

KINGDOM OF SWAZILAND  
MINISTRY OF HEALTH

# ANNUAL NATIONAL SEXUAL AND REPRODUCTIVE HEALTH PROGRAM REPORT



2015

**Monitoring & Evaluation Unit**  
Strategic Information Department



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# LIST OF ACRONYMS










ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CMS	Central Medical Stores
EmONC	Emergency Obstetric and Neonatal Care
FANC	Focus Antenatal Care
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IATCC	Inter-agency technical coordinating committee
ICPD	International Conference on Population and Development
IHM	Institute for Health Measurement
LLAPLa	Life Long ART for Pregnant and Lactating women
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, neonatal and child health
MoH	Ministry of Health
NHSSP	National Health Sector Strategic Plan
PAC	Abortion and Post Abortion Care
PHU	Public Health Unit
PMTCT	Prevention of Mother to Child Transmission
DHS	Swaziland Demographic and Health Survey
SGBV	Sexual Gender Based Violence
SID	Strategic Information Department
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SDG's	Sustainable Development Goals
STIs	Sexually Transmitted Infections
TT	Tetanus
TWG	Technical Working Group
VIA	Visual inspection with acetic acid

# ACKNOWLEDGEMENT

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Finally but not least, MOH acknowledges with profound gratitude the support accorded by the Institute of Health Measurement (IHM).

# Dashboard on SRH Key Performance Indicators

Thematic area	Indicator name	Baseline (2014)	Target (2018)	Actual output/outcome by 2015	Status	Reason for not achieving
MNCH	# of Maternal death (Maternal Death Review reports)	35 deaths	reduce by 6 deaths per yr (<11 deaths)	29 deaths		Facility Inadequate staffing in numbers and skills
	% of pregnant women attending ANC at 1 <sup>st</sup> trimester (< 16 weeks)	28% (SRH annual report)	60% (increase by 8% per year)	28% Routine HMIS data		Poor community and health care worker sensitization on the importance of early ANC attendance
	% of HIV positive pregnant and lactating women receiving lifelong ART	90%	90%	93% Routine HMIS data		
	% of women attending PNC 7-14 days	59%	90%	67% Routine HMIS data		Inadequate community sensitization
	% of Fresh Still Births (FSB) among total still births.	unknown	Reduce by 90 % <10% FSBs	37% Routine HMIS data		poor management of labour
ASRH	% of adolescent 10-15 deliveries among total adolescent deliveries (10-19)	4% 105/2557	<1%	4% 110/2793 Routine HMIS data		Limited access of adolescents to Family Planning. However, different activities have been introduced and impact will be realized later
	% of adolescent pregnancies (adolescents giving birth)	16.7%		16.7% MICS 2014 16% HMIS		This data is from the survey (MICS 2014) and will be tracked after another survey
FP	Unmet need for FP	15%	10%	15% MICS 2014		Next MICS will give us progress
Cancers of the reproductive system	% of women screened VIA positive	13% 468/3652		12% 940/7595 Routine HMIS data		There are more women being screened for VIA

# EXECUTIVE SUMMARY

The annual report seeks to monitor the effectiveness of the strategies as stipulated in the SRH strategic plan 2014-2018 in terms of achieving the set targets. It is stated in the strategic plan that maternal and neonatal deaths should be reduced by 50% by 2017. However, findings have shown that maternal and neonatal deaths have remained high over the years despite the many interventions to improve maternal and neonatal health. By 2018, it is expected that 60 percent of pregnant women should make their 1st ANC booking during the first trimester (SRH Strategic Plan), however by 2015, evidence from routine data shows that only about 28 percent of these women come in during the first trimester. Presenting late in pregnancy then makes scheduling of the four focused visits impossible.

According to the MICS, only 2 percent of pregnant women do not attend ante-natal care and institutional deliveries stand at 87.7 percent. The many (9%) home deliveries reported through HMIS particularly in the Lubombo (31%) still pose as a challenge in combating maternal and neonatal mortality. Still births remain high (156) and this speaks to the quality of care that the women receive during ante-natal care and at labor and delivery. Syphilis contributes to poor pregnancy outcomes which may include still births. During the year, 613 pregnant women screened for syphilis and about 9 percent of the women who had screened positive for syphilis were not started on treatment.

Cancers are one area that need special attention and robust strategies that will promote prevention. Screening for cervical cancer has intensified with over 11000 women screened. The data has also shown that at inpatient more cases of prostate cancer are identified, however, little is known about the screening for prostate cancer because there are no data tools that capture such information. On a positive note, deaths due to reproductive health cancers have decreased over the years from 17 percent in 2012 to 12 percent in 2015.

## Recommendations

- Conduct a mid-term review for the Sexual Reproductive Health and Rights Strategic Plan 2014-2018
- Use findings and recommendations from the numerous studies conducted by the program to inform policy, programming and mid-term review of the SRH strategic plan.
- Strengthen health education on;
  - Early ANC booking, Institutional deliveries, Use of long-active Family Planning methods
- Increase facilities with maternity wings at Lubombo and intensify community mobilization for institutional deliveries
- Improve the quality of care at ANC and L&D to reduce the number of still births
- Strengthen ASRH services and information to reduce teenage pregnancy
- Strengthen FP to reduce abortion cases and increase HCW skill on how to conduct Post abortion care
- Initiate all women who screen positive for syphilis at ANC to improve pregnancy outcomes
- Intensify screening for cervical and prostate cancer and develop data collection tools
- Train HCW on data collection tools and review data collection tools



# CHAPTER 1: INTRODUCTION



In 2015 the population of Swaziland was estimated at 1,119,375, with 531, 737 males and 587, 638 females. Women of childbearing age (15-49 years) make up 26 percent of the population while all females account for 54 percent of the population and the estimated annual births rate is of 34, 571. The crude birth rate is 30.88 per 1000 with an expected natural increase of 1.18 percent<sup>1</sup>. The total fertility rate is estimated at an average of 3.5 births in a woman's life, compared with 6.4 births in 1986 Population and Housing Census, and 3.8 births in the 2007 Population and Housing Census.

According to the Swaziland Household Income and Expenditure Survey (SHIES), 63 percent of the population is living in poverty. The economic status of a population has a bearing on their health and wellbeing. The country has an estimated 40 percent unemployment rate<sup>2</sup>. The country's socio-economic challenges are exacerbated by the highest prevalence of HIV and AIDS rates in the world (26.1% of population aged 15-49 ), which is also reflected in its very young population (over 50% of population is younger than 20 years).

The maternal mortality ratio remains high at 320 per 100 000 live births<sup>4</sup>. None pregnancy related infections especially HIV account for 46percent of these deaths<sup>5</sup>. There is some evidence to support the fact that the country is making progress in areas related to maternal health; contraceptive prevalence rate of 65 percent, 98.5 percent of women attending at least one ANC visit and about 88 percent delivered by skilled birth attendants; frequency on ANC visit of women who attended at least 4 visits is about 76 percent, institutional deliveries 87.7 percent and the FP unmet need at 13 percent for the population, however, unmet need for the HIV positive women remains unknown. Also notable is the reduction in child mortality; neonatal Infant 19 to 20 per 1000, infant mortality rate from 79 to 50 per 1000 from 2010 to 2014<sup>6</sup>).

## 1.1 STRATEGIC DIRECTIONS

Program implementation is guided by the SRH policy and strategic plan 2014-2018 which are aligned to the global and national policy documents and strategies such as the ICPD Programme of action 1994, the national Health policy and National Strategic plan. SRH interventions also seek to reduce morbidity and mortality related to sexual reproductive issues. SRHP's performance is measured mainly by the maternal and neonatal death ratios which contributes to the national life expectancy ratio. However, there are other indicators that measure program performance like the unmet need for family planning, teenage pregnancy and the CPR amongst others.

### Vision

A healthy and well informed population with universal access to quality SRH services, that are sustainable and which are provided through an efficient, effective and rights based support system.

### Mission

To provide, facilitate and support an integrated and well-coordinated sexual and reproductive health services and information upholding the rights of women, men, youth, adolescents and children in Swaziland.

## A Swaziland Case for Investment in Maternal Health

The SRH program in line with the Sustainable Development Goals (SDGs) and the National Health Sector Strategic Plan II focuses on ensuring healthy lives with a life course approach to health.

### Sustainable Development Goals:

In September 2015, a summit of heads of state adopted the Sustainable Development Goals (SDGs). Swaziland did not perform well in the MDGs, and as such the SRH program is undertaking early, consistent, and timely review of the SDGs that are related to SRH. This focus is to ensure that progress is measured as early as possible, and where new interventions are needed, the program will undertake these timely.

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1. Swaziland Population Projections 2007-2013

2. Swaziland Labour Force Survey 2010, Central Statistics Office

3. Swaziland Demographic and Household Survey 2006/7

4. UN Global Estimates 2012 report

5. Confidential Enquiry into Maternal Deaths Triennial Report 2010

6. Multiple Indicator Cluster Survey 2014

## Goal 3. Ensure healthy lives and promote well-being for all at all ages

Goal 3. Ensure healthy lives and promote well-being for all at all ages	
3.1 by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio (MDG Indicator) and rate
	Percentage of births attended by skilled health personnel (MDG Indicator)
	Antenatal care coverage (at least one visit and at least four visits) (MDG Indicator)
	Post-natal care coverage (one visit) (MDG Indicator)
	Coverage of iron-folic acid supplements for pregnant women (%)
	Percentage of health facilities meeting service specific readiness requirements.
3.2 by 2030 end preventable deaths of newborns and under-5 children	Percentage of infants under 6 months who are exclusively breast fed
	Neonatal, infant, and under-5 mortality rates (modified MDG Indicator)
	Percent of children receiving full immunization (as recommended by national vaccination schedules)
	Percentage of births attended by skilled health personnel (MDG Indicator)
	Antenatal care coverage (at least one visit and at least four visits) (MDG Indicator)
	Post-natal care coverage (one visit) (MDG Indicator)
	Incidence rate of diarrheal disease in children under 5 years
by 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne	Percent HIV+ pregnant women receiving PMTCT

### 1.2 OBJECTIVES OF THE SRH REPORT

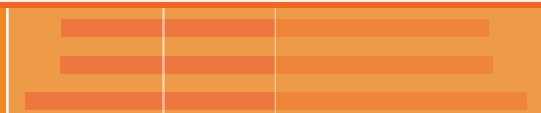
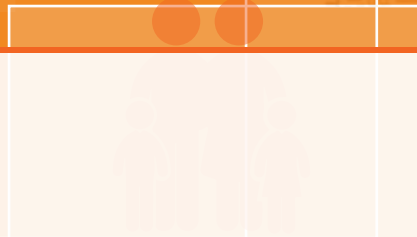
The objective of the SRH 2015 report is to present major achievements of the program towards set targets mainly as outlined in the SRH strategic Plan 2014-2018. Findings from this report will then be used to inform data/report utilization to improve on outcomes. It is intended that this report will continue to be produced annually in order to identify trends and changes over time.

### 1.3 THE 2015 ANNUAL SRH PROGRAM REPORT-WRITING PROCESS

The report writing process started by formulating a tabulation plan and consultation with the SRH program officers to determine areas to be included in the report. Thereafter data mining by HMIS was done based on the agreed upon data needs. The data was then scrubbed and prepared for analysis.

A meeting was held whereby specific information was provided by the SRH program. After this meeting, the report was written and sent to the program for finalization.

# CHAPTER 2: SRH PROGRAM DESCRIPTION



The Ministry of Health through the Sexual and Reproductive Health Program, is mandated to coordinate all SRH interventions in the health sector. The mission for the SRH program is to provide, facilitate and support integration and mainstreaming of sexual and reproductive health services whilst upholding the rights of women, men, youth, adolescents and children in Swaziland. The program’s implementation is guided by the National Sexual Reproductive Health and Rights Strategic Plan 2014-2018 which has 11 focus areas as follows; MNCH, ASRH, Family Planning, Abortion and PAC, STI, TB, HIV and AIDS, Infertility, Cancers of the reproductive system, Gender and SRH including GBV, Sexual dysfunction, SRH and aging and Community involvement and participation. The implementation of each component is based on the 5 strategic activities namely;

- Policy and legal
- Advocacy and IEC
- Capacity building
- Service delivery
- Research and M&E

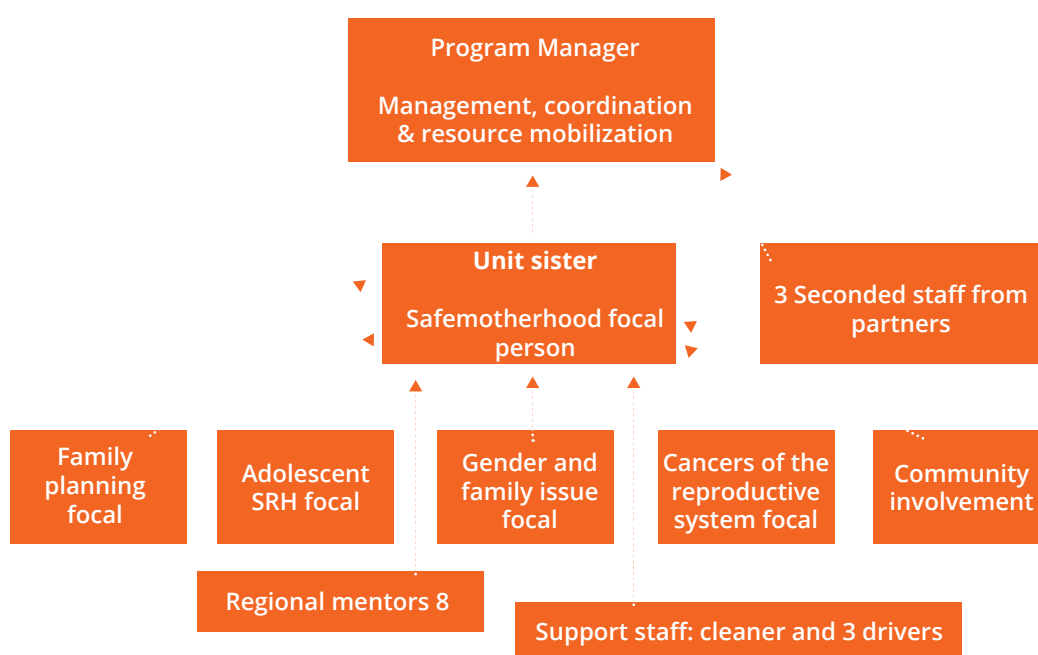
## 2.1 Coordination of SRH Program

Sexual reproductive health services are coordinated nationally, regionally, facility and at community by the program. SRH interventions are delivered using the adopted public health and primary health approaches as derived from the 1994 International Conference on Population and Development (ICPD) and the Maputo Plan of Action 2006 declaration endorsed by Swaziland among other countries.

Coordination of the program is supported by an Inter-agency Technical Coordinating Committee (IATCC) which meets quarterly. A number of technical working groups have been commissioned to harmonize technical assistance and foster collaboration in the development of interventions of different thematic areas of SRH.

## 2.3 Human resource management

The Program has 3 program officers: the program manager, and 2 officers in its establishment register. It has 3 seconded staff from partners: MNCH technical advisor, EmONC advisor, and MNCH advisor. Two officers have been seconded from the regions and there are support staff which are 3 drivers and 1 cleaner.



## 2.4 Allied Services

The SRHP does not function in isolation. To effectively and efficiently deliver SRH services the program works in collaboration with other departments within government (MOH) that provide allied services. These services are as follows:

**Laboratory Services** – services required by the SRH program include; Pregnancy test, Blood group test, Haemoglobin test, Rhesus factor, syphilis test, HIV test, CD4 count, viral load and Pap smear. There has been good collaboration with the laboratory regarding the routine SRH services. However, stock outs of syphilis test kits, pregnancy test and CD4 reagents were experienced in 2015.

**Drugs and consumables** – the central medical stores (CMS) is responsible for SRH related drugs and consumables. 2015 was a relatively good year, however there were stock outs of infant NVP syrup, magnesium sulphate, and oxytocin. CMS is actively involved in the logistic management information system (LMIS) for family planning. Lessons learnt is that, the LMIS need to be scaled up to service the other SRH drugs; to prevent stock outs and drugs expiring in the facilities.

**Lay staff** - Mentor mothers, Expert clients, and Community health workers have been engaged by the program for supportive services both in the facilities and community level especially in the roll out of LLAPLa (lifelong ART for pregnant and lactating women) and promotion of early ANC booking and institutional deliveries

## 2.5 Infrastructure

As part of improving MNCH services and reducing maternal and neonatal deaths, the MOH is currently upgrading health centers to have theaters so that they are enabled to conduct caesarean sections and other operations.

Even though there are these improvements, space is still needed in clinics to provide MNCH services and the reviving of type B clinic.

A Chemotherapy unit which is based at the Mbabane Government Hospital for cancer clients started functioning in 2015.

## 2.6 Technical and Financial Support

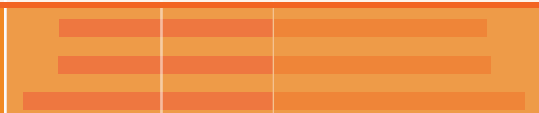
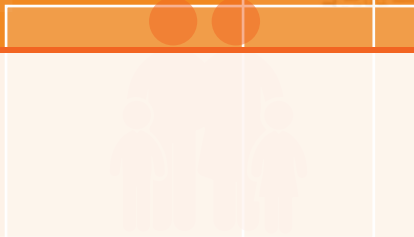
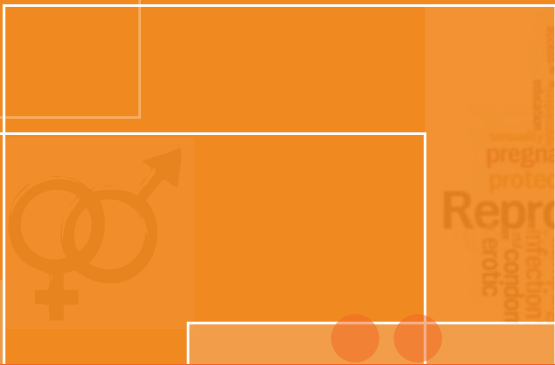
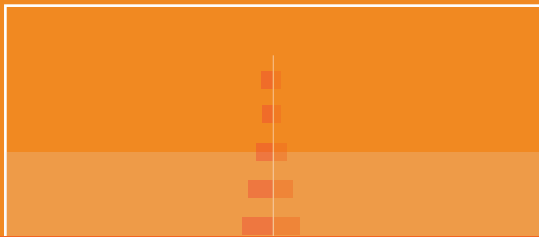
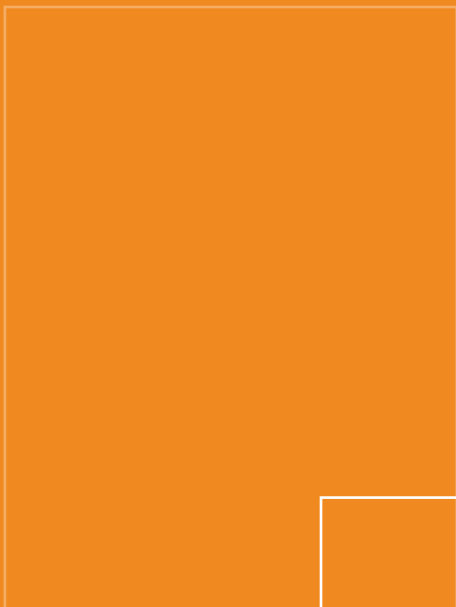
The maternal and neonatal death ratios are key indicators that measure MOH's performance hence MOH remains committed to funding SRH services, supplies and commodities. In 2015, government had a budget line for the SRH program, however there is a substantial contribution from partners both technically and financially.

## 2.7 Strategic Information Department (SID)

The SRH report utilizes data collected from the routine HMIS as well as from surveys conducted. Using indicators from the Indicator protocol the program reports on its performance regionally, nationally and globally. Informing some indicators routinely usually is impossible as HMIS in some areas does not disaggregate data as per program needs. Therefore the SRHP needs to work with HMIS to review data collection tools even before the roll-out of CMIS to make sure all essential program components are captured.

Another key area that needs focus is data utilization and this does not only mean the producing of reports but rather action or activities that have been informed the program reports.

# CHAPTER 3: SRH PROGRAM SERVICES AND OUTPUTS



This section covers the 11 program areas as per the SRH strategic plan 2013-2018, highlighting key program areas in achieving set targets. Data analysis (descriptive methods) will be used with comparisons from previous years, trends will be used to articulate progress made over the years where applicable. However, proper analysis of progress in all the 11 intervention areas is dependent on availability of data within the health management information system (HMIS). The following maternal, neonatal and child health; family planning, cancers of the reproductive system, ASRH, abortion and post abortion care, infertility, STI's, HIV and AIDS, gender and SRH including GBV, sexual dysfunction and community involvement & participation in SRH.

### 3.1 Maternal, neonatal and child health

The Maternal, neonatal and child health component is one key area that receives significant attention as the SRHP's performance is mainly measured on maternal and neonatal deaths. As a result the substantial resources and efforts have been invested to combat this; these include the Quality of Care (QoC) assessment which was conducted during the year (report to be disseminated in 2016), maternal death audits are conducted every quarter as well as trainings on MNCH. This section describes the following aspects of MNCH; ANC, Deliveries, and PNC.

#### Antenatal Care

Ante-Natal care has been a success story for Swaziland with 98percent of pregnant making at least 1 ANC booking leaving only 2 percent of women not attending ANC<sup>7</sup>. According to the WHO guidelines, for ANC to achieve its full potential women should make their 1st ANC booking during the 1st trimester and make 4 ante natal visits which facilitates the provision of focused essential interventions which may include amongst other things the identification and management of obstetric complications.

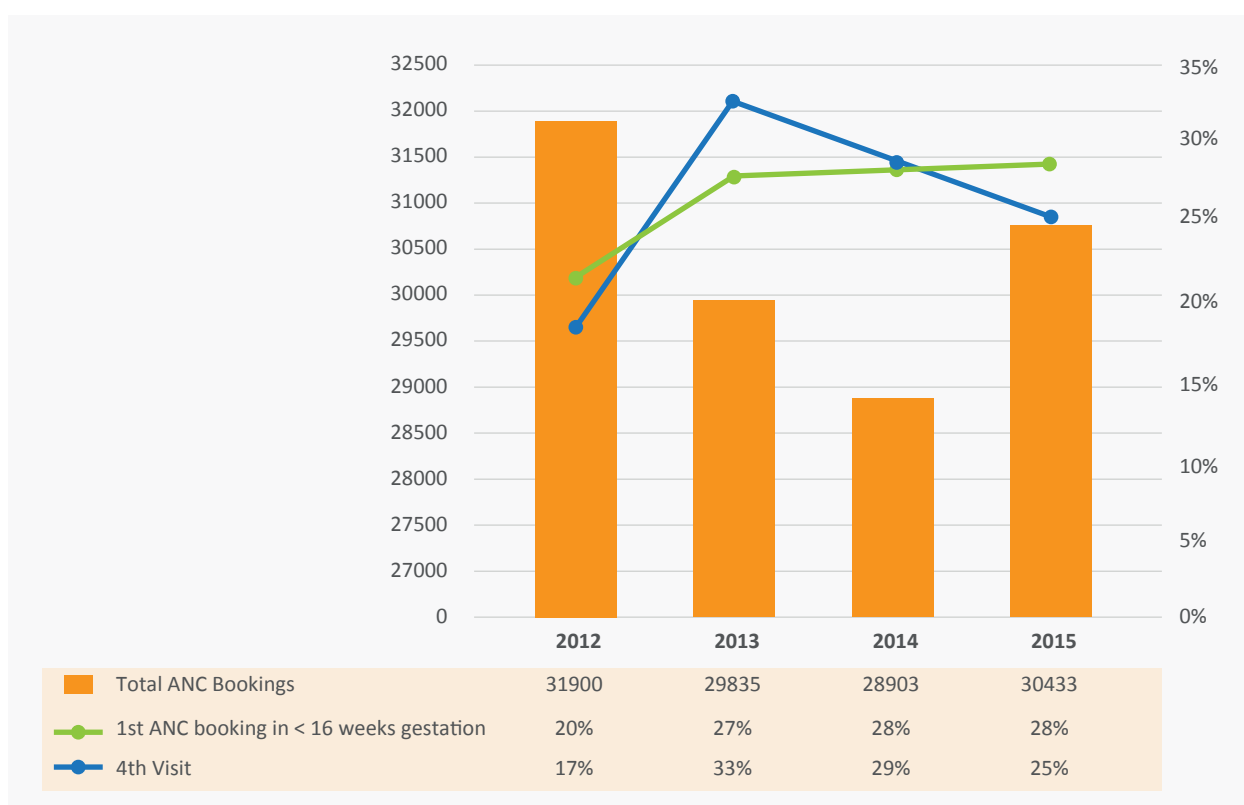


Figure 1; ANC bookings, 2012-2015

Figure 1 above, details the ANC visits made by pregnant women; total number of women who attended ANC, number of women making their 1st ANC booking within the 1st trimester and women making a forth ANC visit. In total, there were 30, 433 women who came for ANC (at least 1 visit).

7. Multiple Indicator Cluster Survey 2014



Figure 1 also shows a trend of women who made their 1st ANC booking in less than 16 weeks of gestation. Though there has been an increase from the 20 percent that was reported in 2012, the trend has remained the same since 2013. The program still needs to re-strategize in order to meet the 60 percent target of 2018 as stipulated in the SRH strategic plan.

The trend of women making 4 ANC visits (NB: visits not focused) has been fluctuating over the years.

### Pregnant Women Receiving Tetanus Toxoid Vaccinations

ANC provides an opportunity to vaccinate pregnant women with the recommended doses of tetanus toxoid vaccination. WHO reports tetanus as the second leading cause of death from vaccine preventable diseases. With immunization from the tetanus toxoid vaccination, the disease is completely preventable and has been controlled over the years through prevention. Swaziland with no exception has been able to immunize and control tetanus by vaccinating women with TT during pregnancy. However, the gap still remains with data limitations whereby it is still not easy to ascertain if these women are able to complete the recommended doses.

Findings from the Multiple Indicator Survey 2014 depicted that 83% of women aged 15-49 with a live birth in the last 2 years were given at least two doses of tetanus toxoid vaccine within the appropriate interval prior to the most recent birth. Figure 2 below shows the number of pregnant women who were vaccinated with TT over the years. The trend has been similar in recent years whereby TT1 and 2 are the most commonly reported. According to HMIS data 3 suspected cases of tetanus were reported at inpatient in 2015.

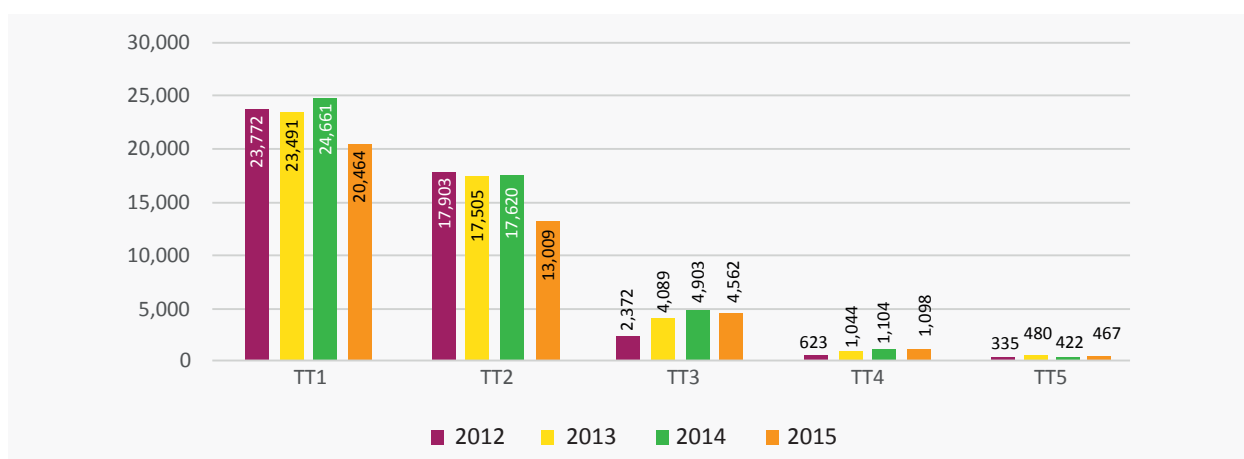
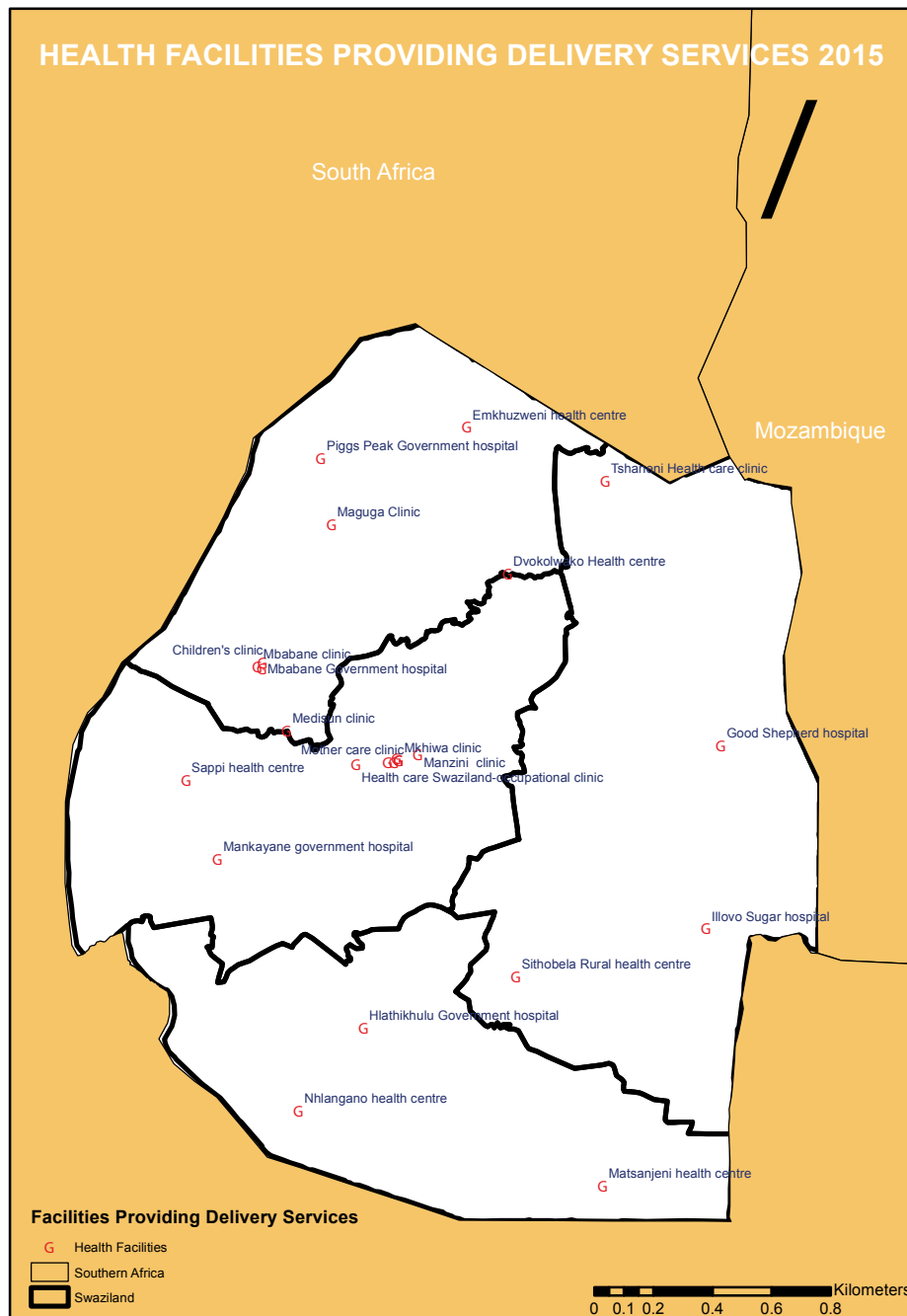


Figure 2; Tetanus Toxoid for pregnant women, 2012-2015

## Deliveries

Swaziland has a fertility rate of 3.3 and pregnancies reported through the HMIS have decreased over the years. This has however had an impact on the number of deliveries occurring. Contrary to what is projected in the Swaziland Populations Projections 2007-2030 whereby the growth rate is about 1.1 per year, routine data has proved that births are actually declining.



The table below shows the number of deliveries (27,363) reported through HMIS with 46 percent of the deliveries accounting to Manzini. Ninety one percent were institutional deliveries. Lubombo still continues to have the highest home deliveries and contributes to 31 percent of the home deliveries that occurred nationally. However, when comparing the deliveries that occurred within a region Lubombo still has the highest (16%) home deliveries with Manzini having the lowest (4%).

Table 1: Deliveries-home & institutional by region

REGION	Institutional deliveries	Home deliveries	Total
Hhohho	4768	567 (11%)	5335
Lubombo	3897	752 (16%)	4649
Manzini	12014	540 (4%)	12554
Shiselweni	4282	543 (11%)	4825
<b>Total</b>	<b>24961</b>	<b>2402 (9%)</b>	<b>27363</b>

### Types of Delivery

Government promotes the reduction of giving birth through C-section in favor of vaginal delivery except in cases whereby a procedure is necessary. WHO considers 15 percent to be ideal for caesarean section. Figure 3 below shows the proportion of women who gave birth. Ten percent of the women delivered through the caesarian section with the rest through vaginal delivery. Of the NVD, 3 percent were BBA and assisted deliveries (forceps and vacuums).

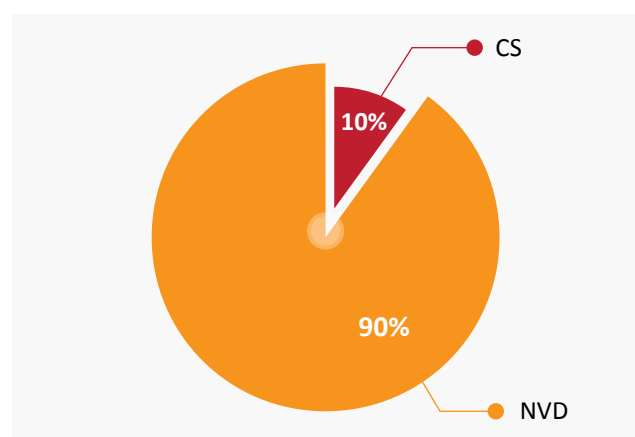


Figure 3; Types of delivery 2015

### Still births

Generally, a still birth is a birth of an infant that has died in the womb after having survived through at least the first 28 weeks of pregnancy. Still births can be fresh or macerated and are an indication of the level of quality of care received by pregnant women during ante-natal (for macerated) and at labor (for fresh). According to HMIS data, 1 percent (156) deliveries were still births with 37 percent of them being fresh. Swaziland has an ANC coverage of 98 percent and over 70 percent (MICS 2014), women make 4 ANC visits. However, routinely it is reported that very few women come for their 1st ANC booking within 16 weeks of gestation which then makes it impossible to schedule for the expected 4 focused visits; and this could be another contributing factor to having so much macerated still births. On the other hand, institutional deliveries and skilled birth attendants are high yet 37percent of the still births were fresh.

### Postnatal Care

Immediate postnatal (within 7-14 days of giving birth) care is critical for newborn and maternal survival. Part of the strategies to improve the provision and access to PNC services the SRHP is committed to strengthen service provider's skills and competencies in the provision of MNCH services, to provide MNCH facilities with equipment and supply as well as to ensure the provision of quality post-natal care. This is evidenced by the graph below which shows an increasing trend of women attending the 1st PNC within 7-14 days. In 2015, 67 percent of the women who had delivered attended ANC within 7-14 days of giving birth.

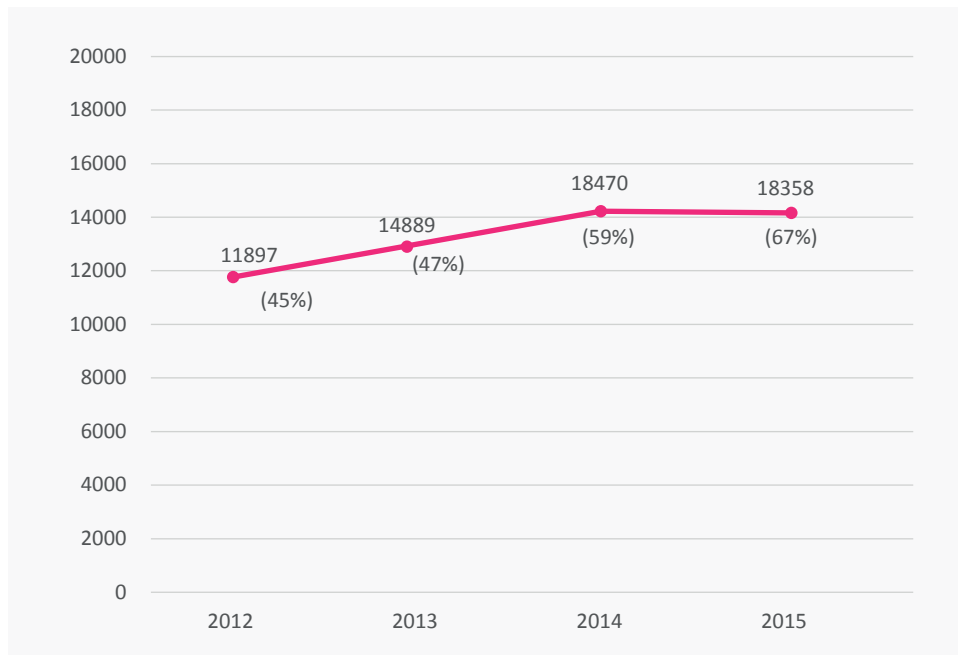


Figure 4; Women attending PNC within 7-14 days, 2012-2015

### 3.2 Adolescent and Youth Sexual Reproductive Health and Rights

Adolescent and Youth sexual reproductive health and rights (ASRH) is a component that seeks to increase demand for and utilization of comprehensive information and integrated SRH services for adolescents and young people so as to reduce teenage pregnancy. MICS 2014 depicts an early child bearing of 16.7 percent (Percentage of women age 20-24 years who had at least one live birth before age 18). This is almost similar to what the graph below demonstrates that 16 percent adolescents gave birth at health facilities. ASRH still has data limitations routinely as the data collected is not disaggregated by age hence it is not easy to determine amongst other services adolescents who accessed FP services.

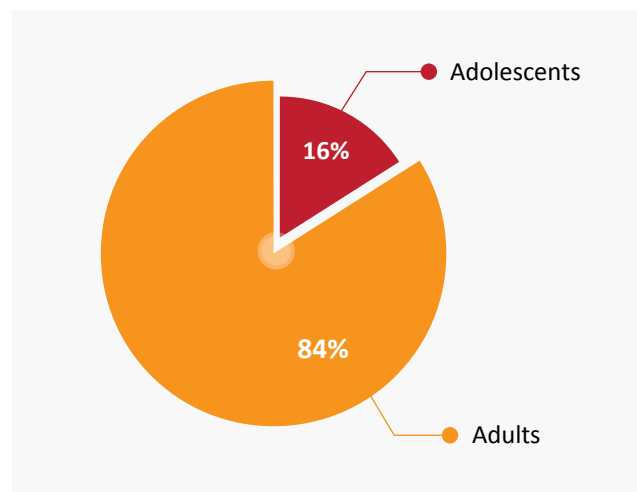


Figure 5; Births by age categories, 2015

In 2015, 245 nurses were trained on ASRH/YFS quality service provision to make health facilities youth friendly and accessible by young people. As a result of these trainings, teen clubs attached to health facilities were developed. A number of assessments were conducted during the year targeting ASRH service provision and use and these include;

- Youth friendly assessment (Report available)
- Knowledge attitudes and perceptions (KAP) for ALHV in Swaziland Assessments
- Impact of teen clubs for ALHIV
- Assessment on socio cultural influences on ASRH uptake of services by young people
- Assessment on the risk factors for teenage pregnancy and the youth perspective on teenage pregnancy and health needs in Nkalashane, Swaziland

### 3.3 Family Planning

The outcome of providing FP is to reduce unintended pregnancies in women of reproductive age especially among adolescents and HIV positive women (SRH strategic plan 2013-2018). This can be measured through these indicators; unmet need for FP, unmet need for FP among HIV positive women and the contraceptive prevalence rate (CPR).

**Table 2; Family planning commodities, 2013-2015**

Groups	Commodity	2013	2014	2015
Condoms	Female	64,454	75,131	206,269
	Male	1,385,869	2,107,439	3,842,011
<b>Condoms Total</b>		<b>1,452,336</b>	<b>2,182,570</b>	<b>4,048,280</b>
Implants	Implanon	142	513	170
	Jadelle	3,535	3,103	4,057
<b>Implants Total</b>		<b>3,677</b>	<b>3,616</b>	<b>4,227</b>
Injectable	DMPA	48,827	91,371	119,729
	Norigynon	14,861	10,289	10,737
	NST	241,609	199,810	164,691
<b>Injectable Total</b>		<b>305,297</b>	<b>301,470</b>	<b>295,157</b>
IUCDs	IUCD	1,261	1,961	1,514
Orals	Lof	109,125	103,252	107,043
	Micro	18,921	24,361	22,893
	Ovral	62,758	73,025	68,096
	Post 2	2,591	1,957	3,376
<b>Orals Total</b>		<b>194,656</b>	<b>202,595</b>	<b>201,408</b>

Table 2 shows the family planning commodities that were distributed from 2013-2015. According to HMIS data, the distribution of the female condom has increased from the 64,454 that was reported in 2013 to 206,269 in 2015.

For implants, jadelle is the mostly used and the number of women inserted have increased when compared to 2014. Overall, there were 295,157 injectable's administered to women and the table above is showing a decline. Administering of the IUCD is fluctuating. The lofiminal is the most common oral method followed by ovral.

### 3.4 Abortion and Post Abortion Care

One of the key outcomes of this thematic areas is to reduce incidence of abortion and this can be attained through universal coverage of FP services, quality of ante natal care and provision of prenatal services. The confidential enquiry into maternal deaths triennial report 2011-2013 revealed that from the maternal deaths audited abortion attributes to 9% of all the deaths and is the 3rd leading cause of maternal deaths.

Out-patient data does not clarify if the abortion cases reported were spontaneous, medically induced or if it was post abortion care. Abortion remains illegal in Swaziland except in situations whereby the constitution allows.

The graph below shows the number of women who were provided with abortion services (PAC or abortion). For 2015, 3553 abortion cases were reported.

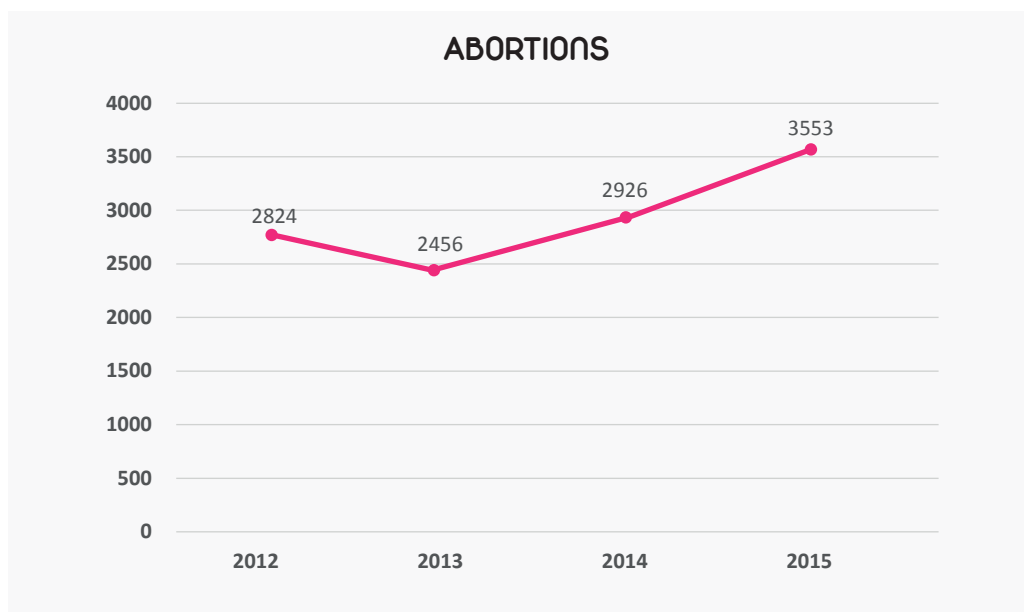


Figure 6; Abortion and Post Abortion Care (PAC) services, 2012-2015

The data does not segregate between illegal or medically induced or spontaneous abortions

### 3.5. STIS, HIV AND AIDS

Operationally, STI's are under the National AIDS Program (SNAP) and for the purpose of the report this section will be aligned to the SRH Strategic Plan 2013-2018 and focus is on syphilis and HIV among pregnant women.

#### Syphilis Screening At ANC

Routine screening of syphilis for pregnant women is done mainly at their 1st ANC visit. The table below shows the women who were screened for syphilis. Screening for syphilis was at 58 percent in 2013 which is lower than the expected as every pregnant woman should be screened, this was due to stock outs of test kits, however, coverage improved in the years 2014 and 2015. Over the years, women testing positive for syphilis have been over 500 and the proportion has decreased from 3 percent to 2 percent. Over 90 percent of these cases were treated leaving about 9 percent of them not known if they had started treatment. This poses a challenge as untreated syphilis infections results in a high risk of poor pregnancy outcomes, including miscarriages, premature births, stillbirths, or death in neonates.

Table 3; Syphilis screening among pregnant women, 2013-2015

Region	# of 1st ANC's	Tested for syphilis		Testing Positive		Treated for syphilis	
		#	%	#	%	#	%
2013	29,835	17,182	58%	566	3%	528	91%
2014	28,903	28,722	99%	788	3%	743	95%
2015	30,433	27,628	91%	613	2%	555	91%

#### HIV/AIDS

The country has been implementing PMTCT since 2003, piloted in 3 facilities country wide. The provision of PMTCT has evolved over the years with the introduction of efficacious regimens and new strategies which include the SRH/HIV integration. The 4 prong PMTCT approach is implemented in Swaziland which involves main streaming of HIV testing in all SRH entry points; provision of family planning to HIV positive women who do not intend having children; prevention of mother to child transmission of HIV as well as the provision of treatment and care.

The table below shows that over the years, more than 20 percent of pregnant women come in for ANC with an already HIV positive status and HIV testing coverage has improved whereby almost all pregnant women are tested for HIV. The positivity rate at ANC is 37%.

**Table 4; HIV services for pregnant women, 2012-2015**

Year	# of women making at least 1 ANC Visit	# of women who know their HIV status prior to ANC	# of women offered HTC at ANC	# of women who know their HIV status	Total pregnant positive women
2012	32,434	6,337 (20%)	23,514	29,851 (92%)	11,164 (34.4%)
2013	29,835	6,809 (23%)	22,742	29,551 (99%)	11,305 (38.4%)
2014	29,740	7,102 (24%)	21,978	29,080 (97%)	10,560 (35%)
2015	30,433	6,373 (21%)	20,829	27,202 (88%)	10,513 (39%)

### 3.6 Infertility

In general, infertility is defined as not being able to conceive after one year of unprotected sex. Infertility is not only a women’s condition, men can be affected too. A Centre for Disease Control and Prevention (CDC) study analyzed data from the 2002 USA National Survey of Family Growth and found that 7.5 percent of all sexually experienced men younger than age 45 reported seeing a fertility doctor during their lifetime. To diagnose infertility health professionals begin by collecting a medical and sexual history from both partners. The initial evaluation usually includes a semen analysis, a tubal evaluation, and ovarian reserve testing.

Again this is another area that has data limitations as the data collection tools do not determine whether clients seen were infertile or not but rather it reports on the number of cases of fertility problems. In 2015, 3846 cases related to fertility problems were seen with 412 of these cases being males.

### 3.7 Cancers of the Reproductive System

The main focus of this strategic area is to reduce morbidity and mortality related to reproductive system cancers through screening and early detection. This can be achieved through increased access to reproductive cancer services. These services entails prevention (Screening using VIA and PAP Smear) as well as recently introduced treatment methods (provision of cryotherapy and LEEP).

#### Cervical Cancer Screening

Figure 7 shows the women who were screened for cervical cancer through Pap smear and the Visual Inspection Acetic Acid from 2012 – 2015. Screening has intensified over the years with more women (11,248) screened in 2015. However, the figure also suggests that more positive cases are identified when more women are screened. The proportion has however remained stable over the years.

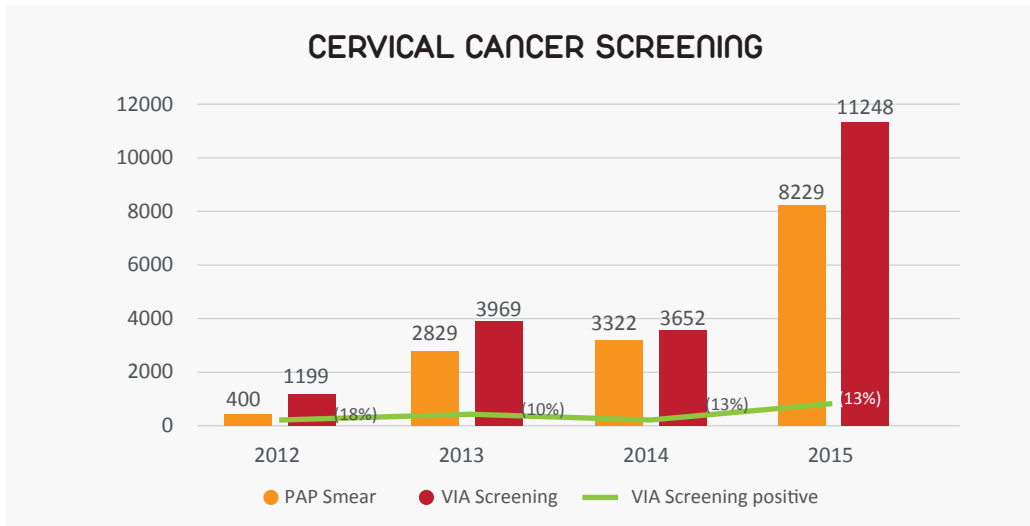


Figure 7; cervical cancer screening 2012-2015

### Admissions due to Reproductive system cancers

The figure below shows inpatient admissions due to cancers of the reproductive system (breast, cervical and female breast) from 2012-2015. Cervical cancer has been on the lead followed by prostate cancer then female breast cancer. The trend has been the same except in 2014 whereby there was a notable increase in admissions due to prostate cancer.

Figure 8 also shows the outcomes of these admissions. Data shows that deaths due to cancers of the reproductive system have actually decreased from 17 percent in 2012 to 12 percent in 2015 with more clients being discharged.

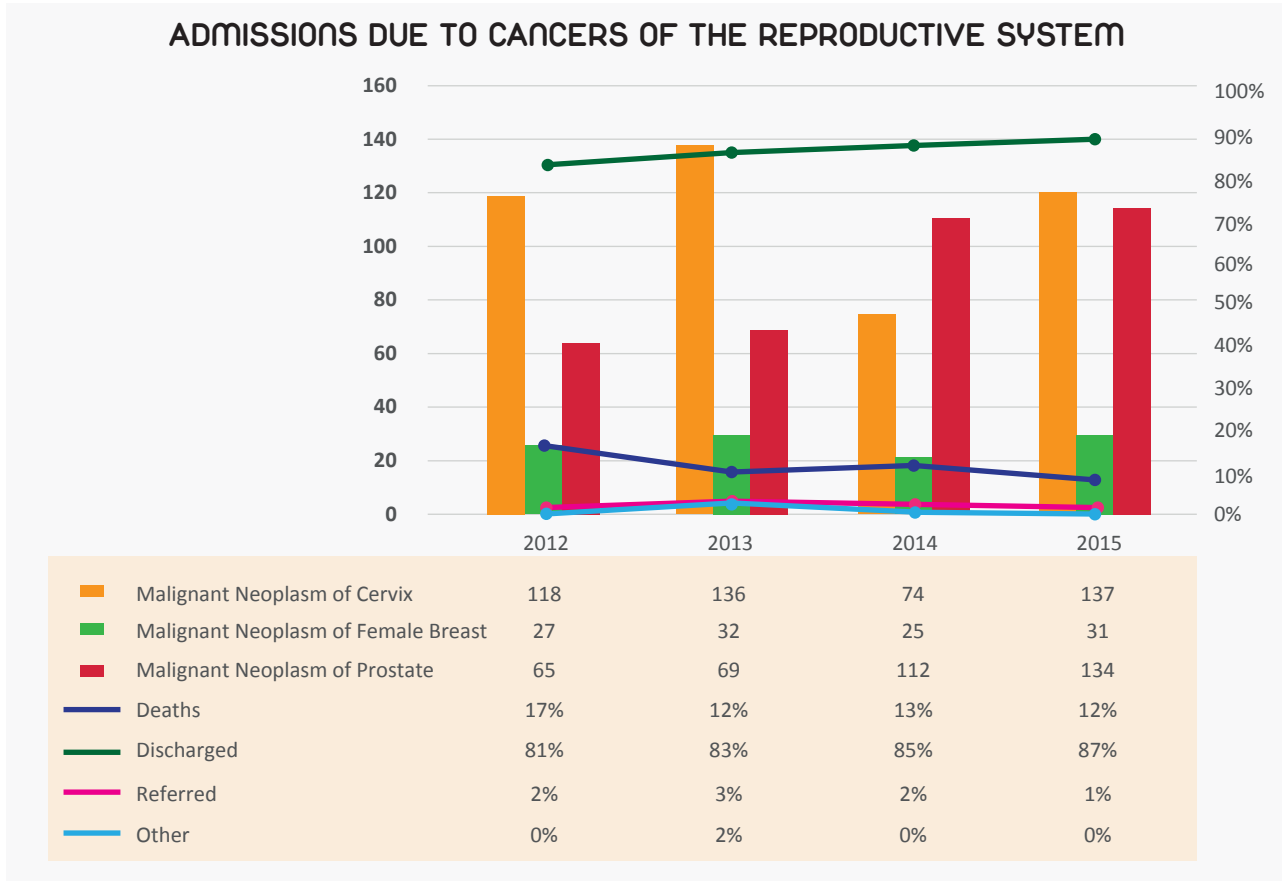


Figure 8; Admissions due reproductive system cancer, 2012-2015



### **3.8 Gender and Sexual and Reproductive Health Including GBV**

Gender related issues including Gender based violence cannot be separated from sexual and reproductive health particularly in a HIV era. Hence the SRH strategic plan promotes the mainstreaming of gender within integrated SRHR and HIV services as well as to develop capacity to provide integrated services for prevention and the management of GBV at health facilities. The gender and SRH including SRH component lacks proper data collection tools as a result there are no data available for this component for the year.

In 2015, in an effort to improve GVB prevention and management of cases within the health sector, the following was done;

- Revision of guidelines and training manual
- Developed GBV protocol
- Sensitized management and staff on GBV
- Conducted forensic training
- Scaled up One-stop center to hospitals (in progress)

### **3.9. Sexual Dysfunction**

Sexual dysfunction is a topic that most people are most hesitant to talk about and seek ways of addressing it yet treatment is available. Clinical syndromes that impair sexual functioning (sexual dysfunction) include sexual aversion, dysfunctional sexual arousal and vaginismus in females, and erectile dysfunction and premature ejaculation in males. Health facilities do not have standalone sexual dysfunction service points but rather integrated into the other health services. For 2015 only 2 sexual disorders were reported at inpatient.

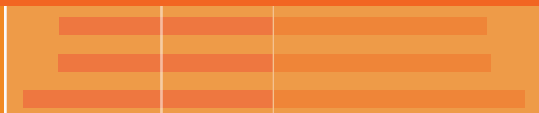
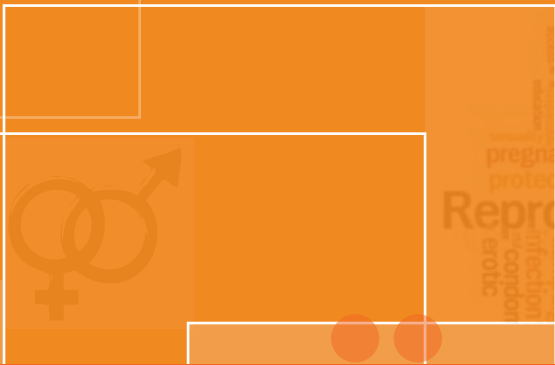
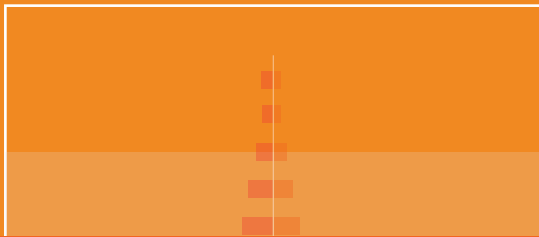
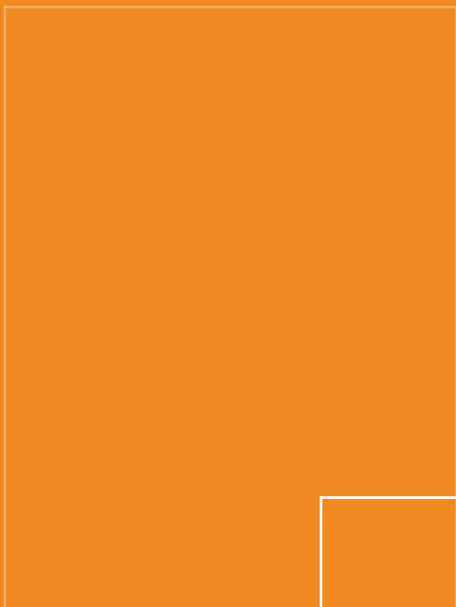
### **3.10. Sexual and Reproductive Health and Ageing**

The ageing people have sexual and reproductive rights and needs too, hence the program is committed to improve the SRH status for the elderly. The SRH strategic plan stipulates that guidelines for SRH and ageing should be developed and that an assessment to determine the SRH needs for the elderly and ageing should be conducted. Though services may be provided to the elderly and ageing, measuring accessibility of SRH services for this target population is limited because of data constraints which do not classify SRH services by age.

### **3.11. Community Involvement and Participation in SRH**

SRH initiatives solely relies on clients having a health seeking behavior therefore it is important to strengthen the community involvement and participation in SRH to improve SRH outcomes. In this regard the program works closely with community based health workers (lay community workers) and community leaders. The improved outcomes particularly at ANC and PNC are a joint effort between the program, facility health care workers and community based workers. However, further improvement on community ownership and participation in SRH initiatives is still necessary so that more women deliver at hospitals, partners support their women who are in need of family planning amongst other things

# CHAPTER 4: SRH PROGRAM ACHIEVEMENT AND BEST PRACTICES



As stated in chapter 2 of this report the SRH program component implementation is based on the 5 strategic activities namely; Policy and legal, Advocacy and IEC, Capacity building, Service delivery and Research and M&E.

## **POLICY AND ADVOCACY**

In 2015, the following guiding documents were finalized;

- Finalized FP guidelines
- MNCH curriculum
- Teen club curriculum developed
- MPNDSR guidelines
- New HIV guidelines
- Developed the Swaziland EMONC Services (SEC) guidelines
- GBV manuals

## **CAPACITY BUILDING**

Capacity building involves staff training as well equipping facilities with commodities, supplies and equipment to effectively provide services.

- Trainings conducted were on; IMPAC for TOT, FP, PMTCT including LLAPLA, EmONC, GBV training and ASRH.
- Functioning of the Chemotherapy unit at Mbabane government hospital
- Upgrading of health centers to have Theatres
- The revamping of MGH maternity

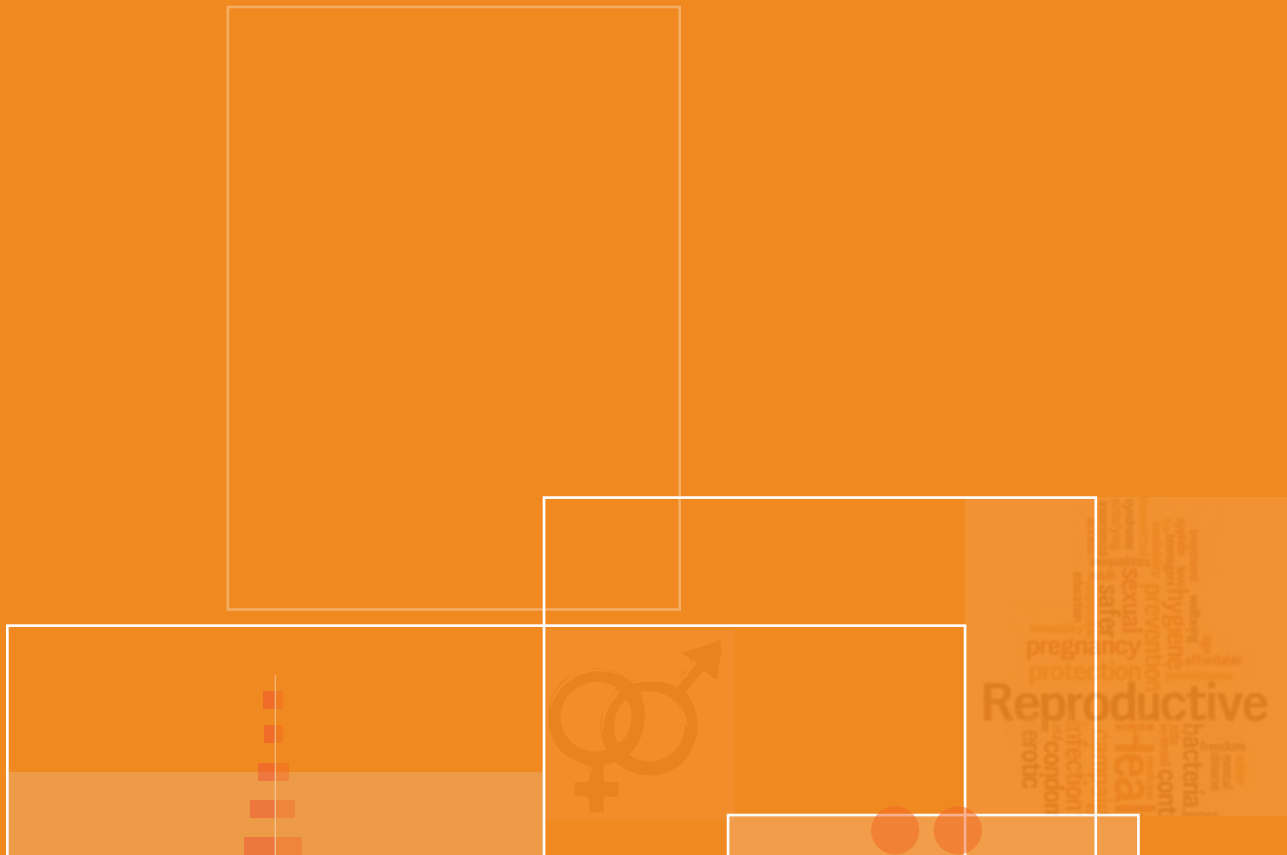
## **SERVICE DELIVERY**

By 2015 almost facilities (except a few) providing PMTCT had transitioned from option A to LLAPLA for PMTCT which will help reduce the incidence of infants testing HIV positive at 6-8 weeks of birth. On the other hand, Mentorship and Continuing Medical Education (CME) was provided to all maternities and facility visits were conducted after maternal death reviews. There was an increase of Youth Friendly Services and teen clubs.

## **DATA/M&E**

A score card which is web based was developed with focus on the key SRH indicators. A quality of care (QOC) on MNCH assessment was conducted which ascertained the quality of MNCH services particularly at labor and delivery sites.

# CHAPTER 5: CONCLUSIONS AND ACTION POINTS



## 5.1. CONCLUSIONS

The MDG's focused on the reduction of maternal and neonatal mortality through the provision of quality comprehensive MNCH services. With the end of the MDG era, the country is now committed to the Sustainable development goals (SDG's) which focuses mainly on the eradication of maternal and neonatal mortality. Evidence shows that the country is making progress in areas related to maternal health; contraceptive prevalence rate of 65 percent, 98.5 percent of women attending at least one ANC visit and about 88 percent delivered by skilled birth attendants; frequency on ANC visit of women who attended at least 4 visits is about 76 percent, institutional deliveries 87.7 percent and the FP unmet need at 13 percent.

The annual report seeks to monitor the effectiveness of the strategies as stipulated in the SRH strategic plan 2014-2018 in terms of achieving the set targets. It is stated in the strategic plan that maternal and neonatal deaths should be reduced by 50% by 2017. However, findings have shown that maternal and neonatal deaths have remained high over the years despite the many interventions to improve maternal and neonatal health. By 2018, it is expected that 60 percent of pregnant women should make their 1st ANC booking during the first trimester (SRH Strategic Plan), however by 2015, evidence from routine data shows that only about 28 percent of these women come in during the first trimester. Presenting late in pregnancy then makes scheduling of the four focused visits impossible.

According to the MICS 2014, only 2 percent of pregnant women do not attend ante-natal care and institutional deliveries stand at 87.7 percent. The many (9%) home deliveries reported through HMIS particularly in the Lubombo (31%) still pose as a challenge in combating maternal and neonatal mortality. Still births remain high (156) and this speaks to the quality of care that the women receive during ante-natal care and at labor and delivery. The quality of care (QOC) assessment that was conducted during the year identified the gaps and provided recommendations on how to improve the quality of maternal health services. Syphilis contributes to poor pregnancy outcomes which may include still births. During the year, 613 pregnant women screened positive for syphilis and about 9 percent of the women who had screened positive for syphilis were not started on treatment.

Cancers are one area that need special attention and robust strategies that will promote prevention. The data in chapter 3 have shown that screening for cervical cancer has intensified with over 11,000 women screened. The data has also shown that at inpatient more cases of prostate cancer are identified, however, little is known about the screening for prostate cancer because there are no data tools that capture such information. On a positive note, deaths due to reproductive health cancers have decreased over the years from 17 percent in 2012 to 12 percent in 2015.

As stated earlier that the purpose of the program annual reports is to measure performance towards achieving the set goals as articulated in the strategic plan. Even though the strategies in the SRH strategic plan are clear, monitoring and evaluating them becomes difficult as some of them do not link to the baselines, targets and indicators.

## 5.2. ACTION POINTS

In order to improve on program performance and be able to meet the 2018 targets the following need to be done;

- Conduct a mid-term review for the Sexual Reproductive Health and Rights Strategic Plan 2014-2018
- Use findings and recommendations from the numerous studies conducted by the program to inform policy, programming and mid-term review of the SRH strategic plan.
- Strengthen health education on;
  - Early ANC booking
  - Institutional deliveries
  - Use of long-active Family Planning methods
- Increase facilities with maternity wings at Lubombo and intensify community mobilization for institutional deliveries
- Improve the quality of care at ANC and L&D to reduce the number of still births
- Strengthen ASRH services and information to reduce teenage pregnancy
- Strengthen FP to reduce abortion cases and increase HCW skill on how to conduct Post abortion care
- Initiate all women who screen positive for syphilis at ANC to improve pregnancy outcomes
- Intensify screening for cervical cancer and develop data collection tools
- Train HCW on data collection tools and review data collection tools

## CHAPTER 6: REFERENCES

Government of the Kingdom of Swaziland (2007), Population and Housing Census. Mbabane, Swaziland. Central Statistical Office. Volume 5

Government of the Kingdom of Swaziland (2007), Swaziland Population Projections 2007-2030; Changing Shape of the population Pyramid. Mbabane, Swaziland. Central Statistical Office.

Government of the Kingdom of Swaziland (2010), Multiple Indicator Cluster Survey (MICS). Mbabane, Swaziland. Central Statistical Office.

Government of the Kingdom of Swaziland (2014), The Extended National Multisectoral HIV and AIDS Framework (eNSF 2014 –2018) Mbabane: Government of Swaziland.

Ministry of Health (2007), National Health Policy. Mbabane: Ministry of Health.

Ministry of Health (2008 a), National Health Sector Strategic Plan 2008-2013. Mbabane: Ministry of Health.

Ministry of Health (2013), National Policy on Sexual Reproductive Health. Mbabane: Ministry of Health.

Ministry of Health (2013), Swaziland Service Availability Mapping (SAM). Mbabane: Ministry of Health.

Ministry of Health (2015), Swaziland Integrated HIV Management guidelines of 2015

Ministry of Health (2014), Confidential Inquiry into Maternal Deaths 2011-2013;

Villar J, Bergsjö P: WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model. Geneva: WHO; 2002.

