
# PRIMARY HEALTHCARE

## INVESTMENT CASE

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# INTRODUCTION

Following the Alma-Ata Declaration on Primary Health Care (PHC) in 1978, the Kingdom of Eswatini commissioned its National Health Policy (NHP) in 1983 toreflect the adopted PHC approach to healthsystem strengthening. The NHP aim in 1983 was "to improve the health status of the Eswatini people by providing preventive, promotive, rehabilitative and curative health services which are relevant and accessible to all".

The three specific objectives were:

1. To Improve the health status of theSwazi people by providing preventive, promotive, rehabilitative, and curative services accessible to all citizens;(
2. To ensure equal access to quality health care by all Swazis by phasing out geographic, financial, and cultural barriers; and
3. To reorient the health care system away from expensive, urban-based curative services towards rural-based, inexpensive promotive and preventive services.

To achieve these objectives, an attempt has been made to implement the comprehensive model of PHC through: (a) Community-based, community health worker-led approach which involves Rural Health Motivators and other community health volunteer groups. Apart from health promotion activities, delivery of community- based surveillance and preventive activities, as well as the management of minorillnesses and first aid, community-based care includes some level of referral management.

(b) Nurse-led primary care services are delivered through PHC clinics and public health units (PHUs). Experienced nurse-midwives are carefully selected and deployed to lead basic essential primary care services delivery in communities with high client volumes (PHUs) or low client volumes (PHC

The Head of the PHC facility, often designated either as a Matron or Nurse Manager, is supported in primary careservices delivery by other cadres of clinical and non-clinical staff. (c) Collaborative partnerships between the Ministry of Health (MoH), private sector, faith-based organizations, multilateral, and bilateral institutions and implementing partners, civil society organizations and non- governmental organizations, et cetera.

Having achieved appreciable successes in the initial implementation of the PHC approach, Eswatini was on course to achieving the NHP goals until the major outbreaks of HIV/AIDS and Tuberculosis struck between 1990 and 2005, devastating the health system and weakening PHC, and resulted in health resources being diverted into fighting the outbreaks. Subsequently, in 2010, the MoH launched an Essential Health Care Package (EHCP) for Eswatini - a framework to guide the provision of essential health services to all people livingin the Kingdom of Eswatini.

The implementation of a revised EHCP insince 2018 was affected by the COVID-19 pandemic which disrupted the provision of essential health services, thus increasing morbidity and mortality3.

In a recent rapid assessment of PHC3 in Eswatini conducted by World Health Organisation (WHO) in 2021, it was found that the implementation of the PHC approach is currently facing difficult challenges which could affect the quality and coverage of essential services, increase financial exclusion, and worsen health outcomes. Consequently, the MoH is collaboration with the WHO, United Nations Childrens Fund (UNICEF) and the Clinton Health Access Initiative (CHAI) implemented a PHC improvement intervention which includes the creation of an investment case to mobilise additional investments for PHC in Eswatini.

# SITUATIONAL ANALYSIS AND IMPACT OF PHC APPROACH IMPLEMENTATION IN ESWATINI

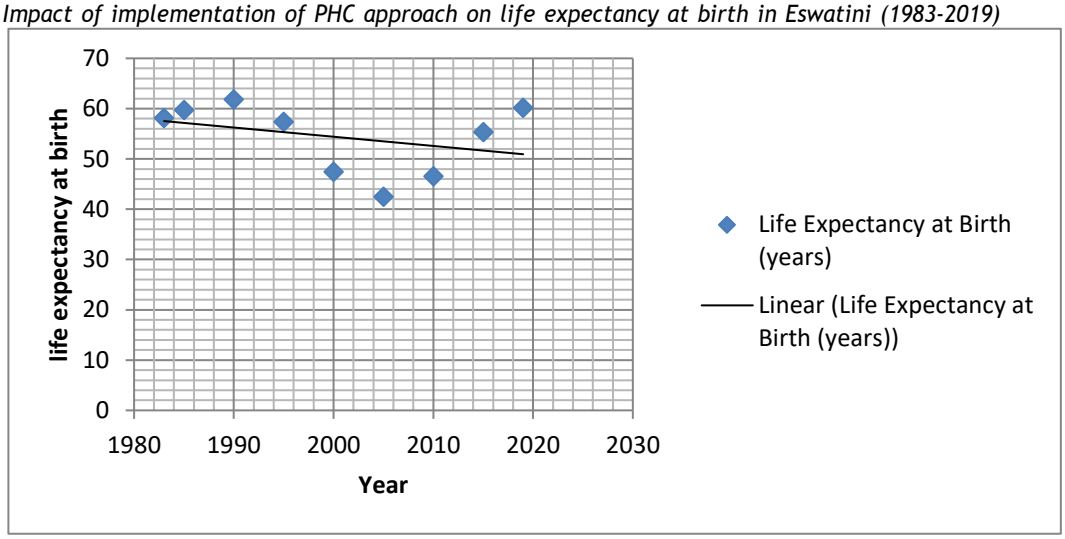
Significant improvement has occurred in effective coverage of essential health services from 44.8% in 1990 to 53.4% in 2019 in Eswatini; see Table 1. However, increasingly, community members in Eswatini are demanding several primary care services, including maternity, family planning, essential newborn care, basic mental health, basic dental, and skin care services, among others. Addressing these unmet demands for essential healthcare services in Eswatini is important to the attainment of Universal Health Coverage (UHC) by 2030.

| Year | UHC Effective Coverage Index of Essential Services (%) | Observed Change Per Year |
|---|---|---|
| 1990 | 44.8 | The average percentage effective change per year from 1990 to 2010 was -1.2 (significant) |
| 2010 | 35.0 | |
| 2019 | 53.4 | The average percentage effective change per year from 2010 to 2019 was 4.7 (significant) |

Catastrophic out-of-pocket payment for PHC services has reduced yet an increasing number of EmaSwati suffer financial risk exposures: The implementation of thefree-of-charge user fee policy for PHC services by the Government of Eswatini contributed to a reduction in out-of- pocket payments for PHC services, thus improving financial access. However, a community levy of between 5 and 10 Emalangeni is charged in PHC Clinics and PHUs. Available evidence suggests that about 9.7% of EmaSwati suffered catastrophic out-of-pocket payment for health services in 2015, but in 2021 where major stock-outs of essential medicines, vaccines and other health commodities occurred, many more EmaSwati are expected to have incurred catastrophic payments for essential medicines and health commodities.

Life expectancy at birth in Eswatini, whichwas 58.16 years in 1983, has improved to 60.19 years in 20199: Despite the improvements realized in life expectancyat birth (Figure 1), communicable diseases such as HIV/AIDS, Tuberculosis, COVID-19, and the non-communicable diseases and their associated risk factors still linger and may take their toll.

*Figure 1 Impact of implementation of PHC approach on life expectancy at birth in Eswatini (1983-2019)*




Even though under-five child mortalityrate has seen a significant reduction from 96.4 per1000 live birth in 1983 to 49.4 per1000 live birth in 2019 in Eswatini, more needs to be done to reduce preventable deaths in children under the age of five. Preventable under-five child deaths from severe malnutrition, anemia, home accidents (falls, drowning, burns, etc.), late care seeking for severely ill children, among others will have to be tackled comprehensively.

Similarly, reductions occurred in infant and neonatal mortality rates from 69.7 and 24.8 per 1000 live births in 1983 to 38.6 and 18.4per 1000 live births respectively in 2019. Despite these reductions, more needs to be done to sustain the gains being made in infant and neonatal deaths. The three major causes of neonatal deaths–birth asphyxia, prematurity and neonatal sepsis - must increasingly be tackled to ensure neonates survive and thrive.

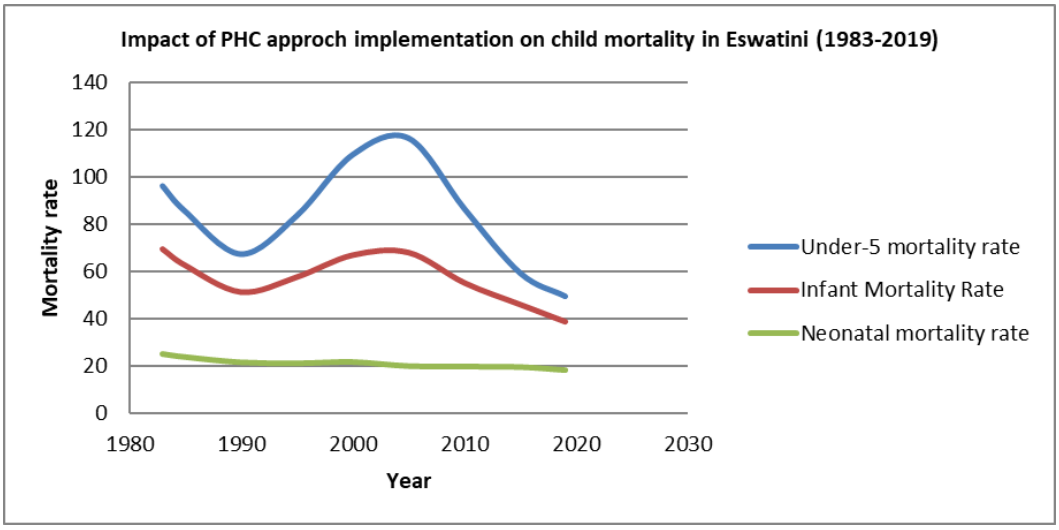
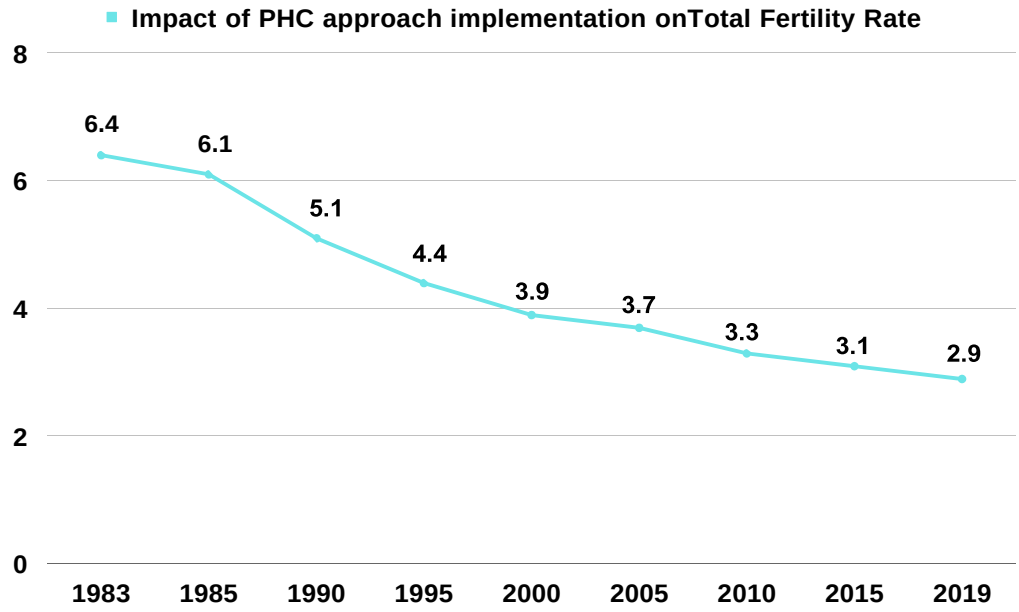



*Figure 2: Impact of PHC approach implementation on child mortality in Eswatini (1983-2019)*

Even though there has been a significant reduction in Total Fertility Rate from 6.4 in 1983 to 2.9 in 201913(see Figure 3), unplanned pregnancy rates have remained high (about 70%) while the unmet need for contraceptives have remained high at about 34%).




Maternal death reduction trends between 1985 and 2020 have not progressed at expectedrates and more innovative approaches are needed if the Sustainable Development Goals (SDG) target is to be met: The maternal mortality ratio has reduced from 560 in 1985 to 437 in 2020 in Eswatini, necessitating the need to comprehensively review and innovatively tackle the leading causes of maternal deaths, including: haemorrhage 45.1%; obstructed labour 26.2%; puerperal sepsis 9.6%; anaemia 2.2%; HIV/AIDS 2.2%. There is also a need to strengthen and scale up basic Emergency Obstetric and Newborn Care care services in PHC facilities to better link with comprehensive EmONC services at the secondary and tertiary levels of care in Eswatini.

## PURPOSE AND OBJECTIVES OF THE INVESTMENT CASE

The purpose of this investment case is to quantify the current spending on health and PHC in Eswatini, and to estimate the current financial gaps in meeting theneeds of the population and finally estimate the impacts of investing more in healthcare as it relates to improved health-related SDG outcomes.

This investment will be a starting point to raising additional resources towards strengthening the implementation of the PHC approach to make it fit for purpose, to truly serve as a cornerstone for a strong, resilient health system in Eswatini, and to enable the attainment of UHC in Eswatini by 2030 and contribute to the attainment of the health-related SDGs.

## CURRENT STATUS OF PHC IMPLEMENTATION FINANCING

In the last decade, the Kingdom of Eswatini has made some progress in itscurrent health spending. It has been estimated that the Government of Eswatini averagely devotes about 10% of its annual budgetary allocations to health.In the financial year 2022/23, this equates to about SZL 2.4 billion.

However, evidence from our estimates has shown that the bulk of these funds areused in supporting secondary and tertiary level healthcare services delivery including referral of patients outside the country for treatment. It's worth nothing that a lot of PHC services are also being provided at tertiary level.

The average PHC budget in the last three years is estimated to be about 30% (SZL 720 million) of the total health budget. PHC budget numbers were estimated from specific budget lines focused on PHC, and administration of PHC services.

In addition, on the expenditure side, the most recent evidence was from the National Health Accounts conducted for financial year 2017/2018 which estimated a total expenditure of SZL4.701 billion. The study estimated that 23.5% (SZL 1.104million) of total current expenditure onhealth was spent on primary health care. Spending on health system administration which was at 16.2% (SZL 761 million)included some PHC level administration.

We estimated the administration spending at the PHC level to be about 8% (SZL 376 million) of the total health expenditure which sums up the total health expenditure at the PHC level to be at 31.5%(SZL 1.480 million).

Maternal death reduction trends between 1985 and 2020 have not progressed at expected rates16 and more innovative approaches are needed if the Sustainable Development Goals (SDG) target is to be met:

The maternal mortality ratio has reduced from 560 in 1985 to 437 in 2020 in Eswatini,

To understand the cost of providing quality PHC services to meet the needs of EmaSwati, CHAI received funding from UNICEF to cost the services being provided at PHC facilities in Eswatini[1]. If estimated for the population, the assessment suggested that about SZL 2 billion to 2.2 billion is needed to meet the needs of the population at designated PHC facilities based on two scenarios. These estimates suggest a significant gap from the current level of PHC spending in Eswatini. (see Table 2).

The costing is based at the point of care and not the cost of delivering the comprehensive primary healthcare system which include other variables such as supportive supervision, and administration.

Table 2 Total PHC costing estimates at the point of care in Eswatini

| Scenarios | Amount | Source/methodology |
|---|---|---|
| **Scenario 1** | SZL 2billion | The average utilization number of PHC services used to estimate for the population |
| **Scenario 2** | SZL 2.2billion | Eswatini incidence and prevalence data sourced from the global burden of disease was used to estimate for the population |

Current investment dedicated to PHC suggests that PHC is not currently prioritized in Eswatini, and little attentionis being paid to addressing health promotion and preventative services. In the recent PHC rapid assessment conducted by WHO, it was reported that shortages/stock-outs of essential medicines, vaccines and health commodities existed throughout PHUs and PHC clinics.

High out-of-pocket expenditure (OOPE) for medications from privately-owned pharmacies was reported by clients and community leaders as a result of essential commodities stock out in PHC facilities which is a setback in the progress towards UHC.

# INVESTMENTS NEEDED IN PHC IMPLEMENTATION

Great financial investments and sustained commitment is needed to implement PHC level intervention. Based on NHA report on key investors in the healthcare sector, such as donors, Non-Governmental Organizations (NGOs), Private insurance, and the historical government of Eswatini budget allocation on health, we estimated the total health expenditure to be currently around SZL 4.8 billion. Based on existing evidence, we estimate only about 32% of this amount is spent at the PHC level which amounts to SZL 1.53 billion.

For the government of Eswatini to effectively provide quality PHC services in all designated facilities, we estimated that about SZL 2 billion to SZL 2.2 billion is required annually based on 2 scenarios to strengthen PHC to make it fit-for-purpose, equipped and to drive our quest to attain UHC and the health-related SDGs. The current gaps, based on the two scenarios, are estimated to be around SZL 465 million to SZL 665 million. The PHC rapid assessment extensively discussed the current gaps in the lens of the WHO health system building blocks; however, the investment case will focus on key issues for MoH consideration. The gaps in PHC spending are largely driven by the provision of essential medicine, human resources for health in PHC facilities and poor health worker morale due to inadequate financial and non-financial incentives.

The problem of essential medicines, vaccines, and other health commodities stock-out is not new across many Low and Middle Income Countries (LMICs) and was recently validated by the PHC rapid assessment as a serious issue that comes with great unintended consequences for an average LiSwati. Many people are forced to purchase medications at an exorbitant rate in private pharmacies to meet their health needs.

As a result, some EmaSwati may have incurred catastrophic payments for essential medicines and health commodities which could further push them below the poverty line.

Human resource cost is another important driver of the additional resource needed for PHC implementation. The government of Eswatini is already paying for sizeable portion of critical human resource positions across the country, however, some gaps exist. There is a room for improvement in areas such as filling of vacant positions to reduce the pressures in high volume PHC clinics and PHUs; balancing the skill mix and inequality in the distribution of experienced nurses and midwives in PHC facilities is essential to improving the maternal and child health outcomes. In addition, a significant number of PHC Level facilities with midwives were not providing skilled delivery services– contrary to the guidelines and standards set by the EHCP.

It's worthy of note that the PHC rapid assessment documented that the morale of PHC managers and supervisors are low due to various issues such as unavailability of vehicles and fuel for supportive supervision duties. Logistics issues including the unavailability of emergency Ambulance services at the most crucial times due to unreliability and poor performance of the National Ambulance Services.

Increasing non-availability of essential health commodities, drugs and supplies has been cited as a major cause of low morale as healthcare workers are helpless to provide the needed care for the sick and vulnerable. In addition, it was cited in the PHC rapid assessment that delayed promotion of healthcare workers, inadequate financial compensation and poor working environments have contributed to skilled professional workers at PHC levels 1 and 2 being unhappy and not having the motivation to work.

**SZL 6 - 6.6 Billion**

In the short-term (2023-2025), an investment of SZL 6 billion to SZL 6.6 billion is required to revitalize and scale up the implementation of PHC in Eswatini.

**SZL 16 - 17.6 Billion**

Medium-term 2026 and 2030, an investment of SZL 16 billion to SZL 17.6 billion is required to maintain and sustain the implementation of PHC and sustain the gains from improved health outcomes.

## KEY DRIVERS FOR ADDITIONAL INVESTMENTS IN PHC

- Additional investments to meet essential medicines, vaccines, and other health commodities needs including those that we meet the needs of adolescents
- Additional investments to meet human resource needs for critical positions across the country is essential to improving the maternal and child health outcomes
- Additional investment to support health system strengthening including leadership and governance, monitoring and evaluation, supportive supervision etc

## RETURNS ON INVESTMENT

The investment in PHC will contribute significantly to having a healthy, productive population in Eswatini to contribute to sustainable economic growth and development. A healthy, vibrant, and well-educated LiSwati population will drive the quest to attain more economic prosperity that the government and people of Eswatini desire.

Strengthening the implementation of the PHC approach in Eswatini between 2023 and 2030 will contribute towards not only substantial progress towards UHC and an improved life expectancy at birth, but also the attainment of the health-related SDGs. Below are some of the baseline indicators and medium-term goals that could be achieved based on estimation from existing sources: (See Table 3)

Table 3 Projected health related SDGs targets for Eswatini

| Indicator | Current status | Forecasted 2025 SDG Targets |
|---|---|---|
| **Coverage of UHC essential services index** | 63.4 in 2019[1] | 70 |
| **Under-five child mortality rate (per 1000 live births)** | 74 in 2018[2] | 37 |
| **Neonatal mortality rate (per 1000 live births)** | 20 in 2018 | 17 |
| **Maternal mortality ratio (per 100,000 live births)** | 452 in 2018 | 352 |

[2] Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) https://unstats.un.org/sdgs/indicators/database

[3] Eswatini Sexual, Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategic Plan (2019 – 2023)

# RECOMMENDATIONS AND CONCLUSIONS

PHC services including the communityhealth services in Eswatini provide high- impact health interventions and are essential for achieving UHC and the health-related SDGs. This investment case highlights the current spending on the PHC service delivery, and the gaps basedon two scenarios. It further demonstrates that improving the coverage and quality of delivery of essential health services based on the PHC approach will result in the attainment of the health-related SDGs.

The investment case makes an argument for the additional investment needed in PHC to meet the health needs of the Eswatini population which will be channeled to address the bottlenecks identified in PHC implementation and discussed extensively in the PHC rapid assessment.

This will be the first step in revitalizing the PHC delivery system in Eswatini. As a priority, attention should be focused on addressing issues around stock-out of essential medicines and commodities to make meaningful progress towardsimproved health outcomes and reduced catastrophic health expenditure. In the short to medium term, we estimate that improved investments on essential medicines and commodities will have the greatest impact and substantially improve the health-related SDGs.

## Key areas of focus to sustain and mobilise resources for PHC :

15%

The central government should further demonstrate its commitment to improving health outcomes by mobilizing resources. The government should strive towards moving towards the Abuja declaration by allocating 15% of the national budget to health in the medium term. In addition, increase the share of PHC in the MoH budget.

Domestic revenue mobilization could also include earmarking additional "sin" taxes on cigarettes, alcoholic beverages to health, which are harmful to the health and wellbeing of people.

The government should advocate and encourage private philanthropy donations, private enterprises and high net worth individuals to donate towards PHC service delivery.

Technical and financial commitments from donors are critical to revitalize PHC service delivery. The government should also put in place a transitioning plan to ensure the sustainability of the support. Development partners should prioritize system thinking/strengthening approach.

The government should strengthen referral systems by improving linkages between level 1 and 2. Additionally, we recommend stronger gatekeeping mechanism to keep PHC services at the clinic level, which isthe assumed to be the most efficient level to provide these services.

Finally, it is recommended the MoH undertakes a stakeholder engagement summit to revisit and reprioritize the national EHCP of Eswatini to clearly define the services to be obtainable at the PHC level - a necessary step towards an operational plan development for PHC service provision.

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