry of Youth, SNYC CANGO (Supper Buddies, Lusweti)
		b.6.2.2 Scale up youth-friendly counselling and health service delivery	Long Term	
	b.6.3 Lack of country specific guidelines for CSE.	b.6.3.1 Develop country specific guidelines and orientation for all sectors on the guidelines	Short to Long	MOH, FLAS, MOET, Ministry of Youth; SNYC; CANGO; Supper Buddies; Lusweti; Parents
		b.6.3.2 Advocate/lobby for SRH amongst parents and community leaders and policy makers	Medium to Long	

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
B.7 Strengthen school health programs	b.7.1 Low coverage of the school health programme adversely affecting the issues of sexuality and teenage/adolescent pregnancies	b.7.1.1 Clear guidelines on the operations and structure of the school health programme	Medium to Long	MOH, FLAS, UN; MOET, Ministry of Youth; SNYC; CANGO (Supper Buddies, Lusweti)
		b.7.1.2 Build capacity of teachers to promote effective school health	Short to Medium	
	b.7.2 High levels of school dropout due to pregnancy resulting to unsafe abortion	b.7.2.1 Increase access to Comprehensive SRH programme.	Short to Medium	MOH, FLAS, MOET, UN
		b.7.2 Develop strategies geared towards adolescents, e.g., Prong 1		
C. The Prioritised Solutions are: Improving Quality of Skilled Birth Attendance during labour, delivery and post-delivery				
C.1 Strengthen capacity of health workers (doctors and midwives/ nurses) to deliver quality safe motherhood interventions	c.1.1 Inadequate experiences and capabilities of health workers to provide quality care during ANC, labour/delivery and PNC	c.1.1.1 Strengthen training, mentorship and supervision for doctors and midwives/nurses to competently address obstetric complications during labour, delivery and post-delivery	Short to Medium	MOH (SRHU), EGPAF
		c.1.1.2 Intensify clinical orientation for newly graduated midwives/ nurses and train them to properly understand the guidelines for delivery of quality maternal and newborn care services	Short to Long	MOH and UN Partners
C.2 Strengthen the use of partogram to monitor labour	c.2.1 Inadequate compliance to the use of the partogram to monitor the stages of labour	c.2.1.1 Develop checklist and orient practicing midwives/nurses on use of programme to monitor labour	Short	MOH and UN Partners
C.3 Ensure constant stock of all basic essential/emergency drugs and supplies at all delivery facilities	c.3.1 Poor forecasting and weak information management system	c.3.1.1 Provide pharmacists/ pharmacist assistants orientation for procurement and distribution guidelines to manage effective forecasting and logistics management and establish a dashboard for stock alerts	Short	MOH and Partners
C.4 Strengthen community mobilization and education to improve health seeking behaviour	c.4.1 Inadequate Life Saving Skills at community level to recognize early risks signs	c.4.1.1 Develop Life Saving Skills Manual and train community and home-based health workers on life saving skills to support referrals to health facilities	Short	MOH and UN Partners
C.5 Improve supervision	c.5.1 Inadequate supervision and monitoring	c.5.1.1 Provide supervision guidelines and orient supervisors to strengthen supportive supervision at delivery facilities	Short	MOH and UN Partners

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
D. The Prioritised Solutions are: Improve access to quality skilled birth attendance and quality of MNCH services				
D.1 Improve road infrastructure in hard-to-reach areas	d.1.1. Poor road infrastructure during and after rains resulting in muddy and slippery roads for rainy season in 48 communities (e.g., Bhandeni, Kasiko, Bhahwini Chiefdoms)	d.1.1.1 Regular upgrade and maintenance of feeder gravel roads in at least 48 communities; semi-tarred road (gravelling)	Medium	MOWT; Community WB; MEPD; Ministry of Tinkhundla
	d.1.2 Low and informally constructed bridges (e.g., Tholulwazi, Maphalaleni ,Bhandeni, Bhahwini Chiefdoms)	d.1.2.1 Reconstruction and upgrading of 26 low bridges to the national approved standards (Malaysian style)	Medium	MOWT; Community WB; MEPD; Ministry of Tinkhundla
	d.1.3 Inadequate community involvement in infrastructure projects	d.1.3.1 Train communities and involve them in construction of roads and other infrastructure	Medium to Long Term	MOWT; Community WB; MEPD; Ministry of Tinkhundla
D.2 Improve transport network especially in hard-to-reach areas	d.2.1 Absence/inadequate public transport network (e.g., Bhandeni, Kasiko, Bhahwini, Mkhiweni, Lufafa, Mhlabeni, Tholulwazi and Kholwane-2 Chiefdoms)	d.2.1.1 Enforce the Road Traffic & Transportation Act	Medium to Long Term	RTB; MOWT; SCATA; MEPD; Ministry of Tinkhundla; Community; WB
		d.2.1.2 Amend the Road Traffic & Transportation Act to: a) issue new permits for areas without transport; b) conduct regular inspection of public transport especially in rural areas to ensure they are roadworthy at all times c) advocate withdrawal of permits from drivers who do not want to ply the road	Long Term	RTB; MOWT; SCATA; MEPD; Ministry of Tinkhundla; Community; WB
	d.2.2 Irregular transport delivery services in hard-to-reach areas (e.g., Bhandeni, Kasiko, Bhahwini, Mkhiweni, Lufafa, Mhlabeni, Tholulwazi and Kholwane-2 Chiefdoms)	d.2.2.1 Upgrade the gravel and informal road infrastructure to attract transport operators in hard-to-reach areas	Medium	Community; WB; MEPD; Ministry of Tinkhundla
		d.2.2.2 Provide awards for best performance in transport service delivery	Medium	Community MOWT; Ministry of Tinkhundla; RTB; SCATA
D.3 Improve availability of safe running water in health facilities and communities	d.3.1 Inadequate availability of safe running water in health facilities - 14 namely (Mpolonjeni, U-TECH, Ndzevene, Tsambokhulu, Nkaba, Heefords, Ngowane, Siphocosini, Ntfonjeni, JCI, Moti, Nhletsheni and Musi clinics) Mangweni	D.3.1.1 Drill boreholes, improve water treatment and promote water harvesting in 3 health facilities: Ndzevane, Musi, Mangweni and Siphocosini	Short Term	ME&NR; SWSC; RWS; SWADE; MOH; MEPD; CSO; Community
	d.3.2 Inadequate access to safe water for hard-to-reach communities	d.3.2.1 Drill boreholes and train communities for effective management	Long Term	MERE; SWSC; RWS; SWADE; MOH; MEPD CSO; Community, MOWT
		d.3.2.2 Train communities and equip them with safe water harvesting techniques	Long Term	

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
D.4 Improve the consistency and availability of electricity power supply in health facilities	d.4.1 Frequent electricity power cuts in 20 health facilities (e.g., Ekuphileni, Ndzingeni, MaIndzela, Mshingishingini, Ntfonjeni, Nkaba, Hhukwini, Sigangeni,Motshane, Horo, Herefords, Nyonyane, Musi, Dwalile, Mangcongco, Mpuluzi, Hlane, Kamfishane, Bhahwini and New Heaven)	d.4.1.1 Provide: • Backup generator • Solar energy • Other power generating initiatives such as invertors	Medium to Long Term	ME&NR; SERA SEC; MOH Mommond
D.5 Improve communication network in health facilities and communities	d.5.1. Health facilities without telephone lines (e.g., Ekuphileni, Ndzingeni, Hhukwini, Ngowane, Mangweni, Bulandzeni, Nyonyane, Malandzela, Bhalekane, Ndvabangeni, Musi, Mpuluzi, Luve, Sigcineni, Zondwako, Bhahwini, Dwalile, Mangcongco, Mbikwakhe, Maloyi, Hlane, New Thulwane, Tsambokhulu, Lubuli, Konjwa, Khubuka, U-TECH, Khwezi, Shewula, Sigcaweni, Bhenezar, Moti, Mashobeni and Phunga)	d.5.1.1 Provide • Landline telephones in all identified areas • Provide official cellphone • Wireless fixed telephones • Local Area Network (LAN)	Short to Medium Term	SPTC; MTN; MOH; MNRE
	d.5.2 Absence of telephone services at community level to call an ambulance when pregnant woman is due	d.5.2.1 Provide telephone coin boxes in chiefdom area and Gogo Center	Short to Medium Term	SPTC; MTN, MOH, MNRE
	d.5.3 Most of the communities in hard-to-reach areas do not have access to telephone services and are unaware of the use of toll free numbers to call an ambulance (e.g., Kasiko, Kholwane, Tholulwazi, Bhahwini, Mhlabeni, Bhandeni and Lufafa)	d.5.3.1 Conduct Public awareness on toll free numbers	Short Term	SPTC; MTN, MOH, MNRE
	d.5.4 High mobile telephone network tariffs	d.5.4.1 Lobby for subsidized rates for very poor communities	Long Term	SPTC; MTN, MOH, MNRE
		d.5.4.2 Regulate telephone and mobile phone tariffs	Long Term	
		d.5.4.3 Advocate and lobby Government for other cellphone service providers to join the market	Long Term	
E. The Prioritised Solutions are: Improve early and appropriate health seeking behavior				
E.1 Dispel harmful practices, beliefs, myths and misconception on SRHR	e.1.1 Beliefs, myths and misconceptions on SRHR (ANC and FP service delivery)	e.1.1.1 Create awareness and sensitize communities and families on SRHR (ANC and FP)	Medium to Long Term	Communities, Ministry of Home Affairs, League of Churches, Council of Churches and Church forums, MOH, UN, WVI, Save the Children, PEPFAR
E.2 Eliminate home deliveries by unskilled persons	e.2.1 18% of Pregnant mothers deliver at home assisted by unskilled persons (TBAs, relatives, friends, others)	e.2.1.1 Provide capacity building to community leaders (chiefs, opinion leaders), TBAs and FBOs on the dangers of home deliveries and non-compliance to ANC	Medium to Long Term	
		e.2.1.2 Sensitize the TBAs and advocate for withdrawal of the delivery kits provided by MOH	Medium to Long Term	

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
E.3 Total cessation of harmful practices	e.3.1 Use of traditional concoctions to accelerate labour and unsterilized instruments for conducting delivery in communities	e.3.1.1 Provide capacity building to community leaders (chiefs, church and opinion leaders), TBA, traditional healers, on the dangers of concoctions and unsterilized instruments	Short to Long Term	Communities, MHA, League of Churches, Council of Churches and Church forums, MOH & THOs, UN, WVI, Save the Children PEPFAR
E.4 Improve security at community and health facility levels	e.4.1 Increasing levels of crimes and burglary in some rural health facilities	e.4.1.1 Improve fencing in rural health facilities and provide flood lights	Long Term	PMO, Royal Swaziland Police, Communities, Business Community, MOH
		e.4.1.2 Provide security training and security devices for health workers in affected health facilities	Medium to Long Term	
	e.4.2 Absence of Police Posts in rural communities	e.4.2.1 Strengthen community police and equip them with essential tools and supplies	Long Term	PMO, Royal Swaziland Police, Communities, Business Community
		e.4.2.2 Deploy security police to affected communities	Long Term	
		e.4.2.3 Provide flood lights in high crime zones in communities	Long Term	MOH MOWT Royal Swazi Police
F. The Prioritised Solutions are: Reduce food insecurity and improve nutrition at household level				
	f.1.1 Low productivity and production at household level of agricultural commodities	f.1.1.1 Increase adoption of good agricultural practices to improve productivity. Intervention to target 500 households per region	Long Term	MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD
		f.1.1.2 Increase adoption of good animal husbandry practices for indigenous poultry, goats and pigs. Target 250 commercial indigenous poultry farmers per region	Medium Term	
	f 1.2. Shortage of water for irrigation	f.1.2.1 Promote backyard gardens in each homestead that does not have one Target establishment of 250 backyard gardens per region	Medium Term	MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD
		f.1.2.2 Promote small-scale water harvesting technologies for 250 households per Region.	Long Term	
		f.1.2.3 Promote use of drought tolerant crops/Target diversification into cassava, sorghum and cowpeas by 500 households per region	Long Term	
	f.2.1 Poor dietary diversity at household level	f.2.1.1 Sensitize pregnant women to consume iron-rich food to reduce the prevalence of anemia by 10%	Short Term	MOA; MOF, UN, WVI, NERCHA, SWADE, SNNC, Development Partners, FBOs, ACAT, IRD
	f.2.2 Balanced diet issues/High consumption of maize crops	f.2.2.1 Promote the consumption of locally available balanced diet through community meetings	Short Term	

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Timeline	Potential Partner(s)
	f.2.3. Poor food storage and security at household level	f.2.3.1 Train 1000 households in food preservation and storage	Short Term	MOA, Financial Institutions, CSOs, MOT, SNNC, MOH, UNICEF, IRD, ACAT
		f.2.3.2 Support the promotion of exclusive breast feeding/Training of 510 RHMS workers (17 Health facilities)	Short to Medium Term	MOA, SNNC, CSOs, MOT, SNNC, MOH, UNICEF
	f.2.4. High levels of unemployment in hard-to-reach rural communities	f.2.4.1 Train communities on SME entrepreneurship skills and link them to financial institutions	Short to Medium Term	MCIT, MOA, NERCHA, FBOs, Financial Institutions, MOT, SNNC, CSOs, WVI, UN
G. The Prioritised Solutions are: Monitor and Evaluate				
	g.1. Monitor progress towards the set targets and goals	g.1.1 Identify benchmarks where they do not exist/strengthen M&E in sectors who do not have M&E officers	Short term	MEPD, MOH, MOHA, MOT, MOWT, MOA
		g.1.2 Conduct programme reviews annually		

TABLE 7: COSTING OF THE COUNTRY ACTION PLAN

Priority MDG Target	**Goal 5:** Improve Maternal Health **Target 5a:** Reduce by ¾ between 1990 and 2015 the maternal mortality ratio (92/100,000 live births) **Target 5b:** Achieve, by 2015, universal access to reproductive health
MDG Indicators	5.1 Maternal Mortality Ratio 5.2 Proportion of births attended by Skilled Health Personnel 5.3 Contraceptive prevalence rate (%) among married women 15–49 years 5.4 Adolescent birth rate per 1000 women 5.5 Antenatal care coverage (%): at least one visit and at least four visits 5.6 Unmet need for family planning (%)

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
A. Improving HIV management before, during and after pregnancy				
A.1 Strengthen capacity for comprehensive HIV prevention interventions for HIV-negative pregnant women and their partners (including adolescent and young women)	a.1.1 Low coverage for HIV/AIDS prevention interventions outside the MNCH platform	a.1.1.1 Strengthen the HIV/AIDS prevention interventions (e.g., increase number of staff/nurses, equipment/transport for the outreach/mobile programme), train staff and equip staff to improve HTC and PITC	MOH (SNAP), NERCHA UN (UNFPA, UNICEF), PSI	6,000–00
A.2 Strengthen education and quality counselling for HIV-positive women on SRHR	a.2.1 Inadequate education and counselling on SRHR for HIV-positive women	a.2.1.1 Educate HIV-positive women on SRHR	MOH, UN (UNFPA, UNAIDS)	10,000

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
A.3 Integrate PMTCT into all MNCH care platforms (ANC, Labour and Delivery, Postnatal) and strengthen linkages with TB, ART and other relevant services	a.3.1 Low coverage for training in IMAI, NARTIS and PMTCT	a.3.1.1 Increase training for IMAI, PMTCT, NARTIS and continuously provide supervision and mentoring to trained HWs	MOH (SRHU, RHMT, SNAP); UN (WHO, UNICEF), EGPAF, ICAP, Baylor	10,000
	a.3.2 Revised PMTCT Guidelines not adequately disseminated to service providers	a.3.2.1 Translate revised PMTCT Guidelines into practice and develop customized communication packages, tools and standard operating procedures (SOP) on integrated services	MOH, UN (WHO), EGPAF, MSF	5,000
	a.3.3 TB Guidelines are not adequately integrated into HIV and Obstetrics Guidelines	a.3.3.1 Incorporate the TB Guidelines into HIV and essential Obstetric Care Guidelines	MOH (SRH TB Programme); WB, UN (WHO), GF, MSF	3,000
	a.3.4 Low capacity in stock management and forecasting for PMTCT commodities/Weak stock management information and distribution systems	a.3.4.1 Procure PMTCT Commodities and distribute to facilities	MOH, NERCHA, GF,	5,000
		a.3.4.2 Strengthen the procurement system, management and dissemination of commodities	MOH, UN (WHO, UNICEF)	3,500
		a.3.4.3 Train pharmacists/pharmacist assistants in stock management and forecasting and provide orientation on procurement guidelines	MOH, UN (WHO, UNICEF)	3,000
A.4 Strengthen capacity to deliver on integrated PMTCT services	a..4.1 Shortage of qualified staff at all facilities and high staff burn-out	a.4.1.1 Formalize task shifting/sharing policy; train, mentor and support staff with SOP to deliver integrated package of PMTCT services	MOH, UN (WHO)	Salary
		a.4.1.2 Mobilize retired midwives/ nurses; train and support them to participate in the integrated PMTCT services	MOH, UN (WHO, UNICEF), EGPAF	Salary
		a.4.1.3 Integrate comprehensive PMTCT curriculum into pre-service training of nurses and midwives as part of the HIV curriculum	MOH, UN (WHO, UNICEF), EGPAF	8,000
		a.4.1.4 Advocate for persons with experience to be assigned in maternity wards for long period and promote to supervisor within the Department	MOH (SRHU, Directorate, CNO, Hospital Matrons)	none
	a.4.2 Establishment Register Order is outdated	a.4.2.1 Review Establishment Register Order revise placement of staff to match needs	MOH (Directorate, CNO); Ministry of Public Service	none
	a.4.3 Inadequate laboratory infrastructure and services, e.g.: • CD4 count machine only in PHUs • Inadequate transport for CD4 and TBS samples for assessment	a.4.3.1 Provision of training on laboratory management, equipment/ supplies and critical staffing at all levels of care	MOH (Laboratories Services Dept.)	3,500

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
A.5 Enhance community capacity to improve participation and support for PMTCT and MNCH care services	a.5.1 Lack of accurate knowledge and information on protective behaviours for HIV prevention and weak linkages/and referral mechanisms between communities and health facility-based services	a.5.1.1 Intensify advocacy on Social Behaviour Change Communication (SBCC) interventions at community level	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI	6,000
		a.5.1.2 Sensitize HWs on effects of stigma and discrimination to health service delivery	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI	5,000
		a.5.1.3 Strengthen the mobile/out-reach HTC programme to reach the communities	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI, PEPFAR, NERCHA	Transport and Salary
A.6 Improve coordination, supervision and monitoring for effective implementation of the integrated PMTCT initiative	a.6.1 Inadequate coordination and supervision of programmes at all levels	a.6.1.1 Orient HWs and Coordinating Committees at all levels to improve performance management system	MOH, CHIMSHACC, TIMSHACC, REMSHACC, PSHACC	5,500
A.7 Improve Family Life Educationn				2,019,329
B. Improving access to modern family planning by HIV-positive women and adolescent/youth				
B.1 Ensure availability of modern FP commodities at health facilities at all times	b.1.1 Inadequate modern FP commodity supply and distribution to facilities	b.1.1.1 Procure and distribute modern FP commodities including condoms to all facilities in a timely manner	MOH (SRHU, CMS), NERCHA (GF), UNFPA, AIDS Health Care Foundations, population Services International (PSI), FLAS	5,000–00
B.2 Expand access to modern FP methods for women living with HIV, adolescents, young women and all women of reproductive age	b.2.1 Limited community-based contraceptive distribution system	b.2.1.1 Scale up community-based distribution of FP commodities (including distribution of condoms by non-health distribution points)	MOH, (SRHU), CMS, NERCHA, UN (UNFPA, WHO)	5,000
	b.2.2 Inadequate skills and knowledge on SRHRs by health workers and adolescents as well as women of reproductive age, respectively	b.2.2.1 Develop standardized routine SRH, (including FP) package after delivery and train HWs and adolescent/young women on SRH for modern FP methods	MOH (Chief Nursing Office, SRHU facility supervisors, SRH-mentors, senior nurses); UN (UNFPA, WHO), FLAS; EGPAF	15,000–00
	b.2.3 Low capacity in stock management and forecasting/Weak stock management information and distribution systems/Low capacity in stock management	b.2.3.1 Scale up the integration of SRH and HIV commodities (including condoms and other commodities for long-term methods) into the national medicines and pharmaceuticals supply chain management	MOH (SRHU, Central Medical Stores), MSH, UNFPA	3,000–00
		b.2.3.2 Train facility pharmacists and pharmacist assistants on FP stock/ logistics management and forecasting to ensure supply at all times	MOH (SRHU), CMS, UN (WHO)	5,000–00

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
B.3 Integrate FP into ART, TB, PMTCT and MNCH services	b.3.1 Slow integration of FP into ART, PMTCT, TB and other MNCH services (coverage)	b.3.1.1 Review FP Guidelines in the context of HIV, develop SOP/Train ART, PMTCT and other MNCH service providers for the integration of FP into ART, PMTCT, and MNCH (ANC, Labour/ Delivery, PNC)	MOH (SRHU, SNAP; Central medical Stores, Health Education Unit); UNFPA; FLAS; EGPAF	7,200–00
		b.3.1.2 Provide modern FP commodities to ART, PMTCT, TB sites and delivery facilities	MOH (SRHU, CMS, SNAP); UNFPA;	nil
		b.3.1.3 Strengthen the linkages of SRHR and HIV TWG	MOH (SRHU), EU/WB	
B.4 Enhance Community knowledge, public awareness and understanding of SRH and HIV	b.4.1 Limited knowledge on SRH rights among communities	b.4.1.1 Mobilize Communities on FP targeting RHMs, adolescents, youth, women and men, PLHIV, opinion leaders, MPs, media and couples to create demand (including demand for long-term) FP commodities	MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA	10,000–00
		b.4.1.2 Include SRH into PLHIV and TB treatment literacy manuals and the correct messaging for service delivery	International Centre for AIDS prevention-ICAP; MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; EGPAF	5,000–00
		b.4.1.3 Develop and implement SRH promotion and marketing strategy	MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; CHAI	5,500.00
	b.4.2 Low male involvement due to misconceptions and attitude towards SRH	b.4.2.1 Develop and implement male-friendly strategies and messages to raise SRH awareness including FP	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL	3,500–00
B.5 Improve coordination, supervision and monitoring to ensure effective implementation	b.5.1 poor coordination, supervision and monitoring	b.5.1.1 Strengthen coordination among FP stakeholders for comprehensive SRH implementation	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL	2,500–00
		b.5.1.2 Orient HWs and RHMTs at all levels to strengthen coordination and performance management system	MOH and EGPAF	2,000–00
B.6 Strengthen provision of sexual and reproductive health and empowerment programs for adolescents	b.6.1 High level of teenage pregnancies and drug abuse among school going children	b.6.1.1 Train career guidance and counselling teachers on comprehensive sexuality education (CSE)	MOH, FLAS, UN, MOET Supper Buddies, SNYC	12,600
		b.6.1.2 Train health workers on counselling and youth friendliness to accelerate service provision and uptake	MOH, FLAS, UN, MOET Supper Buddies, SNYC	26,500
		b.6.1.3 Strengthen mental health education in school (ECCD) up to high school.		
	b.6.2 Limited integration of sexuality education in school curriculum	b.6.2.1 Develop SRH/CSE materials to be used by teachers and peer educators	MOH, FLAS, UN MOET, Ministry of Youth, SNYC CANGO (Supper Buddies, Lusweti)	2,790
		b.6.2.2 Scale up youth-friendly counselling and health service delivery		nil

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
B.7 Strengthen health promotion in schools	b.7.1 Lack of country specific guidelines for CSE.	b.7.1.1 Develop country specific guidelines and orientation of all sectors on the guidelines	MOH, FLAS, UNFPA MOET, Ministry of Youth, SNYC CANGO (Supper Buddies, Lusweti), Parents	3,100
		b.7.1.2 Advocate/lobby for SRH amongst parents and community leaders and policy makers		
	b.7.2 Low coverage of the school health programme adversely affecting the issues of sexuality and teenage/ adolescent pregnancies	b.7.2.1 Finalize working documents for school health	MOH, FLAS, UNFPA MOET, Ministry of Youth, SNYC CANGO (Supper Buddies, Lusweti)	2,000
		b.7.2.2 Promote a multidisciplinary and multisectoral school health services to promote effective school health		
	b.7.3 High levels of school dropouts due to unsafe abortion	b.7.3.1 Comprehensive SRH programme in place	MOH, FLAS, MOET, UN	0
C. Improving quality of skilled birth attendance during labour, delivery and post-delivery				
C.1 Strengthen capacity of health workers (doctors and midwives/ nurses) to deliver quality safe motherhood interventions	c.1.1 Inadequate experiences and capabilities of health workers to provide quality care during ANC, labour/delivery and PNC	c.1.1.1 Strengthen training, mentorship and supervision for doctors and midwives/nurses to competently address obstetric complications during labour, delivery and post-delivery	MOH (SRHU); EGPAF	5,000–00
		c.1.1.2 Intensify clinical orientation for newly graduated midwives/ nurses and train them to properly understand the guidelines for delivery of quality maternal and newborn care services	MOH	5,000
C.2 Strengthen the use of partogram to monitor labour	c.2.1 Inadequate compliance to the use of the partogram to monitor the stages of labour	c.2.1.1 Develop checklist and orient practicing midwives/nurses on use of partogram to monitor labour	MOH	3,000–00
C.3 Ensure constant stock of all basic essential/emergency drugs and supplies at all delivery facilities	c.3.1 Poor forecasting and weak information management system	c.3.1.1 Provide pharmacists/ pharmacist assistants orientation for procurement and distribution guidelines to manage effective forecasting and logistics management and establish a dashboard for stock alerts	MOH	3,500–00
C.4 Strengthen community mobilization and education to improve health seeking behaviour	c.4.1 Inadequate Life Saving Skills at community level to recognize early risks signs	c.4.1.1 Develop Life Saving Skills Manual/Train community and home-based health workers on life saving skills to support referrals to health facilities	MOH	6,000–00
C.5 Improve supervision	c.5.1 Inadequate supervision and monitoring	c.5.1.1 Provide supervision guidelines and orient supervisors to strengthen supportive supervision at delivery facilities	MOH	3,500–00

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
D. Improve access to quality skilled birth attendance and quality of MNCH services				
D.1 Improve road infrastructure in hard-to-reach areas	d.1.1 Poor road infrastructure during and after rains resulting in muddy and slippery roads for rainy season (e.g., Bhandeni, Kasiko, Bhahwini Chiefdoms)	d.1.1.1 Regular upgrade and maintenance of feeder gravel roads; semi-tarred road (Malaysian style)	MOWT; WB; MEPD; Community; MOT	50,000
D.2 Improve transport network especially in hard-to-reach areas	d.2.1 Low and informally constructed bridges (e.g., Tholulwazi, Maphala-leni, Bhandeni, Bhahwini Chiefdoms)	d.2.1.1 Enforce the Road Traffic & Transportation Act	MOWT; WB; MEPD; Community; MOT	30,058
	d.2.2 Inadequate community involvement in infrastructure projects	d.2.2.1 Train communities and involve them in construction of roads and other infrastructure	MOWT; WB; MEPD; Community; MOT	5,000
	d.2.3 Absence/inadequate public transport network (e.g., Bhandeni, Kasiko, Bhahwini, Mkhiweni, Lufafa, Mhlabeni, Tholulwazi and Kholwane-2 Chiefdoms)	d.2.3.1 Enforce the Road Traffic & Transportation Act	MOWT (SCATA &RTB); WB; MEPD; Community; MOT	8,000
		d.2.3.2 Amend the Road Traffic Transportation Act		30,000
		d.2.3.3 Upgrade the gravel and informal road infrastructure to attract transport operators in hard-to-reach areas	MOWT (SCATA & RTB); WB; MEPD; Community; MOT/MOJ	25,000
		d.2.3.4 Provide awards for best performance in transport service delivery	Community; WB; MEPD	5,000
		d.2.3.5 Issue new permits for areas without transport	Community; WB; MEPD	nil
		d.2.3.6 Conduct regular inspection of public transport especially in rural areas to ensure they are roadworthy at all times	Community; WB; MEPD	nil
		d.2.3.7 Advocate withdrawal of permits from drivers who do not want to ply the road	MOWT; WB; MEPD; Community; MOT	nil
D.3. Improve availability of running water in health facilities and safe water in communities	d.3.1 Inadequate availability of safe running water in health facilities - 14 namely (Mpolonjeni, U-TECH, Ndzevene, Tsambokhulu, Nkaba, Heefords, Ngowane, Siphocosini, Ntfonjeni, Mangweni, JCI, Moti, Nhletsheni and Musi clinics)	D.3.1.1 Drill boreholes, improve water treatment and promote water	Community; MOWT; Tinkhundla; RTB; SCATA	81,000
	d.3.2. Inadequate access to safe water for the hard-to-reach communities	c.3.2.1 Drill boreholes and train communities for effective management	ME&NR; SWSC; RWS; SWADE; MOH; MEPD CSO; Community	81,000
		c.3.2.2 Train communities and equip them with safe water harvesting techniques		

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
D.4 Improve the consistency and availability of electricity power supply in health facilities	d.4.1 Frequent electricity power cuts in 20 health facilities (e.g., Ekuphileni, Ndzingeni, MaIndzela, Mshingishingini, Ntfonjeni, Nkaba, Hhukwini, Sigangeni,Motshane, Horo, Herefords, Nyonyane, Musi, Dwalile, Mangcongco, Mpuluzi, Hlane, KamfishaneBhahwini and New	d.4.1.1 Provide: • Backup generator • Solar energy • Other power saving initiatives such as invertors	ME&NR; SERA SEC; MOH Mommond; Private Energy Generators; MOH	323,760 (16,188x20)
	d.4.2 Health facilities without telephone lines (e.g., (Ekuphileni, Ndzingeni, Hhukwini,Ngowane, Mangweni, Bulandzeni, Nyonyane, Malandzela, Bhalekane, Ndvabangeni, Musi, Mpuluzi, Luve, Sigcineni, Zondwako, Bhahwini, Dwalile, Mangcongco, Mbikwakhe, Maloyi, Hlane, New Thulwane, Tsambokhulu, Lubuli, Konjwa, Khubuka, U-TECH, Khwezi, Shewula, Sigcaweni, Bhenezar, Moti, Mashobeni and Phunga)	d.5.1.1 Provide • Landline telephones in all identified areas • Provide official cellphone • Wireless fixed telephones • Local Area Network (LAN)	SPTC; MTN; MOH; MNRE; MICT	5,000–00
	d.4.3. Absence of telephone services at community level to call an ambulance when pregnant woman is due	d.5.2.1 Provide telephone coin boxes in chiefdom area and Gogo Center	SPTC; MTN, MICT MOH, ME&NR	4,000–00
	d.4.4 Most of the communities in hard-to-reach areas do not have access to telephone services and are unaware of the use of toll free numbers to call an ambulance (e.g., Kasiko, Kholwane, Tholulwazi, Bhahwini, Mhlabeni, Bhandeni and Lufafa)	d.4.4.1 Conduct public awareness on toll free numbers	SPTC; MTN, MOH, ME&NR, MOT, MICT	
	d.4.5 High mobile telephone network tariffs	d.4.5.1 Lobby for subsidized rates for very poor communities	SPTC; DPMO, CSOs, ME&NR, MICT	nil
		d.4.5.2 Regulate telephone and mobile phone tariffs		
		d.4.5.3 Advocate and lobby Government for other cellphone service providers to join the market		
E. Improve early and appropriate health seeking behavior				
E.1 Dispel harmful practices, beliefs, myths and misconception on SRHR	e.1.1 Beliefs, myths and misconceptions on SRHR (ANC and FP service delivery)	e.1.1.1 Create awareness and sensitize communities and families on SRHR (ANC and FP)	Communities, Ministry of Home Affairs, League of Churches, Council of Churches and Church forums, MOH, UN, WVI, Save the Children, PEPFAR	70,637
E.2 Eliminate home deliveries by unskilled persons	e.2.1 18% of Pregnant mothers deliver at home assisted by unskilled persons (TBAs, Relatives, friends, others)	e.2.1.1 Provide capacity building to community leaders (chiefs, opinion leaders), TBAs and FBOs on the dangers of home deliveries and non-compliance to ANC		

Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
E.3 Total cessation of harmful practices	e.3.1 Use of traditional concoctions to accelerate labor and unsterilized instruments for conducting delivery in communities	e.3.1.1 Provide capacity building to community leaders (chiefs, church and opinion leaders), TBA, traditional healers, on the dangers of concoctions and unsterilized instruments	UNICEF, UNDP, WVI, Save, UNFPA, WFP, WHO, PEPFAR, Communities, MHA, THO. League of Churches, Council of Churches and MOH, Church forums, MOH & THOs	39,186
E.4 Improve security at community and health Facility levels	e.4.1 Increasing levels of crimes and burglary in some rural health facilities	e.4.1.1 Improve fencing in rural health facilities and provide flood lights		nil
	e.4.2 Absence of Police Posts in rural communities	e.4.2.1 Provide security training and security devices for health workers in affected health facilities	PMO, Royal Swaziland Police, Communities, Business Community, MOH	28,800,000
		e.4.2.2 Strengthen community police and equip them with essential tools and supplies		2,560
	e.4.3 Absences of Police Posts in rural communities.	e.4.3.1 Deploy security police to affected communities		–
		e.4.3.2 Provide flood lights in high crime zones in communities		1920–00
F. Reduce food insecurity and improve nutrition at household level				
	f.1.1 Low productivity and production at household level of agricultural commodities	f.1.1.1 Increase adoption of good animal husbandry practices for indigenous poultry, goats and pigs. Target 250 commercial indigenous poultry farmers per region	MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD	3,600–00
		f.1.1.2 Promote backyard gardens in each homestead that does not have one. Target establishment of 250 backyard gardens per region		51,000–00
	f 2.1. Shortage of water for irrigation	f.2.1.1 Promote small-scale water harvesting technologies for 250 households per region.	MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD	258,400–00
		f.2.1.2 Promote use of drought tolerant crops/Target diversification into cassava, sorghum and cowpeas by 500 households per region		
	f.2.2 Poor dietary diversity at household level	f.2.2.1 Sensitize pregnant women to consume iron-rich food to reduce the prevalence of anemia by 10%		3,600
	f.2.3 Balanced diet issues/High consumption on maize crops-	f.2.3.1 Promote the consumption of locally available balanced diet	MOA; MOF, UN, WVI, NERCHA, SWADE, SNNC, Development Partners, FBOs, ACAT, IRD	4,000
	f.2.4. Poor food storage and security at household level	f.2.4.1 Train 1000 households in food preservation and storage		nil

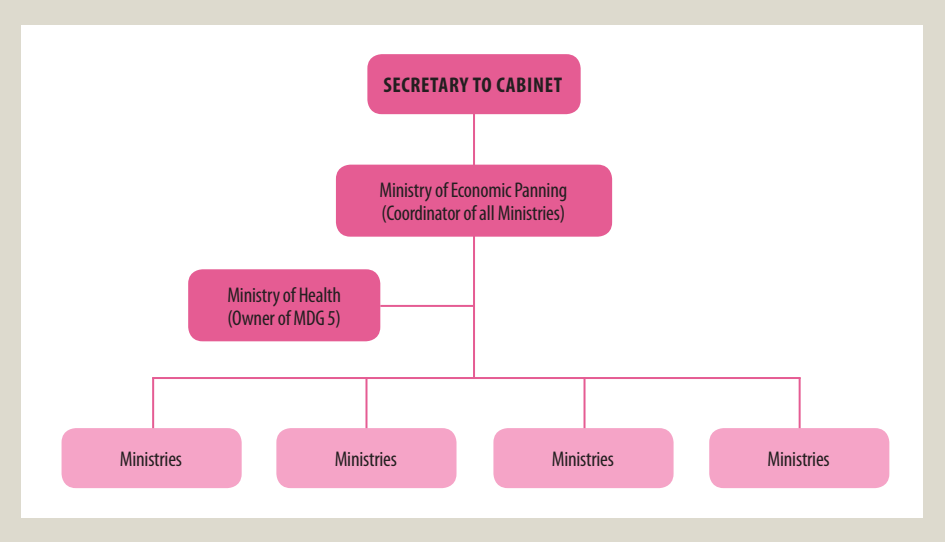
Prioritized Interventions (Areas)	Prioritized Bottlenecks	Indicative Acceleration Solution 2013–2015	Potential Partner(s)	Total Cost (USD)
	f.2.5 Poor food storage and security at household level	f.2.4.1 Train 1000 households in food preservation and storage		nil
		f.2.5.1 Promote exclusive breast feeding/Training of 510 RHMS workers (17 Health facilities)	MOA, Financial Institutions, CSOs, MOT, SNNC, MOH, UNICEF, IRD, ACAT	4,800–00
	f.2.6 High levels of unemployment in hard-to-reach rural communities	f.2.6.1 Train communities on SME entrepreneurship skills and link them to financial institutions		70,550
G. Conduct monitoring and evaluation				
G.1 Monitor progress towards the goals		g.1 Identify benchmarks where they do not exist/Strengthen M&E in sectors who do not have M&E officers	MCIT, MOA, NERCHA, FBOs Financial Institutions, MOT, SNNC, CSOs, WVI, UN	4,600–00
		g.2 Conduct programme reviews annually		
		g.1 Identify benchmarks where they do not exist/Strengthen M&E in sectors who do not have M&E officers	MCIT, MOA, NERCHA, FBOs Financial Institutions, MOT, SNNC, CSOs, WVI, UN	40,000
		g.2 Conduct programme reviews annually		
H. Advocacy				
		h.1 Sensitize cabinet ministers	MEPD, MOH, UN, MOT	10,000
		h.2 Sensitize parliamentarians TindvunatetiNkhudla and Bucupho.		
Total				**US$2,992,952**

Implementation, Monitoring and Evaluation Plan

Implementation plan

The implementation of this plan will be the responsibility of the Ministry of Economic Planning and Development, with the Ministry of Health as the lead partner. The MEPD will facilitate by providing a platform for all government ministries and other keys stake-holders forming part of the MDG 5 Acceleration Framework. The MEPD will also provide technical support to all implementing partners in areas of planning, implementation as well monitoring and evaluation where required. To ensure that the action plan is well coordinated and practical, **Figure 10** is a proposed organogram, discussed with stakeholders, for communication among implementers; the same structure will also be used for reporting purposes.

FIGURE 10: **COORDINATION FRAMEWORK FOR MONITORING AND EVALUATION OF MAF**



Monitoring and Evaluation plan

A monitoring and evaluation plan has been proposed to measure progress towards the achievement of the actions stipulated in this document. All implementers will be responsible for monitoring their commitments within and beyond the plan of action. All implementers are expected to establish or strengthen M&E systems. Reports on progress made will be directly reported to the Ministry of Economic Planning and Development then reported to the Secretary to Cabinet, as shown in the organogram above. For the purpose of M&E, indicators to track progress have been developed. For output indicators, data is expected on an annual basis while an evaluation will be conducted at the end of the implementation plan. For indicators without baseline data, responsible implementers are expected to conduct baseline surveys to inform baseline information. A detailed report focusing on progress made, problems encountered and potential rewards will be prepared by MEPD and MOH and shared with stakeholders through dissemination workshops and on the Swaziland Government website.

Table 8 provides an implementation and monitoring plan indicating when activities will be undertaken, the responsible party and indicators for monitoring. While the progress of activities in achieving the MDG target will be monitored annually, the progress of MMR will be monitored as per the existing country's monitoring system from each Ministry. The data will be collected through the existing routine Information Management System (IMS) or through surveys. The year 2016 will be used to take stock and generate knowledge products for sharing and learning lesson.

TABLE 8. IMPLEMENTATION, MONITORING AND EVALUATION. PLAN (2013–2015)

Priority MDG Target Goal 5:	Improve Maternal Health **Target 5a:** Reduce by ¾ between 1990 and 2015 the maternal mortality ratio (92/100,000 live births) **Target 5b:** Achieve, by 2015, universal access to reproductive health

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
			5.1 Maternal Mortality Ratio **5.2 Proportion of births attended by Skilled Health Personnel** **5.3 Contraceptive prevalence rate (%) among married women 15–49 years** **5.4 Adolescent birth rate per 1000 women** **5.5 Antenatal care coverage (%):** **• at least one visit** **• at least four visits** **5.6 Unmet need for family planning (%)**	Survey Report	MOH, CSO
A. Improving HIV management before, during and after pregnancy					
A.1.1 Low coverage for HIV/AIDS prevention interventions outside the MNCH platform	a.1 Strengthen capacity for comprehensive HIV prevention interventions for HIV-negative pregnant women and their partners (including adolescent and young women)	a.1.1.1 Strengthen the HIV/AIDS prevention interventions (e.g., increase number of staff/nurses, equipment/transport for the outreach/mobile programme), train staff and equip staff to improve HTC and PITC	% of HIV-negative women sero-converting during pregnancy and breastfeeding	Programme Reports	MOH (SNAP), NERCHA, UN (UNFPA, UNICEF), PSI
A.2.1 Inadequate education and counselling on SRHR for HIV-positive women	a.2 Strengthen education and quality counselling for HIV-positive women on SRHR	a.2.1.1 Educate HIV-positive women on SRHR	% health facilities with at least one person trained on PMTCT	Programme Reports	MOH, UN (UNFPA, UNAIDS)
A.3.1 Low coverage for training in IMAI, NARTIS and PMTCT	a.3 Integrate PMTCT into all MNCH care platforms (ANC, Labour and Delivery, Postnatal) and strengthen linkages with TB, ART and other relevant services	a.3.1.1 Increase coverage on training for Facility Health Workers on IMAI, PMTCT, NARTIS and continuously provide supervision and mentoring to trained HWs	% of health care workers trained on IMAI	Programme Reports	MOH (SRHU, RHMT, SNAP); UN (WHO, UNICEF), EGPAF, ICAP, Baylor
A.3.2 Revised PMTCT Guidelines not adequately disseminated to service providers		a.3.2.1 Translate revised PMTCT Guidelines into practice and develop customized communication packages, tools and standard operating procedures (SOP) on integrated services		Programme Reports	MOH, UN (WHO), EGPAF, MSF
A.3.3 TB Guidelines are not adequately integrated into HIV Guidelines		a.3.3.1 Incorporate the TB Guidelines into HIV and essential Obstetric Care Guidelines		Programme Reports	MOH (SRH TB Programme); WB, UN (WHO), GF, MSF

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
A.3.4 Low capacity in stock management and forecasting for PMTCT commodities/ Weak stock management information and distribution systems		a.3.4.1 Procure PMTCT commodities and distribute to facilities	% of health facilities reporting a stockout of essentials medicines as defined by essential drug list	Programme Reports Health Facility Survey Report	MOH, NERCHA, GF
		a.3.4.2 Strengthen the procurement system, management and dissemination of commodities			MOH, UN (WHO, UNICEF)
		a.3.4.3 Train pharmacists/ pharmacist assistants in stock management and forecasting and provide orientation on procurement guidelines			
A.4.1 Shortage of qualified staff at all facilities and high staff burn-out	a.4 Strengthen capacity to deliver on integrated PMTCT services	a.4.1.1 Formalize task shifting/sharing policy, train, mentor and support staff with SOP to deliver integrated package of PMTCT services	% of health care workers trained on task shifting	Programme Reports	MOH, UN (WHO)
		a.4.1.2 Mobilize retired midwives/nurses/Train and support them to participate in the integrated PMTCT services	%/number of retired midwives trained and involved in PMTCT service delivery	Programme Reports	MOH, UN (WHO, UNICEF), EGPAF
		a.4.1.3 Integrate comprehensive PMTCT curriculum into pre-service training of nurses and midwives as part of the HIV curriculum	%/number of pre-service schools that have integrated PMTCT curriculum into existing pre-service HIV curriculum	Programme Reports	MOH, UN (WHO, UNICEF), EGPAF
		a.4.1.4 Advocate for persons with experience to be assigned in maternity wards for long period and promote to supervisor within the Department	%/number of hospitals that have adopted the above policy	Health Facility Survey	MOH (SRHU, Directorate, CNO, Hospital Matrons)
A.4.2 Establishment Register Order is outdated, (e.g., still advocating for minimal staffing for lower level health facilities)		a.4.2.1 Review Establishment Register Order/Revise placement of staff to match needs		Human Resource Records	MOH (Directorate, CNO); Ministry of Public Service
A.4.3 Inadequate laboratory infrastructure and services (e.g., CD4 count machine only in PHUs; inadequate transport for CD4 and TBS samples for assessment)		a.4.3.1 Provision of training on laboratory management, equipment/supplies and critical staffing at all levels of care	% of health facilities providing outreach for HTC	Health Facility Survey	MOH (Laboratories Services Dept.)

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
A.5.1 Lack of accurate knowledge and information on protective behaviours for HIV prevention and weak linkages/and referral mechanisms between communities and health facility-based services	a.5 Enhance community capacity to improve participation and support for PMTCT and MNCH care services	a.5.1.1 Intensify advocacy on Social Behaviour Change Communication (SBCC) interventions at community level		Survey Report	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI
		a.5.1.2 Sensitize HWs on effects of stigma and discrimination to health service delivery	%/number of HWs by cadre, sensitized on stigma discrimination to health service delivery	Programme Report	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI
		a.5.1.3 Strengthen the mobile/ outreach HTC programme to reach the communities	%/number of outreach services on HTC conducted monthly/regularly	Programme Report and Survey Report	MOH, UN (UNAIDS, UNICEF, UNFPA), PSI, PEPFAR, NERCHA
A.6.1 Inadequate coordination and supervision at all levels	a.6 Improve coordination, supervision and monitoring for effective implementation of the integrated PMTCT initiative	a.6.1.1 Orient HWs and Coordinating Committees at all levels to improve performance management system	Number of facilities in regions to provide additional information to "fast track" integration of PMTCT into MNCH at multiple levels	Programme Report and Health Facility Survey	MOH, CHIMSHACC, TIMSHACC, REMSHACC, PSHACC
A.7.1.Destruc-tion of family structures by HIV	a.7 Improve Family Life Education	a.7.1.1 Sensitization to enhance the family support systems and structures	%/number of families per chiefdom sensitized on support systems and structures	Survey Report	Local traditional structure; SC; WVI; Extension workers; CBOs, DPMO; MHA
		a.7.1.2 Educate families on the importance of expectant mothers and child birth			
A.7.2 Decay of social moral values		a.7.2.1 Conduct community dialogue to empower women and girls against sexual exploitation	%/number of dialogue meetings on sexual abuse conducted at each Inkhundla	Programme Report	MOET, MOH, MHA, UN, MISA/Media; CSOs-Umhlanga, Lutsango (women and girls), Lusekwane, imimemo, FBO
		a.7.2.2 Revive and preserve good cultural practices i.e., liguma Umcwasho and lutsango (puberty rights) and align with the education curriculum	Report on identified list of Good Cultural Practices	Survey Report	
A.7.3 Negative influence of the media		a.7.3.1 Orientation/sensitiza-tion for the media on gender implications on adverse practices	%/number of media personnel sensitized on gender implications on adverse practices	Programme Report	MISA; UN; DPMO
A.7.4 Fear of and delayed decision making in ANC enrol-ment and delivery		a.7.4.1 Create awareness on importance of early ANC booking, facility delivery and PNC services	% pregnant women coming early for ANC bookings	Health Facility Survey	Local traditional structure; SC; WVI; CBO; DPMO; MHA; MOET; MOH; Media/ MISA; UN; FBOs (Council of Churches, Church Forums, League of Churches)
A.7.5 Inadequate male involvement on SRH and HIV issues including voluntary counselling and testing and practicing safe sex		a.7.5.1 Create male-friendly environment in health facilities	% of health facilities that have a positive environment for males	Health Facility Survey and Community Survey	
		a.7.5.2 Capacity building to orient community leaders, opinion leaders and religious leaders to help in reducing stigma, discrimination and misconceptions related to HIV		Programme Report	

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
A.8.1 Poor road infrastructure during and after rains resulting in muddy and slippery roads for rainy season (e.g., Bhandeni, Kasiko, Bhahwini Chiefdoms)	a.8 Improve road infrastructure in hard-to-reach areas to increase access to HIV outreach programmes	a. 8.1.1 Regular upgrade and maintenance of feeder gravel roads; semi-tarred road (Malaysian style)	%/number of feeder roads in hard-to-reach sites that are regularly upgraded and maintained	Programme Report	MOWT; Community WB; MEPD; Ministry of Tinkhundla
A.8.2 Low and informally constructed bridges (e.g., Tholulwazi, Maphalaleni Bhandeni, Bhahwini Chiefdoms)		a.8.2.1 Reconstruction and upgrading of bridges to the national approved standards	-%/number bridges that have been upgraded to acceptable standards/communities/Inkundla -%/number of bridges in hard-to-reach communities that have	Programme Report and Community Survey	MOWT; Community WB; MEPD; Ministry of Tinkhundla
A.8.3 Inadequate community involvement in road infrastructure projects		a.8.3.1 Train communities and involve them in construction of roads and other infrastructure	Number of communities trained and involved in road construction/ Inkundla	Survey Report	MOWT; Community WB; MEPD; Ministry of Tinkhundla
B. Improving access to modern family planning by HIV-positive women and adolescents/youth					
B.1 Inadequate modern FP commodity supply and distribution to facilities	b.1.1 Ensure availability of modern FP commodities at health facilities at all times	b.1.1.1 Procure and distribute modern FP commodities including condoms to all facilities in a timely manner	% of health facility with FP commodities available	Health Facility Survey Programme Reports	MOH (SRHU, CMS), NERCHA (GF), UNFPA, AIDS Health Care Foundations, PSI, FLAS
B.2.1 Limited community-based contraceptive distribution system	b.2.1 Expand access to modern FP methods for women living with HIV, adolescents, young women and all women of reproductive age	b.2.1.1 Scale up community-based distribution of FP commodities (including distribution of condoms by non-health distribution points)	Number of communities that have a distribution outlet for barrier methods	Community Survey Report	MOH, (SRHU), CMS, NERCHA, UN (UNFPA, WHO)
B.2.2 Inadequate skills and knowledge on SRHRs by health workers and adolescents as well as women of reproductive age respectively		b.2.2.1 Develop standardized routine SRH, (including FP) package after delivery and train HWs and adolescent/ young women on SRH for modern FP methods	Number of standardized SRH packages developed	Programme Reports	MOH (Chief Nursing Office, SRHU facility supervisors, SRH-mentors, senior nurses); UN (UNFPA, WHO), FLAS; EGPAF
		B.2.2.2 Develop strategies geared d towards the adolescents e.g., Prong 1			
B.2.3 Low capacity in stock management and forecasting/ Weak stock management information and distribution systems		b.2.2.1 Scale up the integration of SRH and HIV commodities (including condoms and other commodities for long-term methods) into the national medicines and pharmaceuticals supply chain management		Programme Reports	MOH (SRHU, Central Medical Stores), MSH, UNFPA
		b.2.2.2 Train facility pharmacists and pharmacist assistants on FP stock/logistics management and forecasting to ensure supply at all times	%/number of Pharmacists Assistants that have received training on FP logistics management and forecasting to ensure supply at all times	Programme Reports	MOH (SRHU), CMS, UN (WHO)

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
B.3.1 Slow integration of FP into ART, PMTCT, TB and other MNCH services (coverage)	b.3 Integrate FP into ART, TB, PMTCT and MNCH services	b.3.1.1 Review FP Guidelines in the context of HIV, develop SOP/Train ART, PMTCT and other MNCH service providers for the integration of FP into ART, PMTCT, and MNCH (ANC, Labour/Delivery, PNC)			MOH (SRHU, SNAP; Central medical Stores, Health Education Unit); UNFPA; FLAS; EGPAF
		b.3.1.2 Provide modern FP commodities to ART, PMTCT, TB sites and delivery facilities	% of ART sites that also provide FP services	Programme Report Survey	MOH (SRHU, CMS, SNAP); UNFPA;
		b.3.1.3 Strengthen the linkages of SRHR and HIV TWG			MOH (SRHU), EU/WB
B.4.1 Limited knowledge on SRH rights among communities	b.4 Enhance community knowledge, public awareness and understanding of SRH and HIV	b.4.1.1 Mobilize communities on FP targeting RHMs, adolescents, youth, women and men, PLHIV, opinion leaders, MPs, media, and couples to create demand (including demand for long-term) FP commodities			MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA
		b.4.1.3 Include SRH into PLHIV and TB treatment literacy manuals and the correct messaging for service delivery	Integrated SRHR manual with TB treatment guidelines, PLHIV	Programme Report	International Centre for AIDS prevention-ICAP; MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; EGPAF
		b.4.1.4 Develop and implement SRH promotion and marketing strategy	Availability of SRHU marketing strategy	Programme Report	MOH (SRHU, Health Education Unit, SNAP); FLAS; UNFPA; WVI; CHAI
B.4.2 Low male involvement due to misconceptions and attitude towards SRH		b.4.2.1 Develop and implement male-friendly strategies and messages to raise SRH awareness including FP	Number of strategies and messages to raise SRH awareness including FP	Community survey	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL
B.5.1 Poor coordination, supervision and monitoring	b.5 Improve coordination, supervision and monitoring to ensure effective implementation	b.5.1.1 Strengthen coordination among FP stakeholders for comprehensive SRH implementation	Number of FP activities coordinated with stakeholders for comprehensive SRH implementation	Programme Report	MOH (SRHU, SNAP); FLAS; UNFPA; EGPAF; AMICCALL
		b.5.1.2 Orient HWs and RHMTs at all levels to strengthen coordination and performance management system		Programme Report	MOH

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
B.6.1 High level of teenage pregnancies and drug abuse among school going children	b.6 Strengthen provision of sexual and reproductive health and empowerment programs for adolescents	b.6.1.1 Train career guidance teachers on comprehensive sexuality education (CSE)	%/number trained	Programme Report	MOH, FLAS, UN, MOET Supper Buddies, SNYC
		b.6.1.2 Train health workers on counselling and youth friendliness to accelerate service provision and uptake			
B.6.2 Limited integration of sexuality education in school curriculum		b.6.2.1 Develop SRH/CSE materials to be used by teachers and peer educators			MOH, FLAS, UN MOET, Ministry of Youth, SNYC; CANGO; (Supper Buddies, Lusweti)
		b.6.2.2 Scale up youth-friendly counselling and health service delivery	% of health facilities with youth-friendly corners	Programme Report and Community Survey	
B.6.3 Lack of country specific guidelines for CSE		b.6.3.1 Develop country specific guidelines and orientation for all sectors on the guidelines		Programme Report	MOH, FLAS, MOET, Ministry of Youth; SNYC; CANGO; Supper Buddies; Lusweti; Parents
		b.6.3.2 Advocate/lobby for SRH amongst parents and community leaders and policy makers		Programme Report	
b.7.1 Low coverage of the school health programme adversely affecting the issues of sexuality and teenage/adolescent pregnancies	b.7 Strengthen school health programs	b.7.1.1 Clear guidelines on the operations and structure on the school health programme	Availability of guidelines	Programme Report	MOH, FLAS, UN MOET, Ministry of Youth, SNYC; CANGO; (Supper Buddies, Lusweti)
		b.7.1.2 Build capacity of teachers to promote effective school health	MOH, FLAS, UN MOET, Ministry of Youth, SNYC; CANGO; (Supper Buddies, Lusweti)	Programme Report	
		b.7.2.1 Increase access to Comprehensive SRH programme	%/number of health workers trained on youth counselling and youth friendliness	Programme Report	MOH, FLAS, MOET, UN
		b.7.2.Develop strategies geared towards the adolescents e.g., Prong 1			
C. Improving quality of skilled birth attendance during labour, delivery and post-delivery					
C.1 Inadequate experiences and capabilities of health workers to provide quality care during ANC, labour/delivery and PNC	c.1 Strengthen capacity of health workers (doctors and midwives/nurses) to deliver quality safe motherhood interventions	c.1.1.1 Strengthen training, mentorship and supervision for doctors and midwives/ nurses to competently address obstetric complications during labour, delivery and post-delivery	%/number of doctors and midwives who have received mentorship and supervision on addressing obstetric complications	Programme Report	MOH (SRHU); EGPAF
		c.1.1.2 Intensify clinical orientation for newly graduated midwives/nurses and train them to properly understand the guidelines for delivery of quality maternal and newborn care services	%/number of newly graduated midwives/per training institution, oriented on guidelines for delivery of quality	Programme Report	MOH

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
C.2 Inadequate compliance to use of the partogram in monitoring the stages of labour	c.2.1 Strengthen the use of partogram to monitor labour	c.2.1.1 Develop checklist and orient practicing midwives/ nurses on use of partogram to monitor labour		Health Facility Report and Programme Report	MOH
C.3 Poor forecasting and weak informa-tion management system	c.3.1 Ensure constant stock of all basic essential/emer-gency drugs and supplies at all delivery facilities	c.3.1.1 Provide pharmacists/ pharmacist assistants orientation for procurement and distribution guidelines to manage effective forecasting and logistics management and establish a dashboard for stock alerts	- %/number of Pharmacists Assistants that have received training on procurement guidelines - %/number of Pharmacists Assistants that have received training in stock management and forecasting - Number of facilities that have established a dashboard for stock alerts	Programme Report	MOH
C.4 Inadequate Life Saving Skills at community level to recognize early risks signs	c.4.1 Strengthen com-munity mobilization and education to improve health seeking behaviour	c.4.1.1 Develop Life Saving Skills Manual/Train community and home-based health workers on life saving skills to support referrals to health facilities	- Number of life skills manual developed - Number of trained community/ home-based health workers/ Inkundla on life saving skills	Programme Report	MOH
C.5 Inadequate supervision and monitoring	c.5.1 Improve supervision	c.5.1.1 Provide supervision guidelines and orient supervisors to strengthen supportive supervision at delivery facilities		Programme Report	MOH
D. Improve access to skilled birth attendance and quality of MNCH services					
D.1.1 Poor road infrastructure during and after rains resulting in muddy and slippery roads for rainy season in 48 communities (e.g., Bhandeni, Kasiko, Bhahwini Chiefdoms)	d.1 Improve road infrastructure in hard-to-reach areas	d.1.1.1 Regular upgrade and maintenance of feeder gravel roads in at least 48 communities; semi-tarred road (Malaysian style)	%/number of feeder roads in hard-to-reach sites that are regularly upgraded and maintained	Programme Report and Survey Report	MOWT; Community WB; MEPD; Ministry of Tinkhundla
D.1.2 Low and informally constructed bridges (e.g., Tholulwazi, Maphalaleni, Bhandeni, Bhahwini Chiefdoms)		d.1.2.1 Reconstruction and upgrading of 26 low bridges to the national approved standards	- %/number bridges that have been upgraded to acceptable standards/communities/ Inkundla - %/number of bridges in hard-to-reach communities that have been re-constructed	Programme Report and Survey Report	MOWT; Community WB; MEPD; Ministry of Tinkhundla
D.1.3 Inadequate community involvement in infrastructure projects		d.1.3.1 Train communities and involve them in construction of roads and other infrastructure	%/number of communities trained and involved in road construction/ Inkundla	Survey Reports	MOWT; Community WB; MEPD; Ministry of Tinkhundla

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
D.2.1 Absence/ inadequate public transport network (e.g., Bhandeni, Kasiko, Bhahwini, Mkhiweni, Lufafa, Mhlabeni, Tholulwazi and Kholwane-2 Chiefdoms)	d.2 Improve transport network especially in hard-to-reach areas	d .2.1.1 Enforce the Road Traffic & Transportation Act	Number of meetings held to Enforce the Road Traffic & Transportation Act	Programme Reports	MOWT
		d.2.1.2 Amend the Road Traffic & Transportation Act to: a) Issue new permits for areas without transport b) Conduct regular inspection of public transport especially in rural areas to ensure they are roadworthy at all times c) Advocate withdrawal of permits from drivers who do not want to ply the road	- Amendment Status of the Road Traffic & Transportation Act - Number of areas without transport that has been offered new permits - Number of regular inspections of transport in rural areas - Number of permits withdrawn from drivers who do not want to ply the road	Programme Reports and Community survey	
D.2.2 Irregular transport delivery services in hard-to-reach areas (e.g., Bhandeni, Kasiko, Bhahwini, Mkhiweni, Lufafa, Mhlabeni, Tholulwazi and Kholwane-2 Chiefdoms)		d.2.2.1 Upgrade the gravel and informal road infrastructure to attract transport operators in hard-to-reach areas	%/number of gravel and informal roads upgraded to attract transport operators in hard-to-reach areas	Programme Reports	
		d.2.2.2 Provide Awards for best performance in transport service delivery			Community MOWT; Tinkhundla Ministry; RTB; SCATA
D.3.1 Inadequate availability of safe running water in 14 health facilities, namely: Mpolonjeni, U-TECH, Ndzevene, Tsambokhulu, Nkaba, Heefords, Ngowane, Siphocosini, Ntfonjeni, JCI, Moti, Nhletsheni, Musi, and Mangweni clinics	d.3 Improve availability of safe running water in health facilities and communities	d.3.1 Drill boreholes, improve water treatment and promote water harvesting			ME&NR; SWSC; RWS; SWADE; MOH; MEPD; CSO; Community
D.3.2 Inadequate access to safe water for the hard-to-reach communities		d.3.2 Drill boreholes and train communities for effective management	%/number of communities/ Inkundla that have drilled boreholes for: improved water treatment/Promotion of water harvesting.	Programme Report and Community Survey Report	ME&NR; SWSC; RWS; SWADE; MOH; MEPD; CSO; Community
		d.3.3 Train communities and equip them with safe water harvesting techniques	%/number of communities/ Inkundla that are trained with water harvesting techniques	Community Survey	

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
D.4.1 Frequent electricity power cuts in 20 health facilities (e.g., Ekuphileni, Ndzingeni, Malndzela, Mshingishingini, Ntfonjeni, Nkaba, Hhukwini, Sigangeni, Motshane, Horo, Herefords, Nyonyane, Musi, Dwalile, Mangcongco, Mpuluzi, Hlane, Kamfishane, Bhahwini and New Heaven)	d.4 Improve the consistency and availability of electricity power supply in health facilities	d.4.1.1 Provide: • Backup generator • Solar energy • Other power saving initiatives (such as invertors)	%/number of health facilities that are provided with backup electricity power supply: • Backup generators • Solar Energy • Other Power saving initiative	Programme Reports Health Facility Survey	ME&NR; SERA SEC; MOH, Mommond
D.5.1. Health facilities without telephone lines (35) (e.g., Ekuphileni, Ndzingeni, Hhukwini, Ngowane, Mangweni, Bulandzeni, Nyonyane, Phunga)	d.5 Improve communication network in health facilities and communities	d.5.1.1 Provide • Landline telephones in all identified areas • Provide official cellphone • Wireless fixed telephones • Local Area Network (LAN)	%/number of identified health facilities that have been provided with: • Landline telephones • Official cell phones • Wireless fixed phones • Local Area Network (LAN)	Programme Report and Heath Facility Assessment	SPTC; MTN; MOH; MNRE
D.5.2 Absence of telephone services at community level to call an ambulance when pregnant woman is due		d.5.2.1 Provide telephone coin boxes in chiefdom area and Gogo Center	%/number of telephone coin boxes in chiefdom area and Gogo Centre provided	Community Survey	SPTC; MTN; MOH; MNRE
D.5.3 Most communities in hard-to-reach areas do not have access to telephone services and are unaware of the use of toll free numbers to call an ambulance (e.g., Kasiko, Kholwane, Tholulwazi, Bhahwini, Mhlabeni, Bhandeni and Lufafa)		d.5.3.1 Conduct public awareness on toll free numbers	Number of adverts/sensitization meetings on toll free numbers	Programme Report	SPTC; MTN; MOH; MNRE
D.5.4 High mobile telephone network tariffs		d.5.4.1 Lobby for subsidized rates for very poor communities	Number of poor pregnant women in households receiving subsidized rates for very poor communities	Community survey Programme reports	SPTC; MTN; MOH; MNRE
		d.5.4.2 Regulate telephone and mobile phone tariffs	%/number of types of telephone phone tariffs regulated	Programme Report and Survey Reports	
		d.5.4.3 Advocate and lobby Government for other cellphone service providers to join the market		Survey Reports	

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
E. Improve early and appropriate health seeking behavoiur					
E.1.1. Beliefs, myths and misconceptions on SRHR (ANC and FP service delivery	e.1.1 Dispel harmful practices, beliefs, myths and miscon-ceptions on SRHR	e.1.1.1 Create awareness and sensitize communities and families on SRHR (ANC and FP)	%/number of Community Leaders, FBO and TBA per Inkundla trained on dangers of home deliveries and non-compliance to ANC	Programme Report	Communities, Ministry of Home Affairs, League of Churches, Council of Churches and Church forums, MOH, UN, WVI, Save the Children, PEPFAR
E.1.2 18% of pregnant mothers deliver at home assisted by unskilled persons (TBAs, Relatives, friends, others	e.1.2 Eliminate home deliveries by unskilled persons	e.1.2.1 Provide capacity building to community leaders (chiefs, opinion leaders), TBAs and FBOs on the dangers of home deliveries and non-compliance to ANC	%/number of Community Leaders, FBOs and TBAs per Inkundla trained on dangers of home deliveries and non-compliance to ANC		Communities, Ministry of Home Affairs, League of Churches, Council of Churches and Church forums, MOH, UN, WVI, Save the Children, PEPFAR
		e.1.2.2 Sensitize the TBAs and advocate for withdrawal of the delivery kits provided by MOH	%/number of TBAs per Inkundla sensitized for withdrawal of delivery kits provided by MOH	Programme Report Survey Report	
E.1.3 Use of traditional concoctions to accelerate labour and unsterilized instruments for conducting delivery in communities	e.1.3 Total cessation of harmful practices	e.1.3.1Provide capacity building to community leaders (chiefs, church and opinion leaders), TBA, traditional healers, on the dangers of concoctions and unsterilized instruments	%/number of Community Leaders, FBOs, THOs and TBAs per Inkundla trained on dangers of concoctions and unsterilized instruments	Survey Report	Communities, MHA, League of Churches, Council of Churches and Church forums, MOH & THOs, UN, WVI, Save the Children PEPFAR
E.1.4.1 Increasing levels of crimes and burglary in some rural health facilities	e.1.4 Improve security at commu-nity and health facility levels	e.1.4.1.1 Improve fencing in rural health facilities and provide flood lights	%/number of rural health facilities adequately fenced and provided with flood lights in rural areas	Health Facility Report	PMO, Royal Swaziland Police, Communities, Business Community, MOH
		e.1.4.1.2 Provide security training and security devices for health workers in affected health facilities	%/number of health workers trained on security measures in affected areas	Programme Report	
E.1.4.2 Absence of Police Posts in rural communities		e.1.4.2.1 Strengthen community police and equip them with essential tools and supplies		Community Survey Report	PMO, Royal Swaziland Police, Communities, Business Community
		e.1.4.2.2 Deploy security police to affected communities	%/number of communities with security police in affected areas	Community Survey Report	
		e.1.4.2.3 Provide flood lights in high crime zones in com-munities	Number of communities/Inkundla with flood lights installed in high crime zones	Community Survey Report	PMO, Royal Swaziland Police, Communities, Business Community

Prioritized Bottlenecks	Prioritized Interventions (Areas)	Indicative Acceleration Solution 2013–2015	Indicators	Means of Verifications	Responsible partners
F. Reduce food insecurity and improve nutrition at household level					
F.1.1 Low productivity and production at household level of agricultural commodities		f.1.1 Increase adoption of good agricultural practices to improve productivity; intervention to target 500 households per region	Number of Households/region that have increasing agricultural practice	Community Survey Report	MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD
		f.1.2 Increase adoption of good animal husbandry practices for indigenous poultry, goats and pigs/Target 250 commercial indigenous poultry farmers per region	Number of communities/Inkundla who receive subsidized inputs for farming	Community Survey Report	
F 1.2 Shortage of water for irrigation		f.1.2.1 Promote backyard gardens in each homestead that does not have one/Target establishment of 250 backyard gardens per region	Number of communities/ chiefdoms/Inkundla who have backyard gardens		MOA; MOF, MNRE, UN, WVI, NERCHA, SWADE, Development Partners, FBOs SNNC, ACAT, IRD
		f.1.2.2 Promote small-scale water harvesting technologies for 250 households per Region	Number of households that have harvested water/region	Community Survey Report	
		f.1.2.3 Promote use of drought tolerant crops/Target diversification into cassava, sorghum and cowpeas by 500 households per region			
F.2.1 Poor dietary diversity at household level		f.2.1.1 Sensitize pregnant women to consume iron-rich food to reduce the prevalence of anemia by 10%	Number of sensitization meetings held at Inkundla level for women to eat iron-rich food	Community Survey Report	MOA, MOF, UN, WVI, NERCHA, SWADE, SNNC, Development Partners, FBOs, ACAT, IRD
F.2.2 Balanced diet issues/High consumption of maize crops		f.2.2.1 Promote the consumption of locally available balanced diet	Number of households/chiefdoms consuming locally available balanced diet	Community Survey Report	
F.2.3 Poor food storage and security at household level		f.2.3.1 Train 1000 households in food preservation and storage	Number of households trained on food preservation per chiefdom/ Tinkhundla	Community Survey Report	MOA, Financial Institutions, CSOs, MOT, SNNC, MOH, UNICEF, IRD, ACAT
		f.2.3.2 Promote exclusive breast feeding; training of 510 RHMS workers (17 health facilities)	% of mothers who are exclusively breast feeding their infants	Programme Report Community Survey Report and Health Facility Report	
F.2.4 High levels of unemployment in hard-to-reach rural communities		f.2.4.1 Train communities on SME entrepreneurship skills and link them to financial institutions	Number of communities/Inkundla trained on entrepreneurship skills	Programme Report and community Survey Report	MCIT, MOA, NERCHA, FBOs Financial Institutions, MOT, SNNC, CSOs, WVI, UN

Conclusion and way forward

MDG 5 is achievable, if supported by the right set of policies, targeted technical assistance, institutional capacity, adequate funding, and strong political commitment. Swaziland selected to strengthen MDG 5—which seeks to improve Maternal Health—for acceleration, given the importance of overcoming setbacks in this area.

The MAF Action Plan for Accelerated Progress on Maternal Health aims at complementing existing interventions. It also seeks to contribute to operationalizing the EMTCT and other similar Frameworks/Plans of Action by identifying in a comprehensive manner the bottlenecks and focusing on a prioritised solution. The MAF assessment aimed at supporting Government and stakeholders to better understand the key bottlenecks in improving maternal health and formulate an effective action plan to reduce the obstacles hindering progress. It was observed that MMR is high in the country despite the notable good indicators such as high ANC attendance, ART prophylaxis uptake, health facility deliveries, PMTCT uptake, etc. This is attributable to direct and indirect maternal health causes among others; severe bleeding, pre-eclampsia, advanced AIDS and TB as well poverty, unemployment and inaccessibility to health facilities due to poor roads, bridges and public transport and many more.

The development of the MAF Country Action Plan was participatory in all the stages of development; hence, it was a success, as demonstrated by the achievement of the planned objectives.

This is confirmed by the following:

- Relevant literature was reviewed and strategic interventions were identified.
- Key bottlenecks for the acceleration of maternal health programs were identified that were beyond the Ministry of Health.
- Key indicative solutions to address bottlenecks were identified across all sectors using the MAF solution criterion tool (impact magnitude, impact speed, sustainability and adverse impact).
- The compact country Plan of Action was finally produced.

Way forward

- Hold a one-day meeting to refine activities (short, medium and long term)
- Print and bind the MAF Report
- Conduct an advocacy meeting with new cabinet ministers and parliamentarians
- Launch the MAF document
- Execute planned activities, including monitoring and evaluation

ANNEXES

ANNEX A: PERSONS CONTACTED FOR THE MAF PROCESS

Names & Surnames	Department
Rejoice Nkambule, Stephen Shongwe, Simon Zwane, Thandi Mudzebele, Nokuthula Dube, Nompumelelo Dlamini, Sibusiso Mamba, Gaive Shongwe, Dudu Dlamini, BonisileNhlabatsi, Lucia Maseko, Lindiwe Magongo, Petronella Vilakati, Zinwie Mkwati, Patience Zwane, Mabuza Phindile, Elizabeth Nxumalo, Zwane Prudence, Nompumelelo Dlamini, Dumsile Nxumako, Phindile Mabuza, Lindiwe Dlamini, Patronella Vlakati, Phindile Madlopha, Ntombikayise, Lindiwe Malaza, Margaret Lubhedze, Margaret Nhlebela, Nomathemba Gunindza, Alice Gina, Ruth Mamba, Muhle Dlamini, Thandie Maphalala, Zandile Masangane, Jane Shongwe, Mumcy Thwala, Sibusiso Mamba, Thulisile Shabangu, Dr. Jeff K. Mathe, Daniel Sithole, Funwako Dlamini, Mildred Xaba, Xolile Dlamini, Dudu Mbuli, Thembisile Khumalo, Dudu Mbuli, Sifiso Mavuso, Phumzile Mabuza, Sifiso Dlamini, Sivikelo Hlanze, Dudu Ncamphalala, Constance T. Vilakati, Dorcas N. Dlamini, Nomsa Mulima	Ministry of Health
Bertram Steward, Joyce Tibobo Dlamini, Lonkhululeko Magagula, Colins Tshabalala, Mphumuzi Sukati, Sandra Monsoor, John Murphy, Janet Mzungu, Lungile Dladla, Phindile Masango, David Kunene, Mdumiseni Dlamini, Peter V. Ndlela, Nomvula Ndwandwe	Ministry of Economic Planning and Development
Gloria Billy	Strategic Intervention Advisor, UNAIDS
Israel Dessalegne, Kabiru Nasidi, Fatou Leigh, Zuzana Brixiova, Shadrack Tsabedze, Nandipa Bujela, Ayodele Odusola, Sithembiso Hlatshwako, Kifle Tekleab,Osten Chulu, Auxilia Ponga, Akua Dua-Agyeman, Mavis Nxumalo, John Magagula, Eunice Kamwendo	UNDP
Marjorie Mavuso, Dr. Hassan Mohtashami, Sanelisiwe Tsela, Happiness Mkhatshwa, Tamari Silindza	UNFPA
Muriel Mafico, Nelisiwe Dlamini, Florence Naluyinda-Kitabire	UNICEF
Dudu Dlamini	WHO
Thembi Dlamini	NECHAR
Calista Chen	World Bank
Zodwa Gamedie	World Vision International
Isabella Ziyane Sthembile Motsa, Patricia J Musi	UNISWA
Elliot Jele	RED CROSS
Dr. MumantoMinra	PEPFAR/USAID
Mohammed Mahdi, Thembie Masuku	EGPAF
Daniel B Addiyu	RFMH
Xolisiwe Dlamini	Nursing Council
Muziwethu Nkambule, Dumisane Simelane, Sifiso Ndwandwe, Luyandza Dlamini, Zelda Nhlabatsi	FLAS
Bhekithemba Gama, Ntokozo Mngometulu, Andreas Dlamini	ICT
Winile T. Stewart, Nhlanhla Sithole, Xolile Nxumalo, Nompumelelo Ntshalintshali, Sabelo Simelane, Khulekane Sifundza, Winnie Khumalo, Muzi Khumalo	Ministry of Natural Resources
Zanele Mavuso	Swaziland Electricity Commission
Cynthia Maziya-Dlamini, Tsembani Dlamini, Shadrac Mavuso (RTD), Trevor Tshabalala, Clement Dlamini, Naniki Mnisi, Nsika Dlamini	Public Works and Transport

Names & Surnames	Department
Phililе Nzima –Dlamini, Canan G. Mathabela, Mandla Dlamini, Sara Vilakati, Bhekikhaya Dlamini, Alfred Gule, Almah Gamedze, Arch Bishop K.V Manikela	League of African Churches
Julliet Vilakati	Ministry of Tourism
Fortunate Ginindza, Lungile Ginindza, Buyisile Xaba, Nomsa Mamba Amos Msibi, Nomzamo Magongo, Muntu Almeida, Dingiswayo Mthethwa, Vusi Mabuza, Vincent Shabangu	Tinkundla Administration & Development
Sabatha Khumalo, Jane Mkhonta Xolisile Hlophe, Vera Hlatshwayo,	DPM - Gender Office, Social Welfare
Xolisile Dlamini	EPR
Stanely Dlamini, Gugu Simelane, Thoko Gumedze, Gama Ncenekile	Ministry of Justice
Mr. Robert Thwala, Thembumenzi Dube, Thembani Dlamini, Nelson Mavuso	Ministry of Agriculture
Under Secretary Sicelo Dlamini	Prime Minister's Office
Lucky Masuku, Mamba Bongekile, Duduzile Fakudze, Mandla Masuku, Anold Dlamini	MOHA
Nomathemba Hlophe	Ministry of Labour
Nomzamo Magongo, Melusi Mngomezulu, Tsini Mkhatshwa	CANGO
Ronny Nkumane	SPTC
Winnie Magagula	SANU
Dr. S. Mntshali	MOET

Annex B: MAF Preparation Process

The process of the preparation of the MAF Country Action Plan was participatory, interactive and nationally driven under the leadership of the Ministry of Health (MOH) with day-to-day responsibilities handled by the Sexual Reproductive Health Unit (SRHU) with technical support from the UN specialized Agencies. The rollout of the MAF preparation was carried out in several stages, as follows:

- UNDP led consultations and introduction of MAF to the Ministry of Economic Planning and Development (MEPD). This was followed by an MAF introductory and consensus-building workshop in November 2011, organized jointly by the Poverty Unit of the MEPD and UNDP Swaziland. Stakeholders from the government, especially from the MDG technical working groups, attended the workshop. The workshop familiarized participants with the MAF concept; shared experiences from selected African countries that have already implemented an MAF; and stimulated discussions among participants on which of the lagging MDGs were suitable for acceleration. The technical working groups suggested the following MDGs for further consideration: (i) access to clean water—MDG 7; (ii) gender equality at higher levels of education (and higher share of women in technical fields)—MDG 3; and (iii) maternal health—MDG 5. During a subsequent meeting organized by the Poverty Reduction Unit, maternal health (MDG 5) was selected for acceleration under the MAF. The reasons for this selection were: (i) MDG 5 has reversed markedly in the 2000s, with

the maternal mortality ratio (MMR) more than doubling between 2002 and 2007, thus calling for urgent need to accelerate progress towards this Goal; (ii) technical feasibility of applying the MAF to MDG 5. Progress towards reaching MDG 5 is likely to have positive spillovers on several other MDGs, namely MDGs 2, 3, 4 and 6, among others; and (iii) MDG 5 has received political commitment and priority in the country.

- The next stage involved the development of a Concept Note by UNDP, which was implemented jointly with the Ministry of Health and the UN Country Team for the MAF rollout.

- A national Technical Task Team comprising Ministry of Health (MOH), UNICEF, UNFPA, WHO, UNAIDS and UNDP was established and chaired by the Deputy Director of Health Services-Public Health to provide leadership, guidance and direction for the rollout. The UN Inter-Agency Team (UNFPA, WHO, UNAIDS) provided technical inputs while UNDP played a coordinating role and ensured quality assurance.

- One international consultant was recruited to support the technical team and managed the day-to-day process of the MAF rollout. The consultant was paired with the Midwife of the Year award winner to work as counterpart. The consultant's activities comprised two parts: to first develop a Background Paper (BP) and then the Country Action Plan between the period November 2012 to April 2013, one year after the initial workshop in November 2011.

i) The preparation of the Background Paper involved research and a literature/desk review of secondary data and information. On-line research, institutional studies/reviews, reports and project documents as well as national policy documents were utilized to gather information for the paper. This was supported by individual and group discussions/focus group discussions and consultative meetings with the national MAF Technical Task Team including the UN Inter-Agency Technical Team, and key officials of MEPD, NERCHA, MOH and WB. Field visits were undertaken in two health facilities (Lobamba and Motshane Clinics) and Mankayana Government Hospital to validate and update available information gathered. Additional data was sourced from the UN websites, such as the Statistical Department website.

ii) Part II, involving the CAP formulation, started with a three-day technical workshop on 4–6 March 2013 at the Sibane Hotel, Ezulwini, that trained the MAF task team on the tools and methodology for the analysis to formulate the CAP. The process was conducted under a ministerial task team. MOH expanded the MAF Technical Task Team and invited representatives from all levels of the health sector structure to bring in the field experiences, academia, development partners and NGOs operating in the health sector to the workshop providing local knowledge and clear understanding of the issues. Over 30 participants attended the workshop. UNDP Regional Service Centre for Eastern and Southern Africa in Johannesburg provided two resource persons (MDG Policy Advisor and Gender Practice Theme Leader) that trained the expanded technical team on the application of the tools and methodology for the MAF analysis leading to the identification of key strategic interventions, bottlenecks impeding the implementation of the interventions and the definition of solutions to address the bottlenecks. The four interventions identified during the workshop included:

- Family planning
- Emergency Obstetrics and Neonatal Care
- Skilled birth attendance
- Medical conditions: HIV, TB, Eclampsia

iii) A smaller group from MOH/SRHU and UN inter-agency team was set to finalize the CAP formulation. The team reviewed the workshop outcomes, reprioritized the interventions and bottlenecks, strengthened the solutions' analysis and developed the MAF Implementation and M&E Plan aligning the indicators to the health sector Monitoring and Evaluation Framework. After the analysis, the medical conditions intervention area was dropped for the following reasons: a) there was not much information to link the MAF to the non-communicable diseases (e.g., hypertensive disorders, reproductive cancers, diabetes, etc.) even though the impact in maternal health was noted; b) HIV has a significant impact but numerous activities were already ongoing to rectify the situation; and c) the limited timeframe to the MDG target year, 2015.

iv) On 28 March 2013, at the debriefing meeting with the Chair of the MAF Technical Task Team (Deputy Director, Health Services-Public Health), HIV was reintroduced into MAF because: a) it is the most significant lead cause of maternal death; and b) the linkage between MAF and HIV is paramount and should align with the Elimination of MTCT National Strategic Framework and Accelerated Action 2011–2015 (EMTCT), which had been launched a few days prior to the debriefing.

v) A review was undertaken using the EMTCT framework, the 2012 HSSP MTR Report and the 2012–2017 SRH Integrated Strategic Framework as a guide and reference by the consultant with technical guidance and support from UNAIDS. The interventions, bottlenecks and solutions were thus revised accordingly. The revised intervention areas included:

a. Improving HIV management before, during and after pregnancy;

b. Improving access to modern family planning (FP) methods by HIV-positive women; and

c. Improving quality of skilled birth attendance during labour, delivery and post-delivery.

vi) The reference documents/strategies (e.g., 2011–2015 EMTCT Framework and 2012–2017 SRH Framework and Plan of Action) drawn up to develop the MAF Action Plan have not been costed. Annual Workplans for implementation have not been articulated and/or consolidated to show a composite costing/budgeting. The SRHU is now in the process of compiling the budget for the Integrated Strategic Plan of Action. The 2011–2015 EMTCT is also not costed. Data was not available to cost the MAF Compact and to assess the resource need for the MAF. WHO expressed their interest in supporting the sector ministry to determine the budget, available resources and establish the financing gap at a later date.

Annex C: Overall MDG progress in Swaziland

MDG 1: Eradicate extreme poverty and hunger according to the CSO 2011 SHIES, poverty reduction was experienced nationwide, across all regions and among rural/urban dwellers and by gender during the 2000–2010 decade. The six-point decrease in average national poverty (from 69 percent to 63 percent) lowered the number of poor people by 37,500 (from about 678,500 individuals to 641,000). Extreme poverty on the other hand fell only by 1 point from 30 percent to 29 percent. Rural poverty dropped from 80 percent to 73 percent and urban from 36 percent to 31 percent. Poverty among male- and female-headed households also declined but at different proportions. Male-headed households dropped 8 points (from 67 percent to 59 percent) and 5 points for female-headed households (from 72 percent to 67 percent). The Comprehensive

Agriculture Sector Policy focusing on poverty alleviation, food security and sustainable natural resources management was the key driver supporting the progress.

On MDG 1 (B), Achieve full and productive employment and decent work for all, including women and young people showed no progress. All indicators declined from the 2006/07 levels. Employment-to-population ratio that increased from 28 percent in 1986 up to 37 percent in 2006/07 (in two decades) declined to 33.6 percent in 2010. The proportion of employed people living below US$1 (PPP) per day also dropped from 49.5 percent in 2006/07 to 37.4 percent in 2010. The level of self-employed workers having own-account status and relatives working in the establishment fell from 4.09 to 3.19 percent. **Under MDG 1(C), malnutrition in children under-five who are underweight and wasting** improved, declining from 10 percent in 1990 to 6.6 percent in 2010 and 2 percent in 1995 to 1 percent in

What are the MDGs?

Swaziland along with 189 UN Member States adopted the Millennium Declaration (MD) at the turn of the millennium in September 2000 and laid out the vision for common values and renewed determination to achieve decent standard of living for the world's population. The eight (8) interrelated and reinforcing Millennium Development Goals (MDGs) aimed at halving the proportion of people living below the poverty line; ensuring universal access to primary education; promoting gender equality; reducing child mortality; improving maternal health; reversing and halting incidence of HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and promoting global partnership for development between developed and developing countries by the year 2015.

It sets out the mutual commitment between developing and developed countries to achieve these eight development goals by 2015 and was expected to generate outstanding and coordinated action within the United Nations and related institutions, the wider development partners and most importantly the developing countries. The eight goals are:

Goal 1: Eradicate extreme hunger and poverty

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDs, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Global partnership for development

2010, respectively. The two indicators are likely to be achieved. Stunting stagnated around 27–31 percent. The proportion of population below minimum level of dietary energy consumption is improving, from 18 percent in 2004 to 11.3 in 2008.

MDG 2 – Achieve universal primary education is on track. The Net Enrolment Ratio has increased steadily since 1990 from 74.3 percent to 81.9 percent in 2005 and further to 92 percent in 2010. Completion rate also followed the same trend increasing from 62 percent in 1990 to 92.7 percent. Repetition rate has stagnated since 2000, showing a negligible change in 2009 from 16.5 percent to 15.8 percent. Progress in adult literacy has been mixed, from 79.2 percent in 2000 to 95.4 percent in 2006/07, but dropped to 92.5 percent in 2010. The achievement in the overall education targets has been made possible by Government policy to: (i) widen access to primary education; (ii) introduce the school feeding programme; (iii) provide free textbooks and exercise books; (iv) provide school capitation grants; (v) implement the Care and Support for Teaching and Learning Programme; and (vi) implement the State Funded (free) Primary School Initiative for grades 1 and 2.

MDG 3 – Promoting gender equality and empowering women is on track. Gender parity at primary, secondary and tertiary education is achieved. From 1990 to 2010, parity at tertiary level has increased consistently from 0.75 to 1.21, showing more girls than boys now enter tertiary learning institutions. Parity at 1.24 at the secondary level exceeded the target of 1.06. The primary parity at 1.01 is also achieved. The share of women in wage employment in the (non-agricultural) public sector is doing well, increasing from 30 percent in 1990 to 48.67 percent in 2008. The employment level fell in the private sector from 33 percent in 2006/07 to 29 percent in 2010. Proportion of seats held by women in the national Parliament increased by 50 percent, from 6.3 percent in 1990 to 13.6 percent in 2010. The overall Gender Inequality Index (GII) of **0.546** reported in the 2011 Global UNDP Human Development Report is high for a country with such impressive gender parity at the various education levels.

MDG 4 – **Reducing child mortality** is off-track to achieve the target of reducing (by two-thirds), between 1990–2015, the under-five mortality rate irrespective of the slight progress made in 2010, reducing under-five and infant mortality rates from 120 and 85 in 2006/07 to 104 and 79 per 1,000 births respectively. Compared to the early nineties, the current status is not sufficient progress. Immunization coverage against measles for 1-year olds initially dropped from 85 percent to 72.3 percent between 1990 and 2000 but picked up in 2006/07 (81.7 percent) and 2010 (97.8 percent). High impact child survival interventions and new immunization vaccine; Vitamin A supplementation; universal long-lasting insecticide-treated bed nets; Integrated Child Survival Interventions; education on feeding practices of TB and HIV-infected breast-feeding mothers; and early HIV test for pregnant women and free universal access to PMTCT, among others, have contributed to the progress in the child survival rate.

The progress in achieving **MDG 5 – Improving maternal health and reducing by three-quarters the maternal mortality ratio and achieving universal access to reproductive health between 1990** and **2015** is uneven. The country is off-track in reducing MMR by ¾ and achieving the national target of 92/100,000 by 2015. Since 1990 to 2006/07, MMR increased from 110/100,000 live births to 589.[22] Meanwhile, the target to achieve universal access to reproductive health and related indicators progressed remarkably. ANC for first visit in 2010 was estimated at 97 percent and the recommended four visits, 76.6 percent; total deliveries attended

[22] (i) 2006/07 SDHS estimates MMR at 482/100,000 (page 11); (ii) UN and WB 2008 estimate MMR at 420 per 100,000; and (iii) several documents including the MDG Reports use 589/100,000, sourced from the Central Statistics Office.

by skilled health personnel, 82 percent,[23] contraceptive prevalence rate among married women, 15–49, increased from 27.9 percent in 2000 to 65.2 percent and unmet need for family planning from 24 percent in 2006/07 to 13 percent. Adolescent birth rates also dropped from 134 per 1,000 women in 1990 to 89 per 1,000 women in 2010. Government measures such as: (i) free antenatal and postnatal care; (ii) free universal and well equipped PMTCT care; (iii) deployment of midwives to facilities including clinics; (iv) development of competency-based midwifery curriculum; (iv) opening maternity wings in clinics; (v) integration of family planning and sexual reproductive health/HIV services in health facilities; (vi) maternal death reviews; and (vii) Adolescent Sexual and Reproductive Health SBCC and community mobilization are expected to show positive results to help sustain the outcomes.

MDG 6 – Combat HIV/AIDS, malaria and other diseases is off-track and not likely to be attained by 2015. HIV prevalence was at 26 percent for the productive age group (15–49 years) and 19 percent for the population age 2 and older. The incidence among pregnant women also followed a similar pattern, rising from 3.9 percent in 1992 to 42 percent in 2008 before dropping slightly to 41.1 percent in 2010. This translates into an estimated 13,536 pregnancies or HIV-exposed infants per year and accounts for an estimated 46 percent of maternal deaths and 47 percent of under-five deaths. HIV/AIDS was declared a national disaster in 1999, and numerous interventions have been embarked upon to stabilize the epidemic. Some key interventions include: (i) the establishment of the Cabinet Committee on HIV/AIDS in the Office of the Deputy Prime Minister for commitment, leadership and ownership in response to the HIV epidemic; (ii) establishment of the National Emergency Response Council on HIV and AIDS (NERCHA) to take responsibility for mobilizing an expanded response to the epidemic, in line with the National Strategic Framework 2009–2014; (iii) HIV/AIDS Prevention and Care Programme including PMTCT; (iv) HIV education in schools; and (v) the ART programme. Almost every Swazi citizen knows about HIV/AIDS, ranging between 92 percent women and 89 percent men. The urban/rural knowledge about HIV is also high at 92 percent for urban and 89 percent for rural citizens. The comprehensive knowledge about HIV prevention and transmission is, however, low ranging from 58 percent for women and 54 percent for men in 2010. The level of knowledge varies with the level of education for both men and women, ranging from 36 percent for women with no education to 83 percent with tertiary education and 27 percent for men with no education to 89 percent for males with tertiary education.

What is Maternal Health?

- It is the health of women during pregnancy, childbirth and postpartum period.
- Major causes of maternal morbidity and mortality are hemorrhage, infection, high blood pressure, unsafe abortion and obstructed labour.
- MDG 5 calls for reducing by ¾, MMR and achieving universal access to RH by 2015.

MMR is the number of the deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to/or aggravated by the pregnancy or its management in one year, per 100,000 live births.

[23] Again, precise qualifications of 'skilled personnel' need to be clarified.

On Malaria, the 2010 Multiple Indicator Cluster Survey (MICS) identified that 32 percent of the population reside in malaria-endemic areas. Lubombo Region is the most affected where all households are in malaria-endemic areas, while it is only 9 percent in the Manzini Region. The National Malaria Control Programme aims to achieve at least 60 percent of pregnant women and children under five in the malaria areas sleeping under a long-lasting insecticide-treated bed net.

Most of the TB indicators have either kept on increasing since 1990 or declined from 2008 levels. Incidence associated with TB continued to increase in the two-decade period, going from 267 per 100,000 populations in 1990 to 1287 in 2010. The prevalence also increased from 629 to 936 per 100,000 populations in 2008 but dropped to 704 per 100,000 in 2010. Mortality associated with tuberculosis for HIV-negative patients increased from 45 deaths per 100,000 in 2000 to 67 in 2008, dropping to 32 in 2010. The detection rate improved from 34 percent in 2002 to 84 percent in 2010. The interventions like the newly constructed National TB hospital at Moneni and another TB clinic at Nhlangano by Médecins Sans Frontières are intended to bring services to TB patients.

MDG 7: Ensure environmental sustainability: Once halving by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation, Swaziland is likely to attain the indicator on safe drinking water coverage nationwide. The national coverage improved from 39 percent to 67.3 percent between 1990 and 2010 and the same happened with rural water coverage from 40 percent in 1997 to 60 percent in 2010. Conversely, urban water supply has declined from 89 percent in 1997 to 92.2 percent to 91 percent in 2010, although this is still higher than in rural areas. In terms of access to improved sanitation coverage, the country recorded negative growth from 74.52 percent in 1997 to 49.5 percent in 2007 until rising to 53.8 percent in 2010. In the rural and urban areas the trend was similar. Between 1997 and 2000, the urban coverage increased from 95.74 percent to 96.5 percent and then dropped to 43.5 in 2007 before rising to 50.7 percent in 2010. Rural coverage was increased from 63.56 percent to 65.7 percent but declined to 52.1 percent in 2007, improving slightly to 54.7 percent in 2010.

Proportion of population living in slum areas/ informal settlements in the urban areas improved in Mbabane and Manzini in particular due to the World Bank peri-urban upgrading initiative. Manzini City Council upgraded two informal settlements and allocated plots to the household.

MDG 8: Developing global partnership for development: Over the period 2000/01–2006/07, total public and publicly guaranteed external debt stock increased from E1.6 billion in 1999 to E2.42 billion by June 2006. The 2012 National MDG Report notes that at the end of December 2011, total public external debt stock was at the level of E2.77 billion coming from multilateral, bilateral and private creditors including African Development Bank Group, EIB, International Bank for Reconstruction and Development and International Fund for Agricultural Development. Bilateral sources comprised the Governments of Denmark, Germany, Japan, Kuwait, South Africa and Republic of China (Taiwan). The public debt service ratio to exports of goods and services from 2006 up until 2011 ranged between an average of 2.18 percent and 2.6 percent with increase at 3.09 percent in 2009. Debt service as a percentage of GDP was estimated at 1.44 percent in 2006, 1.73 percent in 2009 and 1.34 percent in 2010. Telephone lines per 100 population stagnated within 4.16 percent in 2006 to 4.27 percent in 2010, whereas cellular subscribers per 100 population increased from 18.87 percent in 2005 to 65.86 percent in 2010. Internet users per 100 population slightly increased from 1.2 percent in 2005 to 1.4 percent in 2008.

QUANTIFIABLE PROGRESS TOWARDS THE ACHIEVEMENT OF THE MDGS IN SWAZILAND

Goals and Targets	Indicators	Indicator Status						MDG Target
		1990	1995	2000	2005	2006/07	2010	2015
GOAL 1 ERADICATE EXTREME POVERTY AND HUNGER								
1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day 1.B: Achieve full and productive employment and decent work for all, including women and young people 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.1 Proportion of population below $1 (PPP) per day	59	66	69 (2001)	–	–	63	40
	1.2 Poverty gap ratio	–	48	32.4 (2001)	–	–	30.4	24
	1.3 Share of poorest quintile in national consumption	–	3.9	4.3	–	7	1.9	8
	1.4 Growth rate of GDP per person employed	–	–	–	–	–	–	–
	1.5 Employment-to-population ratio (%)	28 (1986)	31 (1997)	–	–	37	33.6	80
	1.6 Proportion of employed people living below $1 (PPP) per day	–	–	–	–	49.5	37.4	20
	1.7 Proportion of own-account and contributing family workers in total employment	–	–	–	–	4.09	3.19	–
	1.8 Prevalence of children under-five years malnourished (%):							
	• underweight	10	7	10	5.1 (2004)	5	6.6 (2009)	5
	• stunting	–	27	30	–	29	31	–
	• wasting	–	–	2	–	3	1	–
	1.9 Proportion of population below minimum level of dietary energy consumption	–	–	–	18 (2005)	–	11 (2003)	9
GOAL 2 ACHIEVE UNIVERSAL PRIMARY EDUCATION								
2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education (%)	74.3	–	79.2	81.9	86.7	88.3	100
	2.2 Proportion of pupils starting grade 1 who reach last grade of primary (%)	62	61 (1997)	77.5	77.4	78.5	92.7	100
	2.3 Literacy rate of 15–24-year-olds, women and men (%)	83.7 (1986)	–	79.2	–	95.4	92.5	100
	2.5 Primary school repetition rate (%)	–	–	16.5	17.1	–	15.8 (2009)	–

Goals and Targets	Indicators	Indicator Status						MDG Target
		1990	1995	2000	2005	2006/07	2010	2015
GOAL 3 PROMOTE GENDER EQUALITY AND EMPOWER WOMEN								
3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in:							
	• primary education	0.99	–	0.94	0.94	0.92	1.01	1.01
	• secondary education	0.99	–	0.90	1.01	1.01	1.24	1.06
	• tertiary education	0.75 (1991)	–	0.90	1.05	1.06	1.21	–
	3.2 Share of women in wage employment in the non-agricultural sector	30	33.2	25.2	23.5	47	48.6 (2008)	50
	3.3 Proportion of seats held by women in national parliament	6.3	–	3.1	10.8	10.8	13.6	30
GOAL 4 REDUCE CHILD MORTALITY								
4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate (per 1000 live births)	96	106 (1997)	122	–	120	104	32
	4.2 Infant mortality rate (per 1000 live births)	72 (1991)	78	87.7	–	85	79	23
	4.3 Proportion of 1-year-old children immunised against measles (%)	85	94 (1997)	72.3	–	81.7	97.8	100
GOAL 5 IMPROVE MATERNAL HEALTH								
5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio 5.B: Achieve, by 2015, universal access to reproductive health	5.1 Maternal mortality ratio (per 100,000 live births)	110 (1991)	370	229 (2001)	325	589	–	92
	5.2 Proportion of births attended by skilled health personnel (%)	–	56 (1994)	70	74 (2002)	74.3	82	–
	5.3 Contraceptive prevalence rate (%) among married women 15–49 years	–	–	27.9	–	59.3	65.2	–
	5.4 Adolescent birth rate per 1000 women	134 (1991)	–	102.8	–	111	89	–
	5.5 Antenatal care coverage (%):							
	• primary education	–	–	79	–	97	97	100
	• secondary education	–	–	–	–	–	76.6	–
	5.6 Unmet need for family planning (%)	–	–	–	–	24	13	–

Goals and Targets	Indicators	Indicator Status						MDG Target
		1990	1995	2000	2005	2006/07	2010	2015
GOAL 6 COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES								
6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.1 HIV prevalence among population aged 15–49 years (%)	2.3	10.6	32.2 (2002)	25.6	26	26	–
	6.2 Condom use at last high-risk sex (%):							
	• Women	–	–	–	–	54.2	73.1	_
	• Men	–	–	–	–	70.4	69.2	–
	6.3 Proportion of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS (%):							–
	• Women	–	25	–	–	52.1	58	–
	• Men	–	–	–	–	52.3	54	–
	6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14 years	–	0.91	–	–	0.97	0.99	–
	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs (%)	–	–	–	–	–	72	–
	6.6 Incidence and death rates associated with malaria per 100,000	–	–	39.4	–	36.6	1.5	–
	6.7 Proportion of children under 5 sleeping under insecticide-treated bednets (%)	–	–	0.1	–	0.6	–	–
	6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	–	–	2.25	–	0.6	1.7	–
	6.9 Incidence, prevalence and death rates associated with tuberculosis per 100,000							
	• Incidence rate	267	–	801	1141	1198	1287	–
	• Prevalence rate	626	–	740	788	812	704	–
	• Mortality rate	–	–	45	40	40	32	–
	6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course (%)							
	• Case detection rate	–	–	–	44	58	84	–
	• Treatment success rate	–	–	–	–	68	71	–

Goals and Targets	Indicators	Indicator Status						MDG Target
		1990	1995	2000	2005	2006/07	2010	2015
GOAL 7 ENSURE ENVIRONMENTAL SUSTAINABILITY								
7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest	36	–	45 (1999)	–	–	–	–
	7.2 CO_2 emissions, total, per capita and per $1 GDP (PPP)	–	–	0.3	0.2	0.2	–	–
7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.3 Consumption of ozone-depleting substances	0.8	36	1.6	6	5.5	–	–
	7.4 Proportion of fish stocks within safe biological limits	–	–	–	–	–	–	–
7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.5 Proportion of total water resources used	–	–	23.1	–	–	–	–
7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.6 Proportion of terrestrial and marine areas protected to total territorial area (%)	523.29	523.29	523.29	523.29	–	523.29	–
	7.7 Proportion of species threatened with extinction	–	–	–	9	–	9	–
	7.8 Proportion of population using an improved drinking water source (%)	39	43	51	61	–	67.3	–
	7.9 Proportion of population using an improved sanitation facility (%)	49	49	72	55	49.5	53.8	–
	7.10 Proportion of urban population living in slums	–	–	–	–	–	–	–

Goals and Targets	Indicators	Indicator Status						MDG Target
		1990	1995	2000	2005	2006/07	2010	2015
GOAL 8 DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT								
8.B: Address the special needs of the least developed countries *Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction*	8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes	4.57	3.25	0.86	1.73	–	2.55	–
	8.5 ODA received in small island developing States as a proportion of their gross national incomes	–	–	–	–	–	–	–
	8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries	–	–	–	–	–	–	–
8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	8.9 Proportion of ODA provided to help build trade capacity	–	–	–	–	–	–	–
	8.12 Debt service as a percentage of exports of goods and services	5.3	1.5	2.1	1.4	2.0	2.39	–
	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis	–	–	–	–	–	–	–
8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.14 Telephone lines per 100 population	–	–	–	4.16	4.35	4.27	–
	8.15 Cellular subscribers per 100 population	–	–	–	18.87	37.34	65.86	–
8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.16 Internet users per 100 population	–	–	–	1.2	1.4 (2008)	–	–

European Commission 2007 Annual Operational Review, Swaziland

Annex D: In-Depth Analysis Of The Non-Health Sectors

Methodology

In an effort to conduct an in-depth analysis of the non-health sectors agencies, a literature review was carried out on the draft MAF report and other relevant literature in order to make an informed decision on how to proceed.

Based on the literature review, a validation exercise was conducted so as to confirm the information collected on literature. The validation exercise was conducted in eight communities that were defined as hard-to-reach with more than two challenges, such as a bad road with no bridge and poverty. Another criteria was a community using a health facility that had recorded more babies that were born before arrival (BBA) in a health facility. In all the eight communities, a focus group discussion was held with a group of 8 to 10 women of childbearing age, using a standard tool. Communities visited are shown below.

Findings

Where do mothers deliver?

In all eight focus group discussions, it was mentioned that most mothers deliver in health facilities; however, some deliver at home assisted by relatives or older women regarded as experts in conducting deliveries. At times, RHMs are called for assistance, and some women deliver on their way to facilities.

Among those traditional birth attendants who reported that they assist in deliveries, it was mentioned that they use broken bottles or dried roofing grass too cut the umbilical cord. The TBAs reported that they never received any training, whether formally or informally, but they use personal experience gained during their own deliveries. However, at Kholwane 2 in the Shiselweni region, TBAs reported that they received training from the MOH. On the same note, RHMs mentioned that they do not conduct deliveries but only refer clients to health facilities because they did not receive delivery kits and

TABLE 9: COMMUNITIES WHERE THE VALIDATION EXERCISE WAS UNDERTAKEN BY REGION (HARD-TO-REACH SITES) 2012-2013.

Region	Health Facility	Number of babies BBA	Name of community	Challenges
Manzini	RFMH	117	Bahwini and Mkhiweni	Bad road, no water and low bridge
	Mankayane	52		
Lubombo	Good Shepherd	82	Mhlabeni and Bhandeni	Bad road, no water, no transport and poverty
	Sithobela	23		
Shiselweni	Hlathikhulu Govt.	103	Kholwane 2 and Tholulwazi 2	Bad road, no bridge, no water and poverty
	Hospital	–		
	Matsanjeni	21		
Hhohho	Mbabane Govt.	119	Lufafa and Kasiko	Bad road, no bridges, no transport, and poverty
	Dvokolwako Health Center	47		
	Piggs Peak Govt.	26		
	Hospital	–		

they stressed that one of their roles is to refer women in labour to health facilities. Relatives (aunts) also conduct deliveries.

The TBAs conduct deliveries for free although at times a token of appreciation, such as clothing and chicken, is given to the TBA, as stated by the eBhandeni community.

Why do mothers deliver outside health facilities?

There were several reasons for not going to health facilities for delivery. It was reported that some of the mothers who deliver at home are those who never attended ANC or had late bookings due to decision-making at home. Some women said that they are afraid of being scolded by nurses for not having attended antenatal care, as is the case with most teenage mothers who usually hide their pregnancies.

Other women indicated that they are afraid of attending ANC because of the belief that the tablets given at the clinic make the babies big, which may require caesarean section. Some claim that they have had a history of false labour and had to return home. However, some of the women reported that after delivery, they visit the facility the following day to get immunizations.

Harmful and cultural practices

It was reported that some use an herbal concoction *(masheshisa)* to speed up labour pains. They also indicated that they use a broken bottle or dried roofing grass to cut the baby's cord. To accelerate the healing process, red ochre and methylated spirit are used. Respondents also mentioned that they use any string available to tie the cord. These were general practices reported in all the regions.

Mode of travel

Most of the respondents reported that they first walk around 1–10 kilometers to the main road where they can catch public transport. It usually takes them 1–4 hours to reach the station.

In one of the research sites (KaSiko) it was noted that the bus fare costs E20.00–E30.00. However, those from Lufafa and Mhlabeni pay E15.00–E50.00. Some reported that the kombi (vehicle) used is very inconsistent and unreliable because it is old and occasionally breaks down. In most communities like Bahwini, KaSiko and Tholulwazi, there is only one bus, which leaves in the morning at 7 a.m. or 8 a.m. during the week and none over the weekend. Furthermore, it was noted that if the transport vehicle has passed, or was unavailable, the client has to hire private transport, which costs E200.00–E800.00 for a single trip.

Reasons for lack of transport

Most respondents mentioned that the terrain is bad, especially after rainfall, and becomes slippery and muddy. In addition, bridges are very low and during rainfall it is not easy to cross the river since the water is always above the bridge. The bus is available only once in the morning, but some clients may need transport at any time of the day. Most of the community members live far away from the main road to access the bus or public transport. Furthermore, they live in mountainous areas and have to travel about two (1–4) hours to reach the main road.

Previous efforts made in addressing identified issues

In most of the communities it was reported that the status of the **road** was reported to elders of the community. In one community (Mkhiweni) it was reported to the Road Transport Board at the Ministry of Works and Transport (MOWT), which promised to send someone to do an inspection

and take it up from there. On another note, the issue of the **clinic** has been discussed with the Mkhiweni umphakatsi and later with the MOH who gave them a draft Clinic Plan.

The issue of water shortages was discussed at the umphakatsi of Ebhandeni with World Vision International, who promised to provide assistance, but nothing has been done yet.

Decision-making about attending ANC and place of delivery

In all eight focus groups, the women recorded that they rely on their husbands and in-laws to decide when to start ANC and where the baby will be delivered. This was said to be influenced by availability of funds to travel (hiring a car) and the cost of delivery in a health facility. It was also recorded that poverty also influences where women deliver; they have to negotiate whether to use limited funds for hiring expensive transport (E400.00–E800.00) or opting to buy food. They delay going to the clinic because they usually believe that they are having or will experience false labour pains and will have to return home without having delivered, while some women delay going for early booking because they fear being tested for HIV.

Gender issues

From all the discussion, it was established that most women who attend ANC get an HIV test, and those that test positive are initiated to ART. However, it was reported that some husbands of women who have tested HIV positive are reluctant to go for an HIV test, and at the same time they refuse to use the condom. Furthermore, the assessment revealed some women have late bookings due to delayed decision-making by the husband. Additionally, during the study it was highlighted that family planning is not accepted by men.

Another issue of concern was infant feeding for an HIV-positive mother whereby she has to choose one feeling option for the infant; however, it was noted that the in-laws would force the women to feed the child using more than one option at a time.

Work load for women

In most of the focus group discussions it was indicated that most women are overburdened with work, which ranges from household chores to cattle rearing and farming. It was recorded that even if the husband is not employed, the responsibility of looking after cattle lies with the women.

Identified key non-health issues

Availability of health services and road infrastructure network

Each focus group was asked to identify three health related issues affecting the health of pregnant women in their community. Almost all the focus groups recorded the issue of the unavailability of a nearby health facility. However, they appreciated the monthly outreach services, except when it has rained and the road is bad. They also cited challenges caused by the poor road infrastructure, compounded by low or inexistent bridges.

Food security

Some of the respondents at Ebhandeni, Mkhiweni, KaSiko and Bhahwini reported that most of their households have poor crop yields. They argued that there is no one to provide technical support on farming. Some attribute poor farming to high costs of farming inputs, which is also influenced by the fact that men have no gainful employment.

Safe water

The other issue reported was absence of safe water for human consumption as reported by Mkhiweni, Bhandeni, Mhlabeni, Bhahwini and

Kholwane. The Bhandeni community even reported that they illegally cross the Mozambican border to get clean water, and most often they are reprimanded. Furthermore, some observed that some facilities would not offer delivery services due to inadequate running water.

Travelling to health facilities in terms of safety and poor communication network

Although most of the communities reported having to walk long distances before reaching the main road, only one community at Bahwini identified lack of security in the area since there is no police station nearby. Most of the communities reported issues of non-availability of telecommunications at the chiefdom area and in some nearby health facilities such as Moti and Bhahwini clinics, etc.

Teenage pregnancy and drug abuse

Some communities identified teenage pregnancies and drug abuse as a problem caused by the long distances students walk to get to school. This was expressed by KaSiko, Lufafa, Kholwane and Bhandeni.

Family planning/HIV testing and counselling

In all the focus groups, women expressed concern about husbands' reluctance to use family planning (condom), and at the same time they are reluctant to go for HIV testing.

Discussion

The assessment confirmed the issues that were documented in literature. The issue that some mothers deliver at home and on the way to the facility is a reality, which is also confirmed by the SAM and 2010 SRH report, that states that 82 percent of mothers deliver in a health facility, implying that 18 percent deliver outside health facilities.

Some of the reasons cited for deliveries at home and on route were lack of waiting huts at the referral health facility in addition to long distances to walk to the main road (1–10 km). This is compounded by the bad terrain and low bridges, which hinder the availability of public transport; furthermore, the public transport only leaves at 7 a.m. in the morning each day, with nothing after that. On another note, once the transport has left, the woman is subjected to high (E200.00–E800.00) costs since she must hire private transport to take her to the hospital. Because of poverty, some households debate whether to buy food or use the money for one person to go to the hospital, hence most often the pregnant woman is advised to deliver at home by relatives or someone who is known to be an expert in conducting deliveries.

In other situations, the women will be rushed to a nearby clinic for delivery only to find that the facility does not conduct deliveries due to its limited infrastructure or due to water shortages. Consequently, the midwives refer the client to the nearest referral hospital. However, it is unfortunate that the clinic does not have an ambulance or a telephone to call the ambulance to transport clients.

Another issue of concern was the decision-making at the household level. It is true that if there is a delay in decision-making for going to the hospital, the women will deliver at home or on the way to the health facility. This is evidenced by 2012 HMIS data, which recorded that 119 babies were born before arriving in Mbabane Government Hospital, 117 before they reached RFMH, 103 before reaching Hlathikhulu Government Hospital and 82 before reaching Good Shepherd.

What is of importance is that women who deliver at home or on the way are assisted by women who are not skilled and also use harmful

practices. These include the use of a broken bottle or dried roofing grass to separate the umbilical cord as well as using available any string to tie the cord. Furthermore, the traditional birth attendant cannot recognise signs of severe bleeding or difficult labour, hence, more women will continue to die whilst giving a life.

Conclusion

The study revealed that although many women attend ANC and deliver in health facilities, a significant percent still deliver at home. This is influenced by several factors such as late booking for ANC clinics because of health workers' and traditional birth attendants' attitudes and relatives assisting in home deliveries even though only one site reported that they were trained by health workers.

Health facilities for some communities do not offer delivery services, some women live very far from health facilities and have to walk several hours to the bus stop. It was noted that transport is scarce to ferry them to health facilities since transport is only available once a day. The terrain of the road is also a setback; thus, during rainy days they fail to transport people. To hire private transport is equally difficult because of the escalating costs of the transport. Gender and poverty issues are also at play as they would prefer to deliver at home rather than spend the little they have for delivery instead of food. Food security is also a challenge for most communities. Climate change observed through heavy rainfall, drought and floods was cited as a cause for concern that has contributed to the failure to access health facilities.

There are some who still practice harmful interventions such as *'masheshisa'* traditional concoctions to speed up delivery, which is dangerous. Apart from that, the TBAs and others who offer delivery services use broken bottles and grass to cut the umbilical cord with a risk of contamination or tetanus. Some of the communities indicated that they have water shortages, hence hygienic practices are hardly observed. This does not only affect households but the health facilities also. While some communities appreciate outreach sites, services are only offered once a month.

Way Forward

There is a need for the Ministry of Health to work collaboratively with other Ministries to address issues that are beyond the scope of health such as bridges, road, transport, water, etc., as shown in the table below. The role of the Ministry of Planning and Economic Development as a convener and coordinating agency for the Ministries cannot be overemphasized. It is recommended that these two key Ministries work close together and immediately commence the implementation of the MAF Action Plan on reducing maternal deaths in Swaziland.

TABLE 10: IDENTIFIED SECTORS AND INTERVENTIONS	
Ministry	**Area of Expertise**
Office of the Prime Minister	Construction of police station and security for clinics
DPMO - Gender and Social Services	Issues of gender and women and child rights and re-enforcement of the law on the use of condoms
Ministry of Works and Transport	Roads, bridges, public transport and construction of waiting huts
Ministry of Education	Teenage pregnancies and drug abuse
Ministry of Home Affaires	Religious issues
Ministry of Information and Communication Technology	Telephone services and other communication services
Ministry of Natural Resources	Water and electricity
Ministry of Economic Planning	Poverty alleviation
Ministry of Agriculture	Improvement of crop production
Ministry of Tinkhundla	Cultural issues and dispelling myths
Ministry of Health	Provision of health care services

Annex E:

Key Non-Health Contributory Factors to Maternal Death\Presentation on MAF to MAF validation 18th November 2013 Autosaved.ppt

ANNEX F: MAF STEERING COMMITTEE		
Name	**Title**	**Organisation**
Mrs. Joyce T. Dlamini (Chair)	Under Secretary	Ministry of Economic Planning and Development
Ms. Rejoice Nkambule	Deputy Director	Ministry of Public Health
Mr. Colin Tshabalala	Principal Planner	Ministry of Economic Planning and Development
Ms. Duduzile Dlamini	Family Health Programme Office	WHO
Ms. Fatou Leigh	Economic Advisor	UNDP
Ms. Marjorie Mavuso	Assistant Representative	UNFPA
Ms. Phumzile Dlamini	Program Analyst-Gender	UNFPA
Ms. Muriel Mafico	Assistant Resident Representative	UNICEF
Ms. Gloria Bille	Strategic Interventions Advisor	

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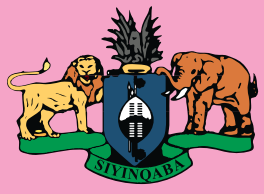

MDG ACCELERATION
FRAMEWORK

September 2014