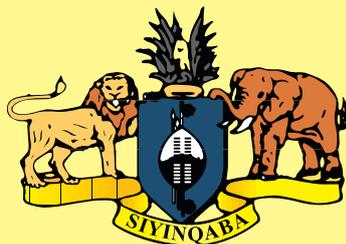




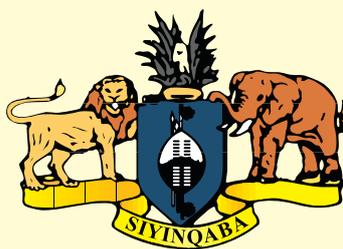
**SECOND PROGRESS REPORT ON THE ACHIEVEMENT
OF THE
MILLENNIUM DEVELOPMENT GOALS**



SWAZILAND GOVERNMENT



SECOND PROGRESS REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS



**SWAZILAND GOVERNMENT
MINISTRY OF ECONOMIC PLANNING
& DEVELOPMENT**



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The document was prepared by Colin Shalala (Senior Economist – Poverty Unit-MEPD), Thembe Zwane (Senior Economist-Sectoral Unit-MEPD), Thandokuhle Ngozo (Economist–Sectoral Unit-MEPD), Dumisani Shongwe (Economist-Sectoral Unit-MEPD) and Nokwazi Mhlanga (Economist –Research Unit-MEPD).

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ACRONYMS

MDGs	-	Millenium Development Goals
NGOs	-	Non-Governmental Organizations
HIV	-	Human Immunodeficiency Virus
AIDS	-	Acquired Immuno-Deficiency Syndrome
TB	-	Tuberculosis
FDI	-	Foreign Direct Investment
EU	-	European Union
HDI	-	Human Development Index
GDP	-	Gross Domestic Product
SACU	-	Southern African Customs Union
CHS	-	Community Household Surveillance
WFP	-	World Food Programme
SNL	-	Swazi Nation Land
SHIES	-	Swaziland Household and Income Expenditure Survey
MT	-	Metric Tones
VAC	-	Vulnerability Assessment Committee
NERCHA	-	National Emergency Response Council on HIV/AIDS
GER	-	Gross Enrolment Rates
NER	-	Net Enrolment Rates
UNDP	-	United Nations Development Programme
SACMEQ	-	Southern African Consortium for Monitoring Education Quality
UPE	-	Universal Primary Education
AIR	-	Apparent Intake Rate
STIs	-	Sexually Transmitted Infections
PMCT	-	Prevention of Mother-to-Child Transmission
ANC	-	Ante-Natal Care
VCT	-	Voluntary Counseling and Testing
ITN	-	Insect Treated Nets
SEA	-	Swaziland Environment Authority
SSX	-	Swaziland Stock Exchange
SADC	-	Southern African Development Community
COMESA	-	Common Market for Eastern and Southern Africa
ODA	-	Official Development Assistance
IFC	-	International Finance Corporation
EIB	-	European Investment Bank
TDCA	-	Trade Development Cooperation Agreement
MOHSW	-	Ministry of Health & Social Welfare

SUMMARY SHEET

GOALS	TARGETS	INDICATORS	STATUS	OUTCOME
Goal 1 Eradication of Extreme Poverty & Hunger	Target 1: Reduce by half the proportion of people living on less than a dollar a day Target 2: Reduce by half the proportion of people who suffer from hunger	Proportion of Population Below \$1 per Day Poverty Gap Ratio, \$1 per day Share of Poorest Quintile in National Income or Consumption Prevalence of Underweight Children Under Five Years of Age Proportion of the Population below Minimum Level of Dietary Energy Consumption	Increased from 66% in 1995 to 69 % in 2001. Decreased from 10 % in 2000 to 7 % in 2007. Increased from 1% to 2% It increased from 77.5% in 2000 to 81.9% in 2005. It decreased from 91.39 in 1997 to 91.2 in 2002.	The country is unlikely to meet this goal in 2015.
Goal 2 Achieve Universal Primary Education	Target 3: Ensure that all boys and girls complete a full course of primary schooling	Net Enrolment Ratio in Primary Education Proportion of Pupils Starting Grade 1 who Reach Grade 5 Literacy Rate of 15-24 year-olds	It increased from 34.0% in 2000 to 36.6% in 2005 Remained 0.94:1 for both periods 2000 and 2005. Increased from 1:1 in 2000 to 1.01:1 in 2006.	The country is likely to meet this goal in 2015.
Goal 3 Promote Gender Equality & Empower Women	Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015	Ratio of Girls to Boys in Education • Primary • Secondary • Tertiary Share of Women in Wage Employment in the Non-Agricultural Sector Proportion of Seats Held by Women in National Parliaments	Increased from 0.92:1 in 2000 to 0.98:1 in 2005. Decreased from 25.2% in 2000 to 23.5% in 2005 Increased from 8% in 2000 to 20% in 2005.	The country is likely to meet this goal in 2015.
Goal 4 Reduce Child Mortality	Target 5: Reduce by two thirds the mortality rate among children under five	Under-Five Mortality Rate Infant Mortality Rate Proportion of 1year- old Children Immunized Against Measles	Decreased from 122/10000 in 2000 to 120/10000 in 2006. Decreased from 87.7/1000 in 2000 to 85/1000 in 2006. Increased from 72% in 2000 to 82% 2006.	There is a potential to meet this goal in 2015.
Goal 5 Improve Maternal Health	Target 6: Reduce by three-quarters, between 2000 and 2015, the maternal mortality ratio.	Maternal Mortality Ratio Proportion of Births Attended by Skilled Health Personnel	Increased from 229/100000 in 2000 to 589/100000 in 2006.	The country is unlikely to meet this goal in 2015.

PROGRESS REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS

<p>Goal 6 Combat HIV/AIDS, Malaria & other Diseases</p>	<p>Target 7: Halt and begin to reverse the spread of HIV/AIDS</p> <p>Target 8: Halt and begin to reverse the incidence of malaria and other major diseases</p>	<p>HIV Prevalence Among 15-24 year-old Pregnant Women</p> <p>Prevalence and Death Rates Associated with Malaria</p> <p>Proportion of Population in Malaria Risk Areas Using Effective Malaria Prevention and Treatment Measures</p> <p>Proportion of Tuberculosis Cases Detected and Cured Under Directly-Observed Treatment Short Courses</p>	<p>Increased 70% in 2000 to 74.1% in 2006.</p> <p>Decreased from 39.4% in 2000 to 34.6% in 2006.</p> <p>Decreased from 4.1/1000 in 2000 to 2.2/1000 in 2006.</p> <p>Increased from 856/100000 in 2000 to 1182/100000 In 2006.</p> <p>Increased from 42% in 2000 to 56% in 2006. Declined from 38.2% to 27.2%</p>	<p>The country is unlikely to meet this goal with regards to HIV/AIDS but with regards to Malaria the country has potential to meet this goal.</p>
<p>Goal 7 Ensure Environmental Sustainability</p>	<p>Target 9: Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources</p> <p>Target 10: Reduce by half the proportion of people without sustainable access to safe drinking water</p> <p>Target 11: Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020</p>	<p>Forested land as percentage of land area</p> <p>Carbon Dioxide Emissions and Consumption of Ozone-Depleting CFCs</p> <p>Proportion of the Population with Sustainable Access to and Improved Water Source</p> <p>Proportion of the Population with Access to Improved Sanitation</p> <p>Slum population as percentage of urban population</p>	<p>Decreased from 3.07 imported metric tones to 0.19 imported metric tones</p> <p>Increased from 28000 people in 2000 to 41000 people in 2005 in urban areas.</p> <p>Increased from 42% in 1990 to 54% in 2006 in rural areas.</p> <p>Increased from 21000 people in 2005 to 41 000 in 2007 in urban areas.</p> <p>Increased from 250000 people in 2001 to 540000 in 2005.</p>	<p>The country is likely to meet this goal in 2015.</p>
<p>Goal 8 Develop a global partnership for Development</p>	<p>Target 12: Develop further an open, rule-based, predictable, non discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction — both nationally and internationally</p> <p>Target 13: Address the special needs of the least developed countries Includes: tariff and quota free, access for least, developed countries', exports; enhanced programme of debt relief for HIPC's and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p>		<p>This goal does not have specific indicators but it has targets.</p>	<p>Swaziland is currently facing a decline in economic growth and Foreign Direct Investment (FDI) and is unlikely the targets of this goal given her low economic growth rate.</p> <p>However, it is worth noting that Swaziland is doing well on the financial sector performance and debt management.</p>

PROGRESS REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS

<p>Goal 8 Continued</p>	<p>Target 14. Address the special needs of landlocked countries and small island developing States</p> <p>Target 15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.</p> <p>Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.</p> <p>Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</p> <p>Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p>			
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Foreword

The adoption of the Millennium Development Goals as drawn from the United Nation Millennium Declaration in 2000 was a seminal event in the history of the United Nations. The Kingdom of Swaziland is therefore proud to be one of the implementers of such a declaration that was adopted by the Heads of States and Governments. According to the unprecedented promises by the world

“This Progress Report is a comprehensive document that tracks the progress of MDG targets from 2000 to date and how far we need to go in order to meet our 2015 MDGs. Swaziland is on track in meeting some Goals but facing challenges in meeting others. One of the challenges in tracking the progress is the inadequate data management. For us to know how far are we from achieving them and how far we still have to go, we need to have timely and reliable data”

leaders including Swaziland it constitutes a single package; peace, security, human rights development and fundamental freedoms.

As a developing country what is of vital importance is to be alert that, as much as the MDGs are achievable, they are people-centered and are based on global partnership. Therefore the responsibility of Swaziland as a developing country is to get her house in order so that the developed countries can support these efforts. Accountability, Commitment, Prioritization of Economic Growth issues and Corruption Free Nation are some of the essential efforts the country needs to embark on.

This Progress Report is a comprehensive document that tracks the progress of MDG targets from 2000 to date and how far we need to go in order to meet our 2015 MDGs. Swaziland is on track in meeting some Goals but facing challenges in meeting others. One of the challenges in tracking the progress is the inadequate data

management. For us to know how far we are from and how far we still have to go, we need have timely and reliable data.

It is my singular honour to present this document as a country's MDGs progress report.

I therefore commend this document as a key source in the preparation for the next General Assembly to be held late this year in the United States of America.

The Hon. A.M. C. Dlamini

Minister for Economic Planning & Development



Introduction

Swaziland is proud to be one of the 191 countries that committed to the implementation of the Millennium Declaration adopted by Heads of States and Government at the 55th Session of the UN's General Assembly in September 2000. The UN's declaration was a seminal event in history of the United Nation constituting of an unprecedented promise by the world's leaders to address a single package of peace, security, development, human rights and fundamental freedom.

The former Secretary General of the United Nation Kofi Annan in his March 2005 report entitled "In Larger Freedom; Towards Development, Security, and Human Rights for all". He made this important point 'we will not enjoy development without security, we will not enjoy security without development and we will not enjoy either without respect of human rights'. The message is clear that development is inclusive, unless all of these are advanced, nothing will succeed.

It is therefore, for this reason that the report encompasses all the eight Millennium Development Goals (MDGs), ranging from halving of the poverty and hunger; halting of the spread of HIV/AIDS to development of global partnerships.

What is plausible with the MDGs is that they are people-centred; time bound and measurable. They are also based on a global partnership, which means that both developing countries and developed countries have an important and complementary role in ensuring that these goals are achieved. Since the MDGs have unprecedented political support, embraced at the highest levels by developed and developing countries they are achievable.

What remains to be done is for every stakeholder including our public, private sectors and NGOs to collectively put their efforts together if we are to achieve our MDGs by 2015. To accelerate our economic growth which is the mainstay of the MDGs, the nation needs collective effort coupled with commitment and accountability.

It is therefore hoped that the development challenges and support articulated in this document will assist the country to strengthen its planning framework. What is worth noting is that with the adoption of the MDGs Swaziland prepared the Poverty Reduction Strategy and Action Programme which fully integrates MDGs.

Summary of Goals

Goal 1 Eradication of Extreme Poverty & Hunger

Currently the trend illustrates that poverty and hunger are on the increase in Swaziland in both rural and urban areas, with people living on food aid increasing from 210,000 in 2005/06 to more than 400,000 in 2006/07. The status of agricultural performance is showing



signs of negative growth as a result of persistent long dry spells; poor market prices; high production cost; high unemployment rate; and HIV/AIDS. 69% of the population is living below the poverty line. Poverty is more prevalent in Shiselweni and Lubombo regions but estimated to be more deeper in peri-urban areas.

According to the assessment of food security status, it is less than 15% of homesteads that produces enough to eat. About 75% of the homesteads are dependent on employment as a source of income and 12% from farming. It is therefore a challenge for the country to accelerate the current economic growth to

more than 5% to address poverty reduction and make meaningful progress towards achieving MDGs in 2015. It is imperative to seriously consider the approval of the pending policies; the implementation and the support of the strategies and policies.

Goal 2 Achieve Universal Primary Education

Swaziland has taken great strides in improving access to primary school education. After experiencing a long term decline which reached the lowest point in 2003, primary school enrolments have picked up in recent years. Total enrolments had decreased from 213,986 in 2000 to 208,652 in 2003; but have risen by 8.8% to 226,914 in 2006, from the 2003 level. The Net Enrolment Rate has increased from 77.5% in 2000 to 81.9% in 2005. On the whole, the enrolment of girls is lower than that of boys although this tends to balance out at secondary level.

The improvement in some of the indicators is a consequence of a number of initiatives the Swaziland Government and her partners have undertaken to ensure access to education, including: the introduction of a bursary scheme for orphaned and vulnerable children, the introduction of free books as well as the gradual introduction of free exercise books at the primary school level.

Despite the improvements, there are many children of school-going age who are still out of school. About 18% of school-going children are excluded from the system. Many who are in the system also drop out or repeat grades, with a repetition rate averaging 16% and a dropout rate of about 6.2% in 2003. The challenge is therefore still needs to be done to address the internal inefficiencies as well as quality aspects of the education system.

Goal 3 Promote Gender Equality & Empower Women

Swaziland shows signs of being able to achieve its goal 3 Target. Trends of these indicators reflect an upward movement towards gender equality.



In the education system, the boys' participation outweighs that of the girls but the difference is marginal, with an average female participation rate of 49.2%.

In the area of public participation, while female representation in parliament and in Cabinet is still minimal, trends show that there is an upward mobility. The present parliament (2003-2008) constitutes 20% members of the female gender, an improvement from 8% representation in previous parliament (1998-2003). In Cabinet 4 out of the 18 members (including the office of Deputy Minister), show an improvement from previous governments. More so, in 2006, Swaziland saw a historic representation where the offices of the Deputy Prime Minister and the single post of deputy-Minister became occupied by females.

In the Swaziland civil service 58% of professional, technical, administrative and managerial positions are occupied by women. The situation is in contrast in the private sector only 30.2% of females hold similar positions.

Goal 4 Reduce Child Mortality

Under-five mortality trends indicate that under-five mortality has been increasing since 1997 from 106 per 1 000 live births to 122 per 1 000 in 2000, stabilizing at 120 per 1 000 in 2006. Nonetheless, the rate of increase between 2000 and 2006 was not as pronounced as in the period between 1990 and 2000. On the other hand, malnutrition amongst under 5s is estimated to be 39% causing stuntedness and underweight prevalence is estimated to be 10%. 47% of deaths are HIV/AIDS related.

Infant mortality increased from 78 per 1000 live births in 1997, to 87.7 per 1000 in 2000 and stabilized at 85 per 1000 in 2006. Stabilization of infant and under-five mortality rates is expected to continue as the up-take on the Prevention of Mother to Child Transmission intervention increases.

The re-focus of government efforts towards the provision of safe drinking water and sanitation will also act as a contributing factor towards reducing child mortality. It is

estimated that only 36% of households had access to clean safe water in the country during the dry season and as such the likelihood of children having diarrhea was increased by 32%. Prevalence of under weight children due to malnutrition has reduced between the period 2000 and 2006 from 10% to 7.4%. Prevention programmes such as measles immunization coverage had been declining from 94% in 2003 to 60% in 2005. However an increase in immunization coverage was recorded in 2005 from 60% in 2006 to 82% in 2006.

A national immunization campaign reached a significant coverage of children age between 9–59 months of 91.3%. The immunization programme has a high utilization rate on static facilities of over 80%. Despite the stable picture of infant mortality, a further reduction of infant mortality will be achieved through significant gains in the national HIV/AIDS response, food security and improvement of access to safe water and sanitation. There is a potential to make progress towards achieving this goal, however, with the current food security crisis, under 5s are very vulnerable thus mortality likely to increase.

Goal 5 Improve Maternal Health

Maternal mortality continues to be a major problem in the country as the probability of life being at risk every time a woman is pregnant was estimated to be 1 in 69 in 2003. In this regard maternal mortality trends show that maternal mortality increased from 229 per 100, 000 live births in 1997 to 589 per 100,000 live births in 2006. The continuous increase in maternal mortality rate is associated with the rapid spread of the HIV and AIDS epidemic and limitations of the health system.

According to preliminary results from the Demographic and Health Survey 2007 the percentage of women assisted by a health professional has increased from 70% in 2000 to 74.1% in 2006. Further, the percentage of women delivering in health facilities have increased from 56% in 2000 to 74.1% in 2006. Despite the increases in the health seeking behaviour of pregnant

women the country has not made significant progress towards achieving this MDG goal.

Goal 6 Combat HIV/AIDS, Malaria & other Diseases

Evidence from ANC attendees shows that there has been a positive trend in the level of HIV prevalence across all age groups in the period 1998 to 2004 with the highest prevalence occurring in the age group 25 – 29 years followed by 30 – 34 years. However, there was a consistent decline among the age group 15 – 19 years between 2002 and 2006 from 32.5% to 26 % respectively. The prevalence rate in the broad age category of 15 to 24 years decreased between 39.4% in 2002 to 34.6% in 2006. On the contrary HIV prevalence for the age groups 30 – 34 and 35 – 39 years maintained an increase in the same period. Using the age group of 15 -19 and 20 – 24 years as a proxy for HIV/AIDS incidence, it may be inferred that Swaziland is showing decreasing signs from 32.5% in 2002 to 26.0% in 2006.

There has been a significant reduction in the incidence of clinical malaria from 4.1 per 1000 people in 2000 to 2.2 per 1000 people in 2004. The significant decrease in the incidence of the disease can be attributed to a number of factors including high indoor residual house spraying coverage, erratic rainfall trends, improved public consciousness and awareness in affected communities. The number of laboratory confirmed cases has dropped from an average of 4, 000 per year during the period 1995 – 2000 to less than 300 per year during the 2004/05 malaria transmission season.

Tuberculosis has become one of the leading causes of morbidity and mortality among adults in Swaziland. The number of TB cases notified in Swaziland over the last 15 years has increased six-fold. In 2000 the prevalence rate of TB was estimated at 856 per 100, 0000 people rising to 1182 per 100, 000 in 2006.

It is estimated that approximately 36% of households in 2006 had access to an improved source of water and 47% lacked access to improved sanitation. There has been a significant increase in the incidence of diarrhoeal diseases from 177 cases per 1, 000 people in 2001 to 279 cases per 1, 000 in 2006. With the exception of Malaria, the country has not made significant progress towards achieving this MDG.

Goal 7 Ensure Environmental Sustainability

Environmental management has taken a centre stage in Swaziland. The number of projects that have been subjected to environmental assessment has increased from 55 in 2000 to 204 in 2006. The integration of environmental issues into national development has seen the waste management licenses and special waste licenses increasing from 1 to 7 and 1 to 2 respectively over the past five years. However, waste disposal and management remains a key challenge.

Progress has also been made in the provision of clean drinking water and slum upgrading. The number of people without clean drinking water in urban areas has decreased from 37 percent in 2000 to 21 percent in 2005 and there has been an increase in the slum upgrading beneficiaries from 21,000 in 2005 to 41,000 beneficiaries in 2007. In rural water supply, 42% of the rural populace had been served safe drinking water since 1990. In 2006, the proportion of rural population with access to safe drinking water has increased to 54%.

The challenge remains in waste disposal management, climatic change and law enforcement.

Goal 8 Develop a Global Partnership for Development

Swaziland's trade and financial system has been faced with serious challenges in attracting Foreign Direct Investment (FDI) due to the competition for the FDI with economically superior neighbours. FDI inflows have declined from E665 million in 2000 to E56 million in 2006. The country's balance of payment (BoP) trends reflect that export performance has been poor compared to imports.

However, the performance of the financial industry has been progressive and sound as measured by the superior average risk weighted capital adequacy ratio when compared with the statutory minimum adequacy ratio of 8 percent.

Swaziland external debt has also been kept within the internationally recommended standards and is therefore sustainable. The country has also made meaningful inroads in both telephonic and mobile penetration rate as reflected by the increase in the number of subscribers for the two national providers for these services.

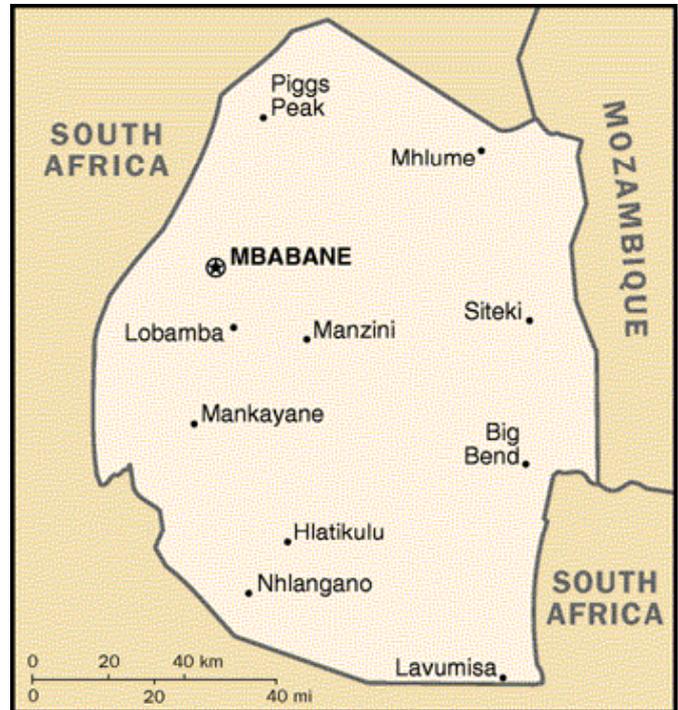
Swaziland's membership to big trading organisations have paid dividends in the past but with the changing trading regimes, challenges of penetrating those markets and maintaining a secured share has posed serious challenges. The EU market for sugar is under threat with the forthcoming price reduction and removal of preferences.

Swaziland: Development Context

Swaziland is a small, landlocked country covering an area of 17,364km² situated between South Africa and Mozambique. It is divided into four geographical regions that run from north to south, and four administrative regions. Its population stands at about 1.1million (2004), of which about 70% lives in rural areas. The population growth rate is 2.9% annually.

The country has witnessed a discernible decline in key social indicators in the early 1990's. This is in stark contrast with the impressive record of the 1980's. Human Development as measured by the Human Development Index (HDI) reached 0.623 in 1990 before declining to 0.500 in 2004. The prevalence of poverty has worsened from 66% in 1995 to 69% in 2001. The prevalence of HIV/AIDS has escalated from 3.9 % in 1992 to 42.6 % in 2005. The unemployment situation has also worsened from to 29 percent in 2001. It must be noted that the most single factor behind this marked decline in the social indicators is the widespread of HIV/AIDS.

The period after independence in 1986 was characterised by an impressive economic feat propelled by the negative political developments that prevailed in Mozambique and South Africa at the time. South Africa at the time was experiencing the climax of the apartheid regime premised on white minority rule while Mozambique was over the same period entangled in internal civil war. For this reasons many firms found it worthwhile to invest in Swaziland and target the bigger market in South Africa. As a result, many economic benefits accrued to Swaziland and of particular importance was the huge Foreign Direct Investment (FDI) inflow to the kigdom. The country's economic performance reflected this as the growth in Gross Domestic Product (GDP) grew by 8.5% in 1986/7.



However a drastic change in economic kismet was experienced in the 1990's. When a new democratic governments were ushered in both in South Africa and in Mozambique. Many firms relocated back to these countries and that resulted in Swaziland losing most of the FDI to these countries and consequently the country had to compete with these countries for FDI. A reflection of this economic decline is captured in the massive plummet in the GDP growth rate from 8.5% in 1986/7to 2.3 in 2005.

A whole range of factors running across the entire economic spectrum can explain the economic plunge that the country has experienced since the mid 1990's. They include among others exogenous factors like prolonged drought, high oil prices, exchange rate volatility, declining prices of export commodities combined with erosion of preferences in protected markets and the loss of textile quotas in 2005, which resulted in the loss of an estimated 50% of the jobs in the garment industry.

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Table 1 : Major Economic Indicators, 2000-2006

Item	2000	2001	2002	2003	2004	2005
Nominal GDP (E Million)	9,629.9	10,846.0	12,560.0	14,422.4	15,390.3	16,615.6
Real GDP (factor cost) E' Million	1,481.1	1,503.4	1,545.6	1,590.7	1,623.8	1,661.5
Real GDP growth rate	2.0%	1.7%	2.8%	2.9%	2.1%	2.3%
GDP Per Capita						
Agric. % of GDP at Factor Cost	9.9	8.8	8.7	8.7	8.7	8.7
Manuf. % of GDP at Factor Cost	35.8	35.6	35.4	35.0	34.4	34.0
Govt. % of GDP at Factor Cost	16.5	16.6	16.3	16.4	16.5	16.4
Paid Employment ('000)	92,093	92,607	95,358	98,139.47	100,246.2	102,553.8
- Private	63,598	63,816	66,267	68,199.92	69,663.93	71,267.54
- Public	28,495	28,791	29,091	29,939.55	30,582.24	31,286.22
Paid Employment Growth Rate	3.50%	0.60%	3	2.90%	2.10%	2.30%
Balance of Payments						
Exports	6,281	8,975	9,521.3	10,492.7	11,229.8	11,622.8
Imports	7,188	9,628	9,397.5	9,707.4	10,326.7	11,158.3
Trade Balance	-907	-653	123.8	785.3	903.1	464.5

Source: Ministry of Economic Planning and Development

After recording sizable surpluses during much of the 1990s, the central government budget recorded persistently widening deficits between 1999/2000 and 2005/2006. The budget deficit increased from 1.7% of GDP in 2000/2001 to 4.5% in 2005/06. The main driver for the fiscal deficit has been a massive increase in the wage bill, which rose from 11.2% of GDP in 2003/04 to 15% of GDP in 2005/06. Low levels of revenue

collections particularly in the non-SACU domestic revenues have also been a contributing factor to the fiscal deficit, although this is expected to improve with the restructuring of revenue collection systems and institutional structures which are in the offing. The fiscal deficits have been financed by the depletion of reserves combined with increased domestic borrowing.

“The country has witnessed a discernible decline in key social indicators in the early 1990’s. This is in stark contrast with the impressive record of the 1980’s. Human Development as measured by the Human Development Index (HDI) reached 0.623 in 1990 before declining to 0.500 in 2004. The prevalence of poverty has worsened from 66% in 1995 to 69% in 2001. The prevalence of HIV/AIDS has escalated from 3.9 % in 1992 to 42.6 % in 2005. The unemployment situation has also worsened from 29 percent in 2001. It must be noted that the most single factor behind this marked decline in the social indicators is the widespread of HIV/AIDS”

Goal I



Eradicate Extreme Poverty and Hunger

TARGETS

- ▶ Halve the proportion of the people of the Kingdom of Swaziland whose income is less than the total Consumption Poverty Line.
- ▶ Half the proportion of people in human poverty as measured by Human Poverty Line (HPI).
- ▶ Halve the proportion of people who suffer from hunger by 2015
- ▶ Reduce by half between 2000 & 2015, the proportion of children under-five who are malnourished.

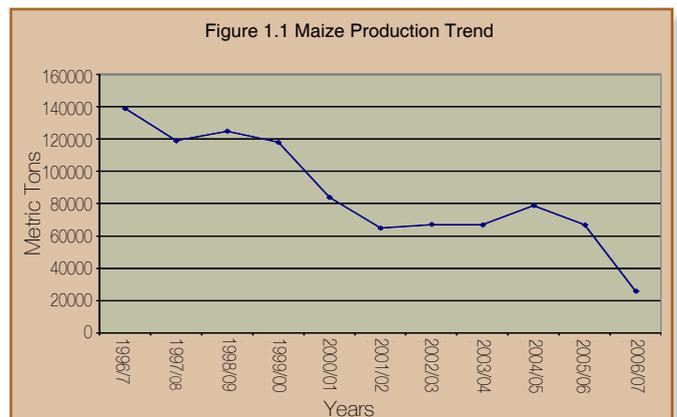
STATUS AND TREND

More than 70% of the Swazi population reside in rural areas and predominately dependent on subsistence farming and/or livestock herding. According to the WFP’s Community Household Surveillance (CHS) food monitoring system; food production (mainly maize) represents the primary livelihood activity as subsistence or for cash. Maize is the primary crop and recently sugarcane growing has increased substituting for the fall-out of cotton as the cash crop on Swazi Nation land (SNL). However, self-sufficiency in maize production has never been achieved. In a normal year, approximately 60% of food consumed in Swaziland is imported. In addition, the drought, declining off-farm incomes resulting from retrenchments and HIV/AIDS have rendered large numbers of households’ dependent of food aid.

Income distribution is skewed in Swaziland. According to SHIES 2001, nationally 56% of wealth is held by the richest 20% while the poorest 20% own less than 4.3%. Swaziland has recorded a Gini Coefficient of 51% (SHIES 2001) which is considered great inequality according to the international standard which set at not more than 40% (Wikipedia Web site 2007). This provides one of the major contributory factors to current levels of poverty. The country’s target is therefore to half the income inequality from 51% in 2001 to 25% in 2015.

According to the agricultural census, 75% of households dependent on employment income for their livelihood and only 12% is derived from agricultural activities. Thus with a poor economic performance, the impact on families is quite significant. Agricultural production has taken a decline and in particular maize production has drastically dropped rendering households dependent on food aid. Maize being a staple food in Swaziland; hunger and poverty are not only associated with its shortage, but directly affect hunger and poverty. Maize production has declined since 2002 when the country was hit by severe drought and production fell from 8,201MT in 2000/01 to 26,000MT in 2006/07 (see figure 1.1).

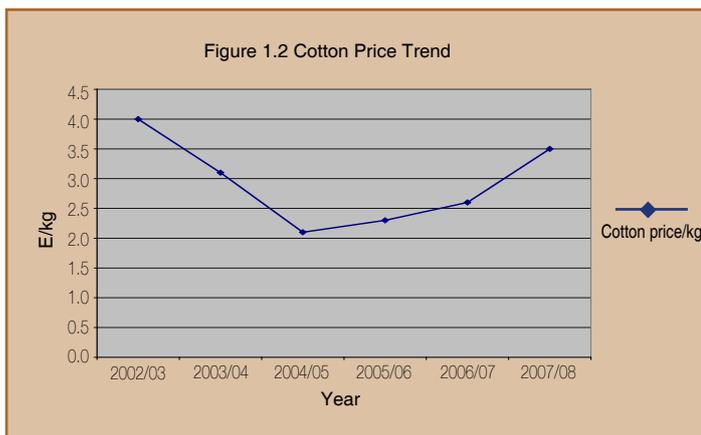
The prevailing dry spells, high cost of agricultural production, reduced arable land and HIV/AIDS have exacerbated the already poor agricultural performance thus pushing the population of Swaziland deeper into poverty and hunger situation. Shiselweni and the Lubombo regions are the most vulnerable regions where hunger and poverty are at peak as a result of the above mentioned effects. The Shiselweni and Lubombo regions recorded the level of 76% and 73% respectively of the households below poverty line. The other two regions recorded 61% and 70% (SHIES 2001).



Source: Central Statistic Office 2007

The country's gross domestic requirement for maize was estimated at 126,000MT during the marketing season 2006/07, with the local production estimated at 67,000MT before it fell to 26,000MT for the 2006/07 season representing only 20% of the domestic requirement. The domestic shortfall is therefore expected to increase from 57,300MT in 2006/07 season to an estimated 173,800MT for 2007/08 season. As a result, the number of people dependent on food aid has increased to about 400,000. The figure is representative of the number of households which have no purchasing power to access food in the market. Government has responded by providing a supplementary budget to source food from neighbouring countries to feed vulnerable households.

Cotton production was once a major cash crop on Swazi Nation Land especially in the Lowveld contributing immensely to the livelihoods of the communities. The situation has since changed as a result of debt, dry spells and poor market prices that discouraged the producers. The price dropped from E4.00/kg in 2002 to E2.10/kg in 2006 and was only subsidized by E0.20/kg to reach E2.30/kg in 2006 (see figure 1.2). The result was a number of communities' livelihoods dropped below the poverty line.



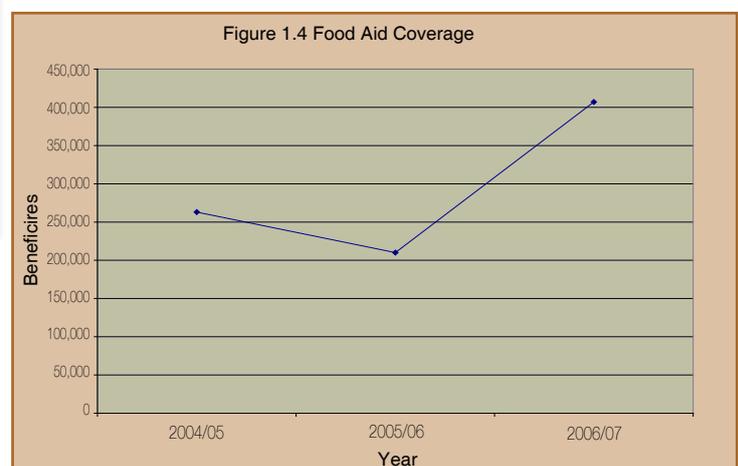
Source: Swaziland Cotton Board, 2007

According to the SHIES 2001, the number of households who have never produced enough food increased from 51% to 56% and the households which had produced surpluses before dropped from 9% to 5%. Furthermore, the prices for basic foodstuffs like mealie meal and bread

has risen radically. Consequently, meeting the goal of eradicating hunger is a challenge for Swaziland presently. The WFP Crop and Food Supply Assessment Mission to Swaziland (2007) observed that 21% of the nation's households are food insecure while 69% is living below the poverty line, based on an approach that measures a household's capacity to access food (purchase power), dietary diversity and production levels. According to Swazi VAC (2006), approximately 40% of the poor were not accessing sufficient food, with a further 40% receiving food aid.

The poor rainfall distribution resulted in poor production of maize causing a hike in maize price, from E1,249 per MT in 2005 to E2,085 per MT in 2007, representing a 67% price increase in two years. This implies that as communities are finding it difficult to produce maize it becomes scarce resulting to hike in maize price. Vulnerable people are therefore denied access as they can not only be unable to produce, but also to purchase.

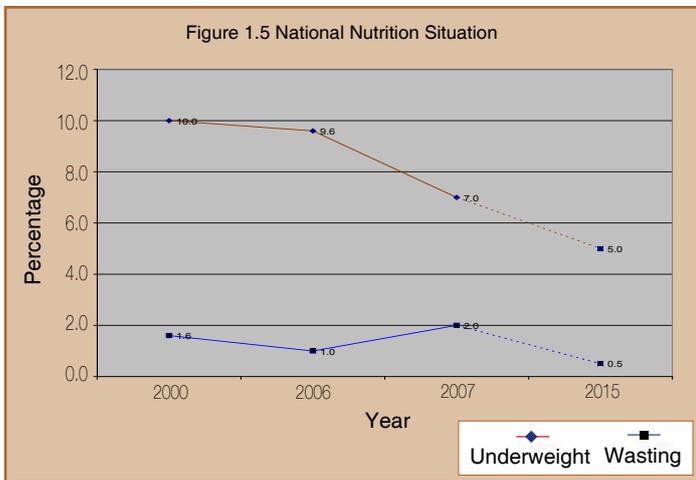
Swaziland is currently facing major challenge in humanitarian situation as a result there is a high incidence of vulnerability of the population. The proportion of the population that needs food assistance is inversely proportional with the agricultural productivity. According to FAO/WFP CFSAM (2007) the number of people in need of food aid rose from 210,000 to 400,000 people in 2005/06 and 2006/07 respectively as a result of direct or indirect decline of maize production. (See Figure 1.4)



Source: Swazi VAC 2007

The proportion of people in need of food aid represents a significant 34% and is rising given the reduced agricultural production. The challenge is to increase food production so that access can be increased especially from the poor.

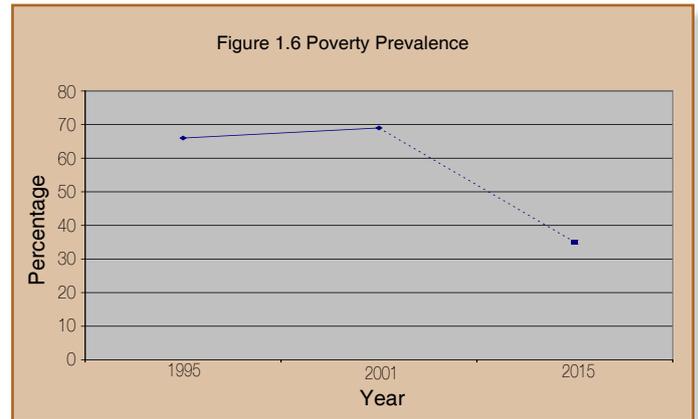
Of the 69% people living below poverty line, most of them are children. Malnutrition of children under 5 years is therefore one of the major indicators for people who suffer hunger. Present statistics indicate that 39% of under 5s are stunted and this has a huge impact on the goal on infant mortality.



Source: The Multi-Cluster Survey (MICS) 2000

In addition, some of the under 5s are wasting and some vitamin A deficient. Wasting is a very sensitive indicator which is related to food access and nutrition and thus closely linked to the performance of the agricultural sector. As maize production showed a significant fall from 67,000MT to 26,000MT in 2005/06 and 2006/07 respectively and while wasting rose from 1.0% to 2.0% (see figure 1.5).

FAO/WFP CSFAM conducted in 2007 stated that, food production represents the primary livelihood activities, either subsistence or for cash. Approximately 40% of rural households are dependent on food production. About 8% are engaged in casual labour while 9% are on petty trade or small business. Formal employment being the primary source of income, counts for only 8% of the households.



Source: SHIES 2001

The projection is to half the poverty prevalence to 35% by 2015 from 69% in 2001 as reflected in figure 1. 5.

It is therefore a challenge for the country to accelerate the current economic growth to more than 5% and consider pro-poor programmes, if the 2015 MDGs are to be fulfilled. It is imperative to seriously consider the approval of the pending policies; the implementation and the support of the already established strategies and Policies

CHALLENGES

The country faces challenges in terms of urgent interventions that enhance the acceleration of the economic growth, these include;

- Approval and implementation of Land Policy
- Effective implementation of the Agricultural Policy
- Support advocacy in the fight against the spread of HIV/AIDs
- Support the implementation of the Food Security Policy

Other challenges that the nation need seriously consider in order to be on target by 2015.

- ▶ **Revive cotton production through irrigation and provide cost effective irrigation system**
Cotton once contributes significantly to both the community's livelihoods and the economic growth

rate of the country. The challenge is to revive the project through the establishment of the irrigation schemes/development for smallholder farmers and improve the producer price per kilogram.

▶ **Creating an environment for pro-poor growth**

The Poverty Reduction Strategy and Action Programme is the appropriate tool to achieve pro-poor growth. The challenge therefore is the support of the programme through all Government Ministries, Non-Government Ministries and Private Sectors.

▶ **Adoption of the MGD-Based Planning**

The Country needs have this long-term vision that is consistent with the Millennium Declaration, based on nationally-determined priorities, that is supported by medium-term cross-sectoral strategies, which

are measured against progress towards concrete MDG outcomes.

MDG-based planning focuses or channels the national programmes such that Millennium Development Goals are achieved by 2015. The challenge is to establish and support MDG-Based programme in order to realize our dream (MDG 1) by 2015.

▶ **Reduce dependence on rain-fed agriculture and increase agricultural production.**

Highly dependence on rain-fed agricultural production has been conspicuous in the drought prone areas, where hunger and poverty have been in rampant. The challenge therefore is to establish irrigation schemes/development to small-holder farmers so as to increase productivity.



Goal III



Achieve Universal Primary Education

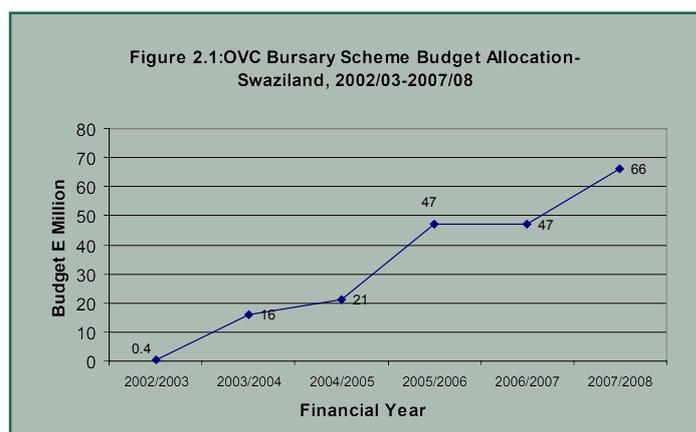
TARGET

- ▶ Ensure that by 2015, all boys and girls will be able to complete a full course of primary schooling.

STATUS AND TRENDS

During the first two decades after independence, Swaziland made remarkable progress in expanding educational provision. By 1985 the country had achieved universal primary education as there were enough school places for all school-going aged children. However, by the turn of the Century these gains could not be sustained due to a weakening economy, a high population growth rate, the impact of HIV and AIDS, worsening poverty and persistent droughts. These factors eroded capacities of families to meet the cost of educating their children and resulted in a general deterioration of the education system. This was exacerbated by the escalating numbers of orphaned and vulnerable children who failed to access education due to non-affordability. Thus growth in primary school enrolments slowed down in the late 1990s and began to decline in 2000. There was a 2.5% decline in enrolments between 2000 and 2003 from 213,986 to 208,652 pupils, respectively (See Table 2.1).

In recent years, the Government of Swaziland has scaled up efforts to ensure that all pupils, irrespective of their socio-economic classification, have access to education, particularly in the last four years. Initiatives that have been implemented which have reduced the cost barriers to accessing education include: the provision, since 2002, of free books to all public primary school pupils; the gradual introduction of free stationery beginning with the first four grades in 2006 and rolling out the programme to grades 5, 6 and 7 in 2007; and the introduction of a bursary scheme for the education of orphaned and vulnerable children, which has seen a substantial increase in the budget allocation towards educational grants. The bursary budget allocation rose from E0.4 million in 2002/2003 to E66million in 2007/2008. Figure 2.1 depicts the budget allocations towards bursaries since 2003.



Source: Government of Swaziland Budget Estimates, 2002/03-2007/08

Since the introduction of the bursary scheme, a huge number of orphans and vulnerable children at primary and secondary levels, who would otherwise not be in school, have participated in education. 3500 pupils (representing 1.7%) at primary level and 2015 pupils (representing 3.3%) at secondary level benefited from the educational grants in 2002/2003. The situation improved substantially by 2005/2006, as about 73 000 pupils at primary school level (32% of the total primary school enrolment) and 20 000 pupils at secondary school level (25% of the total secondary school enrolment) benefited from the Fund. Also, some non-state organizations such as churches and agencies like UNICEF and the National Emergency Response Council on HIV and AIDS (NERCHA) have boosted school enrolments by paying for school fees for some of the orphaned and vulnerable children.

Table 2.1: Primary School Enrolments - Swaziland, 2000 - 2005

Year	Total Enrolments	Male		Female		Pupil Teacher Ratio
		Number	%	Number	%	
2000	213986	110444	51.6	103542	48.4	31
2001	212064	108990	51.4	103074	48.6	32
2002	208998	107490	51.4	101508	48.6	31
2003	208652	107600	51.6	107600	48.4	31
2004	218352	112807	51.7	105545	48.3	32
2005	221596	114482	51.7	107114	48.3	33

Source: Central Statistics Office, Education Statistics 2000-2005

PROGRESS REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS

As a consequence of all the aforementioned initiatives, enrolments have increased considerably. By 2005, total primary school enrolments had risen by 6.2% to 221,596 pupils from the 2003 level. Preliminary data indicate a further 2.4% rise in enrolments in 2006, resulting in a total increase of 8.6% in enrolments since 2003. The primary school enrolment patterns can be seen in the evolution of Gross Enrolment Rate (GER) and the Net Enrolment Rate (NER), as depicted in Table 2.2 and Figure 2.2. Both indicators show the steady decline in enrolments until 2003, after which they start picking up. The GER declined sharply from 102.4% in 2000 to 85.5% in 2002; whilst the NER fell from 77.5% to 72.9% over the same period. As already pointed out, the country has seen an encouraging rise in education indicators in recent years, with the NER standing at 81.9% in 2005.

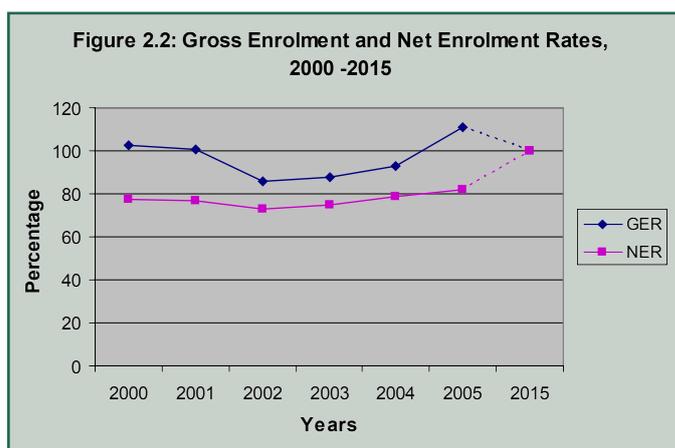
Table 2.2: Gross Enrolment and Net Enrolment Rates by Gender - Swaziland 2000 - 2005

Year	Indicator	Total	Male	Female
2000	GER	102.4	105.7	99.0
	NER	77.5	77.4	77.6
2001	GER	100.4	103.2	97.6
	NER	76.7	76.3	77.0
2002	GER	85.5	86.2	84.7
	NER	72.9	71.5	74.3
2003	GER	87.7	90.2	87.7
	NER	75.1	75.3	74.8
2004	GER	93.2	96.4	90.1
	NER	78.4	78.5	78.2
2005	GER	111.0	115.0	107.0
	NER	81.9	81.5	82.3

Source: Ministry of Education-Swaziland, UPE Draft Indicators Manual

The system generally provides an adequate number of teachers, as the teacher to pupil ratio has averaged 1:31 over the past five years. There has been a slight increase to 33 pupils per teacher in 2005, which is attributed to the surge in enrolment numbers in recent years. This increase in the ratio has remained minimal due to the fact that the Government and communities have continued

to invest in school infrastructure like classrooms and teachers' houses. This is also supported by a low pupil/classroom ratio, which stood at 15:1 in public schools and was even lower for private schools in 2005. The proportion of unqualified teachers was 8.1% in 2005. This translates into a ratio of pupils to a qualified teacher of 36:1 in the same year.



Source: Ministry of Education, UPE Draft Indicators Manual

The national indicators obviously conceal variations among regions as well as between urban and rural schools. For instance, Table 2.3 reveals that at 10.1%, the Lubombo Region had the highest proportion of unqualified teachers in 2005. This is unsurprising, given that this is the most impoverished of the country's four regions, and hence would not be very attractive to qualified teachers. The shortage of qualified teachers is a particular hindrance for rural schools, since these schools tend to be less resourced than urban ones, thus making these schools unattractive to qualified teachers. There is thus a need to address these equity concerns across regions as well as the rural-urban divide, in terms of infrastructure and materials provision for schools and staff, as well as the provision of teachers.

Table 2.3: Primary School Enrolments, Teachers & Pupil Teacher Ratios by Region - Swaziland, 2005

Region	Enrolments	Teachers	Proportion Uncertified Teachers	Pupil Teacher Ratio	Pupil to Qualified Teacher Ratio
Hhohho	57785	1577	6.7	37	39
Lubombo	47612	1429	10.1	33	37
Manzini	63945	2016	6.3	32	34
Shiselweni	52254	1719	9.2	30	33
Total	221596	6741	8.1	33	36

Source: CSO Education Statistics, 2005

In terms of gender, there are no significant variations between boys and girls enrolments at the primary school level, although more boys than girls were enrolled in the system between 2000 and 2005, as reflected by the gender disaggregated GER indicators (See Table 2.2). But the NERs reveal that, in general, there are more boys who are out of age than girls in the system. It has also been observed that girls tend to

Table 2.4: Promotion Rates, Repetition & Dropout, in Primary Schools 2000 - 2005

	2000	2001	2002	2003	2004	2005
Promotion Rate	0.78	0.76	0.78	0.77	0.80	0.78
Repetition Rate	0.16	0.16	0.15	0.16	0.16	0.17
Dropout Rate	0.06	0.08	0.08	0.07	0.04	0.05

Source: Ministry of Education

complete school earlier than boys, progressing through the system more quickly. This is reflected in a higher

completion rate for girls than boys at 86.3% and 81.4%, respectively, in 2005.

Despite the laudable achievements, however, many school-going aged children are still out of school. The Net Enrolment Rate, for instance, reveal that around 18% (2005) or about one in five pupils of primary school going age (6-13 years), are not in school. Participation is low amongst children in rural settings, the peri-urban poor, those with disabilities and those affected by HIV/AIDS. The cost of education has been identified as the main barrier to participation, particularly for the children

from poor settings. In the case of the disabled or children with special needs, the low participation in education is compounded by inadequate facilities and materials for their education. The cost-reducing initiatives and bursaries have largely benefited those children who were already in the system, and therefore could be identified by the school authorities. Those who never entered the system have remained excluded. Thus there is a need to cater for out-of-school youth and the disabled in order to make the UPE goal a reality.

The efficiency and quality aspects of the education system are other areas of concern. Available data suggests that of those who enter the system, only about half complete the full seven year primary course, and many take as long as 10 years to do so, due to high repetition rates. The educational policy in Swaziland allows for repetition of a grade twice, which means, theoretically, that a child can take as much as 21 years to complete the primary school level. As can be seen in Table 2.4, the repetition rate averaged 16% at primary

level between 2000 and 2005, while the dropout rate was 6% over the same period. Closer examination of educational data by grade reveals that both the repetition and dropout rates are particularly high in the

Table 2.5: Percentage of Children starting Grade 1 who reach Grade 5, 2000 - 2005

Year	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	Average Over Period
Those Who Repeated no More Than Two Times	71.1	71.4	73.3	85.4	77.4	75.7
Those Who did not repeat any Grade	34.0	36.5	36.5	40.9	36.6	36.9

Source: Ministry of Education, Swaziland

first four grades of primary school. By 4th grade, nearly 20% of grade 1 pupils had dropped out. These rates are unacceptably high, as they imply that about 1 in 5 pupils who enter the schooling system cannot even attain the most minimum level of education required to read and write. There is clearly a need for a review of the repetition policy to improve internal efficiency, while taking cognizance of the quality aspect of education.

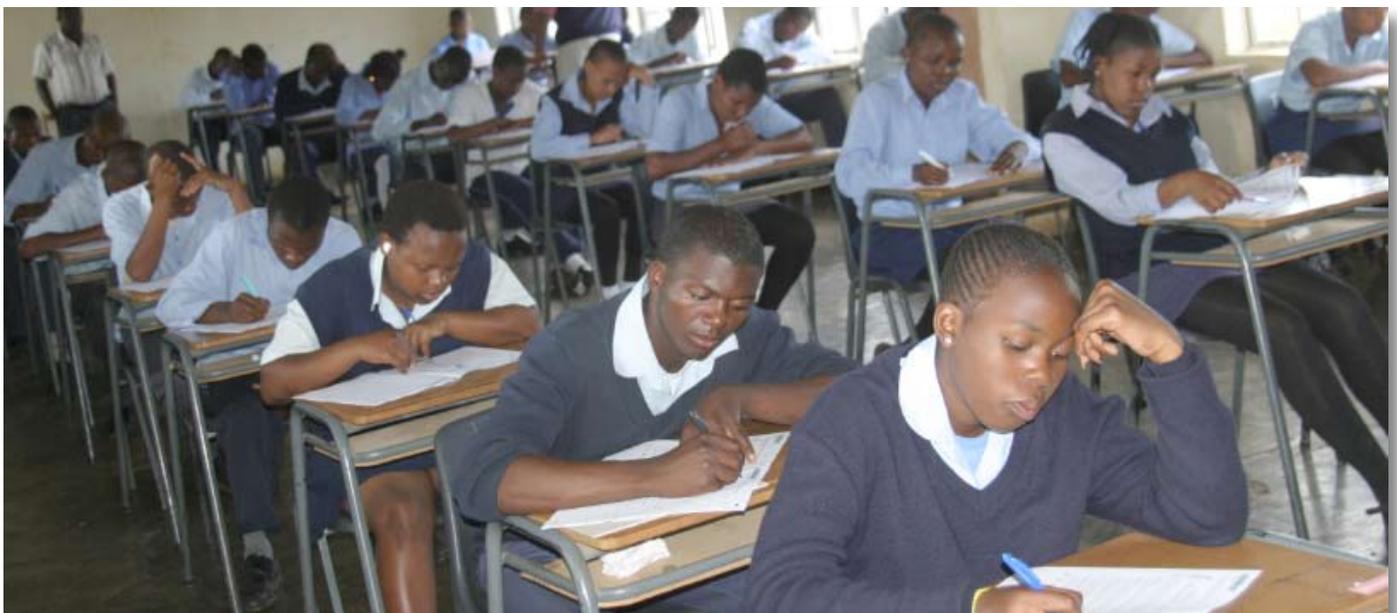
Table 2.5 depicts the retention level of the primary education system over the period 2000 to 2005. Without repetition, only an average of 36.9% of the children progressed up to Grade 5. This percentage doubles if those who repeated up to two times are taken into consideration. This is not an acceptable situation, because it reflects that only a little more than a third of the children who start Grade 1 reach a level where they could be considered literate. It is also a reflection of the challenges facing the Government of providing not just access to education, but also quality education in an efficient manner.

Unfortunately, recent data on literacy rates for 15-24 year olds is unavailable, as this would shed light on the performance of the education system. According to the 1997 Population Census, the literacy rate was at 91.3%, with the females having a slightly higher rate at 92.4%

than males (90.2%). Although these rates were relatively high, the UNDP Swaziland Human Development Report for 2004 estimates the literacy rate at 91.2% for 2002, reflecting a slight drop in this indicator.

In terms of educational attainment, results from the Southern Africa Consortium for Monitoring Education Quality (SACMEQ) indicate low student performance in many areas. Both reading and mathematics scores of Swazi sixth graders are much lower than those achieved by other sub-Saharan countries with lower GDP per capita.

In general, progress is being made in addressing access to primary school education, although even in this aspect, there are some children who are excluded from the education system. Poverty in Swaziland has led to decreased demand for education, as it has made education less affordable to poor households. Nevertheless, more attention needs to be paid to other aspects of education, such as efficiency and quality. With more intense efforts in addressing the lingering challenges of the education system, there is potential for the country to attain Universal Primary Education by 2015.



CHALLENGES

- ▶ Access to education is still a challenge in view of HIV/AIDS. The numbers of orphans is rapidly increasing as a result. Orphans bear higher risk of not being enrolled in school, dropping out, repeating and poor school performance.
- ▶ The need to review and develop non-formal education (i.e., out-of-school and adult education) to cater for over-aged children, since UPE cannot just be attained through formal education alone. For example, the Apparent Intake Rate (AIR) of 145% in 2005 reveals that 45% of Grade entrants were of the wrong age, which includes over-aged children.
- ▶ Efficiency and equity of the education system
- ▶ Quality of Education
- ▶ Financing of Education in light of an adverse fiscal position and poor economic climate.
- ▶ The institutional arrangements and management capacity is weak. The regulatory framework is based on legal acts, regulations and guidelines for primary and secondary education that were set up in the 1970s and revised and enhanced in the 1980s

Constitution, which provides for the introduction of free primary education within three years of its coming into force (i.e., from February 2008)

- ▶ **Strategic Direction** – Development of a National Education Strategy is underway, which will incorporate the UPE and EFA objectives, among other things
- ▶ **Resource Provision** – At an average of 25% over the period 2000-2006, Education receives the largest share of the national budget, although there is room for substantial improvement in terms of re-distribution to the primary school level.

PRIORITIES FOR DEVELOPMENT AND DEVELOPMENT ASSISTANCE

- a. Capacity building on MDG-Based planning
- b. Strengthening Systems – including a Monitoring and Evaluation system to track progress in the achievement of the Goal
- c. Resources – Financial, Technical and Human resources in order to improve the capacities of the education institutions to plan, implement and monitor progress.
- d. Capacity for data collection and analysis

SUPPORTIVE ENVIRONMENT

- ▶ **Policy Environment** – the National Development Strategy, the National Education Policy of 1999, National Development Plans, the Prime Minister's Transformation Statement, and the Country's

Goal III



Courtesy by SEDCO

**Promote Gender Equality and
Empower Women**

TARGETS

- ▶ To eliminate gender disparity in primary and secondary education by 2005 and at all levels by 2015.
- ▶ To increase the participation of women in decision-making in all levels to 50:50 by 2015.

STATUS AND TRENDS

Gender Equality is a basic human right which ensures that all people, irrespective of gender, are given equal opportunities thus enhancing their chances of getting out of poverty and leading productive lives. In Swaziland, there is no explicit gender discrimination policy in terms of literacy and employment. However, when compared to their male counterparts Swazi women tend not to have equal opportunities because of cultural, religious attitudes and traditional as well as modern laws. For instance, in accessing education, where are resource constraints and a choice has to be made between sending a boy or a girl to school, there is a tendency among poorer rural households to favour to boys education. While women head 43.2% of total households in Swaziland, 63% of female headed households are poor and lack productive assets compared to 52% of the households headed by males.

Until the recent constitutional dispensation, women had limited access to land. Women rarely hold leadership positions and the level of women's participation in politics is low. On the whole women and girls appear marginalized. The MDG targets to eliminate gender disparity in education and increasing the level of participation of women in decision-making positions are thus supported to best reflect the country's gender equality needs. More so, the participation of women in decision-making levels is believed to be a good tool to improve governance.

Whereas population statistics reveal that there are

112,419 girls of the primary school age group (6-13 years) the primary school enrolment rates for 2000 show that there were 103,542 girls in school and from a population of 110,248 boys there were 110,444¹ boys in school. In 2005 enrolments improved to 107,276 girls and 114,320¹ boys. In both periods, girls constituted an average of 48.4% of the total primary school student population, revealing that there were more boys than girls in the system. Also, by looking at the population and enrolment figures it is revealed that some girls who are supposed to be in school do not attend yet the boys figures show that all and more boys enter into the system. In 2000, the primary school net enrollment rate (NER) was 77.6% for girls and 77.4% for boys. By 2005 this improved to 82.3% for girls and 81.5% for boys. (See figure 3.1)

The net enrollment rate indicates if pupils who are of a specified age group are at the appropriate level of education, for primary education the specified age group is 6-13 years. The trend in net enrolment for both sexes is improving and the girls that are in the system are more appropriately aged than their male counterparts meaning that when parents make the decision to send the girl child to school, they enroll them at an appropriate age. Factors influencing poor net enrolment rates for boys include late starting and higher incidences of repetitions. The 2005 primary school completion rates were 86.3% for girls and 81.4% for boys. This shows that the girls make better progress than boys.

The situation changes significantly at the secondary education level where in terms of enrolments boys lag behind girls. 2005 Population figures for the secondary school ages of 13-18 years reveal that there are 74,404 girls and 30,250 were enrolled in 2000, while boys population is 71,871 boys and 30,003 were enrolled. Gross enrollment figures improved to 35,789 girls and 35,338 boys in 2005, with girls constituting an average

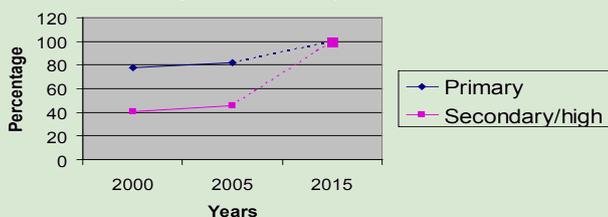
of 50.3% of the total students population. At this level, while the number of girls in school is more than that of boys we notice that gross enrollments for both sexes are less than half their population numbers, with the situation slightly worse for girls whose GER averages 44.4%. Factors affecting the poor enrolments at this level include poverty and the HIV/AIDS consequence of child headed homesteads, teenage pregnancies for girls and the poor absorptive capacity of the education system in terms of the availability of school spaces. NERs for the secondary level are low at an average of 39.2% for both sexes. The NER increased from 40.5% for girls and 38% for boys in 2000 to 45.7% for girls and 44.6% for boys in 2005. (see figure 3.1) This reveals that both groups are not appropriately aged for this level of education and like is the case in primary education boys are worse affected. Completion rates are lower for girls at 73% and 83% for boys as girls drop outs due to teenage pregnancies.

as teaching (education) and nursing. The gender pattern in the selection of fields of study in tertiary education is a key issue in debates about gender equality because the decisions students make about their preferred tertiary studies can have a strong influence on their future lives, their jobs and the roles available to them in society. In Swaziland female enrolments into higher return fields of science, business and Law are lower than those of males. 2005 enrolment statistics show that female enrollment into the fields of teaching and nursing accounted for 45.7% of the total female enrolment in tertiary institutions, while only 35.3% males enrolled in those fields.

Although there are positive improvements in enrolments at all levels of education a lot more work still needs to be done. This includes improving the absorptive capacity of the education system, introducing school feeding systems, enforcing safety at school for girls in particular, cheap and standard uniforms and psycho-social interventions for traumatized children and encouraging girls to enroll into high return tertiary courses. Education improves employment opportunities, especially in getting into formal wage employment and education is expected to improve the chances of women to compete with men in getting to higher levels of management and decision-making at the political level.

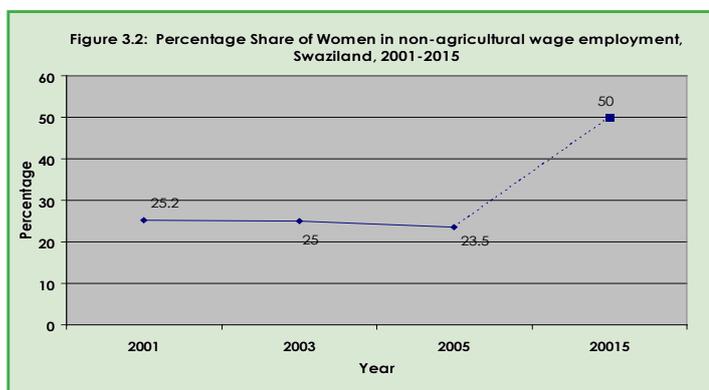
In Swaziland only 31% of the population is employed and this represents 39.6% males and 23.5% females. Most women are found in the informal sector of employment, mainly in micro enterprises and in the agricultural and food production sector where about 70-80% of women carry out the work. The participation of women in the non-agricultural wage employment sector remains poor. This indicator shows the degree to which the labour market is open to women, in the industry and services sectors. A higher share of women in the non-agricultural wage employment sector can improve their livelihoods in terms of higher earning. In 2001, only 25.2% of women

Figure 3.1: Net Enrolment Rates, Girls, Swaziland, 2000-2015



Source: Education Statistics, 2000 and 2005

Full time enrolments in tertiary education increased from 4,191 in 2000 to 5,890 in 2005. While there are slightly more male students than females, over this period, women continued to progress towards achieving parity with men. In the 1999/2000 academic year female students constituted 47.8% of total enrolments and the situation improved to 49.6% 2004/05. Although female enrolments are increasing the higher numbers are recorded because of increased registration in fields such



Source: Employment and Wages, 2005

There has been a significant improvement in women representation in Parliament. In the present Parliament (2003-2008) the representation of women stands at 20%, an improvement from the previous representation of only 8% in 1998-2003. While this is an achievement, it still stands short of the stipulated 30% quota that was set to be achieved by 2005 and an anticipated 50% by 2015. Nonetheless, Swaziland is committed to ensuring a 30% women's vote in the 2008 parliament and a 50% women's vote target can be achieved by 2015. (See table 3.1)

Indicator	1998	2003	2008	2015*
Total No. of seats	95	95	95	95
No. of Women	8	19	28	48
No. of Men	87	76	67	47
Proportion of Seats held of Women in National Parliament (%)	8	20	30	50

Source: Parliament statistics, 2006

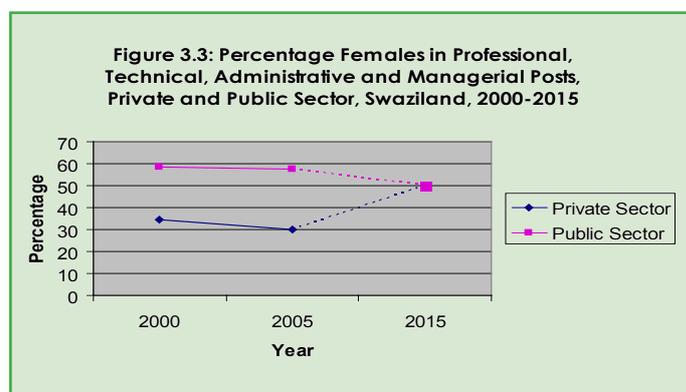
Female representation in Cabinet has also improved. In the 1998-2003 government, from a total of 18 members including the Prime minister only 2 members were female, a 12% representation and the situation improved to 4 members, 22% representation, in government. Further, in 2006 Swaziland saw a historic representation where the offices of the Deputy Prime Minister and the single post of deputy-Minister became occupied by

females. There have been some improvements, though minimal, in the area of the Judiciary where out of the 7 High Court and Industrial Courts judges, 1 is female, an improvement from the previous term where there was no female representation.

In the area of Local Governance, traditionally all Chiefs are males and females can only act in regency until the rightful heir is installed. In urban local government, from a total of 12 urban government Local Authorities, 4 local managers are female (giving a 33% female representation), and 36% of local councilors are female. This area has improved from the previous situation where only 15% of local managers and 30% local councilors were female.

In the Swaziland civil service women hold a greater percentage of the total professional, technical, administrative and managerial positions than males. In 2000 women occupied 58.3% and the situation reduced slightly to 57.5% by 2005.

The situation in the private sector is less representative where in 2000 only 34.4% females held similar positions, with the situation declining to 30.2% in 2005. (See figure 3.3).



Source: Employment and Wages, 2005

Most women are not adequately empowered economically and socially they are not in full control of the social dimensions that determine their health, such as the number of children to have and the health risks. The spread of HIV and AIDS is fueled by gender inequality where women have no voice in sexual matters therefore becoming more vulnerable to infection and make up the majority of newly infected people. Statistics from the 2006-07 Demographic and Health Survey reflect that the prevalence rate among women between the sexually active age group of 15-49 years is 31.1% while that of men, within the same age group, is 19.7%. The past years have seen an increase in the number of women and children that suffered from physical and sexual violence. This is partly explained by the deteriorating socio-economic situation, as well as the negative cultural beliefs related to the cure of HIV and AIDS including STIs. 50% of working women do not have a pension fund and have limited access to credit with married women having to acquire spousal support in order to access credit the formal financial system.

Overall, Swaziland is committed to meeting its 2015 gender equality goal. In most areas the indicators demonstrate upward mobility towards the targets. It is important to note that although the gender target concentrates mainly on the female sex, there is need to be cognizant of the fact reverse discrimination against men is not acceptable. In the areas where women folk remain vulnerable efforts are being made to better them and such efforts are seen in the Constitution. The Constitution aims to improve the female status; it advocates for equal access to land, repeals all discriminatory practices and laws against women and states that each child, irrespective of gender, has the right to education.

The national policy on gender is, therefore, to create an environment that would enable investment, trade and economic prosperity for all equal partners.

CHALLENGES

The following are the challenges that the nation needs to seriously consider in order to be on target by 2015.

- ▶ Gender specific research needs to be undertaken on the relationship between gender and other economic, social and political factors.
- ▶ The strengthening of national statistical offices to gather and analyze sex disaggregated data are key to understanding and developing solutions.
- ▶ A cultural overhaul regarding mindset to gender issues.
- ▶ A review and repeal of all discriminatory laws and removing the minority status of women.
- ▶ The need for stronger legal rights for women, these include women's access to property, productive assets, inheritance rights, protection for violence etc.
- ▶ Gender-specific violence needs to be eliminated as women lack protection from risks such as domestic violence and vulnerability in the hands of their partners.
- ▶ Gender mainstreaming needs to be enforced.
- ▶ The health system needs to be designed to respond equally to the specific needs of women and men. Inadequate care for women during pregnancy and childbirth can lead to unnecessary deaths.
- ▶ The micro enterprise sector needs to be supported and developed to ensure equal opportunity to employment and income generation activities.

SUPPORTIVE ENVIRONMENT

- ▶ The constitution
- ▶ The National Gender policy
- ▶ Establishment of a Gender Department
- ▶ Labour statistics: The Ministry of enterprise and Employment has embarked on a labour force survey that will tabulate the number of skills available in the country, including a job survey on both the private and public sector. This effort will make data on the labour force readily available.

Goal IV



Reduce Child Mortality

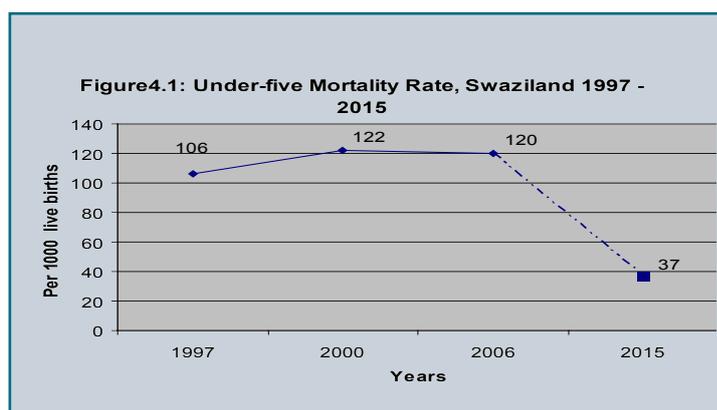
TARGET

- ▶ Reduce by two-thirds, between 2000 and 2015, the under-five mortality rate.

STATUS AND TRENDS

Approximately 54 percent of the population in Swaziland constitutes children under the age of 18 years indicating a challenge for child health and early adult reproductive health programmes. Child mortality is closely linked to poverty, education and poor healthcare services. Of significant importance is the quality of healthcare services in rural areas versus the quality in urban areas, access to safe water and sanitation and the level of food security at household level. Education of mothers also influence mortality levels and saves children’s lives. During the early 1990’s infant and child mortality had declined drastically. The decline was due to the positive impact of child survival interventions like safe motherhood and neonatal care programmes.

However, by the late 1990’s under-five mortality began to rise. The hard-won child survival gains were being reversed as a direct and indirect impact of the HIV and AIDS epidemic, teenage pregnancies and the concomitant rise in poverty levels. Trends indicate that under-five mortality was reduced to as low as 82 per 1000 live births in the early 90’s and later rose to 106/1000 live births in 1997, 122 per1000 live births in 2000 and 120 per 1000 live births in 2006. Nonetheless, between 2000 and 2006 the rate of increase was not as pronounced as in the late 90’s resulting in stabilization of the mortality rate. The stabilization can be explained by the refocus of government interventions on child health due to the surging numbers of orphans and vulnerable children. Such a trend is expected to continue as the government is taking a holistic approach in addressing child welfare issues. The target is to reduce under-five mortality to 37/ 1000 live births by 2015 (see figure 4.1).



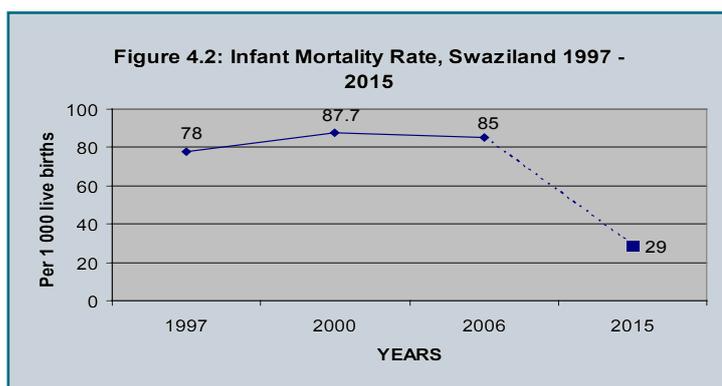
Source: Central Statistics Office

According to the Child Health Epidemiological Group, 2006, HIV/AIDS is the leading cause of mortality among children in Swaziland. HIV/AIDS is responsible for 47% of under-five mortality, neonatal 27%, pneumonia 12%, diarrhoea 10% and others 4%.

Infant mortality rate has been declining steadily from 98 per 1000 live births in 1986 to an estimated 74 per 1000 live births in 1993. Infant mortality began to rise in the late 90’s to 78 per 1000 live births, and reaching 87.7 per 1000 live births in 2000 before stabilising to around 86 per 1 000 live births between year 2000 and 2006 as shown in figure 4.2. This implies that 1 in 12 children will die before their first birthday and 1 in 8 will die before attaining the age of five years. The stabilization of infant mortality can also be attributed to the scaling up of Prevention of Mother to Child Transmission (PMTCT) which began with development of guidelines and mass capacity building for health workers.

It is reported that 54% of infant deaths occurred within 28 days of birth and 19% occurred within the first week of birth in 2002. In addition a high still birth rate of 19 per 1000 live births was also recorded in 2002. On the overall the perinatal mortality rate was 29 per 1000 live births in 2002. Although data for 2006 is not available an upward trend is predicted in line with marital mortality. Most perinatal deaths were due to low birth weight, hypothermia, birth asphyxia, brain trauma and infections including AIDS.

PMTCT rollout has observed a significant increase in the number of health facilities providing the service from 10% in 2004 to 71% at the end of 2006. The strategy also changed from voluntary testing and counselling in 2005 to a provider initiated HIV testing and counselling. The provider initiated testing and counselling has realized an increase in the number of antenatal attendees who were voluntarily tested from 15% in 2004 to 66% in 2006. Follow-up of women and their children after delivery is clearly defined in the PMTCT guidelines which include continuous counselling on HIV prevention, infant feeding, family planning and provision of cotrimoxazole prophylaxis to HIV exposed children from six weeks. The target is to reduce infant mortality to 29 per 1 000 live births by 2015.



Source: Central Statistics Office

Unsatisfactory child health outcomes can also be explained partly by low coverage of safe water supply and sanitation. Since year 2000, it has been reported that children from households without access to safe water and sanitation have an increased likelihood of having diarrhoea by approximately 32% compared to 19% if the household has access to safe water. Access to safe drinking water has been highly compromised by erratic rainfall and the prevalent drought situation. It is estimated that only 36% of households in the country had access to safe water during the dry season and from these only 44% is within 15 minutes of a water source. Further, sanitation coverage remains low estimated at

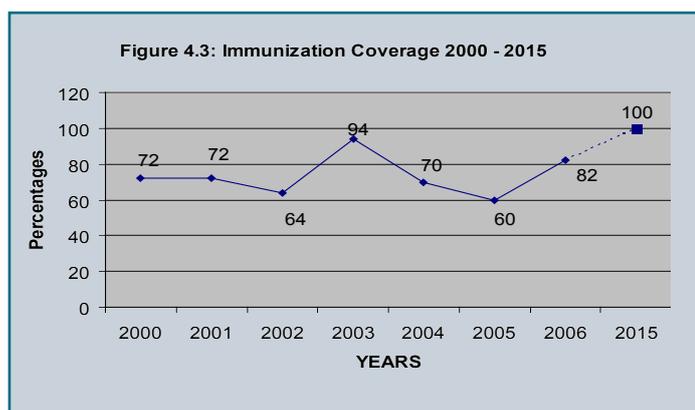
40 – 45% in rural areas and 63% in urban areas. Low coverage of sanitation is attributed to lack of maintenance of water supply and waste water disposal systems in residential areas. Solid waste disposal systems are rudimentary and poor household sanitation practices include dumping of waste in brow-pits, on plain land or on banks of rivers.

Children's malnutrition was a minor problem until the late 1990's but became critical after adverse weather conditions and increasing prevalence of HIV/AIDS beginning the year 2000. The prevalence of underweight children in Swaziland had shown a declining trend from more than 25% in the early 1990's to 10% in 2000 and 7.4% in 2006. During the same period the prevalence of moderate to severe wasting has reduced to 1%, though showing a slight increase to 2.2% in 2006. The slightest increase is attributed to the food security crisis and erratic rainfall pattern from 2002 to 2006. Regional variation is high though ranging from 1.0% in the Lubombo region to 2.7% in the Hhohho region. The increasing number of households who depends on food aid and have limited access to water and sanitation has increased the risk of childhood illnesses and child mortality.

Prevention programmes such as immunization against childhood illnesses also contribute to the reduction of peri-natal, neonatal and child mortality. The Swaziland Expanded Programme on Immunization programme focuses on childhood vaccine against preventable diseases which includes poliomyelitis, measles, tuberculosis, diphtheria, pertussis, neonatal tetanus and hepatitis B. Other child survival interventions have been included in previous immunization campaigns. These include vitamin A and de-worming tablets. Measles immunization coverage has been on a consistent decline from 94% in 2003 to 60% in 2005.

On the contrary there has been a dramatic decrease in disease incidence and outbreaks of measles. Suspected cases fluctuated downwards from 2, 201 in 1996, to 10

in 2000, 72 in 2001, 64 in 2002, 94 in 2003, 70 in 2004, 60 in 2005, 82 in 2006 and 100 in 2015. The programme has also successfully eliminated neo-natal tetanus and has achieved certification standards in polio eradication. In national immunization campaign conducted in 2006, 91.3% of children aged 9 – 59 months were immunized against measles. Vitamin A and Albendazole were also administered during the campaign and the coverage was 87.4% for both interventions. On the overall the programme has a high utilization rate of over 80% using static health facilities as well as outreach sites for vaccination services. The national target is achieving 100% immunization coverage by 2015.



Source: MOHSW

Although the country continues to make significant strides towards achieving this MDG a significant decrease in infant mortality depends largely on gains made in the fight against HIV and AIDS, food security, poverty reduction and improvement in access to safe water and sanitation.

CHALLENGES

There are a number of challenges in the reduction of infant and child mortality rates by two thirds between 2000 and 2015.

- ▶ **HIV and AIDS and other diseases**
The HIV and AIDS epidemic has placed children under an increased state of vulnerability. Pediatric HIV care and treatment is still limited in the country as it fall short of the 15% of the overall anti-retroviral treatment programme. Prevention of Mother to Child services uptake is still low as approximately 66% of pregnant women are enrolled for the programme. These services are still not adequately decentralized to rural areas. Further, the integrated management of childhood illnesses strategy is still inadequately integrated in child health programme.
- ▶ **Limited Human Resources for Healthcare service provision**
There are various limitations in terms of skilled attendance and management of childhood illnesses.
- ▶ **Availability of Essential Medicines and Vaccines**
Access to essential medicines and vaccines must be improved for all children including orphans. The removal of all cost barriers in access to essential medicines will significantly improve the health of children.
- ▶ **Management and Coordination of Orphans and Vulnerable Children's Issues**
A project approach is being utilized in implementation of child health interventions and social welfare related issues. A one stop shop in the management and coordination of child welfare issues is required, utilizing the Integrated Management of Childhood Illnesses strategy.
- ▶ **Access to Safe Water and Sanitation**
Access to clean safe water and sanitation should be improved as it is the major contributor of poor

child health outcomes.

▶ **Underdeveloped Monitoring and Evaluation Systems**

A comprehensive surveillance system needs to be developed covering all aspects of child health. Existing systems are limited as they only consider routine immunization and HIV/AIDS indicators and exclude other key indicators such as nutrition and other diseases.

SUPPORTIVE ENVIRONMENT

Swaziland has various policies and programmes that are supportive to the reduction of child and infant mortality. Some of these include;

▶ **Expanded Immunization Programme**

The Expanded Immunization programme has maintained high immunization coverage of about 80%. Swaziland conducts national immunization campaigns and institutes an effective surveillance system, thus creating an enabling environment for universal immunization for children.

▶ **Child Supplementary Feeding Programmes**

Child supplementary programmes provide food for children at school and at community level through the neighbourhood care points. These programmes are able to bridge the gap between

all children including orphans and vulnerable children.

4 **A National Response to HIV and AIDS**

The government has constituted the National Emergency Council Against HIV and AIDS which facilitate the multi-sectoral response. This institutional arrangement facilitates the procurement of antiretroviral and related drugs, including PMTCT to mitigate the impact against HIV and AIDS. A significant stride in this area is the establishment of the children's centre of excellence which focus on paediatric HIV treatment, prevention, research and training.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

Major areas for development assistance to meet the challenges for reducing child mortality are as follows:

- ▶ Sustained increase in immunization coverage
- ▶ Provision of safe water and sanitation
- ▶ Increased financing of child survival strategies
- ▶ Improve human resources capacities; the country has a few pediatricians and very few are trained properly on integrated management of childhood illnesses.
- ▶ Establishment and strengthening of food security programmes.

Goal V



Courtesy by Mantenga Village

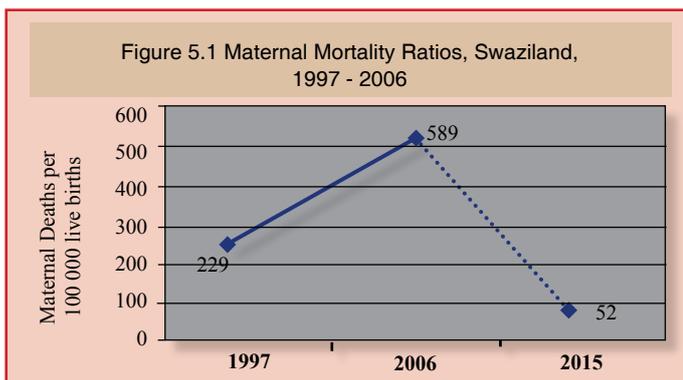
Improve Maternal Mortality

TARGET

- ▶ Reduce by three-quarters, between 2000 and 2015, the maternal mortality ratio.

STATUS AND TRENDS

The quality of reproductive health care services is the major determinant for maternal and child health. Maternal mortality continues to be a major problem in Swaziland. The probability of life being at risk every time a Swazi woman becomes pregnant was estimated to be 1 in 69 in 2003. The maternal mortality ratio were estimated to be 229 deaths per 100 000 live births in 1997 rising steadily to 589 per 100 000 live births in 2005 as shown in figure 5.1. The continuous increase in maternal mortality rate is associated with the rapid spread of the HIV and AIDS epidemic and limitations of the health system. The target is to reduce maternal mortality to 52 per 100 000 live births by 2015.



Source: Central Statistics Office

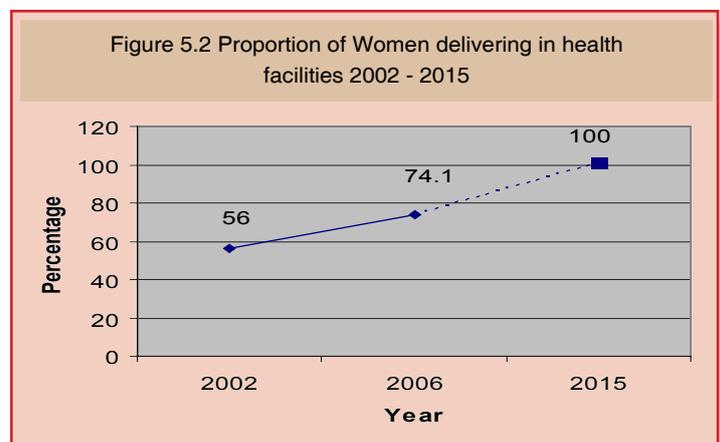
The magnitude of maternal mortality can be reduced drastically if mothers have equitable access to quality antenatal, delivery and post-natal care. Expectant mothers in Swaziland die due to puerperal sepsis (25.6%), hemorrhage (7%), ruptured uterus (2.3%), septic abortion (9.3%), eclampsia (4.3%), Aids (9.3%), medical diseases in pregnancy (16.3%), Pulmonary TB (9.3%), malaria in pregnancy (7.0%) and other (9.3%). Although, the average time to access a health facility was 41 minutes in 2002, maternal and peri-natal services needs to be expanded and improved in poor regions as Shiselweni and Lubombo.

According to the reproductive health needs assessment (2002) and the Demographic and Health Survey (2006-07),

the percentage of women delivering in health facilities has increased from 56% in 2002 to 74.1% in 2006 as shown in figure 5.2. In 2002 it was reported that 44% of mothers delivered at home and of these, 44% were assisted by traditional birth attendants, grandmothers and relatives (23%), rural health motivators (12%) neighbours (3%), and 16% delivered on their own. The situation in 2006 improved with only 25.9% of mothers delivering at home.

The Demographic and Health Survey 2006-07, states further that, 97.1% of pregnant women received antenatal care from a health professional, 74.1% delivered by a health professional, 74.7% whose live births were protected against neonatal tetanus and 88.2% were given iron tablets/syrup during pregnancy. The proportion of mothers assisted by skilled health personnel has not increased significantly from a 70 % recorded in 2000, despite that 80% of the population is within an hour walking distance to a health facility.

Further, the health system faces several limitations which include shortage of adequately skilled nurse-midwives and doctors for maternal care, poorly equipped maternity units and the non-functionality of the referral system. The limitations of the health system places the lives of a significant number of pregnant women at risk as some studies have revealed that 27% of ANC and women in maternity wards each year were aged below 20 years. This age is considered to be at the beginning of their reproductive life. Therefore, a number of women are at risk of pregnancy complications as they engaged in unprotected sex at early ages.



Source: Central Statistics Office

On the overall it can be concluded that the country has not made significant progress towards achieving this MDG. This situation is further exacerbated by the continuous increases in HIV and AIDS infection rate which is proportionately higher among women of child bearing age groups. Amid the high proportion of women giving birth at health facilities the health system is non-responsive due to several reasons which include limited funding, non-availability of essential drugs, shallow skill mix and limited quantities of human resources which erodes the capacity of the system. An in-depth analysis of infants' deaths in 2002 revealed that approximately 54% of deaths occur within the first four weeks of birth and 19% within the first week of birth. These statistics by and large are associated with the health status and quality of care given to the mother during pregnancy and delivery. The national reproductive health strategy 2002 to 2006 has not been fully implemented and its impacts have not been evaluated.

CHALLENGES

Swaziland is faced with a number of challenges in the area of reducing mortality. These include

▶ HIV and AIDS Epidemic

The HIV and AIDS epidemic has placed mothers under an increased state of vulnerability. The challenge is to reverse the HIV and AIDS epidemic, increase the uptake of PMTCT and provide other effective interventions.

▶ Inadequate access to health care services

Nearest low level health facilities do not provide for maternal health care services and public transport system to tertiary hospitals is unreliable. These factors coupled with the high poverty rates and unemployment rates results to poor health seeking behaviour. The distribution of gynaecologists is skewed towards urban health facilities thus limiting access to a significant number of women in rural areas. Further, the referral and communication system has not been fully developed, which results in inadequate management of complications.

▶ Improving data collection

The surveillance system for maternal services including

maternal audit has not been adequately developed, therefore resulting in severe data limitations in terms of maternal health. Data gathering capacity therefore needs to be strengthened, including the registration of major events such as births and deaths.

▶ Gender inequalities

Men participate selectively in reproductive health services yet as partners they significantly impact on women's health seeking behavior. There is a great need therefore to mainstream gender issues into reproductive health policies.

▶ Human resources for health shortages

The appropriate staffing patterns in various health institutions needs to be improved in view of the prevalent attrition factors. There is also a need for strengthening the capacity of health providers through continuing medical education as well as periodic updates.

PRIORITIES FOR DEVELOPMENT ASSISTANCE

▶ Human Resources for Health

Ensure adequate numbers of health personnel at all appropriate levels of health care and have the knowledge, technical skills and positive attitudes to manage reproductive health issues.

▶ Strengthen Regional Planning Of Maternal And Neonatal Care

In order to ensure an effective referral system, planning for maternal and neonatal care including family planning should be strengthened from regional level.

▶ Gender Mainstreaming in Sexual and Reproductive Health Services

A strategy to involve men in sexual and reproductive health services should be developed.

▶ Appropriate Technology and Management

Health facilities should be properly equipped with appropriate technology and the equipment be well maintained. Health facilities should also be managed appropriately to improve service delivery.

Goal VI



“A Nation at War with HIV/AIDS”

Combat HIV/AIDS, Malaria and Diseases

TARGETS

- ▶ Have halted, by 2015, and begun to reverse the spread of HIV and AIDS.
- ▶ Have halted, by 2015, and began to reverse the increasing incidence of Malaria, TB and Diarrhoeal diseases.

STATUS AND TRENDS

HIV/AIDS continues to be an overwhelming crisis, rapidly spreading and impacting deeply on the social, cultural and economic aspects of the Swazi nation. The rising prevalence of the HIV and AIDS infection rates and its consequences are putting enormous pressure on an already stretched health care system in Swaziland. Over half of all hospital beds are taken by HIV and AIDS related illnesses, rendering non-HIV/AIDS patients' limited access to health care. The crude death rate has increased as a result of AIDS mortality, from 9.9 to 22.7 deaths per 1000 people in 2005.

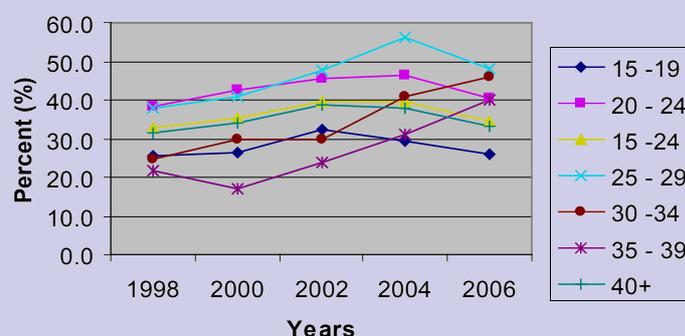
HIV AND AIDS

Since the first HIV and AIDS case was discovered in Swaziland (1986), the HIV/AIDS incidence has continued to increase and approximately about 220, 000 people were living with HIV and AIDS in 2004. The prevalence rate among antenatal clients as measured by the sentinel surveillance has continued to increase from 34.2 % in 2000 to 39.2% in 2006. Sentimental surveillance data trends show that the epidemic is beginning to stabilize, as the prevalence rate dropped from 42.6% in 2004 to 39, 2 % in 2006.

Evidence from ANC attendees shows that there has been a positive trend in the level of HIV prevalence across all age groups in the period 1998 to 2004 with the highest prevalence occurring in the age group 25 – 29 years followed by 30 – 24years. However, there was a consistent decline among the age group 15 – 19 years between 2002 and 2006 from 32.5% to 26 %. The prevalence rate in the

broad age category of 15 to 24 years stabilized from 39.4% in 2002 to 34.6% in 2006. On the contrary HIV prevalence for the age groups 30 – 34 and 35 – 39 has maintained an increase in the same period. These trends implies that there has been a shift of the burden of the pandemic from the young age groups of 15 – 24, 25 – 29 years to the middle age groups of 30 – 34 and 35 – 39 years. Figure 6.1 below shows the prevalence trends among the various groups from 1998 to 2006. Using the age group of 15 -19 and 20 – 24 years as a proxy for HIV/AIDS incidence, it may be inferred that Swaziland is showing decreasing signs from 32.5% in 2002 to 29.3% in 2004 and 26.0% in 2006. The DHS 2007 shows that the interventions being pursued by Swaziland has started to show positive impacts on the population. The country's objective is to reduce the number of sexually active persons who have had sex with more than one partner by 25%.

Figure 6.1 Trends in HIV Prevalence among Pregnant Women by Age, 1998 - 2006



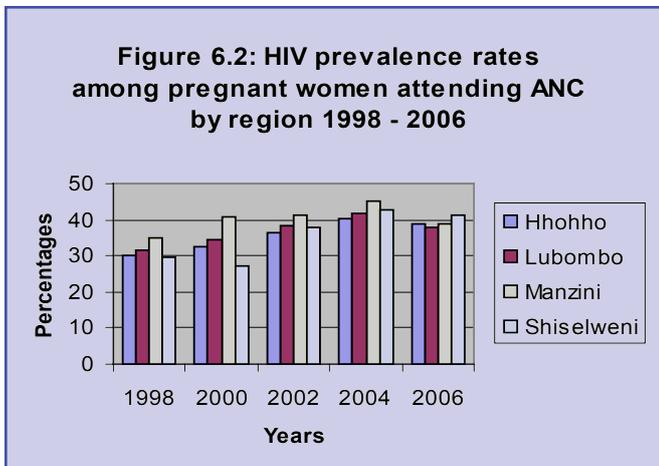
Source: MOHSW

Regional variations show that the epidemic has been increasing since 2000 and have stabilized between 2004 and 2006. It is worth noting though that Shiselweni region has recorded dramatic increases of 41.5% in 2006. Although, the prevalence is generally high in all the four regions of the country, Manzini region recorded the highest decline from 45.1% in 2004 to 38.6% in 2006 as shown in figure 6.2 below. The level of HIV prevalence depicts insignificant variations between urban and rural areas as they were 35.6% and 32.7 % for urban and rural areas

in 2000, 44.5% and 40.3% in 2004 declining to 41% and 37% in 2006.

treatment of malaria cases have been reported to be as low as 0.08%.

The targets are to: reduce hospital case fatality rate to 2% by 2007, reduce malaria incidence rate to less than 40 cases per 1,000 people, reduce malaria mortality rate to 3 per 100,000 by 2007, and reduce the proportionate malaria attributed morbidity to 2% by 2007.

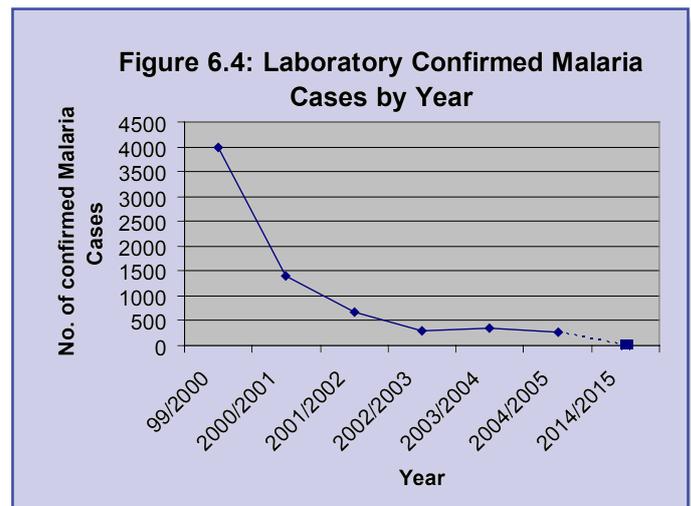


Source: MOHSW

The number of children orphaned by AIDS in Swaziland was estimated at around 70,000 in 2006. Of the estimated 220,000 people living with HIV/AIDS in the country, it is estimated that approximately 15,000 children of ages 0 – 14 years are living with HIV/AIDS. Of these 1,600 have enrolled for Anti-retroviral treatment. Also, while among the under-fives, HIV and AIDS is now considered to be the number one killer.

MALARIA

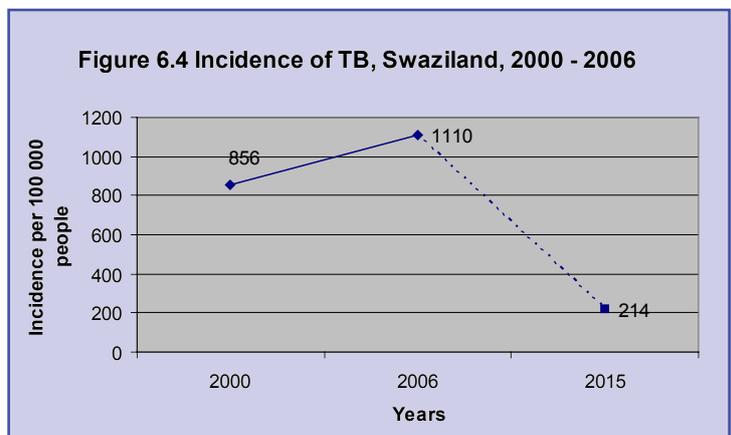
Overall, Swaziland appears to be winning the war against malaria as there has been a significant reduction in the incidence of clinical malaria from 4.1 per 1000 people in 2000 to 2.2 per 1000 people in 2004. The significant decrease in the incidence of the disease can be attributed to a number of factors including high indoor residual house spraying coverage, erratic rainfall trends, improved public consciousness and awareness in affected communities. The number of laboratory confirmed cases has dropped from an average of 4,000 per year during the period 1995 – 2000 to less than 300 per year during the 2004/05 malaria transmission season (see figure 6.4 below). Also noted is the significant reduction in the number of malaria deaths from an average 80-90 deaths per year during the period 1995 – 2000 to less than 10 during the 2004/2005 malaria transmission season. Clinical failures against the



Source: MOHSW

TUBERCULOSIS

Tuberculosis is one of the leading causes of morbidity and mortality among adults in Swaziland. The number of TB cases notified in Swaziland over the last 15 years has increased six-fold. In 2000 the prevalence rate of TB was estimated at 856 per 100,000 people rising to 1182 per 100,000 in 2006 (see figure 6.4 below).

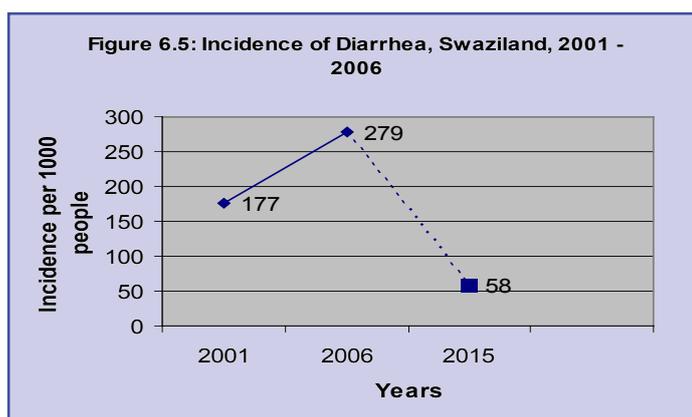


Source: MOHSW

The country has recorded a sputum smear positive case detection rate of 42% in 2005 and it increased to 52% in 2006. Treatment success among sputum smear positive TB cases enrolled in 2004 is only 51%. 33% of sputum smear positive TB cases are censored or lost during follow-up. Rising poverty levels, poor environments and the HIV virus have contributed to the resurgence of TB, which thrives on immune system weakened by chronic infections. In this regard the proportion of TB cases registered which are tested for HIV vary between 40 and 90% with more than 80% TB-HIV co-infection observed.

DIARRHEAL DISEASES

In 2006 it is estimated that approximately 36% of households had access to an improved source of water and 47% lacked access to improved sanitation. Diarrhoeal diseases, largely preventable through access to safe water for consumption, sanitation and food hygiene were responsible for approximately 13.3% of all out-patient consultations in 2001. There has been a significant increase in the incidence of diarrhoeal diseases from 177 cases per 1, 000 people in 2001 to 279 cases per 1, 000 in 2006 (see figure 6.5). The target is to reduce the incidence of diarrhoeal diseases by two-thirds in 2015.



Source: MOHSW

CHALLENGES

This is the priority goal that underlies the achievement of almost all other goals. The major challenge faced by the nation is to combat and reverse the spread of HIV and AIDS within the immediate future. Some of the operational challenges in this area are as follows;

▶ Impact Mitigation

There is a need to establish and strengthen programmes geared towards minimizing the socio-economic impact of HIV and AIDS. The impacts includes the prevalence of orphans, a humanitarian crisis as a result of vulnerability due to poverty and intermittent droughts and floods, increased morbidity associated with HIV/ AIDS, inability of the health system to effectively respond to the burden of disease, reduced human capacity to implement the national response to HIV/AIDS. Already the economic gains realized in the past decades are beginning to be eroded as life expectancy and other quality of life indicators decline. With such challenges, it is difficult to reach some of the MDG goals.

▶ Research, Monitoring and Evaluation

A strong national sector-based monitoring and evaluation framework is needed to track the progress made in the national fight against HIV/AIDS, utilizing data gathered through surveys and or research and data collected as part of routine monitoring activities. There is also a need for resource mobilization and adequate allocation of resources for monitoring and evaluation, especially in the health sector. An effective structure for identification of priorities for operational research is required.

▶ Effective Behaviour Change Communications Programmes

Whilst the national response to HIV/AIDS has scaled up significantly, behaviour change towards risky behaviours in the population remains a challenge. As studies indicates slight decline in the number of new infections among young women there is a great need to strengthen and expand prevention, especially behaviour change activities focusing on the youth. Implementation of behaviour change communication strategies has not made significant positive impacts as yet.

▶ Adults Interventions

The 2004 and 2006 sentinel surveys are showing

an emerging HIV epidemic among the women aged 30 years and above. This advent therefore, is dictating the need for specific interventions targeting this population group to ensure that they receive appropriate care and support.

▶ **Voluntary Counselling and Testing and Prevention of Mother to Child Transmission**

HIV prevalence continues to be a national challenge and so does the need for voluntary counselling and testing facilities for the general population and some target groups. Utilization of VCT facilities remains low, for example in 2006 21.9% of women and 8.9 men aged between 15 and 49 years tested and received results. While 66% of pregnant women accessed PMTCT services in 2006. The current approach of provider initiated HIV testing and counselling, is a positive strategy to increase the number of people who know their HIV status and eventually properly cared for and supported. There is need for a more aggressive sensitization campaigns for people to go for testing.

▶ **STI Care**

The current surveillance indicates that STI prevalence continues to be very high in the country and 56% of those who reported having genital ulcers or vaginal discharge were HIV positive. There is therefore a need to strengthen the current case management and support at all levels and among all sectors of the health system. In this regard capacity requirements for in-service training, ensure availability of essential drugs, including new drugs.

▶ **Youth Interventions**

To maintain a consistent decline in HIV infections among the youth, existing health facilities need to be increasingly focused on youth friendly services which is a challenge. Support to existing school programmes like health clubs should be intensified and supported by government. Special programmes for out-of school youth should be well established, expanded and supported.

TUBERCULOSIS

▶ **Quality of Laboratory Service**

Laboratory services do not adequately support the requirement of the national tuberculosis programme as only 55% of TB cases are being enrolled for treatment without smear examination. Laboratory services are constraint by limited human resources and limited laboratory supplies and equipment. The challenge of limited laboratory services and infrastructure means that the country cannot effectively respond to the threat of MDR/XDR TB public health problem.

▶ **Human Resources**

Availability of health personnel for the national TB programme is limited and centralized which limits their performance in the field. Further, the staff needs to be equipped with further TB training. As adequate numbers of staff is a pre-requisite for proper TB control, appropriate trained staff patient ratios have not been achieved and deployed in the critical areas of programme management, laboratory support and logistics.

▶ **Management**

Recurrent shortage of TB drugs at all levels is an indicator of inadequate TB drug management capacity. Over and above, there are inadequate TB recording and reporting systems at all levels. Infection control mechanisms remain a challenge.

▶ **Patient Care**

Although TB regimens are standardized and implemented countrywide defaulter tracing is not well implemented at all levels. Further, TB patients are not supported with any food supplements due to limited space availability and other logistics at health facilities.

MALARIA

▶ **Epidemic Preparedness and Response**

The country is not adequately equipped with weather

focusing equipment and capacity therefore making it difficult to predict malaria epidemics. The health system as well requires to have an effective and operational emergency preparedness plan which will compromise and delay response efforts at time of Malaria outbreaks.

DIARRHOEA

Low coverage in terms of access to safe water and sanitation remains a major challenge in the quest to reduce the incidence of diarrhoea and other waterborne diseases. The impacts of diarrhoeal diseases have an adverse effect on children under-five years of age which results in an increase in child mortality.

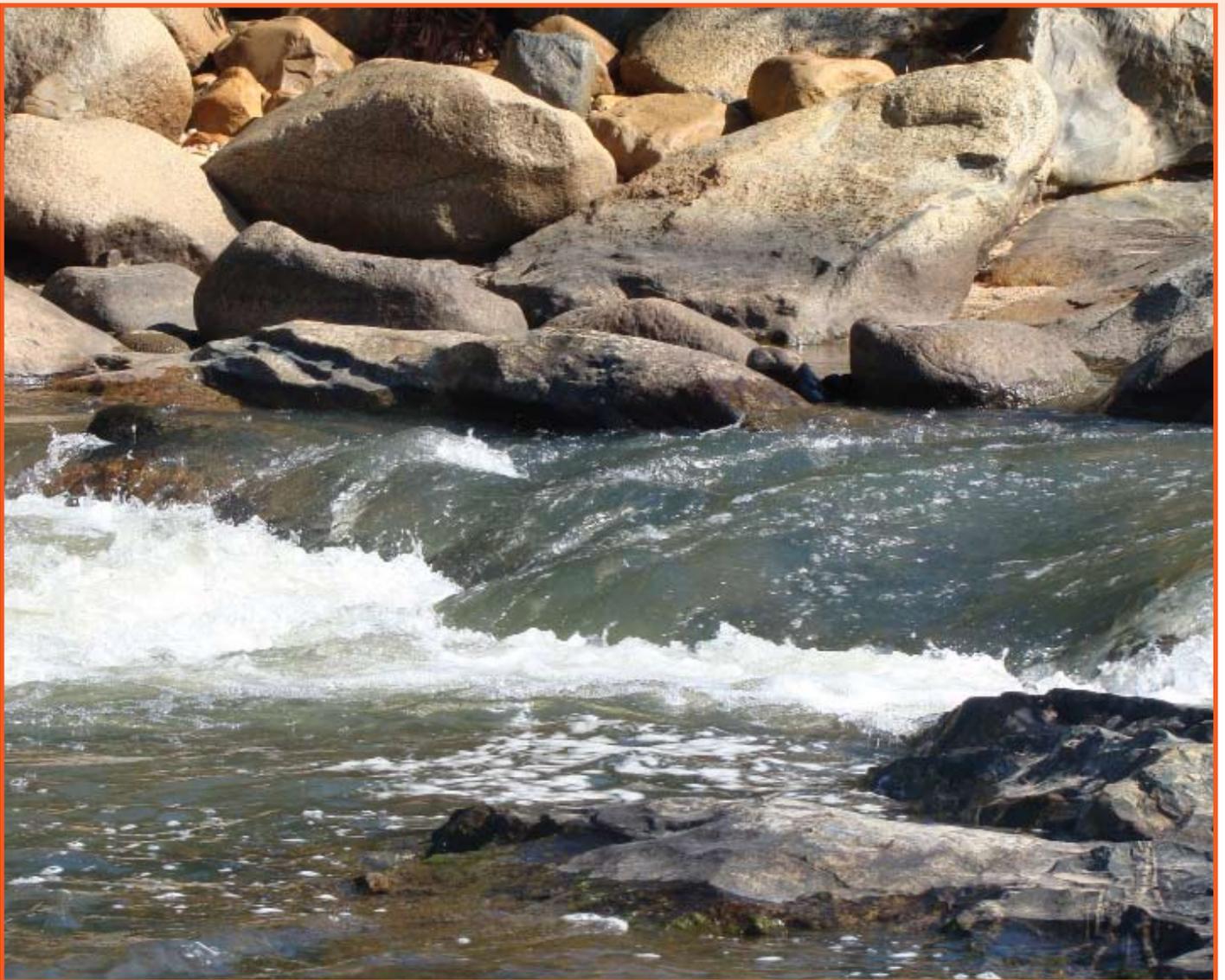
PRIORITIES FOR DEVELOPMENT ASSISTANCE

- ▶ Strengthening the capacity of the health system to effectively respond to the burden of disease

associated with HIV/ AIDS, TB and other diseases.

- ▶ Establishment of a National Medicine Regulatory Authority. This independent entity needs to be set up to regulate the manufacture, importation, exportation, distribution, and sale of pharmaceutical products and related commodities, and to ensure the quality and safety of medicines as well as their rational use.
- ▶ Human resource capacity development and retention needs to be addressed in order to win the battle against HIV/AIDS and TB. Human resources will also be required for appropriate staffing of laboratory facilities to effectively manage emerging threats such as the MDR/XDR TB.
- ▶ Support to boost the immune levels and to delay the onset of full blown AIDS and TB.
- ▶ Training women and children on the use of ITNs.

Goal VII



Ensure Environment Sustainability

PROGRESS REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS

TARGETS

- ▶ Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
- ▶ Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
- ▶ By 2022, achieve a significant improvement in the housing condition of at least 1,000,000 slum dwellers, peri urban and high density lodgers.

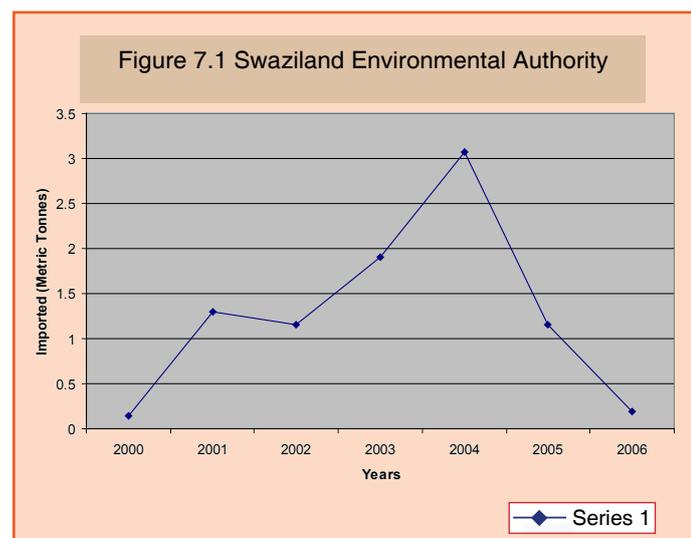
STATUS AND TRENDS

Swaziland has achieved significant progress in environmental sustainability even though there are challenges in some areas.

The use of depleting substances in Swaziland is decreasing and the country is within its allocated quota as shown in the table below.

Table 7: Use of depleting substances 2000 - 2006

Year	2000	2001	2002	2003	2004	2005	2006
Imported Metric Tonnes	14	1.3	1.16	1.9	3.09	1.15	0.19



Source: Swaziland Environmental Authority

The percentage of protected areas has been increasing since 2002 and the projections are showing that the country will meet its target if all the proposed sites are gazetted. The number of wastewater treatment plants is increasing and the quality in rivers is also improving. Two additional proper solid waste disposal sites have been approved since 2002. The number of waste management licenses has increased from 1 in 2003 to 7 in 2006 and there has also been an increase in the number of special waste licenses issued from 1 in 2005 to 2 in 2006.

However, Swaziland is still facing some challenges in the waste disposal management. There are currently only two properly designed land fill ages in Mbabane and Piggs Peak for industrial waste management. The other industrial areas use dump sites for industrial waste management.

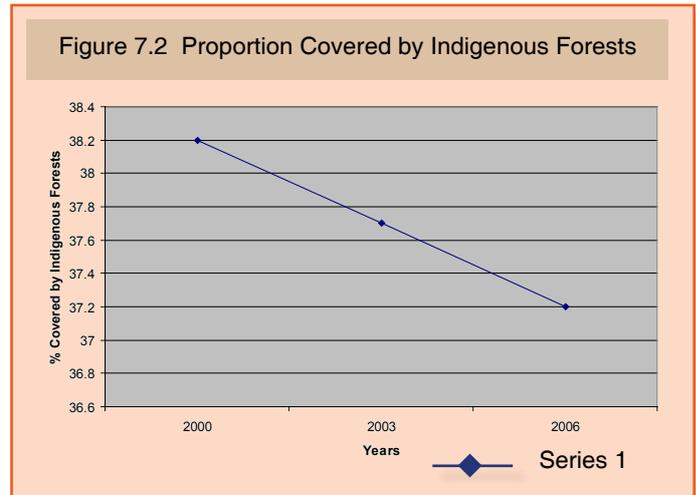
In urban areas homesteads use there is a waste collection system in place. However, the system is not working properly as it suffers from lack of full coverage. The system is only concentrated in the central business district areas of major cities and selected dwelling areas. Since the waste collection system in urban homesteads is the responsibility of the local government authorities they are not able to cope with the full coverage of urban homesteads owing to their financial position. In rural areas homesteads use backyard pits for the disposal of waste.

With regards to water and air pollution there is monitoring of water pollution in Swaziland. Water samples are periodically taken from the major rivers and sent to the laboratory to analyze them for pollutants. The air pollution control regulation has been submitted to Parliament for approval.

Four incinerators have been established in the country since 2000 and three of these will be upgraded to function more efficiently and effectively. Since 2002, the number of industries with wastewater treatment plants has increased and almost all wet industries established after 2000 have wastewater treatment facilities.

However, there is an increase in the threatened plants and animal species and there are high incidences of soil erosion. Even though there is no monitoring system for air emission in Swaziland this is usually inferred from the quality and amount of energy consumed in the country. The table below depicts the percentage of energy type consumed per type. The analysis reveals that there is high consumption of fuel wood than the other types.

Indigenous forests cover in Swaziland has declined from 38.2 percent to 37.2 percent owing to the cutting of trees for sale and clearing of land for development. With regards to climate change it is important to note that in order for any country to confidently analyze the developments in climate change patterns that results in natural disasters such as drought, floods and storms there has to be consistent research that has been carried out spanning a period of at least 30 years. Swaziland does not have the capacity to carry out such studies. However., what can be noted is that the current changes in the weather patterns that the country experiences is a result of past generations. Consequently the behaviour of the current generation will severely affect future generations through drastic changes in future weather patterns.



Source: SEA

With regards to access to safe drinking water and sanitation, access to safe water in urban areas have increased from 28 000 to 41 000 people in urban areas in the as well as the other gazzeted towns, translating to a national urban coverage of 65 percent. The urban population without sustainable access to safe drinking water has fallen from 37% in 2000 to 21 percent in 2005.

Table 7.2: Classification of types of energy in Percentage

Type of Energy	Biomass(bagasse,woodetc)	Petroleum	Bituminous Coal	Electricity
Percentage	50	20	20	10

Source: SEA

Another crucial factor in climate change is that Swaziland like most African countries lacks the adaptation capacity to these changes in weather patterns. When natural disasters hit the country there is no adaptation system in place to mitigate the effects of such disasters.

The number of projects that have been subjected to environmental assessment has increased from 55 in 2000 to 204 in 2006.

In rural water supply, 42% of the rural populace had been served safe drinking water since 1990. In 2006, the proportion of rural population with access to safe drinking water has increased to 54%.

There has been an improvement in the housing conditions of slump dwellers, with an increase in slump upgrading beneficiaries from 21000 in 2005 to 41 000 beneficiaries in 2007. Within the peri urban population, the slump upgrading beneficiaries increased from 250 000 people in 2001 to 540 000 people in 2005. Moreover, there have

also been a total of 1453 plots that have been serviced with roads, storm water drains, sewer and electricity.

- ▶ Creating environmental awareness among politicians and parliamentarians for ease of policy implementation.

CHALLENGES

- ▶ The development of a strategic plan that will be instrumental in tracking progress in environmental management
- ▶ Human and financial resources that will be adequate in enforcing the environmental requirements and standards
- ▶ Equipment for data collection and dissemination of environmental related data in order to influence the policy environment.

SUPPORTING ENVIRONMENT

- ▶ National environmental Policy
- ▶ Swaziland Environmental Plan
- ▶ National Solid Waste Management Strategy
- ▶ National Biodiversity Strategy and Action Plan
- ▶ Environmental Education Strategy
- ▶ National Biosafety Policy

Goal VIII



**Develop a Global Partnership
for Development**

TARGETS

- ▶ Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.
- ▶ Address the special needs of the country's landlocked status.
- ▶ Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long run.
- ▶ In cooperation with strategic partners, develop and implement strategies for decent and productive work for everyone.
- ▶ In cooperation with pharmaceutical companies, provide access to affordable essential drugs.
- ▶ In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

STATUS AND TRENDS

This goal effectively underpins the efforts of developing countries to achieve all of the other MDG's as demonstrated by the acknowledgement that significant effort is required of both developing and developed countries in achieving the MDG's.

It is different from the other goals in that while goals 1-7 have specific indicators that have to be met by an individual country, goal 8 tracks progress within the international community. Given its nature, goal 8 consists of several crosscutting issues, which on their own require a complex analysis which makes it difficult to package them neatly in the context of the stated targets. Some of the indicators refer specifically to Less Developed Countries that are highly indebted poor countries. Swaziland is not in this category of countries.

Therefore, the analysis under this goal will focus on the aspects that have been deemed relevant to Swaziland.

FINANCE AND INVESTMENT

Swaziland is facing momentous socio-economic and developmental challenges. These have been exacerbated by very low rates of economic growth which have averaged

less than 3 percent in the last five years. The low rates of economic growth have manifested into high unemployment levels and increases in the incidents of poverty.

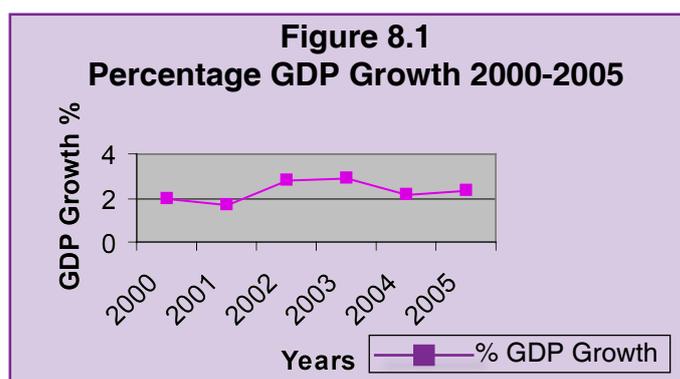
Table 8.1 Percentage GDP growth 2000-2005

E('000)	2000	2001	2002	2003	2004	2005
% GDP growth	2.0	1.7	2.8	2.9	2.1	2.3

Source: CBS Annual Report 2005/06

Table 8.1 above shows that Swaziland's real gross domestic product (GDP) averaged 2.3% per annum between 2000 and 2005. The growth of the economy has in the recent past been constrained by both natural disasters such as droughts as well as market related risks such as the appreciation of the exchange rate which affects the exporters, competition in the global market and declining prices of agricultural commodities.

Figure 8.1 below shows the percentage real GDP growth trend spanning the period 2000 to 2005. There was a downward trend recorded between 2000 and 2001 from 2.0% to 1.7% respectively. While the real GDP growth hit its lowest point in 2001 it recovered somewhat in 2002 from 2.8% to a peak of 2.9% in 2003 before falling again in 2004 and 2005 to 2.1% and 2.3% respectively. This fluctuation in real GDP growth is explained by the intermittent rainfall and uneven weather patterns that the country has experienced which have had a major impact on the performance of the agriculture sector. The volatile exchange rate has also resulted in this jagged economic performance given its impact on the performance of the manufacturing sector.



Source: CBS Annual Report 2005/06

The slowdown in the expansion of economic activity is also a reflection of low growth rate in Foreign Direct Investment (FDI) in Swaziland. The Kingdom has experienced a marked decline in Foreign Direct Investment (FDI) in the last five years as shown in table 8.2 below. Net FDI inflow dwindled from E665 million in 2000 to E56 million in 2006. This is attributed to the fact that the country is competing robustly with its neighbours for FDI. South Africa and Mozambique are bigger economies with larger markets and they have been experiencing higher economic growth rates compared to Swaziland. These and other factors have rendered them more competitive for FDI inflows.

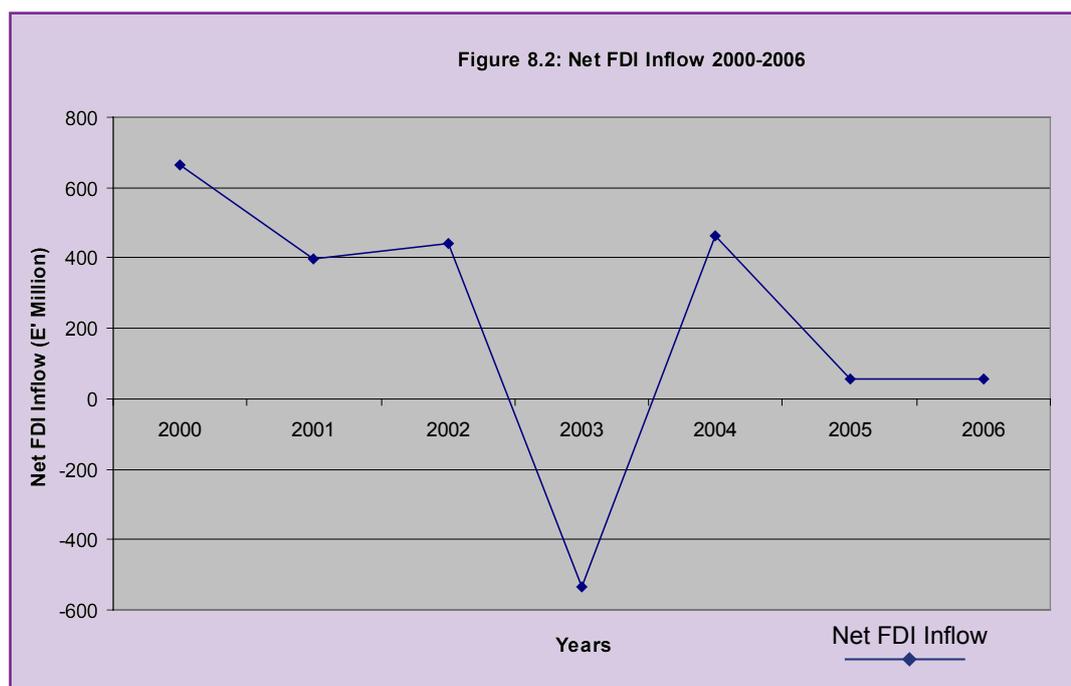
Even though FDI inflows have shown a downward trend in Swaziland, total investment as measured by capital formation has been increasing between 2000 and 2005 as shown by figure 8.3. The trends as reflected in table 8.3 shown an upward trend of the total capital formation from E1,916.7 million in 2000 to E3,808.5 million in 2005. This is attributed to the fact that over the period under review both private and public capital formation increased. Private capital formation increased from E1,323.2 million to E2,426.6 million while the public capital formation increased from E593.5 million to E1,381.9 million over the same period.

The table below shows that the country experienced severe decline in FDI inflows in 2003 although a sharp recovery was experienced the following year FDI inflows remained significantly low.

Table 8.2 Foreign Direct Investment Inflow 2000-2006

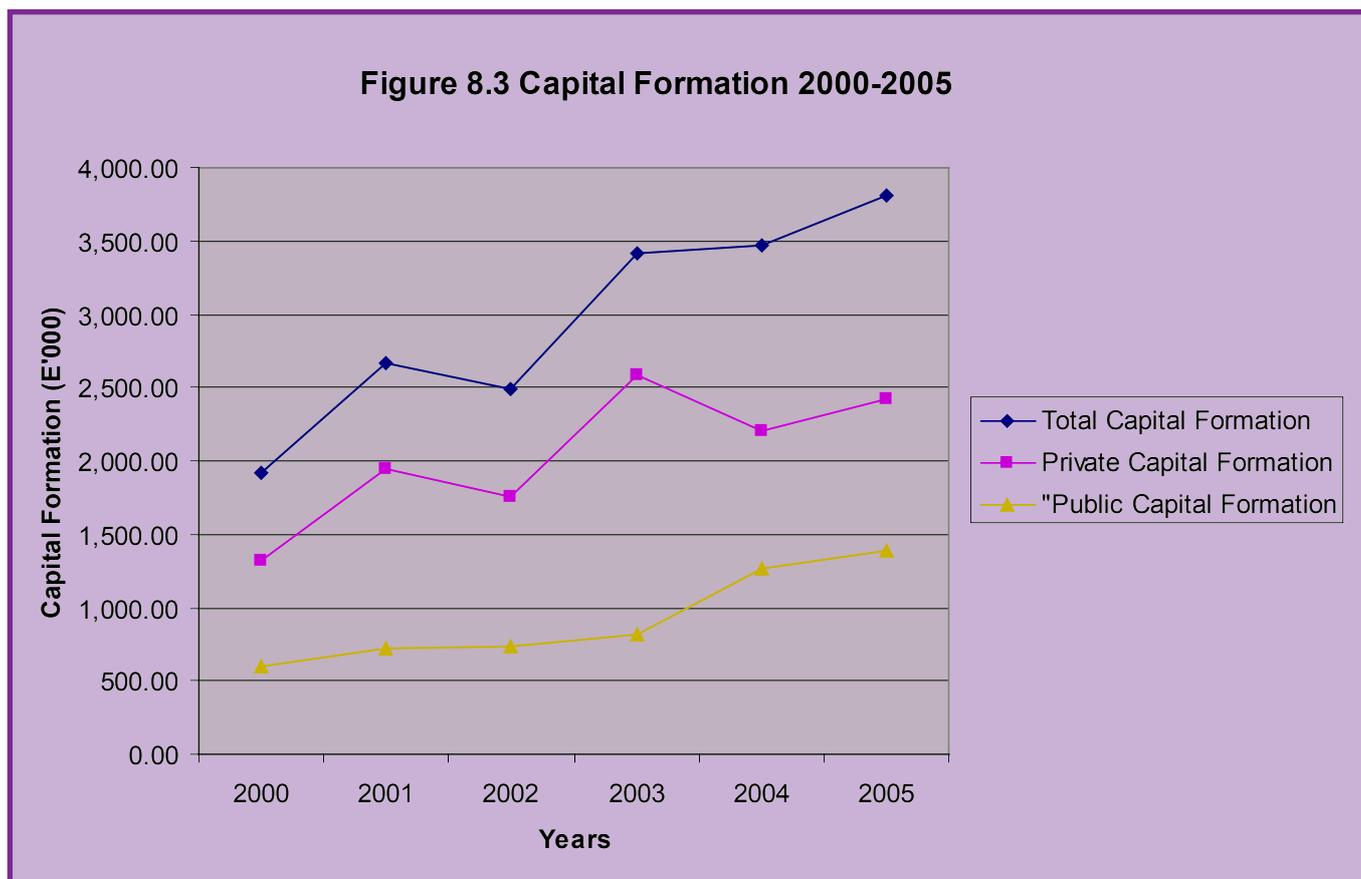
E('000)	2000	2001	2002	2003	2004	2005	2006
% GDP growth	665.0	396.0	442.9	-534.5	465.1	56.1	56

Source: CBS Annual Report 2005/06



Source: CBS Annual Report 2005/06

Figure 8.3 Capital Formation 2000-2005



Source: CBS Annual Report 2005/06

The country's financial sector performance has also been impressive, the banking industry is well capitalized, liquid, financially sound and prudently managed. This has been reflected in the improvement of the average risk weighted capital adequacy ratio for the industry from 15.7 % in 2004/2005 to 26.3% at the end of December 2006 against the statutory minimum adequacy ratio of 8 %.

The performance of the Swaziland Stock Exchange (SSX) has not been satisfactory when compared with other markets in the region. However, the SSX All Share Index ended higher at 175.21 points in 2006 when compared to 155.10 points recorded at the end of 2003. The number of listed companies has increased slightly from 5 in 2000 to 6 in 2006.

With regards to the external debt situation in the country, the ratio of external debt to Gross Domestic Product (GDP) has remained well below and within the limits for a country of Swaziland's size. The ratio increased from 22 % in 1998 to reach 33% in 2001 before declining to 18 % in 2006.

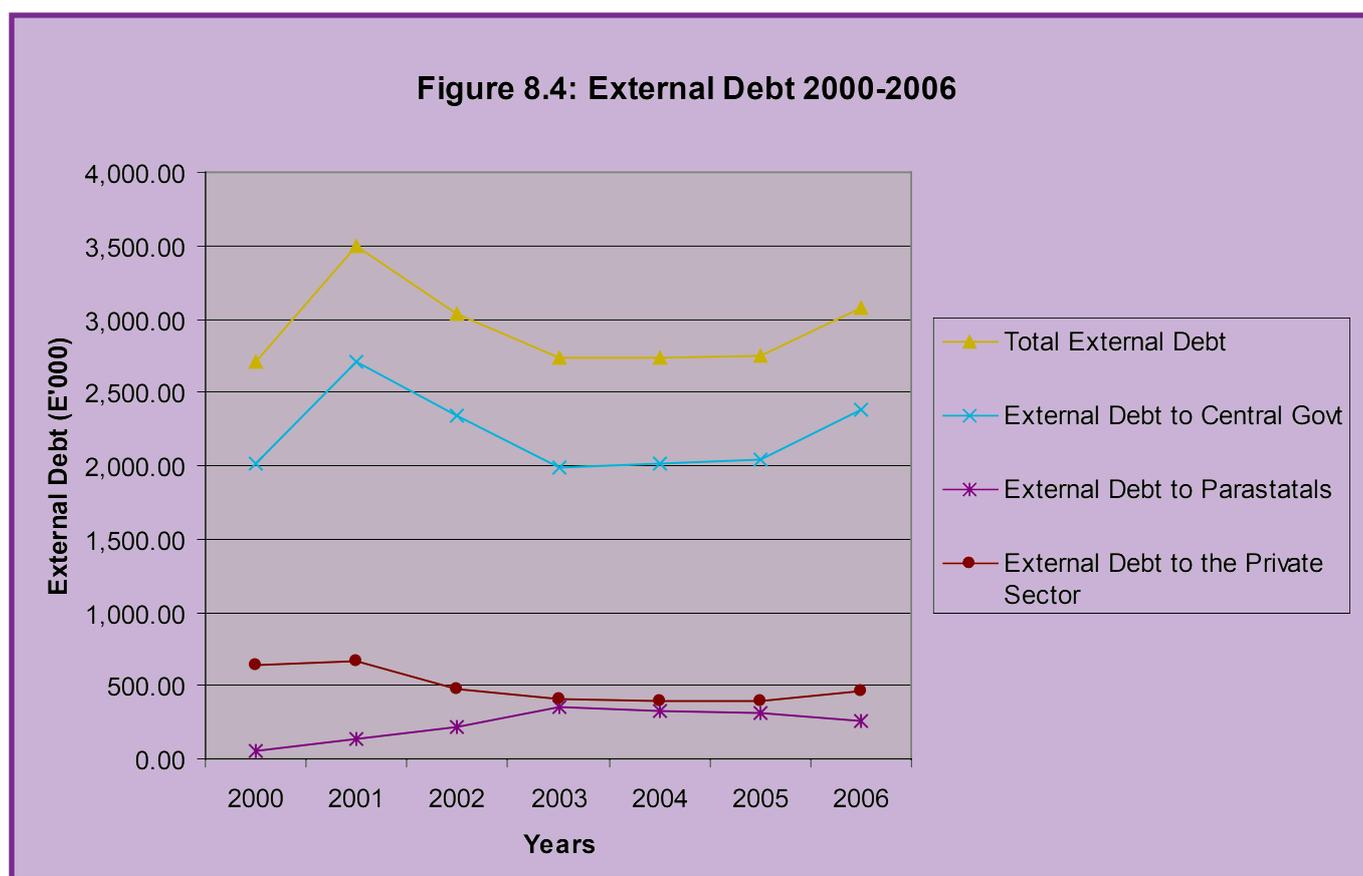
DEBT MANAGEMENT

While a debt situation remains manageable, an in-depth analysis shows that external debt has worsened from E2, 710.4 million in 2000 to E3, 081.4 million in 2006. A sizeable chunk of the external debt is to the central bank. The external debt to the central bank has increased from E2, 018.1 million in 2000 to E2, 374.7 million in 2006 while external debt to parastatals in 2000 stood at E52.3 million and increased in 2006 to E256.6 million. However, the external debt to the private sector decreased in 2000 from E640 million to E456 million in 2006.

Table 8.3 External Debt in Swaziland 2000-2006

(E' Million)	2000	2001	2002	2003	2004	2005	2006
Total External Debt	2,710.4	3,498.1	3,031.2	2,741.3	2,732.8	2,749.5	3,081.5
External Debt to Central Govt	2,018.1	2,703.8	2,339.2	1,986.5	2,011.3	2,044.8	2,374.7
External Debt to Parastatals	52.3	132.0	214.1	351.9	327.1	313.1	256.6
External Debt to the Private Sector	640.0	662.2	477.8	403.4	394.4	391.7	456.3

Source: CBS Annual Report 2005/06



Source: CBS Annual Report 2005/06

UNEMPLOYMENT SITUATION

The unemployment environment in Swaziland reflect the fact that the long period of sustained economic growth that Swaziland experienced during the 1980's to early 1990's did not translate to decent and sustainable employment creation. The national unemployment remains very high at 29%. The unemployment rate for the youth is estimated to be over 40%. The sharp decline in economic growth and particularly the poor performance of the agriculture sector has exacerbated the unemployment situation in the country.

TRADE

In terms of trade performance, Swaziland's economy is export oriented with the exports sector at 56% of GDP between 2000 and 2005, rising to 64% between 2004 and 2005. The appreciation of the exchange rate was the main factor responsible for the diminishing increase in the volume of exports during the period under review.

On the other hand, imports more than doubled between 2000 and 2004. Contributing to the rise in imports was the increase in the importation of manufactured goods which account for over half of all country's total imports.

Table 8.4 Exports and Imports 2000-2005

E('000)	2000	2001	2002	2003	2004	2005
Exports	7,863.5	10,454.2	11,169.7	11,953.9	14,227.7	13419.2
Imports	9,311.7	11,540.6	11,421.7	11,673.1	14,409.5	14,094.9

Source: CBS Annual Report

On the international trade front, Swaziland is a member of various regional trade groupings. The most important one is the Southern African Customs Union (SACU) because more than half of the government revenue receipts come from it. Swaziland is also a member of the Southern African Development Community (SADC) and the Common Market for Eastern and Southern Africa (COMESA). There are various trade negotiations that are currently underway under these groupings and Swaziland is actively participating in them since they have a significant bearing in her economic welfare.

Swaziland's main export items are Sugar, Wood pulp, Citrus and canned fruits among others. However the most important export item is sugar.

The sugar industry is of critical importance to Swaziland's development, and plays a multifaceted role in the economy. It contributes about 18 % to national output and over 35% of the workforce in the agricultural sector is employed in the sugar industry. Swaziland's sugar industry has consistently ranked among the top ten most efficient producers of sugar.

The sugar industry is now facing several challenges, primary of which has been the appreciation of the local currency, and, recently, the process of erosion of preferences in the EU market. The result of these developments is a reduction in export earnings and a reduction in industry revenues. The EU has announced reforms to its internal sugar market regime, which will result in the lowering of prices obtainable in the EU by a cumulative 36% over the next four years (between 2006 and 2009).

Swaziland is challenged with responding both to the need for reform in order to ensure the continued viability of the sugar industry and the requirement of the EU. Top this end a comprehensive strategy to which the support could be channeled has been developed.

The strategy seeks to minimize the possibility of deterioration in living standards resulting from the reforms and to support diversification initiatives, both within the sugar industry and outside to other sectors. This will also include the provision of social safety nets to ensure that people who were dependent on the sugar industry are able to continue supporting reasonable livelihoods. Other macroeconomic imbalances will result from the EU sugar reforms such as negative effects on export earnings, balance of payments, government revenue and increased expenditures on social services, increasing unemployment and worsening poverty situations.

OFFICIAL DEVELOPMENT ASSISTANCE

According to estimates by the Commonwealth Secretariat, Swaziland received just \$24.7m of disbursed Official Development Assistance (ODA) in 2002. Its per capita net resource flows from all sources in that year was \$25. This was one of the lowest of 52 low and middle-income small states. This does not compare with countries like St Lucia and Dominica in the Caribbean and Solomon Islands in the Pacific, all of which received more than \$100 per capita. The UNDP's 2005 Human Development Report showed that Swaziland received in just \$27.1m of ODA in 2003, or \$24.5 on a per capita basis. This does not compare with \$55 for neighbouring Mozambique, \$53.8 for Zambia, \$46.5 for Tanzania, \$45.4 for Malawi, \$44.4 for Ghana, \$42.1 for the Gambia and \$38.0 for Uganda. Whereas ODA represented 1.5 % to 2% % of GDP recently for Swaziland, for all the other above countries, it was over 10% and even reached 15% in some cases. This is far lower than 6.3% of GDP levels of 1990. The aim should be to get it back to around this rate although, the need for stimulated growth is greater at this time than it was then. Gross investment in 2002/03 was about \$371m. For the needed 30% gross investment rate, investment would have to be about \$545m, which implies an additional \$174m of investment is required. Assuming a similar

division between public and private investment as in the recent past and that more public investment would generate private investment, it is estimated that about \$50m (about 2.5% of GDP) of public investment would be required annually in the near term. On the basis that this may take the form of ODA, it will take aid to about 4 to 4.5% of GDP. Swaziland would need to increase its investment to 35% of GDP to bring about a 7% rate of growth. To maintain this momentum, the aim of Swaziland and its development partners should be to increase ODA to about 6.5% to 7% GDP in the longer term. This would still be below what countries in similar circumstances are now receiving. It is however a reasonable target and in line with increasing assistance to Africa and the scale and

CHALLENGES

The main challenge is to devise policies and programmes that are pro growth so that the socio economic situation can improve.

Financial and human resources are required so that the country can be represented in crucial activities, including trade negotiations, trade exhibitions, and other meetings. Other resources such as computers and lack of access to the internet need to be addressed.

Swaziland did not succeed in getting concurrence from the other SACU member States to take part in the Common Market for Eastern and Southern Africa (COMESA Free Trade Area (FTA)). Since COMESA is the country's third

Table 8.5 ODA to Swaziland between the period 2004-2007

GRANTS	2004/05	2005/06	2006/07	2007/08
	ALLOCATION (US\$)	ALLOCATION (US\$)	ALLOCATION (US\$)	PROJECTIONS (US\$)
Republic of China	9,169,078	9,230,769	11,466,769	10,960,882
Japan	6,738,506	1,584,615	371,218	441,176
UNICEF	3,854,677	3,692,308	3,692,308	3,529,412
UNDP	332,000	340,308	300,000	286,765
UNFPA	300,000	276,923	276,923	264,706
UNCHR	161,408	0	0	0
FAO	795,000	103,846	1,593,846	1,523,529
EU	9,433,244	9,476,923	6,204,253	8,823,529
TOTAL	30,783,913	24,705,692	23,905,317	25,830,000

Source: Ministry of Economic Planning & Development

objectives envisaged. The achievement of these greatly enhanced investment rates, would require developing a momentum also in private investment. Complementary effort is to some extent built-in since larger involvement of the World Bank Group and the EU in Swaziland's partnership development effort would inevitably involve institutions like IFC, MIGA and the EIB.

important market this means that for Swaziland to be able to export to COMESA, a yearly derogation has to be sought from COMESA Member States. This creates great uncertainty for our exporters. This arrangement needs to be sorted out once and for all so as to create certainty and predictability in the COMESA market.

The SACU-EU Trade relations pose a major challenge for Swaziland and its SACU partners. At the moment there are two trade agreements running concurrently with the

EU by SACU Member States. These are the Trade Development Co-operation Agreement (TDCA) between South Africa and the European Union (EU) and the Cotonou Agreement between other four SACU members (Botswana, Lesotho, Namibia and Swaziland-BLNS) and

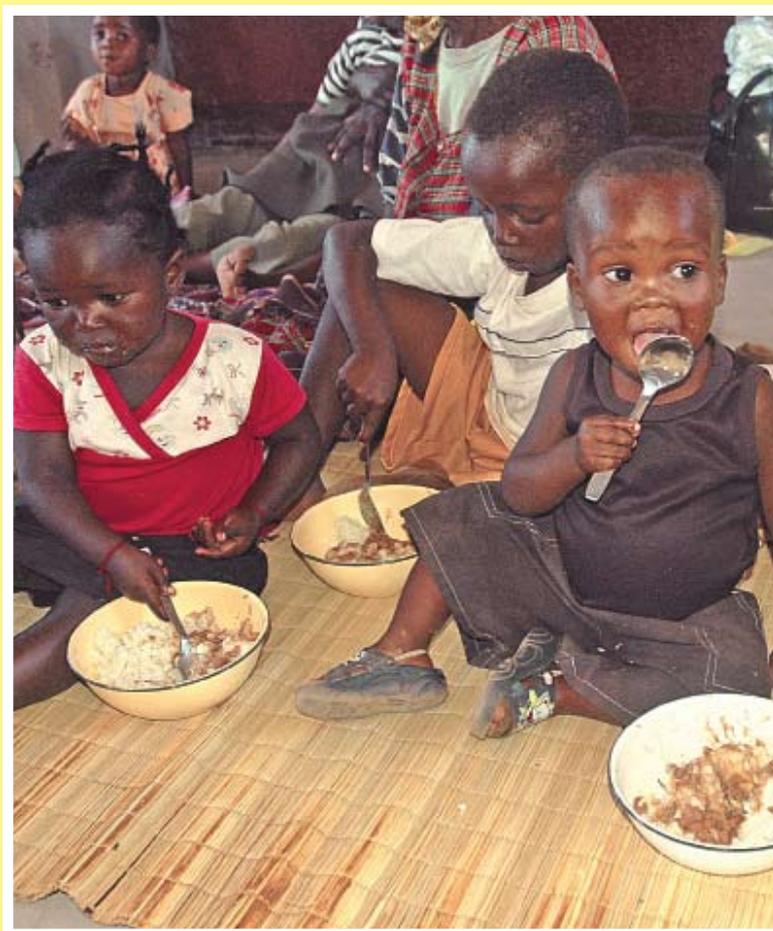
African, Caribbean and Pacific Countries and the EU. There is a need to re-align the two Agreements so that SACU trade uniformly as a Customs Union with the EU.

SUPPORTING ENVIRONMENT

- ▶ Poverty Reduction Strategy and Action Programme
- ▶ Economic Recovery Plan
- ▶ National Adaptation Strategy for EU Sugar reforms

References

1. Ministry of Economic Planning and Development, “Economic Review and Outlook 2002/03 - 2006/7”
2. Ministry of Economic Planning and Development, “Economic Review and Outlook 2004/05 -2007/8”
3. Ministry of Economic Planning and Development, “Economic Review and Outlook 2006/07 -2009/10”
4. Central Bank of Swaziland of Swaziland “Annual Report 2005/06”
5. Central Bank of Swaziland of Swaziland “Annual Report 2002/03”
6. Central Statistics Office, Education Statistics, 1999 -2005, Mbabane
7. Ministry of Economic Planning & Development, A Poverty Reduction Strategy & Action Programme, Volume I, Mbabane, 2006
8. Ministry of Education-Swaziland, UPE Draft Indicators Manual, Mbabane
9. Ministry of Education-Swaziland, Universal Primary Education (UPE) Plan of Action Draft, Mbabane, 2005
10. Ministry of Economic Planning & Development, National Development Strategy (NDS), Mbabane, 1999
11. Ministry of Health and Social Welfare, Reproductive Health Needs Assessment, Mbabane, 2002.
12. Ministry of Health and Social Welfare, Expanded Programme on Immunization Comprehensive Multi-Year Plan, Mbabane, 2007- 2011.
13. Swaziland National Vulnerability Assessment Committee, Swaziland National Vulnerability Assessment, Mbabane, September 2006.
14. National Emergency Reponse Council on HIV and AIDS, National Multisectoral Action Plan for HIV and AIDS 2006/2007, Mbabane 2006.
15. The World Bank, Swaziland Expenditure Review, Strengthening Public Expenditure Policy and Management for Services Delivery and Poverty Reduction, Southern Africa, 2006
16. Ministry of Health and Social Welfare, The Health Sector Response to HIV and AIDS Plan in Swaziland, Mbabane 2006.
17. United Nations Population Fund and Ministry of Health and Social Welfare, Swaziland Community Health Survey, Mbabane 2002.
18. Ministry of Health and Social Welfare and United Nations Children’s Emergency Fund, National Plan of Action for Orphans and Vulnerable Children, Mbabane 2006 -2010.
19. National Emergency Response Council on HIV and AIDS, Swaziland UNGASS Country Report, Mbabane 2005.
20. Ministry of Health and Social Welfare, Annual Health Statistics report, Mbabane 2001.
21. Ministry of Health and Social Welfare, Annual Report for National Malaria Control Programme, Manzini, 2003.
22. Ministry of Health and Social Welfare, Sero-Sentinel Surveillance report, Mbabane 2006.
23. Central statistics Office, Demographic and Health Survey Report, Mbabane, 2007.
24. World Health Organization, Child Health Epidemiological Reference Group, estimates of the burden of malaria morbidity in Africa in children under the age of five years, Geneva, 2005.
25. Ministry of Ministry of Enterprise & Employment, Contributions of the Ministry of Enterprise and Employment to the MDG’s 2000-2007, Mbabane, 2007.
26. World Bank, Swaziland: Achieving Education for All, Challenges and Policy Directions, Africa Region Human Development Working Paper Series No. 109,2006.



MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT

SWAZILAND GOVERNMENT

SEPTEMBER, 2007

