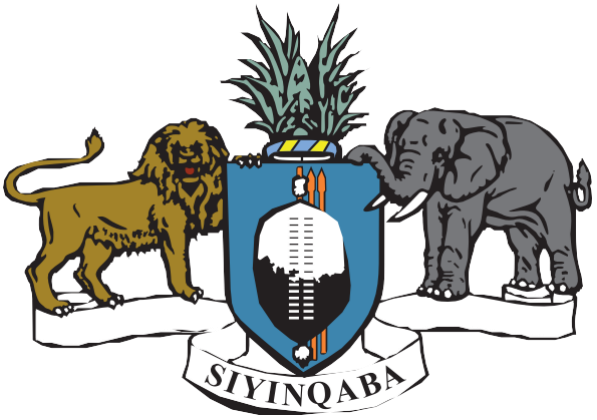
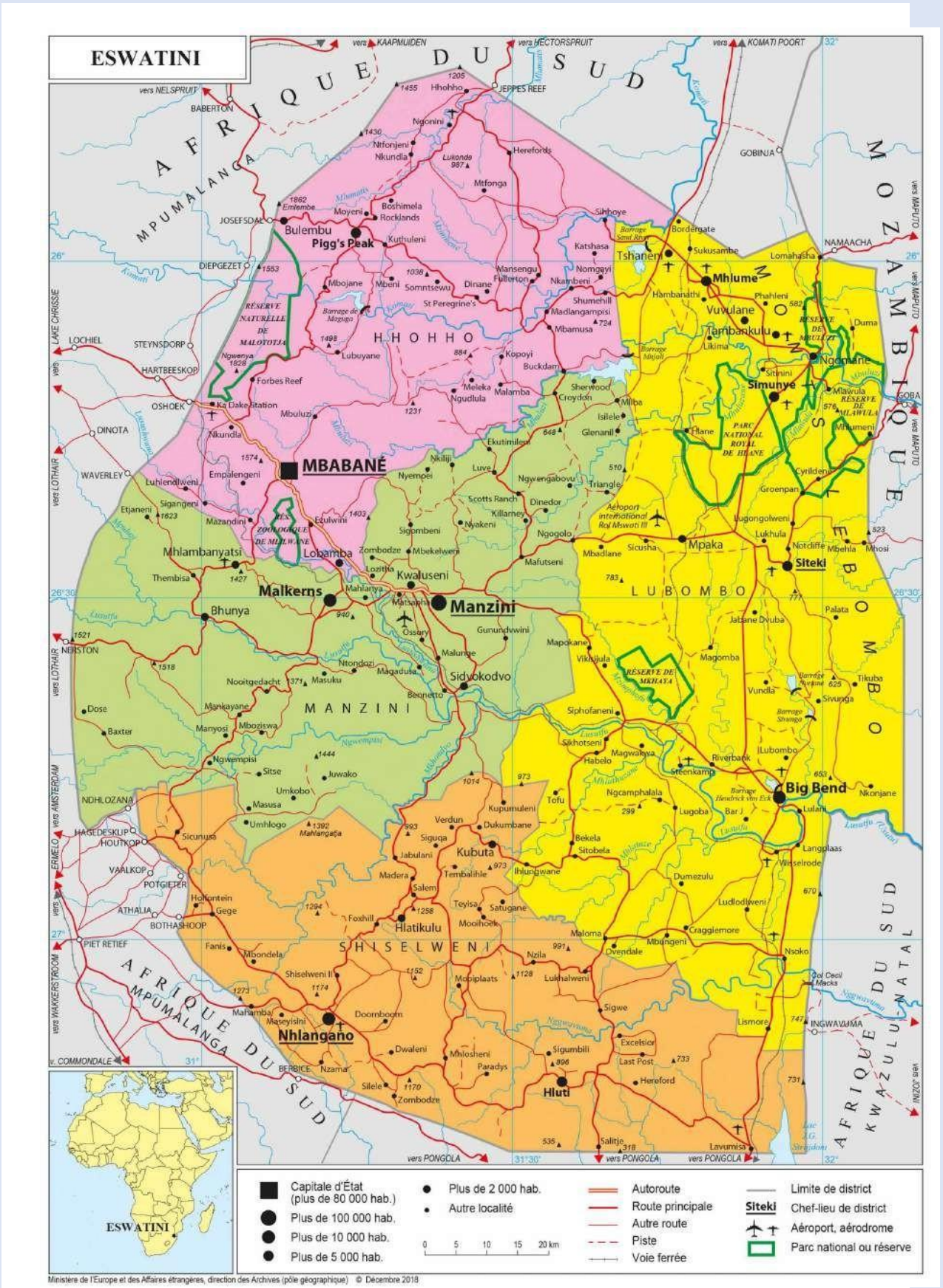


KINGDOM OF ESWATINI

TABLE OF Contents

MAP OF ESWATINI



KINGDOM OF ESWATINI

FOREWORD

Cancer is a growing public health concern in Eswatini, posing a significant burden on individuals, families, and the healthcare system. The World Health Organization (WHO) underscores cancer as the second leading cause of death globally, with an estimated 10 million deaths in 2022, according to the International Agency for Research on Cancer (IARC) through its GLOBOCAN 2022 database, underscoring the urgent need for effective strategies to combat this disease.

The National Cancer Control Strategy 2025–2029 serves as a comprehensive roadmap for strengthening cancer prevention, early detection, diagnosis, treatment, palliative care, and survivorship programs in alignment with national and global commitments.

This strategy builds upon past efforts and aligns with the National Health Sector Strategic Plan, the Eswatini Non-Communicable Diseases Strategy, and the World Health Organization's Global Cancer Control Initiatives. It outlines evidence-based interventions and a Multisectoral approach to reduce the incidence, morbidity, and mortality of cancer in Eswatini.

The successful implementation of this strategy requires collaboration among government institutions, healthcare professionals, civil society organizations, development partners, and the community at large. Strengthening data collection and reporting will be essential for informed decision-making and resource allocation.

On behalf of the Ministry of Health, I extend my gratitude to all stakeholders who contributed to the development of this strategy. Together, we can improve cancer outcomes and ensure that every person in Eswatini has access to timely, quality cancer care.

Mduduzi Matsebula
Minister of Health
Kingdom of Eswatini

Acknowledgements

The development of the National Cancer Strategy is the result of collective efforts and collaboration among various stakeholders. The Ministry of Health extends its deepest gratitude to all individuals and organizations who contributed to the creation of this important document. This includes government institutions, non-governmental organizations (NGOs), development partners such as World Health Organization (WHO), implementation partners PEPFAR and international agencies such International Atomic Energy Agent (IAEA). Their invaluable expertise, resources, and commitment have been instrumental in shaping this strategy.

Special appreciation is also extended to the technical teams within the Ministry of Health, including public health programs and units, whose input and guidance were critical throughout the process. The contributions of healthcare professionals from multiple levels of the health system are distinctly recognized for their active participation in consultative meetings and workshops.

Lastly, the Ministry acknowledges the dedication and expertise of the members of the Cancer Task Force. Their unwavering commitment and technical proficiency were key drivers in ensuring the successful development of this strategy. Together, these collaborative efforts represent a shared vision for reducing the burden of cancer and improving health outcomes for all citizens.

KINGDOM OF ESWATINI

List of Acronyms

AFCRN- African Cancer Registry Network

AI - Artificial Intelligence

CBE- Clinical Breast examination

DRE- Digital Rectal examination

EHCP- Essential Health Care Package

EML- Essential Medicines List

ENCR- Eswatini National Cancer Registry

IAEA- International Atomic Energy Agency

IARC- International Agency for Research on Cancer

LEEP- Loop Electrosurgical Excision Procedure

LMIC- low- and middle-income countries

MOH- Ministry of Health

MOU- Memorandum of Understanding

NCCP- National Cancer Care Program

NCCS- National Cancer Care Strategy

NCD- non-communicable diseases

NORA- Network for Oncology Research in Africa

PSA- Prostate-Specific Antigen

SACU-Southern Africa Customs Union

SARA- Service Availability and Readiness Assessment

SDG- Sustainable Development Goals

VIA- Visual Inspection with Acetic Acid

Definition of Terms

Capacity building- is the systematic process of enhancing and expanding the skills, knowledge, and overall abilities of individuals or organizations.

Comprehensive Cancer Services- cancer care services that address the full spectrum of a patient's needs physical, nutritional, emotional, psychosocial, spiritual, and financial have been found to greatly improve survivor's quality of life and outcomes**.**

Workforce- the group of people who work in a company, industry, country, etc**.**

Metastases- when cancer cells break off from the original tumor, enter the bloodstream or lymphatic system, and then spread to other areas of the body.

Human Development Index-is a metric compiled by the United Nations Development Programme and used to quantify a country's "average achievement in three basic dimensions of human development: a long and healthy life, knowledge, and a decent standard of living."

Essential Health Care Package- a critical set of most cost effective, affordable, and acceptable interventions for addressing health conditions, diseases associated factors that are responsible for the greater part of the disease burden of a given community.

Patient Navigation- the individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care

Referrals and linkages- key components of improved service demand and accessibility. Effective referral systems combine high-quality communication and operations (structure, monitoring systems and referral tools).

Executive Summary

The National Cancer Control Strategic Plan (NCCSP) 2025–2029 outlines Eswatini's commitment to reducing the national cancer burden through a comprehensive and integrated framework for cancer prevention, early detection, treatment, palliative care, and data-driven strategies. The strategy aligns with global health priorities, including the WHO Global Action Plan for Non-Communicable Diseases, to achieve equitable, high-quality cancer care and prevention.

The Global Cancer Burden stands at over 19 million new cases and 10 million deaths annually, with 70% of cancer-related deaths occurring in low- and middle-income countries. Eswatini is also challenged with a high burden of infection-related cancers (e.g., cervical cancer and Kaposi's sarcoma). The situation is compounded by HIV prevalence, insufficient healthcare infrastructure, and gaps in diagnosis and treatment. The strategy also builds on progress made in the implementation of global frameworks and initiatives, including HPV vaccination and cancer early detection programs. Eswatini bears the highest burden of cervical cancer globally, driven by one of the world's highest HIV prevalence rates. Women living with HIV are at markedly increased risk of HPV persistence, precancer progression, and cervical cancer at younger ages. This strategy therefore positions cervical cancer elimination as a national public health priority and a core component of women's health. In Eswatini the National Cervical Acceleration Elimination Plan (2024-2030) clearly stipulates the framework of achieving 90-70-90 which is line with the WHO Global Strategy and African Regional Framework.

The Eswatini Cancer Control Program prioritizes prevention through vaccination (HPV and HBV vaccines) and lifestyle modifications to reduce cancer risk factors. Key focus areas also include expanding early detection for cervical, breast, prostate, lung, and colorectal cancers, enhancing diagnostic techniques, pathology laboratories such as immunohistochemistry, HPV testing and diagnostic radiology, and improving treatment and care. Additionally, the program aims to strengthen oncology services, including surgery, chemotherapy, and immunotherapy. Other areas of priority include establishing specialized centers, including pediatric oncology units, palliative Care (expanding services at all levels of care), radiotherapy and nuclear medicine, and integrating NGOs into delivery, data and research, strengthening the cancer registry and promoting evidence-based interventions.

The strategy aligns with WHO's Global Action Plan for Non-Communicable Diseases (2023–2030),

the Global Strategy to Eliminate Cervical Cancer, the Global Breast Cancer Initiative (GBCI), and the UN Sustainable Development Goals (SDG 3.4). The strategy has been developed through a participatory approach which included stakeholder consultations, workshops, and technical meetings with stakeholders at all levels. The strategy has been informed by findings from the comprehensive assessment of Eswatini's capacities and needs (Impact Review) conducted in 2024 through the support of International Atomic Energy Agency (IAEA), WHO and International Agency for Research on Cancer (IARC).

The vision of the Eswatini Cancer Program is to create an enabling environment for reducing cancer morbidity and mortality. The vision reflects the country's commitment to a future where cancer is no longer a public health crisis.

The mission is to promote evidence-based cancer care across the continuum. The mission emphasizes the importance of education, evidence-based interventions, and stakeholder collaboration in addressing cancer's challenges. It underscores the integration of community-focused and scientifically sound solutions into all aspects of cancer care.

The goal is to achieve a 30% reduction in cancer morbidity and mortality by 2030. This ambitious goal aligns with the United Nations Sustainable Development Goals (SDG 3.4) and WHO's global commitments, addressing Eswatini's cancer burden through a holistic and scalable framework. The strategy will focus on universal Access and Equity (ensure care for all, regardless of socioeconomic status), innovation (leverage technology like AI and telemedicine), sustainability (long-term solutions for infrastructure, funding, and workforce development), risk management (identifies risks across financial, human resource, operational, data, and environmental domains. Implementation of the strategy will leverage on the existing HIV laboratory platforms, community systems, and digital health infrastructure to accelerate scale-up while maximizing cost-effectiveness.
The strategy will also cover risk mitigation strategies including increased funding, improved infrastructure, enhanced training, and streamlined operations. The strategy will maximize impact through comprehensive cancer care. This means focusing on early detection, better treatment to promote long-term patient survival. The programme will priorities awareness campaigns (target communities with education on prevention and early detection), palliative and rehabilitative services (integrate into healthcare at all levels), strengthen workforce capacity (training healthcare workers in cancer care).

The implementation of the NCCS is rooted in the following core values to ensure equity, quality, and

sustainability:

Universal Access and Equity: Healthcare services will be accessible to all, regardless of socioeconomic status, geographic location, gender, age, or ability to pay.

Ethics and Confidentiality: Upholding patient privacy and confidentiality across all levels of service delivery.

Evidence-Based Practices: Interventions and decisions will be grounded in scientific evidence and public health principles.

Holistic Approach: Cancer care will address the physical, emotional, social, and spiritual needs of patients and their families.

Partnership and Multisectoral Collaboration: Foster partnerships across governmental, private, and community sectors to leverage resources and expertise.

Accountability and Transparency: Ensure stakeholders, organizations, and service providers uphold ethical practices and are held accountable for outcomes.

Human Rights and Dignity: Strategies will align with international human rights conventions, guaranteeing respect and dignity for all individuals.

Compassion and Empathy: Deliver care with genuine concern for patients and their families.

Innovation and Technology: Leverage modern technologies, including AI and telemedicine, to enhance cancer care services.

Sustainability and Integration: Ensure long-term solutions and seamless coordination across all healthcare systems and programs.

Human-Centered Approach: Prioritize patient experiences, needs, and preferences throughout the care continuum.

The specific objective of strategy is to provide strong strategic leadership and governance to ensure effective coordination across the cancer control continuum. A key priority is resource mobilization, securing sustainable financial, human, and material resources through strategic partnerships while fostering robust internal and external communication networks. The strategy also focuses on

delivering integrated and comprehensive cancer services to enhance treatment outcomes and improve long-term survival rates. Strengthening the capacity of the healthcare workforce, alongside improving facility infrastructure and systems, is essential for effective service delivery. Additionally, the strategy emphasizes the advancement of research, the optimization of information systems, and the integration of innovative technologies to support evidence-based programming, technology investments, and policy advocacy.

This comprehensive strategy underscores Eswatini's commitment to reducing the cancer burden and enhancing quality care through collaboration, innovation, and a patient-centered approach.

Chapter 1: Introduction

1.1 Background

Cancer is one of the four major non-communicable diseases, that has become a leading global cause of death and a major barrier to increased life expectancy. It encompasses over 100 disease types characterized by the uncontrolled growth and spread of abnormal cells, with metastasis being the primary cause of cancer deaths.

Globally, cancer causes more than 19 million new cases and nearly 10 million deaths each year, with the burden rising due to aging populations, lifestyle changes, and inequitable access to healthcare. Low and middle-income countries carry over 70% of cancer deaths, and survival rates for common cancers like breast and cervical cancer are often below 15% in low-income settings. Sub-Saharan Africa, including Eswatini, faces heightened challenges due to limited healthcare infrastructure, low awareness, and competing health priorities.

1.2 Country Profile

Eswatini's high HIV burden contributes to elevated rates of infection-related cancers, especially cervical cancer and Kaposi's sarcoma. Women living with HIV require adapted early detection intervals and differentiated clinical pathways, which should be explicitly reflected in national guidelines. The National Cancer Control Program has made important progress in prevention, early detection, and treatment, but significant gaps remain in diagnosis, treatment access, palliative care, and cancer data systems.

The NCCP Strategic Plan 2025–2029 outlines a roadmap to address these challenges and align with global WHO priorities. It aims to operationalize integrated, people-centered cancer services anchored in PHC platforms and aligned with the WHO Cervical Cancer Elimination Initiative.

1.2.1 Demographic information

According to the 2017 census, Eswatini has a population of 1.093,238 million, with slightly more females (51.4%) than males. The population is very young, with a median age of 21.7 years and 56% of people under 25. Only 4.6% are aged 60 and above. Women of reproductive age (15–44 years) represent over a quarter of the female population. The largest age groups are children and adolescents (0–19 years). This youthful demographic requires the need for strong, long-term cancer prevention strategies.

1.2.2 Socioeconomic situation

Eswatini is a lower-middle-income country with an HDI of 0.608, ranked 138 globally. Economic growth remains below the level needed to reduce poverty, affected by drought and declining SACU revenues. The country invests 12% of GDP in social sectors, but social protection coverage still has gaps. Poverty remains widespread: 58.9% of the population lives below the national poverty line and 20.1% are in extreme poverty, with rural areas most affected. This situation requires Eswatini government to allocate cancer resources for the underprivileged.

1.2.3 Health System Overview

Eswatini's health system delivers cancer services through five levels of care:

Level 1 – Community: Community health workers serve as the first entry point for cancer prevention, community awareness, navigation, and linkage to HIV, maternal health and PHC services, supporting early identification and continuity of care.

Level 2 – Primary Care (Clinics & Public Health Units): Primary health care facilities serve as the main platform for integrated cancer prevention and early detection. Services include HPV-based early detection, screen-and-treat approaches, management of precancerous lesions, integration with HIV and SRH services, and basic palliative care

Level 3 – Health Centres: Health centres function as intermediate diagnostic hubs, supporting biopsy services, triage, and referral coordination to reduce delays across the continuum of care.

Level 4 – Regional Hospitals: Cancer early detection and biopsy services and surgery. Regional hospitals should host multidisciplinary tumor boards and provide decentralized chemotherapy and surgical oncology services where feasible.

Level 5 – National Referral Hospitals: National referral hospitals provide specialized oncology services, including advanced diagnostics, surgical oncology, systemic therapy, and coordination of radiotherapy and international referrals.

Phalala Medical Referral Fund

Supports patients who need specialized care unavailable in Eswatini, mainly in South Africa. Radiation therapy are currently accessed through international referral mechanisms, highlighting the urgent need to accelerate national radiotherapy capacity as a core component of cancer control.

Chapter 2: Situational Analysis

Overview of Cancer Control in Eswatini

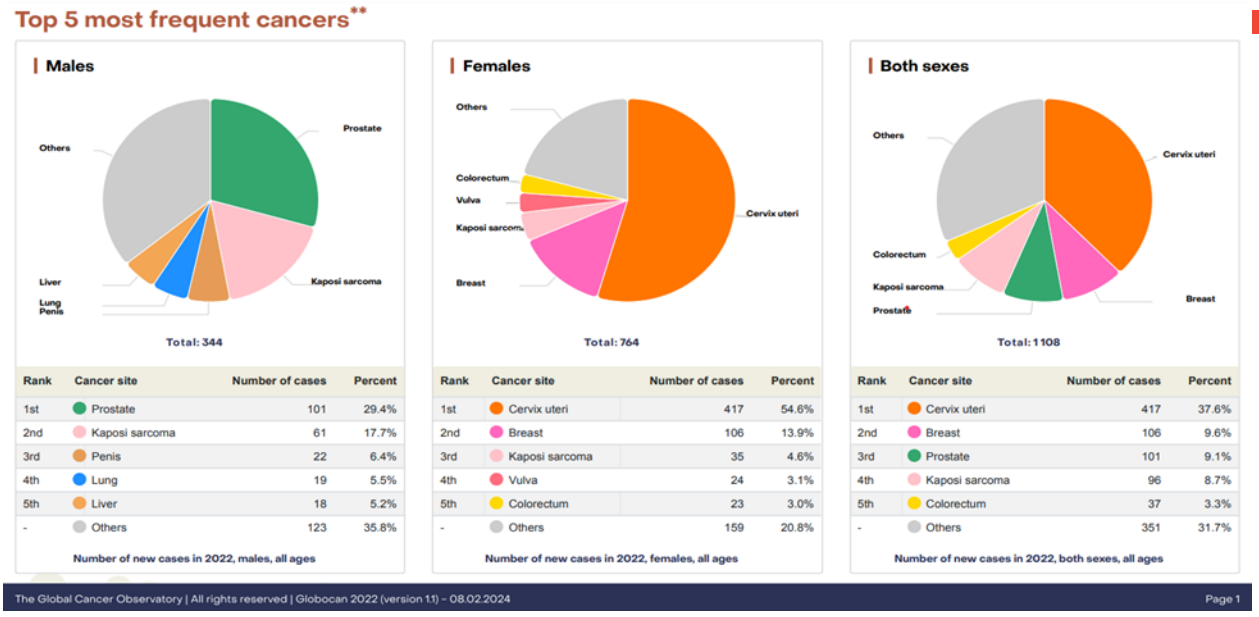
This section outlines the current landscape of cancer control in Eswatini, describing the cancer burden and its strong links to HIV. It highlights progress and remaining gaps across the cancer care continuum, including early detection, diagnosis, treatment, palliative care, and data systems. It also reviews national planning, leadership, and governance structures to assess the effectiveness of coordination. These insights guide priority-setting and help strengthen the country's overall cancer prevention and control efforts

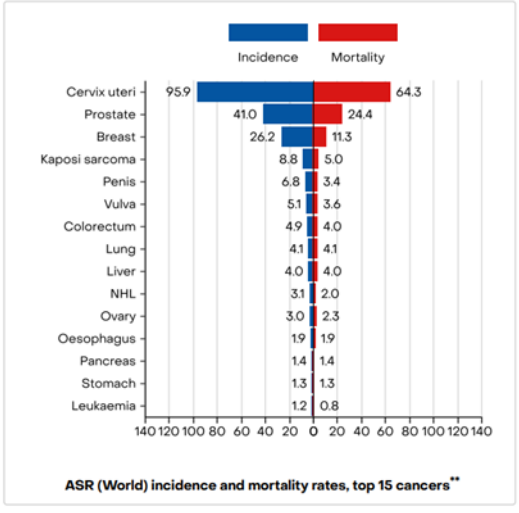
2.1 Burden of Cancer

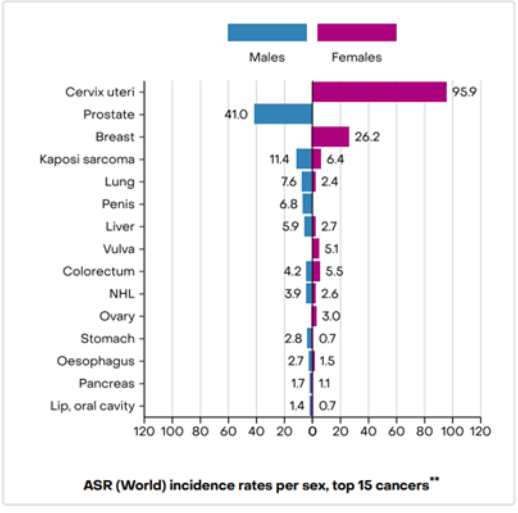
Eswatini faces a high cancer burden, with incidence at 135.3 per 100,000 and mortality at 88.8 per 100,000 (Globocan 2022). Cervical cancer is the leading cancer among women, largely preventable and yet has very high incidence (95.9/100,000) and mortality (64.3/100,000). Among men, prostate cancer is the most common and the top cause of cancer deaths (incidence 41.0/100,000; mortality 24.4/100,000).

In 2022, the country recorded 1,108 new cancer cases and 697 deaths, with women disproportionately affected. Childhood cancers made up about 3% of cases, with leukemia being the most common. These patterns highlight the urgent need to strengthen prevention, early detection, and treatment services especially for cervical, breast and prostate cancer.

TOP FIVE CANCERS IN ESWATINI 2022 INCIDENCE AND MORTALITY RATE 2022







SOURCE: NCCU

2.2 National Cancer Control Planning and Governance

The NCCU leads Eswatini's cancer control, implementing the NCCP, aligning with national/global priorities, and coordinating multisectoral partners.

Achievements

- ✓ Implemented NCCP 2019–2023; 82% progress by 2022.
- ✓ NCCU partially staffed (53%).
- ✓ Increased early detection access (60% → 69%) and operationalized the National Cancer Registry.
- ✓ Formed multisectoral technical working group and integrated with other health programs.
- ✓ Supported by Phalala Fund for oncology referrals, especially pediatric.

Challenges

- ✓ Childhood cancer is underrepresented in NCCP.
- ✓ Limited NCCU capacity; irregular TWG meetings.
- ✓ Weak private/NGO coordination and referral backlog.
- ✓ No structured resource mobilization; limited multisectoral data.

Recommendations

- ✓ Fully staff NCCU and establish a dedicated budget line.

Establish a formal integrated governance platform linking HIV, SRH, NCD and cancer programmes.

2.3 Registration and Surveillance

The Eswatini National Cancer Registry, established in 2015, collects nationwide cancer data from multiple sources using CanReg5 and international standards to inform policy and planning.

Achievements

- ✓ Population-wide data coverage and integrated sources.
- ✓ Functional infrastructure and staff training.
- ✓ Early research partnerships and international collaborations.

Challenges

- ✓ Cancer not legally notifiable; limited private sector data and underreporting.

Recommendations

- ✓ Advocate for mandatory cancer reporting, improve data sharing and diagnostics, platforms interoperability of data systems , and enhance data quality.

2.4 Prevention

Cancer prevention in Eswatini targets modifiable risk factors and infections. Key lifestyle risks include tobacco, alcohol, poor diet, physical inactivity, and obesity, while infections such as HIV, HPV, and HBV drive infection-related cancers. ART clinics serve as priority entry points for cervical cancer screening and follow-up. Prevention efforts include vaccination, health education, early detection, and lifestyle interventions.

Lifestyle Risk Factors

- ✓ Tobacco use increased from 6% (2014) to 11% (2024).

- ✓ Alcohol use rising (22% current drinkers; binge drinking (12–15%).
- ✓ Over 85% of people consume insufficient fruits/vegetables; physical inactivity and obesity are increasing, especially in urban women.
- ✓ Cervical cancer screening improved (21.7% - 65.9%), but high-performance tests like HPV DNA testing are limited.

Challenges

- ✓ Low public awareness and knowledge gaps.
- ✓ Limited resources for prevention and lifestyle modification.
- ✓ Unclear roles across NCD and cancer programs.

Recommendations

- ✓ Launch targeted public health campaigns.
- ✓ Increase resources for lifestyle and cancer prevention programs.

Infections as Risk Factors

- ✓ HIV prevalence 24.8%, driving Kaposi sarcoma, cervical cancer, and non-Hodgkin lymphoma.
- ✓ HPV vaccination achieved 74.4% coverage among eligible girls: plans for boys underway.
- ✓ HBV vaccination nearly universal for third dose; birth dose not yet implemented.

Challenges

- ✓ Lack of national HPV burden data; dependency on donor funding.
- ✓ Limited HPV DNA testing; delays in pap smear results.
- ✓ Weak surveillance for infection prevalence.

Recommendations

- ✓ Implement the Cervical Cancer Elimination Plan.
  Strengthen HBV and HPV vaccination, including boys and birth dose (HepB0).
  Improve early detection and lab capacity, ensure reagent supply, and enforce tobacco control.
- ✓ Generate national data on HPV to guide interventions and increase domestic funding for sustainability.

2.5 Early Detection

Early detection is crucial for improving cancer survival in Eswatini, where most cases are diagnosed at advanced stages.

Challenges

- ✓ Limited early detection and diagnostic infrastructure.
- ✓ Insufficient skilled staff.

Recommendations

- ✓ Expand early detection equipment and infrastructure.
- ✓ Train and retain adequate staff to achieve full coverage by 2027.

Cervical Cancer

Eswatini is committed to the WHO Cervical Cancer Elimination Initiative, aiming to reach the 2030 targets of 90% HPV vaccination, 70% early detection coverage, and 90% treatment for cervical disease. This effort is critical as the country faces very high cervical cancer incidence (95.9/100,000) and mortality (64.3/100,000). Early detection uptake in Sub-Saharan Africa including Eswatini is affected by low awareness, cultural beliefs, privacy concerns, and financial barriers.

About 91% of health facilities provide cervical cancer screening, and 85% of the population lives within 8 km of a health facility, indicating good access. Eswatini is also piloting nurse led LEEP services, with one trained nurse performing about 10 procedures monthly.

Achievements

- ✓ Strong government commitment to WHO elimination initiative
- ✓ Draft national cervical cancer elimination plan (2025–2030)
- ✓ Established national early detection program
- ✓ Early detection availability in most facilities
- ✓ Pilots for HPV testing and nurse-led Loop Electrosurgical Excision Procedure (LEEP)
- ✓ Clear referral system

Challenges

- ✓ Early detection guidelines not aligned with WHO
- ✓ Shortage of trained healthcare workers
- ✓ Opportunities
- ✓ Development of the elimination plan
- ✓ HPV guideline alignment underway
- ✓ Expanding partnerships (WHO, NGOs, regional bodies)
- ✓ Increased community awareness efforts

- ✓ Transition to HPV DNA testing as the primary early detection modality should be accelerated through integration with existing molecular testing platforms such as GeneXpert.
- ✓ Operational integration of early detection within HIV platforms should be prioritized as the primary scale-up strategy.

Breast Cancer

Breast cancer is the most common cancer globally and a leading cause of cancer deaths among women, with survival gaps driven by late diagnosis and limited healthcare access. The WHO Global Breast Cancer Initiative (GBCI) aims to close these gaps through health promotion, timely diagnosis, and quality treatment. In Eswatini, breast cancer is the third most common cancer, but the country lacks national early detection guidelines and largely depends on clinical breast examinations (CBE) due to limited resources. Early detection coverage is unknown, and infrastructure constraints persist.

Achievements

- ✓ Improved CBE skills among nurses through targeted training.
- ✓ Youth-focused awareness activities under the ECPT project.
- ✓ Strong partnerships with NGOs (ECN, Baylor Clinic, FAWEESWA) supporting early detection.
- ✓ Alignment with WHO's GBCI pillars on promotion, early detection, and timely diagnosis.

Challenge

- ✓ Limited access to mammography, ultrasound, and trained specialists.
- ✓ Unknown national early detection coverage and reliance on CBE with minimal imaging services.

Recommendations

- ✓ Intensify public awareness and promote CBE.
- ✓ Expand CBE training for health workers.
- ✓ Strengthening partnerships with community organizations.
- ✓ Increase access to imaging services (mammography, ultrasound).
- ✓ Introduce standardized national treatment protocols.

Prostate Cancer

Prostate cancer early detection in Eswatini is mainly done through Digital Rectal Examination (DRE), with very limited use of PSA testing and unknown early detection coverage. Even when

abnormalities are detected, a lack of skills, equipment, and biopsy capacity leads to delays in diagnosis and treatment.

Achievements

- ✓ DRE is established as the primary early detection method.
- ✓ Recognition of the need for provider training and increased awareness among men aged 50+.

Challenges

- ✓ PSA testing is rarely available or used; coverage is unknown.
- ✓ Limited biopsy skills and resources delay diagnosis.
- ✓ Weak laboratory capacity, inadequate provider training, and poor referral linkages.

Low awareness among high-risk men reduces early detection uptake.

Recommendations

- ✓ Conduct targeted awareness campaigns for men aged 50+.
- ✓ Expand training for providers on DRE techniques.
- ✓ Partner with private labs/NGOs to scale up PSA testing.
- ✓ Strengthen integrated care pathways from early detection to treatment.
- ✓ Secure sustainable funding for prostate cancer services.

Colorectal Cancer

Colorectal cancer early detection in Eswatini is opportunistic, with no organized national program. The previous National Cancer Prevention and Control Strategy made only minimal reference to colorectal cancer. Systemic challenges, limited infrastructure, funding constraints, and shortages of trained professionals result in late-stage diagnosis and poor outcomes.

Achievements

- ✓ Colorectal cancer was minimally included in the previous national strategy, with a target to expand early detection and linkages to care.
- ✓ The strategy aimed to increase facilities offering early detection to 60%.

Challenges

- ✓ No formal or organized early detection program.

- ✓ Inadequate infrastructure and diagnostic equipment.
- ✓ Lack of trained personnel for colonoscopy/sigmoidoscopy.
- ✓ Insufficient financial resources for colorectal early detection servises.
- ✓ Majority of cases are detected at late stages.
- ✓ Lower national priority compared to cancers like cervical and breast.

Recommendations

- ✓ Integrate colorectal cancer awareness into existing health education efforts.
- ✓ Train healthcare workers to identify early signs and refer appropriately.
- ✓ Assess current national capacity to guide early detection scale-up.
- ✓ Strengthen referral pathways for timely diagnosis.
- ✓ Invest in infrastructure and workforce to build endoscopy capacity.

Lung cancer

Lung cancer early detection and management in Eswatini are improving through collaboration with the TB programme and the *Secure the Future – Lung Cancer in Eswatini* initiative. Efforts include strengthening the cancer registry, improving early diagnosis, and raising community awareness. However, early detection coverage is still limited, and diagnostic capacity remains weak.

Achievements

- ✓ Strengthened National Cancer Registry for better lung cancer surveillance.
- ✓ Community awareness campaigns have been developed to educate the public about risks and symptoms.
- ✓ Training programs were launched to build health worker capacity in diagnosis and patient management.

Challenges

- ✓ Very limited early detection availability and constrained diagnostic infrastructure.
- ✓ Delays in diagnosis due to lack of standardized tools and limited pathological services.
- ✓ Low public awareness, particularly among high-risk groups.
- ✓ Symptom overlaps with TB lead to misdiagnosis and delayed treatment.

Recommendations

- ✓ Introduce targeted early detection for high-risk groups (e.g., smokers, chronic respiratory patients).
- ✓ Invest in radiology, pathology, and biopsy services to strengthen diagnostic capacity.
- ✓ Continue healthcare worker training and CME.
- ✓ Integrate TB and lung cancer services with clear protocols.
- ✓ Mobilize funding and partnerships to expand detection and treatment services.

Diagnostic Imaging and Nuclear Medicine

Eswatini's diagnostic imaging capacity remains limited and highly centralized, with most services concentrated in Mbabane. The country has no public-sector radiologists and no nuclear medicine services, forcing reliance on private facilities or external referral.

Achievements

- ✓ Basic imaging (X-ray, ultrasound) is available in major hospitals, performing 10–15 procedures daily.
- ✓ Functional CT/MRI machines exist, along with three mammography units.
- ✓ Ultrasound waiting times are under five days; X-rays are available without delays.
- ✓ Two radiologists are in training abroad; one medical physicist is available.

Challenges:

- ✓ Advanced imaging is limited in rural areas; public sector lacks radiologists, leading to radiographers interpreting scans.
- ✓ Frequent equipment breakdowns, lack of maintenance, and unreliable supplies drive patients to costly private services.
- ✓ Significant regulatory gaps: no radiation safety oversight, no dosimetry monitoring, and unsafe equipment placement.
- ✓ No endoscopy or nuclear medicine services; absence of quality assurance mechanisms.

Recommendations

- ✓ Recruit radiologists with IAEA support and strengthen radiation safety systems.
- ✓ Enact nuclear legislation and establish a regulatory authority.
- ✓ Improve equipment maintenance, expand ultrasound use, and introduce digital imaging technologies.
- ✓ Develop a national quality assurance framework and explore long-term nuclear medicine

Pathology and Laboratory Diagnosis

Pathology services are centralized in Mbabane and Manzini, with the National Anatomical Pathology Laboratory (NAPL) as the reference center. While basic services exist, significant delays, shortages, and outdated equipment hamper timely cancer diagnosis.

Achievements

- ✓ NAPL provides histopathology, cytology, HPV testing, and some immunohistochemistry.
- ✓ Routine pathology is available in major hospitals; digital access through Disa Lab exists.
- ✓ Government courier system supports sample transport; public pathology services have no user fees.

Challenges

- ✓ Severe backlogs (3–6 months) due to high workload and limited staff (only two pathologists).
- ✓ Ageing equipment, reagent shortages, and weak supply chains.
- ✓ Limited specialized testing, molecular diagnostics are outsourced at high personal cost.
- ✓ Weak quality systems and inactive tumor boards.

Recommendations

- ✓ Develop an Essential Diagnostics List; upgrade NAPL equipment and expand IHC capacity.
- ✓ Strengthen sample transport, IT systems, and supply chain reliability.
- ✓ Offer specialized training and pursue laboratory accreditation in the medium term.
- ✓ Digital pathology and telepathology partnerships should be explored to reduce turnaround times and improve access to expert interpretation.

Treatment Services

Medical Oncology

Cancer treatment capacity has grown with the establishment of the Manzini Oncology Unit in 2022, significantly improving national access to chemotherapy and specialist care.

Achievements

- ✓ A 60-bed oncology ward and outpatient clinic established at Manzini.
- ✓ Chemotherapy also available at Mbabane Hospital (12 chairs).

- ✓ Presence of oncologists, oncology nurses, and supporting clinical staff.
- ✓ National cancer treatment protocols developed.

Challenges

- ✓ Limited specialist workforce to support multidisciplinary care.
- ✓ Outdated Essential Medicines List misaligned with procurement systems.
- ✓ No standard operating procedures for safe chemo administration.
- ✓ Lack of regional chemo services and inactive tumor boards.

Recommendations

- ✓ Recruit and train oncology specialists; develop SOPs based on WHO guidelines.
- ✓ Align the EML with WHO and national tender lists.
- ✓ Strengthening forecasting and costing of cancer medicines.

Surgical Oncology

Cancer-related surgeries are mostly conducted by general surgeons, with services concentrated in Mbabane. Specialist capacity and surgical oncology infrastructure remain insufficient.

Achievements

- ✓ Surgical oncology available at Mbabane Government Hospital (≈30 electives weekly, 15% cancer-related).
- ✓ Free healthcare supports access; NCPCS recognizes surgical oncology needs.

Challenges

- ✓ No dedicated surgical or gynecologic oncologists; only three anesthesiologists.
- ✓ Limited theatre space, consumable shortages, and long delays (up to 6 months).
- ✓ Lack of training programs, tumor boards, and regional surgical capacity.

Recommendations

- ✓ Develop a National Surgical, Obstetric, and Anesthesia Plan (NSOAP).
- ✓ Expand theatre capacity and train general surgeons in oncologic procedures.
- ✓ Establish tumor boards and standardize essential surgical devices.

Pediatric Oncology

Eswatini's pediatric oncology services are nascent, with most children referred abroad for treatment under the Phalala Fund.

Achievements

- ✓ Childhood cancer focal person appointed at NCCU; health worker training and caregiver support established.
- ✓ Referral pathway to Chris Hani Baragwanath Hospital exists.

Challenges

- ✓ No in-country pediatric oncology treatment services or specialists.
- ✓ Weak follow-up systems for referred children; poor data quality.
- ✓ Inadequate palliative care and limited morphine access.

Recommendations

- ✓ Include pediatric oncology in the revised NCPCS and integrate into child health platforms.
- ✓ Strengthen early diagnosis and referral systems.
- ✓ Develop a roadmap for pediatric oncology services at Manzini Hospital and improve palliative care.

Radiation Oncology

Radiotherapy is a major gap in Eswatini's cancer care system. The Ministry of Health has initiated the process of establishing the country's first radiotherapy unit.

Achievements:

- ✓ Site identified at Manzini Hospital; TWG on Radiotherapy established.
- ✓ USD 1 million allocated in the 2024 budget for initial works.
- ✓ A bankable document is available to guide investment and resource mobilization.
- ✓ National Nuclear and Radiation Safety Regulatory Bill 2024 was enacted.

Challenges:

- ✓ No national radiotherapy strategy; no trained radiation oncology workforce.
- ✓ Weak diagnostic and treatment systems that should support radiotherapy.

Recommendations:

- ✓ Expedite establishment of regulatory body of nuclear legislation.
- ✓ Develop a phased radiotherapy roadmap aligned with cervical cancer elimination priorities, ensuring access to curative treatment pathways..
- ✓ Plan long-term workforce development (radiation oncologists, medical physicists, RTTs).
- ✓ Strengthen overall cancer diagnostics and referral pathways.

Palliative Care and Survivorship

An estimated 12,000 people require palliative care annually. Although policy support exists, services face staffing, funding, and medicine availability constraints.

Achievements

- ✓ National clinical guidelines established; >100 health workers trained.
- ✓ Multi-level service delivery model operating from community to hospitals.
- ✓ Government financial support for community organizations.
- ✓ NCPCS aims for 80% facility coverage.

Challenges

- ✓ Insufficient staffing and inconsistent funding.
- ✓ Irregular supply of essential medicines, notably oral morphine.
- ✓ No local training programs; reliance on external support.
- ✓ Sustainability concerns.

Recommendations

- ✓ Review and strengthen the national palliative care strategy.
- ✓ Invest in staffing, funding, and reliable medicine availability.
- ✓ Establish local training programs and streamline opioid access.
- ✓ Sustain partnerships to ensure nationwide coverage.

The Essential Health Care Package (EHCP) report (2025) divides the health care system into five (5) health service delivery levels.

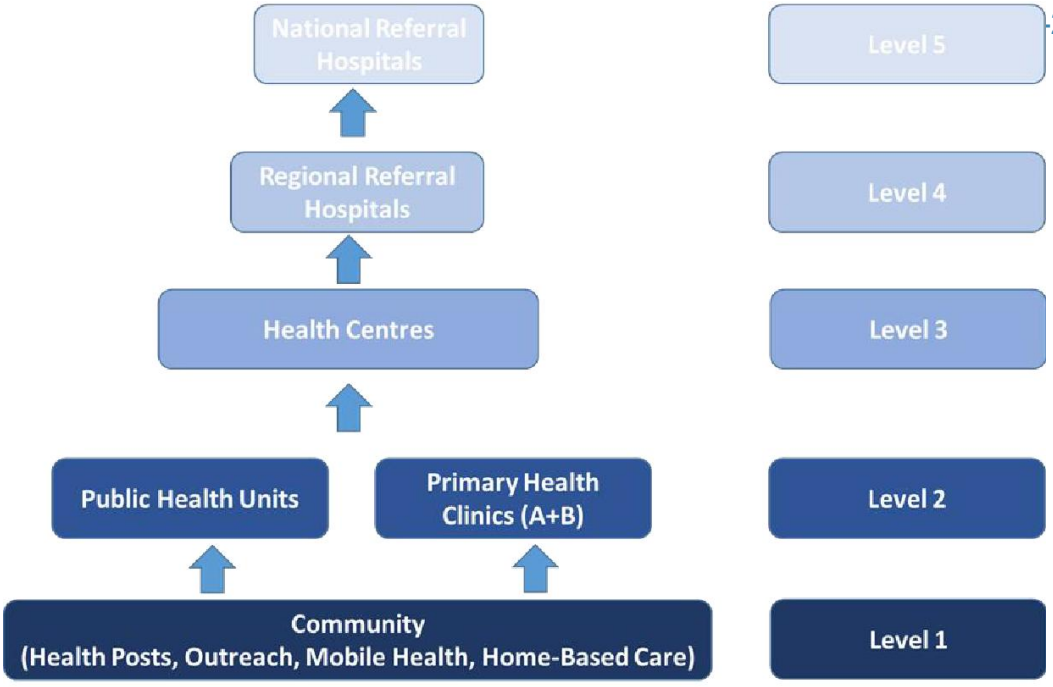
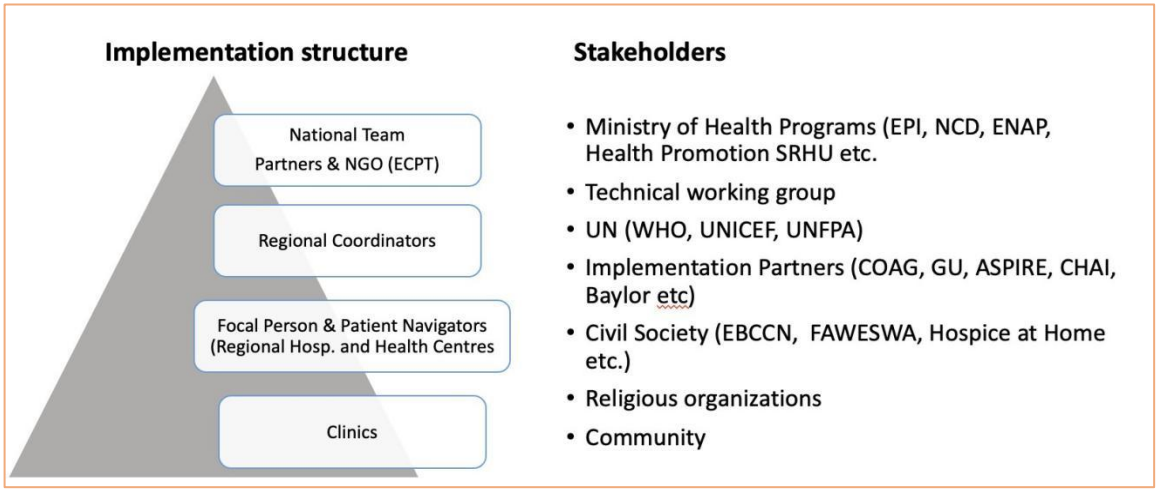


Figure 3: Health Care System Delivery

Figure 1: Implementation arrangements for cancer control activities



Source: NCCU

The above figure summarises the implementation arrangements for cancer prevention and control interventions with the support from different partners. One of the key strengths is the availability of regional coordinators and cancer patients' navigators at regional hospitals and health centres helping patients overcome various huddles in the referral pathway.

Chapter 3- SWOT Analysis Summary

This section provides a strategic SWOT analysis of Eswatini's 2019–2023 Cancer Control Strategy. It highlights strong political commitment and governance capacity such as an active National Cancer Control Programme and dedicated funding while acknowledging operational weaknesses like inconsistent resource mobilization and shortages in the cancer workforce. It also identifies major opportunities, including digital health advancements and global partnership support, and outlines key threats such as donor reliance, financial uncertainty, and limited infrastructure. Overall, the analysis offers a clear foundation for sharpening priorities, improving resource allocation, and guiding impactful actions for the next five-year cancer control plan.

SWOT Analysis of Eswatini's 2019–2023 Cancer Control Strategy

Strength	***Weaknesses***
Leadership and Governance and Financing	
✓ Political will to continuously re-affirm the commitment to cancer elimination and control by Ministry of Health. ✓ Establishment of National Cancer Control Program. ✓ Government commitment to cancer care through the Phalala Medical Fund, covering referrals and treatment costs for oncology patients, particularly paediatrics. ✓ Functional infrastructure includes office space, IT equipment, secure storage, and dedicated transport. ✓ Mid-Term Review of previous strategy conducted in 2022 identifying progress and gaps. ✓ Integration opportunities identified across MOH programs (e.g., HIV, EPI, TB,	✓ Insufficient domestic resource mobilization: Budget line for the established program (responsibility center). ✓ Childhood Cancer not fully integrated into the NCCP (2019-2023) ✓ Limited operational capacity and reliance on partner-supported NCCU positions. ✓ Inconsistent technical working groups ✓ Sub-optimal coordination and reporting mechanisms among non-governmental and private sector stakeholders. ✓ Absence of a structured resource mobilization plan. ✓ Limited data to track progress in multisectoral partnerships and stakeholder engagements.

Nutrition). ✓ Cervical cancer elimination efforts are integrated into other programs – riding on other program resources (i.e. HPV vaccination being done by School Health program, SRH, EPI and Health Promotion, ENAP).	
Early Detection	
✓ Availability of health care workers and staff trained in cancer continuum of care (early detections, treatment, palliative care) ✓ Decentralization of early detection services such as breast, prostate, cervical, childhood cancers ✓ Increased types of cancers screened from breast and cervical cancers to prostates, lung and childhood cancers. ✓ Increased access to early detection services (from 60% to 69%). ✓ Partnership Development: Active collaboration with NGOs such as ECAN, Baylor Clinic, LISTEN, FAWEESWA to support early detection and education. ✓ Strong government commitment to the WHO Cervical Cancer Elimination Initiative ✓ Developed Cervical Cancer Elimination strategic plan (2025 - 2030) ✓ Alignment with Global Initiatives: pillars promotion, early detection, and timely diagnosis	✓ Low uptake of prostate and childhood cancers early detection services. ✓ Lack of access to expertise for prostate, colorectal early detections ✓ Under-utilization of cancer early detection equipment ✓ Referral pathways & counselling not well integrated. ✓ Lack of Male involvement in female cancers and the same with lack of female involvement in male cancers. ✓ Current guidelines not aligned with WHO recommendations. ✓ Shortage of trained healthcare workforce.
Pathology and Laboratory Diagnosis	
✓ Centralized Pathology Services	✓ Under-utilizing of equipment that can give us

✓ Basic Infrastructure in Place: Key facilities like NAPL, Raleigh Fitkin Memorial Hospital, and several faith-based and public hospitals are equipped to provide routine pathology services, including immunohistochemistry and HPV testing. ✓ Sample Transportation and Information Systems in place through government support and partners. ✓ Availability of a Pathology Laboratory ✓ Availability of Immunochemistry tests ✓ Reduced turn-around times for pathology results. ✓ Available of Immunohistochemistry equipment and reagents ✓ Diagnostic imaging services, including X-ray and ultrasound, are available in major public and private hospitals, with a daily volume of 10–15 procedures. ✓ Functional CT and MRI machines exist, along with three mammography units (one public, two private).	broad spectrum of diagnosis such as HPV genotyping early detections. ✓ Inadequate skills and resources prevent timely biopsies, delaying diagnosis and treatment. ✓ Long turn-around time due to backlog ✓ Low awareness among high-risk male populations affects early detection uptake. ✓ However, the CT & MRI machines exist with mammography, they are not enough for the country. ✓ Equipment breakdowns, lack of consumables, and absence of maintenance programs disrupt public sector services, pushing patients to unaffordable private options. ✓ Endoscopy and nuclear medicine services are virtually non-existent, and there are no established quality assurance frameworks or radiation protection officers. ✓ Weak Quality Systems: No National Cancer diagnostic standards or funded external quality assurance programs are in place.
Treatment	
✓ Development and Implementation of National Cancer Treatment Protocols based on International Standards. ✓ Chemotherapy drugs included in the Government's medicines tender system. ✓ Chemotherapy drugs are partner supported. ✓ Precancerous lesions treatment available (thermos-coagulation, cryotherapy, and LEEP)	✓ Inconsistent availability of chemotherapy drugs ✓ Inadequate nutritional impact/support for cancer patients ✓ Backlog of patients referred for cancer treatment due to limited funds and specialist appointment delays. ✓ There is a critical shortage of qualified radiologists in the public sector, forcing

✓ Availability of Patient Navigators has improved patients' retention to care and treatment. ✓ Radiation Therapy services available with private sector and government in the process of establishing radiation therapy. ✓ Establishment of a 60-bed oncology ward and outpatient clinic at Manzini Hospital. ✓ Expansion of Chemotherapy Unit ✓ Two radiologists are currently training abroad, and there is one medical physicist in the country. ✓ The NCCU has appointed a focal person for childhood cancers who is part of the Ministry's child health Technical Working Group. ✓ Ongoing pilot programs for HPV testing-based early detection strategy and LEEP training for nurses ✓ Health worker training on early detection and awareness campaigns has been conducted. ✓ Caregiver support groups have been established on childhood cancers. ✓ A referral system exists through the Phalala Fund, allowing suspected paediatric cancer cases to be treated at Chris Hani Baragwanath Hospital in South Africa. ✓ Funding allocated in the 2024 national health budget for the construction of the radiotherapy unit. ✓ Availability of cancer documents (guidelines, Standard operational procedures (SOPs),	radiographers and referring physicians to take on interpretive roles. ✓ Absence of standard operating procedures for safe chemotherapy administration. ✓ Lack of regional chemotherapy services and underdeveloped tumour boards. ✓ Lack of in-country pediatric oncology treatment services. ✓ Very limited specialist capacity to diagnose and treat childhood cancers. ✓ Inadequate paediatric palliative care and limited access to morphine. ✓ The Nuclear and Radiation Safety Law is still awaiting enactment by the National Assembly.

Prevention Strategies	
✓ Partnership support for cancer prevention ✓ Dedicated government funds for vaccine procurement. ✓ Community engagement towards awareness and education ✓ Ongoing campaigns to raise awareness, early detection services, community engagement and social mobilization activities. ✓ Program on cancer control risk factors has been introduced (tobacco, alcohol,). ✓ Reviewing of tobacco product control Act. ✓ Cancer elimination efforts are integrated into other programs – riding on other program resources (i.e. HPV vaccination being done by School Health program, SRH, EPI, TB and Health Promotion, ENAP, CBHS).	✓ Limited evidence on the prevalence of HPV in the country hinders targeted interventions. ✓ Limited enforcement of tobacco & alcohol control on legislations. ✓ Integration is limited to some prevention interventions, but there is a gap for more integration in the other parts of the continuum of care (diagnosis, treatment). ✓ Cervical cancer interventions are donor dependent. ✓ Undefined roles and responsibilities on integration with other programs. ✓ Current guidelines not aligned with WHO recommendations: ✓ Inadequate skills and resources prevent timely biopsies, delaying diagnosis and treatment. ✓ No Organized Early detection Program: Current colorectal cancer early detection is opportunistic, lacking systematic protocols or population-level outreach.
Palliative & Survivorship	
✓ Formation of Cancer Survivors in some cancers. ✓ National Palliative Care clinical guidelines have been developed. ✓ Over 100 healthcare professionals have received training in pain management and palliative care. ✓ A multi-tiered palliative care delivery model operates at community, health centre, and	✓ Waiting time for referral for external services still not well coordinated ✓ There is no comprehensive cancer survivors' network to include all cancers. ✓ Uncoordinated structure on palliative care at national level ✓ Inconsistence of Palliative Care medicines. ✓ Inadequate staffing and limited funding hinder service delivery.

hospital levels. ✓ Availability of Palliative Care models (health facility and community based) ✓ Trained personnel on palliative care ✓ Support of partners in Palliative and Survivorship ✓ The government provides financial support to civil society organizations involved in community-based palliative care. ✓ Palliative Care services are introduced in some cancer-related health facilities.	✓ Essential medicines like oral morphine are not consistently available. ✓ There is no local palliative care education or training programs, creating dependence on international support. ✓ Sustainability is a concern due to reliance on external partners.
Human Resource Skills	
✓ Availability of cancer specialist ✓ Oncologist ✓ Pathologist ✓ Nurse oncology ✓ Increased number of health care workers trained on cancer services (early detection, cancer management and palliative care ✓ Formation of intersectoral response team to cancer control ✓ Availability of cancer coordinators overseeing the implementation of cancer in all regions.	✓ Insufficient human resources at facility level to provide early detection services. ✓ Inadequate training at all levels- Training one person per facility is not sustainable.
Registration and Surveillance	
✓ Population Based National Cancer Registry collecting information on cancer incidence and mortality ✓ Cancer Strategic Information and Surveillance staff on the structure of National Cancer Control Program. ✓ Cancer indicators and data included in the HMIS & CMIS	✓ Limited oncology research capacity ✓ Data capturing at community level is not. ✓ Standardised. ✓ Insufficient resources for system maintenance and management. ✓ No unified data collection and reporting across ✓ public and private facilities.

✓ Initial partnerships are formed with academic and research institutions for data use. ✓ Operationalization of the National Cancer Registry improving data availability. ✓ Integration of data from diverse sources including public hospitals, pathology labs, and international treatment facilities. ✓ Ongoing capacity development through local and international training (e.g., AFCRN).	✓ Limited dissemination and sharing of research findings. ✓ Lack of legal and strategic oversight: Cancer is not notifiable, and there is no legal mandate or advisory committee to guide reporting and registry operations. ✓ Data and system gaps: Limited access to private records, underreported deaths, diagnostic delays, and absence from global databases affect data quality.
Opportunities	**Threats**
✓ Presence of a decentralized health care system ✓ Some Cancer services are well decentralized ✓ Existence of a well-established decentralized HIV and TB management ✓ On Integration of vaccination in ART/TB/NCDs clinics. ✓ Existence of public private partnerships ✓ Existing HIV infrastructure to promote integration. ✓ Growing partnerships with WHO, NGOs, and regional organizations.	✓ Global and local financial instability
✓ Availability of international donors to fund and support cancer initiatives. ✓ Utilize Ministry of Health budget cycle. ✓ Established partnerships with local and international NGOs, businesses.	✓ Cervical cancer interventions are budgeted under other responsibility centers (Phalala, oncology /NCD hospital)
✓ Availability of local oncologist at the national hospital to train and mentor health care workers	✓ Inadequate infrastructure ✓ Emerging global pandemics

✓ Ongoing development of the National Cervical Cancer elimination plan ✓ HPV guidelines under development with possible alignment to WHO recommendations ✓ Ongoing education and awareness campaigns	✓ Referral infrastructure challenges ✓ Funding constraints: Insufficient resources to scale up programs. ✓ Cultural/religious resistance: Ongoing challenges in addressing misconceptions. ✓ Resource Limitations: Inadequate access to mammography, ultrasound, and trained personnel due to financial and infrastructure constraints. ✓ Low Early detection Coverage: Unknown early detection coverage with reliance on limited CBE use and low mammography availability.
✓ Availability of Electronic Medical record systems that can be upgraded to interconnect cancer vaccination, early detection and treatment. ✓ Availability of data to inform evidence-based programming & future research areas.	✓ High reliance on donor support
✓ Development of National Plan for cervical cancer elimination that emphasizes HPV vaccination. ✓ Adoption of WHO SAGE recommendations on HPV single dose ✓ Planned review of national HPV guidelines. ✓ Strengthen cervical cancer elimination strategy within the cancer control.	✓ Global supply limitations that may hinder vaccination efforts. ✓ Insufficient and unpredictable financial resources to support scale up of HPV vaccination. ✓ High dependence on external funding may impact sustainability.
✓ Including cancer module in training institutions and in the in-service trainings.	✓ Rotation of trained healthcare workers in facilities has resulted in brain drain.

Chapter 4: Strategic Priorities : Vision Mission and Goals

This chapter outlines the strategic direction for cancer control in Eswatini, articulating the Vision, Mission, overarching Goal, and the key Strategic Pillars that will guide national efforts to reduce the burden of cancer and improve population health outcomes.

Vision

Eswatini free from preventable cancers and related suffering.

Mission

To reduce the burden of cancer in Eswatini by strengthening prevention, early detection, diagnosis, treatment, palliative care and survivorship services through sustainable patient, equitable and evidence – based strategies to enhance the wellbeing of the population of Eswatini.

Goal: Achieve a 30% reduction in cancer mortality by 2030 from 2024 baseline.

2030 Targets:

Cervical Cancer

90% of girls fully vaccinated with the HPV vaccine by 15 years of age

70% of women are screened with a high-precision test (HPV DNA test) at 35 and 45 years of age

90% of women identified with cervical disease receive treatment and care

Breast Cancer

Reduce breast cancer mortality by 2.5% per year

Promote early detection so that at least 60% of breast cancers are diagnosed at an early stage (I or II)

Comprehensive breast cancer management to deliver the full treatment course to at least 80% of diagnosed patients.

Childhood Cancer

At least 60% survival for all children with cancer by 2030.

Lung Cancer

Reduce the population of currently smoking by 2.5% annually from 11% (Steps, 2024)

Strategic Objectives

1. By 2029, achieve and sustain 90% HPV vaccination coverage among girls aged 9-14 years,

and reduce cancer risk factors by at least 3% from 2024 baseline.

2. Expand the national diagnostic capacity and quality systems for early detection of cancers through introduction and decentralization of new technologies by 2027.
3. Build a patient navigation system for timely diagnosis and treatment initiation within 6 weeks of diagnosis for cervical, breast, prostate and lung cancer by 2029.
4. By 2029, ensure that at least 80% of health facilities provide comprehensive quality cancer services including palliative and rehabilitative care as defined in the essential health package with zero stock out of essential medicines and supplies.
5. By 2029, enhance the governance and sustainability of cancer control by fully staffing the NCCP, secure long-term financing mechanisms, and foster resilient multisectoral collaboration
6. By 2029, strengthen cancer data systems and research capacity to generate high-quality evidence for informed decision-making
7. Achieve at least 60% survival for children with cancer by 2029.

Chapter 5: Strategic Framework - Strategic Objectives and priority interventions

To achieve the strategic objective and targets the following inteventions have been prioritised for implementation.

Objective 1: By 2029, achieve and sustain 90% HPV vaccination coverage among girls aged 9-14 years, and reduce cancer risk factors by at least 3% from 2024 baseline.

1.1 Priority Intervention: Strengthen multisector coordination and policy integration

Activities:

1.1.1 Establish a National Cancer Prevention Task Team including all key MOH programs and partners.

1.1.2 By 2027, establish an SOP or MOU to integrate cancer prevention efforts across Ministry of Health programs, development partners, CSOs, and other government sectors, clearly defining roles, responsibilities, and shared objectives for coordinated action

1.2 Priority Intervention: To significantly reduce cervical and liver cancer risk.

Activities:

1.2.1 Expand access to HPV vaccine

1.2.2 Create awareness on cervical cancer risk prevention

1.2.3 Finalize and implement HPV vaccination guidelines and tools.

1.3 Priority Intervention: Increase community awareness about cancer risk factors, risk reduction behaviors and interventions

Activities:

1.3.1 Train key stakeholders (CHWs, teachers, media, traditional leaders, and healers, religious and youth leaders), at least 1000, annually on cancer risk factors.

1.3.2 Promote healthy lifestyles in communities, workplace, schools and health facilities

Objective 2: Expand the national diagnostic capacity and quality systems for early detection of cancers through introduction and decentralization of new technologies by 2027.

2.1 Priority Intervention: Improve technology integration and service expansion

Activities

2.1.1 Introduce Picture Archiving & Communication System (PACS) in all imaging departments

2.1.2 Expand ultrasound services in all health centers.

2.1.3 Decentralize imaging services and establish satellite diagnostics e.g. telemedicine in rural areas.

2.1.4 Decentralize HPV / DNA testing by multiplexing of Gene Xpert.

2.1.5 Strengthen immunohistochemistry testing at the National Anatomical Pathology Laboratory.

2.1.6 Establish a rapid frozen section to facilitate urgent cancer diagnosis.

2.1.7 Advocate for recruitment of one haematologist

2.1.8 Conduct training in haematology and molecular diagnostics

2.2 Priority Intervention: Enhance operational systems and quality standards

Activities:

2.2.1 Strengthen sample transport logistics

2.2.2 Advocate for national laboratory accreditation.

2.2.3 Optimize operational efficiency and accuracy at NAPL by standardizing core processes

2.2.4 Engage the laboratory to improve on turn-around time for results

2.2.5 Advocate for improved ordering (supply chain logistics) systems

Objective 3: Scale up integrated cancer services (cervical, breast, prostate, lung) and ensure treatment initiation within one month of diagnosis by 2029.

3.1 Priority Intervention: Expand technical expertise and regulatory capacity

Activities:

3.1.1 Establish in-service training programs for quality cancer continuum of care.

3.1.2 Decentralise cancer early detection and pre-cancer treatment services as per guidelines

3.1.3 Strengthen integration of cancer early detection in existing programs.

3.1.4 Strengthen structured early detection outreach campaigns.

3.1.5 Capacitate health care workers to provide cancer early detection and pre-cancer treatment (LEEP and FNA)

3.1.6 Provide mentorship on palliative care in level 3–5 facilities with primary care linkages.

3.1.7 Strengthen referral and linkages.

Objective 4: By 2029, ensure that at least 80% of health facilities provide comprehensive quality cancer services including palliative and rehabilitative care as defined in the essential health package with zero stock out of essential medicines and supplies.

4.1 Priority Intervention: Improve availability of comprehensive cancer treatment services

Activities:

4.1.1 Decentralize cancer services and palliative care programs to secondary and tertiary health facilities

4.1.2 Collaborate with stakeholders to strengthen and coordinate the cancer care services including palliative care.

4.1.3 Improve patient's long-term outcomes and overall quality of life by integrating supportive care with clinical phases of cancer care.

4.1.4 Facilitate establishment of tumor board forums

4.1.5 Facilitate establishment of radiotherapy and nuclear medicine units to improve treatment outcomes.

4.1.6 Review guidelines for palliative care, including curative and palliative surgery.

4.1.7 Train healthcare workers on early warning signs of all priority cancers and refer appropriately.

4.1.8 Incorporate early warning signs of all priority cancers in preservice training

4.1.9 Strengthen patient navigation

4.2 Priority Intervention: Standardize professional practice for cancer care

Activities:

4.2.1 Develop and review guidelines (cancer treatment, palliative care, psychosocial policy, nutritional, cervical cancer early detection and management)

4.2.2 Develop and implement WHO aligned SOPs for chemotherapy safety

4.2.3 Harmonize palliative care curriculum for healthcare worker training into national palliative care policy

4.2.4 Determine oncology specialized needs

4.2.5 Advocate for recruitment and training specialized oncology personnel to enable comprehensive care

4.3 Priority Intervention: Collaborate with CMS for improved supply chain processes

Activities:

4.3.1 Improve forecasting, quantification, and costing of cancer medicines and consumables based on disease burden to ensure consistent availability.

4.3.2 Advocate for procurement of equipment with maintenance plans.

Objective 5: By 2029, enhance the governance and sustainability of cancer control by fully staffing the NCCP, securing long-term financing mechanisms, and fostering resilient multisectoral collaboration.

5.1 Priority Intervention: Strengthen the National Cancer Control Program capacity

Activities:

5.1.1 Advocate for recruitment of personnel, at least 1 epidemiologist, 1 M&E officer.

5.1.2 Conduct skills audit assessment using competency-based tools to assess current skills and identify skills gap

5.1.3 Build NCCU staff capacity based on skills assessment report

5.2 Priority Intervention: Strengthen cancer legislative related frameworks

Activities:

5.2.1 Establish a Multisectoral Cancer Response Advisory Committee.

5.2.2 Develop the Cancer Prevention and Control Act.

5.2.3 Advocate policies for essential cancer service access.

5.2.4 Develop, disseminate and implement policies

5.2.5 Advocate for the implementation of Tobacco Act

5.2.6 Institutionalize cancer as a notifiable disease, through the multisectoral advisory committee.

5.2.7 Enactment of comprehensive Radiation and Nuclear Act

5.3 Priority Intervention: Strengthen coordination, partnerships and accountability mechanisms for cancer prevention and control

Activities:

5.3.1 Convene quarterly multisectoral TWG coordination meetings

5.3.3 Activate national cancer control sub-committees.

5.3.3 Establish public-private partnership through formal agreements for improved reporting systems and delivery of cancer services in line with national standards.

5.4 Priority Intervention: Increase sustainable financing mechanisms

Activities:

5.4.1 Advocate for increased public financing to ensure UHC

5.4.2 Advocate for the National Health Insurance to reduce out-of-pocket expenditure.

5.4.3 Strengthen sustainable financing models to improve cancer services and access programs such as donations, grants etc

5.4.4 Leverage on private medical aid providers for cost savings and financing mechanisms

5.4.5 Support country work plans and ring-fenced cancer budgets.

5.4.6 Advocate for program financing from levies and sin taxes.

Objective 6: By 2029, strengthen cancer data systems and research capacity to generate high-quality evidence for informed decision-making

6.1 Priority Intervention: Strengthen data collection, quality, reporting and use

Activities:

6.1.1 Conduct quarterly Quality of Care Audits (QOCA) and incorporate recommendations into continuous quality improvement (CQI).

6.1.2 Conduct Data Quality Audits (DQA)

6.1.3 Strengthen data collection system to track patient linkage through the continuum of care (early detection, diagnostic, treatment, and mortality)

6.1.4 Leverage digital health and innovation

6.1.5 Conduct quarterly performance monitoring of program indicators

6.1.6 Monitor client satisfaction and experience

6.1.7 Standardize community data collection tools

6.2 Priority Intervention: Promote operational research and evidence generation

Activities:

6.2.1 Collaborate with academic and health institutions to conduct cancer related research.

6.2.2 Incorporate priority cancer research studies into the Research Agenda.

6.2.3 Create research partnerships and mentorship programs.

6.2.4 Operationalize data for research and programming

6.2.5 Develop research abstract on cancers

Objective 7: Achieve at least 60% survival for children with cancer by 2029.

7.1 Priority Intervention: Strengthen Early Detection of Childhood Cancers

Activities

7.1.1 Increase Public Awareness

7.1.2 Build Capacity of Health Care Workers

7.1.3 Develop training manual for childhood cancers

7.1.4 Integration of childhood cancers into programs

7.2 Priority intervention: Improve Treatment, Palliative Care, Rehabilitation and Survivorship

Activities:

7.2.1 Map and implement referral pathway at each service delivery point i.e community, primary care site, health center, hospital etc

7.2.2 Advocate for UHC inclusion of childhood palliative services

7.2.3 Establish a Pediatric Oncology Centre of Excellence in Manzini

7.2.4 Actively receive and track children receiving treatment in South Africa through the pediatric oncology unit in Manzini

7.2.5 Establish champion programs to support newly diagnosed children

7.2.6 Improve survivorship support programs and school re-integration programs.

7.3 **Priority Intervention:** Strengthen Multi-sectoral Coordination

Activities

7.3.1 Establish a National Childhood Cancer Taskforce

7.3.2 Develop Integrated Referral and Data Systems

7.3.3 Conduct Joint Awareness and Capacity-Building Campaigns

Chapter 6: Conclusion

This National Cancer Control Strategy provides a comprehensive roadmap to reduce the burden of cancer in Eswatini by 2029. Through clearly defined objectives, priority interventions, and targeted activities across prevention, early detection, treatment, research, and governance, the strategy emphasizes a coordinated, integrated, and evidence-based approach.

Successful implementation will require strong collaboration among Ministry of Health programs, development partners, civil society organizations, and other government sectors, supported by sustainable financing, robust data systems, and continuous capacity building. By operationalizing this strategy, Eswatini can achieve significant improvements in cancer prevention, early diagnosis, treatment outcomes, and survivorship, ultimately improving population health and quality of life.

This strategy serves as a call to action for all stakeholders to work together in a unified effort, ensuring that no one is left behind in the fight against cancer. Its full implementation will position Eswatini to meet its national targets, strengthen health system resilience, and create a sustainable foundation for ongoing cancer control and research.

List of References

1. Anderson, B. O., Yip, C. H., Smith, R. A., et al. (2006). Breast cancer in limited-resource countries: Guidelines from the Breast Health Global Initiative. *The Breast Journal*. https://doi.org/10.1111/j.1075-122X.2006.00273.x
2. Bruni, L., et al. (2023). *Human papillomavirus and related diseases report*. ICO/IARC. https://hpvcentre.net
3. International Agency for Research on Cancer. (2014). *Cancer registration: Principles and methods (IARC scientific publications No. 164)*. IARC.
4. International Agency for Research on Cancer. *Global Cancer Observatory: Cancer Today*. Lyon, France: IARC; 2022. Available from: https://gco.iarc.fr/today
5. International Atomic Energy Agency. *Radiation Safety and Regulatory Framework Guidance for Member States*. Vienna: IAEA; 2022.
6. Ministry of Health, Eswatini. *Childhood Cancer Services Assessment Report*. Mbabane: MOH; 2023.
7. Ministry of Health, Eswatini. *Essential Health Care Package 2025 Review: Cancer Services Section*. Mbabane: MOH; 2025.
8. Ministry of Health, Eswatini. *Eswatini National Cancer Registry Annual Report 2022*. Mbabane: MOH; 2023.
9. Ministry of Health, Eswatini. *Eswatini Population and Housing Census 2017*. Mbabane: Central Statistics Office; 2017.
10. Ministry of Health, Eswatini. *HPV Vaccination and Cervical Cancer screening Guidelines Draft 2024*. Mbabane: MOH; 2024.
11. Ministry of Health, Eswatini. *Lifestyle Risk Factors and Cancer Prevention Data Report 2024*. Mbabane: MOH; 2024.
12. Ministry of Health, Eswatini. *National Cancer Control Program Governance and Policy Framework 2024*. Mbabane: MOH; 2024.
13. Ministry of Health, Eswatini. *National Cancer Control Program Strategic Plan 2025–2029*. Mbabane: MOH; 2024.
14. Ministry of Health, Eswatini. *National HPV Vaccination Coverage Report 2024*. Mbabane: MOH; 2024.
15. Phalala Fund. *Medical Referral Program Annual Report 2023*. Mbabane: MOH; 2023.
16. Pritchard-Johnson, K., et al. (2021). Improving outcomes through global childhood cancer initiatives. *Journal of Global Oncology*, *7*(5), 1–10. https://ascopubs.org/journal/jgo

17. United Nations Development Programme. *Human Development Report 2023*. New York: UNDP; 2023. Available from: http://hdr.undp.org
18. World Health Organization & St. Jude Children's Research Hospital. (2020). *Global Initiative for Childhood Cancer*. WHO.
19. World Health Organization. (2002). *National cancer control programmes: Policies and managerial guidelines* (2nd ed.). WHO.
20. World Health Organization. (2003). *WHO Framework Convention on Tobacco Control*. WHO.
21. World Health Organization. (2007). *Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action*. WHO.
22. World Health Organization. (2013). *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*. WHO.
23. World Health Organization. (2017). *Best buys and other recommended interventions for the prevention and control of noncommunicable diseases*. WHO.
24. World Health Organization. (2018). *Monitoring framework for national cancer control programmes: Indicators and core data elements*. WHO.
25. World Health Organization. (2018). *The WHO essential diagnostics list (EDL)*. WHO.
26. World Health Organization. (2020). *Cancer country profiles 2020*. WHO.
27. World Health Organization. (2020). *Global strategy to accelerate the elimination of cervical cancer as a public health problem*. WHO.
28. World Health Organization. (2023). *WHO report on the global tobacco epidemic 2023*. WHO.
29. World Health Organization. (n.d.). *Breast cancer: Prevention and control*. WHO. https://www.who.int/cancer/prevention/diagnosis-early detection/breastcancer/en/
30. World Health Organization. *Cancer: Key Facts*. Geneva: WHO; 2023. Available from: https://www.who.int/news-room/fact-sheets/detail/cancer
31. World Health Organization. *Cervical Cancer Elimination Initiative 2030 Targets*. Geneva: WHO; 2020.
32. World Health Organization. *Global Breast Cancer Initiative (GBCI): Implementation Guidance*. Geneva: WHO; 2021.