

SWAZILAND GOVERNMENT

SWAZILAND MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT



“Swaziland on the road to development”

Ministry of Economic Planning and Development

SEPTEMBER 2010



**SWAZILAND MILLENNIUM
DEVELOPMENT GOALS
PROGRESS REPORT 2010**

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ACRONYMS

ACAT	Africa Cooperative Action Trust
ACP	African, Caribbean and Pacific
AGOA	African Growth and Opportunity Act
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANCs	Antenatal Clinics
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CFSAM	Crop and Food Security Assessment Mission
COMESA	Common Market for Eastern and Southern Africa
CSTL	Care and Support for Teaching and Learning
DAC	Development Assistance Committee
DFQF	Duty Free and Quota Free
DOTS	Directly Observed Treatment Short Course
EAC	East African Community
ECCD	Early Childhood Care and Development
EMIS	Education Management Information Systems
EU	European Union
FANR	Food, Agriculture and Natural Resources
FAO	Food and Agriculture Organisation of the United Nations
FDI	Foreign Direct Investment
FTA	Free Trade Agreement
GBV	Gender-based Violence
GDP	Gross Domestic Product
GHG	Greenhouse Gas
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information and Communications Technology
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IPCC	International Panel on Climate Change
IRS	Indoor Residual Spraying
ITN	Insecticide-treated Net
KDDP	Komati Downstream Development Project
LFS	Integrated Labour Force Survey
LLIN	Long-lasting Insecticidal Net
LRP	Lead Replacement Petrol
LUSIP	Lower Usuthu Smallholder Irrigation Project
MDGs	Millennium Development Goals
MDR TB	Multiple Drug Resistant Tuberculosis

MEPD	Ministry of Economic Planning and Development
MFA	Multi-Fiber Agreement
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
NDS	National Development Strategy
NER	Net Enrolment Ratio
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Governmental Organisations
NMC	National Maize Corporation
NNS	National Nutrition Survey
NTCP	National Tuberculosis Control Programme
NUPU	Non-Formal Universal Primary Education
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OVC	Orphaned and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
POPs	Persistent Organic Pollutants
PRSAP	Poverty Reduction Strategy and Action Programme
PTA	Preferential Trade Agreement
RECs	Regional Economic Communities
RSSC	Royal Swaziland Sugar Corporation
SACU	Southern African Customs Union
SADC	Southern African Development Community
SCHS	Swaziland Community Health Survey
SDHS	Swaziland Demographic and Health Survey
SEPI	Swaziland Expanded Programme on Immunisation
SHIES	Swaziland Household Income and Expenditure Survey
SME	Small and Medium-sized Enterprise
SNMCP	Swaziland National Malaria Control Programme
SNTC	Swaziland National Trust Commission
SPHC	Swaziland Population and Housing Census
SVAC	Swaziland Vulnerability Assessment Committee
SWSC	Swaziland Water Services Corporations
T21	Threshold 21
TB	Tuberculosis
TIDCA	Trade, Investment and Development Cooperation Agreement
ULP	Unleaded Petrol
UMR	Under-five Mortality Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UPE	Universal Primary Education
WFP	World Food Programme
WHO	World Health Organisation
XDR TB	Extensively Drug Resistant Tuberculosis

FOREWORD

The Kingdom of Swaziland is a signatory of the United Nations Millennium Declaration and is proud to present Swaziland's 2010 Millennium Development Goals (MDGs) progress report, which follows the 2003 and 2007 MDG reports. The report is a product of several consultations with development partners, non-governmental organisations, civil society, faith-based organisations and government ministries.

The planning framework of this country is guided by the National Development Strategy (NDS) and Poverty Reduction Strategy and Action Programme (PRSAP). The PRSAP is a strategic planning document designed to guide the formulation and action for poverty reduction in all the key areas of development. The document is an outcome of much wider and intensive consultations with a cross section of stakeholders. The process of preparing this document was inclusive and relied, notably, on participation of the underprivileged.

The PRSAP is commensurate with the MDGs and operationalises the NDS. This MDG progress report has come at an opportune time when the head of State, His Majesty King Mswati III has officially assumed the Chairmanship of Common Market for Eastern and Southern Africa (COMESA).

Achieving the MDGs will provide a platform for Swaziland to accomplish her objective of becoming a first-world country. Considerable progress has been made in some development areas, such as the adoption of the new constitution, introduction of free primary education, establishment of the anti-corruption commission, and introduction of the OVC and elderly grants.

Pending the finalisation of the currently ongoing Swaziland Income and Expenditure Survey (SHIES), which will provide current statistics on the poverty rate and enhance the country's total outlook on

the achievement of our MDGs. This will be improved by the numerous interventions the country has embarked on since the 2001 survey.

As a developing country, achieving some of the MDGs by 2015 may be challenging. Among factors that could impede progress are climate change, the global economic crisis, and the drastic reduction in SACU revenue. We hope, however, that by the year 2015 measurable strides will be made in all the MDGs. This will require full support from all stakeholders, especially the international community.

The adoption of the country's constitution further enhanced our chances of achieving the MDGs as it allows women equal opportunities to men with regards to access to land. It also introduces free primary education, whilst costly to Government's limited resources allows a lot of children access to basic education.

The 2010 MDG report tracks the progress the country has made in achieving the MDGs since 2000. It will inform stakeholders of the current development status of the country, highlighting areas where special attention is needed.

It is my honour to present this document as Swaziland's 2010 MDG progress report and recommend it as a key source in the preparation for the next General Assembly to be held this year in the United States of America.



HRH Hon. Prince Hlangusemphi
Minister for Economic Planning & Development

ACKNOWLEDGMENTS

This document was prepared by an MDG Technical Team comprised of Victor Mhlongo, Lungile Mndzebele, Peter Ndlela, Sanele Shabangu, Dumsile Nyoni, Deepak Sardiwal (Cross-Sectoral Division MEPD), Richard Dlamini, Mfanzile Shongwe (Sectoral Division MEPD) and Vangile Dlamini (Macroeconomic Unit MEPD).

























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2010 MDG STATUS AT A GLANCE

Swaziland's progress towards achieving the MDGs

GOALS / TARGET	WILL THE GOAL / TARGET BE MET	STATE OF SUPPORTIVE ENVIRONMENT
ERADICATE EXTREME POVERTY AND HUNGER		
Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	 Potentially	 Strong
Achieve full and productive employment and decent work for all, including women and young people	 Potentially	 Strong
Halve, between 1990 and 2015, the proportion of people who suffer from hunger	 Potentially	 Strong
ACHIEVE UNIVERSAL PRIMARY EDUCATION		
Ensure, by 2015, that all boys and girls will be able to complete a full course of primary schooling	 Likely	 Strong
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN		
Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education by 2015	 Likely	 Strong
REDUCE CHILD MORTALITY		
Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	 Likely	 Strong
IMPROVE MATERNAL HEALTH		
Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	 Likely	 Strong
Achieve by 2015 universal access to reproductive health	 Likely	 Strong
COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES		
Have halted by 2015 and begun to reverse the spread of HIV/AIDS	 Potentially	 Strong
Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it.	 Likely	 Strong
Have halted by 2015 and begun to reverse the incidence of malaria	 Achieved	 Strong
Have halted by 2015 and begun to reverse the incidence of tuberculosis	 Potentially	 Strong

2010 MDG STATUS AT A GLANCE

Swaziland's progress towards achieving the MDGs (continued)

GOALS / TARGET	WILL THE GOAL / TARGET BE MET	STATE OF SUPPORTING ENVIRONMENT
ENSURE ENVIRONMENTAL SUSTAINABILITY		
Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	 Potentially	 Good
Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	 Potentially	 Strong
To have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	 Potentially	 Good
DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT		
Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	 Potentially	 Good
Address the special needs of the least developed countries	 Potentially	 Good
Address the special needs of landlocked and small island developing States	 Potentially	 Good
Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	 Potentially	 Good
In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	 Likely	 Good
In co-operation with the private sector, make available the benefits of new technologies, especially information and communications	 Likely	 Good

KEY

WILL THE GOAL OR TARGET BE MET

COUNTRY WILL MEET THE MDG 

COUNTRY MAY OR MAY NOT MEET THE MDG 

STATE OF SUPPORTING ENVIRONMENT

POLICIES IN PLACE, GOVERNMENT COMMITMENT IS HIGH 

POLICIES IN DRAFT FORM, WORK IN PROGRESS 

INTRODUCTION

Background to the MDGs

In 2000, the Kingdom of Swaziland signed the United Nations Millennium Declaration and, in so doing, embraced the Millennium Development Goals (MDGs) and the challenge of achieving them by 2015. These inter-related and mutually-reinforcing goals centred on important development priorities pertaining to poverty eradication, education, gender equality, health, HIV/AIDS, environmental sustainability and a global partnership for development. Their achievement will lead to a significant improvement in the welfare of the Swazi people and, a decade after the Declaration, the country remains fully committed to fulfilling this.

The country's platform for development

Swaziland is guided by the National Development Strategy (NDS) and the Poverty Reduction Strategy and Action Programme (PRSAP), both of which complement the development ideals of the MDGs. The NDS was developed in 1997 and encompasses the country's long-term vision of being among the top 10 percent of medium human development countries by 2022. The PRSAP, officially launched in 2008, operationalises the NDS and is the overarching framework for achieving Vision 2022.

The country's 2010 MDG Report

The country's maiden MDG Progress Report was produced in 2003 and was followed by another in September 2007, which reported that the Kingdom was likely to meet three of the eight MDGs (MDGs 2, 3 and 7). This report documents the extent of progress towards MDG achievement in the country as of year 2010.

It expands upon the 2007 Report, using data from the 2007 Population and Housing Census, 2007 Demographic and Health Survey, and 2007/08 Integrated Labour Force Survey. A Macroeconomic Model (Threshold 21), currently being developed by the Ministry of Economic Planning and Development, further strengthens the report through its historical database and projection of future trends given the current strategies and policies of the country.

The report highlights a number of important achievements, such as the introduction of the State Funded Primary Education Programme in 2010, whilst also noting the challenges, including slow economic growth and the continued high incidence of HIV. It seeks to deepen national understanding of why progress is being made with some MDG indicators but not others and proposes ways forward. In this way, the report serves as an important document for stakeholders to expedite progress towards the timely achievement of the MDGs.

“Their achievement will lead to a significant improvement in the welfare of the Swazi people and, a decade after the Declaration, the country remains fully committed”

The report-writing process

The report-writing process went through many stages, the first being the establishment of an MDG Technical Team. An Introductory MDG Workshop was then held to officially launch proceedings and initiate discussions amongst stakeholders. Following this, the MDG Technical Team undertook data collection and consultations with stakeholders. This led to the production of a draft MDG Report which served as the basis for further stakeholder discussions. Two Stakeholder Review Workshops were subsequently held to receive the guidance, feedback and valued recommendations of stakeholders. The final report was completed in September 2010.

Involvement of stakeholders

A key feature of the MDG report-writing process was its

inclusive nature, with all stakeholders participating – the Government of Swaziland, NGOs, civil society, private sector, donor community and development partners. Once finalised, this 2010 MDG Report will be translated into SiSwati and Braille – unlike preceding ones – ensuring its accessibility to a much wider audience.

Organisation of the report

The report is organised according to the UN guidelines on MDG country reports, beginning with a “2010 MDG Status at a Glance”. This summarises the likelihood of the country meeting each of the MDG Targets by 2015 and the state of the supportive environment for each of them. The overall development context in Swaziland is then outlined in broad terms, followed by eight sections that address each of the MDGs.

This 2010 MDG Report was a national effort. It is hoped that it achieves its purpose of raising awareness, strengthening relationships among stakeholders and renewing commitment towards the development and future prosperity of the country

KINGDOM OF SWAZILAND: DEVELOPMENT CONTEXT

The Kingdom of Swaziland is a small landlocked country in Southern Africa. It borders both South Africa and Mozambique, and has an area of 17,364km². Major exports for the country include sugar, wood pulp and soft drink concentrates. The Kingdom's population stands at 1,018,449, of which 52 percent are under the age of 20 years and 78 percent reside in rural areas (SPHC 2007). An important milestone in the country's recent history was the adoption of Swaziland's new

constitution in 2005. With an estimated nominal GDP per capita of US\$2,994 in 2007 (Central Bank Quarterly Review June 2010; SPHC 2007), Swaziland remains classified as a lower-middle income country. However, it faces challenges similar to low-income economies. Key socio-economic indicators for the past 20 years are given below.

Table A: Key socio-economic indicators for the country, 1986-2007

	1986	1997	2007
Population	681,059	929,718	1,018,449
GDP growth rate	8.5% ¹	3.8% ²	3.5% ³
Unemployment rate	24.4%	22.8%	28.2% ⁴
Adult literacy rate	70.1%	81.3%	89.1%
Adult HIV prevalence	0%	.	25.9% ⁵
Life expectancy	56	60	43

Source: Swaziland Population and Housing Census 1986, 1997 & 2007, ¹ Annual Statistical Bulletin 1988, ² Central Bank Quarterly Review September 2003, ³ Central Bank Quarterly Review June 2010, ⁴ Integrated Labour Force Survey 2007/08, ⁵ Swaziland Demographic and Health Survey 2007

The Swazi economy performed very well in the 1980s, attracting large inflows of foreign direct investment (FDI) as the country enjoyed a regional advantage due to civil war in Mozambique and the continuation of Apartheid in South Africa. Economic growth was high and the country boasted impressive human development indicators.

However, over the past decade or so there has been a marked reversal in several development trends as captured in the country's declining Human Development Index (HDI) score. Swaziland's HDI score for 2010 is actually lower than what it was in 1995, although there has been an improvement in recent years (table B).

Table B: The country's Human Development Index score, 1990-2010

	1990	1995	2000	2005	2009	2010
HDI score	0.511	0.523	0.490	0.474	0.492	0.498

Source: Human Development Report 2010

Increased competition for FDI from Apartheid-free South Africa and war-free Mozambique has significantly diminished growth opportunities. In terms of ease of doing business, Swaziland ranks 118th in the world (Doing Business Report 2011) and this has hindered the country's ability to attract and retain FDI. Changes in the international trade environment have also compounded matters with the phasing out of many preferential trade arrangements. These include those that benefited the textile and garment sector as well as those which ensured a high price for the country's sugar exports to the European market.

More recently, the country has been affected by the global economic and financial crisis mostly through its second round effects. As the economies of Swaziland's major trading partners – South Africa, the EU and the US – declined, demand for Swazi exports fell, with the manufacturing sector being particularly affected. This contributed to the closure of companies such as SAPPI Usuthu Mill and Swazi Paper Mills. The global crisis has also contributed to the unprecedented fall in trade-related revenue which the country receives from the Southern African Customs Union (SACU). The country has been overly dependent on SACU receipts and in 2008/09 it accounted for 66 percent of the country's total revenue and grants (Central Bank Annual Report 2009/10). However, in 2010/11, SACU revenue fell by a staggering 62 percent, from E5.19 billion to E1.97 billion (Central Bank Annual Report 2009/10), largely in response to lower trade, and this considerably reduces the resources available to the country for MDG-related initiatives.

The PRSAP estimated that the country would need to achieve an annual average growth rate of 5 percent to have a chance of meeting its poverty-reduction targets. However, economic growth in 2009 was an estimated 1.2 percent and a 2 percent growth rate is projected for 2010 (Central Bank Annual Report 2009/10). The failure of economic growth to create sufficient employment represents a major challenge for the

country. Unemployment levels are high, especially among the youth, with the labour force continuing to grow at a much faster pace than employment creation.

A huge aggravating factor in all of the above has been HIV/AIDS. HIV prevalence among 15 to 49 year-old adults is 26 percent (SDHS 2007) and there were over 150,000 Swazis living with HIV in 2007. By diminishing labour supply, lowering productivity, weakening the human capital formation process, increasing food insecurity and diverting scarce resources to tackling the disease, the HIV/AIDS epidemic presents a significant challenge to the nation.

However, the country continues to strengthen interventions to reverse the impact of the pandemic. The country's HIV prevention package has integrated male circumcision with universal access as the target. 69 percent of pregnant HIV positive women have received ART to reduce mother to child transmission of HIV (UNGASS 2010). ART services are being decentralised and 84.5 percent of the population with advanced HIV have access to treatment (Ministry of Health monitoring and Evaluation Report December 2009).

High levels of poverty, income inequality, food insecurity, inadequate access to productive assets such as land, vulnerability to environmental shocks, Tuberculosis and dependency on food aid are some of the other issues the country is currently grappling with.

While these factors make achieving the MDGs more challenging, they by no means preclude the attainment of them. An objective of this report and the widely consultative process adopted in its preparation is to galvanise the country into understanding the nature and deep causes of Swaziland's development status and prospects, as well as to search for means of addressing them.

MDG 1: ERADICATE EXTREME POVERTY AND HUNGER



MDG 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1.A Halve, between 2000 and 2015, the proportion of people whose income is less than one dollar a day

Indicators

1.1 Poverty Head Count Ratio (Percentage of Population below the National Poverty line)

1.2 Poverty Gap Ratio

1.3 Share of Poorest Quintile in National Consumption

Status at a glance



Will target be met		Potentially
State of Supporting Environment		Strong

Table 1.1 Status in Figures

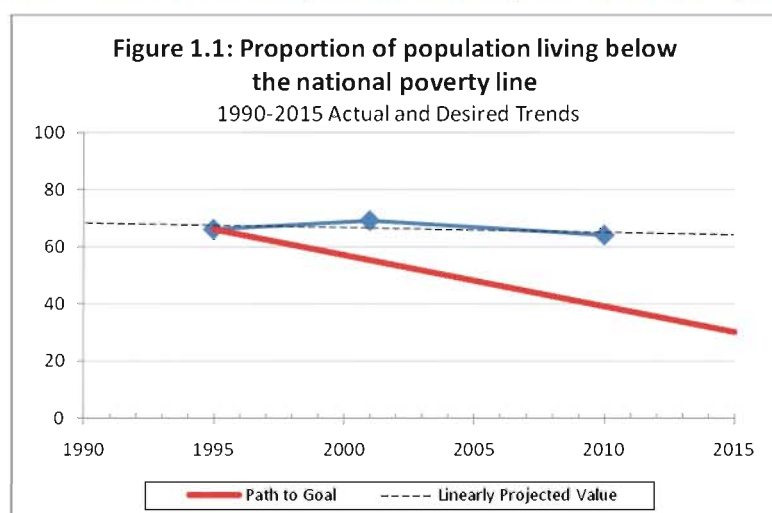
Indicator	1995	2001	2010	2015*
Percent of population below the national poverty line	66	69	64 [#]	30
Urban		50		
Rural		76		
Poverty gap ratio	48	33		
Share of poorest quintile in national consumption	3.9	4.3		

Source: SHIES (1995 & 2001); # T21 2010 projection

* Desired target

Status and trends

Indicator 1.1 Poverty head count (percent of the population below the national poverty line)



Source: SHIES (1995 & 2001); T21 2010 projection

The prevalence of poverty, measured by the proportion of people living below the poverty line, increased from 66 percent in 1995 to 69 percent in 2001 as shown by the Swaziland Household Income and Expenditure Survey (SHIES) of 2001, Figure 1.1. Examination of the proportion of the population living below the poverty line revealed that poverty increased during the period 1995 to 2001. This is attributed to many factors: inter-alia, the decline in incomes and stagnation of real private consumption associated with slowing economic growth that started in the early 1990's and worsened post 2000; the fall in real GDP growth from an annual average of 8 percent in the 1980s to 3.5 percent in the 1990s and down to 2.4 percent in 2001 (Economic Review and Outlook 2002); the relocation of some companies from Swaziland to South Africa after the democratisation process of South Africa that led to increases in unemployment rates; and the impact of HIV/AIDS during the same time.

This is consistent with the fall in the prevalence of poverty projected in the T21 model, currently being developed by the Ministry of Economic Planning and Development to project poverty figures. Projections indicate that poverty is declining. In fact, 64 percent is projected to be the population living below the poverty line for the year 2009/10. A more definitive picture on the current status of poverty in the Kingdom is expected after the completion of the SHIES 2009/2010.

Although the long-term trend in poverty decline appears to have resumed as per the model, uncertainty remains about the current status. The economy is still absorbing the impact of the recent international economic crisis and the drastic reduction of national resources caused by decline in the Southern African Customs Union (SACU) revenue.

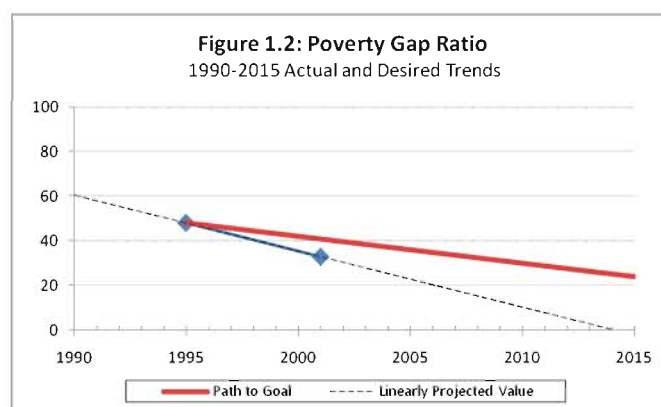
Looking ahead into the medium and long term, and notwithstanding the impacts of the recent exogenous shocks still to be accounted for, it is reasonable to expect that poverty will continue along its long-term descent.

The country's Poverty Reduction Strategy and Action

Programme (PRSAP) made clear that the country would have to boost economic growth to at least 5 percent per year to make a major dent on poverty because growth of both private and public incomes and concomitant consumption, which are critical to the well-being of the population, depended on it. This is not the case currently. An enabling environment, therefore, needs to be created for economic growth to reach the desired level in the short run.

Indicator 1.2 Poverty gap ratio

The poverty gap ratio shows the average extent to which individuals fall below the poverty line. The indicator measures the "poverty deficit" of the entire population and the per capita amount of resources that would be needed to bring all poor people above the poverty line through perfectly targeted cash transfers. According to the SHIES 1995, the poverty gap ratio was 48 percent. In 2001, the SHIES reported 33 percent, which is still very high. The poverty gap for rural areas is reported to have been 37 percent, versus 20 percent for urban areas. (SHIES 2001). Figure 1.2 below shows that Swaziland is going in the right direction but would still need to work hard to accelerate progress.



Source: SHIES 1995, 2001

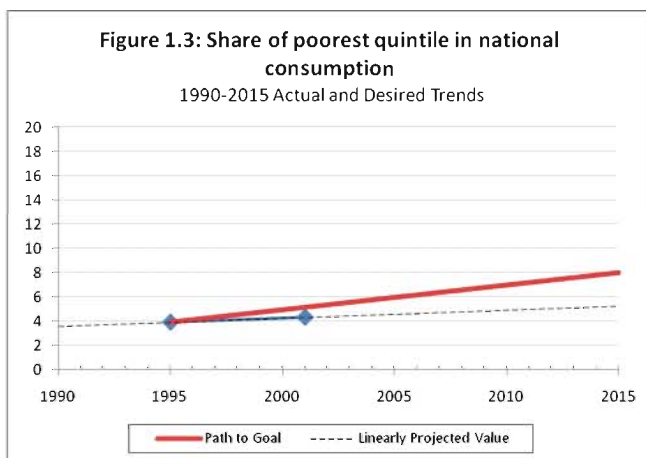
In addition, SHIES (2001) determined that the higher the dependency ratio [ratio of the number of dependents members (under 14 and over 60 years of age) in a household to the total household size] the more likely the household members will be poor. Programmes that offer OVCs, old people and the poor choices in terms of reproductive health would help improve the poverty gap ratio.

Indicator 1.3 Share of poorest quintile in national consumption

Share of the poorest quintile in national consumption is the income that accrues to the poorest fifth of the population. The consumption of the poorest fifth is expressed as a percentage of total household consumption (or income), and it gives a relative inequality measure.

In 1995, the poorest quintile consumed 3.9 percent of the total consumption in the country, compared with 59 percent consumed by the richest quintile. According to SHIES (2001), the bottom fifth of the quintile was consuming 4.3 percent of the total consumption, while the richest quintile was consuming or had 56.4 percent. (Figure 1.3). Although the share of the poor has increased, it is too low relative to that of the rich.

The SHIES of 1995 stated that the Gini coefficient of the country was 50.7 percent. The SHIES (2001) discovered the Gini Coefficient for the country was 51 percent, with urban and rural areas at 50 percent and 45 percent respectively (Figure 1.3).



Source: SHIES 1995, 2001

An average person in the richest quintile commands more than 13 times the consumption expenditure of the average person in the poorest 20 percent of the population.

Target 1B Achieve full and productive employment and decent work for all

Status at a glance

Will target be met	● Potentially
State of supporting environment	● Strong

Indicator 1.1 Growth rate of GDP per person employed

Data for this indicator is limited since the country has traditionally relied on the Swaziland Population and Housing Census (SPHC), which occurs every ten years, for information on the total number of people employed in the country. This changed in 2007 with the carrying out of the 2007/08 Integrated Labour Force Survey (LFS), the first comprehensive labour force and informal sector survey to be undertaken in the country.

In 2007, the total number of employed people in the country stood at 222,771 (LFS 2007/08) while GDP at (2000) constant prices reached E12, 323 million (Swazi-Info). In the year 1997, 185,038 people were employed (SPHC 1997) whilst GDP at (2000) constant prices was E9, 599 million (Swazi-Info). Using these figures, the growth rate of GDP per person employed – a measure of labour productivity growth – was 6.6 percent between 1997 and 2007. Another Integrated Labour Force Survey will be conducted this year and will allow for a more updated assessment of labour productivity growth in the country.

Indicator 1.2 Employment-to-population ratio

The employment-to-population ratio is the proportion of a country's working-age population that is employed and is a good indicator of an economy's ability to provide jobs.

The 2007/08 LFS indicated that the country had an employment-to-population ratio of 37%. This ratio is almost identical to the one reported in the 2007 SPHC and is an improvement on previous years. However, with only 37% of the working-age population employed in 2007 the country is some distance away from achieving full employment. One reason for the low employment-to-population ratio is the country's poor labour force participation rate – many Swazis are out of the labour force and not economically active. The second explanation is the country's high unemployment rate – many of those in the labour force struggle to find employment.

Table 1.2: Employment-to-population ratios, 1986-2007

Year	1986	1997	2007
Employment-to-population ratio	28%	31%	37%

Source: LFS 2007/08, calculated from the SPHC 1986 & 1997

The country's unemployment rate stood at 28.2 percent in 2007 (LFS 2007/08), which was not much better than the 29.1% reported in the 2001 Swaziland Household Income and Expenditure Survey (SHIES). Moreover, if discouraged workers – those who have stopped looking for employment but want to work and are available to work – are included among the unemployed, the unemployment rate in the country rises to 38.0 percent in 2007 (LFS 2007/08). The growth of the labour force is much higher than employment creation in the country and these high levels of unemployment represent a substantial barrier to eradicating poverty.

More recently, the global economic and financial crisis has had a detrimental impact on employment prospects in the country. Reduced demand for Swazi exports contributed to the closure of companies and the loss of around 3,000 jobs in the manufacturing sector (Budget Speech 2010). In response, the country has set itself the target of creating at least 10,000 jobs in 2010.

Swaziland's labour force participation rate of 52 percent (LFS 2007/08) also indicates that many are economically inactive, i.e. not working and not looking for work. This could be due to attendance in school or university but the 2007/08 LFS also reveals that sickness is an important factor.

This is consistent with the country's high HIV/AIDS

prevalence rate and further underscores the importance of ensuring antiretroviral drugs are provided to all those that need it. Another factor driving the country's low labour force participation rate is discouragement, with many no longer seeking employment in the belief no jobs are available.

Indicator 1.3 Proportion of employed people living below \$1 per day

Data for this indicator is limited but useful information can be extracted from the out-dated 2001 SHIES.

The 2001 SHIES reported that households with an employed head were less likely to experience poverty, as shown in table 1.3. While unsurprisingly lower, it is disappointing that employment of the household head does not result in more pronounced reductions in household poverty.

Table 1.3 Poverty rate by household employment status in 2001

Poverty rate for all households	56%
Poverty rate for those households with an employed head	47%

Source: SHIES 2001

A closer inspection of the 2001 SHIES reveals that an important determining factor is the nature and type of the employment. Those households whose head was involved in paid non-seasonal work had a much lower poverty rate of 36 percent (SHIES 2001). In contrast, 60 percent of households headed by a self-employed worker were in poverty and this rises to 62 percent for those headed by a paid seasonal worker (SHIES

2001). This strongly indicates that employment which provides a guaranteed stream of income throughout the year will have a far greater poverty-reducing impact, as one would expect. Households with unpredictable income flows are also inhibited from overcoming poverty due to the requirements of financial institutions in the country which prevent them from accessing loans.

Target 1.C Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicators

- 1.1 Prevalence of underweight children under five years of age
- 1.2 Proportion of the population below minimum level of dietary energy consumption

Status at a glance



Will target be met	 Potentially
State of supporting environment	 Strong

Table 1.4 Status in figures

Indicator	2000	2007	2008	2009	2015*
Prevalence of underweight Children under five years of age (%)	10	5	7.2	6.6	5

Source: MICS 2000, SDHS 2007, NNS 2008, SVAC 2009

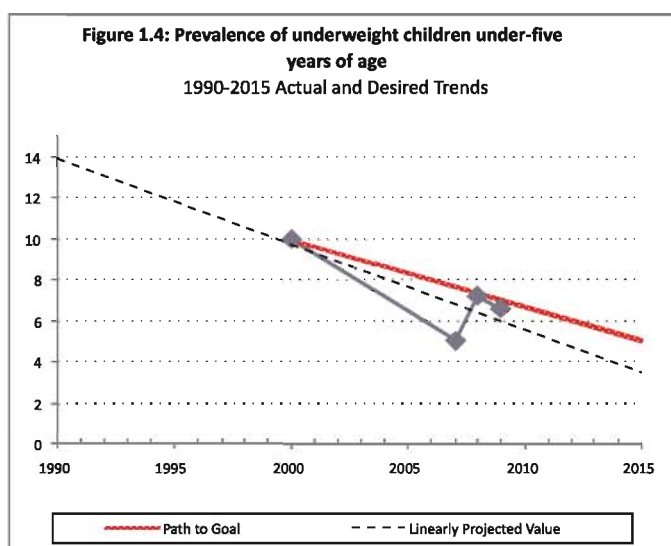
* Desired target

Status and trends

Indicator 1.1 Prevalence of underweight children under five years of age (weight for their age)

Prevalence of underweight children under five years of age is defined as the percentage of children under five whose weight for their age is less than minus two standard deviations from the median for the international reference population, aged zero to 59 months.

Figure 1.4 shows that data for underweight children has been going up and down in the country. The prevalence of underweight children nationally was 5 percent in 2007 and for severely underweight was 1.1 percent. The rural areas had the highest prevalence of underweight children at 5.6 percent, while the urban areas were at 4.5 percent (SDHS, 2007). The trend shows a huge decline of about half in 2007 and a slight increase to 6.6 percent in 2009 in Figure 1.4. With an integrated approach to child health, this indicator target can be achieved by 2015.



Source: MICS 2000, SDHS 2007, NNS 2008, SVAC 2009

Indicator 1.2 Proportion of population below minimum level of dietary energy consumption

The proportion of the population below the minimum level of dietary energy consumption is defined as the percentage of the population whose food intake falls below the minimum level of dietary energy requirement (2100 kcal). It also refers to the percentage of the population that is undernourished.

According to the National Nutrition Survey (NNS) of 2008, 11.3 percent of the population were below the minimum level of dietary energy requirement when they examined the two categories of poor food consumption and borderline food consumption. Poor food consumption is the consumption of only cereals and vegetables on a daily basis. Borderline food consumption is the consumption of cereals, vegetables, oils and pulses, but with a nutritive value that is less than 2100 kilo calories. Adequate or acceptable food consumption is consumption of food whose nutritive value is 2100 kilo calories and above.

The production of the staple food crop maize is used as a measure of availability. Food production for the country, (Table 1.5) shows a declining trend from 2004/5 to 2006/7. In 2004/05, total production was 68,565 metric tons, declining to 46,604 metric tons in 2006/07. Although an increase to 70,672 metric tons was observed in 2008/09, this was not enough to satisfy the minimum national food requirement of 120,000 metric tons. (Cereal Food Balance Sheet, 2008/09) As maize is a staple food, any shortage of it creates an increase in the proportion of the population that is below the minimum level of dietary energy consumption.

Table 1.5 Maize Production by Agro-Ecological Zone - 2004/05 - 2008/09 in Metric Tons

Agro-Zone	2004/05	2005/06	2006/07	2007/08	2008/09
Highveld	25,027	27,058	16,248	24,180	24,300
Middleveld	27,154	28,629	19,697	23,598	29,695
Lowveld	12,173	7,228	7,738	10,129	12,540
Lubombo	4,211	2,921	2,921	4,087	4,137
Total	68,565	65,836	46,604	61,994	70,672

Source: SVAC 2009

Accessibility to food in the country is based on what people grow, what they are given as food aid and/or what they are able to buy in the market to meet their food basket.

Food aid has been a resource for the poor over the years. When production is low and the poor cannot afford to buy food, food aid becomes the solution. Table 1.5 below describes the situation of food aid from 2002 to 2009.

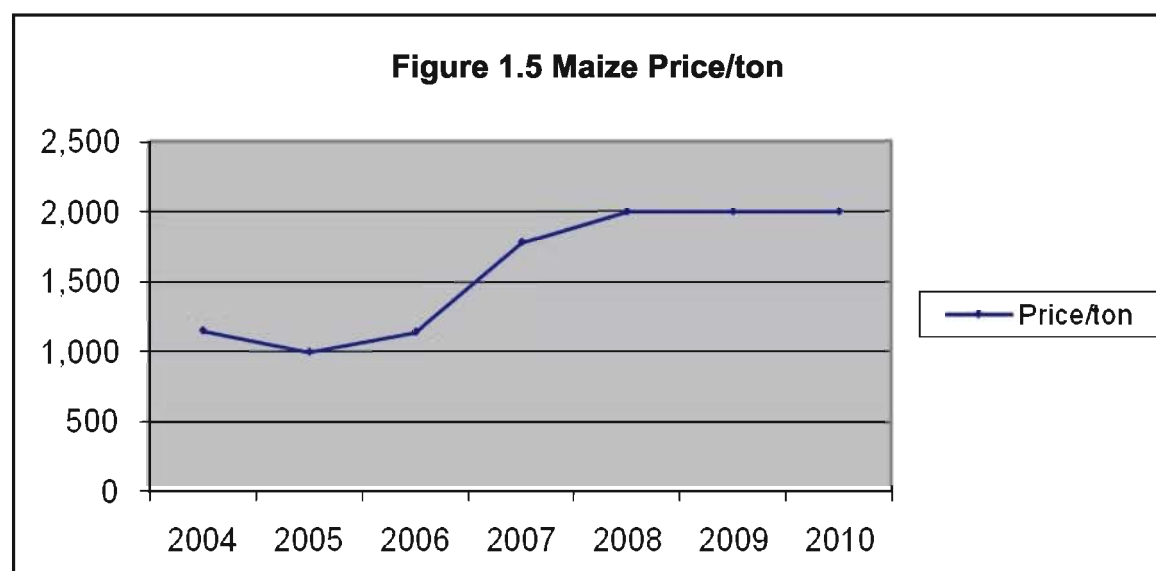
Table 1.6 Food aid Projections and responses in terms of beneficiaries (2002 to 2009)

Year	2002	2003	2004	2005	2006	2007	2008	2009
SVAC / CFSAM projections	297,000	217,000 (Jan – March)	262,000	226,640	298,700	345,012	287,000	256,383
WFP Beneficiaries	214,589	264,637	177,050	245,586	241,575	258,335	344,514	217,297

Source: Emergency Food Security Assessment Report by SVAC & SADC FANR (2002) FAO/WFP CFSAM Report 2003, 2004 & 2005. SVAC projections and WFP Response (2002 to 2009)

According to SVAC, FAO and WFP, more than 200,000 people needed food aid every year from 2002 to 2009. The figures above show that more than 210,000 people received food aid from WFP and partners every year, except in 2004. The fact that food aid is given every year seems to suggest that a dependency syndrome has developed. Most of the time, food aid is given to people who have no other means of survival; and if that food aid is not given, some people may die.

Maize prices are used as a measure of food prices in the country and can indicate accessibility to food by the poor. Figure 1.5 below shows a trend of prices of maize per ton from 2004 to 2010. Prices of maize per ton increased exponentially from 2005 to 2008, which was due to high shortages from domestic production. This allows for market forces to be at play as high demand triggers high prices, given the limited supply. From 2008 to 2010, a constant price range of E2000 was observed.



Source: NMC

While prices made it difficult for people to purchase the staple food they needed, farmers who managed to grow enough and were able to sell surplus, benefited from

price increases, which might have improved their household incomes.

Figure 1.7

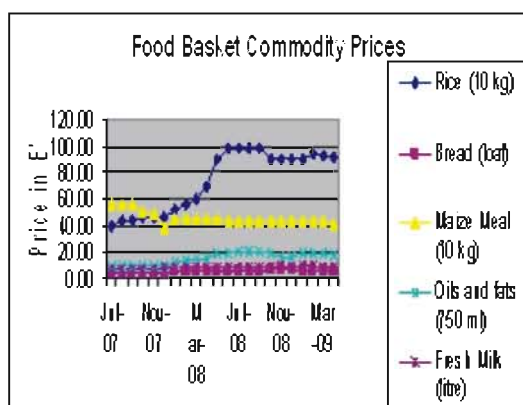
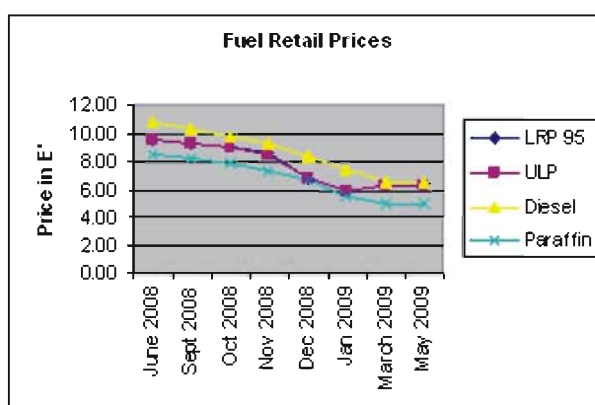


Figure 1.8



Source: SVAC 2009

Fuel price is one of the major drivers for the commodity prices in the market. Figure 1.8 above shows a declining trend for the two year period June 2008 to May 2009. This decline, however, did not translate into a reduction in the price of food basket commodities (Figure 1.7) as food prices still increased.

Inequality analysis

- Poverty is more prevalent in rural areas, with 76 percent source poor people compared with urban areas that have 50 percent poor people. The regions of Lubombo and Shiselweni are the poorest in the country, requiring priority in development interventions.
- Food security is crucial for the country as it is in many countries in Sub-Saharan Africa. Not all regions are food secure. According to the Vulnerability Assessment Report of 2009, the Lubombo region has the highest number of people classified as vulnerable to food insecurity and accounts for 30 percent of the total vulnerable people in the country. Regions like Lubombo, therefore, need to be given priority.
- In 2008, the prevalence of underweight children in Swaziland was 7.3 percent. The total underweight for the urban and rural areas was at 6.5 percent and 7.8 percent respectively. Hhohho had the highest prevalence rate of underweight at 8.2 percent, while

Shiselweni, Lubombo, and Manzini had the prevalence rates of 7.3 percent, 6.7 percent and 6.4 percent respectively (NNS,2008). Hhohho is better off compared to the other regions in terms of poverty and food production, but the impact of HIV/AIDS could have caused the high underweight prevalence rate. HIV/AIDS is higher in urban areas than in rural areas (SDHS, 2007), and Hhohho is the more urbanized region in Swaziland. All regions, but especially Hhohho, need strategies to deal with the underweight problem.

- According to the 2008 NNS report, the most poverty-stricken agro-ecological regions of the country (Lubombo and Shiselweni),are more than twice as likely to be on the poor food consumption and borderline food consumption category, with proportions of 18.7 percent and 15.4 percent respectively. The better-off regions (Manzini and Hhohho) are least likely, with proportions of 6.1 percent and 7.9 percent respectively (NNS, 2008). Targeted food security strategies will need to take this into account.
- Children from rural areas are nine times more likely to fall within the poor food consumption category than those from urban areas with the proportions of 3 percent and 0.37 percent respectively (NNS, 2008). This, therefore, demands that more attention be given to rural children.
- As shown in Table 1.4 earlier, the Lowveld and

Lubombo regions had the lowest maize production in all the years. These regions have limited arable land and the climate is not favourable for crop production. This situation can be improved if the government would assist farmers in the Highveld and Middleveld to grow surplus for ensuring availability of food in the Lowveld and Lubombo. This would work if Lubombo and Lowveld people were supported through micro-financing to strengthen and build capacity for a vibrant SME sector whose income would ensure accessibility to food

- Unemployment in the country has a strong rural dimension – those residing in rural areas are much more likely to be unemployed than those living in urban areas. This has consistently been reported in country-wide surveys such as the SPHC and SHIES. In 2007, the unemployment rate of rural areas was 32.7 percent compared to 21.9 percent in urban areas (LFS 2007/08).
- A wide range of employment indicators reveal that men possess noticeably better employment prospects than women. In terms of the employment-to-population ratio, women have a much lower ratio of 31 percent compared to the 43 percent for men. With regard to unemployment, the rate is visibly higher for women – 31.2 percent compared to 25.7 percent for men (LFS 2007/08).
- At 53.3 percent, the unemployment rate of youths (those aged 15 to 24) is considerably higher than for the general population (LFS 2007/08).

Supportive environment

- There are several good plans and policies that have been created to address environment for poverty, food insecurity and underweight. Chief among them are the National Food and Nutrition Policy and Strategic Plan, the National Food Security Policy and the Poverty Reduction Strategy and Action Programme. The main challenge is getting them implemented.
- There is a Comprehensive Food Security Policy for the country that addresses the issue of agricultural inputs for production. This has led to efforts to subsidise farming inputs. Although its sustainability is an issue for concern, it represents a strong step by government aimed at assisting farmers to increase production to reach total requirement levels and self-

sufficiency in the long run.

Key bottlenecks constraining progress and how to address them

- **Poverty:** Poverty is complex and requires integrated interventions. Lack of coordination is a big bottleneck in dealing with poverty. Government, development partners, stakeholders, the rich and the poor must all be involved in the eradication of poverty. Government must ensure that there is effective coordination as all partners get involved in the fight against poverty.
- **Water policy:** The current water policy is in need of review. Current policy prioritises commercial over domestic use. Huge dam projects and big rivers are targeted at supporting commercial production for export.
- **Land issues:** The country has only a draft land policy. As a result, the land issues it was supposed to address remain unresolved. Land issues have been worsened by the lack of a legal framework. Arable land suitable for agricultural production is currently used for other activities, such as settlements and industrial sites.
- **Absence of microfinance policy:** The country does not have a microfinance policy that regulates the micro-enterprise environment. There is, however, a cooperatives policy that regulates the cooperatives environment, which provides for microfinancing. The cooperatives are exclusionary by nature, as membership requires one to be gainfully employed to ensure monthly contributions and security to service loans.
- **Job losses:** The closure of several companies and retrenchments in 2009 led to more than 1,233 job losses. In 2010 alone, 3,000 jobs have been lost, reducing consumable income for many households in Swaziland. In such situations, people do not have a choice but to reduce their food intake.

New challenges with unanticipated consequences

- The financial crisis is the cause of retrenchments and closure of companies. It has also led to the reduction of demand for exportable products in Swaziland. The impact, therefore, both at the macro- and micro-levels cannot be underrated. The result is the increase of the proportion of people who cannot afford enough food.
- The impact of HIV/AIDS intensifies when the population lacks food or has insufficient food. Having access to nutritious food is particularly important for those taking ARVs. Lack of food and income can also

force people into developing survival mechanisms that render them vulnerable to HIV/AIDS.

How Swaziland will accelerate progress in this MDG

- Implement the Poverty Reduction Strategy and Action Programme effectively, as well as other policies conducive to reducing poverty in the country.
- Prioritise the sector responsible for increased productivity agriculture by allocating resources and encouraging civil society and other agencies to invest in agriculture.





MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION



MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Status at a glance

Will Target be Met		Likely
State of Supporting Environment		Strong

Target 2A Ensure that, by 2015, all boys and girls complete a full course of primary schooling

A clear relationship between education and poverty was reported in both the 1995 and 2001 Swaziland Household Income and Expenditure Survey (SHIES) and in recent years the country has taken huge strides

towards achieving universal primary education. More steps are required if this crucial development objective is to be achieved.

Status and trends

Indicator 2.1 Net enrolment ratio in primary school

The net enrolment ratio (NER) is the number of children that are of official primary school-age and enrolled in primary school over the total population of children of

official primary school-age. Data for this indicator is presented below.

Table 2.1: Trends in primary school enrolment and net enrolment ratio

Year	Primary School Enrolment	Net Enrolment Ratio ¹
2000	213 986	79.2
2002	208 998	72.1
2004	218 352	81.9
2006	229 686	85.1
2007	232 572	86.7
2008	229 650	.
2009	231 066	—

Source: Education Statistics 2000-2007; ¹ Free Primary Education Handbook 2008; EMIS Survey Report 2008 & 2009

Table 2.1 indicates that both primary school enrolment and the NER have increased steadily since 2002, having previously experienced a decline. This is a particularly impressive achievement given the decrease in the primary school-aged population between 1997 and 2007 (SPHC 1997 & 2007), which is projected to continue into the future (Threshold 21). It is a reflection of increasing efforts by the government to ensure all children have access to education irrespective of their socio-economic status.

This widening of access began in 2002 with the introduction of the Orphaned and Vulnerable Children (OVC) initiative. This scheme involves the Government of Swaziland providing bursaries to OVC in order to make school more affordable for them. Funding for the OVC initiative has increased substantially since its inception, rising from E16 million in 2002 to E123 million in 2010 (2009 and 2010 Budget Speech). In 2009, a total of 85,530 OVC were benefiting from the scheme in primary schools (EMIS Survey Report 2009). To further improve access as well as quality, feeding

schemes have been introduced and textbooks, stationery and exercise books are now free in primary schools. The Care and Support for Teaching and Learning (CSTL) Programme has also been introduced to improve both enrolment and retention, and selected primary schools are benefiting from the School Capitation Grant Scheme. Many of these measures have coincided with an increase in the NER from 72 percent in 2002 to 86 percent in 2007, which is a very laudable achievement. However, this still implies that 14% of children of primary school-age were not in school in 2007.

A major milestone occurred in 2010 with the launch of the State Funded Primary Education Programme for grades 1 and 2, which saw the government absorb the financial costs of education for these grades. Preliminary data suggests this has led to a significant increase in enrolment, with the number of children in grades 1 and 2 increasing by over 10,000 in 2010 (EMIS department). The programme has been designed so that it extends to an additional grade every year so that by 2015 all grades are covered. This represents substantial progress and is a very necessary although insufficient condition for achieving this MDG.

Indicator 2.2 Proportion of pupils starting grade 1 who reach the last grade of primary school

The proportion of children who started grade 1 and reached grade 7, having not repeated more than twice,

was estimated at 59.8 percent in 2006/07 (EMIS Department). The 2007 Swaziland Demographic and Health Survey similarly reported that one in three pupils who start grade 1 will, on average, not complete grade 7, the last grade of primary school. Additional data is presented in table 2.2.

Table 2.2: Proportion of children starting Grade 1 who reach Grade 5, 2000-2007

Year	2000/ 2001	2001/ 2002	2002/ 2003	2003/ 2004	2004/ 2005	2005/ 2006	2006/ 2007	Average over period
Those who repeated no more than two times	71.1%	71.4%	73.3%	85.4%	77.4%	.	78.5%	76.2%

Source: Swaziland Universal Primary Education Indicators Manual, EMIS Department, Swaziland MDG Report 2007

Between 2000 and 2007 only 76.2 percent of children who started grade 1 managed to reach grade 5, suggesting that student retention in the primary education system is a serious challenge. Such a low figure can be explained by the country's high repetition and drop out rates. For instance, 8 percent of grade 6 students and 14 percent of grade 7 students dropped out of school in 2007 (Education Statistics 2007). Of equally great concern are the very high repetition rates in primary school - in 2007, 18 percent of pupils repeated a grade, with grade 1 experiencing the highest repetition rate (Education Statistics 2007). Such high levels of repetition and drop out have long been a feature of the education system in the country and represent an unacceptable situation. Moreover, projections from the country's macroeconomic model, Threshold 21, indicate that the proportion of pupils who start grade 1 and reach grade 5 will not rise above 80 percent in the foreseeable future, given the current strategies and policies of the country. Strong corrective action is needed so that the education system becomes more efficient.

Threshold 21 suggests that child death due to HIV is one of many factors contributing to high drop out rates. The further scaling up of prevention of mother-to-child transmission of HIV would thus improve not only health outcomes, but also educational outcomes. Other ways forward are proposed later in the section.

Teachers have an important bearing on the quality of education a child receives and in 2009 the country had a pupil-teacher ratio of 31:1 (EMIS Survey Report 2009). This is impressive and below the national primary school benchmark of 40 pupils to 1 teacher. However, it is unclear whether the situation on the ground is as impressive. The ratio above includes head teachers and deputies who do not always participate in teaching, and teacher absenteeism is also an issue with an estimated 10 percent of teachers not being at work on an average school day (World Bank 2006). A number of teachers also do not have the requisite qualifications to teach at primary school level.

Indicator 2.3 Literacy rate of 15 to 24 year olds

The literacy rate of 15 to 24 year olds - also termed the youth literacy rate - is the percentage of the population aged 15 to 24 that can read and write, with understanding, a short simple statement in any language.

Table 2.3 indicates that literacy rates for 15 to 24 year olds have risen steadily over the past two decades. The youth literacy rate increased from 83.7 percent in 1986 to 91.7 percent in 1997 before further improving to 95.4 percent in 2007 (SPHC 1986, 1997 & 2007).

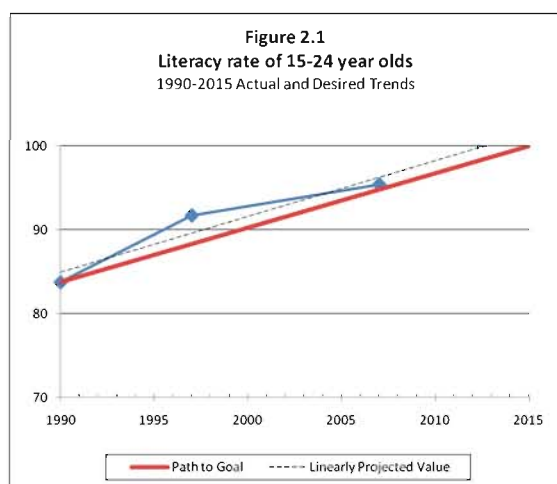
Table 2.3: Literacy rates of 15-24 year olds, 1986-2007

Year	1986	1997	2007
15-19	86.1%	92.6%	96.1%
20-24	80.6%	90.7%	94.5%
15-24	83.7%	91.7%	95.4%

Source: Calculated from the SPHC 1986, 1997 & 2007 (Vol. 1)

This youth literacy rate of 95.4 percent is higher than the overall literacy rate in the country, which stands at 89.1 percent (SPHC 2007), and encapsulates improvements the country has made in terms of education. Youth literacy has the potential to increase further as education becomes more accessible and of better quality. It is important here to not ignore those

children and young adults who have altogether missed out on primary education and are now over-aged. Rural education centres need to be adequately supported along with Sebenta which offers non-formal universal primary education (NUPE). Figure 2.1 provides a graphical representation of literacy rates for 15 to 24 year olds.



Source: Calculated from SPHC 1986, 1997 & 2007
Note: 1986 figure used for 1990

Inequality analysis

Gender inequality

The available data suggests there are no significant differences in the educational performance of girls and boys.

In terms of youth literacy, females have continued to possess a marginally higher literacy rate than their male counterparts, as shown in table 2.4.

Table 2.4: Literacy rates of 15-24 year olds by sex, 1986-2007

Year	Males	Females
1986	83.1%	84.3%
1997	90.7%	92.7%
2007	94.9%	95.9%

Source: Calculated from SPHC 1986, 1997 & 2007 (Vol. 1)

With regard to the net enrolment ratio, girls outperformed boys in 2007 (SDHS 2007). This has generally been the case in previous years although the differences are small (Swaziland UPE Indicators Manual).

Available data on the proportion of children who start grade 1 and reach the last grade of primary school is not disaggregated by gender. However, it should be noted that in 2007 15 percent of girls repeated a grade in primary school compared to 20 percent for boys (Education Statistics 2007). The higher repetition rate of boys is consistent with previous years (Education Statistics 2000-2006). In terms of drop outs, the 2007 SDHS reported that boys dropped out more in the first

three grades while girls generally had a higher drop out rate for the subsequent four grades of primary school.

There is also evidence of a gender dimension in terms of subject choice in schools (Swaziland CEDAW Report 2010). For instance, Home Economics is popular among girls only, while boys are much more likely to choose Technical Drawing.

Regional inequality

The data indicates that Lubombo and Shiselweni are the worst performing regions. For instance, in terms of youth literacy, the Lubombo region had the lowest levels in 2007, as shown in table 2.5.

Table 2.5: Literacy rates of 15-24 year olds by region in 2007

Age	Hhohho	Manzini	Shiselweni	Lubombo
15-19	96.3%	97.3%	96.4%	93.9%
20-24	94.9%	96.8%	94.4%	90.4%

Source: Calculated from SPHC 2007 (Vol. 1)

This is of particular concern since this same outcome was also observed in 1986 and 1997 - Lubombo has

consistently possessed the lowest literacy rates in the country (table 2.6).

Table 2.6: Literacy rates of 15-24 year olds by region, 1986 and 1997

Year	Hhohho	Manzini	Shiselweni	Lubombo
1986	85.0%	90.7%	86.7%	70.7%
1997	92.2%	94.8%	92.3%	85.7%

Source: Calculated from the SPHC 1986 & 1997

This is likely to be a strong contributing factor in Lubombo's high poverty rate, which stood at 73 percent in 2001 against a national average of 69 percent (SHIES 2001).

With regard to the net enrolment ratio, Shiselweni was the worst performing region in the country, followed by Lubombo (SDHS 2007).

Shiselweni, the poorest region in the country, also performed poorly in terms of drop out rates. For every single primary school grade, a greater percentage of children dropped out in Shiselweni than in any other region (SDHS 2007). Lubombo experienced the highest repetition rates.

Urban/rural inequality

As with poverty, the data indicates that rural areas are significantly more disadvantaged compared to urban areas.

For instance, youths living in urban areas are more likely to be literate than youths residing in rural areas – 97.3 percent versus 95.1 percent (SPHC 2007). This was also the case in 1997 with 94.3 percent of urban youths being literate compared to just 90.8 percent for their rural counterparts (SPHC 1997). This under-performance of rural youths in literacy also applies to rural adults as well.

The 2007 SDHS reported a lower NER for rural areas as well as higher repetition rates in every single grade of primary school. Rural areas also experienced a higher drop out rate for the first three grades of school (SDHS 2007).

The pupil-teacher ratio of 31:1 reported earlier was simply an average and masked evident differences across the country. Urban and peri-urban areas tend to have much higher ratios which at times exceed 90, while some rural areas can have less than 10 pupils per teacher.

Finally, there are notable urban-rural imbalances in terms of the distribution of qualified teachers. It is heavily skewed in favour of urban schools due to poor facilities in many rural and remote schools.

Supportive environment

The country's new constitution provided for free primary education, making it an explicit constitutional right for every child.

Primary education has become more accessible because of the State Funded Primary Education Programme, which will be extended to all primary grades by 2015.

Disadvantaged children continue to be supported by the OVC initiative.

The country's new Education Policy, which is soon to be finalised, will replace the now outdated National Education Policy of 1999.

New challenges with unanticipated consequences

The global economic and financial crisis has significantly reduced the financial resources available to the Government of Swaziland.

This provides a welcome opportunity to increase the efficiency with which existing education resources are used. Education expenditure is skewed heavily towards tertiary education and allocating a greater proportion of the education budget to primary education would make this MDG more achievable.

Attaining universal primary education also requires all stakeholders to collaborate and this need is even greater following the global economic crisis. The country will not be able to overcome all the identified challenges without support from its development partners.

Key challenges/how the country can accelerate progress in this MDG

The very high repetition rates represent a major challenge. A repetition policy exists which allows for no more than 10 percent of students in a class to repeat a grade, and this policy needs to be implemented. A thorough investigation of the varied and complex reasons for high repetition and drop out is also required.

High levels of poverty are still a reality in the country. This reduces the demand for education and is contributing to the high drop out rates. In addition to prohibitive financial costs, poor households often need child labour for domestic and economic purposes. Tackling the deep-rooted causes of poverty, particularly in Shiselweni and Lubombo, will accelerate progress in this MDG.

The repetition rate for grade 1 was 21.9 percent in 2007 (Education Statistics 2007), suggesting a substantial proportion of children enter grade 1 without the requisite primary-school readiness, especially children from disadvantaged backgrounds. More investment is needed in Early Childhood Care and Development (ECCD) so that it becomes accessible to everyone and not just the wealthy.

The country's policy states that no child should walk more than five kilometers to attend primary school, which is currently not the case particularly in rural areas. This hinders access to education since many children, especially the young, are not able to travel such long distances on a daily basis. There is a need to identify those areas where this policy does not hold and for appropriate action to be taken.

One reason for girls dropping out of education is pregnancy. Six percent of women aged 25 to 49 had given birth by age 15 and 33 percent by the age of 18 (SDHS 2007). Reproductive health needs to be taught effectively in primary schools.

The Government of Swaziland has provided a number of new classrooms in recent years to accommodate increases in primary school enrolment. However, in 2009, 63,000 primary school children were enrolled in classes bigger than 50 (EMIS Survey Report 2009). Such large class sizes create a poor learning environment and a more aggressive expansion of classroom numbers will improve the situation. This is especially required given the future rolling out of the State Funded Primary Education Programme to all grades.

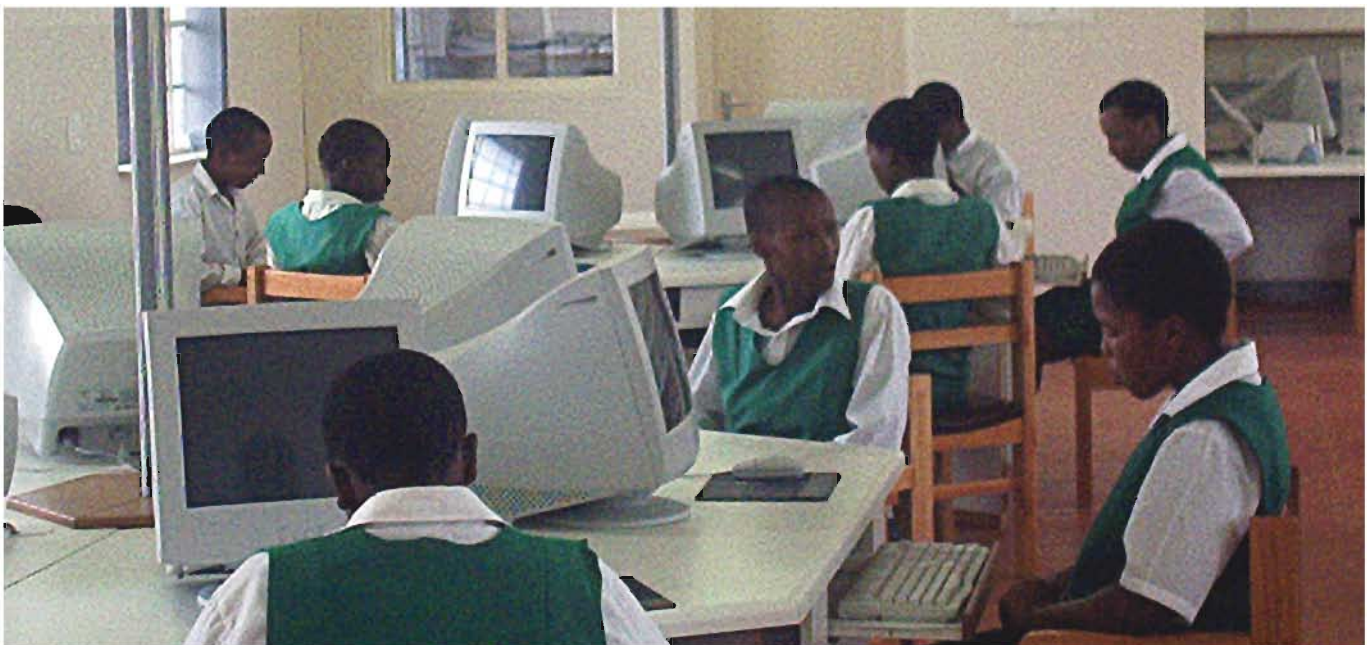
While there has been much improvement, there is a need for school facilities to be further enhanced.

Several still lack electricity, an adequate number of desks and chairs, as well as access to water and sanitation. Targeting rural and remote areas for improvement may incentivise more qualified teachers to work there.

There are many instances of children not attending school merely because of the high cost of school uniforms. Interventions are needed to prevent such occurrences.

Monitoring and evaluation structures for education require strengthening so that policy makers have timely access to important information. This involves enhancing capacity for data collection and analysis.

Education should make pupils more employable, yet the country's education system is not career oriented. School curricula need to be revised based on labour market information so that they are more relevant to the economic needs of the country. Given the large numbers of children who do not participate in secondary education, career guidance and vocational training should begin at primary school. Finalising the Human Resource Development Plan and Strategy would be another step in the right direction.



MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN





MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Target 3.A Eliminate gender disparity in primary and secondary education preferably by 2005, and in all levels of education no later than 2015

Indicators

- 3.1 Ratio of girls to boys in primary, secondary and tertiary education
- 3.2 Share of women in wage employment in the non-agricultural sector
- 3.3 Proportions of seats held by women in National Parliament

Status at a glance

Will target be met	 Likely
State of supporting environment	 Strong

Indicator 3.1: Ratio of girls to boys in primary, secondary and tertiary education

The ratio of girls to boys in primary, secondary and tertiary education is the ratio of the number of female students enrolled at that level to the number of male students enrolled. Table 3.1 below shows the respective ratios for all levels of education.

Since 2000, the ratio of girls to boys in primary education has remained almost constant, averaging 0.93, highlighting that there are more boys enrolled in primary school than girls. However, there are more girls of school-going age than boys, and the desired ratio is 1.01. Which will be enhanced with further Government

support for OVC in particular the girl child.

On the other hand, secondary education statistics show that there are slightly more girls enrolled than boys, with a ratio that is greater than one. However given the population demographics of the country, in which there are more girls of secondary-school age than boys (over 5,000 in 2007), girls are still disadvantaged at this level and there is sufficient room to support girl retention in school as a result of early pregnancy, poverty and the impact of HIV and AIDS.

Table 3.1: Ratio of girls to boys in primary, secondary and tertiary education

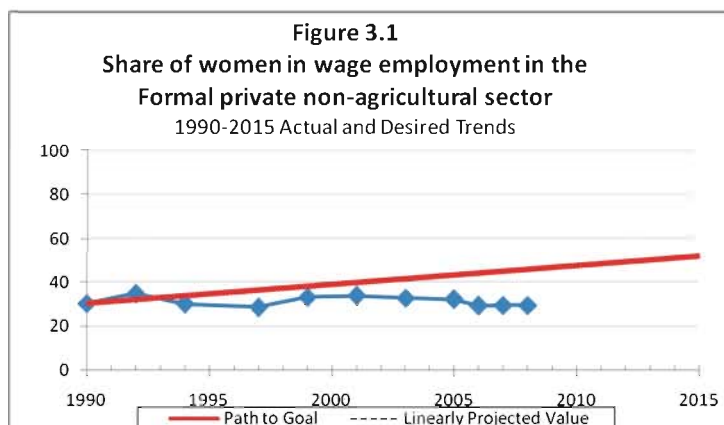
Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007	2015 *
Ratio of girls to boys in primary	0.99	0.94	0.95	0.94	0.94	0.94	0.94	0.92	0.92	1.01
Ratio of girls to boys in secondary	0.99	1.01	1.01	1.01	1.00	1.01	1.01	1.01	1.01	1.06
Ratio of girls to boys in tertiary education						1.03	1.05	1.03	1.06	-

Source: Annual Statistics Bulletin 1990 & Education Statistics 2000-2007
Note: * Desired target

Indicator 3.2 Share of women in wage employment in the non agricultural sector

In Swaziland, wage employment data is differentiated by private and public sector. The share of women in wage employment in the non-agricultural sector is the

number of female workers in wage employment in the non-agricultural sector expressed as a percentage of total wage employment in that same sector.



Source: Employment & Wages Survey results 2008



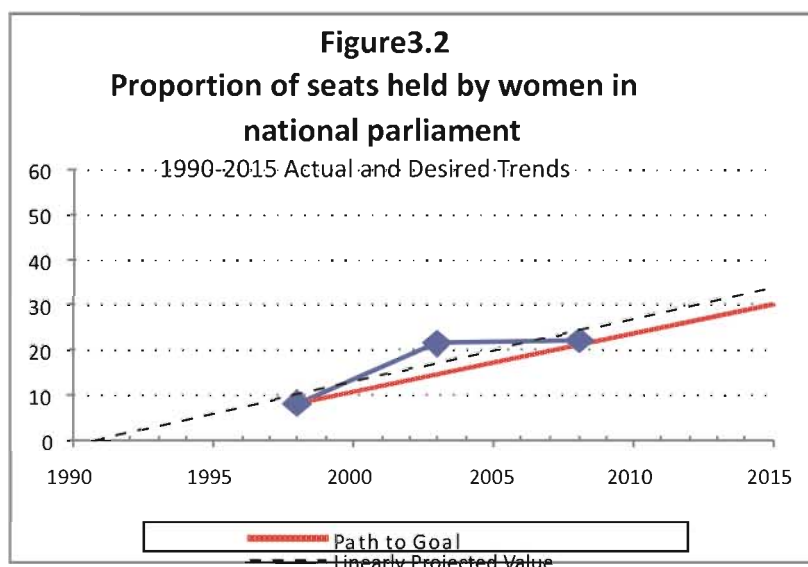
Figure 3.1 above shows that the private sector is not performing toward the target as expected. Instead, there is a constant downward trend rate of 29 percent from year 2006-2007 compared with 33 percent of the

previous years. The public sector shows an impressive upward trend from 47 percent in 2006 to 48.6 percent in 2008. It also suggests a strong potential for reaching the 52 percent target by 2015.

Indicator 3.3 Proportion of seats held by women in National Parliament

The proportion of seats held by women in the national parliament is the number of seats held by women members in single or lower chamber of national

parliament expressed as a percentage of all occupied seats.



Source: Swazilinfo

The country is making considerable progress as shown in Figure 3.2, and achieving the indicator by 2015 is a strong possibility. Thirty percent has been used as a target because it is what the Constitution requires. However, the Southern African Development Community, the African Union and other international bodies have set targets proportionate to the population. The desired target for the country would be 52 percent of seats held by women in parliament.

Inequality analysis

- The country has made remarkable progress in the above indicator. In the current cabinet 2008-2013, there has been a significant improvement in the proportion of ministers who are female showing 28 percent compared to 20 percent in the former Government 2003-2008. Female Principal Secretaries are at 20 percent. Nevertheless, this shows that the top leadership positions in the government are still male dominated, and there is a need to ensure that capable females and males are being given equal opportunities.

Supportive environment

- The strategic positioning of the Gender Unit in the Deputy Prime Minister's Office.
- His Majesty The King signed the SADC Protocol on gender, which shows the countries commitment to The Gender agenda as well as CEDAW (2004) which is now disseminated at grassroots level.
- The Gender Policy, which has recently been approved.

Key bottlenecks constraining progress and how to address them

Violence against female children: According to a UNICEF Study on Violence against Children in Swaziland (2007), violence against female children was highly prevalent. Approximately one in three females experienced some form of sexual violence as a child; nearly one in four females experienced physical violence as a child; and approximately three in 10 females experienced emotional abuse as a child. Boyfriends and husbands were the most frequent perpetrators of sexual violence; male relatives (other than the victims' father) were the most frequent perpetrators of physical violence; and female relatives were the most frequent perpetrators of emotional

abuse. Incidences of sexual violence occurred most often in the home, either the home of the respondent or the home of a friend, relative or neighbour. These issues will be addressed through the accelerated adoption of the sexual offenses and domestic violence bill.

- Gender-based violence (GBV): This is a major problem in the country where women and girls, as well as orphans and vulnerable children, are marginalised, making them susceptible to HIV/AIDS, incest, abuse and rape. Women are more likely than men to become infected through sexual contact and as primary care givers. Gender disparities exacerbate the problem by reducing a woman's voice and choice in issues such as safe sex negotiation and sexual and reproductive rights. The recently approved gender policy seeks to address these challenges through a number of strategies proposed under family planning.
- Legislation: There are several pieces of legislation that need reviewing which are limiting the country's ability to deal with gender disparities, so as to conform to the dictates of the constitution (2005) pertaining to gender equality and women empowerment.
- Legal access: Legal access to land is still predominately through men, although we have seen cases of women accessing land independently. There is a need for a legal framework to regulate open access to land both on tittle deed and Swazi Nation land. The revisions to the Constitution in 2005 took this issue into account, but so far no act has rectified it, i.e. The Deeds Registry Act needs to be reviewed so that it conforms to the Constitution and then enforced so that there are no disparities, in practice, between men and women.

How Swaziland will accelerate progress in this MDG

- There is a need to finalise the legal frameworks to enable the proper functioning of the unit and the country on the whole in terms of gender.
- The private sector and civil society need to be encouraged to invest in gender issues in the country to complement government action.
- The capacity of this function needs to be greatly strengthened by increasing staff working in this unit.

MDG 4: REDUCE CHILD MORTALITY



MDG 4: REDUCE CHILD MORTALITY

Target 4.A Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicators

4.1 Under-five mortality rate

4.2 Infant mortality rate

4.3 Proportion of 1 year-old children immunised against measles

Status at a glance



Will target be met	 Likely
State of supporting environment	 Strong

Table 4. 1 Status in figures

Indicator	1990	1997	2000	2007	2008	2009	2015
Under-five mortality rate	96	106	122	120	-	-	32
Infant mortality rate	70	78	87	85	-	-	23
Proportion of 1 year-old children immunized against measles	85	94	72	60	68.7	72	100

Source: SDHS 2007, SPHC 1997, SMICS 2000, UNICEF 2009

Status and trends

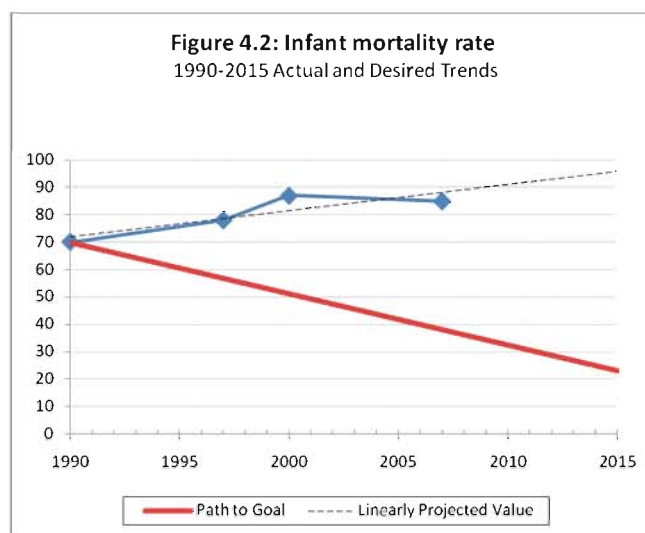
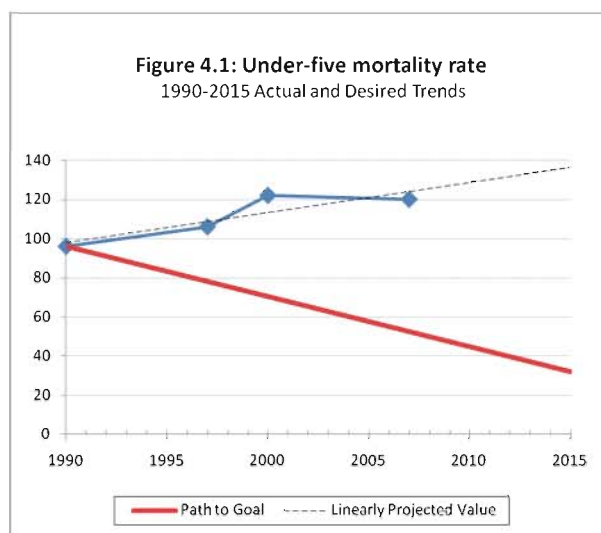
The country has taken important steps towards achieving this MDG. Figures 4.1 to 4.3 show the

progress that has been made so far.

Indicator 4.1 Under-five mortality rate

The under-five mortality rate (UMR) is still high in the country, as illustrated in Figure 4.1. Reducing by two-thirds between 1990 and 2015, the UMR should be 32 deaths per 1,000 live births. The worsening of this indicator from 1997 to 2000 coincided with the growth of the HIV/AIDS pandemic and the food shortages the

country experienced among other issues. However, from 2000 to 2007, UMR fell by two deaths per 1,000 live births. This could have been due to the decline in HIV/AIDS infection from 42.6 percent in 2004 to 39.2 percent in 2006 (11th HIV Sentinel Surveillance, 2008 [this survey is carried out among pregnant women]).



Source: SDHS 2007, SPHC 1997, SMICS 2000, UNICEF 2009

Indicator 4.2 Infant Mortality rate

The infant mortality and the under-five trends are identical as shown in Figures 4.1 and 4.2. Limited progress has been made in the reduction of the infant mortality rate (IMR). HIV/AIDS, pneumonia, diarrhoea and neonatal conditions continue to be the main causes of child and infant mortality in the country. According to Black et. al., the five major causes of child mortality in Swaziland are AIDS, which accounts for 49 percent; pneumonia, 12 percent; preterm birth complications, 9

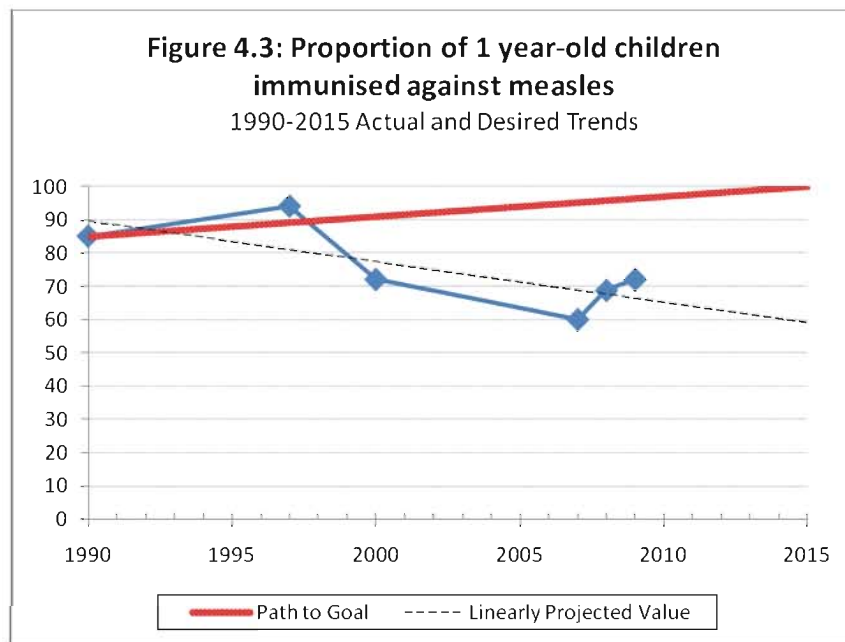
percent; diarrhoea, 8 percent; and other infections, 7 percent. Underlying these direct causes are a variety of complex and interrelated factors that contribute to ill health and mortality, including poverty, vulnerability, lack of education, and poor health care services. Reducing child and infant mortality, therefore, will require that all these issues be addressed effectively.

Indicator 4.3 Proportion of 1 year-olds children immunised against measles

From 1997 to 2005, measles immunisation coverage dropped far below the 100 percent target. The coverage level started increasing again in 2008 when it marginally went up to 68.7 percent. The 2009 report reflected that the coverage is rising as indicated in Figure 4.3.

to the entire population. Routine immunisation is administered to all children less than five years of age, using the super market approach in all the service delivery points across the country. Measles coverage is predominantly an indicator monitored for the reduction of child mortality.

Immunisation is one of the most vital and cost-effective interventions that the health system can make available



The Swaziland Expanded Programme on Immunisation (SEPI) is one of the components of primary health care. Over the years, the programme has contributed to the reduction of the child mortality rate. Although vaccine-

preventable diseases should have been dramatically reduced, HIV/ AIDS has worsened the situation and has contributed to an increase in child mortality as indicated above.

Inequality analysis

● There are no major differences in mortality rates between urban and rural areas. There are, however, significant regional differences as far as under-five mortality is concerned. Under-five mortality is very high in Lubombo followed by Shiselweni. It is much lower in Hhohho. Mortality rates have generally improved over

the years. Still, an examination of the reasons for the high mortality rates in different regions can help ensure that the country addresses underlying causes in all regions as shown in table 4.2.

Table 4.2 Early childhood mortality rates by region

Region	Year 1986 (census)		Year 1997 (census)		Year 2007 (SDHS)*	
	Infant Mortality	Under-five Mortality	Infant Mortality	Under-five Mortality	Infant Mortality	Under-five Mortality
Hhohho	89	137	74	98	71	96
Manzini	90	140	73	97	82	112
Shiselweni	95	158	82	111	76	100
Lubombo	119	154	86	120	78	115

Source: SPHC 1997, SDHS 2007

SDHS* Note that the country figures for Infant mortality and Under-five mortality were 85 and 120 which are higher than the regional figures. All these figures however, are in SDHS.

- The mother's level of education was found to be inversely related to her child's risk of dying. Infant mortality rate was 96 per 1,000 live births to mothers with no education and 48 per 1,000 with mothers with tertiary education (SDHS 2007). The under-five mortality rate was 151 per 1,000 live births to mothers with no education and 53 per 1,000 live births to mothers who had tertiary education.

Supportive environment

- The National Health Policy and Health Sector Strategic Plan and Annual Action Plans provide the necessary framework for addressing issues of child mortality.
- Integrated Child Survival Interventions have been

Education is, therefore, a big determinant of child and infant mortality.

- The probability of dying in childhood is much greater if children are born to mothers who are very young less than 18 years, according to SDHS (2007). The same source indicates that mortality tends to be high when the interval between children is less than 24

defined and are being followed where possible.

- PMTCT services are now universally accessible.
- An established structure for delivery of child survival interventions is readily available and accessible.

Key Bottlenecks constraining Progress and How to address them

- Health systems: drug chain management needs to be improved to limit stock-outs, human resource shortages and uneven distribution and decentralisation of services.
- Access to outreach services: The uneven access to outreach services must be addressed, with

appropriate budget allocation to ensure that rural people can enjoy access to regular services.

- Low demand for child survival interventions: There is low demand for child survival interventions, perhaps due to lack of resources. This has to be reversed.

New Challenges with unanticipated consequences

- Epidemics (new and re-emerging childhood communicable diseases) such as measles, TB and A/H1N1. The Ministry of Health needs to be better prepared for emergencies.
- The HIV/AIDS pandemic has exacerbated child and infant mortality. Addressing HIV/AIDS seriously is critical.

- The global economic recession has affected the government's ability to acquire adequate resources for dealing with issues of child and infant mortality. The country possesses good strategies, but they cannot be implemented effectively without the required resources.

How Swaziland will accelerate progress in this MDG

- Accelerate implementation of High Impact Child Survival Interventions, which have proven to work well to reduce infant and child mortality.
- Implement the Integrated Community Management of Childhood illnesses to improve delivery of child survival interventions to disadvantaged populations.
- Accelerate advocacy communication and social mobilisation of child survival integrated services.
- Review and strengthen Primary Health Care Strategy and Programming.

- Intensify surveillance of epidemic-prone childhood diseases, such as measles due to low immunity, TB and A/N1H1.
- Incentivise health providers, including through rural and urban health motivators.
- Evaluate all health interventions and programmes for effectiveness, and then ensure that only those that are very effective are given priority.
- Improve health infrastructure by providing the equipment necessary for health workers to perform optimally.

05

MDG 5: IMPROVE MATERNAL HEALTH



**HER ROYAL HIGHNESS INKHOSIKATI LAMBIKIZA
IS THE PATRON OF IMPROVING MATERNAL HEALTH**

MDG 5: IMPROVE MATERNAL HEALTH

Target 5.A Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicators

5.1 Maternal mortality ratio

5.2 Proportion of births attended by skilled health personnel

Status at a glance



Will target be met	 Likely
State of supporting environment	 Strong

Table 5.1 status in figures

Indicator	1995	2000	2002	2007	2015*
Maternal mortality (per 100,000)	370	370	229	589	92
Proportion of births attended by a skilled health personnel	-	70	74	74.3	100

Source: HDR 2003, UNICEF 2004, MICS 2000, SCHS 2002, SDHS 2007

Status and trends

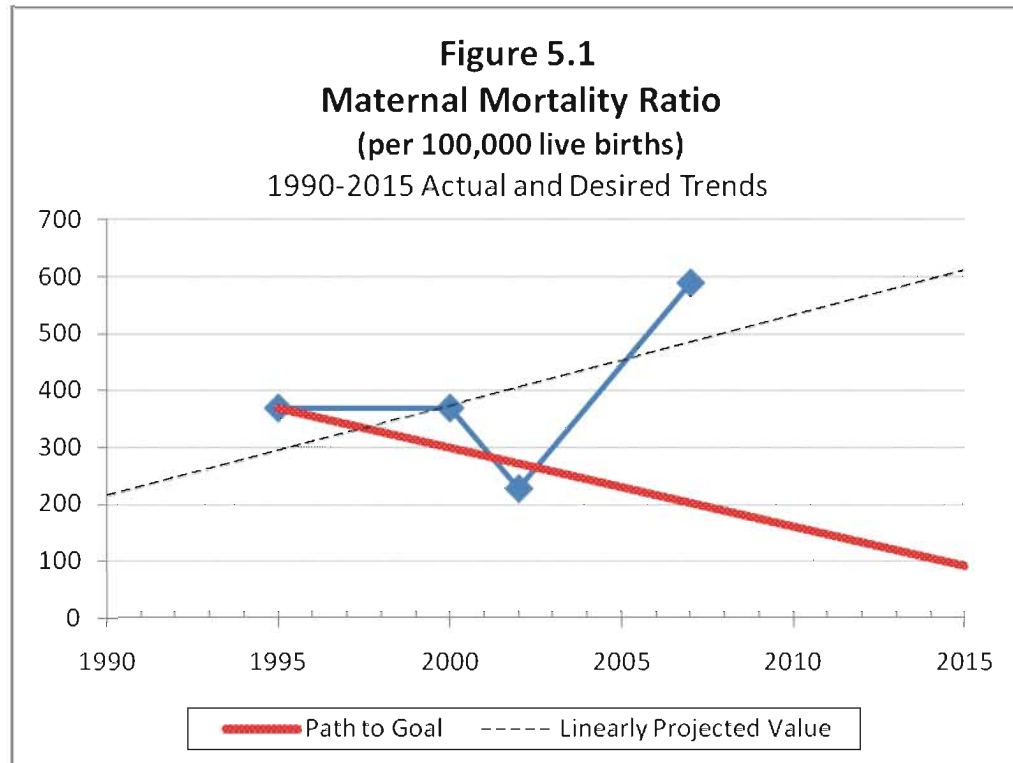
Indicator 5.1 Maternal mortality ratio

The maternal mortality ratio (MMR) is the annual number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy per 100,000 live births. The 10th revision of the International Classification of Diseases makes provision for including late maternal deaths occurring between six weeks and one year after birth.

The maternal mortality ratio was estimated at 370 per 100,000 live births in 1995 (HDR, 2003), rising to 589 per 100,000 live births in 2007 (SDHS, 2007). Figure

5.1 gives a picture of how the country has performed in this area.

It is clear that the maternal mortality ratio of 589 per 100,000 is very high. No woman should die during pregnancy, while giving birth or after giving birth. There is evidence, however, that the effect of HIV/AIDS on pregnant women negatively affects the maternal mortality ratio. The overall level of HIV infection among pregnant women increased more than 10 times from 3.9 percent in 1992 to 42.6 percent in 2004 (HDR 2008). The HIV/AIDS epidemic has worsened the maternal health condition of women. Because of their low immune system, HIV-infected pregnant women are susceptible to opportunistic infections.



Source: HDR 2003, UNICEF 2004, SCHS 2002, SDHS 2007

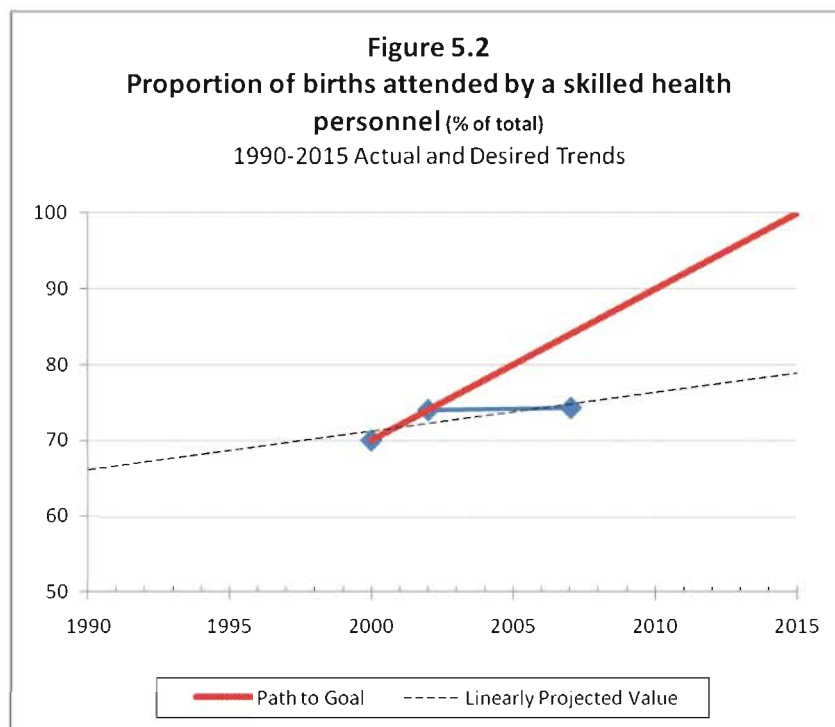
Indicator 5.2 Proportion of births attended by skilled health personnel

The proportion of births attended by skilled health personnel is the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; to conduct deliveries on their own; and to care for newborns.

According to SDHS (2007), 74 percent of births in the previous five years were delivered by a skilled health provider (doctor, nurse, midwife, or nursing assistant); 12 percent by doctors; 57 percent by nurses and midwives; and 5 percent by a nursing assistant. In the

absence of a nurse or midwife, relatives or friends were the next most common attendants to a delivery (16 percent). Five percent of births were assisted by traditional birth attendants, and 4 percent were assisted by no one.

The proportion of births attended by skilled personnel shows an improving trend as captured in Figure 5.2. This has been maintained and is above the average of most African countries. The country is doing very well in this indicator.



Source: MICS 2000, SCHS 2002, SDHS 2007

The important point here is that as more children are delivered in a health facility, chances improve to reduce both maternal and baby mortality. Despite the shortcomings of some health centres, giving birth at a health centre managed by skilled health workers is

better than having a baby at home. In addition the country has launched the Campaign on Accelerated Reduction of Maternal Mortality in 2009 and an accelerated action is being implemented.

Target 5.B Achieve, by 2015, universal access to reproductive health

Indicators

- 5.1 Contraceptive prevalence rate
- 5.2 Adolescent birth rate
- 5.3 Antenatal care coverage
- 5.4 Unmet need for family planning

Status at a glance



Will target be met	 Likely
State of supporting environment	 Strong

Table 5.2 status in figures

Indicator	2000	2002	2007	2015*
Contraceptive prevalence rate	27.9	48.1	50.6	100
Adolescent birth rate	-	-	22.6	-
Antenatal care coverage	-	-	97	100
Unmet need for family planning	-	-	13.2	-

Source: MICS 2000, SCHS 2002, SDHS 2007
Note: * Desired Target

Status and trends

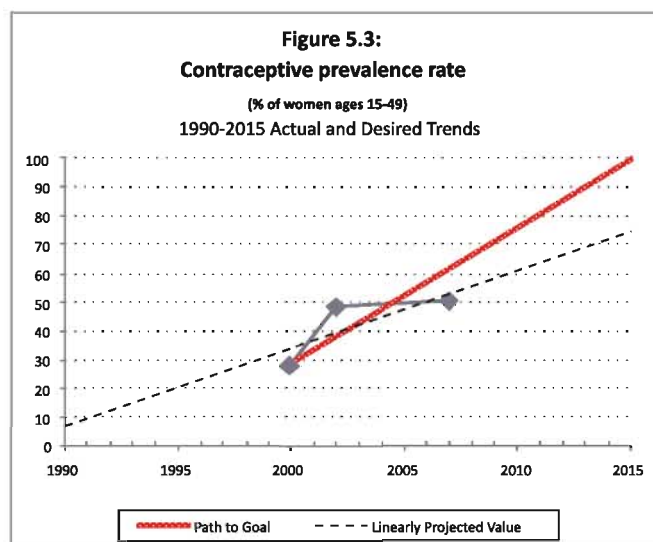
Indicator 5.1 Contraceptive prevalence rate

Contraceptive prevalence rate of modern methods is the percentage of women, married or in union, aged 15 to 49, who are currently using, or whose sexual partner is using, at least one modern method of contraception, regardless of the method.

Data from the SDHS (2007) showed that the contraceptive prevalence rate for currently married women aged 15 to 49 was 50.6 percent and for sexually active unmarried women was 64.5 percent. According to the 2000 MICS, the contraceptive prevalence rate for all women aged 15 to 49 was 27.9 percent. This is lower than the findings of the 2002 Swaziland Community Health Survey, which stood at 48.1 percent as described in Figure 5.3 below.

The use of contraceptives has increased over the years, but it is still below the expected target, as can be seen in Figure 5.3 below. Swaziland needs to ensure that women and men in rural areas are aware of the types of

contraceptives available and can choose among them for themselves.



Source: MICS 2000, SCHS 2002 & SDHS 2007

Indicator 5.2 Adolescent birth rate

The adolescent birth rate is the annual number of births by women 15 to 19 years of age per 1,000. It represents the risk of childbearing among adolescent women aged 15 to 19.

According to the 2007 SDHS, 18.5 percent of the women in the age group 15 to 19 had given birth, and 4.1 percent were pregnant, meaning 22.6 percent of these women had already started childbearing in 2006/7. While only four percent of women aged 15 had

started childbearing, 45 percent of women were either mothers or were pregnant with their first child by the age of 19. Teenagers with less education are more likely to start childbearing earlier than better-educated teenagers. Sixty-one percent of teenagers who had no education had already started childbearing, compared with 15 percent of those with a high-school education (SDHS 2007). Teenagers in the lowest wealth quintile were more than twice as likely to start childbearing earlier as those in the highest quintile (33 percent and

15 percent respectively).

Though there is insufficient data to conduct a trend analysis, it is clear from available data that teenage pregnancies are a major challenge and a contributor to both mother and child mortality. Poverty and lack of education correlate with teenage pregnancies, and should be addressed in this context.

Abortion is illegal in Swaziland except in a few legally defined circumstances. There is, therefore, lack of data on the magnitude and complications of abortion in Swaziland. However, evidence gleaned from the experience of other countries indicates that abortions contribute much to maternal mortality, especially to adolescents and in circumstances where the unmet need for contraception is high.

Indicator 5.3 Antenatal care (ANC) coverage

Antenatal care coverage (at least one visit) is the percentage of women aged 15 to 49 with a live birth in a given time period that received antenatal care provided by skilled health personnel (doctors, nurses or midwives) at least once during pregnancy, as a percentage of women aged 15 to 49 with a live birth in the same given time period.

Total antenatal attendance in the country was 97 percent, of which 88 percent was attended by trained nurses or midwives and 9 percent by doctors. It is estimated that only 26 percent of the women had their first ANC visit before the fourth month of gestation. This reveals that most women attend clinics and hospitals during advanced pregnancy. Antenatal care is more beneficial in preventing adverse pregnancy outcomes when sought early in the pregnancy and continued through to delivery (SDHS 2007).

In terms of the indicator, the country is doing well, since the SDHS information is an average for the five-year period ending 2007. However, the need for continued ANC still needs to be emphasised for its benefits in reducing both child and maternal mortality.

Indicator 5.4 Unmet need for family planning

Women with unmet need for family planning for limiting birth are those who are sexually active but are not using any method of contraception, and report not wanting any more children. This is a subcategory of total unmet

need for family planning, which also includes unmet need for spacing births. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour. For this MDG, unmet need is expressed as a percentage based on women who are married or in a consensual union.

According to SDHS (2007), 99.7 percent of all women and 99.5 percent of all men had knowledge of modern contraceptive methods while 78 percent of women and 79 percent of men had knowledge of traditional contraceptive methods. They also found out that knowledge of contraceptives is universal across all subgroups of population.

In terms of use, only 71 percent of women had used a method of contraception, and 70 percent of them had used a modern method. Meanwhile, only 59 percent of men had ever used a method of contraception, 55 percent having used a modern method. Sexually active unmarried women and men were more likely to have used a family planning method than their married counterparts. Male condom was the top choice of unmarried women and men.

Among women aged 15 to 19, only 28 percent had used a modern contraceptive method, while only 17 percent of men of the same age group had used a modern method.

The limited use of contraception in the country belies general understanding of the need for contraception. This is worrying, particularly with respect to young people.

It is difficult to determine unmet need for family planning in Swaziland, because information is lacking. However, SDHS (2007) results suggest that awareness needs to be raised and resources made available for the population not only to have knowledge but also to use it when appropriate, especially the youth.

Inequality analysis

- The distribution of skilled health staff is biased towards the urban areas, where there are more facilities. Some regions, like Hhohho and Manzini, seem to be better staffed and equipped than others, such as Lubombo and Shiselweni. For example, the proportion of births attended by a skilled health person was for 78.3 percent for Hhohho and 79.9

percent for Manzini, while for Lubombo the figure was 69.5 percent and 65.9 percent for Shiselweni 65.9 percent (SDHS 2007).

- Some town-based health workers who work in rural areas are not available during weekends, compounding emergency situations.

Supportive environment

- There are strategies and policies within the Ministry of Health that provide a guiding framework to deal with health issues in the country.
- The Ministry of Health is aware of successful and proven interventions to deal with maternal health. The Integrated Sexual Reproductive Health Strategic Plan 2008-2015 outlines those interventions.
- The Government's removal of charges for mothers attending the antenatal and postnatal clinics is critical.

Key bottlenecks constraining progress and how to address them

- Distance to the health facilities: Though the goal is to have a health facility within each 8 km radius, this has not been achieved in some rural areas. The longer the distance a pregnant woman travels before reaching a health facility, the greater the risk of maternal mortality, especially during delivery. The Government has made remarkable efforts but there is need to intensify the implementation of this activity.
- Maternity units: Maternity units in some rural areas lack basic equipment and supplies for emergency obstetric care. Government needs to carry out an exercise to identify gaps, and to work with partners to ensure that these maternity units are equipped.
- Human resource skill: There is lack of human capacity to manage obstetric emergencies, with very

few midwives trained in advanced midwifery and those trained not sent where there is need. The Ministry of Health needs to use the information gathered from the various monitoring and research institutions to correct the situation. The involvement of enthusiastic civil society participants could help in this area.

- The attitude to antenatal and postnatal clinics: Some men prohibit their wives from visiting antenatal or postnatal clinics. Some do it because of lack of transport resources, while others are wary of the information their wives may learn there. It is critical to make sure that men are also involved in the campaigns that target the antenatal care coverage and postnatal attendance.

New challenges with unanticipated consequences

- HIV/AIDS has a major impact on maternal mortality. Though HIV/AIDS is not new in Swaziland, it remains a big challenge and there is a need to strengthen the integrated approaches that have been developed in dealing with both.

How Swaziland will accelerate progress in this MDG

- Develop a policy on access (health systems strengthening that includes human resource skills such as training and deployment: equipment and supplies and community mobilisation).
- Develop a policy on linkages/integration of HIV in health programs.
- Improve policy, protocols and standardised guidelines and enforce usage.
- Strengthen research, monitoring and evaluation and implementation of the recommendations.

MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES



MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 6.A Have halted by 2015 and begun to reverse the spread of HIV/AIDS

HIV/AIDS

Table 6.1 A summary of the HIV/AIDS situation in the country

Description	Statistics
HIV prevalence (15-49 yrs), 2007	26%
Estimated population living with HIV, 2009	184,906
Projected number of new infections in 2010	13,795
Estimated AIDS deaths in 2008	7,782
Proportion receiving ARTs in December 2009 according to CD 4 count of 200	84.5%
Proportion receiving ARTs in December 2009 according to CD 4 count of 350	52.8%

Source: SDHS 2007, HIV Estimates and Projections 2010, Ministry of Health Monitoring and Evaluation Report December 2009

Indicators



6.1 HIV prevalence among population aged 15 to 24 years

6.2 Condom use at last high-risk sex

6.3 Proportion of population aged 15 to 24 years with comprehensive correct knowledge of HIV/AIDS

6.4 Ratio of school attendance of orphans to school attendance of non orphans aged 10 to 14 years

Status at a Glance

Will target be met	 Potentially
State of supporting environment	 Strong

Status and Trends

Indicator 6.1 HIV prevalence rate among population aged 15-24

The HIV/AIDS pandemic has had a devastating impact in the country. The HIV prevalence rate among the 15 - 49 years is estimated at 26 percent (SDHS, 2007). Many of the gains that were made in life expectancy in the country are now being reversed because of HIV/AIDS. The 2007 Population Census shows that the average life expectancy, which was rising in the previous three decades, has fallen from 60 to 43.3 years in the intervening 10 years since the prior census. Models that have been run over the period 2000 to 2025 show that the population structure shall become dramatically thin by 2025 (NERCHA annual report, 2009).

The increased death rates and high morbidity adversely affect economic activity by reducing productivity and increasing production costs. With productive members of society becoming sick and dying, there is an increase in dependency. The 2007 SPHC found that 23 percent of children under the age of 18 are orphaned. Overall, 31 percent of children under the age of 18 are classified

either as orphans or vulnerable children (UNGASS 2010). In order for dependent members of society to survive, they have to adopt new coping mechanisms as traditional community coping mechanisms are put under severe strain. The new coping strategies include reliance on government support and assistance from cooperating partners.

The 2007 SDHS reported an overall HIV prevalence rate of 14.4 percent among 15 - 24 year olds, whereby the prevalence of women was 22.9 percent and that of men was 5.9 percent.

There is presently no time series data on HIV prevalence among the population aged 15 to 24 in the country as based on national surveys. The only available time series data is for pregnant women aged 15 to 24. Table 6.2 shows the HIV prevalence rates for pregnant women aged 15 to 24 for the period 1994 to 2008. HIV prevalence for this particular group increased from 18.4 percent in 1994 to 38.1 percent in 2008.

Table 6.2 HIV Prevalence among ANC clients aged 15-24, 1994-2008 in Swaziland

Year	1994	1996	1998	2000	2002	2004	2006	2008
HIV Prevalence (%)	18.4	29.8	32.9	35.4	39.4	39.4	34.6	38.1

Source: 11th HIV Sentinel Surveillance 2008

The percentage of people who received ART in 2009 (Table 6.1) and the percentage of HIV positive pregnant women who received ARVs (Table 6.3) show room for

improvement. The target is for all who need ARVs to receive them.

Table 6.3 Percentage of HIV positive pregnant women who received ARVs to reduce the risk of MTCT 2007 - 2009

Indicator	2007	2008	2009
Estimated number of pregnant women	40,000	40,000	36,882
No of women needing PMTCT	13,278	13,113	11,913
Number of women receiving PMTCT	8,542	8,469	8,182
Percentage of HIV positive pregnant women who received ARVs to reduce the risk of MTCT	64%	65%	69%

Source: HMIS

Indicator 6.2 Condom use at last high-risk sex (15-24)

Condom use at last high-risk sex is the percentage of young men and women aged 15 to 24 reporting the use of a condom during sexual intercourse with a non-cohabiting, non-marital sexual partner in the last 12 months. Data from the 2007 SDHS, showed that a higher percentage of men (91.9 percent) in the 15 to 24 age group engaged in high-risk sex in the last twelve months compared to 68.5 percent of their women counterparts, and 70.4 percent of men used a condom compared with 54.2 percent of women. Overall, condom use at last high-risk sex for the 15 to 24 age group was 61.3 percent.

Indicator 6.3 Proportion of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS

The percentage of population aged 15 to 24 with comprehensive correct knowledge of HIV/AIDS is the percentage of young persons aged 15 to 24 who correctly identify the two major ways of preventing the sexual transmission of HIV (i.e. through using condoms and limiting sexual partners to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. The results of the 2007 SDHS indicate that 52.2 percent of the age group 15 to 24 correctly identified methods of preventing HIV transmission and were able to reject the major misconceptions.

Indicator 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10 - 14 years

The ratio of the current school attendance of orphans to school attendance of non-orphans aged 10 to 14 years is defined as the ratio of the current school attendance rate of children aged 10 to 14, whose biological parents have both died, to the current school attendance rate of children aged 10 to 14, with both parents still alive and who currently live with at least one biological parent.

The SDHS (2007) found that there was a minor difference in school attendance according to survivorship of parents and reported that 90 percent of orphans (94.7 percent male and 85.6 percent female), compared to 92.7 percent of children whose parents were both alive, were in school. The available data indicates a ratio of 0.97 in 2007.

In addition, the 2007 SDHS found that, in general, OVCs were not disadvantaged in terms of access to and attendance in schools in comparison to other children. In fact, the survey found that there were more OVC in class at an OVC to non-OVC ratio of 1.01, as 92.2 percent of OVC and 91.6 percent non-OVC were attending school.

In 2002, the Government initiated the Orphaned and Vulnerable Children Fund. The fund has increased tremendously since its inception, from E16 million to E130 million in year 2008/09 and has benefited over 100,000 OVCs. Some 111,878 children benefited from the fund in 2008 (UNGASS, 2010). It is expected that enrolments will be further enhanced by the free primary education programme that began in January 2010.

Target 6.B Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

Indicators

6.1 Proportion of population with advanced HIV infection with access to antiretroviral drugs

Status at a Glance



Will target be met		Likely
State of supporting environment		Strong

Table 6.4 Status in figures

Indicator	2007	2009
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	51.6	84.5

Source: Ministry of Health Monitoring and Evaluation Report December 2009

The proportion of adults and children with advanced HIV infection receiving antiretroviral therapy is the percentage of adults and children with advanced HIV infection currently receiving antiretroviral therapy according to nationally approved treatment protocols among the estimated number of people with advanced HIV infection. The situation is as presented in Table 6.4 above. Both the figures take into account the eligibility

criterion of a CD4 count of 200. However, in November 2009 this was revised to a CD4 count of 350. The impact of the revised criterion will increase the number of people in need of ART. Furthermore, the new criterion will help in putting those infected into drugs earlier than before.

Target 6.C Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases

MALARIA

It is estimated that 30 percent of the population is at risk of malaria infection. Malaria is more prevalent in the Lubombo region, where more than 50 percent of cases occur. The disease is seasonal and unstable, and closely related to the level of rainfall, which varies

considerably from year to year. The unstable and highly seasonal nature of malaria transmission shows that acquired immunity to malaria to populations at risk is negligible and all age groups are at risk of contracting the disease.

Indicators

6.1 Incidences and death rates associated with malaria

6.2 Proportion of children under 5 sleeping under insecticide-treated bed nets

6.3 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs

Status at a glance



Will target be met	 Achieved
State of supporting environment	 Strong

Table 6.5 Status in Figures

Indicator	2001	2002	2003	2004	2005	2006	2007	2008
Deaths associated with malaria	62	46	30	28	17	27	14	5
Laboratory Confirmed cases of malaria	670	342	574	279	155	78	83	73

Source: SNMCP

Indicator 6.1 Incidences and death rates associated with malaria

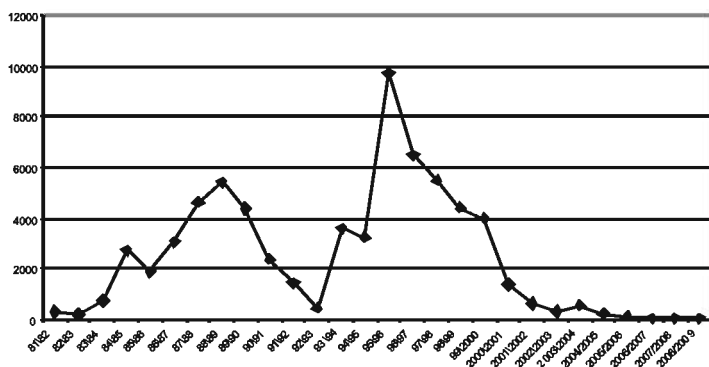
Table 6.5 shows total deaths associated with malaria in the country in the period 2001 to 2008. Deaths associated with malaria decreased from 62 in 2001 to 5 in 2008.

The confirmed laboratory malaria cases (Figure 6.1)

show a downward trend from 9700 cases in 1995 to 73 in 2008. The downward trend can be explained by political commitment to control malaria, as evidenced by the more than 55 percent contribution to the recurrent and capital expenditure on malaria control (Malaria Elimination Strategy, 2008). The country also benefited from the Lubombo Spatial Development Initiative project and the Global Fund.

Figure 6.1

Laboratory Confirmed Malaria Cases by year
1981 - 2009



Source: SNMCP Annual Report 2010

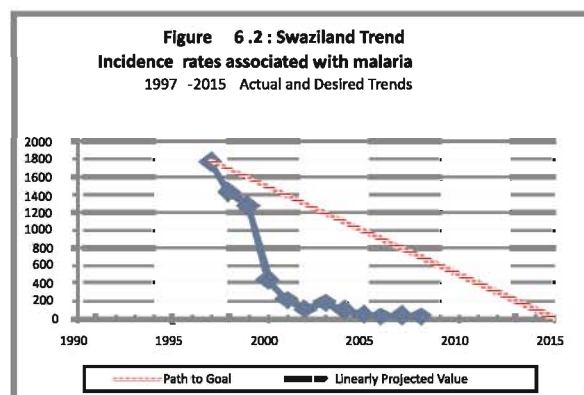


Figure 6.2 shows the number of incidences associated with malaria per 100 000 people. This figure was derived based on the average growth rates of the population census of 1997 and 2007 and taking into consideration that a third of the population is at risk of contracting malaria.

Indicator 6.2 Proportion of children under five sleeping under insecticide-treated bed nets

The proportion of children under five sleeping under insecticide-treated bed nets is the percentage of children under five years of age in malaria endemic areas who slept under an insecticide-treated net (ITN) the previous night, ITN being defined as a mosquito net that has been treated within 12 months or is a long-lasting insecticidal net (LLIN).

Countrywide, only 0.7 percent of children under the age of five had slept under any net in the day before the 2007 SDHS and 0.6 percent slept under an ITN. It is critical to mention that the 2007 SDHS field work did not occur during the period of high malaria transmission and therefore the results need to be taken with caution for they do not represent the situation in all periods.

The backbone of the country’s malaria control strategy is based on selective residual spraying of dwelling houses. According to the annual report of the 2008

National Malaria Programme, the proportion of the population in targeted areas protected by Indoor Residual Spraying (IRS), or sleeping in sprayed structures, was 97 percent.

The IRS is complemented by the distribution of LLIN. The distribution of LLIN targets pregnant women and children under the age of five. The distribution is done at antenatal clinics (ANCs) and during immunisation services for pregnant women and children under 5 in health facilities. The 2007 SDHS found that only 6.1 percent of households countrywide had at least one ITN, and 1.7 percent of households had more than one treated net.



Indicator 6.3 Proportion of children under five with fever who are treated with appropriate anti-malarial drugs

The proportion of children under age five with fever who are treated with appropriate anti-malarial drugs is the percentage of children aged 0 to 59 months with fever in the two weeks prior to the survey who received any anti-malarial medicine within 24 hours of the onset of symptoms. According to the 2007 SDHS, only 0.6 percent of the children under-five who had fever were treated with appropriate anti-malaria drugs.

MALARIA BEST PRACTICE

Malaria has been halted in the country and its impact reversed. Below is an analysis of this success story as a best practice for the Africa region.

1. Government made a commitment to have malaria controlled and followed this up with allocation of financial resources to fight the disease.
2. Heads of State for Swaziland, Mozambique and South Africa signed a protocol to deal with malaria and to work in collaboration across borders.
3. Political stability in Swaziland, Mozambique and South Africa created a conducive environment for economic development, which reduced movement of people across borders, helping further curb transmission of the disease.
4. Government developed a strategy to deal with malaria and coordinated the activities of development partners so that they all followed the strategy, with Government as the team leader.
5. The malaria team gained good experience from global malaria and regional meetings. The malaria team also worked with the global Malaria Elimination Group.
6. Well trained staff, typically of 15 to 20 years' experience, was retained for the malaria programme.
7. The team had strong management and resource mobilisation skills that allowed them to raise required resources.
8. The use of technology in the malaria programme contributed to its success. Geographical Information Systems helped map both priority intervention and success areas.

TUBERCULOSIS

Indicators

6.1 Incidence, prevalence and death rates associated with tuberculosis

6.2 Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Status at a Glance



Will target be met	 Potentially
State of supporting environment	 Strong

Table 6.6 Incidence, prevalence and death rates associated with Tuberculosis 1990 and Period 2000-2007 (per 100 000 population)

Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007
Incidence of Tuberculosis	267	801	916	994	1075	1127	1141	1169	1198
Prevalence of Tuberculosis	629	740	832	693	739	776	788	801	812
Mortality of Tuberculosis excluding HIV	-	45	50	36	38	40	40	41	40
Mortality of Tuberculosis including HIV	-	317	365	201	202	237	268	282	277
Total mortality from Tuberculosis	79	362	415	237	240	277	308	323	317

Source: WHO Global Tuberculosis Control 2009

Indicator 6.1 Incidence, prevalence and death rates associated with tuberculosis

This indicator refers to the estimated number of deaths due to tuberculosis (TB) in a given time period. The indicator reflects the number of deaths per 100,000 population per year. Deaths from all forms of TB are included; however, deaths in HIV-positive people with TB as a contributory cause are not.

The estimated incidence of TB has risen from 1990 levels of 267 to an estimated 1198 cases per 100,000 populations in 2007. Incidences of tuberculosis are on the increase as can be seen on Table 6.6. There is need for more awareness creation so that when people

recognize the symptoms of TB, they will be inclined to visit a health facility. While this may increase the incidence of TB, timely detection will help to reduce deaths.

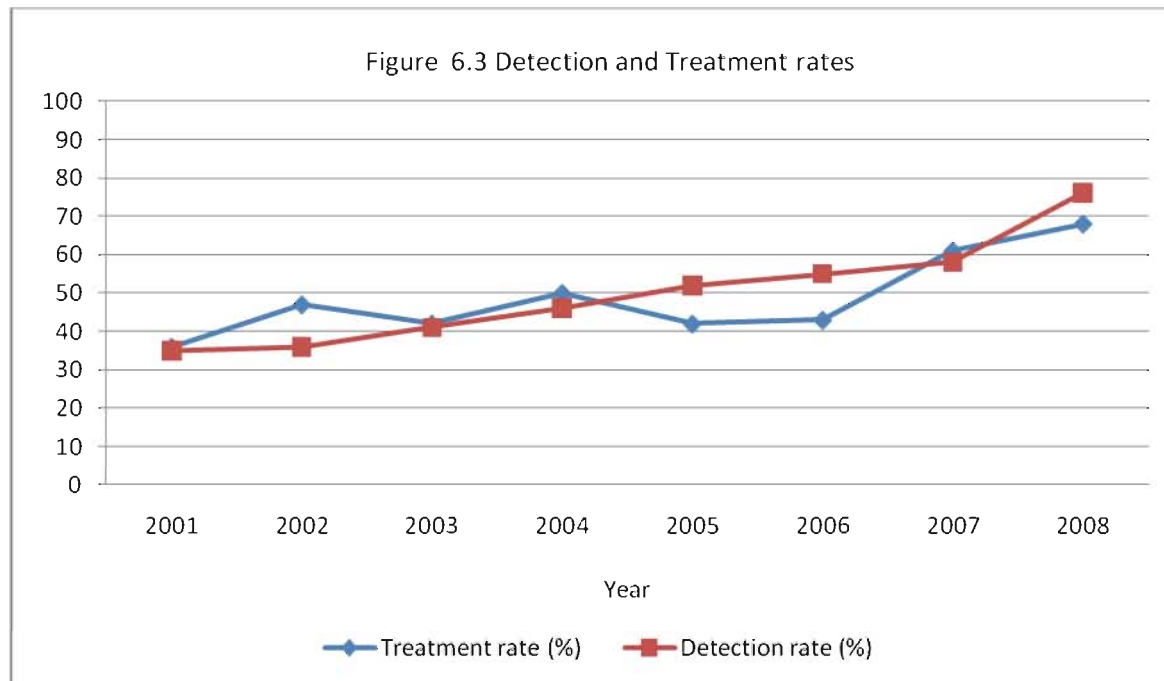
TB prevalence in the country rose markedly, from 629 in 1990 to 812 per 100,000 population in 2007. The impact of HIV/AIDS on TB cannot be underrated.

Mortality due to TB rose from 45 in 2000 to 50 in 2001, then fell to 36 per 100,000 population in 2002. Mortality due to TB then stabilised at around 40 in the period from 2004 to 2007.

Indicator 6.2 Proportion of tuberculosis cases detected and cured under directly observed treatment short course

(DOTS) - called the tuberculosis detection rate - is the percentage of estimated new infectious tuberculosis cases detected under the directly observed treatment, short course case detection and treatment strategy.

The proportion of tuberculosis cases detected and cured under directly observed treatment short course



Source: WHO Global Tuberculosis Control 2009, NTCP Annual Report 2009

The DOTS new smear positive case detection rate and DOTS new smear positive treatment success rate for the period 2001-2008 are as presented in Figure 6.3 above.

According to the 2010 National Tuberculosis Control Programme (NTCP) Annual Report, there were 11,032 cases reported, constituting 9,558 new cases and 1,474 retreatment cases. This reflects a 14 percent increase from the 9,656 cases notified in 2008. Case detection rate stands at 76 percent. The treatment success rate currently stands at 68 percent. Data from the NTCP showed that 84 percent of TB cases in 2009 were also HIV positive. Due to this, the implementation of collaborative TB/HIV activities has been scaled up with more than 95 percent of detected TB cases tested for HIV.

The advent of Multiple Drug Resistant Tuberculosis

(MDR-TB) and Extensively Drug Resistant Tuberculosis (XDR-TB) has further compounded the situation. According to the 2009 NTCP Annual Report, a total of 317 cases of MDR-TB were registered between years 2006 to 2009. Given the emergence of MDR and XDR-TB cases, the country's capacity to contain and curb the spread of this disease needs to be further strengthened.

The current TB situation in the country points to an epidemic that is spiralling out of control. The situation has assumed a dimension that warrants emergency action, and efforts are underway to declare TB a national emergency. It is estimated that 17,000 deaths could occur between 2010 and 2015 if current trends continue, and it is the most productive age group that is disproportionately affected by the epidemic with potentially severe socioeconomic consequences (NTCP TB Emergency Concept Paper, 2010). At the same time,

HIV continues to fuel the TB epidemic in the face of compromised immune status, confronting the country with a dual TB/HIV epidemic.

The current situation suggests this MDG is not likely to be achieved by 2015, however accelerated progress will be made by the declaration of TB as an emergency.

Inequality analysis

- HIV/AIDS and TB prevalence is almost the same in the four regions of the country. Malaria affects the Lubombo region much more than the other regions.
- There are disparities in the distribution of health facilities in the country because the 8 km radius does not take into account population density and topography.
- Rural households are more likely to have nets than urban households. Almost a fifth (18 percent) of households in the Lubombo region, where malaria is prevalent, had some type of net, and 13 percent had an insecticide-treated net.

Supportive environment

- The existence of national frameworks that guide the response to HIV/AIDS, TB and malaria.
- The life skills programmes in all schools are important in helping to combat HIV/AIDS among the youth.
- The presence of condoms on the premises of many institutions helps in the fight against HIV/AIDS.
- Government commitment and good team leadership in dealing with malaria were conducive to success.
- The OVC programme has mitigated the negative impact of HIV/AIDS on children.

Key bottlenecks constraining progress and how to address them

- Lack of a National HIV/AIDS policy in the work place: There is no National HIV/AIDS Policy to provide a framework upon which employers can develop their own policies and HIV/AIDS programme management plans. Government has initiated the process of

developing this policy.

- Drug Resistance: The emergence of Multiple Drug Resistant Tuberculosis and Extensively Drug Resistant Tuberculosis has compounded the situation, requiring more research and new approaches.
- Lack of Coordination: Many partners are dealing with HIV/AIDS in the country, but seem to be poorly coordinated. This leads to duplications that could be avoided. Government is strengthening leadership in this area.
- Workshops and meetings: The many workshops and meetings that health personnel attend can reduce the time they are available to serve patients. While workshops and meetings are important, teams must be selective about attending only those that deliver germane information.

New challenges with unanticipated consequences

- The global economic and financial crisis has had an impact on people in Swaziland as in many other countries. With the resultant job losses, some people have resorted to certain survival mechanisms that are leading to new HIV infections.
- The TB Programme Team is currently overwhelmed by new incidences of TB with strong resistance. Government needs assistance to increase support to this programme.

How Swaziland will accelerate progress in this MDG

- Tuberculosis has to be declared an emergency because of its contagious nature, and the campaign on finishing the protocol of TB drugs must be strengthened.
- Coordination of HIV/AIDS interventions needs to be strengthened.
- The country needs to effectively implement the HIV/AIDS National Strategy.

MDG 7 : ENSURE ENVIRONMENTAL SUSTAINABILITY





MDG 7 : ENSURE ENVIRONMENTAL SUSTAINABILITY

Target 7.A Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicators

- 7.1 Proportion of land area covered by forest
- 7.2 Carbon dioxide emissions, total, per capita and per \$1 GDP
- 7.3 Ratio of area protected to maintain biological diversity to surface area
- 7.4 Energy use (kg oil equivalent) per \$1 GDP
- 7.5 Proportion of population using solid fuels

Status at a glance

Will target be met	 Potentially
State of supporting environment	 Good



Status and trends

Indicator 7.1 Proportion of land area covered by forest

The proportion of land covered by forest refers to the forest area as a share of total land area. Land covered by forest in Swaziland includes indigenous/natural forest and the commercial timber plantations.

The country's forest and flora resources accounted for an average coverage of 36 percent in 1990 and 45 percent in 1999, according to Forest Resource Assessment (1999). The forest cover included three

types, namely indigenous, wattle forest and plantations, as shown in Table 7.1. Forest coverage figures from 2000 to 2010, obtained through linear extrapolation, show that the land covered by forest is increasing steadily (see Figure 7.1). The proportion of forest coverage indicates that areas for forest plantation, flora growing and other invasive (but useful) plants, such as *Dycrostachis cineri*, are increasing.

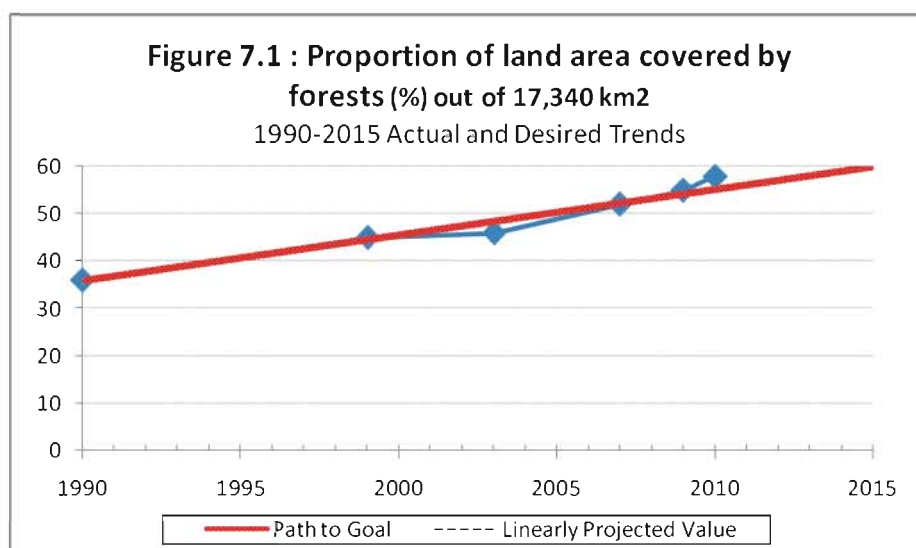
Table 7.1 Total forest cover in 1999

Type of Forest	FPLP (ha) 1999	SGFP (ha) 1990	Percent of total land area	Percent of total forest area
Indigenous	651,771	463,499	37.5	82.7
Wattle Forests	26,440	25,439	1.5	3.4
Plantations	110,222	135,034	6.3	14.0
Totals	788,434	623,972	45.42	100
Total land area	1,736,000 ha	-	-	-

Source: Forest Resource Assessment 1999.

The 1999 Forest Resource Assessment indicated that the total forested area has increased since 1990. The apparent increase, however, might be a result of the differences in mapping detail resulting from the processes used, as the detail level of the 1999 survey was greater.

It should also be noted that developments in the country, including agricultural development, sugar cane production at LUSIP and KDDP, and the presence of invasive alien plants are contributing to a decline in the land covered by forestry and need to be addressed.



Source: Global Forest Resources Assessment 2010

In the face of this increasing commercial timber plantation coverage, the country experienced its worst wildfire disasters in 2007 and 2008. The fires devastated about 40,000 hectares of the timber plantations, resulting in severe damage to the standing trees and the natural environment. Jobs and incomes were lost for families earning a living from forestry resources. As a long-term mitigation plan, the country has developed a National Multi-Sectoral Bushfire Contingency Plan. The plan recognises the importance of cross-border collaboration and provides network collaboration with the country's neighbouring states. Forest cover has contributed to economic development, food security, poverty alleviation, creation of employment opportunities, income generation, water, health, conservation of natural resources and cultural heritage, and helped fight land degradation to sustain socioeconomic livelihoods.

Indicator 7.2 Carbon dioxide emissions, total, per capita and per \$1 GDP

There are three parts of the definition for this indicator. The first is most applicable to Swaziland. Total carbon dioxide emissions are estimates of total carbon dioxide (CO₂) emissions, including anthropogenic emissions, less removal by sinks, of carbon dioxide (CO₂). The term 'total' implies that emissions from all national activities are considered.

Over the past century, concern over climate change has

evolved, resulting in a global convention in the form of the United Nations Framework Convention on Climate Change (UNFCCC) and its Kyoto Protocol. Swaziland signed an accord of commitment to submit carbon dioxide emissions to the UNFCCC. Furthermore, an International Panel on Climate Change (IPCC) was formulated to assess studies that have been conducted on climate change. The assessment made by the IPCC reveals that climate change is indeed a reality.

According to the meteorological department, hydro fluorocarbons (HFCs) are the most important greenhouse gases (GHG) contributing to climate change in Swaziland. HFCs are produced in industrial processes and contribute about 45.8 percent to carbon dioxide (CO₂) emissions. At 33.7 percent, N₂O is the second most prevalent source of carbon emissions. It is produced by waste disposals through combustion/burning. Agriculture through fertilisers contributes about 8.2 percent, while land use contributes about 5.6 percent to carbon dioxide emissions in the country. High GHG emissions do not cause climate change directly but add to global warming, which eventually results in climate change.

In 1994, CO₂ emissions were at 6,330,000 metric tons, and in 2000 increased to 19,763,140 metric tons (Table 7.2 and Figure 7.2). This enormous increase was attributed to a change in the methodologies for calculating the CO₂ emissions. Data collection for CO₂ emissions take time to process and analyse, and require good capacity to do so.

Table 7.2 GHG emissions by SECTOR (metric tons CO₂ equivalent)

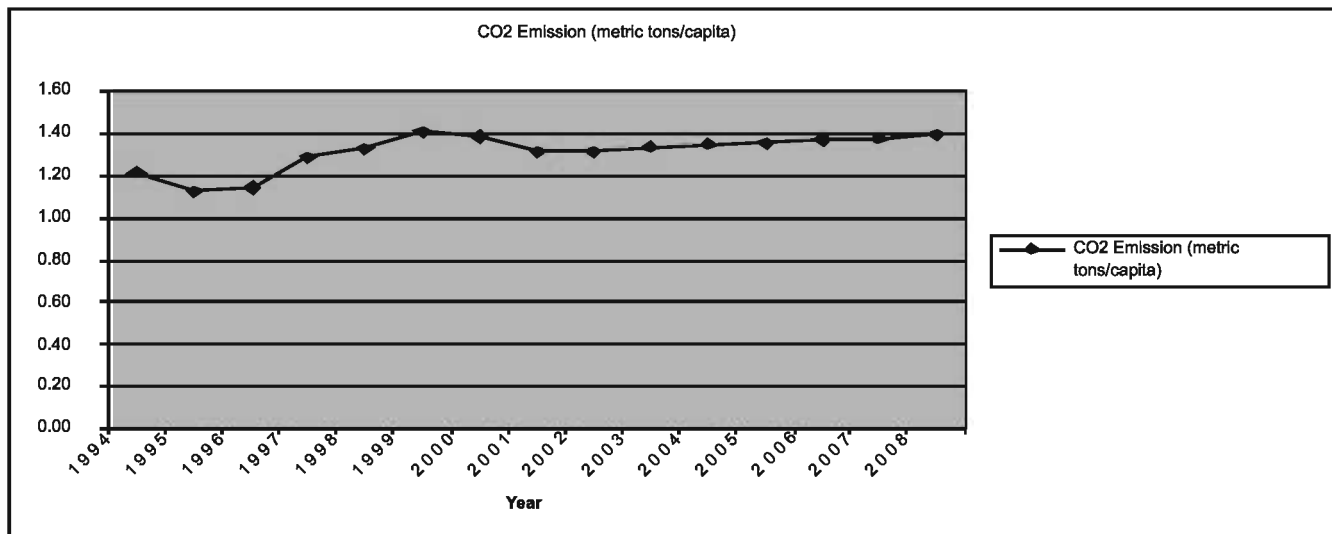
Year	Energy	Industrial Processes	Agriculture	Land Use and Forestry	Waste	Total CO ₂ Emission estimates
1994	1,055,950	3,194,100	1,233,490	346,480	499,980	6,330,000
2000	1,333,800	9,063,500	1,602,910	1,105,130	6,657,800	19,763,140

Source: Meteorological Department

Other contributing factors to total CO₂ emissions include deforestation caused by consumer demand for

fuel wood, house construction, kraal construction, fence construction and craft.

Figure 7.2: CO₂ Emissions by the Energy Sector from 1994 to 2008



Source: Meteorological Department

The country does not have a national adaptation plan for managing its carbon emissions. Having an adaptation strategy is of higher priority, but the preparation of a mitigation plan is also essential. The goal, therefore, is to have a mitigation strategy in place within the next four to five years. This will take the format of nationally appropriate mitigation actions, which are currently being proposed in the UNFCCC negotiations.

On the other hand, Swaziland is part of the Stockholm Convention, which was adopted in May 2001 and came into force in May 2004. The objective of the Convention is to protect human health and the environment from persistent organic pollutants (POPs). The country is committed to implementing the Institutional Arrangement Framework and Policy for the Stockholm Convention on POPs. As part of the implementation of the Stockholm Convention, the country has generated quality inventories to assess the presence of various POPs. The country has also set out an implementation plan to address POPs. The plan is intended to reduce emissions from the burning of waste, and to establish a monitoring system for emissions and their effects on human health and the environment.

Indicator 7.3 Ratio of area protected to maintain biological diversity to surface area

The country has a rich diversity of natural forests and woodlands, comprising up to 36 percent of the country's landscape as of 1990. This rich diversity contains plant species endemic to Southern Africa that are of greatest socioeconomic, medical, cultural and aesthetic importance to the region. In support of the International Convention and National Forest and Environmental Policy, the government is developing and implementing programmes to conserve plant biodiversity in liaison with stakeholders.

According to the Swaziland National Trust Commission (SNTC), the area under protection (biodiversity conservation) is increasing steadily. In 2000, the proportion of coverage was 3.7 percent.. In 2009, this improved to 4.5 percent of legally proclaimed conservation area. If other areas are included that have not been legally proclaimed, but have also been protected for various reasons, this proportion increases to about 11.3 percent.

Despite these efforts, two recently produced red data lists indicate that large numbers of plants and

vertebrates are threatened. The decline in biological diversity is caused by loss of habitat, over-exploitation and the presence of invasive alien species. Habitat destruction is also the result of industrial forestry and large-scale irrigated agricultural expansion. It is expected that in the long term, climate change and desertification will have a further negative impact on biodiversity.

According to the Swaziland Country Environmental Profile (2006), ecosystem biodiversity is threatened by lack of protection and land conversions, which are projected to halve the area of potential protection-worthy ecosystems.

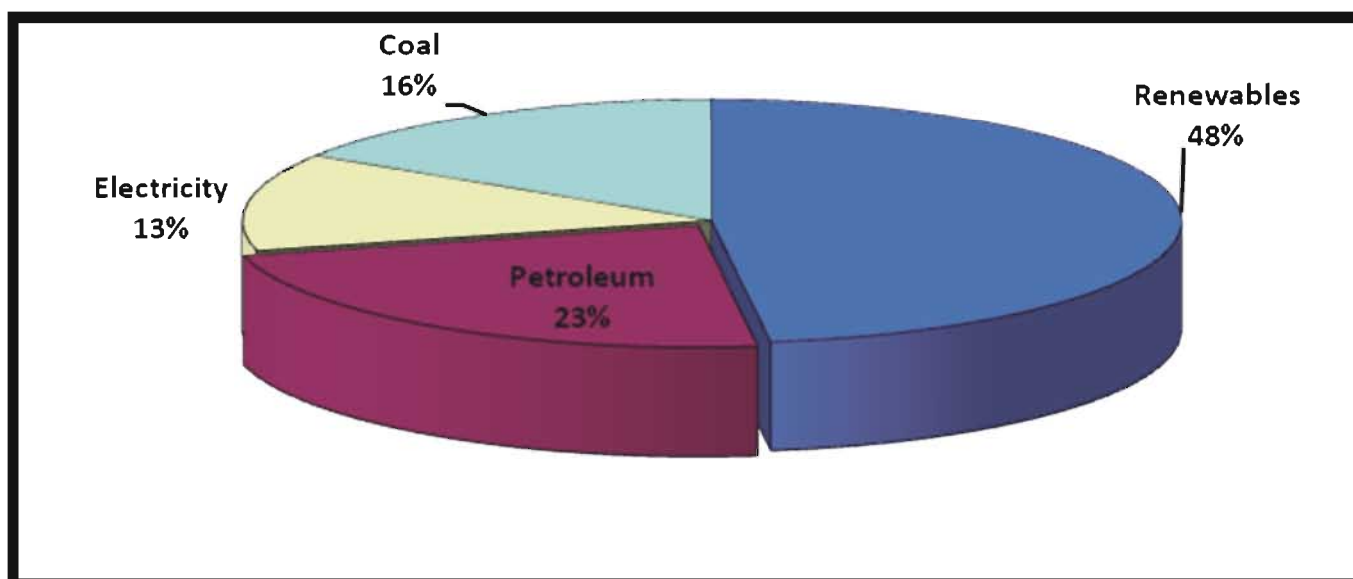
In addition, the country is projected to see the introduction of a very dry tropical forest type of ecosystem in the eastern part of the country, replacing half of the current subtropical ecosystem as a result of climate change.

The areas protected to maintain biological diversity, therefore, will contract unless deliberate efforts are undertaken to shelter and expand them.

Indicator 7.4 Energy use (kg oil equivalent) per \$1 GDP

Energy use in Swaziland is presented in Figure 7.3

Figure 7.3 Energy Use in Swaziland



Source: MNRE. National Energy Policy Implementation Strategy (2009), Energy Department

Swaziland's renewable energy use and potential is critical and accounts for 48 percent of the National Energy Policy Implementation Strategy. Petroleum, coal and electricity contribute 23, 16 and 13 percent respectively, as illustrated in Figure 7.3. Bagasse from the sugar processing industry and wood waste from industrial timber processing are by far the most important sources of renewable biomass energy.

Hydro-electricity is used mostly with an emerging wind sector in potentially suitable sites. Further cogeneration

using bagasse is being planned for RSSC and ILLOVO.

According to the Swaziland Country Environmental Profile (2006), wood fuel is used for energy in rural areas, but demand is estimated to be outstripping supply and leading to deforestation. The national strategy for rectifying this situation is to use energy efficiently, establish community woodlots, and encourage conversion to commercial fuels.

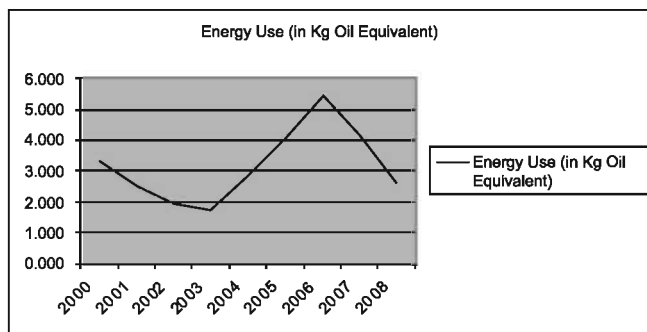
Rural electrification is taking place at a steady rate,

focusing on supplying clinics, schools, and community centres to improve community access. However, high connection and tariff costs mean that few rural households are linked.

A rise in the number of affordable imported cars has also increased the country's energy use. This is evident in the rising consumption figures for unleaded petrol (ULP) and diesel. Energy statistics reveal that between 2000 and 2008, the 1997 LRP decreased by 86.9 percent, ULP increased by 90.8 percent, diesel

increased by 11.0 percent and paraffin decreased by 56.1 percent. Consumption of real energy volumes reached a peak in 2006. This was attributed to lower oil prices between 2005 and 2006, spurring higher demand for fuel energy and imported cars during this period. Real volumes of energy consumption started to come down from mid-2006. However, 2008 onward was unique as the global economic and financial crisis began to affect real fuel demand as shown in Figure 7.4 below:

Figure 7.4 Energy Use (in Kg Oil Equivalent) between 2000 and 2010



Source: Energy Department



The country has started to look at bio-fuels as a supplementary fuel source. Ethanol derived from by-products from sugarcane processing is a potential source for blending petrol.

Indicator 7.5 Proportion of population using solid fuels

The proportion of the population using solid fuels is the percentage of the population that uses solid fuels (fire wood, coal and others).

There has been an increase in the use of solid fuel for warming households and for industrial purposes over the last decade. The country will soon be implementing a project aimed at promoting the use of wood-saving stoves for household purposes.

Traditional solid fuel consumption in the country increases in winter. There is a need to ensure that there are other cheaper energy sources people can use for reducing solid fuel consumption. At present the situation is not too bad because of the programmes being implemented to increase the forest coverage in the country.

The country has produced a forestry bill to address, among other issues, the cutting of trees for selling wood. Community awareness campaigns aim to further reduce tree cutting for this purpose. It is anticipated that this will significantly diminish the use of solid fuel for heating purposes in households.



Target 7. C Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Indicators

7.1 Proportion of population using an improved drinking water source

7.2 Proportion of the population using an improved sanitation facility

Status at a glance

Will target be met	 Potentially
State of supporting environment	 Strong

Status and trends

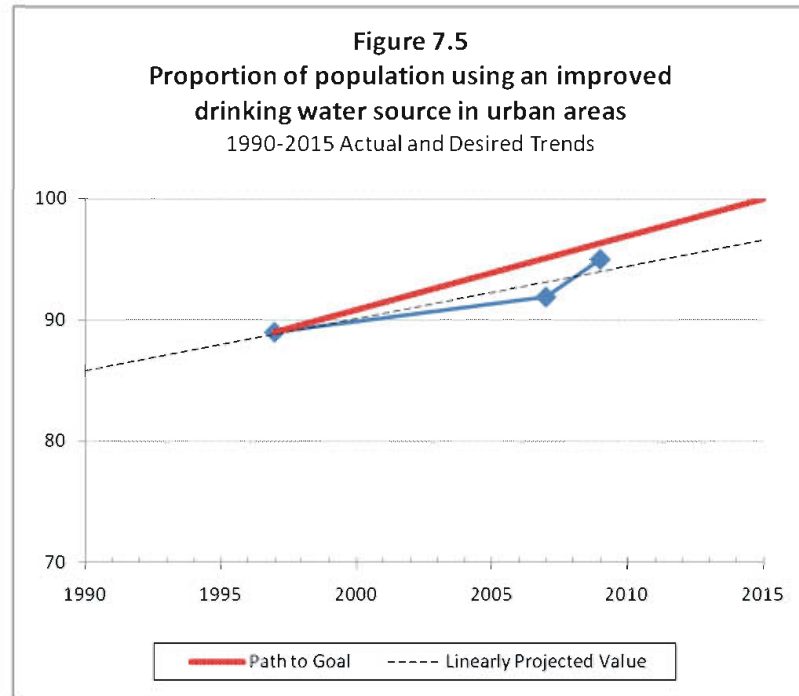
Indicator 7.6 Proportion of population using an improved drinking water source

The proportion of the population using an improved drinking water source is the percentage of the population that use a potable water supply. It does not include unprotected wells, springs, water provided by carts, or bottled water.

Housing conditions vary greatly in rural and urban areas. More than two-thirds of households have access to improved water sources, and three in four households are within 15 minutes of their drinking water supply. About 73 percent of urban households have water piped into their dwellings or yards, while about 23 percent of rural households have direct piped

water. Rural households also rely on public taps, surface water and dug-protected wells for their drinking water. The situation in Swaziland for urban and rural areas is shown in Figures 7.5 and 7.6.

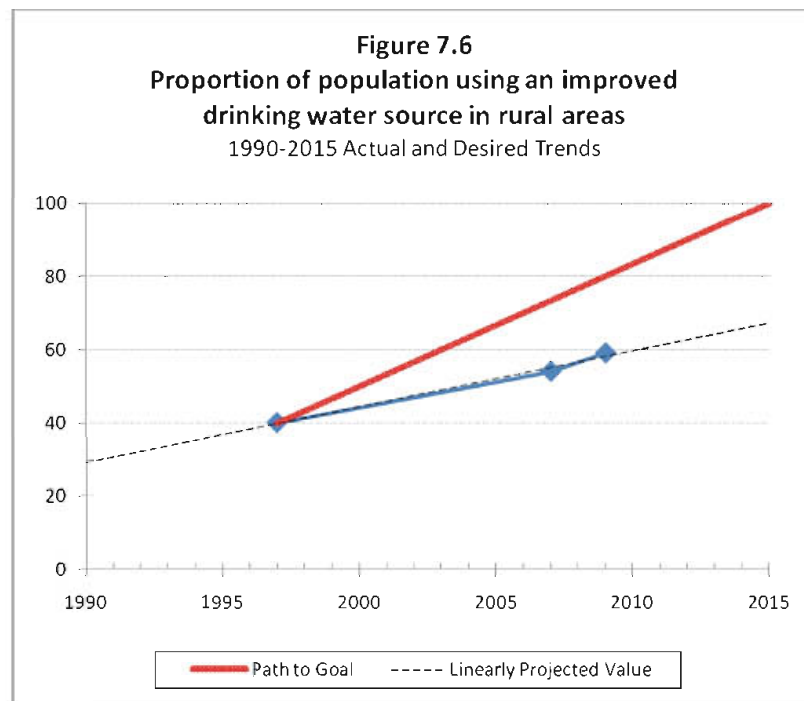
The SDHS (2007) also shows that in urban areas alone, sustainable access to improved water sources increased slightly from 89 percent in 1997 to 91.9 percent in 2007. The latest study by the Swaziland Water Services Corporations (SWSC) reveals that access to improved water stands at 95 percent in 2009, as shown in Figure 7.5.



Source: SDHS 2007, SWSC 2009

On the other hand, the SDHS indicates that sustainable access to safe drinking water in rural areas has been improving since 1997 from 40 percent, to 54 percent in 2007 and 59 percent in 2009 (Figure 7.6). Based on current commitment, it is anticipated that potable water supplies in rural areas will increase to 61 percent by year-end 2010, through the installation of 60 micro

(hand) pumps and the completion of three macro schemes. Projections are that by 2013, rural water supply will increase to 72.8 percent. These figures assume that all previously installed water pumps and boreholes are still working, which may not be the case; as such, they should be taken with caution until verifiable data becomes available.



Source: SDHS 2007, SWSC 2009

Water quality is monitored by the Water Resource Branch under the Ministry of Natural Resources and Energy in industrial and rural areas. These powers are soon to be devolved to River Basin Authorities under the Water Pollution Control Regulations of 2010; Swaziland Water Services Corporation in urban areas and Geological Survey for ground water/boreholes.

Groundwater quality in Swaziland is mostly suitable for domestic use, except in the Lowveld where occurrences of high salinity have been observed. However, contamination of groundwater sources is a potential threat to the future value of these resources. The most likely forms of contamination include bacteria, viruses, hydrocarbons, pesticides and nitrogen.

The availability of water, therefore, needs to take into account issues of quality, It is hoped that these issues will be included in the next surveys.

Based on the current situation, the outlook is favourable for this MDG target to be met.

Indicator 7.7 Proportion of the population using an improved sanitation facility

The proportion of the population using an improved sanitation facility is the percentage of the population with access to facilities that hygienically separate human excreta from human contact.

On average, more than 50 percent of households have an improved toilet facility, according to SDHS (2007). The SDHS (2007) shows that in the urban areas, including the peri-urban areas, access to improved sanitation stands at 55.6 percent and has not been improving significantly. On the other hand, access to sanitation in rural areas has improved significantly to 56.7 percent from 45 percent in 2005. The Ministry of Health in collaboration with relevant stakeholders has more than doubled the construction rate of VIP latrines from 2000 to 2009.

According to the Swaziland Country Environmental Profile (2006), production of solid waste is increasing, but Swaziland lacks adequate capacity and infrastructure to efficiently deal with waste management. A policy and legal framework were developed in 2005. Statistical data on waste generation and service are incomplete because not all urban areas are serviced, and rural information is largely missing. Waste is weighed and licensed landfill records reviewed only sporadically. Reliable data on waste generation is needed to develop realistic and affordable waste-management plans.



As described in the water supply section above, it is assumed that existing sanitation facilities are still in good working condition. In rural areas, some pit latrines last two to three years before needing replacement. This factor needs to be considered when compiling the percentage of households with improved toilet facilities.

Target 1.D By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Indicators

7.1 Population of urban population living in slums

Status at a glance

Will target be met	 Potentially
State of supporting environment	 Good

Status and trends

In the country, there is a preponderance of informal settlements in contrast to slum dwellings. An informal settlement represents unplanned household units (i.e., rented rooms or bed-sitters) in the peri-urban areas. These areas usually lack standard residential structures and infrastructure services. Major informal settlements are found in the peri-urban areas of the country's two cities (Mbabane and Manzini), which together make up about 85 percent of all informal settlements. Boundaries of country towns are small and tend to exclude areas of growing informal settlements, such as the Matsapha industrial town. Towns, as opposed to cities, do not have upgraded programmes, because most of the informal settlements are outside their boundaries.

Because of chronic delays in finalizing the National Land Policy, national programmes aimed at increasing access to secure tenure are moving slowly in the country. Indeed, the policy has remained in a draft form for nine years. It was expected that the finalization of the National Land Policy would eliminate major challenges, such as bias on the basis of place of birth and gender, and affordability to own property. The existence of

informal settlements is mainly a result of these challenges. The situation is further exacerbated by costly private farmlands near towns and cities and the unavailability of Swazi National Land on which to build formal residential townships. Private farmlands tend to be too expensive for the Government to purchase for settlement purposes.

In spite of the many challenges affecting access to secure tenure, there is significant observable progress in major cities. Under the World Bank's urban development upgrading projects in peri-urban areas, there has been a marked increase in the number of plots allocated to households for providing infrastructure services and improving lives. From 2000 to 2009, the volume of informal settlements was reduced 32 percent in both Mbabane and Manzini. During the same period in the capital city of Mbabane, informal settlements decreased at an average of 33 percent. Under the same upgrading project, the Manzini City Council upgraded two informal settlements and allocated plots to the households. Table 7.3 and Figure 7.7 show the trend in informal settlements in Mbabane and Manzini.

Table 7.3 Number of informal settlements in Mbabane and Manzini cities between 2000 and 2009

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Mbabane	12	12	12	9	9	9	8	8	8	8
Manzini	7	7	7	7	7	7	7	7	7	5
Total	19	19	19	16	16	16	15	15	15	13

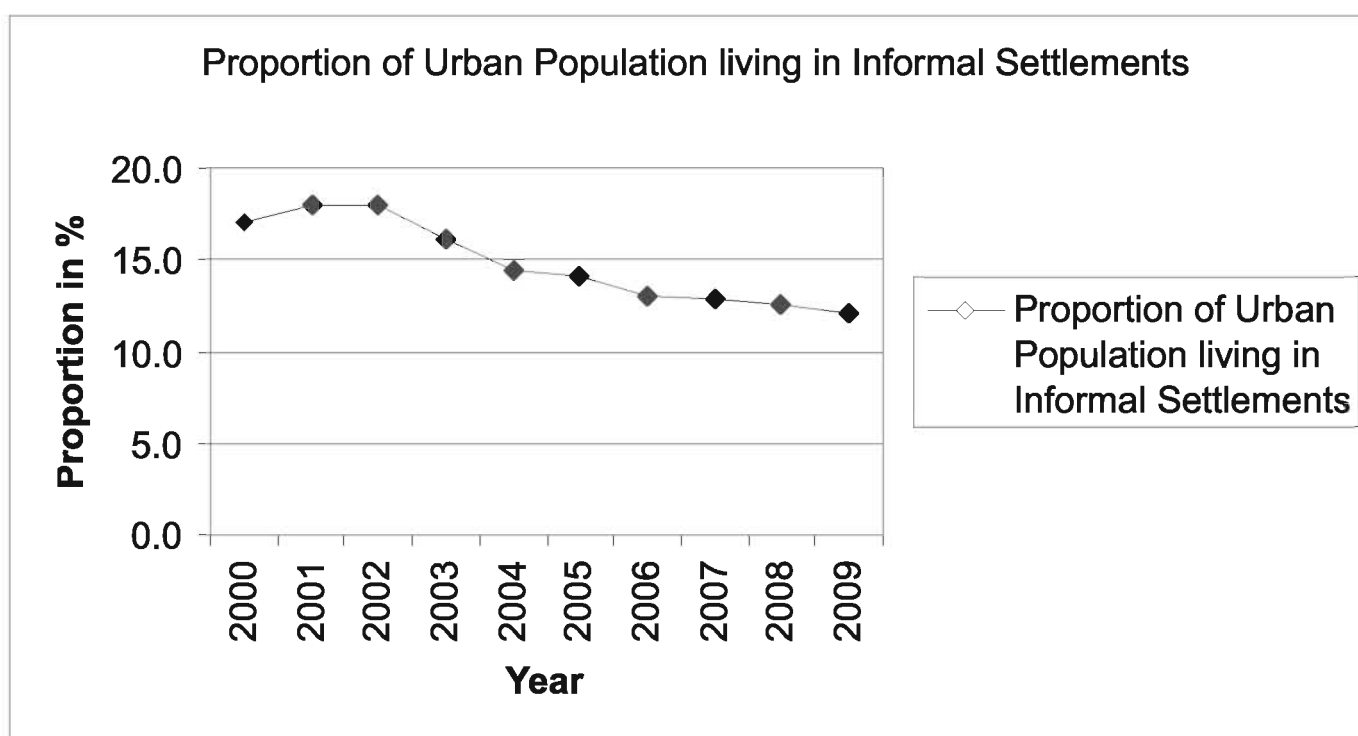
Source: City Councils - Mbabane and Manzini

The allocation of plots significantly reduced the proportion of people in informal settlements from 17.0 percent in 2000 to 12.1 percent in 2009 in the two cities as shown in figure 7.7.

Improvement in informal settlements has focused

primarily on infrastructure, such as the provision of adequate access to roads, storm water drainages, and minimum building standards for people who cannot afford expensive building material.

Figure 7.7: Proportion of urban population living in informal settlements between 2000 and 2009



Source: City Councils - Mbabane and Manzini

Swaziland is moving in the right direction. With more effort and participation by development partners, the country can significantly enhance informal settlements.

Inequality analysis

- As pointed out above, there is commendable progress in terms of forest coverage. The use of solid fuels require more monitoring. The introduction of appropriate technology is admirable and should be encouraged, as it also helps reduce the burden on women of having to look for firewood.
- Access to water is not equitable. The population of the dry region of Lubombo lacks access to potable water, and latrine coverage is low. Efforts are needed to better serve Lubombo in this regard.

Supportive environment

- The Government has signed various protocols and agreements on carbon emissions that can serve as the foundation upon which environmental sustainability can be improved.
- The creation of the Swaziland Water Services Cooperation has helped improve access to safe drinking water for people in urban areas. The government has also established five river basin authorities to manage water at basin level. Capacity is still being developed within these authorities.
- Upgrading programmes for informal settlements in the cities has reduced the number of households in informal settlements.
- Major national policies, legislations and Acts of Parliament aimed at ensuring environmental sustainability include the Environmental

Management Act, Water Act, Swaziland Water Services Corporation Act, Energy Act and Supporting Policies, Housing Act and Fiscal Policies, National Forestry Programme and a Forestry Bill, and the drafting of the Action Plan for the implementation of the Stockholm Convention Persistent Organic Pollutants. There is also a draft National Bio-fuels Strategy and Action Plan in place to explore the potential of bio-fuels.

Key bottlenecks constraining progress and how to address them

- **Capacity of staff:** The government needs to build capacity in the area of sustainable environment, especially the monitoring of carbon emissions. Although emissions are minor from small countries many of which on balance contribute more to refreshing the atmosphere than to spoiling it there is still a need to limit carbon emissions to manageable levels. In addition, the lack of capacity to manage indigenous forests has led to uncontrolled extraction of forest products, such as timber, fruits, edible plants, fuel wood, wood for utensils and craft, and medicinal plants. In rural areas, more than 75 percent of homesteads use firewood for cooking and heating.
- **Deforestation:** Current deforestation and degradation of the natural forest and woodland areas are caused by a complex variety of factors, including population growth, pressure on land, land conversions, growing poverty, inequities in land tenure and access rights. These issues need to be examined if the forest areas are to be protected.
- **Resources:** Lack of financial and technical resources must be examined, and solutions found to ensure availability.
- **Land policy:** The land policy needs to be finalized immediately to ensure success of this MDG.
- **Impact of the global financial and economic crisis:** The impact of the global and financial crisis contributed to the closure of the country's biggest forestry company, SAPPI, and led to layoffs of staff who helped maintain the forest. Alternative solutions and investors need to be put in place.
- **Forest fires:** The devastating forest fires that occurred in the country in 2007, 2008 and subsequent years have reduced the area covered by commercial forest and have affected the ecology in Swaziland. More

sustainable forest management practices must be established.

- **Lack of understanding:** The urban development upgrading project is commendable in both Mbabane and Manzini. However, Manzini is facing a challenge: each time the city starts upgrading an informal settlement, residents tend to move out for fear of having to pay higher tax rates and build another informal settlement, defeating the purpose of the project. The essential problem is that people do not understand the benefits of upgrading for them. The City Council, therefore, must boost efforts in creating awareness and understanding about the advantages of informal settlement upgrading.

New challenges with unanticipated consequences

- **Climate change** is a global threat to biodiversity and is expected to have a significant impact on ecosystems and ecosystem services in Swaziland.
- **Child-headed households** attributable to HIV/AIDS and other causes require support in gaining access to water, pit latrines and solid fuels.
- **Financial constraints** force people to look to forests and the environment as a source of income. Progress made in these areas must be sustained.

How Swaziland will accelerate progress in this MDG

- The country needs to use the constituency (community) approach in dealing with environmental issues. It is vital, therefore, to strengthen ties between local leaders and the people so that they are able to work together effectively on environmental issues.
- All government departments have to take environment issues seriously, and not just those departments that are officially responsible for such issues.
- More waste management programmes to reduce rising emissions.
- More resources are required in order to achieve this MDG and the Government needs to continue working together with development partners to address critical aspects of Swaziland's environment.



MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT



MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

- Target 8.A** Develop further an open rule-based predictable, non-discriminatory trading and financial system
- Target 8.C** Address the special needs of landlocked and small island developing states
- Target 8.D** Deal comprehensively with the debt problems of developing countries through national and international measures to make debt sustainable in the long term
- Target 8.E** In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries
- Target 8.F** In co-operation with the private sector, make available the benefits of new technologies, especially information and communications

Status at a glance

Will target be met	Potentially 
State of supporting environment	Good 

Indicators

Official Development Assistance - Proportion of total bilateral, sector-allocation ODA of OECD/DAC donors to basic social services

Measuring ODA in the country is a challenge as data is not readily available. The country is only able to capture ODA that is directed to Government and also that which is directed to Parastatals and NGOs through the Government. ODA that is directly channelled to Parastatals and NGOs is not captured and hence not reflected in total ODA figures. The National Aid Policy does not seem to address this challenge as it only calls

for parastatals and NGOs to channel their ODA submissions to Government if they wish to get Government assistance, and only encourages Parastatals and NGOs with independently mobilized ODA to report them to the Government with no binding legal framework. Though this is the case figures from few agencies and NGOs are presented as an indication of the resources that they bring.

Table 8.1: Official Development Assistance to Swaziland 2006 - 2009 (US\$)

Source	2006/7	2007/8	2008/9
European Commission	6,204,253	1,400,000	2,864,000
Republic of China Taiwan	11,466,769	7,076,329	18,480,000
Japan	371,218	602,410	361,446
Sub-total: EU, Japan, Taiwan	18,042,240	9,078,739	21,705,446
UNICEF	6,052,222	7,459,974	7,407,466
UNDP	2,750,000	3,956,000	4,083,000
UNFPA	1,336,500	2,189,589	2,346,143
FAO	2,021,846	4,542,092	4,287,092
WHO	1,982,00	1,799,269	3,450,991
WFP	11,174,857.5	11,183,362.5	9,849,300.00
ILO	280,000	280,000	280,000
UNAIDS	-	218,099	123,127
UNODC	-	193,000	499,000
UN System subtotal	23,895,425.5	31,821,385	32,326,119
TOTAL	41,937,665.5	40,900,125	54,031,565

Source: MEPD (Aid Coordination & Management Section), UN Country Office

Total ODA to Swaziland has been decreasing over the years. In 2000/1, ODA was at an all-time high of US\$45.2 million and has been declining gradually. In 2005/6, it dropped to US\$30.8 million. In 2006/7, ODA increased to over US\$41.6 million, and in 2007/8 it fell slightly to about US\$ 40.9 million. In 2008/9, it bounced back to over US\$54 million, surpassing its 2000/1 record.

In 2009/10, however, ODA is expected to decline, as developed countries feel the impact of the food, fuel and global economic crisis. The general medium-term outlook for ODA is not encouraging. Donor agencies are offering bailout packages to their own economies at the expense of developing economies like Swaziland.

Sector allocable ODA to basic social services

Table 8.2: Sector allocable official development assistance to Swaziland 2006 - 2009 (US\$)

Source	2007/8	2008/9	2009/10
Basic education	8,250,000	-	4,017,470
Primary health care	500,000	2,000,000	-
Safe water and sanitation	8,350,002	-	573,300
Agriculture	213,510	0,864,0	1,973,494
TOTAL	17,313,512	4,864,000	6,564,264

Source: Aid Coordination & Management Section

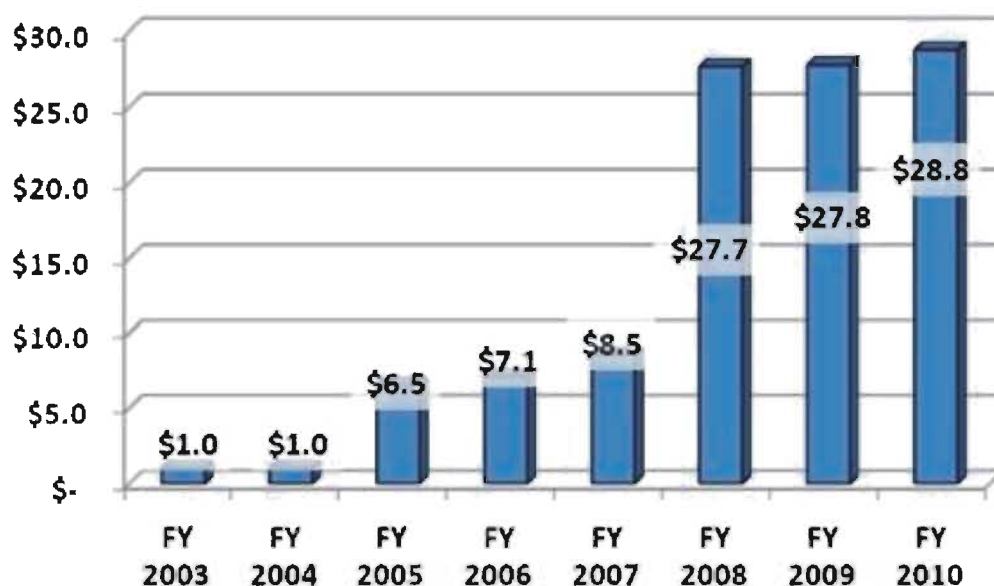
Basic education is comprised of primary education, basic life skills for youth and adults, and early childhood education. ODA support to the education sector between 2007 and 2010 included the funding of the computer programme in public schools and technical support to the Ministry of Education, to mention a few. ODA funds for the education sector decreased by about 50 percent between 2007 and 2009, as shown in Table 8.2.

Primary health care includes basic health care, basic health infrastructure, basic nutrition, infectious disease control, health education and health personnel development. Swaziland gets ODA support in the health sector for the acquisition of medical supplies and equipment, construction of health care facilities and technical support in the form of medical personnel.

ODA for health care increased tremendously between 2007/8 and 2008/9, which is a huge improvement. The ODA for safe water and sanitation declined between 2007/8 and 2009/10, from US\$8.3 million to US\$0.6 million respectively. Projects under this fund include the provision of water supply to schools and support for the rural water project.

Agricultural ODA included a huge increase between 2007/8 and 2008/9, from US\$0.2 million to US\$2.9 million; in 2009/10 it declined to US\$2 million. Between 2007 and 2010, Swaziland received ODA for the control of alien invasive species, construction of a post-entry plant quarantine, the Swaziland Agricultural Development Project, support to smallholder cane growers, and dam construction.

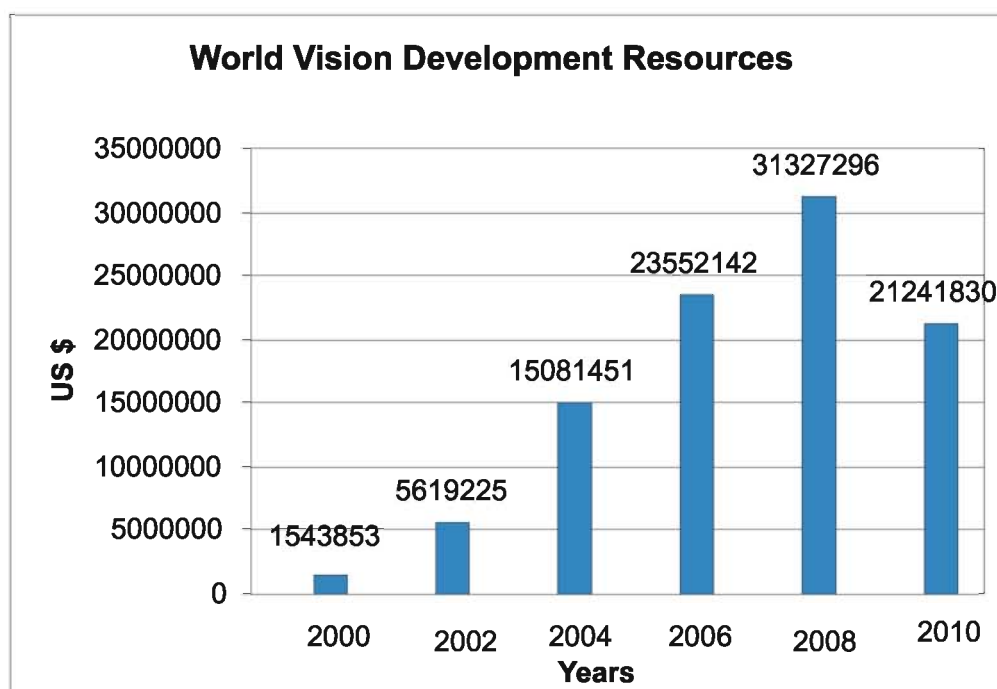
Figure 8.1 Bilateral PEPFAR budget in million US\$ for the last eight years



Source: US PEPFAR 2010

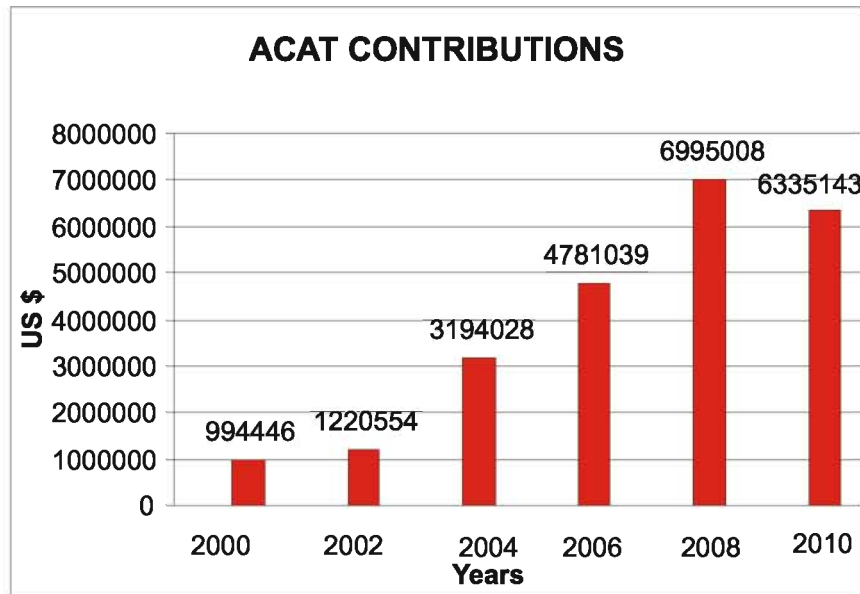
PEPFAR has been a critical resource, especially in the fight against HIV/AIDS in Swaziland. This type of investment needs to be encouraged because it supports

the Government in meeting MDG 6 and others. The resource base for 2010 alone is US\$28.8 million. Some examples of ODA through NGOs follow:



Source: World Vision Records

World Vision has generated more than USDD20 million per year in the last three years.



Source: ACAT Records

ACAT has generated more than USD\$4 million per year for the last five years.

NGOs are contributing to the development of Swaziland. As such, the Government should recognize their efforts and bring them to the table when critical development issues are being discussed.

Both the Government and NGOs must comply with grant requirements attached to available resources. Further, resources must be used within an agreed-upon time period or returned to the source provider. This is a governance issue that requires monitoring, so that resources are appropriately and effectively applied to vital needs.

Impact of the global economic and financial crisis on ODA

In the third quarter of 2009/10, the country experienced the second-round effects of the crisis that affected mostly vulnerable groups. These effects caused donor fatigue and led to NGOs shifting focus to short-term assistance and humanitarian aid. Donor funds are drying up, and donors are increasingly

reluctant to pledge assistance for long-term poverty alleviation programmes (July 2009 Economic Performance Report). Due to the crisis, for instance, the Global Fund five-year assistance was reduced drastically. The National Tuberculosis Programme has been reduced by 10 percent, while the budget for the Swaziland National Network of People Living with HIV/AIDS was cut by 23 percent.

Market access

The country has an open economy characterized by a high ratio of exports and imports to the Gross Domestic Product (GDP). In 2008, the exports-to-GDP ratio was estimated at 60 percent, and the imports-to-GDP ratio was 68 percent (2009 National Development Plan). As a result of this openness, the local economy tends to be heavily influenced by both regional and international trade developments. Swaziland, being a small open economy, tends to be vulnerable to the expansion of international markets as it competes with more developed economies such as the Republic of South Africa (RSA).

The level of integration with the RSA through monetary

and trade relations means that prices, economic performance and investment are heavily influenced by developments in South Africa. South Africa is the country's largest trading partner: in 2008, 93 percent of goods imported by Swaziland were from RSA, and more than 70 percent of goods exported went to South Africa (Economic Performance Report-July 2009). Swaziland's major export markets are the Southern African Customs Union (SACU), Common Market for Eastern and Southern Africa (COMESA), Southern African Development Community (SADC), the European Union (EU) and the USA.

Swaziland, together with RSA, Botswana, Namibia and Lesotho are members of SACU. The main objectives of this union are to increase trade among member states and to create a wider market for all countries concerned. SACU is currently in the process of negotiating with India for a free trade agreement intended to broaden the market for exporters, especially on unbleached coniferous chemical wood pulp, multiple folded or cabled filament yarn of polyester, and paper products. SACU has also concluded a Trade, Investment and Development Cooperation Agreement (TIDCA) with the USA.

In an effort to expand the market base, the preferential trade agreement between the SACU and MERCOSUR (Argentina, Brazil, Paraguay and Uruguay) has since been signed and will come into effect after ratification by all parties. The MERCOSUR market will advance South-South trade.

Swaziland is a member of the Common Market for Eastern and Southern Africa (COMESA), however, the country is operating under derogation, which was granted in December 2008 in COMESA and is valid for two years. The derogation has ensured that the market for exports directed to COMESA does not suffer any disruptions as COMESA moves from a free trade area to a customs union.

As a member of SADC, Swaziland is making progress on the road to trade integration. Since the launch of the SADC Free Trade Area in August 2008, member states have been in the process of fulfilling their obligations under an agreement to phase out tariffs and import quotas by 2012. The tariff phase-down ensures that all goods originating within SADC are duty- and quota-free, which promotes intra-SADC trade and strengthens

regional economic integration. However, in 2010 SADC is expected to move towards a customs union, which will likely affect the competitiveness of Swaziland and its opportunities for future economic development.

In an effort for further regional economic cooperation and integration, the first Tripartite Summit for the Common Eastern and Southern African Community (COMESA-EAC-SADC) was held in October 2008. Following that meeting, the Secretariat for these three regional economic communities are continuing work related to the establishment of the free trade area.

In June 2009, Swaziland signed the SADC-EU (European Union) interim Economic Partnership Agreement to avoid trade disruptions and to preserve trade preferences that expired with the fall of the Cotonou Agreement in 2007. The signing of the agreement has been beneficial, as it offers duty- and quota-free access to the EU market for all exports. It also ensured that the country's sugar exports to the EU were safeguarded when the African, Caribbean and Pacific (ACP) Sugar Protocol expired in September 2009.

Swaziland is among the countries that benefit from the African Growth and Opportunity Act (AGOA), a trade drive initiated by the USA for Sub-Saharan African countries. The country will benefit from duty-free imports of more than 6,500 eligible products into the United States market until 2015.

Impact of the erosion of the Multi-Fiber Agreement (MFA)

The local textile and garment industry was not only seriously threatened, but negatively affected by changes in the global trade regime and trade liberalization, such as the phasing out of the Multi-Fiber Agreement (MFA) in 2005. The removal of quotas on developing countries, principally China, India and Pakistan, eroded the advantage available to SACU countries under the EU ACP Cotonou Agreement.

Generally speaking, the textile and garment industry in sub-Saharan Africa competes poorly against its Asian counterparts, and Swaziland is no exception. Noted

disadvantages include high interest rates, lack of long-term capital, high utilities costs (power and water), low labour productivity, lack of skilled manpower, additional transportation costs (due to Swaziland's landlocked status) and wages double those in China, India and Bangladesh.

The impact of the phasing out of the MFA was felt in the areas of imports, exports and employment levels. During the period 2003-7, exports of textile and clothing declined sharply from US\$489 million to US\$154 million, and imports of textile and clothing also declined from US\$ 99 million to US\$82 million. Subsequently, a large number of establishments terminated operations, resulting in the loss of more than 15,000 jobs within the sector.

Impact of the global economic crisis on trade

The global crisis severely affected Swaziland's textile industry since most of the country's textile companies target the AGOA market in the USA. Purchase orders from local exporters targeting the USA were cancelled as a result of buyer default. Production in the textile and

apparel sectors scaled down accordingly, and some companies were compelled to reduce working hours and staff. So far, two companies have closed down, and more than 3,000 workers have been retrenched.



Production in a number of other sectors was scaled down as global demand slowed in the manufacturing, mining, agriculture, tourism and retail and wholesale sectors. The manufacturing sector recorded negative growth as a result of the slowing global demand and declining commodity prices for the country's major exports, namely pulp, coal and textile. The number of tourist arrivals into the country fell too, reflecting the dampening mood in travelling patterns. The mining sector saw a decrease in global commodity prices such as diamonds and coal, which stalled operations of the new diamond investment in the country. The coal mine scaled down production in response to weak market demand and unfavourable prices, driven primarily by the sharp fall off in the motor vehicle industry. This also threatened the closure of the Maloma Colliery mining company (July 2009 and December 2009 Economic Performance Reports).

Target 8.D Deal comprehensively with debt problems of developing countries through national and international measures to make debt sustainable in the long run

Indicator

Debt service as a percentage of goods and services.

Status at a glance

Will target be met	Potentially 
State of supporting environment	Good 

According to the 2007/8 Central Bank Annual Report, Swaziland's external debt stock was on a continuous upward trajectory between 2005 and 2008, until it declined slightly in 2009. Total external debt stock, including private sector non-guaranteed debt in 2008, stood at E4 billion, an increase of 25 percent from the E3.2 billion recorded in 2007. The growth in debt is primarily due to increased disbursements of loans for large ongoing projects, most of which are at peak implementation. It also reflected in part the depreciation of local currency against the US dollar and other major currencies, in which most external liabilities are denominated.

The central government accounts for a large share of the total debt stock 88.2 percent of the total debt portfolio in 2008. Public external debt, including guarantees to parastatals, stood at E3.5 billion, reflecting an increase of 29.6 percent from the previous year. Private sector non-guaranteed debt amounted to E469.2 million in 2008, a marginal increase of 1.9

percent from the previous year. Although the Government's debt stock has been increasing over the years, and might continue rising, Swaziland remains at sustainable levels (2007/08 Central Bank Annual Report).

In 2009, total public external debt service amounted to E462.5 million, and the country's total debt stock to exports of goods and services stood at 25.7 percent. Total debt stock to GDP was 14.9 percent, and public debt service to exports of goods and services was 2.1 percent. Critical ratios established by the Bretton Woods institutions for highly indebted poor countries indicate that Swaziland's debt ratios have been comparatively low in contrast to other African countries. These, however, could rise dramatically if the fiscal situation deteriorates suddenly as a result of the global economic crisis, and can substantially reduce Government revenues (December 2009, Central Bank Quarterly Review).

Table 8.4: External debt and public debt service as percent of exports on goods and services in Swaziland 2005-2009

	2005	2006	2007	2008	2009
Total external debt (E' Million)	2,581.9	2747.8	3202.8	3969.3	3327.2
Public external debt (E' Million)	2181.7	2301.7	2742.3	3500.1	2972.8
Public debt as % of Total Debt (%)	84.5	83.8	85.6	88.2	89.3
Private non -guaranteed debt (E' Million)	400.2	446.1	460.5	469.2	354.4
Private debt as % of Total Debt (%)	15.5	16.2	14.4	11.8	10.7
Public debt service as % of exports of goods and services	1.3	3.0	2.1	2.0	2.1



Source: Central Bank of Swaziland Annual report 2007/8 and December 2009 quarterly review

Target 8.E In co-operation with developing pharmaceutical companies, provide access to affordable, essential drugs in developing countries

Indicator

Proportion of population with access to affordable essential drugs on a sustainable basis

Status at a Glance

Will target be met	likely 
State of supporting environment	Good 

The country's health management systems are centralized, inefficient and unresponsive to new needs. Over the past years, the country has been experiencing frequent problems relating to shortages of good quality medicines due to challenges in the procurement and distribution of drugs and medical supplies. Generally, there is an imbalance in the distribution of drugs between public and private practice, and between rural and urban areas, which has led to severe shortages in public rural facilities. The most affected by these inefficiencies are the vulnerable groups who rely heavily on public health facilities.

The country has made access to medicines a priority, and primary health care has long since been free (including ART, TB treatment and child immunizations, among other services). By 2007, up to 85 percent of the population lived within a radius of 8 kilometres from a health facility. To further improve access to basic

health care, the country introduced mobile clinics for outreach programmes, rural health motivators, home based carers and community birth attendants. In 2007, approximately 72 percent of the national health budget was absorbed by curative service, which also encompasses drug acquisition. (2008-13 National Health Sector Strategic Plan).

The health sector is feeling the impact of donor fatigue and a reduction in global public resources brought about by the global economic crisis. Already, a third of the national health budget that comes directly from donor agencies has been slashed. As a result, the Global Fund five-year assistance toward the National Tuberculosis Programme has been reduced by 10 percent, while the budget for the Swaziland National Network of People Living with HIV/AIDS has been reduced by 23 percent (2008-13 National Health Sector Strategic Plan).

Target 8.F In co-operation with the private sector, make available the benefits of new technologies, especially information and communications

Information and communications technology



Access to information is essential in increasing people's knowledge and awareness. ICT is a vital development tool, a powerful engine driving modern economies. Information is an enabler for economic development,

improving production capacity and efficiency. In addition, information promotes the rights of people and enables their participation in democratic processes.

Indicator

Telephone lines and cellular subscribers per 100 population
Personal computers in use per 100 population
Internet users per 100 population

Status at a glance

Will target be met	 Likely
State of supporting environment	 Good

Indicator 8.5 Telephone fixed lines and cellular subscribers per 100 population

Telephone subscribers

In 2008, a total of 3,625 new line connections were realized against a national installation target of 3,600. The average lines billed per month in 2009 were 43,711. This shows a decline when compared with the 44,849 connections that were recorded in 2008. The size of the customer base for fixed telephone lines has remained almost the same for close to five years, reflecting a lack of new developments and the relative

attractiveness of mobile telephone service, which continues to grow at a very high rate (2008, 2009 Swaziland Posts and Telecommunications Corporation Annual reports). The country has developed the Swaziland Communication Commission Bill for the establishment of a regulatory authority to enable the introduction of another players in the communications sector.

Table 8.5: Telephone fixed lines 2005 - 2008

	2005	2006	2007	2008
Telephone Fixed lines	42 580	42 800	43 300	44 849
Population			1018449	
Telephone fixed lines per 100 population			4.3	

Source: Swazi Telecom

The number of telephone users has been increasing over the years and continues to do so, albeit at a very low rate, owing to the ever-growing popularity of mobile telephones as shown in Table 8.6. From 2005 to 2008,

the number of telephone subscribers increased by a meagre 2,269. In 2007, there were 4.3 fixed telephone lines per 100 population.

Cellular subscribers

Table 8.6: Cellular subscribers 2006 - 2009

	2006	2007	2008	2009
Cellular subscribers	279 930	388 248	508 442	614 676
Population		1018449		
Cellular subscribers per 100 population		38.1		

Source: MTN Swaziland

Mobile telephones or cellular phones have gained popularity since their introduction in the country in 1998. Between 2006 and 2009, cellular subscribers have more than doubled, from 279,930 to 614,676. For the year 2007, there were 38.1 cellular subscribers per 100 population. However, the cellular subscribers' figures do not necessarily mean that the number of people with mobile telephones has increased, because people may have more than one cellular telephone and number.

Indicator 8.6 Personal computers in use per 100 population

Swaziland does not have data on the proportion of people with personal computers. The country has not

decided upon a good proxy for this variable, hence it cannot be analyzed in this report.

Indicator 8.7 Internet users per 100 population

A luxury no more, the Internet is now an essential part of global infrastructure and a vital tool of economic progress. Since 2006, the country has been developing broadband infrastructure to increase Internet speed and volume.

Owing to the lack of data on Internet users from Internet cafés in the country, the report uses mobile Internet users as a proxy.

Table 8.7: Mobile Internet users 2006 - 2009

	2006	2007	2008	2009
Mobile internet users	140 008	260 070	362 168	373 495
Mobile internet users per 100		25.5		

Source: MTN Swaziland

Since the country's sole mobile telephone provider introduced Internet browsing with mobile telephones, the number of mobile phone users who access the Internet has greatly increased over the years. In 2006, there were 140,008 mobile telephone subscribers who used the Internet. In 2007, the figure increased by 120,062 to reach 260 070. In 2008, it increased by 102,098 to 362,168. And in 2009, it grew again, this time by 11,327 users to reach 373,495. The number of Internet users is expected to increase further as social networking sites like Facebook gain popularity, especially among the young population.

Inequality analysis

Communication technology and the Internet are mostly limited to urban areas. Many rural areas, including schools, do not have access to computers and the Internet. Although the Government has a programme of computerising all schools with support from the private sector, progress has been slow for a number of reasons, including lack of electricity and the remote location of some schools.

Supportive environment

A National Pharmaceutical Policy has been formulated and adopted to ensure that medicines are readily available at all times and are used rationally. Effective debt management in Swaziland is creating a conducive environment for ODA.

Key bottlenecks constraining progress and how to address them

Swaziland is classified as a lower middle-income country, which disqualifies it for concessionary lending.

Swaziland has yet to establish the framework for dialogue with development assistance organizations, envisaged in its PRSAP as a means of boosting external assistance.

Swaziland has yet to decide on the formal adoption of the Paris Declaration, and actively participates in its monitoring exercises.

The delivery of ODA from global development partners poses challenges. ODA does not offer budget support and is not integrated into the national budget where it is most needed, especially given the worsening fiscal position brought on by the steep decline in SACU receipts to E1.9 billion in 2010/11. Also, there is a great deal of uncertainty in terms of which projects are to be funded and the stability of funding for long-term projects that affect Government planning and budgeting.

Trade developments in the EU market saw the reduction of sugar prices by a cumulative 36 percent over a four-year period beginning in 2006, requiring a restructuring of this sector.

Economic activity around the world decreased, and world trade stagnated. Locally, the economic meltdown has been manifested in a slowdown in production, lower export earnings, declining remittances, rising unemployment, poor performance of the tourism and textile sectors, and a slowdown in investment.

New challenges with unanticipated consequences

A key impact of the global economic and financial crisis is that ODA resources committed to Swaziland will likely be reduced, as they were with the TB programme.

How Swaziland will accelerate progress in this MDG

Governance improvements and efficient use of current resources will aim to increase and accelerate ODA.

Competition is needed among cellular phone service providers so that an environment for incentives can be created for offering cheaper, more reliable service and extensive network coverage, especially in rural areas.

CONCLUSION

This 2010 MDG Report indicates that the country has made solid progress towards attaining the Millennium Development Goals.

The country has demonstrated its commitment to accomplishing the MDGs in numerous ways. The State Funded Primary Education Programme, high-level support for male circumcision as part of a comprehensive approach to HIV prevention, and the adoption of the country's National Gender Policy are just a few examples. However, following the global

economic and financial crisis, the country possesses significantly fewer financial resources to fund MDG-related activities. Mitigation measures are in place but Swaziland's development partners also play a crucial role in the country's development trajectory.

The Millennium Development Goals were not merely a national commitment but an unprecedented global one, and the country will need the continued and enhanced support of the international and donor community if it is to achieve its MDG Targets.

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